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Standing Committee on Justice Policy

Committee business

Intimate partner violence

1st Session
43rd Parliament

Wednesday 17 July 2024

Chair: Lorne Coe
Clerk: Thushitha Kobikrishna

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Comité permanent de la justice

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Greffière : Thushitha Kobikrishna

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

COMITÉ PERMANENT DE LA JUSTICE

Wednesday 17 July 2024

Mercredi 17 juillet 2024

The committee met at 1000 in committee room 1.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Good morning, honourable members. In the absence of the Chair and Vice-Chair, it is my duty to call upon you to elect an Acting Chair. Are there any nominations? MPP Dixon.

Ms. Jess Dixon: I nominate MPP Bouma.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Okay. Are there any further nominations? MPP Wong-Tam?

MPP Kristyn Wong-Tam: I would like to nominate MPP Mamakwa.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): This is for the Acting Chair, so this is for who's going to be sitting here—

MPP Kristyn Wong-Tam: Who's going to sit for today?

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Yes.

MPP Kristyn Wong-Tam: Okay; thank you very much.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Are there any further nominations? No?

There being no further nominations, I declare the nominations closed and MPP Bouma elected Acting Chair of the committee.

The Acting Chair (Mr. Will Bouma): Thank you for your trust in me.

COMMITTEE BUSINESS

The Acting Chair (Mr. Will Bouma): Good morning, colleagues. I call this meeting of the Standing Committee on Justice Policy to order. We are meeting today to begin public hearings on the committee's study on intimate partner violence.

Is there anything before we get started? Member Dixon, go ahead.

Ms. Jess Dixon: Thank you, Chair. I have a motion: I move that, in accordance with standing order 119, which stipulates that Chairs of standing committees shall be distributed in proportion to the representation of the recognized parties in the House, the current Chair of the Standing Committee on Justice Policy be removed as a result of the change in her party affiliation.

The Acting Chair (Mr. Will Bouma): I'm just going to give a minute for the Clerk to distribute the motion. Once we have that out—any discussion on the motion? I will let the mover—

Ms. Jess Dixon: No, Chair.

The Acting Chair (Mr. Will Bouma): Nothing?

Member Wong-Tam.

MPP Kristyn Wong-Tam: Thank you very much, to our Acting Chair.

As we all know, this particular committee is tasked with the important work of settling matters around equity, fairness and safety for all communities, including marginalized communities, the safety of women and many others. We believe that this committee should always be and must be, and we must make it to be, a safe space for all communities who come forward to present their concerns. They do so by making deputations, by providing written submissions, and it's important that we hear from them and hear their input because it contributes to the making of good laws.

MPP Ghamari has been an active member on the justice policy committee. She has a long record, and there are many allegations and recorded evidence of Islamophobia, xenophobia and other forms of hate against many minority groups who form Ontario's diverse community. She has recently been removed by her own party, as noted by this motion, because of those incidents, and it's clear that the MPP is unfit to remain as the Chair of the justice policy committee, which is why I am very pleased to be working with the government members to ensure that we have a new Chair. The motion before us has our full support.

The intimate-partner-violence subcommittee has some very important work to do. MPP Dixon and I have worked really hard to create a list of witnesses who will come forward to provide us their expert testimony and to submit proposals and presentations, and these members are taking time from their very busy family-oriented summers.

We want to make sure, when they appear before this committee, that they are presented with a welcoming and safe environment. We cannot have an MPP who holds hateful views about certain marginalized groups in Ontario, namely Muslim and Arab community members, or someone who affiliates herself with far-right extremists to create an environment where these difficult stories that are to be shared, which oftentimes intersect and involve religion, gender, culture, immigration—they have to be shared in a way that allows all of us to hear those stories, and they cannot be at any point held back from telling their truth and sharing their lived experience.

So, for this reason, the motion is important, and it has the full support of the official opposition NDP.

The Acting Chair (Mr. Will Bouma): Any further discussion? Seeing none, are members ready to vote on the motion? All those in favour of the motion? Carried, unanimously. Thank you.

So now we are without a Chair. Is my work here done?

The Clerk of the Committee (Ms. Thushitha Kobikrishna): That is correct.

The Acting Chair (Mr. Will Bouma): Thank you, everyone, for your confidence.

ELECTION OF CHAIR

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Good morning, again, members. It is my duty to call upon you to elect a Chair. Are there any nominations? MPP Dixon.

Ms. Jess Dixon: I nominate Lorne Coe.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Does the member accept the nomination?

Mr. Lorne Coe: I do.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Are there any further nominations? MPP Wong-Tam.

MPP Kristyn Wong-Tam: Yes. I would be very pleased to nominate MPP Sol Mamakwa. He is currently the Vice-Chair, and it would be appropriate to ascend him to Chair.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): All right. MPP Mamakwa and MPP Coe have been nominated. There being no further nominations, I declare the nominations closed.

All those in favour of MPP Coe as Chair, please raise your hand. Having received the majority of the votes, MPP Coe is duly elected as Chair.

MPP Coe, would you please take your chair?

INTIMATE PARTNER VIOLENCE

The Chair (Mr. Lorne Coe): Thank you, colleagues, for the honour to chair this committee.

Madam Clerk, I think we have a preamble that you want me to go through?

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Yes. If you could just start from "The committee has."

The Chair (Mr. Lorne Coe): All right. The committee has invited expert witnesses to provide their oral submissions. Each witness will have 10 minutes for their presentation, followed by 20 minutes for questions from members of the committee. The time for questions will be broken down into one round of 7.5 minutes for the government members, one round of 7.5 minutes for the official opposition and one round of five minutes for the independent member.

The scheduled presenters are in front of you on the agenda. I'm assuming each of you has a copy of the agenda.

DR. KATREENA SCOTT

The Chair (Mr. Lorne Coe): I will now call on Katreena Scott to come forward, please, and make your presentation. Thank you, and good morning.

Dr. Katreena Scott: Good morning.

The Chair (Mr. Lorne Coe): For the record, please, could you state your name and position?

Dr. Katreena Scott: Yes. My name is Katreena Scott. I'm the academic director of the Centre for Research and Education on Violence Against Women and Children at Western University. I'm a professor, a clinical psychologist, and I hold a Tier 1 Canada Research Chair in ending child abuse and domestic violence.

The Chair (Mr. Lorne Coe): Thank you. You'll have 10 minutes for your presentation. After that, there will be questions from members of the committee. Please start your presentation.

Dr. Katreena Scott: May I please have just a second, because I am connected on Zoom and I need to share my screen? Give me one second, please, to get set up.

Sorry, one second. Okay. I'm going to begin, and then I will come back.

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I want to thank the committee for this invitation to speak and for your focus on this important issue. Given that I'm your first witness, I think it is important to begin with a few general points that set some context for the specific recommendations that I will make. The prevalence and impact of intimate partner violence; the economic costs to our health, mental health, justice and child protection systems, and to our workplaces; and the human costs of IPV warrant the declaration of an epidemic.

According to the Ontario femicide report, there were 62 femicides last year. Most of them are intimate partner violence. There are 35 already to the end of June this year. If we understand femicide as the canary in the coal mine, the indication that something is going wrong, then the canary is singing as loudly as it can.

This is a solvable problem. We have empirically supported road maps to change, and following those road maps, taking steps to prevents and respond effectively to intimate partner violence, strengthen relationships and support families are things that will benefit everyone and will create stronger, more connected and more just communities.

Third, our solution needs to be a framework that listens to survivors and recognizes local realities. Criminal justice systems should not be the first line of response; they should be the last result when everything else fails. For this to be true, organizations working to ensure the safety of people in Ontario, particularly women, children and 2SLGBTQQIA+ people, should not themselves be continually facing precarity and deficits in core funding while they continue to deal with overwhelming demand.

And finally, we can do this together. We have a wealth of experience in Ontario. Strong government/community partnerships can guide, implement and monitor solutions that are local, diverse and collaborative.

So, with that, am I going back to my—to share a little bit around—oh, my goodness gracious. I do this all the time, but apparently today I want it to be a little bit more difficult.

I'm going to talk specifically about the issue of responding to individuals that are using harmful, abusive and coercively controlling behaviours. Primarily, this violence is perpetrated by men against women, though it can occur from women to men, in relationships that are queer and of diverse genders. We know that it's also an intersectional problem and that populations and individuals facing structural forms of violence are at greater risk.

In Ontario right now, we have a situation where there's a real gap in services. If you are a person who is causing harm and wishes to seek service, where do you go? If you're a couples counsellor who identifies issues, who do you refer to? If you're a workplace that identifies a concern about an employee, how do you find the right kinds of resources? The reality in Ontario is that we live right now in a system where if there is somebody who is engaging in or is at risk for hurtful, abusive or coercive behaviour, it's very, very difficult to find and get help, and, really, what has to happen is they need to wait until they're involved in the criminal justice system, at which point they can get specialist services and then they're ordered to attend our partner assault response programs.

Now, there is a little bit, a smattering, of programming in this area. There is some project-based funding. There is some United Way-based support, for example for voluntary programs or for Caring Dads. There are some fundraised supports for men's engagement workers, for example in Waterloo. There are some communities, which are being led mostly by shelters, that are working to provide some of these services to those who use abusive behaviours or are at risk of those behaviours, but it's too few and too far between.

So my first recommendation is that we need to invest in a system of response to address abuse, and support survivors and children before criminal charges, when we're concerned about risk factors and warning signs and we want to prevent escalation.

I can talk a little bit more about what that program creation might look like, but here is just a picture of something that's happening in Alberta. This is an example of the men's counselling service. It's led by the shelter. It's a range of different programs that are available and a network of service providers across the province so that people can find and get the help that they need.

My second recommendation is to follow the evidence on improving partner-assault-response-type services. Ontario used to be really a leader in this area, and unfortunately, it has fallen well behind the rest of Canada in the kind of services that it's providing. These are the people that PAR serves right now: people who have already completed the program and are being referred again, a first-time offender, people on a peace bond, and a person who has multiple offences and may be being released from incarnation.

We know what's needed. I wrote a report for the Nova Scotia Mass Casualty Commission that is referenced here with a lot of evidence for it. I'm going to go right to the recommendations. Ways to improve partner-assault-response programs: We need sufficient funding, especially in rural areas, so that program staff can be full-time. We can't have a response to this important of a problem that's available on Tuesdays and Wednesdays and where nobody can take a holiday.

We also need to remember that we're trying to create change, not get people through programs. So if we're trying to create change, we really have to think about what those programs look like. It means offering smaller groups. The recommendation is really to a max of about 12, with more closed or staggered entry. We need to strengthen program content, according to the evidence.

And I strongly recommend that we integrate and incorporate both group and individual sessions. This would allow for risk management, it would allow for responding to individual needs and it would allow us to lengthen service to more like what is recommended internationally, which is closer to 20 or 22 weeks, as opposed to the current 12.

We also need to tighten our justice responses. We know that these programs work best when they are swift and sure, and we have anything but a swift and sure response right now. But the second way to improve the partner-assault-response program links to the first, and it's about knowing that one size doesn't fit all. We have known this for a long time. We don't need to send the same people through the same thing over and over again. We need a variety of programs and capabilities in the field to do this.

We can do this by incentivizing collaboration and cross-agency service that addresses intimate partner violence and substance use, and intimate partner violence and mental illness. We can look at co-led programs for diverse clients. We can fund empirically supported programs directed at fathers and collaborate with child protection. We can create a stream of programing for more serious and repeat offenders, according to the risk-need-responsivity model. This would improve our ways to respond to all of these men.

This is just my very bad graphic showing that if we put both voluntary clients and clients who are referred through the justice system together, we could create a system of response that meets everybody's needs and that could be individualized and follow the evidence around programs that address needs together.

I am using this as a teaser; if people want to see a small sampling of evidence, I'm not going to go over it right now. Instead, what I'm going to do is say that to do this, I do think we need to develop some capability. The reality is that in Ontario—in fact, in Canada—becoming a specialist, developing the specialist services skills necessary to do this work is hard. It's not part of the training programs it should be part of.

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have a social media reach of about 1.5 million and we reach about 40,000 service providers each year, with funding and support from your government, through free webinars and recordings.

The Chair (Mr. Lorne Coe): Excuse me. You have one minute left in your presentation.

Dr. Katreena Scott: Yes. We would like to continue this by developing workforce capabilities and skills-based courses.

And then my final recommendation is for investments in communities that are preventative. Again, your government has invested in broad public education. We need this broad messaging. We have coordinating committees across the province that can do this work. They need to be strengthened and they need to be supported. There is so much more we can do.

I will just conclude with the statement that, in Ontario, a person who is experiencing abuse should be able in reach out, they should be able to find help and we should have a system of response that's effective.

The Chair (Mr. Lorne Coe): Thank you very much for your presentation.

We'll begin our questions and answers with the official opposition, please. MPP Wong-Tam, when you're ready.

MPP Kristyn Wong-Tam: Thank you, Ms. Scott, for your presentation this morning. I know that 10 minutes is not a lot of time, so I also do want to thank you for your written submission, which is really broad and expansive.

I want to also just note that you began your presentation by citing that the declaration of intimate partner violence as an epidemic is essential and that the warrants of meeting that declaration are met, so I want to thank you for that statement.

I want to just dive a little bit deeper into your comments about the cost of intimate partner violence. I think we all recognize the cost to the mental health system, the child welfare system, the health system, education, workplace disruption, housing—it is all very much there. If we don't invest upfront in systemic and broad, sustainable structural programs that are not project-based, we're going to see that the problems will continue to exist. Would you agree with that statement?

Dr. Katreena Scott: Thank you. That's fantastic testimony that I could have added. Yes, I agree. We know that this kind—we need to move this upstream. We need to start meeting the needs of families and children and victims and those who are causing harm. We need to start doing that earlier, because the downstream costs are so much greater, and if we don't do that, those costs are going to continue to be borne by all of those systems.

MPP Kristyn Wong-Tam: In your testimony, and also your written documentation, you stress the importance of upstream prevention, which I think is actually where this committee would like to drive its work. We recognize that when it happens, it's too late, and the effects of stopping it are much harder.

So, with respect to the upstream prevention, we know that government cuts to programs can be very harmful, especially for community-based responses. And in your testimony, you said that we need to have a tailored approach, but you need to be able to be diversify the programs to meet the needs of the community.

From your vantage point—and I know that you have a really broad way of addressing the problem—you spent a significant amount of time talking about what that could look like. Can you elaborate further on what, specifically, we need to walk away with from your deputation and take from there?

Dr. Katreena Scott: It's very hard for me to say one thing that I want you to walk away with. I think what I'll start with is just where I ended: recognizing that there is some foundation of work already in Ontario that can set the context for the kind of change that we need—that is, as you say, local and collaborative and diverse—and that's through the 48 violence-against-women coordinating committees that bring together service providers and people in that area in each community in Ontario.

Those committees also—public education is one of the things that has been, as you note, cut over and over again. Those committees are ones that can reignite the work that needs to be happening in community, in multiple languages and multiple contexts, for the very first part of prevention, which is that everybody needs to be able to recognize risk factors. They need to be able to have a conversation that opens the door, and they need to be able to provide a referral.

But then there needs to be someone to refer to, and that's the second part. We need those services that are not the criminal justice—it's already way too late—but "I'm concerned about what's happening here. I'm concerned about what I'm seeing. How can we do a reach-out and how can we provide service right at that point to address what might be going down a bad pathway?"

MPP Kristyn Wong-Tam: My final question to you—and then I want to make sure I hand some time over to my colleague MPP Glover. You had a slide that specifically spoke about firearms, but it passed by us so quickly. And yet, we know that in Ontario, femicide—we've seen high-profile femicides take place with active gun shooting. Can you just explain what would have been on your slide, if we had the time to see it?

Dr. Katreena Scott: Absolutely. So it's called—but there's so much more we can do; it's not controversial. One of the things we can do is, we can start to share more information, and we can do that through the Chief Firearms Officer of Ontario. It is the case that 29% of domestic-homicide-related deaths or intimate-partner-related homicide deaths are actually caused by firearms. I don't think most of Ontario knows that. And gun owners and non-gun owners alike are not happy with that kind of statistic. We know that access to firearms is an important risk factor for domestic homicide, and when firearms are used it's more likely to be more victims, and these are also often homicide-suicide. But let's think about what we could do. We could include and develop a website that provides this information, along with other information. We could provide posters and public health materials at gun clubs and at places where we sell guns, and we can do

this in collaboration with gun owners so that we can all together understand the risk factors.

MPP Kristyn Wong-Tam: Thank you very much.

The Chair (Mr. Lorne Coe): MPP Glover, please, you have a minute and 50 seconds, sir.

Mr. Chris Glover: I've got two questions I want to ask, and I'll try to make them fairly quick.

Thank you so much for being here. I don't have a lot of experience in researching IPV, but I do have a lot of experience researching gun and gang violence, and in the research that I've done, it's clearly shown that if you come from a violent community, there are all kinds of mental health and physical health impacts that lead you to be more violent. Is there the connection, then, with growing up in a violent community and a greater trend towards being an abuser and intimate partner violence?

Dr. Katreena Scott: Yes, we know that there is a strong relationship between a childhood history of adversity—and that is both within the family and outside of the family—and the development of then both being a victim or a perpetrator of violence in the intimate partner relationship and then subsequently in your family and also towards your children. So I think that is one of the other arguments for as early and as much as possible. There are so many touch points where we could be having these conversations.

Mr. Chris Glover: One of the quotes that I've heard that puts it [*inaudible*] episode of gun violence is a previous episode of gun violence, because it just tends to spiral.

My colleague MPP Wong-Tam was talking about upstream prevention. These communities that have more community violence often have higher rates of poverty; they have housing issues; they have transit issues; they're food deserts. All the social determinants of health are working against them. If we were to address those social determinants of health, starting with poverty, would that help to reduce the intimate partner violence?

The Chair (Mr. Lorne Coe): Thank you, MPP Glover. That concludes the time of the official opposition.

I'd like to move, please, to the independent member. MPP Mantha, please. You have five minutes, sir.

Mr. Michael Mantha: What he said—can you answer that?

Dr. Katreena Scott: The answer is yes.

Mr. Michael Mantha: I'm here to learn from you and all of our presenters who are going to be here. I just have one question for you, and then I'd like you to use the remainder of the time to give us some highlights as far as—you talked about foundation and where certain organizations are already in place that would benefit the advancement of the IPV program.

The reason why we're here today is, a member brought a motion forward to declare the IPV epidemic. Is there any benefit to delaying that?

Dr. Katreena Scott: To delaying it?

Mr. Michael Mantha: Yes. We're going through an entire process that we're going to be using for the next months with organizations. What would have been the benefit of declaring it months ago, when the motion came on the floor of the Legislature?

1030

Dr. Katreena Scott: You know what? I'm going to speak from the perspective of somebody who does this work or is connected with this work day in and day out. There is a real urgency in action, and as I started, this has been a terrible couple of weeks, to be quite honest with you. It's often bad, but this has been a very tough couple of weeks in the gender-based violence world because of the losses that we've experienced in Ontario. So it's hard for me to answer your question around when or do you do it at this point or that. What really is needed is we need government and community to work together, to put time, resources, attention and focus and to make change in this issue in Ontario.

Mr. Michael Mantha: So making the declaration when it was brought up could have been actually helpful to every community, to anyone across this province?

Dr. Katreena Scott: And I think that one of the things I would say that you saw is that you saw community after community, municipality after municipality take it upon themselves to say, "We are declaring IPV an epidemic." It has been a groundswell of individuals who are committed to this issue, who are dedicated to this issue, who are pushing it forward and saying we need to do something.

Mr. Michael Mantha: The foundations of the organizations that are presently out there—women's shelters, drugs and addictions centres—these are places that can capture these individuals. And one of the things that you find through a wealth of information is the service needs to be there when the person says, "I need help" or "He needs help" or "She needs help," and it needs to be done at that point in time. If we don't have that surrounding care, those programs that are there, those individuals that are willing to open up that door, it's a lost opportunity, and it's a lost life.

Those organizations: Can you talk about some of them that are out there that can benefit the advancement of this?

Dr. Katreena Scott: I'm going to echo or emphasize your point: There are so many missed opportunities. When we take a look through the cases that involved tragic deaths, and other cases as well, you look backwards, and there are missed opportunities after missed opportunities after missed opportunities. The reality is there's not enough in terms of a service response to do this. There's not a clear pathway. And I guess that that's one of my main recommendations, that there is a network of providers, of programs, of services so that people can and know where to reach out to and you can, as you say, get the help when somebody is ready to get that help. It just doesn't exist in Ontario at the moment.

Mr. Michael Mantha: The services that you talked about, that there were no services available for either the abuser or the one suffering from abuse, what is being done in Manitoba that could be mirrored here in Ontario?

Dr. Katreena Scott: Okay, so I'm talking—sorry. I needed to be clear on my points. Our shelters work very, very hard to make sure that there is a space and response

to any survivor-victim of intimate partner violence that comes forward. They are stretched, but you can find that service. You can call those services. They will go and do whatever they can to support you.

It is the issue of you are dealing with somebody who is using abusive behaviour where you can't find where to go. And so you have Dr. Lana Wells, who is presenting later to this committee—and that's in Alberta, where they've done a lot of work to invest in creating access to services for those individuals who may be behaving abusively. In Alberta, it involves a website called Men &, which is also a phone, but "phone" means "text," line—

The Chair (Mr. Lorne Coe): Excuse me. Thank you very much for that response. If you could sit back a little bit from your microphone, please, it will help our technology staff a bit when they're modulating the sound.

I'd like to now turn, please, to the government members, and I have MPP Dixon, please, when you're ready.

Ms. Jess Dixon: I'm going to go off a little bit of what you were just talking about. Obviously, I mean, from my experience of being a crown—a lot of experience of referring people to PAR, seeing non-compliance with PAR, and of course, it's after the violence has already occurred. When we're talking about IPV interventions that could be in place when we start seeing concerns as versus, ideally, before the violence, can you sort of take us through a little bit what those alternative pathways would look like, which I think is kind of what you were about to start doing?

Dr. Katreena Scott: Yes. So let's talk about alternative pathways. There are in fact programs that have been developed in Ontario in various projects and through various projects' funding that do this. I'll give you maybe three or four examples.

In Sudbury, at one point, they ran a program called Before Everything Escalates. That program was accessed—if there was a domestic call to police, there was not going to be a charge, but an offer right there at the door is, "Hey, things don't seem to be going well. Why don't you try this?"

I've been involved in a program called Caring Dads, which works with fathers where there are concerns about violence and abuse in the family, and that is whenever there is a child protection—or if you think about child and family services and there's a concern, going to Caring Dads.

We have done some work with programming around, really, higher-risk men and how we do a better job.

The Caring Dads program has cut re-referral from 36% to 22%, so that's a pretty good one. The higher-risk program cut re-referral for criminal justice issues by half. The Sudbury program—everybody around it liked it. It was a strong and a successful program.

So there are these programs that bring people in that have often both an individualized and a group-based component and that can take people at all of those parts and move the needle in terms of change.

The Chair (Mr. Lorne Coe): MPP Pierre, please. Thank you.

Ms. Natalie Pierre: Thank you for your presentation earlier today. You talked a little bit about upstream preventative services. I wonder if you could maybe provide some specific examples of interventions—I know you talked about the program in Sudbury—either in different provinces or in different countries, that you have studied or have come across that you know be effective.

Dr. Katreena Scott: So I think that part of it is creating that service pathway. Maybe what I'll do is I'll talk a little bit about Australia. I testified in Australia to the Victoria commission. Then I went to Australia as they started to implement some of those changes, and part of that was a recognition that we needed to make this shift to more upstream responses. Part of that, then, was starting with, "Okay, let's make sure that we develop the capabilities of the workforce so that we know how to do this."

Then we create a line or a service access point. How do you get somebody to somebody who has the specialization and ability to do this work? That's often through text or phone-based supports, but it also has been through coordinated committees where, for example, there can be an outreach, or a one-stop shop for different people to access those services.

The services themselves: As I said, it's useful to have a combination of empirically supported group-based services and a more open individual way to assess risks and manage what's happening. So you come in, and let's understand what your needs are: What are the things that are increasing your risk for abusive behaviour? And then let's start to do some case management about how we get you into changing and making those things better, be that stabilizing access to housing, be it looking at escalating thoughts and starting to work around those escalating thoughts, be it working on your relationships within your family, be it reducing the isolation that you experience, be it understanding how substance use and abuse are working together to coerce a partner—whatever it is, helping to create a pathway for change for that individual.

Ms. Natalie Pierre: Thank you.

The Chair (Mr. Lorne Coe): MPP Scott, please. Thank you.

Ms. Laurie Scott: How long?

The Chair (Mr. Lorne Coe): You have two minutes and 38 seconds.

Ms. Laurie Scott: Excellent presentation—lots of ideas and thoughts. I'm a person who's in rural Ontario, and rural areas are always a challenge. I think what I see on the ground is situation tables that are with police and all the services—maybe not enough people in proportion.

How do you get the—you know, if they go to the path on the websites that you mentioned—which I'm all for that; I think there's a lot of online training in mental health that has been very good. People kind of help themselves when they're ready to go there. But I don't necessarily have services everywhere all the time, don't want to go through the criminal thing—I shouldn't say "criminal," but the police services. Have you seen other practices—how would I know, in rural Ontario, other than the police? And that's not a bad system that's working right now; I

understand what you're saying. Anyway, can you share any of your best practices?

1040

Dr. Katreena Scott: Sure. I grew up in Lindsay.

Ms. Laurie Scott: Oh, did you really?

Dr. Katreena Scott: I was there last weekend.

Ms. Laurie Scott: Excellent.

Dr. Katreena Scott: I think that the question continues to be, how do you get to those services? And that is the conversations and opening the door to those conversations, which is that investment in—I use the analogy that everybody understands the risk factors for a heart attack. There are signs everywhere, and then there are a lot of people who know what to do next. A lifeguard knows what to do. They know to call 911, and they know to do CPR. How is it that all of our social service providers know to have that initial conversation: "Oh, this is something that I'm worried about. I need to make a referral"? And then I can make a referral to a person, a service that has expertise in having the conversations about risk, understanding risk management, and really addressing the abusive behaviour.

Ms. Laurie Scott: I've got a lot of good services within Lindsay; some people know them, some don't. We have the One Stop that was funded many years ago. We try to reach the Haliburton counties in my area, so that's replicated—rural Ontario. It's spotty, and it's hard.

Advertising—I love what you're saying about that. What about into the schools a little bit, what maybe you've seen—a very delicate subject—but helping the teachers recognize situations, if you can maybe expand?

Dr. Katreena Scott: I would love to do a whole other presentation, but I do know you have one coming on that.

I teach a course to teachers on how you raise issues around safety and gender-based violence and intimate partner violence, how we start having that conversation as early as possible about what is a healthy relationship.

The Chair (Mr. Lorne Coe): Thank you very much for that response. That concludes our questions of this presenter today. Thank you so much for being with us.

Dr. Katreena Scott: Thank you so much. I apologize to the tech people.

UNIVERSITY OF CALGARY

The Chair (Mr. Lorne Coe): Committee members, I'd like to move forward, please, to our next presenter, who is joining us virtually: Lana Wells.

Lana Wells, thank you so much for joining us. For Hansard, would you please introduce yourself—your position, the university you're working with?

Ms. Lana Wells: My name is Lana Wells. I'm an associate professor and the Brenda Strafford Chair in the Prevention of Domestic Violence in the faculty of social work at the University of Calgary.

The Chair (Mr. Lorne Coe): You have 10 minutes for your presentation, and that will be followed by questions from the committee members. You can begin, please, and I'll let you know when you have one minute left in your presentation. Thank you very much for being with us.

Ms. Lana Wells: Thank you, and to the committee members, for inviting me to this important meeting. It's an honour and privilege to be here with you today—and thank you for each of your service in trying to end intimate partner violence and sexual violence.

Before I begin, I'd just like to take this opportunity to acknowledge that I work in the traditional territories of the people of Treaty 7 region in southern Alberta, and the city of Calgary is also home to the Métis Nation of Alberta, districts 5 and 6. But I'm calling today from Whistler, which is located on the unceded territories of the Lil'wat Nation and Squamish Nation, who have lived on these lands since time immemorial.

I was hoping to give you a little bit of background on me. As I mentioned, I'm an associate professor and the Brenda Strafford Chair, and I'm leading a research initiative that's really focused on primary prevention, and that's really about stopping violence before it starts.

When we think about stopping violence before it starts, we need to be partnering and collaborating with all orders of government to inform and influence policy and systems change. We also work with male-dominated environments, like policing, to prevent workplace violence. We partner with leaders and organizations to shift practices and build a prevention workforce, and we work with technology and tech companies to figure out how to leverage technology for violence prevention.

More recently, I've been working with police data sets to better understand the trajectories of male violence and how we can disrupt it. And that's why I'm here today.

I really want to talk about—we know that perpetrators are made, not born. Perpetrators of violence are created in our families, in our schools, in our peer groups, in neighbourhoods. They're created in our sporting associations and sports, in religious communities, at work, throughout all of our institutions. And media and culture play a large role in this.

So today, I wanted to focus on—if we collectively want to stop the perpetration of intimate partner violence and sexual violence, we have to focus our attention on disrupting the pathways of perpetration. That means we have to focus on changing the cultural and structural conditions that actually produce, promote and condone violence. Today, that's what I'm hoping to focus on.

As you think about your strategy in creating a policy framework, this really is about moving our efforts upstream. Policies, our funding mechanisms, our programs and supports, our human resources all need to move in upstream work, and we need to start taking action to stopping perpetration of violence before it starts. Most of our research and investments, especially in governments, are mostly focused on treating or alleviating its consequences, and I think now we have to turn our attention to prevention and specifically preventing male violence. So my recommendation to this committee is that you create a provincial strategy that's focused on both disrupting the trajectories of male violence and mobilizing more men and boys in violence-prevention efforts.

When I make this recommendation, I want us to think about the problem: We know that domestic and sexual violence can affect anyone, but women are overwhelmingly more likely than men to be victims of severe intimate partner violence, domestic violence and sexual violence. We know in Canada men commit 99% of sexual assaults. We know that men perpetrate 83% of violence against women and intimate partner violence, and men are three times more likely than women to offend criminally, including violent crime. We also know that violence disproportionately affects Indigenous peoples and equity-deserving groups, especially women and girls, as I mentioned, and 2SLGBTQIA people.

While it affects all these populations—we know that that those who experience violence results from patriarchal systems, colonialism, toxic masculinities and unhealthy gender norms—men and boys are suffering as well. The research shows that compared to women, men have higher rates of suicide, higher rates of injury and early death, higher rates of alcohol and substance abuse and higher rates of mortality and morbidity. The situation is even worse for racialized and Indigenous men, who are over-represented in many of these categories. This is because they are negatively impacted by patriarchy in addition to other systems of oppression and discrimination.

We know from the research that preventing male violence and advancing gender equity requires men and boys to be part of the solution. This means when men and boys can emotionally self-regulate; embody gender-equitable norms and behaviours; have the skills to disrupt sexism and violence within themselves and their peers; embrace non-violence; have the skills to heal, repair and manage conflict; be accountable; and actively inspire their peers, colleagues and children to do the same, then we can stop violence before it starts.

What can Ontario do to advance this area? I think, really, focusing on removing the burden from victims and victimology and starting to focus our attention on the people and systems that are causing harm, because the cost of raising perpetrators is hurting everyone. I think the case is clear. We have 14 years of data and research that demonstrates that we have to focus on preventing male violence because the reality is that the majority of these perpetrators of intimate partner violence and sexual violence are men. There is a lack of data surrounding male perpetration, especially before they commit the offence, and this is why we need to move upstream to prevention.

1050

We don't have a robust continuum of care to prevent male perpetration of violence. What I mean by that is we don't have a lot of programs and services targeted and directed toward boys and men. We also know that men are reluctant to seek help because of perceptions of stigma and constructs of masculinity, and with that, there are limited services that are actually affordable and accessible. We want more men reaching out, but we also need the services and supports be there.

So the recommendation for next steps, I would suggest, to actually disrupt trajectories of male violence and get more men engaged and mobilized in this area: We need a better data collection system that actually targets the prevention and perpetration of intimate partner violence and sexual violence. Most of the research has been focused on victims. We need to invest in leaders and networks of men throughout the province who are engaged in violence prevention efforts and are leading and mentoring and modelling for other men and other boys, because we know men and boys influence each other. And we also want to support the integration of evidence into practice to build a prevention workforce to actually engage and work with men and boys.

We've been studying and researching this area for 14 years. We've been testing and leveraging promising practices and evidence, and so we really believe that it has to be a key strategy. And right now, in every order of government across Canada—because I've worked with all orders, including the United Nations—there is not a robust investment in strategy, in a policy framework targeting and supporting men and boys, and I think it's time that there be.

Thank you very much. In my written submission, I gave a lot of examples and recommendations on how to move forward. I want to thank you for the opportunity to be here and look forward to questions.

The Chair (Mr. Lorne Coe): We'll begin our questions and answers with the official opposition, please. MPP Wong-Tam.

MPP Kristyn Wong-Tam: Thank you so much, Ms. Wells, for your presentation. I am particularly moved by the focus that you have in addressing violence, especially upstream, by targeting those who end up being perpetrators of violence. I think that's a very important shift in this conversation—and noted in the title of your report, as well, just calling it "Shift."

I'm going to begin by asking whether or not intimate partner violence should be declared as an epidemic just to frame the urgency of the matter and to then use that as a launching pad to where our work should take us.

Ms. Lana Wells: I believe, Ontario, you've already done that. You've stated that it is an epidemic.

The reality is, we know the majority of people have experienced this form of violence or they've witnessed it. It is prolific. Whether you call it an epidemic, a pandemic, it is a prolific—and sexual violence, as well, which is still a hidden issue. I'm hoping, in your strategy, you're going to focus deeply on sexual violence, because that's been an area that's still in secrecy. We have a prevalence study in Alberta. I don't think Ontario has done one yet—but really understanding that. And we see sibling sexual violence on the rise.

So there are lots of different forms of violence that are increasing post-pandemic, and I think it's important that whatever it takes to frame it as a critical issue to get resources and policy change is critical, so yes.

MPP Kristyn Wong-Tam: Thank you very much for that answer. For the record, Ontario has not declared intimate partner violence as an epidemic yet, but we're hoping and striving to getting there.

I want to just bring you to the point of your presentation around the investments to develop a system of services and programs that specifically target men and boys who are perpetuating the violence, which I think is important for us to note, and hopefully, it will be done—research-driven, data-driven—to determine what would be the right programs.

I also want to highlight that, currently, we have a network of services and programs that are not as well funded as they need to be. They're oftentimes project-based-funded. You noted in your report that almost every government within Canada is doing very little to address the perpetuators of violence. But do you have any comments or observations for us about the current system of funding and programs that are in place and how effective it is without adequate, sustainable base funding?

Ms. Lana Wells: Thank you—such a great question. First of all, funding in this area is very episodic, and to your point, projects and one-offs. I think as you think about your strategy, you need a funding mechanism that allows people with long-term funding. Often, governments will fund one year or three years or project-specific or something new versus long-term funding, and I think part of the issue is that the funding mechanisms and the calls that come out are short-term.

I know you're going to hear from Dr. Peter Jaffe on Fourth R, which is a youth-based program that spent 15 years researching and studying and making it evidence-based. You're going to hear from Dr. Deinera Exner-Cortens, who has been supporting the WiseGuyz program that is targeting grade 9 boys. These programs are deeply collaborative between researchers and agencies, and then there's a scaling and support that's needed over time. Kids keep growing up, so we need to keep ensuring that they have access to these programs and services. So they can't be one-offs. They can't be episodic. We need long-term funding, and we need to think of it as part of the social safety net.

MPP Kristyn Wong-Tam: Thank you. I think that's a really important point that you note, that there has to be a continuum of programs as people age. I think that we will have a number of well-qualified expert witnesses called very soon who focus on children and the impact of GBV, IPV and sexual violence on children.

I want to just ask you to elaborate further around issues around poverty, because you talked about the social safety net. In my experience—I represent an area in Toronto known as the downtown east or the east side of Toronto. We have three of the poorest postal codes in Toronto, and the type of violence that we see is oftentimes gun-related and poverty-driven violence. Can you elaborate about the research that you've done about the impacts of poverty and the connections it has with intimate partner violence and sexual violence?

Ms. Lana Wells: I'm so glad you raised that. First, I want to say I was born and raised in Toronto, in North York, so I do have familiarity with Toronto.

For us, when I think about the root causes of violence, what keeps showing up in the research and has to be part of the policy priorities is addressing unemployment; increasing income support; reducing poverty; increasing education rates, because we know there's a direct relationship with education rates and income; preventing homelessness, because we know what happens on the streets in terms of violence; providing adequate health care; and supporting Indigenous sovereignty.

We know that you can't just have these strategies in isolation; they must be connected to root causes. And we know root causes, or the risk factors which you're talking about, increase people's experiences of violence or perpetration of violence.

MPP Kristyn Wong-Tam: Thank you. With respect to consent awareness, because I know that relationships with all people develop as young people, as children, and then young adults: You work in a university environment, and I recognize our previous speaker did as well, so it's not surprising to me that a lot of our academic researchers are subject matter experts, coming from the ecosystem of learning. How important is work such as consent awareness, consent education, allowing children and youth and young adults to learn how to talk about healthy relationships, to identify what abusive behaviour is? How important is something like Consent Awareness Week and consent awareness education in the post-secondary school environment?

Ms. Lana Wells: Well, I'm glad you raise the post-secondary, because we know one in four rapes are happening—sexual assault is so high in those settings and environments, and dating violence is high between 18-to-24-year-olds. So I think whether it's consent education, which is critical; healthy relationships, like you said; emotional self-regulation; the ability to heal, repair and manage conflict; or learning how to be accountable in relationships, these are skills that needs to be taught from early childhood all the way through to adulthood, absolutely, and ongoing.

That's the other piece which I didn't talk about: We have a lot of research around healing, repair and accountability. We need to create alternative approaches and supports for people, so when they are in lower-conflict situations, they have opportunities to get the help that they need. But it's—

The Chair (Mr. Lorne Coe): Thank you, Professor.

We're going to move on now to the independent member. MPP Mantha, please.

Mr. Michael Mantha: Chair, can you give me a reminder when there's a minute left in our time, so that we can try to focus and round things up?

The Chair (Mr. Lorne Coe): Yes.

Mr. Michael Mantha: I want to talk about preventive programs and how they can target individuals who actually take the step of saying, "I need help. My partner needs help." In Alberta, is there a location, a site, a reference point where people can go to and say, "Google, I need help for IPV?" What do you have in Alberta?

1100

Ms. Lana Wells: A great question. We have an initiative called Men &, and it is exactly that. For five years,

they studied what men were googling around asking for help and the typology of terms that they were searching for, and they created an online digital presence, and it's called Men &.

Also, behind that is a counselling service, 24/7, where they're offering counselling for men and their families at no cost, and that comes out of an initiative called FearIsNotLove. It's an organization out of Calgary that has been working for the last five years to develop that.

Failure of sound system.

Ms. Lana Wells: Sorry, I can't hear you. Sorry, go ahead. I couldn't hear you.

Mr. Michael Mantha: My personal experience through work is that the individuals make a decision as far as—they go through treatment; they go through abuse; they go through drugs and addictions. It's only going through those programs and the care that the counsellors walk them through their traumas do they realize that they need care, they need more, they need psychological care, they need to deal with their traumas. They go through this entire process, discovering why they are and where they are at that point in time.

A lot of the issues that we have here in Ontario are there is no aftercare. There are no wraparound services that are available to them. There is no continuance of the progress that you have been making in the discovery of your traumas, of why you are where you are.

The benefits of having that aftercare program and the investments that are required by government to make sure that the organizations are there—how important is it to the success of an individual becoming, again, a contributing individual to society?

Ms. Lana Wells: I think you've named it. We need to invest in people rebuilding their lives. We need a prevention continuum, and we need services and workers who can actually serve these populations across what you're saying. I think there are episodic moments in people's lives, as you said, and we need those supports throughout. We need it to be free and accessible.

Mr. Michael Mantha: You're right because you go through that—I refer to it as the roller coaster ride. You have your ups and downs and lows and highs. You go through traumas, and then you come back down. You deal with the issue, but throughout—I just want to stress the point of making that investment, making that choice as legislators is saying, "We need to do this." And the reason why we need to do this is it will prevent this from happening. It will be educational for individuals. It will give them an option.

I ask of you, how has that choice benefited those who are in Alberta right now?

Ms. Lana Wells: Well, I think we've been lobbying since 2012 for a strategy that creates the system. They have funded $3 million specifically for men and boys, and they keep building on that. First of all, we need a prevention workforce that can actually serve, so you actually have to have good training and ongoing supports and funding. Then, we also need to target particular developmental phases, whether it's fatherhood or adolescence. We know there are key times in men's lives where more supports that are provided can actually help people through those developmental moments, which could help for prevention as well.

Mr. Michael Mantha: And the benefit of providing that additional training to organizations that are there now that can capture those individuals and show them the path to making that decision to either getting help or walking in to get help is also key. So, again, I want to go to how important it is to make sure that those organizations that are not specifically tied to this but are organizations that are surrounding this, that could help an individual to steer them toward making that right choice—how important it is to make those investments.

Ms. Lana Wells: Yes, absolutely. You need that continuum, and you need warm hand-offs. You need a system that can navigate and support people so when they've done their program and service, they can move on to another, because you have expertise in different areas. But the agencies need to be coordinating. They need to make it easy for people, and they need to make it specifically easy for men, and it needs to be free. It needs to be free and affordable, and I do feel governments have a critical role to provide this as a basic service, especially with what we're seeing around anxiety, mental health, violence rates going up—

The Chair (Mr. Lorne Coe): Thank you, Professor, for that response.

Thank you, MPP Mantha, and I forgot to give you the one-minute warning.

Mr. Michael Mantha: So I have one more minute?

The Chair (Mr. Lorne Coe): Maybe next round.

Mr. Michael Mantha: Okay.

The Chair (Mr. Lorne Coe): Thank you.

To the government, please. MPP Bouma.

Mr. Will Bouma: Thank you so much for presenting today. I really appreciate hearing all of these things.

I think so often men can feel awkward in how to get involved and everything else. I was wondering if you could speak to us about what are successful strategies in engaging men and boys in being allies in the fight against intimate partner violence. What have you seen that works, that really engages people? Because it's so easy to feel awkward in these situations and everything else. Yes, when you're male, when you're 6 foot 5, when you weigh 230 pounds, it's hard even to have those conversations because you're constantly worried about how you'll be perceived or anything like that. I was just wondering if you could dig a little bit more for us, for our benefit, into what strategies have you seen successfully turn men and boys into allies, and when does that start, and how does that all work? If you could, please. Thank you.

Ms. Lana Wells: Sure. In 2018, we did a study with 33 men in Canada who are doing this work and engaged in this work and learned lots from them, so I'll pull on that. But I think we have to meet men where they're at. I think we have to come from empathy, not shame and humiliation, and it needs to be co-developed.

So, we have a four-year initiative right now with Calgary Police Service where we are testing an approach that we are building the capacity and skills around psychological safety, preventing sexual violence, supporting healthy behaviours because we know there are high rates of violence within policing in Canada, in paramilitary and military organizations. How we're approaching it—and we've been quite successful—is meeting people where they're at, learning and understanding their needs and then building interventions and supports to support behaviour change. This can be anything from learning how to give and receive feedback well, learning how to use humour in ways that are supportive and fun versus harmful, just some basic social and emotional—and making sure that no question is a dumb question and that we're in it together. We don't have all the answers. We need to learn together. I know right now some people are feeling silenced or awkward or unsure of what to say or if they can say certain things, and I think we really need to come from a compassionate and empathetic approach and meet people where they're at and support everyone in this battle to prevent these multiple forms of violence.

Mr. Will Bouma: Thank you.

The Chair (Mr. Lorne Coe): MPP Dixon, please.

Ms. Jess Dixon: Thank you, Professor Wells. Can you talk a little bit more about how we would actually be evaluating these types of violence prevention methodologies that are directed at men and boys, and I guess a little bit as well about what type of data or studies do we need to do, for example, here in Ontario, to follow up on that?

Ms. Lana Wells: Thanks for that question, because we are so lacking in surveillance data. What I mean by that is just even having data to understand what's happening and what are the patterns and what are the trajectories.

We're partnered with a group out of Australia right now. I think what Ontario will need is a provincial strategy on understanding the perpetration or trajectories of male perpetration of violence. In my report I suggested that you do a provincial-wide survey.

And then, also, you have a lot of police data sets. We're working with police data sets out in Alberta where you can actually—we know, for people who have been charged with domestic violence, three years prior, they start to have DV encounters with police. So right there, we have a group and typology of men that if they got better supports at that time, it might prevent an offence, a criminal charge, later on. So I think it's about collecting police data, looking at that.

I know Dr. Katreena Scott will be there. She's been working with London, Ontario, police data for 19 years, I think.

So, pulling on the data that you have but also building new surveys, and then I think interviewing is critical to collecting—I think you need a data surveillance system. Nobody has one in Canada right now.

The Chair (Mr. Lorne Coe): MPP Dixon, you have three minutes left in questions.

Ms. Jess Dixon: Can you go into that just a little bit more? When you're talking about data sets, is this police data? The idea is that government would collect it and publish it, anonymized, for research purposes? What would that look like?

1110

Ms. Lana Wells: I think you could do a few things. I know the government of Alberta does a perception survey now on family violence. You could do a specific survey that Ontario contracts out to a company or a research lab, to do a survey. We're going to survey 2,000 men who have perpetrated, to understand prevention points, so I think you could do a survey similar to that. There's the IMAGES survey, for which the United Nations partnered with a group called Equimundo. You can replicate that study, which would give you data on men, as well as boys.

I think we need to collect information, and then we have existing data sets. Police collect data on people who they charge or who they go out to for domestic violence encounters. Understanding that data—what we did is we looked at 10 years prior to the charge. What most of the researchers are doing is looking after the charge, so they're trying to prevent recidivism versus trying to actually prevent the charge. I think focusing more upstream and looking at the prior is critical, and we know that there are patterns and trajectories.

So I think gathering the police data sets, which would mean working with police—obviously, ethics, aggregated, getting it anonymized. Having researchers look at that, I think, would also be critical. And then I think you do have programs throughout—there are different programs focused on men and boys in Ontario, so making sure that they're collecting data on the impact of their services.

Ms. Jess Dixon: And do you think that the government, as a government, is well placed to be a central organizing body for that, versus sort of a piecemeal? Like, who is responsible for collecting it?

Ms. Lana Wells: I think you should partner with a university to do that over time, and it needs an investment. We're building something here in Alberta. We're partnering with Australia, and we'd welcome Ontario in that partnership, where we'd build that data surveillance system.

But I would recommend definitely partnering with a local Ontario university to do that kind of research and evaluation over time. It's going to take years to build this surveillance system, because all of our research has been focusing on victims and the experiences of victims. It's a whole new area and there's just not a lot of data.

Ms. Jess Dixon: Okay. And so we would be, in that idea, almost testing certain areas of Ontario as part of it, versus the entirety of the data? We'd be focusing on sort of a representative sample of Ontario, geographically?

Ms. Lana Wells: I think it's both. I think you need to sample all of Ontario, then I think you can look the police data sets and the RCMP data sets. Then I think you need to look at specific regions and communities, because of geographic income-specific things. We are doing stuff in rural Alberta right now. There is more gun violence, more isolation—

The Chair (Mr. Lorne Coe): Thank you, Professor, for your presentation and your responses to the questions from the committee members. I need to now move on to our next presenter.

DR. PETER JAFFE

The Chair (Mr. Lorne Coe): Committee members, our next presenter is Peter Jaffe. Welcome, Mr. Jaffe, to the Standing Committee on Justice Policy. You will have 10 minutes for your presentation, which will be followed by questions from the committee members. Please state your name, sir, for Hansard, and then you will begin your presentation. I'll let you know when you have one minute left. Go ahead, sir.

Dr. Peter Jaffe: Thank you. I'm Peter Jaffe. I am a professor emeritus at Western University, and I'll begin my PowerPoint.

I would like to thank the committee for the opportunity to present to you. As I indicated, I am a professor emeritus at Western and I also have extensive experience as a founding member of the Ontario chief coroner's Domestic Violence Death Review Committee. I want to say for the record that I'm expressing my own personal opinions, based on 50 years' experience in the field. I am not representing the views of the chief coroner or the Domestic Violence Death Review Committee. The committee has a copy of my slides, and I won't address my qualifications, but they are available for the record.

The problem I'm addressing today, obviously, is that intimate partner violence is a serious epidemic across Ontario. The recommendations have been made repeatedly by numerous inquests and by the Domestic Violence Death Review Committee's annual reports, and my concern is a lack of implementation of existing recommendations.

My view is that we have the skills and the knowledge in Ontario, and what we often lack is the ability to implement significant recommendations and sustain those changes over time. Part of what I'm suggesting is the importance of a body that would allow for independent monitoring and auditing of these critical recommendations, and hopefully the ones your committee will be making.

For those of you who don't have a background on the Ontario Domestic Violence Death Review Committee, I've provided the committee with a copy of an annual report. The committee is all work by the coroner's office. We speak for the dead to protect the living, and basically, what we try to do is learn lessons from tragedies in the field, from repeated domestic homicides, and we try to identify how to prevent a tragedy in similar circumstances in the future.

The committee is an interdisciplinary committee and it's been in operation since 2003. We provide a wide breadth of background and expertise. To give the committee just an overview, looking back to 2003 to 2019, 351 cases were reviewed, involving 496 deaths. As you know, some cases involve multiple deaths—potentially homicide-suicides involving children or third parties. Two thirds of the cases are homicides; one third are homicide-suicide.

Most cases have prior warning signs—often a history of domestic violence, actual or pending separation. On the slide and on the annual report, you will see that, often, the perpetrator was depressed, involved in stalking behaviour, and prior threats to harm himself or actually attempt suicide. The victim often has an intuitive sense of fear and is reaching out for help. Victims may be vulnerable because of their own mental health issues or isolation. Perpetrators are often jealous, with prior threats to kill the victim. The perpetrator may be involved with excessive alcohol and drug use, unemployed, and there may be a history of violence outside the family.

One of the things I want to highlight for the committee: The challenge we have, it's often not a one-size-fits-all; there are very different realities for victims and perpetrators. We know that, for example, Indigenous families may be particularly at risk because of the prior history of colonization and oppression, and they may be hesitant to seek out help through government agencies. There may be individuals who are isolated in rural communities and not prepared to reach out for assistance or are isolated. There's also a higher presence of firearms in rural communities, and women in rural communities are much more at risk of domestic violence and death by firearms than women in urban communities.

The important point I want to make in my limited time is that there are very diverse realities. We have to be able to address these very different realities across Ontario.

Domestic homicides are the most predictable and preventable of all homicides. The vast majority have prior risk markers—at least seven or more risk markers. Critical information is often held by friends and family and front-line professionals. We often overlook children, who may become homicide victims themselves or deal with the most horrific of all traumas in losing one or both of their parents and dealing with the aftermath of this trauma. Again, friends and family and police often know the most. Other front-line professionals: family doctors; teachers, as they see the children in the classroom; domestic violence agencies; children's aid societies—we have to do a lot more to educate individuals across different systems.

I circulated an article to the committee about the lessons learned over the last 20 years, and we see the same recommendations over and over again: the need for specific training and education for different professional groups in health, education, law, and a definite need for much broader public education programs and public awareness programs. Those are things that I'll return to.

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Probably the most important word I'm going to say in my 10 minutes is "implementation." We know what to do, and often we don't do it. As many of you know, domestic violence recommendations aren't implemented. Sometimes there are good efforts, but they're not sustained. Recommendations by inquests and our death review committee are advisory; they're not mandatory, and we

see a failure to implement and a failure to audit or monitor the importance of these recommendations.

I'm going to highlight major recommendation areas very quickly, and then I'll address questions at the end.

Obviously, public education is critical. We have a lot of existing resources: neighbours, friends and family, education campaigns. There are also important programs for immigrant/refugee communities, for Indigenous communities, for francophone communities. But the resources are a drop in the bucket compared to what we actually need across the province.

We lack an understanding of firearms and the association of firearms with domestic violence and domestic homicide, so we need much better information.

Much better professional training and education of professional groups across the province: In 2024, there's no excuse for not knowing about domestic violence and domestic violence risk factors that are associated with domestic homicide.

We need to enhance existing services such as probation.

We need to enhance collaboration across agencies and systems.

We need to address repeat offenders. In multiple cases that we've seen—for example, in the Renfrew county case, we have an offender who abused five women over a 20-year period. He should not have been on the streets. He should have been locked up indefinitely through appropriate dangerous offender applications or long-term offender applications. We need to support crown attorneys across the province to be able to be involved in these proceedings.

The Chair (Mr. Lorne Coe): Professor, you have one minute left in your presentation, sir.

Dr. Peter Jaffe: We need to do more about warning future victims, such as what we know through Clare's Law. I know there was a private member's bill that failed, but I think we should look at Alberta legislation and implement something similar in Ontario.

We need to enhance the work of the Domestic Violence Death Review Committee.

We need to—these are recommendations provided by the CKW inquest—make sure annual reports are readily accessible and available to professionals and the public. We need an audit and accountability mechanism. And there are previous recommendations that the committee should look at, such as having a community and government agency with an independent voice to ensure proper audit of recommendations.

We need to make sure prevention programs are available both in colleges and universities and through schools, and I'll address that with my colleagues later on this afternoon.

The Chair (Mr. Lorne Coe): Thank you, Professor. That concludes your presentation.

We'll now begin our questions and answers with the official opposition, please. MPP Glover, please, when you're ready, sir.

Mr. Chris Glover: Thank you, Professor Jaffe, for being here. You mentioned at the very beginning of your presentation the number of years that you've been working in this area. Can you—I didn't quite catch the number.

Dr. Peter Jaffe: Fifty-one years, actually. I started working with the police as a family consultant in London responding to domestic violence calls, and I've been involved in clinical work and research ever since.

Mr. Chris Glover: During those 50 years, are we in a better situation today than we were 50 years ago? Significantly or—

Dr. Peter Jaffe: Good news, bad news: The good news is there's much greater public awareness, so, certainly, there are much better services for victims, perpetrators and children. So, certainly, public awareness and programs have developed.

I think the bad news is that the problems continue to escalate and get worse. We're still seeing a very high level of domestic homicides as we see on a regular basis through our media reports of homicide and homicide-suicides.

Mr. Chris Glover: Statistically, have we made any improvements?

Dr. Peter Jaffe: Statistically, I think we've been able to raise public awareness—

Mr. Chris Glover: But, in terms of the number—you specifically study the number of domestic deaths resulting from intimate partner violence. Has that number gone down, up, or is it the same?

Dr. Peter Jaffe: In recent years, it appears to be up. If you go back over 50 years, I'd say the number is down, but we have a consistent, challenging problem that's not going away.

I think it's important for me to say that one death is one too many, and we're still seeing too many tragedies across this province.

Mr. Chris Glover: You also said that domestic homicide is the most predictable form of homicide. We get the Renfrew county inquest and we get recommendations from it; these recommendations are not acted upon, and so the problem continues. You said that implementation is the problem.

Would declaring intimate partner violence an epidemic help to move the needle?

Dr. Peter Jaffe: Yes. I think it's a first step in the right direction. But those words have to be followed by action—an action plan.

Mr. Chris Glover: Okay. Over the last 50 years, you've seen recommendations come up before but not necessarily be implemented. Is that accurate, and can you expand on that?

Dr. Peter Jaffe: Yes. I think there have been some recommendations out of inquests—for example, including domestic violence in the health and safety act. Obviously, employers are now much more aware about their role and responsibility for employees who are victims of domestic violence. We have much better public education campaigns that are available, much better programs available.

Some things are moving in the right direction, but consistently we've failed to implement good recommendations, so I think there needs to be much more public accountability to audit recommendations.

Mr. Chris Glover: You said in your presentation we know what to do but we don't do it. Why don't we do it?

Dr. Peter Jaffe: We don't do it because our commitment wanes. We recognize the issue: There's a front-page story, there's an inquest, there's a recommendation, and then we move on to the next issue. I think what we fail is to have sustained commitment and clear audits and accountability for action.

Mr. Chris Glover: Okay. Thank you very much for being here and thank you for answering the questions.

I'll pass it to my colleague.

The Chair (Mr. Lorne Coe): MPP Wong-Tam, you have three minutes and 40 seconds.

MPP Kristyn Wong-Tam: I recognize that your expertise is probably unmatched in many ways, just in terms of how long you've been doing this work. I know that my colleague and friend Peggy Sattler, who really would have wanted to be here to hear your presentation and to support you here, would like me to send her regards.

Professor, the summary of your presentation—I would like to just break it down into maybe two words: "accountability" and "transparency." I think you've actually probably hit the nail on the head so hard about the lack of accountability and transparency when it comes to government approach and funding to address the problem—and the systemic problems—around IPV, sexual violence and GBV.

I want to just ask you, because you have done this work for so long, when governments respond to headlines as they emerge through the news, and then there is no follow-up afterwards, what does that do to those who work in the sector in terms of morale, in terms of feeling like they are going to be heard the next time around when they raise their voice?

Dr. Peter Jaffe: I think it can be demoralizing. I believe every government has good intentions, but I think what we have to have is sustained focus and accountability. Certainly when there's a headline story and there are clear recommendations, we need to turn good intentions into sustained action. I think that's what's missing.

The thing with intimate partner violence and gender-based violence is there's no quick fix. It's multiple interventions, both prevention and intervention, and we have to sustain effort. It's not something where you can build a bridge overnight and we've solved the problem. There have to be multiple interventions both in terms of prevention and early identification and ongoing intervention. We're dealing with some very complex social issues, so the quick fix—the headline and quick action—is not going to do it. It's got to be sustained.

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MPP Kristyn Wong-Tam: And, Professor, there's no ribbon-cutting opportunity for some of these strategies. They are long-term, multi-dimensional, multi-year work.

I want to just ask you, with respect to holding government to account—because I think we can all say some very good things after a crisis takes place to provide words that are soothing, but the work continues on the front lines, and it's actually the front-line workers—the researchers, the law enforcement, the courts system—that have to carry the load afterward. Previous speakers have talked about prevention and taking an approach to ensure that structural changes happen as early as possible. If we know the things that need to be done because of all the inquests that have come out in the Domestic Violence Death Review Committee, what would it take for government and opposition to hold ourselves, this Legislature, to account, to make sure that the work is carried out?

Dr. Peter Jaffe: I think there are some good recommendations from the CKW inquest, so I think—

The Chair (Mr. Lorne Coe): Professor, I need to interrupt, please. That concludes the time allotted to the official opposition.

We'll now move to the independent member. MPP Mantha, please begin, sir.

Mr. Michael Mantha: A reminder of the one minute, please?

Can you go ahead and finish your answer, please?

Dr. Peter Jaffe: I think we need an independent voice, so if there was an intimate-partner-violence commissioner, someone who could speak independently, free of government and the Legislature. But then also, have a community and government committee working together where we have the experts within different government ministries and the experts from the community collaborating on developing effective solutions and holding themselves accountable for action.

Mr. Michael Mantha: There's a really important point that you brought up in your presentation: all the red flags. I hope I can get to that question, but I want to talk about the children, overlooking the children and the impacts that they suffer through this. Through my prior employment, I often dealt with parents that were affected by job losses, life stresses, just the negative impacts that happen to them. We often overlook the children. I looked at them as far as why are we overlooking them and how do we deal with their impact.

What I'm finding in my region of northern Ontario is getting those psychological services that are needed for those children is quite lengthy. Believe it or not, it's well over a year to get psychological evaluations and care for a child under the age of 12 years old in northern Ontario. If you're a francophone, it's well over 18 months. I'm being very tight. Some of them are looking at anywhere between two years to get any type of care.

The reason why I raise that is there are many signs that come through your children if you look at an internal relationship and making sure that awareness is there. How important is it that we don't overlook the impacts of what is happening with our children and using that as an opportunity to getting the care or opening up the options of care and assistance for those that are suffering in an IPV environment?

Dr. Peter Jaffe: I couldn't agree with you more. Children are neither seen nor heard, and we minimize the impact of violence on them. The research tells us children suffer terribly, and if we ignore the impact of violence on their childhood, we're ignoring the next generation of

potential victims and perpetrators, so I think meeting the needs of children—in our death review committee, we're currently examining children who, at the extreme, are witnessing homicides and have trouble getting help on a timely basis. This is an issue across the province: getting children's mental health services; dealing with children who are traumatized by violence and getting help on a timely basis. I think your question is really critical.

Mr. Michael Mantha: You often use the words "implementation" and "action," and I convert those into "funding."

You also mentioned about building evidence. I was astonished just seeing the doc that you had up where clergy know about problems, and neighbours, friends, family, lawyers and doctors. How do we take away that stigma of people stepping forward and intervening? Because you're coming in a portion of the picture of what caused or what could have prevented this. How do we take away and make it a normalcy to letting people talk about what they know is going on and raising that awareness?

Dr. Peter Jaffe: We have terrific prevention programs trying to get people more comfortable to address the issues—friends, family, neighbours and front-line professionals, like teachers. At our faculty, for example, we do training with—

The Chair (Mr. Lorne Coe): One minute remaining for questions, MPP Mantha.

Mr. Michael Mantha: Keep going.

Dr. Peter Jaffe: We do a training with pre-service teachers about how to talk to a parent at a parent-teacher night when you're concerned about the symptoms you're seeing in kids. How do family doctor address these issues? We have the knowledge. We have the resources. We have the programs. The trouble is there's only funding that's really a drop in a bucket in terms of the public education that's needed.

I think we have changed public attitudes on other issues, such as drinking and driving, and addictions. I think we have to—the same work, getting people to be able to talk to friends and family about domestic violence, both victims and perpetrators, in a safe way to engage in these conversations and get help on a timely basis.

Mr. Michael Mantha: Thank you very much. I really appreciate hearing your presentation this morning.

The Chair (Mr. Lorne Coe): We'll now turn to the government members for questions, please. MPP Pierre.

Ms. Natalie Pierre: Thank you, Dr. Jaffe, for your presentation this morning. And also thank you for your continued education for the last 50-plus years in this area.

You mentioned a couple of things about risk factors. You talked about training and education. So I'd just like to ask you what IPV prevention strategies you would suggest for school and post-secondary curriculums, and what outcome would you anticipate from such integration of IPV or violence strategies in school curriculums?

Dr. Peter Jaffe: Actually, I'm going to have the opportunity to come back to that question this afternoon. At 3:30, I'm presenting with two colleagues on primary prevention in schools, but I'll briefly now—I think we can invest a lot in preventing the next generation of individuals involved in intimate partner violence through curriculum. I believe we should be able to integrate prevention programs in schools, from junior kindergarten through to the end of high school. I think we should also have those programs in colleges and universities. I think it's critical to focus, particularly, on adolescents, who are developing their first intimate relationships, dating relationships, as I think you may have heard in earlier presentations, and do work on prevention.

There are many effective programs which could certainly change attitudes and behaviours and promote healthy relationships, so I think that certainly should be a government priority through the Ministry of Education in colleges and universities to ensure those programs are available. My view is those programs should not just be an option—maybe we do it; maybe we don't—it should be integrated as an expectation in our education systems at all levels.

Ms. Natalie Pierre: I believe that Western University actually does have a consent training program. Are you able to speak to that or comment on that at all?

Dr. Peter Jaffe: Yes. Western has been a leader in the field in many ways. Obviously, we certainly have a priority in terms of reducing dating violence and sexual violence. Western developed a program for students, beginning in their first year, to understand the meaning of sexual violence and the meaning of consent—what sexual violence is and what lack of consent really means—and those programs are highlighted.

For example, even for first-year students who are in residence, there's week-long training for resident dons and resident leaders to make sure they're aware of dating violence and sexual violence. This awareness is passed on directly to students, and there's early intervention with those issues. So I think there are model programs that could be shared across the province.

Ms. Natalie Pierre: And do you know how long the consent training has been offered? Is this the third year, perhaps?

Dr. Peter Jaffe: I don't know off the top of my head, but it's been multiple years. It's also well responded to. One of the things that I know people worry about is when you present these programs, you're going to get students who are defensive and don't want to hear about it. We find the exact opposite. Students welcome these programs. They're actively engaged.

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You always worry when you talk about intimate partner violence that you're going to have young men defensive, but we find the opposite. They welcome the information. They welcome new ways to talk to their peers about the issues. I think that's critical, because whether you're in university or whether you're in high school, the peer group is essential. The peer group is the front line in seeing these problems and responding to it in a much more effective way.

Ms. Natalie Pierre: We heard earlier today about the stigma for boys and men reaching out for help, so do you

think these types of programs or educational programs for secondary school students or from K through 12 and post-secondary students as well would be helpful in starting to chip away at some of the stigma associated with men and boys reaching out for help?

Dr. Peter Jaffe: Definitely. I think intervening early and often is critical. For years at Western with our two area school boards, we had a breakfast coaching boys and men in terms of addressing these issues. We invited Greg Marshall, our Western Mustangs coach, to talk to boys about missed opportunities to intervene and the things that we often wish we had talked to our sons about earlier. We have 300 student leaders from high school come to these breakfasts and we have smaller group discussions, and everyone leaves not feeling defensive but identifying more about their potential role as a supportive peer and reaching out and reducing the stigma about these issues. So I think we can create multiple opportunities for young men.

Actually, I should say, other than being an old expert, I also have four sons myself, so I've had to walk the talk. I have four boys. They've obviously left home. My oldest is a physician in Toronto. These are regular discussions that we have in trying to find ways to have the discussion in an open way and not be defensive and how you can turn this around and be a leader. So I've had to walk the talk at home.

Ms. Natalie Pierre: Well, thank you for having those conversations. I know they're not always easy to have. I just really commend you and the folks at Western University for the work that you do. I know that there are a number of other colleges and universities in the province that have done work specifically with their athletes, but it's nice to see that Western is rolling this out to all students.

The Chair (Mr. Lorne Coe): One minute left for question, just to let you know.

Ms. Natalie Pierre: All right. Thank you.

So, continuing along around education and public education, you mentioned the Neighbours, Friends and Families program. I was wondering if you could tell me if you believe that has been effective in changing community attitudes towards domestic violence.

Dr. Peter Jaffe: My short answer is that's an area we need more research on. I believe that we have an effective program from the limited research we have done. Our Neighbours, Friends and Families engages individuals to think about domestic violence: what it is, what it looks like, what the warning signs are, how to intervene—

The Chair (Mr. Lorne Coe): Professor, thank you so much for your response to that question and your presentation today.

CHILDREN'S AID SOCIETY OF TORONTO

The Chair (Mr. Lorne Coe): I need to now call on Lisa Tomlinson. You will have 10 minutes for your presentation.

Interjection.

The Chair (Mr. Lorne Coe): Yes, please, just come up to the microphone. Thank you so much for being here. Please state your name for Hansard and then you can begin your presentation. I'll let you know when you have a minute left, and that will be followed by questions from the committee members. Please begin. Thank you.

Ms. Lisa Tomlinson: Excellent. Good morning. My name is Lisa Tomlinson. I'm the CEO at the Children's Aid Society of Toronto.

The Chair (Mr. Lorne Coe): Please begin. Thank you.

Ms. Lisa Tomlinson: First of all, I want to thank the committee for allowing me to have the opportunity to be a witness for the IPV study. As I mentioned, I'm the CEO for Ontario's largest child welfare agency—actually, Canada's largest child welfare agency—and the largest board-run child welfare agency in North America. I'm here today with our chief operating officer as well as our director of communications.

The context today is a Toronto context, although we are one of many agencies in Ontario. We're a non-Indigenous agency and we work with three other child welfare agencies here in Toronto.

My goal today is to give you a small window into the world of the work that we do at CAST. I heard Dr. Peter Jaffe mention earlier the impact on children. That's really what I'm going to be focusing on today, the well-being and safety of children, which is our mandate under the Child, Youth and Family Services Act.

The term around gender-based violence I'm going to use is going to be primarily related to woman abuse because that makes up for 95% of the cases that are referred to our agency. And I'm going to lean into recommendations that I've attached in the written submissions on how the province can consider augmenting services that are already supported through specific provincial ministries.

By the numbers, we're an agency that receives here in Toronto just over 40,000 calls a year; we're a 24/7 agency. Of those 40,000 calls we get, approximately 17,000 relate to children where there's a worry around their safety and well-being. I want to tell you that of those 17,000 calls, the good news is only about 9,000 of those calls end up being cases where a child protection worker actually has to go out and address the safety and well-being of a child.

We work with approximately 1,500 families on an ongoing basis. I want to let you know that of those 1,500 families, approximately—and I keep saying "approximately" because it shifts—68% of those families have had current or historical issues with IPV in the family.

When I started back the second time in child welfare, we had 3,000 children in our care in 1999; we currently have 500. And we see that as a success to keeping children with their family and in communities.

These numbers are consistent, and I did attach it to the written materials. I ask folks to have a look, when you have a chance, at the Ontario Incidence Study of Reported Child Abuse and Neglect. It's very consistent across Ontario and across Canada.

I'm going to give you some context around the cases and what we're seeing and what we're doing. Over the years, I've dealt with an infant who had a skull fracture when their father threw a can at the child's mother and hit the child. I worked with two siblings who laid with their mother in her bed as she took her last breaths after their father had stabbed the mother and refused to allow them to call the police or call any help. I dealt with a four-year-old whose father would rape the mother on the living room floor while his mother kept the little one, while she was being raped, focused on what was on TV, so the child wouldn't see what was going on next to him. I've seen children whose mothers were so overwhelmed with depression and mental health due to violence that they couldn't care for their children and have actually knocked on our door and asked to have their children put into our care. Children in child welfare care do not have good outcomes so it's not the path we want to do. I've also dealt with the unthinkable: the deaths of children by their fathers because their mothers have tried to leave an abusive relationship.

Those are just the cases I have dealt with. In the middle of that, there are thousands of children that we are working with throughout the children's aid society who have similar stories.

We also know the correlation between gender-based violence, physical harm and neglect of children, along with substance misuse and mental health, is an impact for these families. We know that children who come back to our attention when they're 14 and 15—unfortunately, we have a term; we call them "long stayers." They grew up in our care. We know the common factor that all these young people have is they were involved with the child welfare system when they were under the age of five due to family violence and intimate partner violence. So, how do we pay attention to that? That's up to our system to do that work.

The research also tells us that many children and youth exposed to violence are also, as I said, victims to other types of maltreatment.

In my written submission, I've outlined other challenges, but also what's working well, because there are a number of things that are working well within the organization and within the system as well.

Today, I'm going to ask the committee to consider what I call simple, free or low-cost initiatives specific ministries can actually implement. It was nice to hear Peter talking about the Domestic Violence Death Review Committee because that's one that really has some great leverage.

In asking the committee to consider, I want to highlight three specifics that I've included in my written submission. I would ask that the committee considering a multi-ministry working group. There's no ministry service or agency that can do this work alone. In fact, collaboration is essential. These are complex problems and I always say there's no single solution for these; there are multiple solutions. Families come in all different shapes and sizes so the more we can have collaboration and work together, the better.

One of the things that troubled me, that I learned many years ago—and this is really thinking about the Ministry of Colleges and Universities—is there's no social work, social service or child and youth worker program, bachelor's or master's, that has a mandatory family violence program. You can take them as an option, but I don't know any social work position—and maybe somebody would say there are one or two—that doesn't intersect with family violence. How do we think about—and I've been talking with the University of Toronto. How do we talk about making those programs mandatory so that we have skilled social work, social service folks prepared to deal with the families they're working with?

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The Ministry of the Attorney General has a program that they offer called the PAR program. I don't know if you've heard anything about it. It's one of the only court-mandated programs—the Partner Assault Response Program. It is the only program that we're aware of that's available to fathers, men who use violence. It has very little curriculum related to children, and in fact, agencies are able to modify the curriculum. It has not good outcomes. It's very old and antiquated. How do we lean into ministries like the Ministry of Health? Hospitals pride themselves on good technology, updated services and so on. If you walked into a hospital and a nurse was taking your information on a typewriter, you might worry about what kind of services this hospital is providing. I equate the PAR program like a typewriter. We can't be offering services that are outdated through one sector and not in others. So how does MAG look at updating that program?

The Ministry of the Solicitor General, through the coroner's office, has this wonderful Domestic Violence Death Review Committee, and when I say "wonderful"—it's kind of a funny thing to talk about with death. There are incredible recommendations in those reports for each sector, but there's no accountability for those recommendations to be held by anyone.

Child welfare is one of those agencies that is often referenced around education, learning and collaboration. Is it possible to bring folks together through the Ministry of the Solicitor General or through the Domestic Violence Death Review Committee—to bring those sectors together to talk about how these recommendations could be implemented, followed up? How do we look at changing what we're doing and adapt to what is needed in the community? How do we consider a really cross-sectoral table to review recommendations and consider strategies to implement out of some great work that's being done by the coroner's office—out of tragedies, of course, but out of great work?

I do have the written submission, but I will close by saying—I'm trying to pay attention to time—that the Children's Aid Society of Toronto has an investment in this work. Enhancing child safety and well-being is our priority. I want you to know, 40% of the cases that we open—we call it a reopening—40% of domestic violence cases reopen across the province. It's cyclical. We keep seeing these families over and over again. We need to shift

and do our work differently, whether it's services that aren't doing what we need to—I'm all about—I think I heard the term "prevention." How do we look at these young people under the age of five—because the other thing we know is, these young people come to us as adults who are now perpetrating and also as victims of violence, so the cycle is there.

I would add that the Children's Aid Society of Toronto—and I can guarantee my colleagues would say the same—are committed to being part of any table or any type of collaboration that enhances this work. We have work to do in this, as well. This is not something that belongs to others—

The Chair (Mr. Lorne Coe): You have one minute left in your presentation.

Ms. Lisa Tomlinson: —it's something that our own system has some work to do. Thank you.

The Chair (Mr. Lorne Coe): Thank you.

We'll now begin our questions with the members of the official opposition. MPP Wong-Tam, please.

MPP Kristyn Wong-Tam: Thank you, Ms. Tomlinson, for your presentation and taking the time from your busy day to be here with us. It's much appreciated. I also want to recognize and acknowledge on the record that the Children's Aid Society of Toronto does really hard work. It is oftentimes heartbreaking work, but I also know that you and your colleagues do it day in and day out and oftentimes don't get a lot of thanks. So I wanted to thank you today.

I want to just dive into the issues around systemic barriers to preventing intimate partner violence and what needs to be done with respect to government solutions, including funding and supports for services that actually create that safety net, because oftentimes, the social determinants of health are the same as the social determinants of safety—in particular, the structural barriers facing the most marginalized communities, and oftentimes an effect of that is poverty.

Can you speak to the issue of poverty and gender discrimination that you see in the society that you work with, that actually prevents women from leaving violent situations at home that then endangers the children?

Ms. Lisa Tomlinson: Absolutely. So 70% of the families we work with on an ongoing basis experience some level of poverty. That's fairly unique to many of the families—and of course, many of them dealing with intimate partner violence.

It's also important to recognize that there isn't a postal code in the city that we don't touch, but the ones we stay involved with are often those who are marginalized, experiencing poverty and so on.

We certainly see the big items such as housing being an impact—jobs, access to good legal advice or good legal support. While sometimes it's out there, it's also—we're dealing with waiting lists. And I appreciate the context of the north, and we have similar issues in terms of being able to access housing support, legal support and medical care at this point as well, solid medical services, so those everyday determinants of health that really impact an ability of a mother to keep her children safe—I'll say a mother and a father, to keep their children safe, because they're both responsible for that.

MPP Kristyn Wong-Tam: With respect to the systemic barriers of achieving gender equality or even seeing a type of wage parity, and obviously women being disproportionately affected by those challenges, when women and mothers are poor—because the predominant number of those who are on the receiving end of violence are women and girls, and they experience it very differently. When we don't see government investments go towards increasing wages or even addressing employment insurance, with respect to child benefits, with respect to ODSP, for example, what would be the effect on the child? How does it impact the children when their mothers are too poor?

Ms. Lisa Tomlinson: It's hard for me to comment on the bigger picture, but I will bring it down to daycare, daycare subsidies. For many of our families, many of the women we deal with are looking for what I call a fairly simplistic type of—which isn't simple; I get it's complex at times—but daycare spots. Daycare spots allow them to continue in a job that—they may work nights. So how do we get flexible so that they can leave a situation, continue to be employed?

We hear from women; they don't want to rely on systems, they don't want to live in shelters, and I appreciate that. But how does the system flex, augment, adapt to ensure that women are getting what they need to be able to care for their children?

MPP Kristyn Wong-Tam: If those investments were made to ensure that the wait-list is cleared and women and girls and those who are the survivors of violence can access the services when they need it, will that help us in preventing violence in the future?

Ms. Lisa Tomlinson: I can't say it would help us prevent violence in the future. I can tell you it would lower the times of involvement in the child welfare system. And if we can move those families out of our system because families can have safety within their own homes and communities—if you can put us out of a job, we'd really appreciate it, or at least lower some of our staff. If we can get to the work that we need to be getting, we can put things in place that allow us to have families involved with us for less amount of time, then the better, because we're not the ideal system. The child welfare system is not the ideal system to deal with, really, what are other social issues, if that makes sense—or social issues that are impacting involvement with us.

MPP Kristyn Wong-Tam: We're seeing more and more cuts to children's recreation programs. We are seeing cuts to after-school programs. We're seeing cuts to education. The classroom sizes are enlarged, not meeting the Ministry of Education's own standards. We are seeing the removal and the elimination of social workers in education, place-based learning environments. How does that intersect with the work that you do when there aren't the adequate supports out there in the other places where children are?

Ms. Lisa Tomlinson: The challenge with those that we've seen is that it leads child welfare to becoming the catch-all for things that we shouldn't be doing. Our staff are trained, as I said, to be protection workers. They go through training. That is their role. But if they're taking on—and we have seen them taking on additional work, additional responsibilities because of gaps in the sector. It becomes a problem for families in particular, of course—first and foremost, for children and youth—but also for our staff in terms of workload. So our hope is always that families are served in the community and not by the child welfare system.

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MPP Kristyn Wong-Tam: So if you're one of the offices of last resort, you're a service of last resort, you don't really want to be there, because when you interrupt and are called in, everything else in the system and the ecosystem and the safety net has failed.

Is it more costly and does it have more long-term damaging effects than upstream prevention and child-oriented, women-oriented, survivor-oriented services?

Ms. Lisa Tomlinson: I'll give you a concrete example: The city of Toronto has directed their housing and shelter staff to call the children's aid and get us to pay for hotels for them because they can't provide housing. Putting families into a child welfare system is not acceptable. Our work is with kids who have been impacted by abuse and violence, but now we're distracted, I'll say, by work that really isn't our work but is filling another gap.

We want to stay in our lane. We want to stay in what we're supposed to be doing. We want to be creative where we can. We want to augment where we need to. But we want to be able to stick to our core legislated business.

MPP Kristyn Wong-Tam: If there was one request that you could make today of the provincial government, this—

The Chair (Mr. Lorne Coe): Excuse me, but that concludes the time for the official opposition.

We'll move now, please, to the independent member. MPP Mantha, please.

Mr. Michael Mantha: Thank you, and I'd certainly appreciate that one-minute warning.

I want to go back to overlooking children and, again, to one of the questions that I put to the previous presenter: There are many red flags, through a variety of signs—individuals in the community, but also with our children—and they are often overlooked. Let's say in a perfect world that we implement and go into action by providing all the funding that is required to all of the organizations that are needed, that you are provided with a room and a table to bring all of your recommendations that are here. What is the first task of the multi-ministry working group? What is going to be their first task, and what is that going to look like in order to start changing course, start providing services, start getting the support that not only our children need but the family needs?

Ms. Lisa Tomlinson: It's a good question. First of all, that group has to address, "What's the problem? What are we trying to fix? What is it we're trying to change? Who has responsibility for what?" I'm not a believer in turning a system upside down; that's anarchy. We can't turn it upside down, but what's working well, and really understanding.

We're working, and this system's over here, this system's over here, and never in the middle do the two meet. Families are interacting with all of those systems, but we're not interacting with each other in the way that we could effectively. So that's what I would say: from a child welfare perspective, understanding what's our role in this, what do we need to do differently as a sector to support these families, and how do we lean on each other in terms of understanding what your gaps are and how that impacts us.

Part of it is we also have to decide what we should keep doing and what we need to stop doing, because I never believe—building on, you have to get rid of something as well. You have to move something out. You have to move out the old—or whatever it is. Move out what's not working.

But you have to have a good plan, because coming together and just talking is also not the answer.

Mr. Michael Mantha: Well, you're right. Reinventing the wheel is not going to help anyone. However, we've often witnessed government agencies working in silos—"This is mine. This is my area. This is my responsibility"—and this is something that really needs to change, specifically when it comes to these challenges that we have in front of us.

How do you see that table functioning, bringing those individuals where—taking your guard down, having an open mind and opening up yourself to putting the child first and using what the child's experience is in order to help either the parent or the family structure, eliminating some of the violence that they're experiencing. How do you see that functioning?

Ms. Lisa Tomlinson: In terms of this table?

Mr. Michael Mantha: Yes.

Ms. Lisa Tomlinson: Yes, again, I would go to what are the programs that we're offering. I don't see this as a solution that's going to occur in like—this is not six months down the line that it's going to work. It will take months and months.

And to your point, you need to come and be able to listen and to be able to come—"Am I listening? Am I going to be able to act? Am I going to action this? And what needs to happen?" This is a change-management exercise in terms of how we need to operate differently. So there has to be coming with some good will; I always say coming with skin in the game. You have to be able to come and say, "Yes, we need to do things differently." Understand who the clients are. Again, I always say, what is the problem we're trying to fix? What is your problem? What is this?

But the other piece is, we deal, as I said, with MCCSS primarily, but when we delve into having to work with other ministries, we certainly see the disconnect within our own ministry not having those relationships or connections, or sending me off versus me saying, "Hey, why

don't we all come together?" It's, "Well, that's just not how we operate or what we do." We need to ask, "Why not?"

The Chair (Mr. Lorne Coe): One minute for additional questions.

Mr. Michael Mantha: I think it was very important for all of us to hear what you just brought to the floor here, that it's not a comfort zone. It's, "This is our silo," and it's difficult for us to make that step. Everybody is always afraid of change. Change is not a bad thing, and it should be something that is welcome.

So when you're looking at resetting or setting a new course, I believe that if there's something that comes out of these discussions that we're going to be having at the committee stage, a strong message needs to be put forward that we need to change course in order to address a wrong and a stigma that has been happening for a very long time. So thank you very much for bringing your comments to the floor this morning.

The Chair (Mr. Lorne Coe): Thank you very much for your questions.

I now move to the government and MPP Scott.

Ms. Laurie Scott: Thank you very much, Lisa, for your great presentation and your years of service. These aren't easy jobs, so you are in it because you want to make the difference. I love the fact that you've brought some solutions to the table. We always like to hear this. The multi-ministries, for sure—you've explained quite well how we could better work together.

The training was very fascinating to me for the social work. Wow.

Ms. Lisa Tomlinson: Wow.

Ms. Laurie Scott: Wow. I just thought that that was—it happened involuntarily. You probably have to do some training when you do receive the new grads from the social—

Ms. Lisa Tomlinson: So we have our own, and our association provides it as well, which is—

Ms. Laurie Scott: Yes, very critical, so maybe we'll work with the universities to change some of the curriculum on their own.

So you've brought some best practices that we've heard of. I can ask several questions, but one is the PAR Program, because I've heard that for several years. You really have to go through the court system before it's mandated. We've heard some other presenters here talk about different approaches. Do you want to expand on that a little bit more? Or anything you want to expand on on the interdisciplinary groups working together—please go ahead.

Ms. Lisa Tomlinson: In terms of the PAR, the Partner Assault Response Program, it is—listen, it's something, but sometimes just "something" doesn't necessarily mean it's effective. There's no research that we're aware of that has been done or updated. We see men cycling through this, and they cycle through our system as well.

I'm a child-focused agency. There is very little related to fathering. To me, that's also prevention around fathering. We work closely with Dr. Katreena Scott, and we work closely with the Caring Dads program because we also think that it's important that fathers not necessarily have to be before criminal justice. If we can prevent criminal justice, we think, number one, that's a good thing for children and youth. It's a good thing for families. It's a good thing from a cost and systems perspective. But how do we work more proactively with fathers?

That's something our agency and, I know, other agencies—our foundation has supported us with that as well, the Children's Aid Foundation of Canada. So how do we work more preventatively with fathers, so they don't have to be before criminal justice? I'm not sure criminal justice has the most effective strategies in dealing with this.

Ms. Laurie Scott: Definitely a theme that we've been hearing. I think it's wonderful the presenters all kind of know each other so far, because you've invested a lot of time—

Ms. Lisa Tomlinson: And I didn't call them or anything like that.

Ms. Laurie Scott: No, but that's great to see that.

You bring some best practices that you've seen. It's like changing the system from within and how we can do better. Can you give some more examples of the harm prevention expansions that you've seen work? You're correct; I want to recognize that CAS has a lot on their plate. My local one—it's an incredible task that they've been given. Anyway, I just wanted to know if you could expand on any other programs.

Ms. Lisa Tomlinson: Caring Dads has had one of the highest impacts, and then the other one was through the violence-against-women sector. I put in a recommendation a number of years ago. Again, our foundation funded a program where we had four staff from the violence-against-women sector sitting at what I'll call our front door with our telephone intake staff. What we did is we were able to connect families immediately to them; connect families immediately to a violence-against-women worker who could start work with the mother, and we were able to divert those cases from the child welfare system.

Am I putting myself out of business? Yes, possibly, but for good reasons. So how do we have those collaborations, those multi-sector collaborations that are—I understand we need shelters, and I understand the violence-against-women shelters and so on, but how do we move to really being able to address, especially with children, those issues from the front door? So I would say that that type of collaboration is essential or was essential to our work.

Ms. Laurie Scott: I see the organicness on the ground—definitely your area, my area. What can we do, and what can we do better? I say situation tables. That might not be the right thing, but it's a similar situation to try to do the diversion.

I don't know if anybody else has got questions. Do you want me to just keep going?

Okay. I guess the court system, the collaboration, the training—I think we've heard some, obviously, concerns about education. I know there's been some specific training for crown attorneys on the human trafficking file so that they're better understanding. I would say voluntary

judge training for some of the other judges. But is there anything you'd like to recommend or see that might help us streamline some of those services and the court educations that might need to occur?

Ms. Lisa Tomlinson: So, in the last 10 years, I've been invited by the National Judicial Institute to actually do training with judges. And it's just interesting because it's voluntary and it's those who choose to go and want to go and so on. We get some pushback from judges around, "We're neutral; we're not supposed to get into this," so I understand some of the challenges that take us out of people's comfort zones, if that makes sense.

We are looking at our agency in particular—I was just speaking with our chief counsel this week around doing even simple lunch-and-learns. Any entry points we can have with judges, we want to be able to do that, so lunch-and-learns with judges around just understanding the work we do. I don't need them to understand the cycle of violence—well, maybe a little bit, but I don't need them to get into the in-depths but understand, when a woman is being brought to court, what that might mean or what it might not mean, and understanding those pieces so that decisions are made in the best interest of children and youth in the context that I bring.

Ms. Laurie Scott: I think, in general, most people are willing. It's the exposure. So you've invested a lot of time, so thank you for that.

And you do mention 40% of your domestic violence cases are reopened. The victim becomes the perpetrator. We've talked a lot about education, the different points and how to make those changes. I think there are some—

The Chair (Mr. Lorne Coe): One minute remaining for questions, please.

Ms. Laurie Scott: Okay. I guess, from your—because you came from more of an urban perspective that I come from, but the gaps for perpetrators, what do you think—we've talked about PAR, and you've talked about some other programs, but are there any other programs that you could highlight here for us that you've seen working?

Ms. Lisa Tomlinson: It's a real challenging one, because there are very few, right? There are very few, and child welfare, unfortunately, is very woman-focused. Many systems, the medical system—it's often mothers bringing kids to doctors. What you're talking about is a huge shift in terms of it's mothers often going to—not that dads aren't great, but it's often mothers who are going to parent-teacher interviews and so on, and I think that's a broader shift that I won't see in my lifetime, to be honest. And I'm also someone who believes, "Let's start small, and let's start with what's in front of us. Let's start with a program and augmenting however we can."

The Chair (Mr. Lorne Coe): Thank you very much for that response and the question which preceded it.

The committee now will recess until 1:30 p.m. Thank you all for your participation.

Yes, MPP Mantha?

Mr. Michael Mantha: Just a question: We had an 11 a.m. presentation from Peter Jaffe. The 3:30 one is Ray Hughes, Peter Jaffe and David Wolfe. Is that the same presentation, or a different—

Ms. Jess Dixon: Yes. It's a different presentation—like an expert on a different issue that he's presenting on.

Mr. Michael Mantha: Okay.

The Chair (Mr. Lorne Coe): This committee is now recessed to 1:30.

The committee recessed from 1214 to 1332.

The Chair (Mr. Lorne Coe): I'd like to reconvene the meeting of the Standing Committee on Justice Policy. Thank you, members.

CHILD DEVELOPMENT INSTITUTE

The Chair (Mr. Lorne Coe): Our first presenter is from the Child Development Institute, and I understand they're participating through Zoom, Madam Clerk.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): No, in person. They're here in person.

The Chair (Mr. Lorne Coe): All right. Hi. Good. Well, come on forward, please. Thank you.

Interjection.

The Chair (Mr. Lorne Coe): I need to acknowledge MPP Dixon, please. Thank you.

Ms. Jess Dixon: Chair, I'd like to suggest something to the committee that I've conferred with my co-lead on, that when our presenters are doing their opening statements or responding that we allow them a little discretion on time just to finish their sentences.

The Chair (Mr. Lorne Coe): Understood, and I'll do that. Thank you.

Ms. Jess Dixon: Thank you—if the committee is all in agreement for that.

The Chair (Mr. Lorne Coe): I haven't seen anyone put their hand up to say no, so—

Interjection: We'll take it out of the opposition's.

The Chair (Mr. Lorne Coe): I was just about to ask that question, but that's okay.

Ms. Jess Dixon: Thank you, Chair.

The Chair (Mr. Lorne Coe): You're welcome. Thank you.

Welcome, sir. You have 10 minutes to make your presentation. We have Hansard with us, who is recording everything that is being said today, including your opening remarks, but for the record, I need your name, please, and affiliation. Thank you.

Mr. Andrew Reddin: My name is Andrew Reddin, and I'm with the Child Development Institute.

The Chair (Mr. Lorne Coe): Well, thank you, sir. You have 10 minutes to make your presentation—thank you so much—and that will be followed by questions from the committee members.

Mr. Andrew Reddin: Wonderful. Well, thank you very much for inviting me to speak to all of you today. My name is Andrew Reddin, and I am the CEO of the Child Development Institute, or CDI for short.

Since 1909, CDI is a charity that has supported our most vulnerable children, youth and families to lead safer, healthier lives. We are a child care provider and an

accredited child and youth mental health centre that also delivers services that address intimate partner violence, or IPV.

I'm here to speak to the importance of making upstream investments that interrupt the multi-generational cycle of IPV that afflicts our communities and that has only accelerated post-COVID.

We know that, according to Statistics Canada, more than four in 10 Canadian women will have experienced some form of intimate partner violence in their lifetime, including psychological, physical or sexual violence. We also know that exposure to intimate partner violence accounts for a striking 45% of child maltreatment and that children who witness family violence develop twice the rate of psychiatric disorders as those who come from non-violent homes. These disorders often result in significant behavioural issues, including aggression, low self-control, difficulty managing anger and poor decision-making. If these issues go untreated, these children are much more likely to become violent offenders, including perpetrators of intimate partner violence, thereby continuing the cycle of violence through multiple generations.

These are children whom the Child Development Institute serves through our SNAP program. SNAP, which stands for Stop Now and Plan, is a cognitive behavioural model and program for children ages six to 11 who have been clinically assessed as among the top 2% in their age range who are most likely to become violent offenders. Up to 90% of children in SNAP demonstrate anti-social behaviours and poor self-control. Up to 33% of these children experience disruptions in care, and 70% have experienced maladaptive parenting—again, highlighting the need to break this cycle.

Since 1985, SNAP has broken the cycle by equipping these children and their caregivers with evidence-based strategies and techniques that ultimately help these children improve their self-control, regulate their emotions and make better choices. SNAP is an evidence-based program that has been evaluated for its efficacy in diverting children and youth from the criminal justice system while contributing to measurable improvements in mental health. These outcomes have been validated through randomized control trials and other rigorous third-party evaluations. One such evaluation, a cost-benefit analysis published by Professors Farrington and Koegl, has shown that every dollar invested in SNAP results in a $32 savings to society. This remarkable return on investment for Ontario taxpayers demonstrates the power of early intervention and interrupting multi-generational cycles of violence. By investing in children and youth now, we can address many of the root causes of intimate partner violence and work towards a safer, healthier future in which IPV is no longer an epidemic in our province.

CDI continues to measure the impact and efficacy of SNAP and has also worked closely with equity-deserving communities to co-create important adaptations and enhancements to its model, with partners from Black, Indigenous and 2SLGBTQ+ communities. We recognize that our programs must be culturally safe, responsive and relevant to be effective.

We've also achieved economies of scale by scaling SNAP through a growing network of more than 100 affiliate organizations across Canada, 65 of whom are here in Ontario. CDI trains, coaches and equips these affiliates to deliver SNAP in their communities, and we regularly collect data based on the clinical outcomes achieved through each program to really measure and validate SNAP's impact around violence prevention and diversion from the criminal justice system. Some of the communities in Ontario where we have affiliates include Sudbury, Thunder Bay, North Bay, Halton and Ottawa. We've also been designing and have recently rolled out French-language SNAP manuals and resources to better serve Franco-Ontarians, as well.

In terms of our request for support, CDI respectfully requests support from the province of Ontario to continue expanding SNAP throughout Ontario, with a special focus on regions, including in some of our northern Ontario communities, where intimate partner violence is particularly prevalent. With a $4.6-million investment over three years, CDI and our network of affiliates will be able to improve the behavioural and mental health outcomes of an additional 2,000 of our most at-risk children throughout Ontario—children and youth who would otherwise be much more likely to become violent offenders and therefore would be at risk of continuing the cycle of intimate partner violence in their families and their communities.

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As a proven intervention that successfully diverts children and youth from the criminal justice system, SNAP not only helps to prevent intimate partner violence but also prevents children and youth from engaging in other forms of violence. Stringent criminological evaluations of SNAP have shown that the program saves $80,000 to $147,000 per child in average crime-reduction outcomes.

Early intervention is ultimately the most effective and economical approach to preventing violence, including intimate partner violence. By making upstream investments now at a cost of less than $2,500 per child, we can prevent the next wave of intimate partner violence in Ontario while creating safer homes and communities and saving considerable taxpayer dollars. Thank you.

The Chair (Mr. Lorne Coe): Thank you very much for your presentation.

We'll begin our questions with the official opposition, please, through MPP Wong-Tam.

MPP Kristyn Wong-Tam: Thank you, Mr. Reddin. I am very curious about SNAP. Your presentation today is one that I was highly anticipating, so really great to have you here to share your expertise.

I am particularly interested in the effectiveness of SNAP, which you've just in short sentences described and summarized for us. But your organization cannot reach every corner in Ontario and even with a simple request of $4.6 million—which seems like a drop in a hat, to be honest. Are there other partners that you could work with

to ensure that education institutions, schools, post-secondaries—maybe a little bit further down the pipeline in terms of age and development. But are there those partners that you can work with early on to make sure that it's not relying on just CDI?

Mr. Andrew Reddin: That's an excellent question. Thank you.

With our model, CDI partners with other organizations to deliver SNAP on our behalf. We do deliver SNAP directly ourselves in Toronto, but we partner with over a hundred affiliates who we train to deliver SNAP and then we collect the outcome data on their behalf to really demonstrate and measure the collective impact.

But even beyond that network of affiliate organizations, you raise a really good point about the educational system. We actually do have another SNAP stream that is not exclusively targeted to the top 2% of middle-years children who are most likely to commit violent crimes, as our core clinical model is, but our SNAP for Schools program is a universal classroom-based model that is for elementary school students. We are actually already reaching more than 4,000 students each year and we hope to grow that number to 10,000 a year within a few years. We would love to continue expanding that program as well.

We have seen strong outcomes from the SNAP for Schools program. So, for example, of the grade 3 and grade 4 students in Ontario who have completed the 13-week, in-class SNAP for Schools program, which is just interwoven into the regular school day, we've seen 83% of students who complete that program demonstrate reduced aggressive behaviour, 86% having better peer-to-peer relationship and actually 90% better teacher-student interaction. So we really do feel that, as you know, partnerships with educational institutions would be incredibly scalable and we're excited to do more of that work too.

MPP Kristyn Wong-Tam: Thank you. That's very helpful to know.

Is the intention of the CDI to ensure that the principles and the learning of SNAP reach the top 2%, the next category of youth that are most identified at risk of perpetuating harm, and eventually that the general population of students—everybody who touches and interfaces with a school of some sort, including publicly funded, privately funded—so how do we ensure that everyone in Ontario is equipped with these skills that you want these kids to have?

Mr. Andrew Reddin: That's a great question. I would say, in terms of targeting both the most at-risk students and also having a more universal intervention, the current model facilitates that in that we do the SNAP for Schools program, for example, with all children in a grade 3 classroom. However, we also provide individual support and counselling for those students within that classroom who have additional support needs.

Your question, too, about how to engage a greater number of educators—we would actually love the province's guidance on that as well. We do find that it takes time to build relationships with the various boards. We partner currently with about 13 school boards in Ontario, but we would love to deliver SNAP for Schools across every board. I think, really, because our model is pretty economical, part of it—of course, we would always benefit from additional investment, but also strategy around how to engage more school boards across the province, because the decision-making structures seem to be complex.

MPP Kristyn Wong-Tam: And because the Minister of Education would have some discretion and the ministry itself would have discretion on how those guidelines are developed, and then the school boards themselves have even further discretion on what they prioritize, would it be helpful for it to become a clear directive that this is part of the ministry's work? So, therefore, you don't have to negotiate the relationships and develop them piecemeal; there is consistent and core funding that ensures that SNAP and the principles that are result-driven are able to just roll out, universally accessible across Ontario for all school-age children, so it becomes just part of the curriculum. Would that be helpful?

Mr. Andrew Reddin: Absolutely, yes. We have received some funding from the Ontario Ministry of Education in recent years, and those year-over-year contributions have incrementally grown. Of course, if it were possible for SNAP for Schools to be a core part of the curriculum and universally supported provincially, we believe that would have tremendous impact.

We continuously hear from our partners in the education system around, as we all know, the significant challenges around violence in schools, and children who are, particularly post-COVID-onset, really struggling. So having SNAP for Schools embedded as a core component would be our ultimate dream.

MPP Kristyn Wong-Tam: Thank you very much for your intervention and presentation.

I recognize that, because we're not a funding committee, these decisions will have to be made by government and everyone who is part of the ecosystem of decision-making. But I do want to just identify how groundbreaking your work is and how truly effective it is, and also the fact that you're able to build such a strong business case. If we can roll this out across the province, I think we're going to see the tremendous yields up front very quickly, so thank you.

Mr. Andrew Reddin: Thank you very much.

The Chair (Mr. Lorne Coe): One minute remaining for the response. Do you have any other questions?

MPP Kristyn Wong-Tam: Oh, I still have a minute? I'm going to use this minute just to talk about first responders. With respect to first responders, these are the folks who you would have to work with in order to identify which children are at risk. What type of resources do they need in order for them to do the job that you need them to interface with SNAP for?

Mr. Andrew Reddin: That's a great question. We also have rolled out a risk assessment tool that we've also been working to distribute among our education partners, including social workers and child and youth workers in our school system. That does help us assess the risk profile

of students within the school system so that we can be much more objective and responsive in being able to reach those children who are demonstrating the highest-risk factors for the types of behaviours SNAP helps address.

The Chair (Mr. Lorne Coe): Thank you very much for that response.

We'll now move, please, to our independent. MPP Mantha, sir, when you're ready.

Mr. Michael Mantha: What's your French version of SNAP? What's the acronym?

Mr. Andrew Reddin: Ah. We don't have a French-language acronym yet, but we'll have to work on some new branding.

Mr. Michael Mantha: You're going to have to find something as pretty catchy as SNAP.

Mr. Andrew Reddin: Yes.

Mr. Michael Mantha: All right. You said it, so I wanted to hear it.

Mr. Andrew Reddin: Fair enough.

Mr. Michael Mantha: I want you to take the time that I have to walk me through: As a child, I'm going to be submerged into the program. Go.

Mr. Andrew Reddin: Okay, so you're a child who has been referred to us from a number of sources—another community partner, a social worker in a school, a family who has self-referred—and you're coming to one of CDI's sites for the first time. You are meeting a really compassionate care team of interdisciplinary professionals: a lead social worker, a clinical psychologist, a child and youth worker who meets with you and your family to learn more about where you are. What have you been struggling with? We keep pretty small groups because each of our children need a lot of individual attention, so no more than 10 children in one group. We run multiple groups at our service centres, but each child has a unique small-group experience and individual counselling.

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In the 13 weeks, the children are learning skills around getting in touch with their emotions and, as SNAP stands for, to Stop Now and Plan: so to pause, understand their emotions, understand the thoughts that trigger those emotions and then make a better choice, refraining from acting out, refraining from hitting the kid next to them, refraining from yelling at their parent and de-escalating those behaviours and replacing them with healthier ones.

At the same time, parents and guardians are also participating in their own group, so that while the kids are being safely supported in their group program, parents are having their own breakout sessions to learn more effective parenting and coping techniques as well.

After the 13-week program, we continue to provide individual support for those children who need it. One of those brief examples is our youth leadership program. That's for children who are SNAP graduates, if you will, who are now into adolescence and who need help connecting with services in their community like employment, like programs like Pathways to Education to support better educational attainment. The journey with SNAP is not a cold handover; it's really a warm continuum of care.

Mr. Michael Mantha: I'm just very fascinated with how you're bringing in the parents. I'll just share a personal story with you. Just recently, my 25-year-old and I were having communication problems, and we just couldn't talk to each other, so we had to develop—because, you know, I'm a fixer. That's what MPPs do: We fix things. I couldn't approach it with him as a fixer, because that's how he was looking at me, as a fixer. So it took us an individual to come in and give us some new coping tools, to listen and then respond to what you're listening to, but then act on those actual responses.

So the fact that you're bringing the parents into this process is very key, because you can provide all the tools and the wellness to the child, but if you're sending him back to that same environment with no coping tools or no expectations of change, nothing is going to change.

I see you also have here two targeted programs: from six to 11, then you have another from 12 to 18. Is that a continuance of the first one?

Mr. Andrew Reddin: For those children who need it, yes—

The Chair (Mr. Lorne Coe): One minute.

Mr. Andrew Reddin: Sorry.

Mr. Michael Mantha: No, we have a full minute. Go ahead.

Mr. Andrew Reddin: Oh, sorry. Yes, for children who need it, we do have additional support post the middle-years program, although most children who complete the middle-years program don't require subsequent programming afterward. We do a lot of work with their school liaisons, as well, in putting them in touch with community supports. But for some children, they do need more time to practise the behaviours, especially as they enter into adolescence. Their brain chemistry changes, their social relationships change, and they do need additional support, yes.

Mr. Michael Mantha: Imagine that: Parents who learn along with their children. That's pretty remarkable, eh?

Mr. Andrew Reddin: Yes, absolutely.

Mr. Michael Mantha: That's ingenious, too. You mean parents don't know everything?

Laughter.

Mr. Michael Mantha: Thank you very much for coming.

The Chair (Mr. Lorne Coe): Thank you for your response.

To the government, please, for questions. MPP McGregor, please.

Mr. Graham McGregor: Good afternoon. Thanks for joining us and walking us through the effectiveness of SNAP. I wanted to ask if we could dive a little bit deeper on the evidence that you mentioned. So not only do you intervene with at-risk youth, but you mentioned sexual violence, and also just anti-social behaviour and violent tendencies and that kind of thing.

Mr. Andrew Reddin: Absolutely. We use three principal clinical measures in the SNAP program that are both pre- and post-measures, so they measure both the child's risk profile, the protective factors that may mitigate risks and ultimately the extent to which the child is dem-

onstrating those behaviours around anti-social behaviour, anger management, lack of self-control. Really, the most rigorous measure that has sort of been the cornerstone of a lot of the randomized control trials that we've done is the child behaviour checklist, or the CBCL. It's a standardized measure—

Mr. Graham McGregor: Sorry, CBC—child—

Mr. Andrew Reddin: Child behavioural checklist—it's the CBCL.

Mr. Graham McGregor: CBCL, okay.

Mr. Andrew Reddin: That is a standardized measure that has a lot empirical evidence behind it, that if a child can demonstrate changes in clinical effect sizes—so, if a child demonstrates a 0.4, for example, moderate clinical effect size improvement on the CBCL in specific indicators, like the anti-social behaviour, the aggression, the anger management—then that is predictively correlated to percentage reductions in likelihood to commit crimes, to engage in the criminal justice system.

However, we also have done longitudinal data studies in partnership with MCCSS and the Ministry of the Attorney General where we've actually been able to look at—of course, within very stringent privacy parameters—correlating our graduates with criminal record information and really being able to concretely measure how have the rates of offence been decreased as a result of completing the SNAP program.

So I would say it's a combination of the clinical effect sizes from standardized measures like the CBCL, working with our provincial partners to do some confidential data pulls and cross-referencing, and also some of the cost-benefit analysis work that third-party academics have been kind to provide us with.

Mr. Graham McGregor: Could you talk a little bit more—and you mentioned the importance of cultural sensitivity but also cultural relevance. I represent a very diverse area in Brampton, people from all over the world. When you're building out the child risk profile and the CBCL, how do you put that cultural lens—obviously from a sensitivity perspective, which is important, but also from a relevancy perspective—just to make sure that we're getting to the kids? How do you do that?

Mr. Andrew Reddin: That's a good question. One example is, we've been working with some of our Indigenous partners, including an Indigenous consultant, Patty Chabbert, to develop a manual, co-created with our Indigenous affiliates, on delivering SNAP with Indigenous communities. There are really helpful protocols in terms of, for example, to the other member's question around family and parent engagement, starting by consulting with elders in the community about family and kinship systems and getting a sense of where each child is located. What's the network of supports they have from supportive adults in that specific community? Also, some points around language are important. How children describe family, how they describe memory in non-Western terms is also a learning that we've gotten from our Indigenous partners. So, that cultural relevance, speaking the language of our communities and co-creating and co-delivering the program with partners from the community we find really helps build trust, especially with families.

Mr. Graham McGregor: What about with newcomer communities? Again, thinking about my neighbourhood in Brampton, we have large South Asian populations from Punjab, Pakistan, India, Sri Lanka etc. How do you apply that lens with newcomer populations? How does that work?

Mr. Andrew Reddin: Yes. I would say, in speaking with partners like Indus community and South Asian Women's Centre and also from other predominantly newcomer-serving organizations, this is where, I think, talking about things like social skills or de-stigmatizing language, we do find—and this is certainly not exclusive to newcomer or to new Canadians, but certainly our newcomer-serving organizations have shared with us that among their clients there's a higher level of stigma around accessing mental health care. So saying that SNAP is a mental health program isn't going to attract families or make them feel comfortable or safe in the same way as talking about coping at school. So I think, for us, it's really about demystifying some of the clinical jargon with our families and de-stigmatizing it too.

Mr. Graham McGregor: Got it. I appreciate that.

I want to ask a little bit about the broader crime impact. This committee, we are focusing on intimate partner violence and sexual violence, but it occurs to me SNAP has other—there are other crime or violent tendencies that early intervention can really limit. Could you talk about the other types of crimes, of violence that SNAP can prevent?

1400

Mr. Andrew Reddin: That's a great question; thank you. The criminological studies that have been done on SNAP, like the cost-benefit analysis, have been for all types of violent crimes. So to your point, it's not exclusive to intimate partner violence.

I think why we believe SNAP, although it is applicable to all forms of violent crime, has such salience for addressing IPV is unfortunately that multi-generational cycle that we see because so many of our children come to us because they've been impacted by intimate partner violence. At the age of seven, they're already replicating the behaviours that they have witnessed. That's why it has such resonance for us around intimate partner violence specifically.

But you're quite right, and the research does show, that SNAP is applicable to mitigating and preventing all forms of violence.

The Chair (Mr. Lorne Coe): I'm going to have to interrupt because there's only about 14 seconds left.

Mr. Graham McGregor: I appreciate the answers. Thank you.

The Chair (Mr. Lorne Coe): Pose your question and I'll allow the response. Go ahead.

Mr. Graham McGregor: Just as quick as we can: We know early intervention is important. If you were to put an age or a stage of development, when's the best time to intervene?

Mr. Andrew Reddin: I would say, for us, six to 11—the middle years—have been particularly fruitful because it is the earliest that a child can comprehend a lot of the behavioural change techniques that we offer through SNAP.

That being said, I will briefly say we're looking at, is there a SNAP under six? Are there ways that wouldn't involve talk therapy necessarily, but mindfulness, attunement or attachment work that could be done with even younger children? Because, as a child care provider, we're also seeing some significant concerns among our very young kids, too.

The Chair (Mr. Lorne Coe): Thank you, sir, for that response. Thank you, MPP McGregor. Thank you, sir, for your presentation.

OFFICE FOR VICTIMS OF CRIME

The Chair (Mr. Lorne Coe): I will now call up to the presenters' desk Sonya Jodoin, please.

Good afternoon. Could you please state your name for Hansard—just your full name?

Ms. Sonya Jodoin: My name is Sonya Jodoin. I'm not sure what the second part of that was, but I'm the chair of the Office for Victims of Crime.

The Chair (Mr. Lorne Coe): Thank you very much for that. You have 10 minutes for your presentation. As you just witnessed, there will be questions from the members of the committee.

Ms. Sonya Jodoin: When people start asking questions, please talk in the mike because that's what this is set up for, so that I can hear the questions more effectively, hopefully.

With me is Breanna Ellis, who also works for the office and is going to help me with the questions, as well.

As I said, my name is Sonya Jodoin and I'm the chair of the Office for Victims of Crime. We are an advisory board to the Attorney General and it is a respectful and collaborative relationship. For the past while, we've been working diligently on topics specific to intimate partner violence, otherwise known as IPV.

The verbal presentation is a summary of the document already sent to you because I can't read that one in 10 minutes, so bear with me.

Statistics Canada reported that 2022 was the seventh consecutive year that police services saw an increase in IPV-related sexual assaults. That raises the question, why is this increase happening? I should note, which isn't in your documents, that violent crimes have actually been decreasing year after year after year except for in the areas of domestic abuse and sexual assault.

The answer is not simple and spans several different issues, so I want to focus on some of the seemingly smaller gaps that we've heard consistently from victims and survivors of crime and from service providers. The best way for me to do that is to walk through a fictitious case example which is actually also very common.

So we have three siblings: John, Jane and Joan Doe. They are growing up in a middle-class home in a middle-class neighbourhood. Their parents are married. Dad is quite abusive. He mostly pushes mom around versus beating her up all the time, so he's not the image most people have of a domestic abuse spouse. He is, however, aggressive, emotionally abusive, controlling, and described as somebody who would "terrorize the family."

John struggles in school and is disruptive. He's been diagnosed with ADHD and oppositional defiance disorder. He's referred to a local child and youth mental health organization. The intake and referral process for John does not evaluate if domestic abuse is happening in the home. John wouldn't know what domestic abuse was and that it was happening in his home because he's never heard the term before and he's never been taught or trained or given the language to actually talk about what's happening. That means he has no way to tell anybody. And that is gap number 1.

Public education and awareness of healthy and unhealthy relationships needs to start far younger than we are currently doing. Numerous—I couldn't even—numerous survivors of abuse consistently say they wish they knew when they were young kids that the abuse they experienced was not the way all families were and that it was, in fact, abuse, because they didn't have the option to tell anybody until they were much older.

The worker that is connected to John and his family has never had training on domestic abuse, as it doesn't necessarily fit with what they do and it's not required. They would not necessarily recognize any red flags that may exist within the family, and they don't work with parents who are in a domestic abuse relationship.

Research tells us that children who grew up in a home with domestic abuse present are 10 times more likely to abuse a future partner, are 50% more likely to abuse drugs and alcohol, are more vulnerable to anxiety disorders and mental illness, have a 24% higher chance of committing sexual crimes against others, and are six times more likely to commit suicide.

Research also tells us that simply witnessing abuse carries the same risks of harm to children's mental health and learning as being physically abused. There's an overall higher risk of poor health, depression and developing complex post-traumatic stress disorder.

We know from research that growing up in that type of chronic stress will frequently rewire the developing brain, making learning, impulse control and other important executive functioning skills much more difficult, and that would be gap number 2.

When we look at our services in isolation without looking at a more holistic approach that encompasses something intersectional like domestic abuse, we miss opportunities for intervention that are beyond sending a client to another service. The local shelter may very well have something for kids who have grown up in a domestic abuse home. However, if those services—if the mom, in this case, is not ready or willing or isn't at the point in her life where she's able to accept those services, then they're not going to benefit John, because he's not going to access them. In that case, the children's mental health organiza-

tion then is the best place to provide assistance because that's where he's connected to.

The solution to this gap may be as simple as mandatory training for services and organizations that might not provide direct IPV-related services but still interact with individuals that are impacted by it. This may require ensuring someone in the organization has the necessary background and skills to recognize the red flags and know how to work with the child in a way that does not increase harm.

As an adult, John struggles with healthy relationships, is alluded to be abusive, and is repeating the patterns he learned from his parents. At some point, John realizes he wants to change his behaviour, and so he begins looking for a program to help him, but he can't find one. And that is gap number 3.

One of the issues that comes up repeatedly is the fact that a person who is abusive can only get help after they are charged and convicted of a domestic assault and can only be referred from the criminal justice system. Anyone wanting to learn how to not be abusive most often has nowhere to go.

A potential solution may be to develop appropriate services for individuals who are abusive in their relationships and wish to make changes and make them accessible without the need for the criminal justice system intervention.

John's relationships are described as "controlling, manipulative and aggressive," and that behaviour continues towards his partner and his stepchildren, who are now growing up in the same environment John did.

Jane, John's sister, has all the symptoms of post-traumatic stress disorder. She copes using drugs and alcohol. She has significant anxiety and what appears to be obsessive-compulsive disorder and depression. Through help from others, she's able to get on social assistance. Jane meets her boyfriend, who is older, controlling and decides to help her. He's manipulative and would be described as demonstrating coercive control. The relationship is not healthy, but Jane feels she owes him, and she also feels like he has saved her.

1410

Jane tries to get help for her mental illness. She reaches out to a local adult mental health organization. While she knows that her relationship is unhealthy, she feels strongly that she needs to get a handle on her mental health before she can even consider dealing with her relationship. At some point in the assessment process, the staff determines the relationship is abusive. She is told to go and seek services from a local women's shelter and is not picked up by the mental health organization. Even though Jane has legitimate mental health concerns, the organization has no training regarding domestic abuse, and they feel she needs to address that first due to safety issues. As a result, they feel the best person or place to assist her is a violence-against-women service. Jane decides not to seek help. Her relationship is not her priority. This is gap number 4, which is similar to gap number 2.

The lack of training and staff who are skilled in how to work with her safely mean that Jane is not able to get her mental health issues addressed, which are significant. It is also not part of the services that this mental health organization provides. They are not funded for it, they're not structured for it, and it's not included as part of their programming. It's not what they do. This is another common theme from individuals who tell us that when they do try to get help, they often get told that no one at the location can help them and are sent somewhere else, which is frequently not successful for what they need or want.

A potential solution is a cross-sectorial approach, which requires a tremendous amount of co-operation and coordination from different ministries. The current siloed approach to funding and service provision makes it extremely difficult for organizations to somehow figure out how to address this. I do want to recognize that ministries have been working hard to work together on some of these issues.

Jane now has a young child who is in kindergarten and has been flagged by the school as potentially having ADHD. She's still in a relationship with the father, who is still abusive.

A girl who grows up witnessing her mother be abused by her father is six times more likely to be sexually abused. Unfortunately, that's Joan's experience. She tells a friend, who tells the police, and charges are laid. Joan's parents are furious with her for telling someone and letting the police get involved.

Joan stays at different friends' homes to get away from her home environment, and eventually she ends up homeless when those arrangements break down. She meets a boyfriend online, who is going to take care of her, and she is preparing to go and leave and join him. Living in a domestic abuse home and/or being sexually abused or assaulted are significant risk factors for becoming a victim of human trafficking, which is what is happening to Joan.

A relative intervenes, gives her a place to stay and sets up counselling. Joan is diagnosed with PTSD, anxiety and, at one point, bipolar disorder. She struggled with an eating disorder and was suicidal. She required three years of counselling after moving in with her relative to complete her schooling and to even consider a career, which is gap number 5.

Recovery and disruption of the cycle of abuse takes a very long time in most cases. People generally don't jump from an abusive relationship to a healthy one, and limited short-term intervention is frequently not enough for many folks to get there.

What we hear from victims and survivors is the lack of ongoing counselling and support options that a person needs may create barriers for someone to continue along their healing journey.

We now have two of the three children raised in a home that had an abusive parent who are passing on their own trauma, who are teaching patterns and relationships that are unhealthy and lead to multiple issues for the children in their care.

Thank you.

The Chair (Mr. Lorne Coe): Thank you very much for your presentation.

We'll now begin the questions-and-answers part of the committee meeting. I'll turn first to the official opposition, please. MPP Wong-Tam.

MPP Kristyn Wong-Tam: It's very nice to see you again, Ms. Jodoin. I know this is not your first time appearing to speak to this committee.

I recognize that as you were preparing your summation—written summation, I should say—you had spoken to a number of organizations and service providers, experts and professionals, to pull together some of the thoughts which your presentation is now made up of. I want to say thank you. Thank you for taking the task so seriously. Thank you for consulting even those who you work with, because I think that's important. Clearly, you have a collaborative approach.

Your presentation really, for me, hammers home the point that the survivors, the victims of crime, are not seeing ready access to services when they need it. I think you were very clear in identifying what the limitations are when you interface with the justice system—trying to get to it before you interface with the justice system.

Can you explain to us and help us unpack why those services, as needed by the survivors and their families, are not readily available?

Ms. Sonya Jodoin: I'm just going to ask for some clarification quickly, if I can. Do you mean the services such as the mental health services are not available? Or any services in general?

MPP Kristyn Wong-Tam: One of the statements that your presentation said is that the survivors and victims of IPV identify that the people they were talking to were not trained to identify the issue.

Ms. Sonya Jodoin: Right.

MPP Kristyn Wong-Tam: So that was one gap, and then the second gap is that if they were to identify the issue, there was no place to refer them to get help. So why is that?

Ms. Sonya Jodoin: As it stands, again, the way that services are delivered—and this is not meant as a dig at any of the services that exist, but if you're delivering mental health, you're busy; you've got a job and you've got a lane that you stick in. But the reality is, you're seeing people who are struggling with intimate-partner-violence-related issues, and if that comes up, they get told, "Go to this other service."

So we have, in this case example, an individual with significant mental health concerns. She needs to address that in order to even consider what she has to do next with the relationship, but the mental health organization doesn't feel safe in dealing with her, because they don't have any expertise in domestic abuse. So it's fair to send her to this place that does, but that's not what she needs. There are violence-against-women services that are available, but they don't have the training and expertise and the experience in regard to assisting somebody with significant mental health issues, because that's not their lane.

And so that's where you end up, then: with somebody who has got addictions and mental health issues, who maybe really desperately needs to address those, but feels like they don't have an option to because they're being deferred to the violence-against-women sector, which maybe doesn't have—they'll try, but they may not have the pieces that this person needs, or this person may not go.

MPP Kristyn Wong-Tam: So the solution is to make sure that everyone in the ecosystem who is working on safety and community wellness and health has the resources—sustained and ongoing; not just project funding—to make sure that those resources are there for the individuals, survivors and victims, when they need it.

Ms. Sonya Jodoin: I think that there's a multitude of different solutions that you could look at for this. I'm big on training, not surprisingly. There's no mandatory training anywhere in regard to these things, and maybe there should be, because even that alone might be enough to assist somebody from another service to develop the skills they need to safely intervene.

But also, the fact of the matter is, whatever the solutions are, there needs to be another way to look at intimate partner violence than "Here's the lane for intimate partner violence, and for everybody else, go all the way over here." It's too intersectional for that. The solutions don't have to be big, but there are ways to address things.

MPP Kristyn Wong-Tam: That's really helpful. Thank you.

Let me ask you a question that's specifically within your portfolio, and that's the Victims' Justice Fund. I recognize that every deputant that came before us today had some type of program pitch or proposal, and yet you interface directly with the Ministry of the Attorney General, but you're not here asking for any additional funding or support to the Victims' Justice Fund.

Ms. Sonya Jodoin: No.

MPP Kristyn Wong-Tam: Yet we've heard at this committee through other deputations you may or may not have heard—but I suspect you were in the room, because I remember making a note—that survivors and advocates for survivors identified that the Victims' Justice Fund was very difficult to access, and when access was procured, the dollars were too significantly reduced to a thousand dollars. That doesn't really buy you any service, and if you did have access to some pre-existing services, you would then disqualify yourself from the Victims' Justice Fund. Is it in your opinion that you don't need additional support in that fund?

1420

Ms. Sonya Jodoin: No, I did not say that nobody needs additional support—

MPP Kristyn Wong-Tam: So, what do you need?

Ms. Sonya Jodoin: However, not all the solutions require—I mean, some of the solutions to some of the gaps that we've talked about, yes, they're going to need funding. Training needs funding. You've got to pay for training. Some of these solutions, yes, of course, they're all going to need some type of resource, and I 100%

recognize that people are strapped financially from an organizational perspective and that people are scrambling in a lot of ways. I get that.

But if the only solution you have is to go after more money, then—and believe me, as a director, that's what I did. I'm going after the money. However, there are still things that can be done to help to try to address these things. They're not going to solve this all on their own. This is too big, it's too broad, and it touches too many areas and sectors.

MPP Kristyn Wong-Tam: But you're not asking for money for the Victims' Justice Fund today—

Ms. Sonya Jodoin: I'm not here to promote any type of business or organization or service that's asking for money. I am just—and you guys are going to hear from researchers; you're going to hear from people that are running programs. That's what they do. They are going to give you guys all that information.

But I happen to have spent the past two and a half, almost three years talking to people about what the gaps are. So I thought the biggest value for today would be not to focus on where the money should go or what the money should be, it should rather be to focus on some of the littler gaps that—or maybe they're not little; that's not the right word—maybe hidden gaps that I am consistently hearing from everyone over and over and over again, because chances are the office is in a unique position to hear things people may not hear such a breadth of information on.

So my goal today is to share that with you guys, and that can become part of the volume of information, because, like I said, you're going to hear from researchers, you're going to hear from people running programs, you're going to hear some fantastic things, and I fully support a lot of what some people are doing out there and programs are doing, but that's not my role today.

The Chair (Mr. Lorne Coe): Thank you very much for that response. That concludes the questions from the official opposition.

I'd like to turn now to the independent. MPP Michael Mantha, please.

Mr. Michael Mantha: Do you think you can train someone to be empathetic?

Ms. Sonya Jodoin: I don't know. I don't know that I've tried.

Mr. Michael Mantha: Do you think you could train someone to instead hear but listen to someone?

Ms. Sonya Jodoin: I think that many services for non-profits and community-based organizations do actually try hard to do that. Whether or not they're successful is not for me to say.

Mr. Michael Mantha: I'm looking at some of your problems that you've brought here before us, and I'm looking at the one that's identified as problem statement number 5. For me, I refer to it as "pass-the-buck syndrome." It's Friday afternoon, it's 3:30, I'm looking forward to my weekend. I have a person that walks into the office who finally makes the decision to say, "I need help," and you get to a bureaucrat who is not prepared to be listening to you. They are hearing you, and they are hearing to respond instead of listening to the culture and what you're going through. That's a huge problem that we have in some of the programming that we have, and somehow that needs to change.

You brought up another one that is very close to me, that when that person does make that decision, they want to know that the person that I'm talking to is feeling what I'm feeling, is aware of what I've gone though. And the fact that that person has experienced what I've experienced attributes to a lot of the trust that needs to be built between that person and the person that's going to be caring for them. How important is it for an individual who is going to be providing that care or that service or being that shoulder and providing that counselling to that person—that they trust the person they are talking to, that they understand and they have a sense of what trauma they've gone through?

Ms. Sonya Jodoin: I think the premise of providing services in any of these organizations is based on the ability to develop a trusting relationship, and if that's something that's not happening, then that is something that should be looked at closer by the organization that's delivering that service and to figure out, maybe, what's happening and what might be interfering or a barrier in some way, shape or form.

I hear what you're saying, but I can't speak in a blanket term. I know people that will stay there until 7 p.m. to help this person as much as I know someone that would be like, "Next. I'm out of here. I'm out of here at 5." So I can't—it's not a blanket across the board.

Mr. Michael Mantha: In my experience, it's happened both ways, where people have felt frustrated that they went into an office and they said, "Well, they didn't have anything to tell me," or "They passed me off to you," is what they say. And you sit down with them and you listen to them and you're puzzled as to—they're the ones that apparently have the tools and the opportunity to help you, so why are they passing you back off to us?

Anyway, it's frustrating for me—and I just want to make this statement—that sometimes I see there's a lack of empathy, where a person has the courage to step out of a relationship and say, "Hey, this is who I am, this is what I'm going through," and the unfortunate part is those that are there to protect, to listen and to get them to the help they need just aren't listening. That's why I opened up with asking the question, can you train a person to be empathetic, or can you train a person to listen? I'm still puzzled as to not getting an answer to that. I'm not expecting it from you; that wasn't the point. I just think, when it comes to something like this, where we're creating a new path and we're going to be creating policy to help people, those are two very key, important words that I hope are going to continue coming along the way, along with accountability and transparency and action. These are the types of things that I think are going to develop the policy that we're going to need to help people going forward.

Thank you very much for coming in and sharing your words with us.

The Chair (Mr. Lorne Coe): That concludes the question from the independent.

We now will move to the government. MPP Dixon, please.

Ms. Jess Dixon: Thank you so much for coming in. I want to go a little bit more into what you are talking about with these gaps, this insane network that people have to navigate—and so, just a couple of, I guess, practical questions from me and my own lack of knowledge.

We're going to be hearing later on from a place like the Safe Centre of Peel. I haven't heard from them yet. I know there's a couple like that, where the goal is to have services localized so that if you are referring, you're referring somebody down the hall as versus across the city. So we haven't heard from them yet about their model, but I'm wondering if you can talk a little bit about the idea of maybe the benefits and the problems with a geographical localization of services, that idea of the same building, but then what we do in bigger cities or rural areas or up north? Anything you'd have to offer on that.

Ms. Sonya Jodoin: That model has been around, actually, for quite some time and is extremely successful in some areas. They found that it works where they have an employee from different services all in the same building, and they're all co-located. One of the challenges with that model is—I'm from a rural environment, and there are 13 mayors of 13 different towns within the catchment area that I live in. So if you have one place where everybody's working in the building and there's no buses, there's no trains, there's no transit of any kind—we don't even have Uber, right?

1430

Interjection.

Ms. Sonya Jodoin: Yes, I know, eh. There's nothing.

The biggest barrier, then, would come from the fact that people couldn't get to where the service is. I don't want to discount it because I've seen examples going back the past 20 or 30 years where that has been really successful. But you're never going to get one approach that's going to work for urban, rural and remote locations because what works in one area you don't have the infrastructure for in another.

So some of the services out in the rural area, what they've done is they've been pairing up staff to work together. So let's say—like your police and mental health approach. A lot of the police officers are working with a nurse, and they are mobile and they go and they respond or they provide preventative services. We've got other examples similar to that. In a rural environment, that sometimes can be more successful, because you have to be mobile, and that would require very different things than a building where everybody has an office and they're all down the hall from each other.

But ultimately, in the end, the goal is to develop those types of relationships because collaboration on a front-line level is kind of what makes a big difference in terms of being able to successfully get somebody from one service to another.

Ms. Jess Dixon: Thank you. What have you seen as far as—say, hypothetically, we do have that geographical location where we have co-operation, ideally sharing of admin, so even the fact that the person has walked in the door continues—does this exist, or would it be of any use in rural or remote to have this idea of really trying to push awareness that that exists, whether it's posters in town halls or local doctors' offices or schools? I know we have a broadband problem as well.

But this idea to even be that there is a centre, that even if you can't go to, you would be able to get phone or virtual assistance—do you think that would help at all? I don't really know what the communication is like right now.

Ms. Sonya Jodoin: I mean, that always helps. That always does. You can have a wonderful service, and if nobody knows you exist, it doesn't matter how wonderful you are; no one's using your service.

For a rural environment, you have issues with connectivity and data and ability, but also then, when you start looking at intimate partner violence, you have somebody maybe whose phone is controlled or who can't communicate with somebody, if they wanted to, in a service. So again, you have to be much more cautious sometimes in terms of how somebody wants to reach out.

You also have an issue in rural environments with everybody knowing who you are and what you do. We have a service that I've worked with that has an office in a library, because everybody can go to the library, and it doesn't self-identify you as having this type of issue if you go to the library. It makes it safer for the person to go there. In a rural environment, that's hugely important because everybody and their brother is going to recognize you walking into that office door to go get help from whatever service it is, and someone's going to tell everybody else. Your neighbours are going to recognize you. The mailman is going to recognize you, right?

Whatever it is, whatever direction that this ultimately goes in, it really does need to have some awareness and understanding of how the lack of infrastructure, the way things are spread out, the way the services work in rural and remote environments—that there needs to be some ability, for whatever is set up, whatever direction, that they can actually deliver that.

Ms. Jess Dixon: Okay. So we're going to be having a number of presenters that represent those areas and we're going to do some travel. If you were in our position of being able to ask the question, how would it be useful to phrase it if I'm talking to somebody that's from a remote or rural area to say, "What is the best way that you could recommend to me that I would be able to make you aware or make you feel comfortable accessing that service?" I'm just sort of spitballing that. But how would I ask?

Ms. Sonya Jodoin: How do you ask that question?

Ms. Jess Dixon: Yes—

Ms. Sonya Jodoin: Just the way you asked, to be honest with you: What is the best way for you to promote your service? How do you let people know your service

exists? How do you make sure that the victims or survivors or individuals can access your service? How do they find out about you? And folks will tell you.

Ms. Jess Dixon: Okay. So for my purposes, I should make a note that that is a good question to ask when we are doing that, I take it. All right, I will do that.

Just briefly, when you talk about the idea of training and that type of thing, to sort of narrow in, who could theoretically be delivering that training, and are there human resource constraints? Like, what type of person would fill that role?

Ms. Sonya Jodoin: I think that that would take some examination, a little bit. There are some services that exist in the province that have a lot of history and experience with providing training to others.

I think that a best-practice approach in regard to that training would be a recommended way to approach it, because training is different and you want to make sure that, if you're going to do it en masse, everybody has a base level of training and feels confident and comfortable. You're going to want to make sure that that training is actually going to meet those outcomes. And that would take a little bit of development, I think. There are some great resources in Ontario that already exist for that.

Ms. Jess Dixon: Yes.

My last question: When we're talking about, say, teachers and counsellors in schools, what types of issues or challenges are they facing when it comes to them being able to identify that a kid may be coming up in that environment?

Ms. Sonya Jodoin: Teachers and counsellors in schools frequently have kids that tell them things and they may or may not have access to resources right on site. We've had a lot of success with having resources physically in the school location so that teachers themselves can access the resources, because sometimes kids disclose to them, and they don't have the ability to—the kids don't want to talk to anybody else. But if a teacher can go and get those resources right in the same building that they can use and give to somebody else, that is extremely helpful.

I want to recognize how busy teachers are, and that this is a challenge for them. When you talk about co-joining, there's no reason why educational organizations or facilities can't be part of that.

Ms. Jess Dixon: Okay. Thank you so much.

The Chair (Mr. Lorne Coe): Thank so you much for your presentation today and for being with us. That concludes your presentation.

Committee members, you would have noted on the agenda yesterday that you received that there's a gap in that agenda from 10:30 to 11 a.m. Consequently, the Clerk has contacted the presenter who was scheduled at 10 a.m. and asked if they would please present at 10:30. They've agreed to do that. Consequently, with your agreement, the committee will start tomorrow at 10:30 in the morning rather than 10 o'clock. Okay? Thank you for your agreement on that.

THE GATEHOUSE CHILD ABUSE INVESTIGATION AND SUPPORT SITE

The Chair (Mr. Lorne Coe): I'm going to call forward at this present time the presenters from the Gatehouse Child Abuse Investigation and Support Site, please. Thank you.

Welcome. Your mike will be activated by the technology staff; they're just behind to my right. You'll have 10 minutes for your presentation, followed by questions and your answers to those questions. For the record, for Hansard, please state your name and then you can begin your presentation please.

Ms. Maria Barcelos: Thank you. My name is Maria Barcelos.

Ms. Sabra Desai: And my name is Sabra Desai.

The Chair (Mr. Lorne Coe): Thank you again for being here. Could you move your microphones a little bit closer to you, please—just in consideration of those who might have some hearing challenges—so we can hear carefully what you have to say? Please start your presentation.

Ms. Maria Barcelos: Thank you for inviting the Gatehouse to take part in this meaningful discussion here today. Again, my name is Maria Barcelos and I have the privilege to represent the Gatehouse as its executive director alongside by colleague Sabra Desai, chair of the board of directors.

We're also registered psychotherapists with our respective colleges, the College of Registered Psychotherapists of Ontario and the Ontario College of Social Workers and Social Service Workers.

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The Gatehouse is a non-profit charitable organization based in Toronto that for the past 26 years has dedicated ourselves to providing peer support programs and services, community and resources for survivors of childhood sexual abuse and their families. In the last four years alone, the Gatehouse has helped 800 adult survivors and 504 children.

During the pandemic, we immediately transitioned to online services to ensure that survivors had access to support without interruptions due to lockdowns. The Gatehouse introduced self-care-focused groups to help survivors develop coping strategies during lockdowns to reduce the increased feelings of social isolation.

We are not a core government-funded agency. We provide these programs with the financial support of private donations, grants and sponsorships. We deliver services with the help of five paid staff and over 100 volunteers. We also have 10 practicum students per semester—sometimes more—from various colleges and universities, including Humber College, George Brown, Seneca, York University, Metropolitan and the University of Guelph-Humber.

We're going to alternate between myself and Sabra, so I'm going to ask Sabra to do the next part.

Ms. Sabra Desai: Good afternoon, Chair and all committee members. Again, thank you so very much for

inviting the Gatehouse to participate in these very, very important proceedings.

As some of you might know and be aware, these two past weeks have been overwhelmingly hectic for the Gatehouse, with the attention it has brought to the work we do. In the midst of this, we received your invitation with very little time to respond, with all the demands on our time from media and individuals and families wanting to learn more about our services and how we help childhood sexual abuse survivors, as well as our role in providing a safe place and space for investigating allegations of abuse against children. With this in mind, I hope the committee moderator and members are okay with me adding a few more thoughts to what we submitted in writing last week.

The resistance to children's and women's rights is presenting a troubling reality. This troubling reality is reflective of a broader global trend where achieving human rights goals is being obstructed, restricted, undermined and even reversed. We continue to face misogyny and patriarchal resistance, manifesting in a myriad of ways, systemically and in our private homes, in subtle and some in blatant ways, in-your-face acts of abuse, violence and even murder of children and women. Moreover, we have to address socio-economic disparities and the impact of racism and the implications on the pandemic of violence. Women and children are targeted in person within and outside their homes, in public and online. This is not only egregious but repellant.

We cannot remain in denial: Child sexual abuse and intimate partner violence have reached pandemic proportion, and it begs a moral obligation to address both CSA and IPV. We need stronger laws honouring and protecting children's and women's rights. We need robust and timely processes and protocols for prosecuting trans-provincial and trans-national in-person and online crimes to hold perpetrators accountable. Local, provincial and national laws have roles and responsibilities for combatting gender-based violence against all ages that need to be strengthened—intimate partner violence; polyvictimization, including sex for commercial gain, human and sex trafficking; as well as childhood maltreatment; childhood physical abuse; and childhood sexual abuse. The same needs to be done when it comes to online violence on children and women.

Organizations working on combatting violence should be supported, regardless of size, through funding from different levels of government. Childhood sexual abuse, intimate partner violence and polyvictimization are very complex, layered issues requiring cross-sectorial collective strategies as well as collaboration. From research and our own work with adult survivors of childhood sexual abuse, we have learned and know that childhood sexual abuse is linked to adult sexual intimate partner violence. In other words, childhood sexual abuse makes survivors vulnerable to intimate partner violence later in life. It should be noted that with regard to women survivors of childhood sexual abuse, they face significant probabilities of physical abuse.

The ongoing vulnerability faced by childhood sexual abuse survivors highlights the need for continuous awareness and education, starting within elementary school and into high school curricula, as well as post-secondary education programming.

Research done in Quebec, Canada, on childhood sexual abuse involving 8,000 high school students found self-esteem and delinquent behaviour were linked. Childhood sexual abuse contributed negatively to their self-esteem and behaviours, thus requiring early intervention.

We need to focus not only on services for survivors but also early intervention and prevention. Additionally, women and men working on combatting violence should be supported to ensure that they do not develop vicarious trauma.

As a country, we need to create an evolving understanding of interconnections among the various forms of abuse and to create resources for people working with survivors of childhood sexual abuse, intimate partner violence, polyvictimization and revictimization. These are all public health issues requiring immediate attention to stop these forms of violence and stop intergenerational violence. It is our duty to stop childhood sexual abuse, intimate partner violence, polyvictimization and revictimization. If we don't work collectively and collaboratively, the consequences are very costly to society as a whole and especially for vulnerable children and women, in terms of risks to women and children's safety and security.

In keeping with the theme of risks and vulnerability, as a nation, as a province and as municipalities, we need to address the fundamental problems of economy, poverty, housing, health, mental health, education and geography that exacerbate risks and vulnerabilities of children and women falling victim to violence. In short, we have to address structural, systemic causes of vulnerability.

Protection against sexual violence needs to have special, specific and unique legal protections requiring clear definitions of crime and penalties that are consistent across Canada and with international obligations. Penalties must be enforceable.

My colleague and I are not lawyers, but we speak from the perspective of professionals working with adult childhood sexual abuse survivors who tell us about their experiences, their multiple traumas and revictimization within intimate relationships, within families and institutions. They also tell us about legal codes seemingly failing them due to gaps in the codes. These gaps need to be identified by professionals within the legal system and community-based personnel working directly with people victimized by multiple forms of violence to rectify and address the gaps, to address current realities. The current reality also includes recorded videos shared on platforms like X, Instagram, Facebook and other social media platforms. We also need to strengthen survivor and witness protection safeguards. Last but not least, we need to institute options for alternative dispute resolution processes and options.

In terms of the connection between intimate partner violence and child abuse or adverse childhood experiences, we learned from studies that found that all types of

child maltreatment predicted a higher risk of experiencing intimate partner violence and polyvictimization, which includes multiple forms of maltreatment. They were all associated with intimate partner violence, even when considering individual types of maltreatment separately.

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At the Gatehouse, we know that the true prevalence of childhood sexual abuse and childhood sexual violence is unknown, as this is a highly under-reported crime. According to Statistics Canada's general social survey on victimization, an estimated 32% of women and 14% of men in Canada reported experiencing some form of sexual abuse before the age of 16. Other research states that one in 10 Canadians reported being sexually victimized before they turned 16. Statistics Canada in 2018 mentioned that women were also more likely than men to have experienced sexually abusive behaviours more than five times. Women who experience childhood victimization were more likely than men to have ever been forced into unwanted sexual activity by an adult multiple times and more likely to have ever been touched in a sexual way by an adult multiple times. You have the statistics in our report.

In terms of online sexual exploitation, police reported 2,492 incidents of online sexual offences against children in 2022, 139 more than in 2021. Between 2014 and 2022, there were 15,630 incidences of police-reported online sexual offences against children, translating to an average annual rate of 25 incidents per 100,000 children and youth in Canada. Again, these statistics underestimate the true prevalence of childhood sexual abuse, as many cases go unreported due to stigma, fear and other barriers survivors face in disclosing their experiences.

Childhood sexual abuse can have long-lasting effects on survivors' physical health, mental health, relationships and overall well-being. It is often associated with increased risk to mental health. Research indicates that certain populations may be at higher risk of childhood sexual abuse, including Black and Indigenous peoples, individuals with disabilities and members of the LGBTQ+, youth and those from socio-economically disadvantaged communities.

Recently, the Gatehouse was mentioned in an article by the Toronto Star for its role in providing support to one of the most prominent families in Canada. Andrea Robin Skinner shared her story of surviving childhood sexual abuse at the hands of her stepfather. She is Alice Munro's daughter.

When it pertains to intimate partner violence, police-reported statistics indicate that women are overrepresented as victims, accounting for almost eight in 10 victims—in other words, 79%. Forty-four per cent of women or 6.2 million women aged 15 and older have reported some kind of abuse in their intimate partner relationships according to the government of Canada in 2022. These statistics encompass various forms of violence, including physical, sexual, emotional and financial.

Perhaps I shall turn it to you, Maria.

The Chair (Mr. Lorne Coe): May I intervene, please? We are making some discretion from presentations. You're now at close to 14 minutes and 35 seconds. Can you summarize your presentation so we can go to questions please? Thank you.

Ms. Maria Barcelos: I guess I'll summarize with a case study.

The Gatehouse saw multiple examples of women experiencing intimate partner violence and women at risk of intimate partner violence, especially during lockdowns due to COVID. We had a 45-year-old-plus woman who endured intimate partner violence from her husband, and she had been married to him for more than 25 years. We'll call him Mr. B in this example. Despite multiple attempts for her to leave him and their 25-year relationship, the pattern of returning back to him was evident. It became even more evident when she also, of course, disclosed she's a survivor of childhood sexual abuse and came to the Gatehouse for support through our online groups. She came to a group with her face all battered and bruised up, and our volunteer facilitators asked for the staff's support in helping her to get connected with services in the community.

When she was connected with us, we did speak to Toronto Police Service and asked for support and guidance from them as well. She declined their help and continued to stay, with the fear of him harming her cats. Often, perpetrators will also do that: will threaten not only the children but the pets in the family system.

The Gatehouse also supported her, and we went above and beyond as an organization, as our mandate is to help survivors of childhood sexual abuse. Intimate partner violence is not part of our primary mandate. But we supported her through even contacting her landlord to get the locks changed on her apartment, and she did fully report to police. A couple of days later, he was released, Mr. B, and eventually she did take him back with the pressure from the family system.

I guess the point to end off on here is that childhood sexual abuse, child abuse, is a very layered and complex issue that knows no socio-economic boundaries, and it is a predicting factor for intimate partner violence.

The Chair (Mr. Lorne Coe): All right. Thank you very much for your presentation.

We'll know turn to questions. To the official opposition and MPP Wong-Tam, please. Thank you very much.

MPP Kristyn Wong-Tam: Thank you very much to you, Maria and Sabra, for your presentation. I recognize how, out of some of the other presenters, your organization is definitely on the front lines. You're not the research academic think tank; you are the "do tank." And I'm also recognizing that you are doing some pretty heavy lifting with not a lot of resources.

Can you just tell me the pipeline for referrals? How does someone get access to your service?

Ms. Maria Barcelos: Oftentimes, we're getting referrals from places like CAMH and the other hospitals. Because we deal with such a nuanced and unique issue of childhood sexual abuse—and I will speak to what some

members have mentioned before, that, from the therapist side of things, when someone feels that their ability to provide service is beyond the scope of their training and practice, they have to refer that person out, and I feel that's why we get a lot of referrals as well from places like CAMH, that maybe they need more training around how to support survivors of sexual violence and childhood sexual abuse specifically, when they're coming forward.

Ours is a peer support model, which is another unique factor of the Gatehouse. We introduced a clinical service as well. We do provide individual counselling. But peer support is unique in that it's mostly people who have experienced childhood sexual abuse that are helping survivors heal and recover in community, and we do provide training to our volunteers.

So I'm glad that MPP Mantha talked about empathy training. We do integrate some of that into our peer support model training.

MPP Kristyn Wong-Tam: Thank you. That's very helpful to know. I recognize that CAMH might not be your only referral source; I can imagine that there are multiple.

The budget of CAMH is over $370 million. They have 3,000 staff and 500 in-patient beds. I'm not sure if this is the most up to date, but it's what showed up when Google spoke back to me when I posed the question to them.

And when I juxtapose that information with the fact that you have five paid staff and 100 volunteers trying to reach 800 adult survivors and 504 children and no core government funding, how do you do what you do with almost nothing, like fumes?

Ms. Maria Barcelos: I'm trying not to cry here. As a survivor myself, I know that there's a huge gap and a need for this kind of service. And coming from a place of lived experience, we are the experts in our own journeys, and the Gatehouse has been a leader in that field since its inception 26 years ago. Survivor-led establishes that trust more readily, I think, than someone who isn't a survivor themselves. Not to say that non-survivors cannot provide support, but it's just another way to build that trust with people.

How do we do it? We know that children are suffering right now. We know there are children being abused right now, as we're having this meeting. We also know that some legislation has been on the table. Two different bills have been on the table, with MPP Mantha's supported Loverin's Law, Bill 17, in Ontario, and then also there's Erin's Law, which is Bill 123, in Ontario. That is something that we're also actively supporting.

We do it because we know there are so many survivors out there struggling and suffering in silence, and we want to ensure the Gatehouse remains open and there are more places like the Gatehouse in this province and in our country to help survivors.

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MPP Kristyn Wong-Tam: And because your annual budget is only $476,000—and I recognize that you're not asking specifically for money for your service; you're just saying more money is required in order for services like yours to be scaled up. How many clients do you turn away? Or is there a wait-list for your service?

Ms. Maria Barcelos: There's no wait-list for the Gatehouse services at this time. We rarely turn anyone away, really—only if they have complex mental health needs that we are not able to support, like someone who has borderline personality and maybe dissociative identity disorder, which are two comorbidities there that we cannot support. We will refer them out to places like CAMH and Mount Sinai to get assessed and get the support they need there. There are specialized therapy groups, like dialectical behaviour therapy groups, that work for survivors who have those kinds of mental health presentations that are beyond our scope of service. We will still provide peer support to them while they're waiting to get access to that other service.

MPP Kristyn Wong-Tam: Is there ever a situation where CAMH or another large mental health organization or health organization will refer you a client who has complex comorbidities, and it's really underlined with deep trauma as well as mental illness—do you receive those clients from them and then you have to refer back to them saying, "They actually need to be addressed in a hospital setting"?

Ms. Maria Barcelos: Sometimes, yes.

MPP Kristyn Wong-Tam: Okay. So that seems to me clearly what would be a system gap. They should have been caught up at CAMH. CAMH is resourced to provide the support and the specialized support and intervention at that time, as opposed to sending them out to a non-profit with a little storefront in Etobicoke, correct?

Ms. Maria Barcelos: Yes.

MPP Kristyn Wong-Tam: So what would be the recommendation to government? Because obviously the government would be the biggest funder of CAMH services. They are Ontario's mental health hospital. How do we ensure that we stop that gap or close it up?

Ms. Maria Barcelos: I think to work in partnership with CAMH, and also be able to receive some of that funding to keep operating would be great, because we have to search for grant after grant, and we get rejection after rejection as the Gatehouse.

We introduced our online services in 2020, and we're getting survivors from across the country attending our peer support groups online. So we want to expand that because we know that there are gaps also, as you talked about, in remote communities where they can get services through the Gatehouse.

MPP Kristyn Wong-Tam: Would it be fair to say—and I'm not talking to pick on CAMH; I'm just trying to understand what you do versus what CAMH can do, the limits. You are a peer-based support group. CAMH is much more clinical, more institutional, but they're at the table with government. They're at the press announcements with government. They are the chosen service provider. Would be helpful if your organization received a seat at those decision-making tables where your voice would be just as legitimized as big institutions such as CAMH?

Ms. Maria Barcelos: Definitely, yes.

MPP Kristyn Wong-Tam: Because you would be representing survivors in ways that CAMH cannot, and specifically child sexual assault survivors, recognizing that eventually one day we're going to be finding them on the receiving end of being a perpetrator of violence or a victim of IPV. That's why this committee should be working with your organization more closely. Is that correct?

Ms. Maria Barcelos: Yes.

MPP Kristyn Wong-Tam: Thank you very much.

Ms. Maria Barcelos: Thank you.

The Chair (Mr. Lorne Coe): Thank you very much.

We'll now move to our independent, MPP Mantha please, for your questions.

Mr. Michael Mantha: Good afternoon, Maria and Sabra. This is not our first picnic together. We've had some discussions, as you talked about earlier, about Loverin's Law. I think Charmaine would be absolutely pleased that we're talking about her efforts as far as bringing a secure environment to children within our school system and the fact that it continues on, where we're going to continue having those discussions, along with MPP Hogarth's bill, Erin's Law, Bill 123, which is very similar to Loverin's Law. So, hopefully, coming from the government, that bill will prove to be successful, and we'll be able to implement some of those changes that we're looking at doing in the curriculum.

I want to commend you on the peer support that you offer, the program that you support. It's a proven model. We know it works. It works in a variety of—whether it's in a work environment where people suffer being displaced out of their jobs, whether it's in a financial model where people face financial hardships or whether it's in this type of environment, they work. I hope that's going to be part of what this committee considers as far as moving forward as being part of the answer and some of the solutions that we're looking for.

I do want to have a chat with you about—and I hope you're able to expand on this—the alternative dispute resolution processes. Give me a picture. What does that look like?

Ms. Maria Barcelos: I can give you a case example. Marlee Liss is a survivor of sexual assault, and she was also in the news media a few years ago; I actually had a chat with her on Thursday. Restorative justice is an alternative dispute resolution process that is available for survivors of sexual violence. It's not a predominantly offered service. We tend to go to criminal justice route or civil court for restitution or reparation. But restorative justice processes are available, and St. Stephen's Community House was involved in that case to help Marlee and her perpetrator to come to terms with what happened. So the victim and the survivor and the community have to all be in agreeance to take on a process like that where the outcomes could be that mandatory counselling is made available for the perpetrator as well in order that—

Mr. Michael Mantha: That was going to be my next question. We've listened to a lot of programs and services that are available for the victim. However, there is little information or programs out there for the individual who is the abuser who says, "I've got a problem. I need help. Where do I get that help?" Right now, are there programs that you're offering that are available for that particular individual person, he or she, whoever it may be?

Ms. Maria Barcelos: So we offer individual support on a case-by-case basis, and we also refer out to another agency in the community called Bloor West Psychotherapy. They have a program for dual-history offenders, people who have been sexually violated who have also perpetrated and have been charged, so they can get counselling and group support for themselves. We do provide individual peer support or counselling to people who have dual history, so they're a survivor and they have also had some sexual offences.

Mr. Michael Mantha: Again, I'll leave the floor open to you. Is there anything else that you didn't get a chance to touch on that you would like to bring to the attention of the committee?

Ms. Maria Barcelos: Yes. On the point of the offenders, I recently said this is an interview with CBC as well: We need to follow models like Germany. They're really forward-thinking in terms of this, in terms of providing a support line for people who are thinking of offending. We can no longer ignore that these people exist in our society. They do, and they need support as well. As far as I know, there's no actual cure or treatment for sexual offenders, but there may be other things we can do like a support line, like Germany does, where perpetrators or people who are thinking of perpetrating—because there are different levels of that too—can call in to get some help and help mitigate the risk of perpetration happening.

Mr. Michael Mantha: I'll leave you with this in mind: The committee is slated for 10 days of hearings over the course of the next couple of months. Please look at those days and look at the testimony and what other organizations are going to be bringing forward. Please reach out to any of the committee members as far as a view, a point, a question that you would like to see explored or expanded or put forward because we really, around this entire committee room, want to see this being a big success in moving the stakes forward.

The Chair (Mr. Lorne Coe): Thank you, MPP Mantha.

We'll now turn to the government members for questions, please. May I have a question, please? MPP Barnes, thank you very much.

Ms. Patrice Barnes: Thank you so much for your presentation and thank you for the work that you do. It is not an easy space to exist in.

You have talked about the fact that you offer peer support and the crucialness of that for a connection. For recommendations to the government around where you have seen success in that, what would you share with this committee to expand on that or to be effective in the space?

Ms. Sabra Desai: I think we know from experience that this is an extremely complex, layered issue of being a survivor. Again, I'm going to refer to Andrea Skinner's story, as well as the amazingly empathic contributions

made by her siblings. They were recently published, I think, the siblings—only on Wednesday or Monday I think it was; this past few days ago, at least. It's so layered and it's so complex, and it is surrounded by self-blame, shame and guilt, regardless of how people are involved or through what door they enter into this whole complex issue.

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The peer-based model is very effective in that there is already a recognition that each person who is in the circle, in this group, feels some sense of trust: "I am going to be heard by people who have experienced the same story." In addition to that, what they feel through that process of interacting, communicating and intercommunicating at so many different levels—not only verbally, but emotionally and physically—is, "Somebody is hearing my story at last," a story that someone has been living, that that person has been living through for years, for decades.

We have had individuals disclose and come to the Gatehouse and find their voices at the age of 75, at the age of 80, and it has been the first-ever safe place and space that they have experienced to be able to tell the painful stories that they were anguishing over for decades.

Ms. Patrice Barnes: What particular training is associated with the peer counsellors?

Ms. Sabra Desai: I will turn to Maria for that.

Ms. Maria Barcelos: Thanks. We provide a two-day training. It's quite intensive. They're engaged in not only finding out more about the impact and prevalence of childhood sexual abuse; we actually take them through activities on how to facilitate these very difficult topics of trust, shame, guilt, resilience, boundaries.

There are different aspects that are talked about in our programs that we also bring into that training and how to foster a culture of empathy. "I'm here with you" is empathy. There's a big difference between empathy and sympathy, and we talk about that: "I'm here with you on this journey. I'm not here to do it for you on this journey." So we tend to look at those nuances in how to support survivors.

Ms. Sabra Desai: And if I may add, the facilitators have gone through our various programs that are 15 weeks long. The very important point to remember is that the Gatehouse could not serve and keep its doors open were it not for the hundreds of facilitators that have gone through. I think that speaks volumes in terms of what they have gained from participating in our programs and then giving forward. That is the culture that we have.

And if I may add that the Gatehouse has been referred to as this magical place, and once they come to us, they want to give back. So we depend on $10 here, $20 there, $200 here from our participants and whoever is also supporting them. But without the facilitators and the leadership of Maria and the staff—and speaking of the staff, there are only two full-time paid staff, and the other three that make up the team of five are part-time.

Ms. Patrice Barnes: All right. Thank you for that.

The Chair (Mr. Lorne Coe): I have MPP Bouma, please.

Mr. Will Bouma: Time, Chair?

The Chair (Mr. Lorne Coe): You have two minutes and 22 seconds, sir.

Mr. Will Bouma: Piles of time. Thank you very much.

The Chair (Mr. Lorne Coe): You're welcome.

Mr. Will Bouma: Through you: Thank you so much for what you do and for the trauma that you take on. Just in hearing all the stories that you do and the stories that you've shared with us today, I'm very curious. I come from my own experience, and a lot of that has nothing to do with this at all and it's so much outside of my knowledge base. What I'm wondering is—because I'm very curious about that, because Ontario has so many different cultures in it. I was wondering if you could just give us some insights into—and nothing dramatic or even specific cultures or anything like that, but how does your approach change when dealing with victims of intimate partner violence based on their cultural background? Whether that be Indigenous or from the South Asian community or from the Middle East or from northern Europe—because it seems that everyone here is from somewhere, other than Indigenous people, and I was just wondering if you can give us insights on that in the last two minutes.

Ms. Sabra Desai: The staff are a very critical piece in that. They are all trained, and we have at least three staff that are psychotherapists. In our conversations, in our discussions—and I am forever present at the Gatehouse, reminding them of intersectionalities—that regardless of who the person is, regardless of what the person may look like to us, we do not judge. Empathic listening is one of the foundational steps and in addition to that, we need to be aware that we come from all different spaces and places. So we have that continuous and ongoing conversation and we are always looking for opportunities to have dialogues on the difficulties that they have.

The consultation that happens between Maria and myself—because I have done this kind of work for decades. I just will end with this: I've worked within the elementary and secondary school system right here in Ontario. I have also taught in the post-secondary from this perspective, and I continue to do this work with other organizations, trying to get them to do the work from a particular lens. And the reality of what Ontario is, and cities like Brampton—I really appreciated MPP McGregor asking that, and I have had long deliberations with agencies like the Punjabi Community Health Centre.

One of my former student colleagues, I would say, Baldev Mutta—you might have heard—here you go. As an educator, as a person who has been working on these issues for decades, I'm very much committed to continuing to work with folks like yourselves to make Ontario a better place for all.

The Chair (Mr. Lorne Coe): Thank you very much for your response. Thank you again for your presentation, and we'll excuse you now.

Committee members, our next presenters are not available until 3:30, so with your agreement, I'm going to take a quick break—maybe about 10 minutes. Be on time, please, for 3:30.

The committee recessed from 1518 to 1529.

MR. RAY HUGHES

DR. PETER JAFFE

DR. DAVID WOLFE

The Chair (Mr. Lorne Coe): The committee is back in session.

Our next presenters are Ray Hughes, Peter Jaffe and David Wolfe. They are participating by Zoom.

You have 10 minutes for your presentation. For the benefit of Hansard, which records everything that is said here, please state your name, and then you can begin your presentation. You will have 10 minutes, and that will be followed by questions and answers by the official opposition, the independent and members of the government.

Welcome to the Standing Committee on Justice Policy. Can you please identify yourselves and your affiliation? Thank you.

Mr. Ray Hughes: Hello. I'm Ray Hughes. I'm a founding partner of the Fourth R program.

The Chair (Mr. Lorne Coe): Thank you.

Dr. Peter Jaffe: I'm Peter Jaffe, a professor emeritus at Western University.

The Chair (Mr. Lorne Coe): Thank you, sir.

Dr. David Wolfe: I'm David Wolfe, also a professor emeritus at Western University.

The Chair (Mr. Lorne Coe): Thank you, sir. You can start your presentation, thank you, and it's 10 minutes.

Dr. Peter Jaffe: Mr. Chair, can you see first slide?

The Chair (Mr. Lorne Coe): Yes, we can. Thank you.

Dr. Peter Jaffe: Okay. Our presentation this afternoon is on preventing intimate partner violence through a school-based curriculum on healthy relationships. We'll be talking about the Fourth R model.

We begin by acknowledging our late team member, Dr. Claire Crooks, who passed away several weeks ago. She was obviously a critical partner for us in developing the Fourth R and many of our ideas on violence prevention in schools.

The problem we're addressing is how to prevent intimate partner violence. Our very concrete solution is prevention and teaching all students about strategies for healthy relationships through school-based curriculum on healthy relationships. The key, in our mind, is implementing evidence-based curriculum on healthy relationships across Ontario as a long-term investment to prevent intimate partner violence and all its associated harms and costs.

The primary prevention of intimate partner violence has already been recommended by six inquests into domestic homicides and multiple domestic homicide reviews by the chief coroner's Domestic Violence Death Review Committee. So, today, we hope to operationalize this in a very concrete and direct manner.

I turn it over to my colleague Dr. Wolfe to talk about the Fourth R.

Dr. David Wolfe: Good afternoon. The Fourth R was developed to ensure that all youth benefit from relationship education. We know that violence is learned, so someone in society is teaching it in all its many forms at all times. If educators and parents aren't the ones teaching the basics, teens will learn how to navigate relationships haphazardly, from peers, family, video games and the media. Violence is attractive, and problem-solving takes more skill. This is why we developed this program.

The Fourth R is a public health education strategy. We try to inoculate as many people as possible through knowledge and resources and skills. As it says here, it stands for "relationships." It should be taught the same way as we teach reading, writing and arithmetic: You rehearse it, you read about it and, most of all, you practise it. It's a relationship-based, skills-focused approach to prevent adolescent violence but also to build up strengths in youth.

A key change in adolescence is the importance of peer and romantic relationships—and I just want to give you a quick developmental taste of that—which sets the stage for future relationships. We all learn through our relationships with others, so every effort that we assist them in this process will benefit them for years to come. We try to teach skills, we practise real-life dilemmas, we give them feedback, and they learn from their peers and others.

The attraction of the program, as you see in this slide here with prevention opportunities, is that it's universal. Everyone is exposed, and we feel that the issues of healthy relationships and the issue of violence is something that everyone needs some basic information about.

There's no need to identify and separate high- and low-risk youth; everyone is part of the problem and the solution, and importantly, these skills and knowledge can be introduced in a positive, meaningful manner that's developmentally appropriate for these youth, not a one-off or a scare message.

Thank you. Now, I'll introduce Ray Hughes, please.

Mr. Ray Hughes: Thanks, David.

I'm now going to tell you about the Fourth R resources. The resources include detailed lesson plans designed to be taught by teachers and delivered during regular school time in grade 7, 8 and 9 health classes. Since the lessons are aligned with the Ontario health curriculum, students receive academic credit for completing the Fourth R program. In addition, given that health education is mandatory in grades 7, 8 and 9, all adolescents have the opportunity to learn about healthy relationship skills for three consecutive years.

The Ontario health curriculum requires students in grades 7, 8 and 9 to learn about the topics listed on this slide. Students in a Fourth R class study all the required content and learn and practise many skills such as assertive communication and the skills of delay, refusal and negotiation. They also learn the difference between healthy and unhealthy relationships, how to end a relationship or friendship, help-seeking strategies, and many other important concepts.

Fourth R is the only Canadian evidence-based program for Ontario health educators. We have the capacity and expertise to update the program to make sure it includes the most current research and relevant teaching strategies. In 2019, it was updated to include the changes the Ministry

of Education made to the health curriculum. In 2023, it was reviewed and updated by an equity and inclusion authority for any potential bias that could be exclusionary.

One of the challenges of implementing a school-based program is that it will be rejected by teachers unless it satisfies the Ministry of Education course expectations. Since the Fourth R includes detailed lesson plans and meets all required ministry expectations, it easily can be implemented by classroom teachers. We can also assure you that every grade 7, 8 and 9 student in the province will receive a relevant program, as we have resources for English public and Catholic and French public and Catholic students. There is no other Canadian resource that has undergone such rigorous evaluation. The research demonstrates that the Fourth R not only is cost-saving; it also decreases peer and dating violence and increases interpersonal skills.

Our vision is to have every grade 7, 8 and 9 Ontario student participate in the Fourth R program. This means supplying an e-copy of the resource to all grade 7, 8 and 9 health education teachers and to all graduating teacher candidates over the next five years. In addition, we have the capacity to offer online training and support to teachers. We have an extensive inventory of classroom videos and teaching strategies posted on our website for ease of implementation.

We are proposing a five-year term to scale up and support over 18,000 teachers and teacher candidates. After five years, our focus would shift from scaling up to preparing new teacher candidates and replacing teacher-student retirement. Since it's estimated that there are 450,000 grade 7 to 9 students in Ontario schools, the cost to maintain the Fourth R after five years is equivalent to 20 cents per student per year.

Thanks, and back to David.

Dr. David Wolfe: I just want to quickly summarize how to prevent intimate partner violence in the next generation. We've studied this for many years, and the evidence shows that you want to help youth strengthen their relationship skills to make safe and responsible choices. They're going to experiment, but we want them to keep safe and know how to delay.

We want to address the common elements of risk behaviours—what are their goals; that is, making friends and having romantic partners—and counteract pro-abuse messages from their culture: gender, racial stereotypes and sexual orientation. We want to give a positive message, prepare them and not scare them, and we want to provide opportunities to develop their assets and strengths by building their connections.

Peter?

Dr. Peter Jaffe: In conclusion, we think this is a very concrete recommendation—it goes beyond theory—and a chance to implement something province-wide. Everyone you've heard from today talks about intimate partner violence being learned and being learned at an early age. Repeated inquests have told us about the importance of primary prevention, another critical element, and we believe the time is now to implement a program such as this.

We welcome your questions.

The Chair (Mr. Lorne Coe): Thank you very much, gentlemen, for your presentation.

We'll start with questions from the official opposition. MPP Wong-Tam, please, when you're ready.

MPP Kristyn Wong-Tam: Thank you to our three esteemed presenters. This is a very interesting proposal that you are putting forward. I think I would like to learn more about the Fourth R program, and my first question would be, how do you determine the effectiveness of your program?

Dr. David Wolfe: I can address that myself. I think there are many different ways. The way we did it initially was through the youth report in terms of their teen relationships, their violence that they report as a victim or an offender, if they're involved in any sexual relationships and what degree of safe sex they're practising. We also look the involvement of substance—

Failure of sound system.

MPP Kristyn Wong-Tam: I think the screen just froze.

Dr. David Wolfe: Can you see me now?

MPP Kristyn Wong-Tam: Yes. I'm sorry to interrupt. Your screen froze temporarily, but I think we caught it.

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Dr. David Wolfe: Oh. Good. Okay.

We look at the impact on higher-risk youth to see if they are less involved in adolescent dating violence, and we look at even things such as graduation rates because it keeps more disenfranchised youth connected to school. They enjoy it more.

MPP Kristyn Wong-Tam: And your program is specifically tailored for a very short range of educators and students, and that's grades 7, 8 and 9. But what happens before grade 7 and what happens after grade 9?

Dr. David Wolfe: Oh, I'd love to answer that one, because we've been saying for many years that this really should start in grade 1, as you introduce a lot of other things in grade 1—English and so forth. Because you're not introducing the difficult areas at that point, kids are much more receptive to these messages. Ray may be able to address exactly what happens in the curriculum, but to have three years of repeated practice and rehearsal on these skills is more than youth have ever received, to my knowledge, anywhere in the world, so this is a good start.

MPP Kristyn Wong-Tam: So, really, this is a "train the trainer" program. Is that a fair summary?

Mr. Ray Hughes: I can answer that. We have online training that's available 24/7. It's not necessarily "train the trainer." It can be an individual teacher being trained online. Of course, some school boards do prefer in-person training, where school boards probably would prefer to have their personnel trained as trainers so that they could do in person training. But most, given the cost that's involved in face-to-face training, are now opting to do online training.

MPP Kristyn Wong-Tam: I just want to understand, because I think what I'm seeing before me is almost a proposal pitch. You're suggesting that the government engage in a five-year renewable contract with the Fourth R program, and it would cost the government $250,000 each year for each school. Is that correct?

Mr. Ray Hughes: No. It would cost $250,000 total for all the schools in the province of Ontario. That's the total cost for five years. Following the five-year term, the cost then reduces to $90,000 for the entire province—and there are 450,000 students in grades 7 to 9 in every school in the province, so that's equivalent to 20 cents per student. So that's the total cost for all schools in the province.

MPP Kristyn Wong-Tam: Okay. That's very helpful for clarification.

And with respect to any type of comprehensive physical and sex ed curriculum that would be mandated by the Ministry of Education, that should take into consideration healthy relationships, the proper use of language to describe bodies and relationships—all those things that we would anticipate—how does this complement that? How does this sit adjacent to that? What is different about your program?

Mr. Ray Hughes: I can answer that. You're absolutely right. Right now, the Ministry of Education sets out expectations. It's up to every school board or every health education teacher to make lessons that would meet those specific expectations. So right now, not only do you find inconsistencies within a board, within schools between boards, but actually right in schools. Some teachers, perhaps, are spending three lessons. Some are spending one lesson. Some are spending an hour. Some might be spending six hours.

Teachers are making up their own lessons that are not evidence-based, that they're not quite sure if they're going to work or not. The Fourth R program is an evaluated program that's evidence-based, that would ensure a consistent message throughout all the province in terms of covering every single student.

MPP Kristyn Wong-Tam: But again, it's restricted only to grades 7, 8 and 9. So with respect to the comprehensive sex and phys-ed program that the ministry already has in place, is this meant to be complementary program that works alongside the existing curriculum?

Mr. Ray Hughes: The ministry has in place the expectations. They do not have lesson plans in place. They don't have a program in place. They have the concepts in place. A concept would be, "You need to learn about healthy relationships."

After grade 9, there's no mandatory health and physical education; it's optional, so many, many students drop out after grade 9. So the critical formative years for us reaching the adolescents is grades 7, 8, 9, but as Dr. Wolfe already mentioned, we'd love to have it from JK right through. But we had to start somewhere, and we started at grade 9, and then we added grade 8, and now we've added grade 7. Our goal would be, as Dr. Wolfe said, to eventually have some type of Fourth R programming right through to JK.

MPP Kristyn Wong-Tam: May I ask you to help me understand what the advantage is of buying your program as a renewable contract for five years versus having the Ministry of Education, which has a pretty broad, extraordinary reach on everything education in Ontario, do this work once and for all? Obviously, curriculum would evolve, but what's the advantage of buying your program versus having the ministry just do its job?

Mr. Ray Hughes: The ministry has never mandated a program for any subject area. They create the expectations for all subject areas—English, math, science—and they leave it up to the school boards to implement the program to meet the expectations. Some school boards spend their money on textbooks—various things to meet the expectations.

I'm a former health education teacher. Health education does not receive the same priority in terms of implementation. We're called the Fourth R. We think that relationships are as important as the other three Rs: reading, writing and arithmetic. One of the reasons it doesn't receive the same respect is that if you look at grade 9, there's no separate mark for health education. There's no mark for that. There's a mark for the other three Rs, but you will not find one for health education.

So I think we're taking some baby steps here to get a program that health education teachers feel confident in implementing and also possibly bringing some more status—that this is a very important topic that needs to be taught.

The Chair (Mr. Lorne Coe): We'll now move on to the independent. MPP Michael Mantha, please.

Mr. Michael Mantha: Good afternoon, Ray, David.

And it has been a long time we haven't talked, Peter. How are you doing?

Dr. Peter Jaffe: So far, so good.

Mr. Michael Mantha: Gentlemen, when I look at your program, it is my understanding that this is preventive in nature; it's to change the culture. Am I correct?

Dr. Peter Jaffe: Yes. We're trying to encourage learning with youth about healthy relationships, to give them the language to talk about unhealthy relationships and healthy relationships, to have them as more understanding and supportive peers, and to change knowledge and attitudes and behaviour.

Mr. Michael Mantha: So while you're looking at doing that, I'm also looking at triggers that—individual students who are exposed to violence in their family structures. In this manual, are there resources available for them? Are the teachers who are going to be providing this within the curriculum provided with additional training to give those options to the students who are looking for those resources?

Mr. Ray Hughes: Absolutely. The teachers are supported in terms of the training that our online modules—we have four different modules that they can access at any different time. That provides teachers with background information on this particular topic. Then we have listed on our website—we show classrooms in action, lessons being delivered, how to support students who witness

violence at home and other resources that are available. We even have resources available locally for certain parts of this province that they can access—local resources.

We partner our teachers with local partnerships—it may be health organizations, public health; it may be women's organizations—in terms of violence prevention, to get support materials there.

So we have, in every single lesson, in every single year, supporting documents for educators.

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Mr. Michael Mantha: In developing your Fourth R program, what organizations and resources did you rely on in helping you develop this program?

Mr. Ray Hughes: There are four different modules that are outlined by the Ministry of Education that you need to address to meet their criteria. Obviously, we have very strong partnerships with public health in terms of the sexuality content that's there. The organizations dealing with what's called safety and injury prevention—that's basically the unit in which the kids are going to learn the skills about healthy and unhealthy relationships. In the city of London, Ontario, we're very fortunate that we have some very strong organizations there that we've reached out to, including CREVAWC and some of the shelters that are available and many of the experts that work locally there. We've established partnerships in the cities of Ottawa, Toronto and many of the other larger areas throughout the province. And then, of course the researchers, David and Peter, can talk about the research part in terms of the people that we reached out to that helped do it.

We also work very closely with our Indigenous partners. We have an Indigenous [*inaudible*].

Mr. Michael Mantha: That's really what I wanted to hear. That's where I was going with my next question: What outreach was done with Indigenous communities in order for them to be recognized within the context of this curriculum?

Mr. Ray Hughes: Great question. We worked very closely with our local Indigenous partners, the Chippewa and Munsee-Delaware. On our website, you will see the resources that we have to make sure that our Indigenous students are recognized. They're many of our actors in our resources.

Our Indigenous-informed Fourth R program is a completely separate program that's also available that can be implemented. It was developed in Ontario, but also with many contributions outside of Ontario. We have a strong partnership with the Dene community in the Northwest Territories, working with the former Minister of Education there, Jackson Lafferty and Chief Jimmy Bruneau School, who developed many of our videos and the support there. So there has been a lot of outreach. And of course, the Fourth R had full-time Indigenous employees that also helped develop the program.

The Chair (Mr. Lorne Coe): Thank you for that response.

We'll now move on, please, to the government members for questions. MPP Barnes, please. Thank you.

Ms. Patrice Barnes: I just wanted to dig down a little further into some of the conversations about the school programming. Do you already have programming that is being executed in school boards?

Mr. Ray Hughes: Yes.

Ms. Patrice Barnes: And how many boards are you currently working with?

Mr. Ray Hughes: We're in—across Canada, 5,000.

Ms. Patrice Barnes: Five thousand students or 5,000—

Mr. Ray Hughes: Schools.

Ms. Patrice Barnes: School boards? Schools. Okay, thank you. And in those programs that are running already, what is the impact you're seeing and how do you measure it?

Mr. Ray Hughes: I can pass that over to the researchers. They can talk about the evidence and the collection of the data we've done.

Dr. Peter Jaffe: Sure, I can start, and Dr. Wolfe can jump in. Back to your earlier question, obviously, this program has been under development for over 20 years. We basically look at student and teacher attitudes about the receptivity to the material. We do ongoing surveys and evaluation with the students. Dr. Wolfe may have mentioned that we also have teachers observe students. They don't know whether they completed the program or not, but we've watched students' interactions, and when teachers point out student improvement, they're more likely to be those students who have been recipients of the program. So we've been very actively involved in researching the program and the success of the program.

I should also say it's been from coast to coast to coast in terms of looking both at evaluation and also the key issue of implementation: the extent to which the teachers enjoy delivering the program and the extent to which the students find very valuable discussions in terms of the reality of their lives.

Ms. Patrice Barnes: And so my follow-up question to that—

Dr. David Wolfe: Let me just—

Ms. Patrice Barnes: Sorry, you wanted to add to that?

Dr. David Wolfe: I was just going to say, this is where many evidence-based programs go to die, is right before the dissemination. We refuse to let that happen. That's why we've stuck with it for 20 years. It's easier to develop and show it works and then leave it out there for someone else to do, but we really feel that this is something that will continue to be evaluated as it's distributed more widely.

Ms. Patrice Barnes: Okay. Thank you for that response.

And my final question before I turn it over to one of my colleagues: You talked about really training the teachers on how to deliver this program, because they would be the ones that are in schools actually doing the delivery. In the schools that you've had so far, what is some of the feedback on that—teachers being trained to deliver—and what are some of the barriers that you have really encountered? Because if you're talking about training, it would be looking at teachers that are coming out of teachers' college, but you would also run into teachers that are

already in the system. So what are some of those challenges that you've faced in that, and what is some of the feedback that you've had from that?

Mr. Ray Hughes: Our colleague Dr. Claire Crooks has actually done research in this area about teachers' impression of implementing the Fourth R and their satisfaction with the Fourth R. Teachers find the lesson plans to be extremely easy to implement. They find them very engaging with their students. We get such a high satisfaction rate from teachers in terms of the implementation.

On the challenging side of it—of course there are all sorts of challenges, because teachers are currently required in the province of Ontario to meet the expectations. So they have lesson plans already to try to do, and there is some reluctance on the part of teachers for change, because the Fourth R does require some change. It's not static learning; it's very, very interactive learning where the kids participate in the learning. They're active. They watch videos. They practise skills. They try to learn, "How do I support a friend?" And they practise it just like you would on a sports team. It's practise and practise. It's not the type of delivery system where you're putting notes up and the students are not interactive. So that's a barrier.

Another barrier, of course, as I mentioned earlier, is that in the province of Ontario, it's hit-and-miss how many hours you're going to get for health education. Even though there's a requirement about a minimum amount of hours, many students in this province do not get the minimum number of hours of health education. So teachers find, "How can I deliver all these lessons in the time? I'm only doing half the amount of time because that's all I get allocated. The rest of the time is spent in activity." That's probably the biggest challenge that we have.

The Chair (Mr. Lorne Coe): MPP Barnes, please.

Ms. Patrice Barnes: A quick follow-up before I finish: In regard to the amount of time, what is the amount of time that that lesson plan would require for the three Rs? Whether you pick one grade—7, 8 or 9—what would be the time allocation?

Mr. Ray Hughes: The Ministry of Education suggests that you spend 25% of your course time doing health, 75% doing your activity level. So in grade 7, our lessons are designed for 45 minutes, which is a typical period for grade 7 students, and we have 28 45-minute sessions. In high school, they are designed for a semester period of 75 minutes, and there we have 28 lessons, which is slightly under the required time that the ministry has suggested. So we've really spent a lot of time making sure that we're within that allotment.

The Chair (Mr. Lorne Coe): Government, you have one minute and 17 seconds for your next question. There you go.

Ms. Jess Dixon: Gentlemen, can you talk a little bit about, practically speaking, in your most recent rollout with Ontario, what challenges or responses are you receiving from boards, from teachers, from other interest groups—that type of thing?

Mr. Ray Hughes: Well, again, the challenges are that just because you have a resource and you're going to give a resource free to a teacher doesn't necessarily mean they're going to use it. It's not mandated. It's not a mandated program. It's not mandated that the teachers do this type of programming, so that's a big challenge. If a program comes out, like for mental health, and says you must do four lessons—well, they do it. It's got to be done, so it's done. So that's one of the issues that we're having.

The other thing is it's a lot of work. We have a lot of schools in this province of Ontario. It's a huge amount of work. We've determined there are over 18,000 teachers doing health education. To reach out, we need to establish partnerships with our community partners so they can reach out. We need to educate teachers how important this topic is. We have teachers who are uncomfortable with this topic, because either they're experiencing violence themselves or they could be perpetrators of violence.

So there are obstacles out there that we think are not insurmountable.

Ms. Jess Dixon: And just very briefly, is there sort of a short answer to that, the idea that you would really need the assistance of the government and the ministry to rely on their reach and authority in those existing relationships in order to make this actually happen?

Dr. Peter Jaffe: Yes. I can start and Ray can follow. Definitely, because I think preventing intimate partner violence shouldn't be an option. In 2024, every adolescent should understand the issues and how to have healthy relationships, so I think making it mandatory would certainly launch things at a different level than we're at now.

Ray, would you agree?

Mr. Ray Hughes: Yes, 100%. It would make the single most difference in terms of implementation.

Ms. Jess Dixon: Okay. Thank you very much.

The Chair (Mr. Lorne Coe): Thank you, MPP Dixon. Thank you, gentlemen.

This concludes the business of the Standing Committee on Justice Policy for today. The committee will now adjourn to July 18 at 10:30 a.m. Thank you, committee members, for your participation.

The committee adjourned at 1602.

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