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Standing Committee on Justice Policy

Committee business

Intimate partner violence

1st Session
43rd Parliament

Thursday 15 August 2024

Chair: Lorne Coe
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

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Comité permanent de la justice

Travaux du comité

Violence entre partenaires intimes

1re session
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Jeudi 15 août 2024

Président : Lorne Coe
Greffière : Thushitha Kobikrishna

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

COMITÉ PERMANENT DE LA JUSTICE

Thursday 15 August 2024

Jeudi 15 août 2024

The committee met at 1030 in committee room 1.

The Chair (Mr. Lorne Coe): Good morning, members. I call this meeting of the Standing Committee on Justice Policy to order. We're meeting today to resume public hearings on the committee's study on intimate partner violence.

COMMITTEE BUSINESS

The Chair (Mr. Lorne Coe): Are there any questions before we begin? MPP Sattler, please.

Ms. Peggy Sattler: In light of the information that was provided to this committee yesterday by the Clerk about the process to remove a member of this committee, I wanted to move a motion.

I move that the Chair of the Standing Committee on Justice Policy write, on behalf of the committee, a letter to the Standing Committee on Procedure and House Affairs requesting that MPP Mantha be removed from the Standing Committee on Justice Policy.

The Chair (Mr. Lorne Coe): MPP Sattler has moved a motion. Any discussion or comments?

Ms. Peggy Sattler: Can I speak to the motion?

The Chair (Mr. Lorne Coe): Yes, please. Go ahead.

Ms. Peggy Sattler: Thank you very much, Speaker.

I think we would all agree that—given the nature of this study, given the nature of the confirmed violations that MPP Mantha was reported to have engaged in, dealing with sexual harassment of a staff person—MPP Mantha has shown that it's completely inappropriate for him to participate in a study on intimate partner violence, it's completely inappropriate for him to participate as a member of the Standing Committee on Justice Policy and, in fact, it's inappropriate for him to continue as a member of this Legislature.

Now, of course, we can't force MPP Mantha to resign from the Legislature, but we can, as a committee, go through the processes to request his removal from this committee so that a motion can be brought to the Legislature when we return to Queen's Park on October 21 and ensure that he is removed from this committee and this study.

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

Ms. Jess Dixon: I can indicate that government members will support the motion, although I would just remind everyone and those watching that, procedurally, a membership change can't take effect until the House returns, at the earliest.

The Chair (Mr. Lorne Coe): Further discussion on the motion? MPP Wong-Tam, please, when you're ready.

MPP Kristyn Wong-Tam: I'm really glad to hear that we have the support of the government members. I think we can all agree that elected politicians have to be held to a higher standard, largely because of the power that we hold. There is trust instilled in us on behalf of the constituents, the electorate, and when a member of provincial Parliament, a parliamentarian abuses that power, we need to take action. Removing MPP Mantha from this committee is at minimum what we need to do.

We also need to ensure that we send a message to women. We want more women in politics. We want women to see themselves in these roles and be able to work in our offices, and it's up to us to ensure that we create that safe and affirming space.

I wholeheartedly support the motion that MPP Sattler has put forward today.

The Chair (Mr. Lorne Coe): On the motion, any further discussion? I don't see any.

I will now put the question. All those in favour of the motion? Opposed? Madam Clerk, the motion is carried unanimously.

Is there any additional business? MPP Dixon, please, when you're ready.

Ms. Jess Dixon: I move that for phase 1 of the IPV study, expert witnesses that were invited to appear but were unable to attend the hearings be able to submit written submissions to the committee; and that the deadline for written submissions for phase 1 of the IPV study be Friday, September 13, 2024, at 12 noon.

The Chair (Mr. Lorne Coe): On the motion, any discussion, comments? Seeing none, I will now put the question. All those in favour of the motion? The motion is carried, Madam Clerk, unanimously.

INTIMATE PARTNER VIOLENCE

The Chair (Mr. Lorne Coe): Moving on now to the public hearings: As a reminder, 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 the members of the committee. And to the timing of questions, Madam Clerk, can you please speak to that?

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Sure. If there is an absence of the independent member, if the committee is willing—and I understand

we've agreed that we're going to split the time, so the time will go into a second round, and we'll do 2.5 and 2.5, if everyone agrees.

The Chair (Mr. Lorne Coe): Agreed? Great, thank you. I think this will make it a little bit more uniform in our day-to-day.

WILFRID LAURIER UNIVERSITY

The Chair (Mr. Lorne Coe): That being said, I would like to now call on the Wilfrid Laurier University.

Welcome. You will have 10 minutes for your presentation. Please state your name for Hansard, which is the official recording service of the Ontario Legislature, and then you can begin your presentation. I'll let you know when you have one minute left, and then following your presentation, there will be questions from the members of the official opposition and the government members. Please, your name and affiliation. Thank you.

Dr. Halina Haag: Good morning. My name is Dr. Halina Haag, and I'm a Canadian Institutes of Health Research fellow and contract faculty member at Wilfrid Laurier University. Over the last 10 years, my research has focused on brain injury, or BI, caused by intimate partner violence—a common but largely overlooked condition. My work has been recognized and funded through the Ontario Women's Health Scholars Award and the Canadian Social Sciences and Humanities Research Council. I'm widely recognized as one of the leading Canadian scholars in IPV BI and a global expert in the field. I'm also a BI survivor, giving me a unique blend of lived experience and academic knowledge.

Although my work is highly specialized and considers only part of the experience of IPV, it is relevant here as it repositions IPV: It is not only a social challenge; it's also a significant public health care issue and should be understood as such. I'd also like to point out that while my work focuses on women survivors, as they are statistically more likely to experience IPV-BI, it can and does happen to men and other people across the gender spectrum.

First, let's start with the basics: one in three Canadian women will experience IPV in their lifetime. Up to 92% of physical IPV assaults include hits to the head, face and neck, and/or strangulation. After bruising and fractures to the head or face, the most likely form of physical injury resulting from this kind of violence is a brain injury, either from direct blows, being shaken or thrown, or having blood and oxygen supply cut off during strangulation. Research indicates up to 75% of women exposed to physical violence during IPV have a possible brain injury as a result. If we do the math at this point, these numbers work out to one in eight Canadian women who may experience brain injury as a result of IPV; that's the same prevalence rate as breast cancer in this province.

As a result of lack of knowledge and training, most people are unaware of IPV-BI, leaving most survivors undiagnosed and unsupported. Many survivors experience significant challenges with daily living skills that are critical to their ability to assess the situation and plan and execute a safety strategy or successful exit.

I'd like to take a minute to paint a picture of common symptoms of BI and what they mean for women experiencing IPV. Many BI survivors experience challenges with memory—both storage and recall—concentration, decision-making, impulsivity, organizational skills, multitasking, interpersonal communication and the ability to read emotion on another's face. Survivors also deal with physical implications like dizziness, headaches, ringing in the ears and chronic fatigue, along with significant mental health challenges such as depression and anxiety.

All of us use these skills and capabilities every day to decide what and when to eat, prioritize tasks, remember appointments or tell a story to someone in a logical, linear fashion so they understand and believe you. We use them to work, learn, parent, pay bills, leave our homes and find our way back again. The list is endless.

Twenty years post-injury and I still need sticky notes with a list of errands in numerical order when I leave the house or I'll find myself in the middle of downtown, wondering how I got there and why. I still have to make choices about how to best spend my limited energy, and I haven't heard silence in 20 years because there's always a ringing in my ears.

For a woman involved in a violent relationship, these challenges take on a whole new meaning. She may have difficulty telling police, doctors or courts what happened, or her story may change each time. Seemingly, she is then lying or hiding something. She may have trouble remembering to meet with a social worker or lawyer, so she is labelled as being lazy or unwilling to help herself. She may have trouble with organization skills or multitasking, making her an unreliable employee and at risk of financial dependency on her abuser. She may slur her words or be unsteady on her feet, leaving people to think she is drunk or high. In conversation, she may laugh at the wrong things or become easily agitated and angry, putting her in the category of a "difficult" client.

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Her actions are not viewed in the light of a health condition or a disability. They are seen as behavioural choices, making her less deserving of help and leaving professionals, friends and family blaming her.

Let's talk a little bit now about the situation on the ground. All of our IPV services are designed on the assumption that the client is not cognitively impaired, but we now know this is not the likely scenario. Expecting a survivor of IPV-BI to make use of services and supports in their current format is like asking someone who uses a wheelchair to stand up and cross a room to receive care. It won't work. And then, we blame them for not making use of services that are effectively inaccessible.

Even if she knows she's been injured, often she won't seek care due to the shame and stigmas associated with IPV or because previous experiences in the health care system have left her deeply mistrustful of it—or even worse, because she is prevented by the abuser.

Research indicates most shelter workers have never screened a client for brain injury. If shelter workers and others who work on the front lines with women don't know brain injury may be a part of their experience and

haven't learned the signs and symptoms or how to support a survivor, they aren't able to provide appropriate care.

When someone experiences a concussion or brain injury from sports, in a fall or in a car accident, there is a specific pathway of care and clear return-to-play, -school or -work protocols. Ontario led the way in creating these protocols. When a woman experiences a concussion or brain injury through IPV, there is no dedicated pathway of care and no return-to-life protocol. This is the direct result of a lack of knowledge and training around IPV-BI.

Training must be made mandatory for health care professionals, social workers, paramedics, police, women's shelter staff, child protection workers, legal aid and other lawyers, the judiciary, and even more, if the province is dedicated to providing care to its citizens.

Survivors need dedicated support to navigate health care, social and legal systems, as well as access to safe housing, healthy food and permanent employment. Funding navigators to help them work through these systems are key to supporting them. Creating effective programs to support retraining and re-entry into the workforce will provide financial security, personal dignity and control over their own lives.

Finally, how can declaring IPV an epidemic actually make a difference? It will legitimize this as a public concern, not a private one. It will open doors for specialized, dedicated, sustainable funding for targeted services to support people coping with IPV-BI. It will provide a blueprint for the rest of Canada to follow.

You have the chance to once again lead the way to create a pathway for survivors to get timely access to appropriate medical and social care and to support them in rebuilding safe and healthy lives. There can be meaningful, enjoyable life after IPV-BI. I am living proof of that here before you today.

Twenty years ago, no one—not my doctors or my lawyers, my family or my friends, not even I—would have believed that I could be where I am now: happily remarried, with a daughter and a loving husband, having achieved a PhD and financial independence, being a respected researcher and colleague. However, I should not be seen as the standard case. I had advantages and a caring family, access to education and financial support that many of these women do not have, but I can provide hope for what can be achieved with proper support.

My written submission outlined what we already know about IPV-BI and how to address it. This conversation here today was about humanizing those statistics and feeding your drive to do something about it. What I can't give you is the exact cost of putting these solutions in place, but I can tell you this: Whatever it costs to properly fund the training and services needed to support survivors of IPV-BI, it will be less than the billions it already costs in misdirected health and mental health care, social support such as housing and wage replacement, lost labour force productivity, and overuse of the criminal and family justice systems because we don't even recognize IPV-BI, let alone properly support it.

Our team has been working for a decade. We've been creating the necessary resources and tools, and Canada is now seen as a global leader on the IPV front. Our team here in Toronto built the Abused and Brain Injured Tool Kit, an online educational support for front-line workers found at abitoolkit.ca. My colleagues in British Columbia created the SOAR Project—

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

Dr. Halina Haag: —to support survivors of abuse through research. Together with survivors and professionals, we are now developing online training materials for health care providers, along with the standardized identification and support resources and protocols.

We are already building the knowledge base and tools, but you need to be bold. It doesn't matter what your political stripe is. This isn't about partisanship. It is about all of us coming together to do the right thing.

Ontario must again step to the forefront and lead the way. By formally declaring IPV the epidemic it is and putting dedicated resources towards addressing it, you will be the ones who create this change.

Thank you for the opportunity to speak here today. Please feel free to request any further information that you should require.

The Chair (Mr. Lorne Coe): Thank you very much, Doctor, for your presentation. It was right on time.

We're now going to start our questions with the members of the official opposition, please, when you're ready. MPP Wong-Tam.

MPP Kristyn Wong-Tam: Thank you, Professor Haag, for joining us this morning. Your subject-matter expertise is really quite impressive, especially since we've—this is day 8 of our presentations. We haven't heard too much about traumatic brain injuries or brain injuries, and yet you very elegantly and concisely help us make the links.

I'm just interested in knowing, why is it that the intersections between intimate partner violence and brain injuries are not evident to other subject-matter experts who work in the field and sector?

Dr. Halina Haag: This has probably been the best-kept secret in women's health care that I've ever seen. We've known since the mid-1990s in the brain injury community that there was a prevalence rate amongst survivors of intimate partner violence, and every sort of few years, another paper would be published. The interesting part is, until about the mid-2000s to late 2000s, it really wasn't picked up and followed up on, and I can't tell you why. I can guess, but none of the answers I would come up with are particularly flattering for the research community or anyone else. It really was entirely overlooked, which is surprising when you consider how much we know about sport concussion, and how much money and awareness, around professional athletes.

MPP Kristyn Wong-Tam: That's a very interesting point that you raise, because as a former athlete, I know that there are all sorts of protocols for us when we take the field: What is on our head? How do we even fall properly? There's a lot of conversation and discussion about making sure we protect everything that's above our shoulders and neck, and yet we don't hear the same type of concern or awareness around women's brain injury.

In Toronto and right across Ontario, we are seeing an explosion of homelessness. Sometimes that manifests itself in encampments. Most recently, I was speaking to someone who works at the city of Toronto who identified by estimation that perhaps 50% of the people who are living in one particular encampment in Toronto have probably experienced a brain injury. This is because they've gone out to speak to them about their needs, including health needs. I'm assuming that information is not surprising to you.

Dr. Halina Haag: No. We do actually have collected data here of a study that was done a few years ago by the team here at the University of Toronto, including Dr. Hwang, I believe, and Dr. Colantonio. They found, I think, 53%, 56% or something like that, in the homeless population had pre-existing brain injuries. So the brain injury actually predates the homeless condition.

It's also the same in the criminal justice system. We know that well over 60% of folks in the criminal justice system have pre-existing brain injuries. It feeds into this challenge of maintaining employment, of maintaining financial independence.

I can tell you that, even with all the advantages I had, I would have lost my home and been on the street myself 20 years ago without a family that not only felt that backing me financially was an investment, but also had the funds and capacity to do so. Not everybody has that.

MPP Kristyn Wong-Tam: Because we are seeing individuals who are living with and surviving IPV, individuals who have experienced brain injury and trauma—they are oftentimes living in poverty as well, just because they're not able to function and hold a regular job or the expectations of what we would have in conventional employment. We are seeing them over-represented in the homeless population, and what you're saying is we're also seeing them oftentimes undiagnosed if they're living with mental health challenges.

1050

I think that the work of this committee, especially as we study the topic of intimate partner violence—a theme that's come forward from most witnesses is that there's a lack of coordination between sectors, there's a lack of a plan at the minister's level or perhaps the government level, and somehow we are seeing people fall through the cracks.

But you're saying that there is a particular lens that can be put over all of that, and if we were able to draw a conclusion, it may be using some of the tool kit work that you've developed. So I'm curious to know, the tool kit: Who uses it? Who has access to it? And why are those who work in the sector, who are tasked with providing service for IPV survivors and their families—why is this not more commonly known?

Dr. Halina Haag: We're getting there. The tool kit is freely available online. It was developed intentionally to educate front-line workers in the field.

When we first started the work that we were doing 10 years ago, we identified both first responders and front-line workers as the two most needy areas of increasing information and education. Because we can't do everything all at once, we chose front-line workers. We felt that was the highest priority.

In partnership with community organizations and survivors, we designed an online educational resource that just tells people about IPV-BI. It has expanded and been shaped over the last few years. We have a number of resources now. We did a 2.0 version of it in 2023, and it now contains little informational videos, it has a resource library, it has downloadable infographics—tangible resources that can be put to work within these organizations.

And I want to make it clear: It's not their fault. Nobody knew. I can't stress—the fact that I'm sitting here today, that you asked me to come here today and tell you about this, is phenomenal. Ten years ago, this topic didn't exist in conversation. I had to spend the last 10 years yelling from every rooftop that I can find about this. It's astounding that in such a short period of time we would have doubled the amount of literature globally that we have. I now have to create a new systematic review because my old one is outdated. Governments are looking at this—I hope, seriously—and looking at how to solve and address the challenge. And I am even here speaking about it. This is a remarkable achievement in 10 years.

MPP Kristyn Wong-Tam: Because you mentioned in your remarks that service providers do not assume that their clientele is coming to them with any type of cognitive impairment, without the tools and the adequate training and raising awareness, that cycle will continue to perpetuate. So how do we disrupt that? This is the "how." What do we do with the information you've provided to us to ensure that we can actually infiltrate and disrupt the system of service that we know and have in place right now?

Dr. Halina Haag: It's a multipronged solution. We need cross-pollination in between the IPV and the BI worlds. We know how to support both groups—

The Chair (Mr. Lorne Coe): Excuse me. That concludes the questions from the official opposition.

I'm now going to move to the government members, please. Thank you. MPP Saunderson, sir, when you're ready.

Mr. Brian Saunderson: Thank you, Professor, for coming today and sharing not only your clinical expertise but also your lived experience. That makes it very powerful, and it is a tribute to you to have recovered. My sister had brain injury—not from IPV, but from a car accident—was very lucky to survive and went through about two years of re-learning and rehabilitation. She also is a social worker today, an art therapist—it was many years ago.

But I want to tug a bit at your comments about the immediate effects of not just the trauma from the injury but also from the incident, and the counselling or lack of awareness. You speak a bit about how it compounds their dislocation, I guess, from the whole process. Not only are they dealing with the emotional trauma but, because of the brain injury, they're compromised in their coping skills and all sorts of things. When I think of my sister's rehabilitation, I can't imagine mixing those two together.

So I'm wondering if you can just talk to me—because you said there was awareness of the link in the 1990s and then you gave a very passionate answer about how far

we've come in 10 years. What can we do in the next 10 years or shorter to accelerate that and try to get awareness raised but also medical treatment and supports available immediately?

Dr. Halina Haag: What we need is cross-pollination. The intimate partner violence sector and the brain injury sector need to talk to each other. They need to know that they need to talk to each other.

As much public education and awareness as can be made possible is very useful. I think in answer, partially, to your colleague's question, let's go for curriculum. Let's start teaching and training in the training programs themselves. So all of those most immediate: the health care professions—physicians, nursing, all of that crowd; social work; psychology; rehabilitation sciences; all of the folks who are most likely to be in the position to support and who are needed in those positions to support need to be there.

The distinction between the trauma response and the IPV and the brain injury situation is very difficult to tease apart. Brain injury looks an awful lot like post-traumatic stress disorder. Teasing the two apart—I used to think that it wasn't important, didn't matter; we just go after the problem and not worry about which one we're actually dealing with. I don't feel that way anymore. I think, actually, it is important, because what happens is we focus on the mental health challenge, we focus on the PTSD and we're missing the cognitive impairment and the cognitive rehabilitation that can take place.

You personally know just how much we can do for folks challenged with brain injuries. We can rebuild. We can teach them how to cope with the challenges that they face and how to work around those difficulties. It takes time and it takes patience and it takes money. Those rehabilitative services are not available once they leave a hospital. They are not paid for. So that is something that definitely, distinctly needs to change immediately. We need to fund the kinds of services that will address these problems.

Once you see cognitive rehabilitation taking place, then you see a chance for these folks to rebuild their lives. Brain injury is brain injury. It doesn't change whether it has come from IPV or a car accident. But if you never look at the brain injury in the survivor of IPV, you're never actually treating the underlying problem of a lot of the challenges that they're facing.

Mr. Brian Saunderson: You talked at length about data and you being a groundbreaker in this area. I just want to make sure I have the statistics correct. You said that one in three women suffer some form of IPV. We've unfortunately heard that numerous times. And then you said one in eight—now, is that one in eight of those who suffered IPV or one in eight Canadian women generally?

Dr. Halina Haag: That's one in eight Canadian women. If one in three women will experience IPV and 75% of those will experience a brain injury, the math tells me one in eight.

Mr. Brian Saunderson: So 75%.

Dr. Halina Haag: Yes. And that's a conservative estimate. Those of us in the field know that it's in fact far more likely to be mid to high 90s. We have many studies that have 100% of the sample as brain injured. It's not uncommon.

The reason that the statistic is so vague has to do with sampling challenges and has to do with lack of standardized testing for brain injury in this particular population. We don't even have a standardized tool. We have lots of brain injury testing tools but none of them are appropriate in this particular community because of those trauma challenges. So we're working in the community to adjust those tools in order to be able to safely use them within the IPV community.

We also have the challenge that because we don't have dedicated IPV brain injury support services, we're now looking at diagnosing a population that we effectively can't help. There are ethical considerations around that, particularly when there's still a stigma attached to disability and brain injury. If a woman goes into a courtroom and is trying to maintain custody of her children and her abusive partner—and, I might add, that's the person who gave her the brain injury—starts talking about her capacity to parent because she is disabled, then she has a whole new level of risk because of the label itself. So we are very careful in this particular aspect in the field.

Diagnosing is not necessarily the best step forward until we have appropriate services and appropriate understandings of what that means in those other areas like the legal system and the judiciary. We have built-in mental health courts and domestic violence courts. Those people don't know about brain injury. They don't know about the ways in which a survivor may appear different than their expectations when they're giving testimony or when they're behaving the way that they're behaving in a courtroom. And so that whole piece around behavioural choices comes forward and people are put off; they don't want to help because the person appears to be difficult or argumentative or they can't even be bothered to help themselves or they continuously make bad choices.

1100

Every time I tell a front-line worker this piece of information, their whole body language changes, and they sit back and they say to me, "Wait a minute. You mean it's because of a health concern that they can't do these things?" And everything shifts and now they want to go and help again, because it's not personal anymore.

Mr. Brian Saunderson: You started that answer with some pretty startling statistics. So you're saying that over three quarters of the women, probably more, who are victims of IPV have a brain injury of some form.

Dr. Halina Haag: Yes.

Mr. Brian Saunderson: Being a father of three boys and a clumsy ex-athlete myself, I know about concussions and the awareness that has grown, but a big part of the diagnosis is—at least, the experience I had with my sons was, if you don't have a baseline measurement, it's often difficult to tell the level of the concussion or the injury itself. You talked about protocols and treatment: What are the best, gold-standard protocols for diagnosing a head injury?

Dr. Halina Haag: The gold standard currently is—

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

We're now going to move back to the official opposition. MPP Sattler, please, when you have an opportunity.

Ms. Peggy Sattler: Thank you, Dr. Haag, for joining the committee today and sharing your expertise.

You mentioned that existing IPV services in Ontario assume that the client doesn't have a brain injury or is capable of functioning and that there's no screening, no return-to-life protocols. We have heard from many in the shelter services system that the sector is very, very precarious and grossly underfunded, and shelter workers are struggling to get through the day without turning away more and more women.

What are the implications, from a system perspective, if we are going to put in place those IPV protocols for shelter workers to implement to help women move forward?

Dr. Halina Haag: From a shelter worker's perspective, it's going to make their job a heck of a lot easier.

So all I need to have done is five questions to be asked for a basic screening. You hit five yeses, four yeses in those questions, that's a probable brain injury. At that point, you know that what you're dealing with needs to be approached differently. So, from that point of view, you now have a referral pathway. As long as—assuming you have the referral places operating and the services operating in order to be able to send those folks to them, all you need to do in the shelter system is identify that that's what's happening.

Because we don't have those referrals out in place yet, what I tell shelter folks is, "I don't need you to diagnose. I don't want you to diagnose. What I want is for you to be able to be aware of the situation and aware of the implications. So change the lighting in the room. Change the space in which you interview a client. Change your expectations of what she will remember and how she will use that information. Understand that she is coming to you with impairments that will prevent her from being able to recall things in a logical, linear fashion, to be able to remember a list of five or six things to do the next day, and just because she left your office remembering them now doesn't mean she'll remember them tomorrow."

It's procedural things that need to change. It's tiny little things. It doesn't even cost a lot of money. And what I tell them is to assume 100% of your population—

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

We're now back to the government members and MPP Dixon, please, when you're ready.

Ms. Jess Dixon: Thank you so much. We have two and a half minutes. I'm going to grandstand for a second, because I was a crown and I used to, at bail hearings, try to submit a document about strangulation—because I used to deal, only four years ago or so, with a JP that wouldn't put on a weapons condition in a strangulation case because, in his words, "Our hands aren't weapons."

I'm wondering if you could talk a little bit about—if we're talking about police responses to a domestic violence situation, I want to talk specifically about strangulation. What I've heard or been aware of is the idea that the injury may not be visible at that point in time. Can you talk a little bit about what that means or what that looks like as far as the IPV victim trying to tell their story and not having visible damage?

Dr. Halina Haag: The challenge is that cutting off both the blood and the oxygen supply—each is possible and likely to cause a brain injury. Both of those things happen in the neck, so the minute that you have somebody putting their hands around somebody's neck, a brain injury is actually even more likely than a physical assault. The amount of pressure that's required in order to do that and cause a permanent brain injury is less than it takes you to open a pop can, and it doesn't leave marks.

Women don't talk about it because women don't know about brain injury and IPV. They don't stand up and say to physicians, police, social workers, anybody else, "These are the things that happened to me. I think I might have a brain injury. These are the symptoms I'm having. Can we please follow that up?" So that entire conversation never happens.

A police officer standing on the doorstep sees a woman in front of them who's slurring their words, who's unsteady on their feet, who's trying to protect somebody else—because they're not telling a story in a linear fashion. They look behind and see a couple of beer bottles on the coffee table; they think drugs and alcohol, and from that moment forward, that woman's trajectory is changed. If they would look at that woman and think, "Wait a minute, did she just have her head bounced off a wall, or was she strangled?" and now get her into health care, then from that moment, we have a chance of identifying an underlying cause that will now be treated appropriately and allow for effective care.

Ms. Jess Dixon: I only have a few seconds left, so I'll just say, thank you so much for this. On behalf of the committee, your work and your presentation today are something we will most certainly be taking very seriously.

The Chair (Mr. Lorne Coe): Thank you very much, Doctor, for your presentation this morning. That concludes your time.

GUELPH POLICE SERVICE

The Chair (Mr. Lorne Coe): I now would like to call forward the Guelph Police Service to the table.

Ms. Ashley McArthur: Good morning.

The Chair (Mr. Lorne Coe): Good morning. You will have 10 minutes for your presentation. Please state your name for Hansard, and then you can begin your presentation. I'll let you know when you have one minute remaining, and that will be followed by questions, as you saw. Your name, and then you can start your presentation.

Ms. Ashley McArthur: My name is Ashley McArthur. Good morning and thank you for inviting me to speak as an expert on a subject I'm so passionate about, intimate partner violence. My name is Ashley McArthur, and I'm a detective with the Guelph Police Service and chair of the Ontario high-risk intimate partner violence coordinators

committee, a committee composed of officers throughout the province who oversee high-risk IPV investigations. During my 20-year career, I have dedicated my time to ensuring the safety and support of victims, advocating for change where appropriate.

Today, my submissions will focus on four areas of concern and the potential changes I urge the government to consider. The areas are standardized risk assessments, grant funding, court delays and the current bail reality and can be referred to in my written submissions for more details.

At the present time, the province does not have a standardized risk assessment for intimate partner violence cases, meaning that management and flagging of offenders looks different at Ontario's individual jurisdictions. Labelling is important because when an offender is deemed high-risk and they move to a different jurisdiction, if and when they are run through CPIC, the Canadian Police Information Centre, which would happen on something as routine as a traffic stop, they would be flagged. Without it, both the potential victim and responding officer are at risk. By standardizing the threshold for when a risk assessment is used, the identification process would be more consistent, leading to a more just system.

Currently, training is being done on a service-by-service basis. This is inefficient and more costly. Additionally, the type of risk assessment being used can change, leading to training on multiple assessments at even more cost. A provincial assessment would create a more efficient delivery of training programs. Police officers can be trained through a mandatory course as part of their Ontario Police College basic constable training. The training for community and justice partners could be facilitated in a similar manner, reducing the number of courses and total costs.

It is also difficult to collect consistent statistics and data without a standardized approach. The consistent identification of offenders would provide crucial data on which jurisdictions are dealing with the highest volume of offenders, allowing for more proper allocation of resources where they are needed most. It is known that rural and remote communities have a higher rate per capita of high-risk cases, and yet often lack appropriate resources.

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A more systematic system to monitoring IPV cases provides us a better understanding of trends and the effectiveness of different interventions. Creating a more transparent and just process for identifying high-risk offenders not only provides increased safety for officers and potential victims; it allows for the creation of consistent data that is invaluable in creating policy decisions, and that in turn will save significant money.

In our province, government grants are released on an inconsistent basis, and there is a time limit imposed on them. Generally, there is often a large delay in when the money is received, and typically only one community agency can receive that grant despite all agencies having a constant need for funding. With limited time frames, agencies are rushing to utilize the funding without being able to put the proper time into determining where the funding is going to have the greatest impact. If the funding is being used to hire additional workers, adequate time is not being given to train, meaning that by the time they are ready to work with victims, the grant is almost over and the support victims receive is extremely limited. This can create distress among victims who are receiving inconsistent support.

When the grant ends, the service often is removed, leaving victims confused and frustrated, not knowing where to turn to access vital services. It often becomes the police service who then must take on case management once again, causing police burnout and lost time, which comes with a financial cost.

This is a cycle that needs to break. Grants have become a band-aid solution and do not allow for sustainable and consistent services for victims to ensure long-term success. Ideally, support services would receive adequate and stable funding. IPV is not going away. Planning could be put into place on how to best utilize the grant money. This would ensure that services are delivered to the areas of the highest need, and we would work collaboratively to best support victims and offenders.

Reducing the amount of re-training of workers, the duplication of services and the disruption of stable services would create increased victim trust and cost-savings. The reduction in police victim-management would allow for police services to spend more time and resources on prevention programs. Prevention programs are proven to reduce the number of cases that result in arrests, reducing the burden and cost to the police service, victim services and courts.

Proactive early-intervention programs are currently being run in some parts of our province. Later today, you will hear about a program being run out of Waterloo region. I encourage you to listen intently, as these are the sustainable programs we need in our communities.

Within the last five years, there has been a significant change to bail provisions. Even our most high-risk offenders are now receiving bail faster and with less onerous conditions than ever before. This has been termed "catch-and-release," leaving victims in a constant cycle of crisis, meaning victims are utilizing more acute services—police, victim services, hospital care etc.—and are unable to move on to longer-term care services that would lead to less strain on the systems and eventually break the cycle.

The notification to victims that the accused has been so promptly released from detention has created a sense of distrust in the justice system and is often blamed on police. Victims feel as if they're better off dealing with situations on their own and have reported being less likely to call police for future incidents of violence. This also makes victims more likely to recant their initial complaint and leaves offenders feeling emboldened, knowing that there will be little to no consequences to their actions.

The catch-and-release system, in theory, could reduce congestion in court. However, in practice, it is leading to offenders breaking court order conditions at alarming rates, resulting in additional court appearances.

We can all acknowledge that the government has recognized the need to strengthen the province's bail system and ensure that high-risk offenders and repeat offenders comply with their bail. However, significantly more time

has been spent managing each case, decreasing the amount of time and resources that can be put towards what we really need: proactive initiatives decreasing the likelihood of these situations reaching the point of arrest in the first place. Preventing low-risk cases from entering the court system will reduce the pressure on courts and allow them to dedicate the time and resources to high-risk cases, ensuring that they are dealt with appropriately. It is no secret that our court systems in nearly every jurisdiction in Ontario are overwhelmed, resulting in significant backlogs and delays.

I would like to end with providing you the most recent case I was involved in and the costly impact of delays. In May 2021, the accused was charged with IPV-related offences, including sexual assault and assault strangulation. The accused received bail and has remained in the community, attending his 10-day judge-and-jury trial in May 2024. The trial concluded with a finding of guilt by the jury, and sentencing is scheduled for September 2024.

The revictimization of the court process resulted in the victim being hospitalized under the Mental Health Act for seven days immediately following the conclusion of trial. She contributes the 1,115 days between reporting to police and her case being tried as a reason she is unable to heal and reintegrate herself back into the community.

The court process is often described by victims as more painful than the initial attack. Being forced to relive—

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

Ms. Ashley McArthur: Being forced to relive years-old trauma comes at a cost to both our health care and justice systems. The best way to reduce court backlogs is to prevent cases from reaching court in the first place. Proven methods include providing adequate, sustainable and long-term support to victims, and implementing early intervention programs. This is where our focus needs to be. Not only are these methods that will lead to sustainable decreases in court cases, but they also have the greatest impact on victims, services and offenders, leading to a healthier society.

Thank you for allowing me to share my thoughts, not only as a police officer but as a mother. I often remind my victims that I'm just one mom supporting another, and I would like to thank all the women who have trusted me along the way and encouraged me to show up today.

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

Our questions are going to start with the members of the official opposition. MPP Sattler, please, when you're ready.

Ms. Peggy Sattler: Thank you, Detective McArthur, for that detailed presentation, and also very helpful to have those specific recommendations.

I want to start with that story that you shared at the end of your presentation about a survivor who spent over a thousand days from reporting to the police until her case went to trial. We know that that is such a small fraction of survivors who actually go through that process of reporting and then make it to trial, and the fact that she was retraumatized to such an extent by the delays in the process, but by also having to continually share her story, that's something that this committee is looking at. Because the study is on intimate partner violence—but there were two bills before this committee: one on the declaration of the epidemic, but the other one, Lydia's Law, to look at what is causing these delays. I think last year over 1,200 cases were either stayed or dropped or otherwise didn't go through to trial, and that's over 1,200 women who have taken that huge step to seek justice, and justice has been denied.

I appreciate your recommendation was that we have to work to prevent these cases from getting to court in the first place. But for those that do go to court—I don't know if you've had a chance to look at Lydia's Law, which calls on the government to review each of these cases that are stayed or dropped and to identify what is causing this to happen. Do you have other thoughts about what we can do to deal with all of those survivors who are denied justice in our legal system?

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Ms. Ashley McArthur: That's a big question. I think we have to examine where and when women are deciding to pull out of the court system, and there's a big cost to that. We're asking women to come forward and report, and then we're pushing them along and pushing them along to the point where they end up recanting and not wanting to come forward anymore. There's a huge cost associated to that. And then, we do know that we end up back where we started.

In terms of my suggestion, I would think front-loading services and front-loading support in order to get through these court cases in a timely manner—obviously, by still respecting our laws and the rights of the individual. But I just want to stress, too, that I think that's not only important for the victim, but it's also important for the offender who has these looming court cases over them, and definitely something that is not being dealt with efficiently.

Ms. Peggy Sattler: Thank you very much for that.

I want to talk about your second recommendation, dealing with the whole grant labyrinth that agencies find themselves in, in crisis, as services find themselves having to scramble to meet these arbitrary timelines for submitting a grant proposal. And then, as you point out, by the time they get the money, it limits the amount of time that they're able to deliver the services that they're being funded for by the grant.

That is something that we have heard a lot from presenters who have come to this committee, that the project-based funding is not helpful because there's time and effort involved in putting a program and staff into place, and then it leads to survivors being told that the service is no longer available.

There have been many calls for increased, stable, long-term funding for this sector—for shelters in particular, but also for that whole range of victim services. Can you elaborate a little bit more, from your perspective as a police officer, as to why that is so important?

Ms. Ashley McArthur: I can speak to my last experience with a grant, and I just want to make it clear that I was on the front line for 14 years and didn't have a good

baseline on what grants even meant or what they looked like in the world of policing and community agencies.

Coming off the road and taking carriage of the high-risk IPV portfolio, I was introduced to the grants and, obviously, worked at a more intimate level with our community agencies. The last grant that we received, a victim support grant, we were advised that we were successful and received the grant in March. The money did not come until October, and the grant was on a 12-month time restraint, so we had to have everything done, spent, used by March 31 of the following year. That left very little time to actually do some meaningful, long-term work.

We were in a position that, luckily, our victims' services worker was already trained so we could move her right into that position, but imagine having to pull back, train that worker, and then put them forward. We don't know that, 12 months from now, we receive another grant—but, say that grant is awarded to a different community agency. It might look the same and it might have the same criteria, but we are starting from ground zero.

We are now redirecting our victims to another agency, we are retraining somebody who already has the KSAs in the community instead of building our social workers' KSAs. By having stable funding where we're actually able to build on what the community needs and not reinvent the wheel every time a grant comes out, that would be way more cost-efficient and it would allow to build a foundation.

What I have seen from the policing world or standpoint, taking part in a lot of community meetings that look very similar to this, is the current grant system creates a lot of competitiveness amongst our agencies—and understandably so. They're all fighting to get stable funding and it creates—

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

We're now going to move to the government members for questions, please. MPP Dixon, please, when you're ready.

Ms. Jess Dixon: Can you keep talking about what you were just talking about? I was about to ask you—and we all understand that our agencies are doing an amazing job with what they have, but we do want to dig a little bit more into this because it's something we've heard a lot about. I'd love to hear about it from your perspective.

Ms. Ashley McArthur: I can appreciate that. A lot of times in these meetings, I push my chair back and look—because I'm not funded by grants, and I'm very thankful for that, but I can understand why it creates this animosity among our community agencies and why it causes some infighting, because everyone is trying to keep their head above water and everyone is trying to continue to deliver the same standard of service, whether they have a grant or not.

And that's another big issue, that on March 31, the money is gone, and thank goodness everybody pulls together and tries to establish how we can continue the same level of service without the same amount of funding. That becomes very difficult, and that is where it does fall back on the police, and it falls back on the police at a cost.

It ties into the case management. When our victims are not able to be supported on a consistent long-term basis in the community, it becomes—in my position right now, my job is victim management and to make sure I can hold on to them for 1,115 days to get them to trial. That is a huge amount of work. That is texting, that is picking up a bag of milk, that is making sure food insecurity—that is taking my police hat off and putting my social work hat on, and it takes away from my ability to run any sort of prevention programs, bail compliance. The standard things that you think of when you think of law enforcement unfortunately have to take a back seat. This is where stable funding and community agencies not duplicating themselves—I think that is very important. When we look at different jurisdictions, making sure that our agencies are not offering the same sort of services, and so that way we can get more bang for our buck and we can have not a siloed approach, but a very well-thought-of umbrella on where to access services and where to access them on a consistent basis.

It can't be that, in 2024, you used to utilize victim services for this, and now, in 2026, "Sorry, you have to reroute to Women in Crisis," who had to retrain, who had to—the time and energy that goes into the education and redoing their documents and all of that. It just seems very inefficient.

Ms. Jess Dixon: You have a really interesting perspective, like you said, of being outside of the grant process but still seeing so much of it.

One of the big things that sort of has been coming out of this committee and going around in my own brain is this idea of, if we had a community that has a number of different community agencies, victim services etc.—the concept of asking them to come together and say, "All right, who's providing what?" Because we know, although they may be duplicating services, it's not like there's not enough victims for them to serve; it's just how that's actually being delivered. What does each agency bring to the table and what would stable funding look like if they were to come together in a co-operative proposal—where, again, that proposal is not for a grant; it's for an annualized funding that is, I don't know, indexed to inflation or population? From what you've seen from your interesting outside vantage point, do you think that's something that community agencies would be able to do to come together, given that we've unfortunately created this competitive atmosphere? Is that something that you feel, just from an outside perspective, that you think would be possible?

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Ms. Ashley McArthur: Yes. I think there would be some growing pains, obviously, and there would be a lot of table discussions on who's going to do what. You know, everybody always thinks their services are the best, right? But with that stable funding, the agencies are going to be able to be the best at something instead of being just okay at kind of everything.

I think of something like safety planning, where, if we have adequate, stable funding—right now, we might have three different agencies in Guelph that offer safety planning, but we have one particular agency that does it really well and that's probably based off of some extra grant money they had received, some extra training. That would be a

good example of where we need to come to the table. We need to be honest about what everyone is really good at and maybe is not great at, and have those discussions on how to best serve the community. And I would hope that we're all here to do what we say we're here to do, which is serve our vulnerable victims and provide more stable services. Then there's going to have to be some collaboration.

Ms. Jess Dixon: You gave me a perfect segue. We've got two minutes left in this block of questions. Can you talk a little bit about—like, when you talk about safety planning, can you talk about it specifically in the context of catch-and-release, of this very, very quick turnaround between arrest and release? What does that look like in that context?

Ms. Ashley McArthur: Under the current bail provisions, with an example of a catch-and-release situation, it actually doesn't leave any adequate time for safety planning. We've had situations where we haven't even transported the female to the Guelph Police Service for safety planning and our accused is walking out the front door with the release order, right? So safety planning looks very different and it's very reactive instead of being able to create some time and distance to actually put in some very sustainable interventions across many different—whether it's at your home, whether it's at your place of employment.

But unfortunately, with the catch-and-release, we're always in this cycle of making quick decisions and maybe doing things not as thoroughly as we would normally do, and that creates a lot of distrust—a lot of distrust—with our victims. And when I cite that it comes back to police—and I understand it, I completely understand it, from a victim's perspective. You know, you're watching the offender walk out of the courthouse at the same time you're walking into the police station for victim services. They look to us, right? It just doesn't create a sustainable environment, and then a lot of the time—

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

We'll now move to the second round to the official opposition, please. MPP Wong-Tam.

MPP Kristyn Wong-Tam: Thank you, Detective, for your presentation. I recognize that you are the committee chair of the Ontario high-risk intimate partner violence coordinators. How many coordinators are there in Ontario?

Ms. Ashley McArthur: Under the current policing standards, every service has to have a designated coordinator. So, every service within the province of Ontario would have a coordinator. What that looks like in each individual jurisdiction can be different, but—

MPP Kristyn Wong-Tam: And can you tell me, how often does the committee meet?

Ms. Ashley McArthur: We meet quarterly. Since COVID, we've taken on more of a hybrid approach. We have a virtual option and an in-person option, sharing the meeting locations around Ontario.

MPP Kristyn Wong-Tam: And specifically, when you folks are meeting, are you sharing—I'm assuming there's an update of information. There may be some additional requirement for training. But has your committee made specific requests of the government over the years in terms of addressing the rising trend of IPV that you've seen and experienced on the field?

Ms. Ashley McArthur: When I joined the committee, probably in 2016, there was some talk around—and there was a lot of work being done at the committee level and in conjunction with MAG about revitalizing the policing standard, the LE-024. That, with the change in government, came to a halt, and there's been a lot of difficulty in regaining that traction with the government. We do have members of MAG that sit on the committee, but since there's been that, we'll say, lack of government interest—and it happened around the time human trafficking became a big topic, for good reason—the committee has taken on more of an education realm. So I focus on getting out the latest and greatest IPV education out to the committee and it's those individuals' jobs to then carry it through to their service.

MPP Kristyn Wong-Tam: Thank you. That's very helpful information. And so, if the government hasn't—

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

Now, back to the government, please. MPP Saunderson, when you're ready, sir.

Mr. Brian Saunderson: Thank you, Detective, for coming today and sharing your expertise. I think it was the first recommendation that you talked about, and I want to make sure I got this right: It was talking about the standardized testing, but also a protocol for when to implement the standardized testing. Is that right?

Ms. Ashley McArthur: Standardized risk assessment; that's correct.

Mr. Brian Saunderson: So there are two aspects to that: One is having a protocol across the province that's universally and uniformly applied about when to use the risk assessment tool, and then there's also an issue about what standardized tool to use.

Ms. Ashley McArthur: That's correct.

Mr. Brian Saunderson: Okay. And my understanding—we've heard some testimony from forensic psychologists, and one of them was Dr. Zoe Hilton, who was very involved in developing ODARA. I understand the OPP use ODARA. What does your police service use for an assessment tool?

Ms. Ashley McArthur: The Guelph Police Service is currently using ODARA as well.

Mr. Brian Saunderson: Okay. So is ODARA used across the province or not?

Ms. Ashley McArthur: I would say that ODARA is definitely the most commonly used risk assessment across the province. Saying that, it has started to take on a little bit of a different look. I know Peel Regional Police have morphed theirs into a risk assessment that best suits the needs of their community, and that has been endorsed and approved by their crown. When the ODARA is used and how the ODARA is used looks differently in different jurisdictions.

Mr. Brian Saunderson: Okay. So talk to me, then, about standardizing and making this uniform. In your experience,

then, how would we set up our protocols to make sure that happens, and what would they look like?

Ms. Ashley McArthur: Under the policing standards right now, every service is mandated to have a risk assessment. That standard would change to a universal risk assessment that would have to be agreed upon at the provincial level. Then, we would carry on into, "To what standard are we using this?" I would say the most common practice right now is that during every charged IPV offence, the ODARA is initiated and utilized. I think that would be the best practice. I think that's probably the most standard practice across the province, but it's definitely not consistent.

Mr. Brian Saunderson: What kind of training do the officers get in using ODARA? Because it sounds to me that it's clinically proven and it seems to be very scientific, but I would imagine how you administer that could vary—

The Chair (Mr. Lorne Coe): Thank you, MPP Saunderson. That concludes the time available for the government.

Detective, thank you so much for being with us this morning and for your presentation. I now need to move on to our next presenter. Thank you for being with us.

DR. JENNIFER KAGAN

The Chair (Mr. Lorne Coe): Members, our next presenter is joining us through Zoom. If our technician could bring in our next presenter, please. Thank you very much.

Good morning. How are you?

Dr. Jennifer Kagan: Good morning.

The Chair (Mr. Lorne Coe): Thank you very much for joining the Standing Committee on Justice Policy. Could you please repeat your name for the record? You will have 10 minutes for your presentation. I will let you know when you have one minute left. Your name, please.

Dr. Jennifer Kagan: My name is Jennifer Kagan.

The Chair (Mr. Lorne Coe): Well, thank you very much for being here. You can start your presentation and I'll let you know when you have one minute left. Please begin.

Dr. Jennifer Kagan: How much time do I have?

The Chair (Mr. Lorne Coe): You have 10 minutes. I will let you know when you have one minute left.

Dr. Jennifer Kagan: My name is Jennifer Kagan. I'm a physician and a mother and advocate. Some of you may be familiar with our advocacy or have seen some of our advocacy work, because I lost my four-year-old daughter, Keira Kagan, in 2020 in a murder-suicide. The Ontario Domestic Violence Death Review Committee reviewed her case and found that it was consistent with murder-suicide. She and her biological father were found at the base of a cliff in Milton, Ontario, at Rattlesnake Point.

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That made me a bereaved mother, and our advocacy—both my husband and I have advocated since—resulted in the passage of Keira's Law at the federal level, Bill C-233, which will elevate the level of education that federally appointed judges receive on domestic violence and coercive control.

Provincially, your government passed a version of Keira's Law—the bill number has escaped me; I apologize. But essentially that will mandate that new judges in the province of Ontario who are under provincial appointment undergo domestic violence and coercive control education and training. I'm going to get to that in just a moment.

I will tell my story very briefly. I've already summarized. Essentially, I was a victim of domestic violence in my previous marriage. I was subjected to a myriad of types of abuse. I'm sure you've heard from many experts at the committee what domestic violence looks like—some myths and stereotypes. In my case, the perpetrator presented very well: He was working for a large corporation—very high-achieving. It debunks some of the myths and stereotypes that perpetrators present a certain way.

There was a lot of coercive control in my case. I'm sure you've heard a lot about coercive control and what it is: restricting someone's movements and day-to-day activities. I had a tracker placed on my car, unbeknownst to me; a lot of jealousy—I'm not going to get into all of that. There were also isolated episodes of physical violence that I was subjected to.

Essentially, I left the situation. I was living in Halton region at the time and took what was then a nine-month-old child to safety, to Vaughan region. While I was able to leave myself—of course, the highest time for a victim of violence is the time of separation, so while I consider myself somewhat lucky to be alive and not one of your femicide statistics, our daughter was completely unprotected.

I then went to the court system—actually, my ex-husband brought an application denying all sorts of abuse, falsely alleging that I was not only abusive but alienating our daughter, and then the courts essentially put her into unsafe hands with him. I was screaming and shouting from the rooftops that this was a dangerous man who had many risk factors for lethality. I know you've just heard about the ODARA; his risk assessment was off the charts. In fact, when the Ontario Domestic Violence Death Review Committee reviewed my file, they found that there were over, I think it was, 22 risk factors for lethality, yet I could get no one to do a risk assessment. I couldn't get that incorporated into anywhere because it's just not something that was considered.

So ultimately there were failures of the child protection agency, Jewish Family and Child Service, who were tasked with protecting Keira, and she and her father were found dead at the base of the cliff in Milton in 2020.

Our whole focus of our advocacy has been around systemic failures, so looking at the systems that are supposed to be acting in the best interests of the victim and the child, and these systems—in Ontario and elsewhere—are really failing to protect. There are many areas that you'll hear about that need improvement, and our focus, really, has been around these systems—so, looking at education and training, how can we educate these professionals?

Keira's Law was subsequently born out of our tragedy, and in the province of Ontario, this was passed, wherein

judges should be receiving this education. I will admit, I do have concerns around the implementation piece. While I thank your government, and I'm very pleased to see this legislation was so swiftly passed following the federal bill, which was passed last year, I have some concerns about the implementation: What type of education are judges receiving? Who is delivering this education? It's some of those details that I wanted to bring up today, because speaking to victims—and I remain an advocate for victims of violence going through the court system; in addition, my husband is a practising family law lawyer who has been working almost 15 years in the courts day to day. The judges still seem to lack this education, and without an understanding of domestic violence and coercive control, they're not protecting who needs to be protected. Risk assessments are not being done, and as we've stated before, when victims come to the court seeking protection, they're actually being punished. They're being told by their lawyers, "Don't bring up abuse, because not only are you not going to be helped that way, but actually you could lose custody of your child or get into big trouble," so this is not right, when we look at that piece.

And then the other aspect I wanted to bring up today was around the Keira's Law motion. Your colleague MPP Effie Triantafilopoulos swiftly brought forward the Keira's Law motion, which received unanimous support from all parties, and this motion was designed to ensure that other players involved with these cases and with the protection of victims of intimate partner violence and children who are also the victims, of course, receive education on what constitutes domestic violence and coercive control, and this education, as under the Keira's Law motion, was to extend to children's aid workers, to workers at the Office of the Children's Lawyer, which, from my understanding, falls under the portfolio of the Ministry of the Attorney General and, in addition, custody assessors. These are professionals who are involved in these files, making these life-or-death decisions for families who don't have any knowledge of domestic violence. You can essentially have a general degree and say, "Yes, I'm going to be involved in this very complex case," without an iota of specialized training. So, wrong decisions are being made and lives are in jeopardy.

I would also like to add that I'm of the view that police require additional education and training on domestic violence. I will say we have seen some strong willingness from Halton regional police. They really supported our advocacy around Keira's Law and seem really forward-thinking in terms of their willingness to train officers and move this forward, but we would like to see this type of education being rolled out across the province.

I'm trying to think what else I wanted to convey here, essentially.

I have no doubt you've heard from multiple experts around the femicide statistics, and I can tell you, this is not something that somebody wakes up one day and says, "This is going to happen to me." These are situations that people find themselves, unfortunately, entangled in, and it's very unfortunate, but what I think is more unfortunate is when the systems and people in those systems are not acting to protect. It can be very traumatizing, and then, of course, very traumatizing to have to engage with a system that does not understand the domestic violence piece.

So it's important, especially with what's happening federally around criminalization—

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

Dr. Jennifer Kagan: Thank you—around criminalization of coercive control, that—to me, education is a low-cost, low-risk intervention. Really, there's nothing to lose, and that's why we find politically that there isn't really anybody against it. We saw federally, with the passage of Keira's Law, 326 MPs voted in support of that education, but once again, we need to move beyond the passage of the legislation and onto implementation phase so that these are not just laws on paper, words on a paper, that they're meaningfully impactful for residents of Ontario.

I thank you very much, and, of course, dedicate everything that I do to my daughter, Keira, who should be starting fourth grade this year, and instead of celebratory back-to-school, another day for our family in mourning.

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

Our questions will start now with the members of the official opposition. MPP Wong-Tam, please, when you're ready.

MPP Kristyn Wong-Tam: Thank you very much, Ms. Kagan, for your presentation today. I recognize how difficult of a journey this must be for you and your family. I have a five-year-old son, and just the thought of anything happening to him is just—I can't even speak.

Your courage and absolute, resolute determination to ensure that Keira's memory is not lost and that her death is not in vain is something that I think we at this committee must rise to meet and I think that today your presence is going to ensure that we do.

1150

I have followed your case as someone who is just interested in understanding more about how we can prevent human loss, how we protect women and children. So I followed your case as a citizen of Toronto and as a former city councillor, and I remember that the things that came out from advocates who were speaking when asked by the media to comment on the finding of the Domestic Violence Death Review Committee were that—the words "predictable" and "preventable" kept coming out.

I want to make sure that we don't squander this opportunity because you're here today. We know that the reports have come out. We know that the laws have been passed and motions have been declared. But what would give you confidence that you will see the proper provincial rollout and implementation of Keira's Law?

Dr. Jennifer Kagan: I think we need a plan as to the implementation of the training, like a very concrete plan in terms of, who's going to be educated? When is that education going to be happening? Who will be delivering that education? To see that planning will be important because the laws can be nebulous. For us, we want that

accountability piece around, what is actually happening to ensure that the law proceeds as intended?

You mentioned the Keira's Law motion piece, which is extremely important in terms of educating not just judges but children's aid workers, custody assessors, the Office of the Children's Lawyer. I'm sure all of you must receive letters very frequently from victim/survivors who are in these situations.

The inquest into Keira's murder will also be coming forward; I believe we heard 2025. So I know there is going to be a more in-depth look at this. But to me, the crux of the issue—a lot of it pertains to that education piece, and that's been a big part of Keira's legacy for sure.

MPP Kristyn Wong-Tam: This is day 8 of our hearings. We've heard previous speakers speak about the need for a consistent, set standardization of a risk assessment. We've also heard folks who've come forward and taken claim that they have created a risk assessment, or they've audited risk assessments. We have heard from subject matter experts who study risk assessment tools from across the country, looking at ways to refine and to deliver almost the very best tool.

But consistently, what we also hear is that there is no consistency on how these risk assessment tools are rolled out and that there is really no standardization. So I'm curious to know if you can just share a little bit more about, in your situation, how you were not able to get a proper risk assessment done.

Dr. Jennifer Kagan: I would say to the first point, the Ontario coroner's office has studied these domestic homicides for many years. Looking at the risk factors from the Ontario Domestic Violence Death Review Committee, they put together a huge compilation, so I think that's very valuable in that end.

From my standpoint, I couldn't even get the judge to hear, "I'm a victim of violence." The starting point—it was shut down at the door. It was, "How is this relevant to parenting? Domestic violence is not relevant to parenting, so I'm going to ignore it." But there are a number, as you say, of risk assessment tools that have been validated.

Certainly, I would look to the recommendation of experts in the province such as the centre for family violence in London, Ontario, Luke's Place—these are organizations who I certainly would trust to put forward recommendations to your committee.

MPP Kristyn Wong-Tam: I have a question regarding a comment that you made in your deputation. You talked about your ex-spouse putting forward an argument around alienation. Can you explain that to this committee? Was he putting forward an argument around parental alienation? Is that what he was using to justify access to the child?

Dr. Jennifer Kagan: Yes. When I came forward with allegations of abuse and recounted my history of what I had experienced, he then counter-alleged that I was alienating him, which basically—they used this concept to mean that I was preventing him from accessing the child. But I was saying, "This man is dangerous, and the child needs protection." This is a common tactic of an abusive person where they'll put forward that alienation argument, and it's actually very successful. There was research from Joan Meier and also from Professor Linda Neilson at the University of New Brunswick that, when a perpetrator counter-alleges alienation, it very often not only shuts down the complaint of abuse but results in a loss of custody for the victim. It's actually a very successful legal tactic that they're using, and I think that certainly warrants further attention by your committee because it's very problematic and there's nobody really reining this in in the courts.

MPP Kristyn Wong-Tam: I think that parental alienation has been used by men's rights organizations specifically to gain access to children by falsely claiming that the mothers are alienating or separating them deliberately without highlighting or acknowledging the violence factor.

I'm just curious in this for a little bit longer—just to dig into this for one more second—because we haven't heard much about parental alienation, but yet we know, at the same time, women oftentimes stay in abusive and violent situations because of children or the fact that they're fearful that they'll be separated from their child.

I don't expect you to know the answer, but if you do, that's great: With respect to the argument of parental alienation, how often have you seen, based on your research and the fact that you speak to so many people, that that is widely used and then accredited—meaning validated—by judges?

Dr. Jennifer Kagan: I couldn't tell you the numbers, but anecdotally, I hear this a lot—and certainly, I know my husband, in the courts, experiences that a lot.

I could find data for you, if that's something I could come back with, but it is a large problem, and actually, the United Nations women's commissioner has actually put forward a report showing the harm of the use of this parental alienation tactic—

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

We now need to move to the government members, please. I have MPP Dixon, please, when you're ready.

Ms. Jess Dixon: Thank you so much for coming and turning your grief into this much strength.

I agree with you about the concerns over implementation. As you experienced, it's not that it's easy to get a room full of politicians to agree with something, but once you do, and the party for it is over, then you're left trying to figure out what happens.

I feel like there are sort of two main branches of the implementation issue, and one of them is what you were talking about as far as, I think, professions that we have a little bit more control or authority over: crowns even interceding with the law society, children's aid, police. I think with that one, that could be a little bit more along the lines of political will and organization to say, "This is a task that you all have to meet of how you are going to inform yourselves better."

I'm curious, though, about what you've heard or experienced as far as the judicial response because in Canada and in Ontario—you understand this, but I think a lot of people don't understand this—we do have a very, very vigorously

protected judicial independence and there are good reasons for that, but it also means they set their own training, essentially.

I'm wondering what kind of, if any, contacts you've had with the National Judicial Institute, or any rumours you've heard about that.

Dr. Jennifer Kagan: We did meet with the National Judicial Institute and they were very positive around the education piece, and I did notice a willingness to want to implement the changes. I think that will take some time but, from what I understand—and it's, to me, the logistics around who delivers the education and how it differs between federally and provincially appointed judges. From my understanding, their piece would pertain more to the federally appointed judges. Provincially, we have not really had very much contact or understanding around how that would play out in terms of—I guess they would be called the chief justices.

From what I also understood upon my conversation with the National Judicial Institute, there's a provincial rollout that needs to occur and differences even courthouse to courthouse, and—excuse my lay understanding around the structure—I just don't know on a provincial level how that will be rolling out. I do have, as I mentioned, concerns around the implementation because I think even in the face of judicial independence that, obviously, legislation has been passed and so the judges will need to meet that expectation. I don't know what to say more than that.

1200

Ms. Jess Dixon: Yes. And you are right: The NJI is federally appointed, and Ontario judges and justices do have obligations for continuing education similarly to what lawyers have. Since Effie's work on the motion, have you had any further communications with MAG or anybody in government about that?

Dr. Jennifer Kagan: No, we have not.

Ms. Jess Dixon: No. Can I ask, roughly, when did you meet with NJI?

Dr. Jennifer Kagan: That was in December of 2023.

Ms. Jess Dixon: Can you remind me again, when was that motion, the Ontario motion, passed?

Dr. Jennifer Kagan: I believe it was June of 2023.

Ms. Jess Dixon: I know that you keep you ear to the ground very much on this. When we're talking about, say, family lawyers, children's aid workers, the other participants, and this idea of training, are you hearing anything back or rumbles from them about—is it that they're waiting for some sort of order from up top or funding? Do you have any sense of that?

Dr. Jennifer Kagan: It just seems that things have almost reverted to our pre-advocacy phase in the sense that we did start to notice some positive changes that were occurring around the time that the motion was passed, and things in the courts, some outcomes for victims, seemed to be improving. But it seems that since this is maybe out of the public eye a little bit more, things have actually gone back and outcomes for victims are reverting to kind of even pre-advocacy phase. That's worrisome and one of the reasons why I'm strongly advocating that we need to look at the implementation.

I haven't heard anything from the lawyers' end except that I think sometimes people are content to keep the status quo if it's suiting them and turn a blind eye a little bit. But this is important, and there's an urgency. Women and kids are losing their lives very often in this province, so if it needs to be mandated, then it needs to be mandated. But I don't know how much people are going to go out of their way to voluntarily seek this education. I don't know that people like change, right? People want to do things the way that they have always done them, which isn't the right way in this situation.

Ms. Jess Dixon: I know with your partner being a family law practitioner, you might have heard a little bit. Have you heard anything from the OBA or the law society or the trial lawyers or anything like that about them taking steps as far as continuing legal education?

Dr. Jennifer Kagan: Absolutely zero.

Ms. Jess Dixon: Nothing? Okay. So no one has reached out to you, but also you haven't heard any rumours of that.

Dr. Jennifer Kagan: No. We have made contact with the judges, and I can say there are, from a federal standpoint, some—I don't know what I'm at liberty to say, but there are some positive developments. But nothing in terms of the organizations that you have mentioned.

Ms. Jess Dixon: Okay. So right now, we're basically looking at a stagnation as far as progress. You heard a lot of excitement and interest and then it has stopped since then.

Dr. Jennifer Kagan: Exactly.

Ms. Jess Dixon: We've had presentations with them, but your position right now, which I agree with, is that we do have resources that are able to help us with that type of training if we were to mandate it.

Dr. Jennifer Kagan: Without a doubt.

Ms. Jess Dixon: Thank you. Thank you.

Dr. Jennifer Kagan: You're welcome.

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

We're now on to the second round of questioning. I have MPP Sattler, please, when you're ready.

Ms. Peggy Sattler: Thank you, Dr. Kagan, for appearing before us today. I offer my deep condolences on your loss and also my gratitude for your strength and your advocacy.

One of the things that we haven't really focused on in this committee is the reality that there are so many child victims of intimate partner violence. In my community in London, one of the cases that really affected me was the loss of Stephanie and Ashley Daubs, who were two girls. Similar situation as yours—the parents were estranged; the father killed the two daughters in a case of intimate partner violence. It's very concerning, what you said about victims of intimate partner violence being told by their lawyers when they go to court not to bring up abuse because it could affect custody decisions; it could lead to these counter-charges of parental alienation.

I am aware that some US jurisdictions are bringing in legislation to prohibit parental alienation being brought to the court when there is domestic violence or intimate partner

violence involved. It that something that you think we should consider here in Ontario?

Dr. Jennifer Kagan: Yes, I do. There was Piqui's Law, I believe it was called, out of California—maybe I have the law wrong, and I apologize. But certainly, I have seen in other US jurisdictions, as you say, a ban on the use of these allegations of parental alienation in court. As I was mentioning to MPP Wong-Tam, the UN special rapporteur on violence against women and girls has put forward a very lengthy report and recommendation that states ban the use of these allegations of parental alienation in court, that they are resulting in disproportionate harm to women and girls and that action from the government should be taken to curb this, because there are no checks and balances on this in the court, and it's really going on unfettered that a perpetrator of violence can use that tactic of parental alienation.

As I say, I was accused of it, and it was repeated over and over that I'm alienating, I'm minimizing, when of course I was concerned for the welfare of a nine-month-old baby and knew this was a dangerous individual. So they're very powerful allegations, and the court of law—

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

We're now back to the government—MPP Dixon, when you're ready.

Ms. Jess Dixon: We have two and a half minutes left. I know that you've said that Keira was going to change the world, and so she's going to change the world this way, and I think that's incredible.

What I wanted you, just in those last couple minutes, to talk about is—so you had the ultimate tragedy, the ultimate worst possible result. We've heard a lot about how incredibly challenging it is to navigate this system. This is sort of an odd question, but it's something that I often thought about as also a lawyer, if you can comment briefly on—you're obviously an incredibly educated and accomplished person; you're a physician. The struggles that you've faced in navigating this—can you compare that idea of what would it be like for somebody that doesn't have the abilities that you have, and yet you yourself face so many obstacles?

Dr. Jennifer Kagan: That's exactly it. That's why I advocate, to be honest with you, because I did have the resources, and I'm obviously educated and literate in terms of, I speak English as a first language. It's incredibly difficult, and I've heard from so many Ontarians who are having so many difficulties accessing the system. If somebody can't afford to pay a lawyer, they have to self-represent, which is a nightmare. They're going into these courtrooms where they're oftentimes even yelled at by judges for not doing this properly, not doing that properly. It's incredibly difficult to navigate, so there is much that can be done to improve that.

But I would say, largely, despite all those hurdles, if you walk into the courtroom—or your experience with the child protection system, for example, is that the violence is understood and the outcome is positive, then you've gone through all of that, but there is a positive outcome. Many of these people have children who are being abused, who are witnessing violence, whether it's physical, psychological, so they're dealing with children now that were perfectly normal who may have mental health issues or other challenges as a result of that whole court process. A lot of this is so preventable. If victims are not being met with so many hurdles and being retraumatized, then everybody is going to do better, and—

Ms. Jess Dixon: Thank you. We'll remember Keira. Thank you so much for everything you've done.

The Chair (Mr. Lorne Coe): Thank you very much for joining the Standing Committee on Justice Policy this afternoon. That concludes your deputation.

Members, the committee now will recess until 1:30 p.m. today.

The committee recessed from 1210 to 1330.

ONTARIO NURSES' ASSOCIATION

The Chair (Mr. Lorne Coe): Good afternoon, members. I reconvene the Standing Committee on Justice Policy and I would now call on the Ontario Nurses' Association, who are present in front of me.

You will have 10 minutes for your presentation. I'll let you know when you have a minute left so you can sum up, and that will be followed by questions from the members of the official opposition to my left and the government members to my right; that will be 20 minutes in length, approximately.

Please state your names for the record, Hansard, and then following that, you can begin your presentation. Thank you. Your names, please, and affiliation.

Ms. Erin Ariss: My name is Erin Ariss. I'm a registered nurse and I'm the provincial president of the Ontario Nurses' Association.

The Chair (Mr. Lorne Coe): Welcome to the Standing Committee on Justice Policy.

Ms. Erin Ariss: Thank you, Chair.

Ms. Michelle Bobala: My name is Michelle Bobala. I'm also a registered nurse.

The Chair (Mr. Lorne Coe): Thank you so much for being with us this afternoon, and my members look forward to your presentation.

Please begin and I'll give you the one-minute wrap-up time, okay? Thank you very much.

Ms. Erin Ariss: Very good. Thank you, Chair.

As you know, my name is Erin Ariss. I'm a registered nurse and I hail from Kitchener, Ontario—thank you, MPP Dixon.

ONA is Canada's largest nurses' union, representing over 68,000 registered nurses and health care professionals in Ontario. We also represent 18,000 nursing student affiliates. I want to thank, again, MPP Dixon for inviting me to share ONA's feedback on this critical topic.

IPV is not just a justice issue but a public health issue, a gender equity issue—a human rights issue, really. I won't repeat all the statistics mentioned in ONA's submission, but I will say this: IPV's prevalence increases with each passing day we choose not to act. It persists because

we are reactive. We need proactive measures, and it is high time that Ontario declares IPV as an epidemic in Ontario.

ONA wholeheartedly supports Bill 173, the Intimate Partner Violence Epidemic Act. Using the term "epidemic" in public discourse will enhance survivors' recognition of their experiences. This is powerful for IPV victims and survivors, but the declaration means nothing without meaningful actions to back it up. Prevention, support services, access to housing, education, good jobs and related policy changes are crucial to address IPV and effectively support victims and survivors.

As a union, we have a duty to protect workers. IPV is not something people leave at home. Following the recommendations of the Dupont inquest, which examined the 2005 murder of ONA member Lori Dupont, ONA has continued to advocate for other nurses, health care professionals and workers experiencing IPV through its participation in the 2017 violence leadership table discussions and the passage of Bill 168. But there is so much more work that we still need to do.

Section 32.0.4 of Ontario's Health and Safety Act is reactive. It must be amended to include the actions employers can take to support workers. This includes adopting a safety plan checklist and accommodation measures that account for the unique needs of survivors and victims.

We have an excellent resource for employers on addressing IPV: the Violence, Aggression and Responsive Behaviours—VARB—tool kit. However, the Ontario Health and Safety Act and the VARB tool kit do not mention work-from-home employees. In fact, work-from-home employees need additional support to deal with IPV. Work-from-home employees cannot be an afterthought.

We must make relevant changes to the Ontario Health and Safety Act and the VARB tool kit to protect all workers. Workplaces are where perpetrators and abusers target victims and survivors. There's a higher risk of IPV for workers in public settings such as hospitals. We need a province-wide relational security model to protect workers.

Lastly, current domestic-sexual-violence leave offered by the provincial government is not enough. We have included recommendations for the subcommittee to consider improving paid leave for IPV employees. Survivors and victims should not have the added burden of worrying about finances.

As the president of ONA, I represent workers first and foremost. Hence, I spoke about protecting workers dealing with IPV. Now I'll speak to you as an Ontarian. IPV impacts workers and non-workers alike, and I urge the subcommittee to take action to support survivors and victims who do not work or earn less, and to recognize that women of colour, Indigenous women, newcomers, women living with disabilities, and trans and gender-diverse folks are statistically most likely to be vulnerable to IPV. If we cannot protect the most vulnerable, we will fail in our endeavour all over again to protect Ontarians.

I'll now pass it over to my colleague Michelle Bobala, who is also a registered nurse. Michelle will shed light on the role nurses play in supporting IPV survivors and victims, and more importantly, the systemic changes that are needed to support their patients and end the violence.

Ms. Michelle Bobala: Thank you, Erin.

As mentioned, my name is Michelle Bobala, and I am a registered nurse. I work as a forensic nurse and a sexual assault nurse examiner at a sexual assault and domestic violence care centre in Toronto. We provide care to individuals who have experienced sexual assault, human trafficking and domestic or intimate partner violence. Most of our patients are women, but we also see men and trans and non-binary individuals.

As forensic nurses, we provide care plans for patients on a case-by-case basis. We specialize in crisis intervention and forensic and trauma-informed health care services for survivors of sexual assault and intimate partner violence. We provide care to patients up to 30 days following a sexual assault. In these cases, we offer sexual assault evidence collection and documentation, STI testing, toxicology testing, STI prophylaxis, emergency contraceptive options and other forms of care. In most cases, supporting victims and survivors of sexual assault requires four or more consecutive hours of one-on-one nursing care for each patient, due to the complexity of the care being provided and the need to complete thorough documentation that might be used in criminal justice proceedings.

We also provide care to patients who are experiencing domestic or intimate partner violence. Here, we provide care within a broader treatment window, and the care offered includes providing emotional support, documenting assault and abuse history, assessing and documenting injuries, taking photographs and connecting patients to community resources such as trauma counselling and shelter supports.

There are not enough nurse examiners available in Ontario right now to support clients when they need it. As a result, there are significant gaps in patients' ability to receive forensic and trauma-informed care from a specially trained nurse examiner, in particular in northern, rural and remote communities. There is an urgent need for the Ontario government to support the expansion of the Ontario Network of Sexual Assault/Domestic Violence Treatment Centres and hire more forensic nurse examiners.

We are the first member of the health care team in contact with victims and survivors of violence. When someone experiences sexual assault, violence or abuse, it is crucial that they have access to the necessary supports and services, but that is simply not the case right now. Many of the victims and survivors we see do not have access to primary care providers. This means they don't receive the ongoing health care that they require.

One of our recommendations is to expand the RN scope of practice so we can make referrals to improve our patients' access to primary care. For example, survivors sometimes require a referral for gynecology, psychiatry or other specialty mental health services. If we could make these referrals, survivors would have better access to the support that they need.

Lastly, we urge the government to fund and improve access to mental health services and safe shelter beds—

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

Ms. Michelle Bobala: There are substantial wait times to access counselling through the sexual assault and domestic violence treatment centres, through hospitals and in the community, and there is a severe lack of safe, supportive housing and shelter beds for victims and survivors when they are trying to escape an abusive situation and find a place to stay. These services must be available to support victims and survivors, but these services are inadequate or do not exist.

We care deeply for our patients. We cannot support them when the services they need simply are not available. We hope the subcommittee can action the recommendations we've discussed today. We look forward to your questions. Thank you.

1340

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

We're now going to start with the questions from the official opposition members. I have MPP Sattler, please, when you are ready.

Ms. Peggy Sattler: Thank you so much to ONA for coming to us today and for making your presentation. In particular, I want to thank you for your written brief and the recommendations that you include—well, number one, your endorsement of declaring the epidemic, your support for Bill 173, but also your recommendations really highlighting the fact that many of the solutions are already there. They are there in the recommendations from the Renfrew county coroner's inquest, from the Dupont inquest, from other expert reports that have already been presented to the government. So I think that's a really important part of your presentation today.

I wanted to dig a little bit deeper into your recommendations concerning occupational health and safety because that's something that we haven't heard a lot about so far in this committee. As an MPP, I brought in the original private member's bill to create paid leave for domestic violence and sexual violence, so I really appreciate your thoughts on how that can be strengthened. We did hear a presentation yesterday from WomanACT in Toronto. They raised a concern that not enough people are aware that those protections exist in the Employment Standards Act and that people can access that leave.

So, if you could, just expand a little bit more about the changes that can be made to the Occupational Health and Safety Act and also a little bit more about the paid leave provisions for DV and SV that are in the Employment Standards Act.

Ms. Erin Ariss: I'll answer that question.

We do know that section 32.0.4, as we referred to in our submission, is proactive rather than reactive—or we want it to be proactive rather than reactive, and, it says here, "include minimum actions that employers must take as part of minimum precautions." What we need to see is that the act is, if an employer becomes reasonably aware of domestic violence, that they will take these actions.

We would like to see safety plans—mandatory, of course—put in place, that safety plans are comprehensive, that the worker is aware, that training takes place. What we're seeing now is that information is circulated, but there's a difference between providing information and training workers on safety plans. And of course, that is the number one thing we would like to see.

The ESA for the leave: We know that it's cumbersome to access, that one day of a week can be considered one week's leave. It should be paid, it should be 15 weeks at a minimum in length and it should be widely available to victims, survivors and those who have experienced this broadly. We have seen leaves like this in the past and in other jurisdictions as well, I understand, and we would like to see that in Ontario.

We also know that victims and survivors are—that is a barrier to seeking safety, that they are financially constrained, and that the power dynamic need not exist, or we need to do our best to limit that.

Ms. Peggy Sattler: Thank you very much.

The other questions I had were around the SANEs, the sexual assault nurse examiners. Michelle, you had commented or raised the concern about the shortage of these positions across the province. Can you tell us a little bit more about why that is? Is it because of the need for increased funding for the sexual assault/domestic violence treatment centres? Are there other factors at play? Can you just expand a little bit about the importance of having these positions in our hospitals in Ontario?

Ms. Michelle Bobala: Absolutely. As I've mentioned, the care that we provide takes minimum two hours, four hours, sometimes six hours to do. This is not a role that can be added on to the already very overburdened emergency department care providers or to primary care.

It is a very specialized role that then has ramifications in the criminal justice process as well. Injury documentation, assault history, all of these pieces need to be very carefully, meticulously documented, and that's certainly not something that, currently, especially the emergency departments that are so understaffed and overburdened at the moment, could possibly take on.

There are insufficient programs across the province. In more remote communities, it could be several hundred kilometres before someone can actually access a program, and even in more urban centres, the nurses are often only paid as on-call, as opposed to part-time and full-time roles. So it's very difficult for some of the existing programs to even maintain their staffing levels because a nurse cannot survive on an on-call model that is unpredictable. They may get called once and then another time in two to three months again, and also potentially lose their skills over time, right?

One of the issues too is that we're not really able to even determine how many people are not able to access that service because we can't document that. How do we document when there's not a sexual assault nurse examiner available? When someone went to the emerg to try to

access that care, who is keeping that statistic? We just don't know. So if we could have 24/7 access to sexual assault nurse examiners like we do in some programs, then the level of care will be much better, and survivors will be able to access that care and access to justice in a much better way.

Ms. Peggy Sattler: Okay, thank you.

My final question is around prevention. You talked a lot about the role of nurses in responding to cases of IPV or sexual assault. What role can nurses play in prevention of IPV in Ontario?

The Chair (Mr. Lorne Coe): Excuse me. That concludes the time for the official opposition, but we have another round so you might wish to put that question in the second round.

Now, we go to the government members, and I have MPP McGregor, please, when you're ready.

Mr. Graham McGregor: Thank you, Chair, and through you, thank you to our friends from the ONA for being here, and not only being here but the work you do on behalf of your members—just MPP Sattler's question.

Ms. Michelle Bobala: Sure. I think one of the issues is that screening is not happening to the level it could be because of a lack of comfort and experience—it's a very sensitive issue to talk about—and a lack of time. Nurses and health care providers need to be building trust in order to elicit those disclosures, and they don't typically happen on a first inquiry, especially if a relationship of trust or a rapport hasn't been built yet.

In the current state, with nurses just being so overburdened, not enough staffing in the hospitals, there's just no time to really do that, and that relationship can't be built in such a short amount of time when nurses have so many other clients to be taking care of.

The other important piece is, what are we doing with that information when we receive it? If we don't have the available services to refer folks to that we can screen and we can try to prevent and we can try to action in advance, but if we don't have anywhere to direct the client to, it borders on dangerous because if we do send them off to a shelter or to some counselling supports or mental health services and they get denied because there's no space or because there just isn't a centre in that region or there is an eight-month to 12-month wait-list for counselling, that will really shut down a survivor and will really make it unlikely for them to be able to seek help when they're really ready, when they're coming forward.

I fully support further screening and trying to prevent violence and get ahead of it before it becomes very severe for survivors. But we simply can't be screening and then not having the services to support clients.

1350

Mr. Graham McGregor: That's a topic we've heard about. I think we're on day 8 of our study here, and something we hear time and time again is the survivors that I guess we're kind of losing. Imagine the courage it takes to put your hand up once and to ask for help, but then when you have to get mental health services here and you need family counselling here and you need addictions work over there, and support to flee a dangerous situation is, "Go line up at that desk down the street"—the amount of people that we're losing: I think we're hearing that time and time again.

I represent north Brampton. In Brampton, we have the Safe Centre of Peel, where survivors can access support. There are mental health services, family services, the Peel police unit—it's all in that same building. We've heard of that as a model to replicate, certainly in urban areas. We've heard that's different in the rural context.

But from the ONA's perspective, are hub models a helpful thing that we should be rolling out more? Where do you think that's helpful? How can government take leadership and ownership to actually create these hub models across different communities? Given the fact that Safe Centre for Peel happened generally because agencies got together and did it themselves—it was a very bottom-up approach, not a top-down approach. Your advice on how government would do that and mandate that top-down if that's a direction that we're going to go in?

Ms. Erin Ariss: I think from ONA's perspective, provincially, we've supported localized community health care, so a hub philosophy is something that we could support—staffed by the appropriate staff, of course: registered nurses and experts in this field. To have it in one centre is excellent, in one urban centre. But when we look—and Michelle spoke about this earlier—at rural areas, geographically that will be difficult. But it's not impossible, and certainly all Ontarians deserve the same level of care. So it is a mountain to climb, but I'm certain that together we could make sure that all Ontarians receive the care they need.

Mr. Graham McGregor: It's one of the challenges in this space from a governing perspective: the need to respect regional context, but then how do you ensure stability of service in different regions that have different needs and even just different capacities from an HHR perspective and that kind of thing?

I wanted to ask: You talked about the need for more nurse examiners. Do you have a sense, or does ONA have a sense, of how short we are on nurse examiners? How can we recruit them more?

And then a follow-up, which I can remind you of, because I know I've asked big questions: Another one would just be, what province is doing it well? Who's doing it well and who should we copy? But how big is the shortfall and how can we make it better? What can we do to increase recruitment?

Ms. Erin Ariss: There are vacancies across the province, but Michelle can go ahead, as she works in this role.

Mr. Graham McGregor: Beautiful. Thanks.

Ms. Michelle Bobala: I believe you will speak to some other experts on this, such as the director of the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres. I'm sure she will have some very good ideas about this.

I think the expansion of programs is a starting point, because there are only 37 in all of Ontario and Ontario is a vast, vast province. The other issue is the funding. There

has just not been funding appropriately allocated. For example, in Toronto, we do have a model where we have full-time and part-time staff, but for a region of over five million people, we have the equivalent of 5.2 FTE, so the equivalent of 5.2 full-time staff for an enormous number of people.

Other programs don't have that model. They don't have full-time nurses there. They're on call, and they cannot always staff those shifts, so there are days where even in one of these 37 programs which could be expanded, they don't have a nurse available. So I think funding is a big piece of it, and then making those roles actual roles that someone can take as opposed to just having to do it in addition to other work, because then it can't be prioritized.

Mr. Graham McGregor: Of other jurisdictions—Canadian provinces or maybe even states, I guess, if we're looking south—who is doing this well? Who should Ontario replicate?

Ms. Michelle Bobala: I think Ontario is doing it well. The network is doing a great job with the resources that they have. I'm not an expert on other regions, but I know where we're short, where even within a context of having five nurses, it's been very difficult to provide care adequately to patients when they need it. We had a sick call last night, and we had nobody on, so it was just the good nature of other nurses that were willing to take an on-call—

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

We're now going to go back to the official opposition for MPP Wong-Tam, when you're ready.

MPP Kristyn Wong-Tam: Thank you to the ONA reps for being here today. I was trying to remember the Toronto Public Health nurse that we had lost in 2015, largely due to domestic violence—homicide. Her name was Zahra Abdille. But when I looked up "nurse" and "IPV" and "nurse" and "domestic violence," there were four other names that came up just in recent history: Lori Dupont being another one, Shannan Hickey and Susan Chen. So your association has lost a number of members, and these are the ones who have fallen permanently, not including members—because it is a woman-dominated sector—who have been harmed and injured but not necessarily reported and not killed. I recognize that this issue is very deeply personal for, I think, many of the nurses that I've spoken to. But I also just want to say thank you for coming to the committee to speak to us today.

I want to unpack the ONA membership in clinical settings because we have, aside from the fact that there are not adequate rape kits—that's one thing; aside from the fact that there are not enough forensic nurse examiners—clearly, that is another deficiency, but when it comes to ONA members in the clinical setting, how do they see themselves as it relates to the issue of IPV? And how can government do a better job of supporting them so that they can do their job of reporting and identifying it and early detection?

Ms. Erin Ariss: We both probably could tackle this one. I worked for 20 years at St. Mary's General Hospital in Kitchener. It is the regional centre. I can tell you, I triaged thousands and thousands of survivors and victims of IPV. That was my job. To do my job better, we need adequate staff. We need adequate time. My job was different than Michelle's in that a patient presents, and I do the initial screening, but there are barriers to that. I can't really go into that publicly and how we resolve those barriers; we get quite creative to protect our patients. But ultimately, we need more time; we need privacy; we need security to do that and the time to build relationships and trust.

Michelle, did you have something—

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

We now need to move to the government. MPP McGregor, sir, when you're ready.

Mr. Graham McGregor: Michelle, if you did want to add to that answer, I want to give you the time.

Ms. Michelle Bobala: In our role as sexual assault nurse examiners, we also do provide education to emergency departments on ways to identify survivors who have not yet disclosed. They're coming in for STI testing; they're coming in for injuries that are suspicious, but they're not disclosing the violence. So this is education that should be provided and should be mandatory across all hospitals in Ontario, not just these regional programs that are doing that with the limited staffing that they have.

Encouraging education, promoting education that's trauma-informed, making sure that we're not re-traumatizing patients, not making them afraid to come forward in the future—because sometimes we subscribe as a society to myths and stereotypes about intimate partner violence and sexual violence that can be very detrimental, and then patients don't seek the care that they need. So education is a very important piece of that.

Mr. Graham McGregor: Is training to see the signs of intimate partner violence part of the nursing curriculum? Or do you graduate and it's—

Ms. Michelle Bobala: It's been several years since I've—

Mr. Graham McGregor: Fair.

Ms. Erin Ariss: I don't know currently. What I can say to you is it is an advanced skill that a novice nurse—certainly, emergency departments are often the first point of contact. The triage nurse has been, or should have been, employed full-time in an emergency department for two years prior to taking on that skill. You need advanced assessment skills. You need to be able to build trust quickly with your patient in order to screen and get disclosure.

1400

Mr. Graham McGregor: We heard about a similar thing from the coalition against human trafficking. There are different signs, I guess, for different contexts, and sometimes they involve the other. But training around identifying signs of human trafficking—is that something you think would be helpful and help solve the problem, if that was training that nurses received as well?

Ms. Erin Ariss: Yes. There's inconsistent training right now. It's not happening in every centre across Ontario—

Mr. Graham McGregor: So it's happening regionally and it's not consistent across the board?

Ms. Erin Ariss: That's correct.

The Chair (Mr. Lorne Coe): Thank you very much. That concludes the time that we have for your presentation. Thank you so much for being with us this afternoon.

WATERLOO REGIONAL POLICE SERVICE
WOMEN'S CRISIS SERVICES OF WATERLOO REGION

The Chair (Mr. Lorne Coe): Members, our next presentation is going to be by Zoom, and it is the Waterloo Regional Police Service.

Good afternoon and welcome to the Standing Committee on Justice Policy. We're pleased that you're here to make your presentation. If you would, please state your names for the record, which is Hansard, and then you can begin your presentation, which is 10 minutes long. I will let you know when you have one minute left in your presentation.

Your names, please, and affiliation for the record. Thank you.

Ms. Amy Hachborn: Good afternoon. I'm Amy Hachborn, staff sergeant of the intimate-partner-violence unit of the Waterloo Regional Police Service.

Ms. Jennifer Hutton: Good afternoon. I'm Jennifer Hutton, and I'm the CEO of Women's Crisis Services of Waterloo Region.

The Chair (Mr. Lorne Coe): Thank you. You can begin your presentation—which, again, is 10 minutes—and I'll let you know when you have one minute remaining.

Ms. Jennifer Hutton: We are also both partner members of the Family Violence Project of Waterloo Region. Thank you so much for the opportunity to share with you today about our early intervention program.

I'm sure you've been hearing from many witnesses that intimate partner violence is escalating. This is resulting in more complex trauma for survivors. Within our shelters and outreach services, we are seeing greater mental health and addiction struggles. This creates an increasing challenge for our staff who are providing support. Those living in our shelters are staying with us much longer than ever before due to the affordable housing crisis.

As dire as this situation is, of course, our ultimate worry is the increasing rate of femicide and the shocking number of women who continue to be killed by an intimate partner or a family member. The term "femicide" refers to all killings of women, gender-diverse individuals and girls due to gender-related motivations.

Ms. Amy Hachborn: Locally, the region of Waterloo has had 10 homicides related to intimate partner violence over the past 10 years.

Udo Haan and his wife, Edra, were in the process of dissolving their marriage in August of 2018. As is common with many couples who are separating, they continued to live together in their marital home on Sprucedale Crescent in Kitchener. Udo murdered Edra by strangling her. He then proceeded to open a drop line, which caused a buildup of natural gas, leading to an explosion that destroyed their home and severely damaged others on their street. As you can imagine, the impact felt from this incident extends well beyond the victim and her family.

This is one local example of a case that has made its way through the court system. However, we have weekly reminders, with femicides occurring across Ontario at a rate of approximately five per month.

The Waterloo Regional Police Service responds to over 6,000 calls for intimate partner violence each year, with IPV consistently being in the top 10 calls for service.

The intimate partner violence unit is a reactive branch of the Waterloo Regional Police Service. The branch receives investigations from patrol that are turned over once the definition of "intimate relationship" has been met and reasonable grounds for an offence have been established.

Charges in relation to IPV incidents in Ontario are mandatory once police form grounds to believe a criminal offence has been committed. The number of IPV service calls has stayed stable year over year; however, we are hearing from our community partners that they are seeing more intense levels of violence, as well as increasingly complex needs by those they serve. It was imperative for us that we move from a reactive downstream approach to also include a more preventative upstream approach. This is why we created the early intervention program.

Ms. Jennifer Hutton: To prevent criminal offences from happening, Women's Crisis Services and Waterloo Regional Police proposed to work collaboratively and intervene prior to criminal charges being laid, with the ultimate goal of safer and happy families.

During the pilot phase, a plainclothes detective was paired with an outreach worker for Women's Crisis Services. Through this joint intervention, education is provided on the legal framework surrounding intimate partner violence and community referrals are offered, as well as risk assessment, safety planning and ongoing outreach support. When the pilot launched in June 2022, the criteria for referral was having three intimate partner disputes resulting in calls to police that occurred in the preceding three months.

In January 2023, the involved parties determined that we had additional capacity to reach out to even more couples, and we adjusted the criteria to having two intimate partner disputes occurring in the preceding two months. The interventions were completed on a weekly basis with the first method of contact being outreach by telephone. If the telephone call was unsuccessful, then the outreach worker and the detective attended the residence of the couple in person to offer their support. The timeliness in being able to respond quickly and the accessibility of bringing this program into the community helped with its success.

As the program got under way, a gap was identified around the lack of quick-response, one-on-one support for men who were using abusive behaviour, yet were motiv-

ated to address and change this behaviour. At Women's Crisis Services, we worked to help fill this gap through establishing the Engaging Men Program. Now, over 40 men have voluntarily engaged with this support, receiving timely, one-on-one counselling by a male-identified therapist who has specific training and understanding in the nuance of intimate partner violence. Most recently, due to the demand for services, we have started a small wait-list.

I want to quickly share the story of Tim, who accessed our Engaging Men services following support from the early intervention program. Tim had nine sessions. All sessions were free, and following these sessions, Tim reported an improved mood and ability to better navigate his emotions and conversations at home. He stated that he can feel his emotions, but yet not lose control of those emotions. The benefit of being able to offer supports to both members of the couple ensures good communication and updates between our staff on how both parties are doing.

Ms. Amy Hachborn: The success of the early intervention program is largely due in part to the close relationships between Waterloo Regional Police and Women's Crisis, which we share as members of the family violence project. The FVP currently receives no outside funding, paying their coordinator position through existing partner budgets.

When partners of the FVP engage with couples experiencing intimate partner violence, they can ensure the right connections are made with programs and agencies. With the FVP's walk-the-hall model, partner agencies can accomplish in-person hand-offs to other agencies without sending victims to different locations across the region. This model has also seen success in other regions, including the Safe Centre of Peel.

Of course, success is often gauged by statistics, and in our written submission, we shared some very positive findings from the 2023 calendar year in relation to our early intervention program. Over 430 connections were made with couples who had police respond to two or more IPV calls for service. Information was collected which indicated that couples receiving an intervention were in fact calling police less or having others call police with IPV concerns about them fewer times. In the first two months following the intervention, couples that participated in the program had 87.6% less calls to police in the same period prior to the intervention. Six months following intervention, 71.3% were still having less calls to police.

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The statistics show that the positive effects of the early intervention program are stable and the individuals are making significantly fewer intimate partner violence calls to police in the six months after the intervention compared to the six months before the intervention. The quantitative statistics strongly indicate the positive impact of the program, however we have also received equally encouraging qualitative comments, such as, "I can't believe you are doing this," "This is fantastic," "The call was 100% helpful"—

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

Ms. Amy Hachborn: —and they were grateful for the help.

Ms. Jennifer Hutton: This program can be easily scaled and replicated in other municipalities across the province. Of course, there is a cost to running this, and for program growth and sustainability, additional funding is required.

In terms of the cost, the program that we consider includes the salaries of a detective constable, one and a half outreach workers, the family violence project coordinator and the four part-time Engaging Men therapists for a cost of about $365,000 annually. Of course, these costs may vary from one jurisdiction to another. Like any prevention and early intervention program, there is a need for upfront investment, yet the downstream cost savings far exceed the cost of running the program.

One thing that we know for sure is that intimate partner violence without intervention will escalate, and the cost of not intervening—

The Chair (Mr. Lorne Coe): Thank you very much. Your presentation has concluded.

We're now going to move to questions, starting with the members of the official opposition, please. MPP Wong-Tam.

MPP Kristyn Wong-Tam: To our speaker: If I can just invite you to finish your thought.

Ms. Jennifer Hutton: Yes, thank you. I was just going to say that, of course, there is an initial investment, but the cost savings is huge. We would see this potentially in decreased costs on health care, emergency personnel response, shelter stay—any number of ways, and of course ultimately potentially saving lives.

MPP Kristyn Wong-Tam: Thank you very much, Ms. Hutton. I'm just curious to know, with respect to the funding to stitch the two organizations together—one is the Waterloo police and one the Women's Crisis Services—what funding is available to ensure that you folks have the opportunity to collaborate and to build capacity together?

Ms. Jennifer Hutton: A lot of that is done through the family violence project. Right now, that is not funded, so each organization provides a portion of that funding to ensure that we have a coordinator.

MPP Kristyn Wong-Tam: Thank you. And you folks are doing something quite unique. I don't think we see this level of intimate collaboration between the GBV sector and police in all areas and municipalities. Can I ask for the data that you're collecting to show that the results are there? Obviously, you're building a business case so therefore you can receive, I'm assuming, some funding in the future, some sustainable funding so you can build up your capacity. What process are you going through, or the undertaking of that process to provide the business case? And where is that business case and proposal going?

Ms. Jennifer Hutton: Well, we have drafted a business case. Of course, it's helpful to have the resources of the police service because they have access to all sorts of data.

They have the staff to be able to analyze and make sense of that data, so that's been really helpful.

MPP Kristyn Wong-Tam: I know that MPP Catherine Fife, one of our members of the NDP caucus, is a big fan of the work that you are doing, as well as the Waterloo regional police. She has cited the fact that this is a very innovative, collaborative process that needs to be scaled up and exported.

But without the Waterloo police stepping in to say, "We want to partner with you," would your organization have been able to initiate this on your own, if there was no policing partner, with the vast resources that police units and associations and forces come with?

Ms. Jennifer Hutton: I think it would be a big challenge for us. Even the portions of the programs like the Engaging Men—we fund that through fundraising dollars, essentially.

MPP Kristyn Wong-Tam: Recognizing that the police cannot do all this work on their own—they do need you at the table—but if you were not able to meet your fundraising goals, does that mean that the program just falls apart—meaning the early prevention, early detection program?

Ms. Jennifer Hutton: It absolutely could. We try to prioritize prevention and early intervention as much as we can; however, that can be quite dependent on fundraising to do that work.

MPP Kristyn Wong-Tam: When the city of Kitchener declared intimate partner violence an epidemic, I believe the region of Waterloo, shortly afterwards, followed suit. Is that correct, that both the city and region have declared IPV an epidemic?

Ms. Jennifer Hutton: Yes. We've had all three cities, the region and one of our rural municipalities also make the declaration, and we delegated as a family violence project—so Amy and I delegated together, as well as other partner members.

MPP Kristyn Wong-Tam: So that means that the Waterloo Regional Police Service was supportive of the declaration of IPV as an epidemic. That's correct? I see you nodding.

Ms. Jennifer Hutton: Yes, we were.

MPP Kristyn Wong-Tam: Thank you.

If I can come back to the proposal request that's before us now, you were citing that $360,000 could probably get a more full-time project off the ground. I'm assuming it means that everyone is resourced; you've got the crisis intervention workers, you've got the—I think you said—constable that is on the payroll. Who else would be a part of that team? I didn't catch all that you said.

Ms. Jennifer Hutton: We had said one and a half outreach workers because they continue the ongoing support after that initial intervention. Right now, we have four part-time male-identified therapists to do the Engaging Men program and we have the family violence project coordinator. Now, those are salary costs. That doesn't include things like rent or other kinds of resources. That's sort of the basic program that we have in place now.

MPP Kristyn Wong-Tam: Where would you anticipate a program like that being housed? Would it be within the Women's Crisis Services or is it within the police unit? Where would the physical location of these staff be?

Ms. Jennifer Hutton: Do you want to speak to that?

Ms. Amy Hachborn: Currently, we are in the family violence project, which is inside Camino Wellbeing and Mental Health. So the FVP has many members that all work collaboratively together. The great thing about it is that Women's Crisis is right down the hall from our intimate partner violence unit, and so when we're coming together to do early intervention work, they just come down to our office and that's where we make the phone calls.

MPP Kristyn Wong-Tam: Thank you.

You do not receive any core funding as the police to do this work. This is work that you're doing off the side of your desk on top of everything else you're doing. Is that correct?

Ms. Amy Hachborn: The project began as a pilot project, and after the success of the pilot, and then what we were seeing from the numbers, the service dedicated a member to do this work on a full-time basis.

MPP Kristyn Wong-Tam: And the pilot project began in 2022?

Ms. Amy Hachborn: It began in June 2022. It was extended on one occasion, and it officially ended in October 2023. Since then, we've continued the early intervention work.

MPP Kristyn Wong-Tam: Without any core and sustained funding?

Ms. Amy Hachborn: That's correct.

MPP Kristyn Wong-Tam: Okay.

I know that I'm going to run out of time soon.

The Chair (Mr. Lorne Coe): You have 17 seconds.

1420

MPP Kristyn Wong-Tam: I just want to say thank you to the both of you for bringing your deputation to us and also for your excellent written submission.

The Chair (Mr. Lorne Coe): Moving now to the government for questions, I have MPP Dixon, when you're ready.

Ms. Jess Dixon: For the main thrust of my questions, I'm less interested in, "Does the program work?"—because I accept that part. I'm more interested in the implementation. I know we've talked about this a little bit, and it might be me pushing you for more homework again.

I see that there are two spokes to what you're talking about here. One of them is the early intervention program itself as it works with Waterloo regional police and Women's Crisis, and then the other one is how that program itself is situated within the family violence project program, which is in some ways a hub model, like we've been hearing.

Admittedly, in the course of this committee, we've been hearing a lot of concerns about the grant process, and I'm about to talk about the idea of a grant. But you've seen from the Solicitor General, for example, grant programs for bail compliance officers that services could apply for. What I'm wondering is, with this program, is it conceiv-

able that you would be able to put together a plan of, how could other services and other agencies apply for funding to replicate this?

I guess there are multiple parts to that, which are, one, would you be able to draft that as a plan—because I wouldn't really want to offer it as a grant for a build-your-own. I'd like to skip that part. And then another would be, what would various communities need to already have in order to be able to be part of that plan? Because obviously, Women's Crisis was a huge part of that. Would you then be able to—with the costs that you're aware of, we could make a really vague estimate on what it would cost, based off perhaps population or service size from other communities. If you could talk a little bit more about what you think the practical aspects of implementing it—if we were to say, "Okay, we want to champion this," what do we do?

Ms. Amy Hachborn: I would say one of the things that really benefits us working together is that we have an MOU with Women's Crisis. So with that consent in place, we're able to share information a little more freely, so that's a benefit to our relationship. But is it more practical to get this work done when we're both in the same building? It is. But could it be done in smaller areas that don't have this sort of hub model where they're together in the same building? I think the relationship, once it was built, could still exist if people were in different areas.

As far as putting something together for others to work off of for a grant proposal, I'll ask Jen to weigh in on that, as she's got more experience with grants than I do.

Ms. Jennifer Hutton: MPP Dixon, I think we have the model in place. We've talked about things that make it work, even process stuff around the early intervention officer calling a couple. What do they say? How can we draft a script in terms of our learnings? So I think that we have enough information that we could almost essentially create a tool kit that people could use to start a program, to scale it and adjust it depending on their own jurisdiction. So I think we have a lot of learnings, and I think it's just a matter of putting it down on paper a bit more. But there's a pretty specific, clear process that we go through, so I think it's just getting it down on paper a bit more.

Ms. Jess Dixon: I've said I feel like I have a reputation that I never talk to anybody without giving them homework, but I was actually just reading through the Renfrew transcript over lunch; Dr. Peter Jaffe, who we've had, literally mentions this program in his testimony at the inquest, and then goes on to say—he makes it clear it's previous leadership, but that he had gone to police in London and tried to get the chief there to implement the program and had been told, "It's too much work. It's too expensive"—that type of thing. I guess, really, what I would be asking from you is, what would you need to put together that kind of tool kit? Because otherwise, we're just in another position of saying, "Hey, you could look at this program," and this committee isn't in a position to create its own tool kit. We're really looking for what other people are doing and trying to advance that.

What would you need to put together that kind of tool kit to make us better advocates?

Ms. Jennifer Hutton: I think the model is there, and it's not surprising that Dr. Jaffe talked about that. Many years ago, I heard about the Changing Ways model out of London. That's what inspired a lot of this. That was sort of the original model, and we have taken and adjusted. I think it's there. I think it's just a matter of time around getting it down on paper, but I even think that's reasonable in terms of already—we have a pretty clear formula in place for what we're doing and would expect that the success that we've had from this would be replicable in other areas.

Ms. Jess Dixon: All right. Thank you. I've got about a minute left in this one. I will also take this off-line with you guys as well, again, but I would like to request/task you with that, and we can have a conversation about what that would look like.

But we've heard about this, we've had endorsements of this program before you even presented. Really, the word I keep using in this committee and when I talk to people about it is "specificity," is digging down past the "somebody ought to" and into the "well, what is it that we ought to do and how and where and why and how much?"

I've got a few more minutes in our next one, but I will leave it there for now, until my next two and a half minutes, and apologies for the homework assignment, as always.

The Chair (Mr. Lorne Coe): We're now over to the official opposition. MPP Sattler, please.

Ms. Peggy Sattler: Thank you to our presenters for joining the committee today and sharing the innovation and success that you're having in Waterloo region.

We've heard from other deputations about programs that work with low-risk perpetrators, that work with men to change behaviours—because, as you point out, there are men who are motivated, who want to get access to those counselling services. But we have also heard a concern raised about PAR and it being a one-size-fits-all sort of model. We had a delegation from Nova Scotia that talked about the program they used there to engage with men, called the safety and repair approach, that provides individualized support for both the perpetrator and the survivor.

I'm interested in your views on whether PAR provides the opportunity to develop a provincial approach to working with low-risk men, like the Engaging Men program, that could be funded, that could be accessed on a voluntary basis. Can we start with PAR, or do we need to look at something different in Ontario to work with low-risk men?

Ms. Jennifer Hutton: When we started to develop our Engaging Men program, we had talked to PAR facilitators, and a lot of the male therapists that we have working for us part-time are or have been PAR facilitators. A lot of the feedback that we received is, well, typically, men are attending PAR because they're mandated to do so, so that's an element to consider.

The other piece is that what they had seen from their experience is that men attend those sessions, and then, as they get towards the end of those sessions, they start to have a light-bulb moment where they need more. We work

with one local organization that provides PAR services, that when they identify individuals that need something more, they're also referring to our Engaging Men program to do some of that follow-up one-on-one support.

1430

The Chair (Mr. Lorne Coe): Excuse me. Thank you very much for your response. We're now moving back to the government members for a question. MPP Dixon, please.

Ms. Jess Dixon: We have two and a half minutes. What I'm going to ask you to speak about is the—take us through a little bit of how the family violence project happened and what it looks like to be a member of it or even a survivor participating in it as versus, I guess, what used to be there before or what might be in other jurisdictions that don't have the benefit of such a project.

Ms. Amy Hachborn: So the project began in 2006, and it started as a hallway conversation between the sexual assault domestic violence treatment centre lead at the time, there was a member of the police service, and I can't remember who the third person was. But the project is based off of a San Diego model of their family justice centres. The family justice centres are across the United States, Mexico, and there are a few in Canada. Basically, it's bringing in all kinds of different agencies to work together to provide victims seamless resources so that they're not going from place to place or having to make their own calls. One of the great things about it is if we have a victim in, coming to provide us a statement, we do safety planning, but there's so much more that Women's Crisis can offer. So if it's during their working hours, we can just walk our victim down the hall, make a face-to-face introduction and pass them off, and the same thing goes with the sexual assault domestic violence treatment centre. We also have family and children's services, child witness, victim witness, the crown's office, so there are so many different members who are all in the orbit once charges are laid, and we can connect and make sure that the victim feels completely supported.

The family violence project also offers support to people who maybe aren't involved in the court system but are coming in to get advice or just support and the police are not involved. So sometimes they involve a lot of agencies; sometimes they only involve a few agencies. The police are not always necessarily part of the conversations. But we all work together to make sure that nothing is being missed and we don't have any gaps.

Ms. Jess Dixon: Thank you so much. We're just about out of time, so thank you both. I'll be talking to you shortly.

The Chair (Mr. Lorne Coe): Thank you very much, MPP Dixon, and thank you very much for joining the Standing Committee on Justice Policy this afternoon. That concludes the time of your presentation.

Ms. Amy Hachborn: Thank you.

LAW COMMISSION OF ONTARIO

The Chair (Mr. Lorne Coe): I will now call on the Law Commission of Ontario to attend the table, please. Thank you very much. And thank you for taking that seat; I can see you above all the cameras.

You will have 10 minutes for your presentation, and I'll give you a one-minute caution to wrap up when you're approaching the end of your presentation. Please state your name for Hansard, the recording service of Ontario, and you may begin your presentation. Thank you.

Ms. Laura Snowdon: Hi, everyone. I'm Laura Snowdon. I am counsel at the Law Commission of Ontario. I want to start by thanking the members of the committee for having me here today but also for all of the time and attention that you've devoted into this study of intimate partner violence.

I'm here today on behalf of the Law Commission of Ontario, which is Ontario's leading law reform agency. We evaluate laws impartially and transparently in consultation with the public, and we produce evidence-based recommendations for law reform.

I'm going to talk to you about a project that I'm leading at the Law Commission of Ontario which is on protection orders. We are looking at why protection orders are not effectively preventing intimate partner and family violence in Ontario, and I'll start by telling you what I mean when I say "protection orders," because it does have a very broad definition, at least according to the Law Commission of Ontario. Protection orders are legal interventions that are commonly used in cases of intimate partner and family violence because they are designed to reduce the risk of future violence by one person who has been found to pose a threat to another. They try to achieve this goal by imposing conditions on the person causing harm, and the most common conditions that we see in protection orders are sometimes referred to as no-contact conditions, which are communication restrictions, or no-go conditions, which are location restrictions.

When protection orders are accessible and effective, they have the potential to deter violence, to encourage safety planning and to allow for increased monitoring and quick intervention.

Now, there are over 20 different types of protection orders that are available in Ontario, and they are in all different areas of the law, so that covers family law, child protection law, criminal law, Indigenous law and Aboriginal law. They include restraining orders, parenting and contact orders, orders for the exclusive possession of the matrimonial home, peace bonds, bail conditions and sentencing orders.

These different types of protection orders have different definitions of who can apply for protection, different processes for how to apply for protection or how protection is imposed in the criminal context, different evidentiary tests, different sets of conditions that can be included in the orders, different durations, different standards to change the orders and different enforcement mechanisms, and they are also granted by different courts.

If that is not complicated enough, there are also significant differences in terms of the protection orders that are available in Ontario versus in other Canadian jurisdictions. The most important difference that I want to talk to you about today is the fact that almost every other province or territory across Canada outside Ontario has stand-alone civil protection order legislation.

Civil protection orders outside Ontario can usually be obtained on an emergency basis, and in some jurisdictions, they're actually available 24/7. This prioritizes safety and enhances protection at a time when violence is known to escalate, both because the risk factor of an actual or pending separation may be at play but also because we know that there is a risk of retaliatory violence when people initiate legal proceedings for protection.

This brings me to our first recommendation, which is that Ontario does not have emergency access to protection orders, and we need it. In our province, it can take people months to years to obtain protection orders for intimate partner violence.

There are also a number of other access barriers to protection orders that we need to be thinking about. Because of the complicated legal architecture that governs protection orders in Ontario that I described, it's not always clear to survivors what legal protections are available to them, under which type of law they can or should seek a protection order or even which court they should apply to. This is especially concerning because a high rate of survivors are forced to interact with our legal system unrepresented, and that's an impossible burden to place on people trying to get protection. So we urge the government to properly fund Legal Aid Ontario and other supports and services that can be used to assist people at all stages of protection order legal processes.

We should also copy other Canadian jurisdictions by allowing designated representatives—by which I mean law enforcement officers, child protection authorities and intimate partner and family violence service providers—to apply for protection orders on behalf of and with the consent of people in need of protection.

So, let's say we have emergency access, we have stronger legal aid and we have designated representatives. We're still seeing a lot of problems when people get into the courts. The Law Commission of Ontario has been reviewing reported Ontario family law decisions from 2019 to 2023, and our review reveals that many women who seek restraining orders are simply not believed. In some cases, judges have declined to grant restraining orders despite clear evidence of intimate partner violence. In others, judges have found that the evidence presented is incomplete despite women's testimony about the violence underlying their fear.

Our third recommendation is therefore about training and education for judges and police to better understand the dynamics of intimate partner violence, to avoid reasoning based on myths and stereotypes and to accurately assess reasonable fear. We know that risk assessment tools, which I know that this committee has heard about, can be a helpful supplement to decision-making in this regard, but we caution that low risk assessment scores should not be considered determinative for the purposes of protection orders.

Judges and police also need to better understand the purposes, limitations and intersections of the various types of protection orders that I described. I want to pause to emphasize that piece about limitations. There is no legal tool or remedy that will ever entirely prevent intimate partner violence. The Mass Casualty Commission called for a whole-of-society approach. Improving protection orders is one puzzle piece of a much bigger picture.

The note about limitations also brings me to my fourth recommendation, which is that protection order decision-makers in Ontario should be encouraged to make use of the statutory authority that is afforded to them already in Ontario's Family Law Act; the Children's Law Reform Act; and the Child, Youth and Family Services Act that allows courts to craft broad and creative conditions tailored to the unique safety needs of the person they are trying to protect.

We included some examples in our written brief of stronger conditions for protection orders. Some of those include:

—extending protections to children and other family members;

—weapons prohibitions;

—conditions to prevent financial control and abuse;

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—conditions to prevent tech-facilitated violence, which we also saw a lot of in our review of the cases;

—conditions to protect pets and livestock, which is a particular concern in rural communities;

—conditions to encourage accountability and support compliance;

—to prevent interference in immigration processes is also a very important condition; and

—conditions to prohibit the destruction of, or denial of access to, specific mobility equipment for people with disabilities or, for people with hearing difficulties, amplification equipment that they use for their phones. These are only some examples that we've considered.

But when we talk about these conditions, it's also important to talk about non-compliance with protection order conditions. We've learned in our consultations that people affected by protection orders do not always understand what to do or what not to do when protection orders are granted. For example, we've heard that people protected by protection orders sometimes do not know how to report a breach of that order to law enforcement or even that they can report a breach to law enforcement. For these reasons, we recommend that protection orders be written in plain language and clearly explained to all parties.

Another major concern that I want to touch on is police failures to enforce protection orders. We know about cases where the police simply refused to enforce the protection order. We've also learned that the police cannot always find the details of the protection order in their databases, and they may therefore refuse to intervene.

We recommend that Ontario follow the approach of British Columbia and create a confidential protection order database. That database should provide on-demand, up-to-date access to protection orders issued across the province for courts, law enforcement and gender-based violence service providers.

Also, on the topic of enforcement, we recommend that Ontario amend the Family Law Act, the Children's Law Reform Act and the Child, Youth and Family Services Act to include legislative provisions expressly allowing for interjurisdictional enforcement of protection orders. That means that if someone gets a protection order in Alberta, and they come to Ontario, we would have a legislative provision that expressly says that that order is enforceable and a process in place to let them register and have that order be recognized and enforced to continue their protection from IPV.

To increase the effectiveness of protection orders even further, we want to see Ontario strengthen social infrastructure and invest in—

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

Ms. Laura Snowdon: Thank you—strengthen social infrastructure and invest in wraparound services, in part to help people who have used violence against their partners to abide by protection orders. These services include offering people opportunities to learn, to change and to develop new skills, and they have the potential to improve compliance with protection orders by ensuring that people are not left alone to navigate complex issues like addictions, unstable housing, unemployment and entrenched patterns of violence.

Our final recommendation is that government agencies improve data collection on intimate partner violence and the legal remedies like protection orders that are used to respond to it and engage in ongoing evaluation of legal processes, because this is the foundation for research like ours and the recommendations that we're able to put forward before you today.

I will close by thanking everyone for the opportunity to be here. I'm happy to answer any questions.

The Chair (Mr. Lorne Coe): Thank you very much. You had five seconds left—well done.

To the official opposition members—MPP Sattler, when you're ready.

Ms. Peggy Sattler: Thank you so much, Ms. Snowdon, for appearing before this committee and providing such detailed, clear steps for the committee to take to address this problem. I also really appreciate your contextualizing your recommendations as one piece of a much bigger, systemic process that we need to put in place in Ontario to really address the epidemic of intimate partner violence.

Your written submission is terrific, by the way. But I want to thank you for including, in particular, recommendation 2(a) and also recommendation 8. So 2(a) talks about investing in legal aid and other supports and services to assist people in protection order legal processes. Your written submission references the Family Court Support Worker Program, which is something we've heard about at this committee—the value of that program in helping women navigate the court system. I think you said that often women have to represent themselves; they are not believed, and this creates all these barriers to accessing the protection orders, which often are not effective when they are accessed. But I would be interested in your thoughts on the Family Court Support Worker Program because we did hear about that program before, and it is referenced in your written brief.

Ms. Laura Snowdon: It's an excellent program. It's not well-known enough. I'm part of a listserv for legal advocates against sexual violence, and there were recent questions about how to support people in Family Court, because a lot of the lawyers in the listserv work in criminal court, and there's just a general lack of awareness, and that's in the law.

We also consulted with someone who works within the court system, and she told us she could offer her son $100 and ask him to try to find the Family Court Support Worker Program on the website and that he would have a hard time finding that resource. So I think people are struggling to find that that exists, but when they can access it, it is a huge support.

So 2(a) and 2(b) go together because if we do extend the ability to designated representatives to ask them to take further steps to help people with protection orders, we need to continue investing in important and effective services, like the Family Court Support Worker Program, if we want them to take on more of the burden to help people with protection order processes.

Ms. Peggy Sattler: Yes, and that's why your recommendation 8 is also very helpful to ensure that there is that investment in the social infrastructure that people need.

I wanted to ask a question about the tailored protection orders. You've recommended that conditions granted are responsive to individuals' safety needs, but there has been a reluctance within the system to impose tailored protection orders. Can this currently be done, but there has been a reluctance to do so? And if that is the case, why has there been this reluctance to impose tailored protection orders when it seems to be a way to improve the safety of the person who's seeking the order?

Ms. Laura Snowdon: Those are excellent questions. The answer to the first part is yes; this is possible right now. In most protection orders, there are already legislative provisions that are kind of—you could think of them as a catch-all provision. So in family law restraining orders, for example, there's specific statutory authority to order no-contact and no-go conditions, and then there's also a catch-all provision that says "any other condition that the court thinks is appropriate in the circumstances"—similar catch-all condition/provisions in peace bond legislation, section 810 of the Criminal Code, the Child, Youth and Family Services Act and the restraining orders in the Children's Law Reform Act. So it is possible to do it.

I think we've seen a hesitancy in the decision-making. I think that judges are comfortable, when they have statutory authority, to order those conditions. So I think that's

part of the explanation for why we see those no-go and no-contact conditions so clearly, because that is specified in the legislation, and that's what led us to that recommendation that said, "Maybe it would be a good idea to spell out more examples of conditions that we want judges to turn their minds to in the legislation"—so to give explicit statutory authority.

It's also a recommendation—I think it is in our written brief: Professor Linda Neilson in Moncton, New Brunswick, has a recommendation about how family law statutes should have explicit statutory authority for judges to grant weapons prohibitions in protection orders that are granted in the family law context. We don't have that explicit statutory authority, but we do have that open-ended provision, so it could be done, and there's space to expand the legislation in that regard.

Ms. Peggy Sattler: One of the presentations that we heard this morning—Jennifer Kagan; I'm sure you're familiar with her case—was around the importance of education and training for everyone involved in the family law system, from judges to lawyers to custody assessors to CAS workers etc. The concerns that you've highlighted about the ineffectiveness, currently, of the protection orders in Ontario—is there a role for education and training to help address these concerns, in addition to some of the specific changes that you've recommended here?

Ms. Laura Snowdon: Yes, there's a huge role for education and training. The Supreme Court of Canada recognized in 2022—which is too recently in my books—that children are at risk of direct and indirect intimate partner violence when they are in homes where there is violence present—this is Barendregt and Grebliunas—and they also recognized that intimate partner violence in the home affects parenting issues, and that is something that we see overlooked way too often in protection order decision-making.

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That was a factor in Keira Kagan's case as well, the fact that there was no connection or limited connection drawn between the intimate partner violence that Jennifer Kagan was facing and the effects of that violence on her child, Keira. So there's a very important role for education and training around the nuances and the complexities and the extended harms that are part of intimate partner violence so that we don't miss those opportunities to protect people in need of protection and to accurately assess risk in those situations.

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

We're now going to move over to the government, please. MPP Dixon, when you're ready.

Ms. Jess Dixon: Curious—and this is more so me putting on my hat of, "Okay, if I am championing this, what problems then do I have?" and this is probably a bit outside of your wheelhouse, but I'm curious: When you were talking, for example, about if we're increasing protection orders in general or even the—you were talking about the 24-hour judicial response in—I think it was Nova Scotia and Saskatchewan.

Ms. Laura Snowdon: Alberta.

Ms. Jess Dixon: Alberta. I'm curious—and this may be something that you take back because I know you're not actually finished your work on this—what impact could that have on the fact that we are short judges, we are already overburdened? Will that have an impact, if we were to put it in place?

Ms. Laura Snowdon: Yes. Yes, of course it does. I mean, court delays are already causing problems for people who are trying to get protection orders and some of our recommendations do place more of a burden on the court system.

In other provinces, the way that they've navigated that 24/7 access—it means they have to have on-call judges outside of court hours, so that does put increasing demands. Some jurisdictions have dealt with it in different ways. In some cases, it's magistrates or JPs and there are lower evidentiary thresholds for people who are trying to get emergency protection orders, so that means that it's a bit snappier in terms of the judgment. It's a lower evidentiary standard and simplified procedures and you can get your protection order over the phone with your reasonable fear, and then it gets reviewed by a court at a later stage.

So there are ways that other jurisdictions are trying to respond to the fact that this would be overly cumbersome and add to our court delays if we make it a full hearing within 24 hours, but because it's got lower evidentiary standards and those faster procedures—and it's actually better for people to get access to emergency protection orders anyway.

Ms. Jess Dixon: Yes. I face the same problem with provincial bail reform. The main things you need for that are estreatment hearings and bail review, which require judges in courts in order to reduce the backlog that we currently have.

Is it possible—I'm trying to think how, from a cost perspective, if we were to be taking some of these recommendations—you know, the 24-hour-plus review. Do you have any guidance for us on what we could look at to try to figure out, from judicial resources, court resources—like, how many more people do we need in order to make this work?

Ms. Laura Snowdon: So this is a challenge that we're experiencing too because, of course, we want to collect empirical data to make these evidence-based recommendations, and it's in our last recommendation about increased court data collection.

It's actually very difficult for us to figure out how many people are trying to access protection orders. Anecdotally, we know that it's a lot and we can look at the reported decisions, but for example, our review of reported decisions—a lot of Family Court decisions aren't reported, so we're just getting a tiny snapshot and it's probably biased in terms of what's available on CanLII.

Yes, it's hard to cost. I think more data is one of the best ways to try to parcel that out.

Ms. Jess Dixon: Yes. I didn't realize that it wasn't being reported—not even just the data, but not being pub-

lished—that it wasn't reported decisions to the same extent. I didn't know that.

Ms. Laura Snowdon: The Family Court?

Ms. Jess Dixon: Yes.

Ms. Laura Snowdon: Yes. A lot of decisions are not reported in the Family Court.

Ms. Jess Dixon: Is that a privacy issue or we just aren't doing as many of them?

Ms. Laura Snowdon: I think it's a privacy issue. That's my understanding of it.

Ms. Jess Dixon: Yes. That would make sense. That would make sense.

I'm trying to think of the best question. So are you working at all—like, given that you aren't able to actually access that data, is that consideration something that you're going to be trying to keep in mind as you continue working? Because I know this is an entire independent project that, luckily, timing-wise, coincided with me asking you about this. But that idea of how we would try to determine what the consequence—I don't mean "consequence" in a negative way, but what the consequence of implementing some of these recommendations would be on the justice system: Is that something that you think that you may be able to, even with the dearth of data, give us a little bit more information on even down the road when you finish this?

Ms. Laura Snowdon: I think so, yes. In terms of the ripple effects of things, it's definitely something that we're anticipating, and it's one of the reasons why our data collection approach—which is ongoing, but we have a couple of different prongs to it. We're trying to use those different avenues, like our surveys, for example, and a review of reported decisions; but also we're going to review some court files and try to pull as much data as we can from FRANK and ICON, which are the family and criminal court software databases, and possibly from the police as well. So we're going to approach it from a lot of different avenues, which I hope will get us a better understanding of the evidence that we need to make these changes and what impact that will have and where the biggest impact will be.

Ms. Jess Dixon: Do you end up hitting—I only know about peace bonds, probation and bail. Do you end up hitting other charter issues with this, like constitutional challenges and that type of thing?

Ms. Laura Snowdon: Yes. In terms of court coordination, there are some issues with—it's one of the reasons why it's not a recommendation today, because we're still looking at it and exploring it. There are some privacy issues. There are issues with moving evidence from Family Court to criminal courts, because the standard of proof is different. So you run into constitutional issues in that regard and some issues with disclosure.

And there are important considerations around keeping people safe, but also making sure that all of the courts and tribunals that are working with one family have the pieces of information that they need about the family, because what's happening right now is that different actors in the system have different bits of information. The criminal court knows something and the Family Court knows something else, and they're not communicating. That's where constitutional issues could come up.

Ms. Jess Dixon: We've got a minute left in this block. What are some of the consequences of these? Again, I only know about the criminal-area ones, but what are the consequences for non-compliance or breach—like, ranging?

Ms. Laura Snowdon: They're actually very similar. The family law orders, because they don't have an offence provision in the FLA and CLRA, go to section 127 of the Criminal Code.

Ms. Jess Dixon: Okay. That's amazing. I guess that's what you're saying: I've never actually seen it and that is a problem.

Ms. Laura Snowdon: Yes. It can be similar but, again, it's a little bit different because, of course, 810 peace bonds in the Criminal Code are enforced by 811. So even though there might be similar repercussions, it can be difficult for people, especially if they're unrepresented, to understand what that means. How do you even know that it goes to section 127 of the Criminal Code unless someone tells you, "This is enforced by the police"?

Ms. Jess Dixon: Yes. Yes. Absolutely. Thank you. I'll end it there until our next block.

The Chair (Mr. Lorne Coe): We're back to the members of the official opposition, please. MPP Wong-Tam, when you're ready.

MPP Kristyn Wong-Tam: Thank you, Ms. Snowdon. I'm curious to learn more about the BC model as it relates to the protection orders being centralized and accessible on demand to folks who require it. Do you know the history of how that came about and what it is that we need to do in Ontario to replicate that? Who needs to put that together?

Ms. Laura Snowdon: This is a good question. Unfortunately, I don't know the exact genesis of where it came from, but I do know that it's a relatively recent innovation. I imagine that it stemmed from similar problems that we're seeing in Ontario, because we see those across Canada and, actually, internationally as well, which is that there's a lack of coordination between the courts that are granting protection orders and the police who are meant to enforce them.

I mentioned those cases that we're seeing where, in some cases, the police show up on scene and they try to find the protection order in their database. They can't tell if it's the most recent version. Maybe they can't see the conditions of the order.

There are requirements already in Ontario's court forms that court staff get the protection orders registered onto the Canadian Police Information Centre database, CPIC. There are also re suggestions for court staff to send the protection orders to the appropriate law enforcement. But as I mentioned in our written brief, what we're seeing is sometimes happening is, in Thunder Bay, for example, they'll send it to the local law enforcement, and then if that person moves within the boundaries of Ontario, the protection order may not be accessible by a police service that didn't receive a direct copy of it. We understand that

to be a concern even when the protection order is on CPIC. Something is going wrong with police access that we're going to look more into. But the protection order database is one way of trying to make sure that it's more accessible.

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I should say that I have heard from a colleague in BC that it is not working as effectively in BC as they were hopeful that it would be, so if we implement that recommendation, we need to make sure that—it probably does fall on court staff; we need to make sure that they are supported and have the capacity and the training to do that manual entry of protection orders, because it is so crucial to enforcement.

MPP Kristyn Wong-Tam: Thank you. That's really helpful. And so, if we don't have—I mean at this current time—a centralized database of protection orders, are we working with paper here? Is that what's happening in Ontario? Is that—

The Chair (Mr. Lorne Coe): Excuse me, but that concludes your time.

Over to the government, please, and MPP Dixon.

Ms. Jess Dixon: It's interesting. They'll be presenting later, but I was talking to somebody about the bail dashboard system recently, which—I don't completely understand the technology behind it, but what's interesting is, from a criminal compliance, it can almost geotag. As you have officers on patrol, you can literally see as you're coming up on a location or an address of a person that has conditions, whether it's no contact, no attend, that type of thing.

But what I was told—and I'll have to dig into this a little bit more—is that because of, essentially, the systems that Ontario uses to store its data, it's actually really not that big of a deal to potentially load compliance orders onto that as well, so that as you're travelling, police officers would be seeing that and could screen through it the same way they would with bail and probation. The issue is, right now—it's in Toronto, it's in Durham and then the OPP is working on one that I think we're going to hear about this afternoon. But it's currently only for, for the most part, firearms. You can do it for anything, but it is only for firearms.

With your understanding of how all these different types of protection orders work and the value of them, is there value in pushing to learn more about something like that, from a point when you were talking about police not enforcing the ban?

Ms. Laura Snowdon: I think the only concern that I would have with a system like that, based on my understanding of how you've described it—does that mean that the protection orders are just popping up as the police are moving through the area, or is there some—

Ms. Jess Dixon: You can screen—again, my understanding is also limited; it was only a couple of days ago that I was talking about it. You can screen to say, "Okay, I don't want to see these; I don't want to see these," but it means that then, if you're interested, you could theoretically be like, "Oh, I want to go and check enforcement orders" or whatever, and you could be like, "Oh, they're in my area that I could go and verify something."

I don't know—that's more of, like, a bail or probation type of thing, because I guess with protection it would be more about the person reporting it to police and then them responding.

Ms. Laura Snowdon: Yes, that's what I mean. But we're also looking at bail and probation orders as part of our protection order project.

But yes, what we'd be most concerned about seeing is that when people report breaches, the police are enforcing those breaches, as opposed to—we heard about a case from a legal clinic where the perpetrator was at the son's soccer game—

The Chair (Mr. Lorne Coe): Thank you very much. That concludes the time for your presentation from the Law Commission of Ontario. We appreciate the time you spent with us this afternoon.

ONTARIO NETWORK OF SEXUAL ASSAULT/DOMESTIC VIOLENCE TREATMENT CENTRES

The Chair (Mr. Lorne Coe): I will now call on the Ontario Network of Sexual Assault/Domestic Violence Treatment Centres. Please attend the table. Thank you. Make yourself comfortable. You might want to get a glass of water before you start. It's to your left—or my left, sorry.

Interjections.

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

You'll have 10 minutes for your presentation. I'll let you know when you have one minute remaining in your presentation so you can summarize. Could you please state your name for Hansard, which is the recording service for the Ontario Legislature, and then you may begin your presentation.

Ms. Sheila Macdonald: Great, thank you. My name is Sheila Macdonald.

First, thank you for the opportunity to speak with you, and I hope what I say today is a bit helpful to the work that you're doing, which is a daunting responsibility in addressing interpersonal violence.

I'm a registered nurse. I'm the director of the Ontario Network of Sexual Assault/Domestic Violence Treatment Centres and work with the 37 hospital-based programs across Ontario. I have worked in this field for the last 34 years, and I am based at Women's College Hospital across the street. Our services provide the acute and non-acute service to victims/survivors of sexual assault and domestic violence, the follow-up health care and counselling services.

The acute care—what that means—includes the collection of the forensic evidence. You might be familiar with the sexual assault evidence kit. We provide crisis intervention, address health concerns such as the prevention of pregnancy and sexually transmitted infections including HIV. We do the documentation, photographs of injuries, referral to other support services such as shelters, legal services.

Our service supports victims/survivors across the lifespan and gender spectrum. Our services are predominantly provided by sexual assault nurse examiners. Those are nurses who are specially trained. That's one of the things I do in my role as director: arrange that training. We have a Sexual Assault Nurse Examiner Program which is offered to nurses around the province, supported by the Ministry of Health.

In my handout I gave to you, I pulled our 2023 data to give a sense of our volumes. I don't know if you have it, but just to show: The majority of the patients that we serve identify as being female; about 6% are male; and 2.3% identify as trans. One of the initiatives that we're doing in collaboration with the Women's College research unit is a national trans project to increase awareness and knowledge training for health professionals around the issues affecting trans persons and violence, to sensitize our services and make them hopefully more accessible to patients.

In domestic violence, the numbers are similar in terms of who we're serving: predominantly female-identified patients being victimized by their male partners.

In our service as well, in 2023 we provided acute service to about 6,600 clients. We did 17,000 follow-up visits and 22,000 counselling visits, which is kind of consistent over the last few years.

For the sake of time, I just want—I also included a stat around police reporting, because note that—and I'm glad I heard the last presenter—less than 50% of our clients that come forward report to the police in sexual assault, and only about 50% in domestic violence report to the police. So it's a very under-reported crime to the police. Although I'm going to focus in addressing health issues, while our efforts in the criminal justice system—and I support what I heard previously, at least in some of the areas around improving the response, because victims don't have a lot of confidence that the police or the criminal justice system is going to keep them safe and meet their needs, so they don't come forward.

Just to keep going: There has been some change in society over the 34 years I've had. I'm glad that there's more awareness, coming forward etc., acknowledgement of issues of violence. But there is more to be done, and I think some of the issues that reflect gender disparity in our society have to be addressed. That's where pay equity—it's not related directly to the violence, but when people make enough income that they can support their kids or they can support themselves if they have to leave an abusive relationship, that matters—access to housing, empowerment issues, education etc. Our education in schools around healthy relationships and understanding of violence—that has to be integrated through the school system as well.

So I don't run out of time, I'm going to go to—in terms of recommendations: There have been more than a few inquests over the 34 years, and jury recommendations related to interpersonal violence. Maybe it's been done and I haven't seen it, but I think that there are overlapping recommendations that come across them all that have to be looked at, so lay them on top of each other. The Lori Dupont inquest, the May-Iles inquest, the Ryan inquest—there's a whole list of them, and I think we could probably pull out common things that perhaps could indicate or move us forward in terms of what has to be done. That's my first recommendation.

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The second is around how we have inconsistent and optional education for health professionals on IPV. I think it needs to be mandatory. I think we need to have standardized curriculum that's more enforced, because we know everybody accesses health care somewhere. We need to increase the awareness of health professionals but not have it be optional. I know that there are keen, committed nurses, physicians, other clinicians, but I think it has to be embedded and mandatory in their learning, similar to all the training I did when I joined at the hospital. I have to understand what to do if there's a fire. This is too important to leave it as an optional issue.

I also think the topic of violence, gender-based violence needs to be across our education for our student nurses and physicians and social workers as part of the embedded curriculum, not a one-off speaker.

The third suggestion: The problem is the insufficient trauma-informed counselling services. We have counsellors. The wait-lists are six to eight months, and that's only for the clients that we saw in the emergency department. When somebody has the courage to finally come forward to seek help, to say, "I need to get out of this" etc. and the answer is, "We'll put you on the wait-list for our counselling, which is six to eight months away," it's not helpful. It keeps people living in the situation of violence.

I don't know why counselling services are not covered or provided free of charge. It should not be a charge to women to have to pay for it. So, not just counselling to our services but in the shelters and the community services etc., wherever someone comes forward, a survivor has to be able to talk to somebody and sort through what is a very complicated, complexing system to know, "How do I move through it?" and we need better support for clients that way.

The fourth one is around housing, is that there are not enough shelters. I see a patient at 2 in the morning at Women's College, they need a safe place to go, we can't find them a bed. Calling and calling, trying to find, and some people end up going home because there is no place. Where are they going to go with their kids? There just simply aren't enough shelters for the moment, transitional houses, affordable housing, and it's keeping people forced to stay in violent situations because there is no alternative of where they can go and be safe.

The last one is specific to us. We have many survivors, as I said. It's an under-reported crime, but victims of sexual assault will come to see us. I will complete the sexual assault evidence kit. We will store it at the hospital for about a year, which gives people time to think about what they want to do and do they want to come forward. A year is not enough. We've had more than a few people phone up, very upset that we had to get rid of the kit after the year because we're in a hospital, there's storage capacity. I know the centre of forensics is not mandated to

store kits unless there is a police report. So if there is anything that I could suggest, we have to be able to increase the capacity to store kits.

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

Ms. Sheila Macdonald: Great. Thank you very much.

We should be storing them for a minimum of five years so that if someone needs to come forward, they get the counselling, they can talk through, deal with the family, bring themselves to a place that they are ready to proceed into the criminal justice system—and then they go to the police, and the evidence kit doesn't exist anymore because of the time. So I think that it's an easy fix. I think it's a matter of getting agreement on where could these kits be stored, under what authority, which to me is between the Ministry of the Attorney General, Ministry of Health and the Centre of Forensic Sciences. So it would empower survivors if they knew that they were able to store the kits longer. So that's just an issue that our programs are dealing with.

Thank you.

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

We're going to begin our questions with the members of the official opposition, please. MPP Wong-Tam, when you're ready, please.

MPP Kristyn Wong-Tam: Thank you, Ms. Macdonald, for being here today. I recognize that the work you do is critical but also, I think, under-supported based on the witness testimonies we've heard thus far.

I want to understand the process around the administration of the rape kit, because I think that we can all use better education around it. We've had MPPs and colleagues talk about the need to have more rape kits without isolating or adding to it the need that we need to have more forensic examination nurses. But it is the two that we need; is that not correct?

Ms. Sheila Macdonald: Yes, we need both. It's not enough. I've heard the conversations and recommendations around, "Put sexual assault evidence kits in every emergency department in the province to increase access to care." Only 50% or 60% of the survivors that we see want the kit done in the first place. A lot come in because they want the emotional support, they want to know what their options are, they're worried about being pregnant, so the health care etc. You can't just put this box of evidence without having the understanding of the significance of the evidence, what should we tell her to collect etc. So I'm not a fan of the idea of putting it in every emergency department.

We are, however, this year expanding our efforts across the province, supported by the government. I'm so grateful to the Ministry of Health and to the government for the support around increasing our access, education and outreach to all the emergency departments in the province and building strategies around how supporting for that patient who is way up in northern Ontario who can't get to a treatment centre—we do want to support them locally. So we are building these initiatives and working out what are the reasonable or feasible protocols that we can do so that patients don't have to leave their communities for the purpose of getting a kit done.

But you have to do both; you can't just put the box in the emerg and say, "Yes, here. You can just use it."

MPP Kristyn Wong-Tam: Right now, there are 37 hospital-based sexual assault/domestic violence treatment centres across Ontario. If there is an expansion, how many more centres are we expanding to, and are you moving to a community-based health centre? Is that an appropriate location?

Ms. Sheila Macdonald: First of all, a lot of our programs are actually enhancing mobile services. So while there's a program at Women's College Hospital, the team is mobile to the seven emergency departments in Toronto. So we're not going to put treatment centres in seven emergency departments in Toronto; we're going to build our capacity to get out there and provide support, because in many communities, we can do that. Around the province—London is another example; Trenton is another example—the services go out to where they can, and that's where we're building the capacity of nurses on teams, training more so that we can enhance our mobile service versus establishing entire new treatment centres.

Your second, around community: We should always be—and we are; we do collaborate a lot with community partners. We're a 24-hour service. Not all community health centres are open 24 hours a day, so we give mixed messages to patients if we say, "Okay, only during these times."

The second thing: What we have learned a lot over the years is that there are very concerning issues around violence related to strangulation, for example, and drug-facilitated sexual assault. There simply isn't the infrastructure and resources in community health centres to provide what's needed at the time, so I think we need to collaborate. We are wanting the access to be maintained in the emergency department but also away from the emergency department because of the chaos that goes on. So if we can maintain the connection when people need it—because we see a significant percentage of abuse survivors who have a lot of injuries that need the medical attention, and we have to make sure we can provide it.

MPP Kristyn Wong-Tam: Thank you very much. And as the director of the treatment centres, have you folks been keeping track of on average how long does it take for someone to access a kit and have a nurse examiner carry out—I believe it's a four-hour exam. On average, how long does it take to get the kit administered? Obviously, it will probably differentiate between regions. The reason I ask this question is because we've heard from previous witnesses—especially in the north, they talked about Indigenous women having to wait three days in some cases before a kit is administered. And for those three days, they can't bathe and they can't really provide any basic sanitation because their body is a crime scene. Do you know if that information is collected?

1520

Ms. Sheila Macdonald: Well, we don't have the capacity to know unless I specifically hear about it or they report it. But we are building a database that, in the next few years, is going to give us exactly that kind of information. How long from the time somebody presented was the evidence collected? That's one variable, but that's not information we have—except I have heard about it. It's not acceptable.

We trained and worked with the northern nursing stations in Ontario, provided training to them all, to enhance their capacity to complete evidence kits up in the nursing station versus having to fly someone down to Sioux Lookout or Thunder Bay etc. It's not complete yet, but hearing something like that—which, to me, is beyond unacceptable—is why we are continuing.

I have an educator right now who is working specifically in the north to build those partnerships and, hopefully, we're going to be able to address those issues fairly quickly so that we don't have to—that's not okay.

MPP Kristyn Wong-Tam: Can you just describe the clinical setting that your nurses are working in? With respect to the time that someone who has identified, "I need to get an administrated kit done," how long does it take? In terms of nurses that are not trained, who are not forensic examiners, how do they see themselves in that clinical setting in early detection and detention of the early signs of IPV?

Ms. Sheila Macdonald: Well, I think one of the gaps that we have in general is the confidence of our clinicians to screen and identity for IPV. I want to make sure I'm answering your question. I also think we're afraid to ask the question in case the answer is yes—

The Chair (Mr. Lorne Coe): Thank you very much for that response. You might want to hold it until the second round, because we're now moving to the government members, please.

Questions from the government: MPP Smith, when you're ready.

Ms. Laura Smith: I want to thank our partner for being here today and taking the valuable time to be here.

But I have a few questions. I was going to talk about collaboration with our policing partners, which is so important. And I'm wondering if there's something that you can—some guidance that you can provide to it. We have spoken to so many different partners in this area, and we're looking at responsive ways that we can dialogue with our policing partners.

I'm wondering if you can give information about that from your perspective.

Ms. Sheila Macdonald: We work very closely with the police. All our services do. In cross-training, we go to the police college, or for all the detachments, do the training with the police around so that they understand our service and have been able to develop protocols and processes that work to the benefit of the survivor, which is a very huge improvement over a long time ago when things probably weren't so collaborative.

There are challenges. The one thing I'll say as far as the police with us is, over the years, it's become very—they know to bring a victim of sexual assault to our programs, not so much with domestic violence. Our volumes in domestic violence are actually less than sexual assault.

I think it's because domestic violence is a different issue. I think the police often get called to the same address. They might have a certain amount of—sometimes, they have been here before. The victim is not following through. Whereas, in sexual assault, the person does want to come in. They often give victims the cards to say, "Go to the hospital if you have a concern etc." So we're building that partnership more in collaboration. It's important that we see the person and do the assessment and get them into counselling etc.

But the police have been responsive as far as mutual education and protocol development etc.

Ms. Laura Smith: Just building upon that, I think you touched on how a lot of this is under-reported. And so, when we bring the police in, at least we have that reporting aspect to it. But what policy adjustments do you propose would better enable us to support the individuals and the cases that are dealing with IPV and sexual violence?

Ms. Sheila Macdonald: Well, I think, having had the benefit of hearing the last speaker, it's not about the police, per se; I think it's the overall lack of confidence in the criminal justice system and whether it's going to serve the benefit of holding the perpetrator accountable or whether it's going to help keep the victim and their children safer. From some of what I've heard, there's not a lot of confidence that bail or restrictions or whatever—these things are held in place and that they're enforceable. So I think it's those things that have to get addressed.

And then I think the court process itself—we've had more than a few cases where they went through the whole process and the case was dismissed because it took too long to get to trial and there's not enough court staff. We never said that in the first place to our survivors: "By the way, should you actually get through all this and you're ready to go to court, there's a chance it may not make it because there's not enough judges." We didn't know that a few years ago.

So these issues wear on victim/survivors in terms of, "Why should I come forward?" And I want people to come forward, because there needs to be accountability; there needs to be enhanced safety. But those are some of the barriers that just simply have to get addressed, because it becomes a lack of confidence.

Ms. Laura Smith: You talked about the kits—just going back to the kits and the availability and the different resources that are available in different hubs. Now, what steps would you recommend be taken to standardize IPV screening across all different health care settings across Ontario?

Ms. Sheila Macdonald: First of all, it starts with: We need to train all health care staff. We need to develop—and I think it's something that we do in collaboration with our community partners, with experts in the field, around what is the core—if we had to do something in an hour,

what should everybody know? What are the indicators? How would I ask the question? How do I create the environment to ask the question, "Are you safe at home?" And then, what are the resources? Because my recommendations are a little bit linked together. If I'm going to ask a patient about their experience of violence and they say yes, it's not enough to say, "Okay, well, thank you." I have to give them a resource: "What do you need? Who can I refer you to?" And then have the resources there and not have the person be told there's a six-to-eight-month list. Do you know what I mean? That's not a good approach for us to take.

I have a little bit of hesitancy around routine screening by every health professional. We have to set a bit of a parameter so that we're not continually, repeatedly asking our patients, right—myself as a nurse and the physician and then the OT. So I think that even indicator-based—to start with that. What are the flags? Pay attention to the—I remember it from the May-Iles inquest report. There are very clear, repeated—people that come to the emergency department a lot, people with the same chronic—or injuries or etc. There are indicators that can give us some guidance, and I think if everybody has that in mind, they'll start thinking about what's going on with this family.

Ms. Laura Smith: And duplications, as well, because what you're discussing is possibly a duplication because they may already have undergone what they needed to get through and they just need to get to step B or C or D and they don't need to go back to A.

Let's go back to training, because you talked about—or let's talk about mandatory education of health care professionals that specifically deal with IPV and what you think would be an ideal training model.

Ms. Sheila Macdonald: I think what would be first is that everybody understands what is intimate partner violence, what is behind it, what's going on here, because our society is still very much victim-blaming, be it interpersonal violence, be it sexual assault. The first attention is, "Well, why don't you just leave?" or "Why did you do this?"

1530

I think we have to put the awareness and understanding of why people can't get out of the situation. So if she wants to leave but she can't—

The Chair (Mr. Lorne Coe): Thank you. We're going to return to the official opposition now. To MPP Sattler, please, when you're ready.

Ms. Peggy Sattler: Thank you to Sheila Macdonald from the network of sexual assault/DV treatment centres.

Earlier today, we had a presentation from ONA. One of their recommendations was for additional funding to support the expansion of the SA/DV treatment centres. I think you addressed that earlier, where you talked about opportunities to provide these mobile services; you don't have to have one in every specific emergency room.

I'd be interested in hearing your thoughts a little bit more about that, and then, in particular, hiring more of the nurse examiners. The person we spoke to this morning said that there's a real shortage of nurse examiners. She said, in the city of Toronto: five million people, 5.2 FTE nurse examiners—you would question whether that is sufficient to address the need.

Can you talk to us more about the shortage of nurse examiners and then also opportunities to expand the DV/SA treatment centres?

Ms. Sheila Macdonald: Sure. When our programs were first established, we as nurses—and this is how I started—worked on call with a pager from home, to be called in. It's not a financially sustainable—I didn't make any money doing the job as a nurse; it was more of a commitment.

I've been working with the ministry over the last five years, the Ministry of Health, to turn these on-call positions into on-duty, real salary, support etc. So we are having more on-duty nurses, which is increasing our ability to hire and retain them. That's a positive move that we've already been going in and continues this year. In some areas in the province, I think as we identify where are the gaps—I've been doing that with the ministry over the last four years, so we have been enhancing staffing.

In terms of additional—I think there are certain parts of the province that probably should have a treatment centre so that they can provide the support locally in the surrounding area. That will—

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

We're now moving over to the government, please. MPP Saunderson, when you're ready, sir.

Mr. Brian Saunderson: Thank you very much for your presentation today and sharing your experience with us. I want to get a sense of your clientele, because you've talked about how you're predominantly treating sexual assault but also domestic violence and IPV. What roughly would be the division between those two clients?

Ms. Sheila Macdonald: I think about 75% are sexual assault now. In our definition of sexual assault, it could be in the context of IPV, so when we build our database that I talked about, we're going to be able to separate out how many sexual assault clients are in the context of IPV. But anyway, right now, when I say "domestic violence," there is no sexual assault aspect included in that. So we will sort out in the next while that separation in context. But a lot of sexual assault does happen in the context of IPV.

Mr. Brian Saunderson: And when it's in a domestic relationship, then is it the same kind of evidence-gathering process?

Ms. Sheila Macdonald: Yes.

Mr. Brian Saunderson: It is the same? So the rape kit evidence is the same regardless?

Ms. Sheila Macdonald: Yes, because even though it might be, "Well, this shouldn't be relevant," "Well, we don't know if there was—maybe they were separated then there was a restraining order to not come to the house"—that's not for us to sort through, that legal process. "Maybe they never should have been together."

So we'll collect the evidence, and it's up to the police and the crown to figure out, is this relevant? We can't do it in the moment of the crisis.

Mr. Brian Saunderson: Right. And I take from your evidence today that the primary role is harm reduction and the health of the victim, but as you said, it's also that you encourage reporting, because you want to see people held accountable. Is that correct? Predominantly, you want to—

Ms. Sheila Macdonald: Well, it's up to the individual to decide if they want to make the report. We want to provide them with the information, and they can make their own decision. From my own personal—yes, I want perpetrators held accountable, whatever that translates into, but it's up to the victim to decide whether or not they report.

Mr. Brian Saunderson: What's the chain of custody on the rape kit evidence? How does that store? Does it require refrigeration? How much space does it take up and what does that look like?

Ms. Sheila Macdonald: Well, Women's College, because I used to—I know from being the manager there. It's a fairly large room, lock and key—very limited security has access to it. All the evidence kits are sealed.

The Chair (Mr. Lorne Coe): Thank you very much for that response. That concludes the time allotted for your presentation. We wish you well.

Ms. Sheila Macdonald: Thank you.

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

OTTAWA COALITION TO END VIOLENCE AGAINST WOMEN

The Chair (Mr. Lorne Coe): I will now call on the Ottawa Coalition to End Violence Against Women. Good afternoon.

Mx. Yamikani Msosa: Good afternoon. How are you?

The Chair (Mr. Lorne Coe): You will have 10 minutes for your presentation. To begin, would you state your name for Hansard?

Mx. Yamikani Msosa: Yamikani Msosa.

The Chair (Mr. Lorne Coe): Could the technician please turn up the presentation so we can all hear? Thank you. I'll wait until you do that. Very well, thank you.

You have 10 minutes. You can begin your presentation. Thank you.

Mx. Yamikani Msosa: Hello, my name is Yamikani Msosa. I'm the executive director of the Ottawa Coalition to End Violence Against Women. We are a coalition of organizations, individual advocates and front-line workers, located here on unceded, un-surrendered Algonquin Anishinaabe territory also known as Ottawa.

Our focus is prevention, public education, as well as amplifying front-line voices. OCTEVAW wholeheartedly supports Bill 173, the Intimate Partner Violence Epidemic Act, which requires the government to recognize intimate partner violence as an epidemic in Ontario. This was the number one recommendation that was given out of the Renfrew inquest that was directed by survivors, by those impacted and by key advocates within the gender-based violence movement.

We are calling on the provincial government to declare intimate partner violence an epidemic and join many other municipalities across the province that have done so. We believe this action is a first step. Survivors and advocates have shared with us their experiences, and we look forward to working alongside the province in developing these solutions.

OCTEVAW recommends that Bill 173 be accompanied by comprehensive legislative action and investment in services and supports to ensure that IPV is recognized and addressed with urgency. Prevention, support services, access to housing, education, good jobs and policy changes are crucial to mitigate IPV.

Some key three areas that we just want to, off the bat, name is pass Bill 173. It's also important that critical investments are made in prevention and education, which I'll be talking more in detail about. Stabilize funding for the core of community-based, gender-based violence services, particularly those who are focusing on intimate partner violence. So we need those investments because they're buckling under increasing pressures, inflation and more. We also, straight off the bat, want to name that we are in full support of convening a provincial round table, as outlined in the recommendations, that would create space for government and the sector to work together to share knowledge and implement meaningful change.

The current reality: As an organization that is committed to amplifying Black, Indigenous and racialized survivors, we wanted to draw your awareness to the disproportionate impact to those communities. We know that 2SLGBTQ survivors of colour have experienced up to 67% more violence and have experienced at least one form of violence since the age of 15. We know, based on our research that we've done locally, that over 75% of Indigenous women, two-spirit folks and girls have experienced intimate partner violence. Trans, newcomers, sex workers are likely to experience violence three times fold. So it is critical that anything that we do in terms of legislation, policy actions also take into consideration targeted funding for those groups that are often on the margins. There is no one-size-fits-all model.

1540

I also want to draw attention to the fact that in Ontario, we know the Chiefs of Ontario have already declared intimate partner violence an epidemic, and so we call on the province to urgently also consider their 231 calls for justice for missing and murdered Indigenous women, girls and two-spirit folks.

Over the last two years at OCTEVAW, we have listened to the sector across Ottawa. Recently, alongside the city of Ottawa as a partner, we developed a scoping study in collaboration with Unsafe At Home, which is one of the largest housing providers under Interval House. This scoping study broke down the needs of front-line workers as well as survivors of gender-based violence here in Ottawa. What we found through the evidence-based data was that an investment on prevention was a key aspect of addressing intimate partner violence. Ottawa declared intimate partner violence an epidemic in 2022.

When we think about the solutions—and to break the problem further down, when we think about the invest-

ments in prevention, what we are saying is that prevention is access to stable housing. Prevention is education. Prevention is ending cyber violence. It's engaging men and boys. Prevention is perpetrator- or those-who-cause-harm-focused. It's bystander intervention that does not escalate to further harm.

It's important to recognize that in our study around the need for prevention efforts, Black and Indigenous survivors told us that, at times, without alternatives to justice, escalation can lead to more harm within their communities and systemic gender-based violence within the criminal justice system. So we want to draw your attention to that.

In our scoping study, we also found that our key barriers are that funders and governments lack a recognition of investments in early interventions to address the root cause of violence. I'm going to say that one more time: the lack of recognition that early interventions address the root cause of violence, mostly because a lot of what we are witnessing is solutions after the violence happens. And so, in understanding the root causes of violence, it is a critical component that prevention work can inform tailored efforts with and for communities, especially those that are equity-deserving.

So how do we invest in prevention? We support community organizations in researching, testing, implementing and evaluating new evidence-based models, approaches and responses. We improve systems collaboration, as identified in the recommendations, that focus on prevention. And we provide training and education that is trauma-informed, culturally aware and offers alternative justice responses for survivors.

The conduit in which I want to invite the committee to consider is one in which we draw on existing systems. We do not need to recreate the wheel. Coordinating committees across the province, such as Building a Bigger Wave, exist. We have coordinating committees across the province that are already tapped into regional needs, like OCTEVAW.

Coordinating committees are currently shouldering much of the prevention work alongside supporting the different actors. It is a table where we already have justice actors. We already have front-line services, community-based organizations, movements, housing—all of the key stakeholders already at the coordinating committees.

In terms of investing in prevention, what we would like to see is an increase, because coordinating committees right now who are doing the prevention work provincially are getting anywhere from $10,000 to $25,000. So to break down the investment, we're looking at a $4.5-million investment per year, and would encourage the province to consider over four years to really ensure that we can bolster those that are already doing the work under a chronically underfunded sector already.

This would ensure large-scale impact with a diversity of players. We would have justice players, as I mentioned. Depending on each regional composition, you would have different players that are already meeting, already convening to find solutions, already convening on survivor support, already understand the trends. So this funding would allow them to create an enhanced, systemic collaboration that would focus on prevention. So it would be funding for specific prevention dollars in programming through the coordinating committees that have all of the stakeholders at the table.

We know that intimate partner violence has many solutions. There are many dimensions to this work. What we are interested in, what we have heard from survivors, what we have heard from front-line workers, what we have heard from across the gender-based-violence movement is that we need to address the root causes. We cannot continue to advocate for band-aid solutions.

And so, this investment in prevention—

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

Mx. Yamikani Msosa: Yes—so just wrapping it up: The investment in funding dollars would really bolster up what we're already seeing in terms of a crumbling system. So this is one solution we would like to propose, and thank you for offering me the time to share our thoughts from our coalition.

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

We'll turn now to questions, starting with the members of the official opposition and MPP Peggy Sattler, when she's ready, please.

Ms. Peggy Sattler: Thank you so much, Ms. Msosa, for joining the committee today and sharing your perspective.

I have to say I'm a huge advocate of the work that the coordinating committees do. I represent London West. London was the first community in Ontario to form the London Coordinating Committee to End Woman Abuse and they have been very active with building a bigger wave and the work that's going on around the province, as these coalitions come together and advocate.

I want to understand a little bit more about your specific funding proposal. You said $4.5 million a year over four years for the network of the coordinating committees that exist across the province, and you said this would be program funding to undertake prevention work.

Can you expand a little bit more about that and what you envision would happen with this funding you have asked for?

Mx. Yamikani Msosa: Absolutely. Thank you for that question.

What we know is that each region has unique needs. And so, what this funding would allow is for the resourcing of the coordinating committees to be able to develop education efforts if it's needed in their community. They would be able to decide under—it would be ideal if we could have three pillars—whether it be education; whether it be looking at cyber security, cyber sexual violence, cyber gender-based violence; whether it's engaging men and boys in their community; whether it's something else in the rural context that just hasn't applied to folks in Ottawa or Toronto.

These coordinating committees would be able to use this funding to be able to develop a program that speaks to

their unique community needs. It likely would be engaging key stakeholders that are already invested. They're already convening on a monthly, sometimes weekly, basis to talk about the issues that are showing up in the criminal justice system for survivors. They're already talking about what's happening on the ground. So it would allow for a unique, responsive programming to communities through the funneling of coordinating committees, which means that, because we're mandated to have coordinating committees through the province of Ontario, that would allow for us to support that work that's already happening, but with the resources that are needed to mobilize.

Ms. Peggy Sattler: Yes. Thanks very much, and that is a message that has been conveyed to this committee by other deputants, that the solutions have to be local but also diverse—which takes me to my next question.

I was struck by one of the findings that you quoted from the scoping study. In particular, for Black, racialized, 2SLGBTQ+, Indigenous communities, you said that they had reported back that the feeling was, without access to alternatives to justice, that escalation can lead to more harm.

So two questions about that: First, what kinds of alternatives to justice would provide the options that those communities are looking for? Then, the second, just elaborate a little bit about, that escalation can lead to more harm.

1550

Mx. Yamikani Msosa: So I think that what we are looking at is restorative justice, transformative justice models that look at alternatives to justice that may be culturally relevant or competent for survivors of gender-based violence. What we heard in the scoping study is, it's no surprise that with Black and Indigenous survivors of gender-based violence, sometimes it doesn't feel safe to call the police. In Ottawa right now, we're launching an alternative crisis response for mental health. What we're calling for, essentially—in our scoping study, what we found is there's a real need for alternatives, that maybe it's not an armed officer that's coming to the door that could retrigger, because we know the statistics show that police violence is deeply connected and has been experienced by these populations at a higher level.

What we want to say is, we recognize that that sometimes is an impediment to survivors even being able to access the support that they need. As a prevention method, how can we equip communities with the tools around intervention that can lead to de-escalation rather than further escalation?

Unfortunately, I am going to have to draw attention to the fact that in Ottawa, there was an experience where there was escalation that did lead to the death of a Black man, and it was because someone was calling around gender-based violence. So we don't see that as a solution by police; we don't see that as a solution, but we understand that we need alternatives for those very reasons, for trust-building. Because not all survivors are the same, so how do we, even in our justice responses, think about a breadth of ways of engagement that are related to the local communities?

Just one other area I want to draw attention to is this also came up—I didn't mention it earlier, but we did a grassroots Indigenous GBV scoping study as well with Families of Sisters in Spirit and a number of other Indigenous-led organizations. What they were saying was mirroring the same thing; whether it was on reserve or off reserve, we need alternatives that support de-escalation. Part of that in prevention is giving people the tools so that, if it's not a 911 call, maybe it's an alternative number that is being called. I hope that's helpful.

The Chair (Mr. Lorne Coe): Thank you very much for that response. The time has concluded for the official opposition.

We'll now move to the government members—MPP McGregor, when you're ready.

Mr. Graham McGregor: Thank you to our presenter for your time and the work you do in Ottawa. I got to live in Ottawa for a little bit. I used to live near Billings Bridge—spent some time there.

I represent north Brampton now. In Brampton, we have a model that I think really works and really helps. It's not perfect, but we have something called the Safe Centre of Peel, and this is really brought out of the need that when somebody is—sorry, I'm getting echo in my thing. Is that me, or—okay, I'll just keep going.

Safe Centre of Peel is really borne out of the belief that when somebody puts their hand up and has the courage to ask for help, we lose a lot of people when they're sent somewhere else. So you put your hand up, and you need help with addictions issues. IPV is discovered, but this is the addictions place; you have to go down the street for support fleeing a bad situation, an abusive situation. When people have to face the front desk and fill out another intake form and retell their story again and again and again, it can be an awful experience for survivors.

The hub model is designed around having services all together in one building so that, rather than, "Go walk over there," somebody takes you by the hand and brings you over there and then, "Here you go." You get the warm hand-off; you get that support. I view this, in a lot of ways—while we have somebody that needs support, if the purpose of government agencies is to support people, we should be doing everything we can to make sure that they get the support they need. We shouldn't want them to get out. As government, we have to build incentive structures.

Anyway, the hub model for the Safe Centre of Peel is something that we've heard other urban centres really want to replicate. We've heard there are some challenges in a rural context.

In Ottawa, you have both. It's a very large landmass, so you've got some rural communities. Manotick is very different than the Billings Bridge area or the Glebe or anything like that. Is this something that Ottawa is working on? Is there a similar model to the Safe Centre of Peel already in Ottawa? Is it something agencies are talking about? Is this something that you think would serve the community well and something the government should try

to replicate across all communities, but particularly in this case in the Ottawa community?

Mr. Graham McGregor: Oh. You're muted.

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

Mx. Yamikani Msosa: Okay. There we go.

Mr. Graham McGregor: Oh, there we go.

Mx. Yamikani Msosa: Yes. I think that the hub model is an effective strategy. We don't have anything like that in Ottawa yet.

It is something that also came up in our scoping study to explore what it could look like—through, actually, Optiva, since we convened the sector, we have housing, we have sexual assault centres, we have francophone services, we have newcomer services that are all part of our network—so having them have front-line service providers be able to provide support and services to survivors.

That hub could also act as a hub for education. It would also be a support for a recommendation that came forward in our grassroots strategy around addressing IPV in Indigenous communities, to have a safe hub so that, when a search party goes out for, unfortunately, missing Indigenous women or a two-spirit person, this could serve as almost like an HQ for that community search party that happens.

So it is definitely something that has been put on the table for us. Right now in Ottawa we have something called the Vanier HUB, but it is not gender-based-violence specific. As I mentioned also, we are partnering with the city of Ottawa to explore different models. But, yes, I think that if that could be something that exists on a provincial level through the coordinating committees, that would also be an effective strategy.

The key piece I don't want to lose sight of is the fact that, while it's addressing immediate support for survivors, we also don't want to lose sight of the elements of prevention.

Mr. Graham McGregor: Talk to me a bit about prevention. You talked about engaging men and boys. Who is doing that well, and how can government support good work?

Mx. Yamikani Msosa: Absolutely. In Ottawa, we are the ones that are doing it, as well as counselling and family services. We have a program called I Can MANifest Change. It's had several iterations, but we have these mentors that come in and support public education in the school system, in post-secondary—we've worked with the Redblacks, different sports teams—to talk about how we can interrogate toxic masculinity and talk about healthy masculinity and engage young boys as well as men.

Because, one of the areas that we did find is that with young men and boys—they're also experiencing gender-based violence. For young men and boys who are part of the 2SLGBTQ community, they're also experiencing harm. So, as an organization that looks at intimate partner violence from a gender-diverse lens—so men, women, non-binary folks—we see the ways in which engaging in conversations around masculinity are key. I think White Ribbon as well, federally, is doing really great work.

But I think on a local level, what we have found across the board is that we need the local context around prevention efforts, because the ways that cyber-violence is happening in schools in Ottawa are very different than other spaces. So, again, with those prevention efforts we're always thinking about the context and working with the school boards—

Mr. Graham McGregor: You've talked a little bit about—just for time; sorry to cut you off. Do I have time?

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The Chair (Mr. Lorne Coe): Forty-one seconds.

Mr. Graham McGregor: Cultural sensitivity: Obviously, in an ideal world, you would have members from every community that provide every type of service—a nurse—all kinds of things. In the real world, that might not always be pragmatic.

Is it possible to train people in cultural competency and communicate the same result? Is that something that we should be looking at as a government?

Mx. Yamikani Msosa: Absolutely. I think that, when it comes to cultural sensitivity or equity trainings at the intersections of gender-based violence and intimate partner violence, the goal is that we're all on the same page of how it manifests. I think that—

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

I need to now move to the official opposition and MPP Wong-Tam, when you're ready.

MPP Kristyn Wong-Tam: Thank you so much, Yami, for your presentation today. It's very good to see you, albeit it's on the screen.

I wanted to ask, with respect to funding—and I know you have a coalition there in Ottawa and a very large one; you have 30 different organizations that fall under your umbrella. Some of the things that we've been hearing from other deputants who have come forward over the past eight days cumulatively is that the sector is feeling the financial strain, that they're really struggling to retain staff and that two years of a front-line worker would be seen as long-term. And, of course, there is just the lack of services on demand when you need them, such as counselling, as well as crisis intervention support, and shelter and housing.

Are you seeing exactly the same trends in Ottawa?

Mx. Yamikani Msosa: Absolutely. At our front-line-service committee meeting, we talk about some pretty hard things, and one of them is that, because of the lack of access to decent work, the lack of access to decent funding across the gender-based-violence sector, we do have front-line workers that are seeking food banks to be able to meet their daily needs. So we have front-line workers accessing the same services as survivors and clients of theirs because of the nature of the chronic underfunding in the gender-based-violence sector.

And so, absolutely, I think I would say that, when it comes to chronic underfunding—another actual key finding in our scoping study was the need for all levels of government to make key investments. Through service coordination and coalition-building, that was the avenue that the scoping study took around an increase of dollars

to support prevention, because prevention also has support services embedded in it. When you're doing prevention and education, you're also likely going to have to deal with the disclosure, which means that you're going to have to connect with someone to support. So it also acts as a support around reducing wait-list times to talk to someone, to get survivors access to the support that they need.

I hope I answered your question.

MPP Kristyn Wong-Tam: Yes, you have, Yami, and—

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

We're now moving back to the government members, and I have MPP Smith, please, when you're ready.

Ms. Laura Smith: How much time do I have, if I could ask beforehand? Is it two? Two and a half?

The Chair (Mr. Lorne Coe): Yes. The full time.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Two minutes and 30 seconds.

Ms. Laura Smith: Okay. Thank you for clarity. And thank you so much for being here and thank you for enduring through my question.

You talked very specifically about research into evidence-based models. I'm wondering—and please be as specific as possible—about the programs you believe would be beneficial to combat IPV.

Mx. Yamikani Msosa: Can I just ask a clarification?

Ms. Laura Smith: Sure.

Mx. Yamikani Msosa: Your question is—in terms of research, you want to know what evidence-based programs should be—

Ms. Laura Smith: Right. What would work? Out of the research that your entity is looking into, what would you say is the resounding model that you think is going to make a difference?

Mx. Yamikani Msosa: See, I don't think it's "model"; I think it's "models." I think that, when it comes to prevention, it is about ensuring that there is education across the board. That means thinking about education within post-secondary, which we've seen a drastic cut of funding to—

Ms. Laura Smith: Wait, if I could just ask a question: In the research that you've done with your organization, what models do you think make—and my colleague MPP McGregor talked about the hub model that works in Peel, which is effective, and how they quantify what works. I'm just wondering, with the research that you've done—and once again, be very specific—what tools do your studies work, in Ottawa?

Mx. Yamikani Msosa: So, I think, as mentioned, the hub model is one that has been seen as effective and would address a lot of issues. Unfortunately, we don't have one, so when we prototyped it in our research, it was one that was seen as effective. Engaging young men and boys as a prevention tool is something that we see as effective.

I think when it comes to equipping front-line services and shelters, sexual assault centres across the board, gender-based violence programs that are funded through MCCSS, we see the need to have specific education on Black, Indigenous, two-spirit and gender-diverse communities. So that cultural—

The Chair (Mr. Lorne Coe): Thank you very much for being with us this afternoon. That concludes the questions from both the official opposition and the government members. Have a good afternoon.

ONTARIO PROVINCIAL POLICE

The Chair (Mr. Lorne Coe): I will now call on the Ontario Provincial Police. Technician, if you can bring them up, please.

Welcome, sir. You will have 10 minutes for your presentation. For the record here, for Hansard, which is the official recording service for the Ontario Legislative Assembly, could you state your name and affiliation?

Mr. Allan Gelinas: Hi, there. My name is Allan Gelinas—last name is spelled G-E-L-I-N-A-S. I'm a police officer with the Ontario Provincial Police.

The Chair (Mr. Lorne Coe): You have 10 minutes for your presentation. I'll give you a wrap-up reminder at one minute, okay? You can begin your presentation.

Mr. Allan Gelinas: Good afternoon, everybody, and thank you for letting me take part in today's committee hearing. I'll start off and introduce myself. I'm Detective Staff Sergeant Al Gelinas. I'm the unit manager with the OPP bail support team, which is a provincially deployed team with members across the province. Our mandate is developing and initiating offender management and offender apprehension initiatives. Today, I'll talk about bail reform and relate it as much as possible to intimate partner violence.

As a preamble, I think it's important to say that when we speak of bail reform, we must remember that this is a broad term that encompasses a collaborative effort amongst all stakeholders in the justice system: MAG, SolGen, provincial/federal government, social programs. When we speak about the specific role of police in bail reform, I speak of offender management and offender apprehension. Police services are bound by legislative frameworks and policies that govern what we do and how we carry out our duties and bound by case law from binding courts. So when we talk about bail reform, within our control, it's how we manage offenders and offender apprehension.

The current situation—to relate IPV, bail reform and intimate partner violence—is intimate partner violence is arguably the most commonly reported form of violent crimes reported to the police. Research has shown that this is still under-reported even though it's the most common. With our internal policies in place and laying charges whenever grounds are formed, IPV offenders represent a large proportion of offenders who are out on some form of release, either on a form 10 release or a form 11. When, how or if we monitor these offenders varies on a case-by-case basis on an analysis based on several factors.

So why are most intimate partner violent offenders generally released? Well, this is largely attributed to our justice system requirements in balancing the rights of the offender with the consideration and focus on their rights

under the charter, and balancing the need for public safety and ensuring victim safety as well.

A little more in depth about this balancing act: As police officers, we recognize the charter principles of presumption of innocence until proven guilty, our obligations under the Canadian Charter of Rights under section 11 and also the case laws that govern us.

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In R. v. Antic, a Supreme Court decision in 2017, the Supreme Court set out a framework for a ladder principle as the proper approach to deal with bail. This is a Supreme Court binding decision, a decision that was important to all of us as it showed a shift in ideology of how to approach bail. The ladder principle means that the accused should be released at the earliest reasonable opportunity and on the least onerous conditions that satisfy the preconditions set out by the Criminal Code. This was a Supreme Court decision that was followed by Bill C-75. It was codified into the principles of restraint, so now, this is something that we're obligated to follow under the Criminal Code and the Supreme Court of Canada decision.

Tragic events recently, with the death of Greg Pierzchala and other tragic events, brought us forward to the need to revisit bail reform, which led to Bill C-48. Bill C-48 was a pursuit for expansion of bail reform, expansion of reverse onus, specifically with situations of firearms weapons offences and repeat offenders. It's important to note that this bill created further expansion and reverse onus provisions also in intimate partner violence to not only include if an accused had been previously convicted of intimate partner violence or any other serious violent crime. But it also includes discharges, which is a huge factor for us, as many of our IPV cases end up in peace bonds or withdrawals or the victim not wanting to proceed. So using those discharges in a reverse onus situation was a big gain and very welcome change for us within the bill.

What steps are the OPP taking in discussions of bail reform? What are we doing about our offender management and apprehension program? We realize we're important stakeholders in the bail reform process. We've modernized and adapted various crime prevention strategies to align with the new framework that we just discussed. In March 2023, the OPP created the bail compliance warrant apprehension rapid working group. This rapid working group was formed with members across all of our command structure. The working group is mandated to review and modernize all aspects of our crime abatement offender management strategies within the OPP.

In June 2023, the rapid working group transitioned our offender management program, which was the Intelligence-Led Policing—Crime Abatement Strategy, to our current offender management and apprehension program, which is a much more robust and in-depth program. The offender management and apprehension program has two main objectives: offender management and offender apprehension. This was implemented in all detachments across the province. The new OMAP, as we call it, requires all detachment commanders in every detachment to identify an OMAP coordinator within each of their detachments who coordinates offender management strategies.

The role of the OMAP coordinator is key to the success of our program. The coordinator continuously assesses risk and ensures offenders who are released from custody in their jurisdictions on any form of release are appropriately assessed for risk and monitored when needed.

In July 2023, the OPP embarked on a Toronto Police Service bail compliance dashboard, which was also being used by the Durham police service at the time. The bail compliance dashboard is a valuable, map-based tool used to share information amongst the three police services about high-risk offenders released on firearms bail conditions.

In September 2023, the provincial government provided funding under Project Heavy Metal. Project Heavy Metal created a MAG intensive serious violent crime bail team, which works with police services in bail hearings, engaged in conducting specific bail hearings for violent crimes, the expansion of our Repeat Offender Parole Enforcement Unit, the creation of the bail support team and a further expansion of our provincial bail compliance dashboard to include all police services, who will use and access this dashboard to monitor violent offenders.

In March 2024, the OPP saw an opportunity to realign and create a new bureau within the OPP. The Crime Prevention and Community Support Bureau was formed, which continuously assesses and improves various crime prevention strategies within the OPP. Most importantly, the creation of the bureau realigned the OPP's victim response unit, the victim-centred approach team, and the victim specialist with the bail support team under the same bureau and command so they could work as a coordinated response and utilize crime prevention strategies so they could see things through a different lens to prevent victimization and revictimization, and looking at causes of crime.

In March 2024, the OPP also created a wanted persons dashboard to provide live situational awareness of wanted offenders across the province. This gave us the ability to prioritize offences by offence type and last known addresses, making intimate partner violence wanted offenders as a priority one in the dashboard.

The Chair (Mr. Lorne Coe): You have one minute left, sir.

Mr. Allan Gelinas: Next steps for us: Some large gains with Bill C-48. We have seen some challenges also, but some large gains. The next steps for us are working on ways to improve availability and accessibility of statistical information related to bail violations, so how many offenders being out on bail are reoffending for violent crimes. The OPP is working with partners and discussing the benefits of our offender management program and encouraging other police services to also adopt similar programs within the police services.

We're also working with some training that should be delivered across the province on basic assessment of assessing offender management and developing an offender

management plan and legal authorities when conducting compliance checks.

We're also working with MAG to access relevant orders when making release conditions: Family Court orders, child custody orders—

The Chair (Mr. Lorne Coe): Thank you, sir. The time for your presentation has concluded.

We'll move now to questions from the official opposition. MPP Wong-Tam, please, when you're ready.

MPP Kristyn Wong-Tam: Thank you, Detective, for being here today. I'm just wanting to get your opinion, your comments and observations regarding the detention centres, as well as the jails. We're hearing that 80% of those who are held are awaiting bail or awaiting trial. Is that a consideration as you folks are working with the crowns, with the justices on what the next person in line—if you send one more person into the detention centre and the overcrowded jails, does that come into factor when you're making the decisions on the next person on bail?

Mr. Allan Gelinas: For us, we have principles of law within the Criminal Code that govern who gets released and the factors, the tiered factors. There are three principles that we take into consideration. Whether or not the jail is overcrowded is not something we use as a determining factor. We assess risk, risk to the victim, risk to public safety, and court appearance as our determining factors when making those decisions.

MPP Kristyn Wong-Tam: I'm very encouraged to hear that.

I'm just following up on my first question. Especially around bail, what we're also hearing is there is just not enough time in the courts, and I know you don't work exclusively in the courts, but you're tangentially attached to it—that there's just not enough time and resources to assess risk before a judge or a justice puts forth a ruling. Is that an observation of yours as well, that there is a bit of a rushed process?

Mr. Allan Gelinas: It can be, depending on the situations and geography within the province. Obviously, some courts are much more tasked than other. Some of the issues we encounter are interoperability or communication within databases—so not all police databases communicate with each other—access to court documents, whether it be child custody orders, restraints within family courts. They have to coincide with release conditions. So we have to get access to those records to make sure that we're releasing somebody not contradictory to another order, so sometimes those matters are put over until we get those documents or whatnot.

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

I know that in this committee, our Standing Committee on Justice Policy, when we did a review and study on bail—and there's been lots of talk about a broken system. I'm sure you've heard it. It's about identifying what seems to be—or at least a shorthand moniker is that we've got a catch-and-release system, and somehow the criminal justice system is too lenient. But as far as I can tell, police officers are working really hard to carry out the enforcement of law, but there seems to be a disconnect once it interfaces with the justice system. So it's taking longer for folks to be processed; the courtrooms are very crowded. I oftentimes hear about bail hearings being adjourned. That is a regular occurrence in the local city I'm in, in Toronto. Are you seeing that across Ontario, or is that just a localized Toronto problem?

Mr. Allan Gelinas: Well, I think when we say the system is broken, we have to put our minds to how the system is constantly in flux, as in times are always changing and we have to change with them. We have a growing population, including in Toronto. Perhaps our infrastructure or the systems that are in place are not keeping up with the growth. More and more, things are complex when dealing with bail or any kind of court proceedings. So there are, I guess, some discussions that we do hear. However, most of us in management positions recognize that it's a complex situation and something that we have to work together on, and competing interests also serve some of the contributing factors within especially bails.

MPP Kristyn Wong-Tam: Thank you, Detective. In conversations that I've had with local police here in Toronto, there is a sense of demoralization, I would describe it as. The job is tough. It's a very, very tough job, especially when we see the social safety net not working as well as it needs to. There are higher rates of mental illness and mental unwellness that's not being diagnosed and not being treated. Chronic levels of homelessness seem to be plaguing not just Toronto; I know this is an across-Ontario crisis that we're seeing. I'm just curious to know, how does all of that factor in and make your job and the job of officers more difficult in Ontario? And if those systems were adequately supported, would it actually allow you to do the work in a more proactive way around crime prevention? Because right now everything is reactionary.

Mr. Allan Gelinas: There is some pressure. More and more, we see releases, violent offenders being released to communities, and one of the pressures we're seeing across policing is offender management. It's something that we're taking much more seriously across the province. It's something that is—when we say an offender is being released for community supervision, it usually means police supervision—so finding the time between calls for service, finding times between various crime prevention strategies to complete bail violations, especially for violent offenders, and how that looks. So, additional training would be well welcomed and additional resources specifically for bail compliance if we are moving towards community supervision for offenders.

MPP Kristyn Wong-Tam: Can you clarify for us, Detective, who is responsible for bail compliance and enforcement? Because we've heard different answers by different law enforcement outfits over this past year.

Mr. Allan Gelinas: That's fair. There will be different answers, because every police service approaches it differently. I can only speak to the OPP. In the OPP, we have a bail support team; however, we assist in training and providing insight to our OMAP coordinators at each of our detachments.

Each of our OMAP coordinators, what they do: They review who is getting released and whether or not they should be monitored. So that duty goes back to the front-line officer to—

The Chair (Mr. Lorne Coe): Excuse me, sir. That concludes the time for the official opposition for now.

We're going to move to the members of the government. I have MPP Dixon, please, when you're ready.

Ms. Jess Dixon: Thank you for coming today. Can you help me understand—so, I know a microscopic amount about the Toronto-Durham bail compliance dashboard. Are we talking about the same program with OPP? Is OPP running its own program? Do they talk to each other?

Mr. Allan Gelinas: Yes. So, it's the same program. It was launched by the Toronto Police Service. Durham joined after, and OPP also embarked. So it's a tri-police service dashboard currently. However, with Project Heavy Metal, with funding from the provincial government, they've seen value in this, and it's now transforming into a provincial. All 54 police services will be on this dashboard by the fall, on a newly created dashboard that took the ideals of the Toronto Police Service, who were instrumental in developing this.

Ms. Jess Dixon: Run us the elevator pitch of how it works. What does it look like when you're a bail compliance officer out on patrol?

Mr. Allan Gelinas: So, it's a map-based program. It only deals currently with offenders who were released on a firearms-related offence. It's a map with a pin, and when you hover over the pin or click on the pin, it tells you personalized data as to who the offender is, what conditions they're on, what offences they're facing. It tells you the charging area, who is the charging agency. And it tells you how many compliance checks have been conducted on the offender.

Ms. Jess Dixon: Okay. I knew this already, but just to double down on it: So right now, it's only firearms, so unless it was a firearms-related IPV or sexual violence offence, we wouldn't be monitoring any of those on the bail dashboard currently.

Mr. Allan Gelinas: Not currently, but we are collecting the data. So, as those offences are coming, the data is collected within the dashboard; it's just not shown yet to the officer. So there is potential, or the spirit of it is that it will expand in the future to include other violent offences.

Ms. Jess Dixon: And, obviously, if we're talking whether you're in a place that has dedicated compliance or whether you're talking about general patrol, were we to open it up to domestic violence and sexual violence offences, it would be looking at a significant increase in the amount of people that you're monitoring, correct?

Mr. Allan Gelinas: That is correct. So I can only speak for the OPP: Not all intimate partner violence offenders go on to our offender management program. There's a risk assessment done as to if the person should be on it based on a series of risk assessments.

Ms. Jess Dixon: We've been hearing a lot about risk assessments. Is OPP using ODARA?

Mr. Allan Gelinas: We use a risk assessment tool, the domestic—I'd have to get the specific wording of it. But we are using a risk assessment tool, yes, for intimate partner violence.

Ms. Jess Dixon: You may not be able to answer this, but we understand that different police services, victim services etc. may be using different risk assessment tools. So is it theoretically possible that although the bail dashboard would be something accessible ultimately, ideally, by all services, the framework by which you would be identifying somebody as posing a risk could be different in order to actually get them logged onto the bail dashboard in the first place?

Mr. Allan Gelinas: Yes. So the bail compliance dashboard currently is based on a specific criteria of the offence being committed regardless of a risk assessment, but as the capacity grows and the number of offenders on a dashboard, that may be a factor. But currently, it's just based solely on, if an offence meets the criteria—which, right now, is firearms-related offences—they are added to the dashboard.

Ms. Jess Dixon: Okay. So currently it's firearms. Is it theoretically possible, say, on a screening, as far as if you're not putting everybody on, that you could be looking at a risk assessment score and utilizing that score in order to determine whether or not somebody is—whether an accused offence is—whether they become part of the bail compliance dashboard?

Mr. Allan Gelinas: That's something that could be looked at in the future as the capacity grows, yes.

Ms. Jess Dixon: But obviously we'd be looking at something that's a pretty significant expansion of this program.

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Mr. Allan Gelinas: That, I wouldn't be able to—we'd have to talk to our technology support bureau on that.

Ms. Jess Dixon: Okay. Is it possible—I mean, not right now, but just as sort of a thought exercise. Given that right now the bail dashboard is firearms only, is there a way that we would be able to—because, unfortunately, a lot of this data either rests with police or rests with the courts, and bizarrely, the government isn't actually able to access it for the most part.

But say we were to be putting sexual offenders, domestic offenders, onto the bail dashboard. Do we have any way of quantifying how many people we would be talking about, theoretically speaking? Because ultimately everything comes down to cost and labour, and I have no idea how we would estimate what adding those onto the bail dashboard could potentially cost.

Mr. Allan Gelinas: I don't think there would be a significant cost to it. We're already data-inputting all the data within our offender management programs. As people are getting released, we're uploading their undertakings or bail conditions. All that is being put into a police database, and the dashboard extracts that data to add it to the dashboard already. It's more about the filtering and not overwhelming the user as to the data they're seeing.

Ms. Jess Dixon: So the technology can handle it, but the issue would then be, essentially, the workforce having the people available to actually be able to monitor in a meaningful fashion, given the sheer number of orders that could pop up then.

Mr. Allan Gelinas: My understanding is, seeing how the bail compliance dashboard already has the firearms-related offences included, we are looking at onboarding 54 police services and then transitioning to adding additional offences to the dashboard, rather than adding additional offences and then onboarding the 54. We just want to take a measured approach to implementing the dashboard and getting all 54 on board is our primary focus.

Ms. Jess Dixon: Okay.

I'm sorry—you may not have the answer, but I feel like I'm not making myself clear. I understand the rationale behind the idea of adding on services first, but from the province's perspective of grants or funding, if we were to add on all those offences, what are we looking at as far as the number of police officers that we would need to actually monitor it?

Mr. Allan Gelinas: How many police officers would we need to monitor it?

Ms. Jess Dixon: Yes. We're about to run out of time, but I'll ask you in the next one.

Mr. Allan Gelinas: Sorry. It's accessible to every—

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

We're going to go back now to the official opposition. MPP Wong-Tam, please, when you're ready.

MPP Kristyn Wong-Tam: Thank you, Detective.

We've heard in the past at this committee that bail conditions can oftentimes really propel someone's trajectory through the criminal justice system, because the more conditions that are layered on, especially for some individuals, the more likely they are to breach them. So if there is no income, no fixed address, automatically they're going to be in violation of their conditions.

I'm just curious to know—because I think, ultimately, we want to keep people safe. Those who are dangerous should be behind bars so that we keep general society safe, and then for those who are less likely to offend, or are first-time offenders or not violent offenders, let's get them rehabilitated or on a pathway to recovery.

But there are no supports for those who are held and waiting for bail. Someone is detained, but there really is no pathway; there's no support until they are charged and going through the system. Is that correct?

Mr. Allan Gelinas: That would be more of a correctional question. I'm not aware of the supports they have within the institutions, whether it be a holding facility like a correctional institution, rather than a jail. So that question would be more suited towards corrections, who would have more insight on that.

MPP Kristyn Wong-Tam: Okay. Thank you.

The next one I'm definitely going to put into your wheelhouse is regarding the protection orders. We had someone from the Law Commission of Ontario talk about the struggles of keeping all the protection orders in an orderly fashion. When a condition is placed on bail that is, for example, no-contact, what resources do you have to go about proactively ensuring that someone is not going to breach that?

Mr. Allan Gelinas: No-contact orders are difficult to enforce. There are some issues as to some of the new orders that are coming out, which have to do with written revocable consent. Meaning non-con orders, as we call them—the victim decides whether or not they're enforceable, so the victim writes—

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

We're moving now to the government—MPP Dixon.

Ms. Jess Dixon: Sorry, I know this is a bit like a crazy tennis game with us bouncing back and forth.

Similar line—I know I'm poking at a bit of a spot here. Obviously, we have this weird divide between probation and bail where pretty much everyone that's on bail is also on probation at this point in time, but they're monitored by a completely separate officer who is desk-bound. Theoretically speaking, if we thought-exercised that barrier didn't exist, could the probation orders also be on a compliance dashboard, if we were looking at it from a compliance perspective only?

Mr. Allan Gelinas: They could. Like a community supervision order or something along those lines?

Ms. Jess Dixon: Yes. I'm particularly thinking, if we're talking probation, not your low-level probation but child sexual offenders, people that are on orders to not be living near schools, that type of thing where you've got something that's a little bit more enforceable—not to be living with children, that type of thing. Because right now, obviously, our probation officers are desk-bound for the most part, and so their ability to do active compliance is challenged. As I said, at least in my experience of being a crown for 10 years, pretty much everybody that's on bail is also on probation by now.

Mr. Allan Gelinas: It would certainly meet within the mandate of the bail compliance dashboard. The bail compliance dashboard is to share information amongst police services; that's the spirit of it. That's especially true when offenders are charged in one jurisdiction and released to another. Somebody may be charged in Toronto but released to a northern city, and they have no way of knowing that the offender has been released to that jurisdiction. The success of the bail compliance dashboard is the information-sharing for those who pose a risk in our communities, so what you're saying does fit within the spirit of the dashboard.

Ms. Jess Dixon: But yes, there is obviously a divide there. It certainly beats the SCOPE messages I used to

send out, in hopes that somebody would get it, that there's an offender going out—

Mr. Allan Gelinas: If the right person got it.

Ms. Jess Dixon: Yes. So theoretically, that would be possible—if we had the labour etc., we could be looking at using this technology as it exists, as a neutral technology, for compliance orders or for probation for this concept of compliance in general, and that would work with the mapping tool as well?

Mr. Allan Gelinas: Yes, and especially for high-risk offenders—

Ms. Jess Dixon: Thank you.

The Chair (Mr. Lorne Coe): That concludes the time for the government, and that concludes our presentations for today. Thank you, members, for your contributions today in our eighth meeting.

Thank you to the Legislative Assembly staff from legislative research, Hansard and, of course, our Clerk and our technician behind us.

The committee will now adjourn to Wednesday, August 28, 10 a.m., committee room 1, the Legislative Assembly of Ontario.

The committee adjourned at 1638.

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