MH-3

ISSN 1918-9613

Legislative Assembly
of Ontario

Second Session, 39th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 39e législature

Official Report of Debates (Hansard)

Wednesday 21 April 2010

Journal des débats (Hansard)

Mercredi 21 avril 2010

Select Committee on Mental Health and Addictions

Comité spécial de la santé mentale et des dépendances

Mental health
and addictions strategy

Stratégie sur la santé mentale
et les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 21 April 2010

Mercredi 21 avril 2010

The committee met at 1548 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

JOHN HOWARD SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): I believe we have a quorum of members, so we're going to get started. My apologies to our guests. You kind of hit the perfect storm today as far as the legislative agenda's concerned. Some of us were up there trying to read petitions, and we had some ministerial statements. We had a tribute to a previous minister and member, so some of the members will be joining us in progress. But in the interests of not inconveniencing you anymore, if you'd like to come forward and begin your presentation, that would be great. Sit anywhere you're comfortable.

Is the slideshow yours, or is that for the next presentation?

Mr. Bruce Simpson: No, not us.

The Chair (Mr. Kevin Daniel Flynn): Okay. We originally had you scheduled till 4:15, so about a 45-minute presentation. Were you going to leave any time for questions?

Mr. Bruce Simpson: Yes, I think so. In fact, I think in many respects it's easier to make a presentation with questions. I like questions myself.

The Chair (Mr. Kevin Daniel Flynn): Oh, do you? Okay. Well, why don't you kick it off and make some opening statements, and then we'll turn it over to the committee members. I'm sure we'll have a great discussion. Thank you very much for being here, and thanks for your patience. And I need you to introduce yourself for Hansard when you speak.

Ms. Paula Osmok: Thank you. I'll start. I want to say, first of all, how pleased we are to be invited today to speak. As you know from the materials that we've directed to this committee and to others, we've been concerned about community criminal justice organizations not being included in this and other consultations on the issue and feel that our input is valuable. The intersection between mental health and criminal justice involvement is important and challenging.

Our presentation today, as you can see, is being given by three representatives of the John Howard Society: myself, Paula Osmok, the executive director of the John Howard Society of Ontario; to my right is Liisa Leskowski, executive director of the John Howard Society of Thunder Bay, who will bring some more local issues on the ground to you; and to my far right is Bruce Simpson, lawyer and senior partner at Barnes Sammon in Ottawa, who is also a long-serving president of our board of directors at the John Howard Society of Ontario.

For those who don't have a lot of knowledge about the John Howard Society, it's a criminal justice sector social service agency with charitable status that's working to achieve fundamental and long-term changes in individual behaviour, public attitudes towards crime and criminal justice, and government policies that are not grounded in the literature.

The society has a rich history of providing effective, evidence-led programs and services to a variety of groups: those at risk of becoming involved in the criminal justice system, those who are involved in the system, incarcerated individuals, and those who are re-entering our communities on release from prison.

The John Howard Society was established in 1929 by the then chief of police, Brigadier General Draper, who, through his work on the police force here in the city, recognized that men returning from local prisons were very quickly re-establishing their criminal behaviours and, without supports, were quickly returning to prison. He organized a group of citizen volunteers to meet with the men immediately on their release and provided them with support to address their basic reintegration needs, which include things like housing, employment, addiction issues, things that we now refer to as criminogenic factors.

General Draper's belief, which is strongly supported by research today, is that an essential component of community safety lies in social measures that support the re-entry of those who've offended into our communities as law-abiding and contributing citizens.

Currently, in 2010, the John Howard Society across Ontario consists of our provincial office, with the primary responsibility of research and policy, program evaluation, public education, fund development and some administrative matters, such as our benefit and pension plans across the province. We have 19 regional affiliates and a number of sub-offices from those affiliates who are responsible for all of the direct services to members of our community. They include a wide range of early and primary prevention programs, such as parenting and life skills; early intervention programs, including things like

alternatives to suspension; individual group counselling; specialized employment and literacy programs; institutional services, including pre-release planning; as well as re-entry services and supports, which I talked about a little bit earlier.

Interestingly, our newest affiliate, the John Howard Society of York Region, just became operational this year. I know one of your committee members represents that area.

We have over 600 professional staff and almost 1,100 trained and supervised volunteers who are involved in delivering programs and services to our often high-risk and high-need populations.

As you know, the rates of mental health concerns and addiction within prison populations are disproportionately high, and I'd like to just share a few stats that you may already be aware of.

A study was done in Ontario by Dr. Gregory Brown at Nipissing University, and I know that's a name you're familiar with. Just, interestingly, a few of them: 5% of inmates demonstrate a high number of severe symptoms of mental illness; 35% have a moderate number of severe symptoms of mental illness; 61% of men incarcerated have addictive behaviours; 91% of women incarcerated have addictive behaviours; there is no effective support system in place for 62% of the men leaving prison; substance abuse by those incarcerated is eight times more likely to occur than in the general population; a history of physical, emotional, sexual and family abuse is substantially higher among inmates than in the general population; and the ability to function in society for those leaving incarceration is 72% of that of the general population—certainly some stats that are concerning.

While the correctional system makes every effort to identify and treat these concerns, they do persist, and they're often exacerbated by the nature of the institutions themselves.

The relationship between addictions and mental health concerns and the likelihood of re-offending is similarly clear. Without meaningful and ongoing treatment, these factors quickly land releasees back in prison. The interventions and supports provided by the John Howard Society across Ontario break or slow the cycle of incarceration for many of these releasees who have treatment and other service needs.

Comprehensive assessment and treatment of addiction is crucial to the success of reintegration after incarceration. Addiction to illegal drugs and drug-seeking behaviour is a significant factor both for arrest and incarceration, and holding cells in detention centres often find themselves playing the role of a detox centre for addicts who are struggling.

Whether they've been using during their incarceration or undertaking treatment programming, experience with prisoners clearly shows us that many revert to drug taking after release from prison. This behaviour puts releasees at physical risk, dramatically increases their chances of re-offending or breaching, and also significantly increases the chance that any aspects of discharge planning that they've been engaged with while they have been in prison are not likely to be successful.

In addition, experts tell us that an estimated 30% to 50%, or even higher rates, of prisoners have fetal alcohol syndrome disorder, adding another level of need to this population. And we all know that the risk of suicide is much higher with men who are incarcerated, particularly those who are in remand populations.

In a similar fashion, those with significant mental health concerns often engage in a cycle of incarceration and crisis in the community without comprehensive and preventive treatment in place. While good treatment settings do exist within the provincial correctional setting for sentenced prisoners—and I add "sentenced." As you may know, the bulk of our population in provincial institutions right now are on remand; they are not a sentenced population. Those institutions are two in number: St. Lawrence Valley and OCI in Brampton. This treatment, as that points out, is not available to all, including, as I mentioned, remand. Those who show less severe symptoms or who have personality disorders often leave the system without any meaningful assessment and certainly without treatment.

Without reintegration services, those with persistent mental health concerns face fairly gloomy prospects. The transition back into the community can be isolating and jarring, and the search for a treatment provider can be confusing. The lack of resilience and initiative that's so commonly associated with mental health concerns can certainly be a significant barrier to the networks of support that we have in place. When behaviour that has often led to incarceration isn't adequately managed in the community, the road back to prison is the one they likely follow.

The answer to this cycle of abuse and mental health crises lies in meaningful and comprehensive treatment and supportive programming before and after release—again, much of which is already provided by the John Howard Society, and numbers certainly warrant additional programs of this nature.

1600

You may not be aware that the Ministry of Community Safety and Correctional Services is responsible for health care while people are in prison. It isn't the Ministry of Health, interestingly.

Finally, if our goals include good health and community safety, then we do need comprehensive and quality assessments and comprehensive and quality services by professionals and agencies such as the John Howard Society, that understand that the intersection between mental health and addiction concerns and the criminal justice system is significant.

I'm going to ask Liisa to carry on.

Ms. Liisa Leskowski: I apologize. I am the offender who left her phone on that was going off. Although we do respect Paula as the leader of Ontario, music doesn't always play when she talks.

I presented to you when you came to Thunder Bay. I understand you want to hear about prisons.

We are a community justice organization that works outside of prisons—and I personally have a background. I've worked as a chaplain inside the district jail in Thunder Bay and inside the correctional centre in Thunder Bay. I've worked as a reintegration community worker, helping individuals reintegrate back into the community. And for the last four years, I've been the executive director of the John Howard Society. So I've worked both inside and out.

Once a person with a mental illness enters the system, whether that's incarceration in a police lock-up, in a remand centre or a correctional centre, in a provincial or federal facility, it's sadly too late. I think we've failed. As a society I think we've failed, and I think as systems we've failed if someone with a mental illness ends up incarcerated. These are my opinions.

I personally believe that prevention and treatment largely become maintenance of mental health symptoms. Incarceration becomes kind of the accelerant for the disease symptoms.

Prisons are the means of punishment. That fact alone will always trump services that are delivered inside. I know there are a lot of good people involved in MCSCS and the services they provide, who really try to ensure things like psychiatrists' visits once a month, that there are medications, that a person can carry on. However, if that medication is a narcotic, you won't get it because it'll be seen as a controlled substance, and the inmate will go without that. I've seen that happen. There's obviously no cognitive therapy that's going on or supportive mental health programming. Any drug therapy, from what I've seen, will be minimal and maintenance at best, especially if it's a remand centre or a district jail.

The key has to lie in a really strong strategy for diversion of mental health consumers, where possible, from traditional justice services. That's seen as the goal, I think, by most justice sectors and health sectors. However, from my perspective as a community service provider, there has been little or no integration of the new health funding that has been put out over the last 10 years with what has been community-based justice funding.

The bail programs are a perfect example of this. Low-risk individuals are released into community-based service providers, into bail programs, and they are able to supervise and support these individuals in the community. We can support someone for a few weeks to up to a year.

Here are the stats of who is in my bail program. I'm giving you the stats from Thunder Bay's bail program. We support about 250 individuals: 50% struggle with a current or alcohol addiction; 70% have a history of substance abuse; 25% have a diagnosed mental illness, and it goes to more than 50% if it's undiagnosed; 10% have acquired brain injuries; 90% are male, and over 50% are aboriginal.

This is a diversion program that receives no support from mental health services. Bail programs provide supervision of court orders for our clients. Through that, we're able to develop trusting relationships and help that individual in their journey away from conflict with the law. We are funded to address the criminal behaviours, but we often find ourselves scrambling to deliver the human and social services which address the underlying causes, sometimes, of a person's involvement with the law.

When an individual is picked up, they're held overnight. They make their first appearance the next morning, and decisions are made then about whether they can be released on bail or if they'll end up staying in on remand or staying in jail for a little longer—and then, if they do, they'll be sentenced and consequently incarcerated. It would make sense at this intersection to ensure that as many individuals with mental health issues as possible are diverted. However, the need to move people quickly through that process, through the court system, is really challenging. So, when a person ends up that night in jail, the next morning there could be 30 people on a court docket that the crowns and the JPs and the defence bar are trying to push through very quickly. It's virtually impossible to do any sort of assessment at that intersection, at that front end. But there really do need to be supportive mental health services at that end, and those should include not only assessment and referral but support workers to help individuals with mental illness that find themselves getting caught up in our legal system.

The justice system is seen by the health system, including the mental health system, as unresponsive to the diverse needs of the mental health consumer. Health-funded organizations have largely been advocating for pathways to be developed through health and not justice. However, those of us who work with the mentally ill or the addicted offender often, at that intersection of justice and health—namely, community criminal justice organizations—are funded by justice and we feel that we have not been unresponsive to the mental health needs. And if the justice system doesn't get funded as well as the health system, then those of us who deliver services at that end won't receive the resources that are needed to help these clients. As partners with justice in delivering community-based programs and services, our unique position allows us to provide many of the local supports required by mental health consumers. Yet our services have largely been overlooked not only by the health sector but also by the justice sector that funds us. As a result we have seen client caseloads rise, we have seen our budgets cut and we've seen ourselves continually servicing higher-needs mental health clients.

I think there really needs to be a partnership between justice and health, and resources put to a real solid look that is done to say, what are we delivering now that's effective in diverting individuals away from the criminal justice system, and how can we help that? I would strongly advocate for resources to be allocated and used that expand existing community justice services as well as health services. I think the goal needs to be keeping people out of our prison systems. It is not a place for any

sort of therapy or therapeutic environment or proper health service to happen. Thank you.

Mr. Bruce Simpson: I am very glad to be here. My name is Bruce Simpson, as I was introduced. I'm a volunteer with the John Howard Society. I have sat on the board in Ottawa, where I've lived for a number of years, and currently I'm the president of the John Howard Society of Ontario. I just wanted to tell you a little bit about what motivated me to get involved.

I grew up in a smaller community: Pembroke, Ontario. In a small community, everybody kind of knows who gets in trouble with the law and who doesn't. We know what their family backgrounds are. As I was growing up, some of my classmates dropped out of school and got in trouble with the law, and it was never terribly surprising because we knew what their families were like. And if there's anything that became clear to me as I was growing up—although in fairness I think my father, with a few remarks at times, helped me to understand that—it was that the main difference that I could see between me and those of my classmates who dropped out and got into trouble was my parents. My parents celebrated their 67th wedding anniversary a couple of weeks ago. I grew up in a happy household. It wasn't perfect and we weren't rich, but I always went to bed at night feeling completely safe. If there was anybody in the world that I felt completely and utterly safe with, it was my father. I knew that if my father was there, nothing could happen to me, or at least that's the way I felt.

But some of my friends—actually, they weren't always friends, but people I at least knew, who dropped out of school and so on—had fathers who were drunks, fathers who beat them up. And, of course, when I started practising criminal law, that's what I kept seeing. I kept seeing young men in trouble who either didn't have fathers at all because they just took off and ignored them, or fathers who were so bad that they would have been far better off without them. That made me want to do something to help the people that I was actually making money trying to help.

1610

Of course, what also became obvious after a while is that many of these people have serious mental health problems. Now, sometimes it's the mental health problem that's the main reason why they're in trouble with the law. Sometimes it's all of these other criminogenic factors that make them what they are that are impacting on their mental health. There's clearly an overlap between the more traditional kinds of criminogenic factors and mental health issues, and there's an interaction. When you study any science, including a social science, you learn about how things can interact. One of the difficulties with mental health problems is that they make it more difficult for somebody to deal with the kinds of social issues that get them in trouble. They're less likely to get hired, for example, and they have more difficulties in school because of the mental health problems, and of course, getting arrested, the shame that comes with that, being incarcerated, all of these things have a negative impact on mental health.

What the John Howard Society has to offer, and I think that's why it's so important to keep people who deal with people who get in trouble with the law involved in the mental health system—there are lots of people with mental health problems, of course, who never, ever get into any kind of criminal trouble, because despite their mental health problems, they have other strengths, or they may even come from very good families. Mental health can strike anybody. But the people we try to help have both the background and factors that get people in trouble with the law, with or without mental health problems, and, of course, often those criminogenic problems are exacerbated by mental health problems.

These people have learned to trust us because we have staff throughout Ontario who have learned how to gain the trust of these people. One of the difficulties that you have, and you certainly see that when you start to actually meet people who get in trouble with the law—I'm talking about constantly; any young man can get into some minor trouble. What you soon realize is that they don't really think that anybody is actually very good. They think we're all really actually criminals; it's just that some of us are luckier so we don't get caught. They think we'd all steal as long as there was no chance of getting caught. They don't think there are good people, because they haven't met them. One of the things we try to do—partly, we hope, by example, but also by other means—is to help them understand, "Look, the vast majority of people out there may not be perfect, but they're actually pretty good. Most people really are basically honest. Sure, nobody's perfect, but they're pretty good." Because they don't believe that. They have almost invariably—I'm talking about the ones who are continually in trouble. They have usually had very, very miserable backgrounds.

As for female offenders, I don't think I've had one female client, in a criminal sense, who did not have a serious abusive background. Serious offenders have almost invariably been sexually abused as children. If you've got a woman in serious trouble with the law, you can almost bet your bottom dollar she was sexually abused as a child. It just always comes out. It takes a while to get them to tell you that.

But these people need help, and they often can't get it in the more traditional—sometimes they can, but they can't always get it in the more traditional health services area, because they are not comfortable there and they have trust issues. Of course, they often need help not only with mental health issues, but also with the other kinds of issues, life skills and educational skills and so on, that even get people who don't have mental health problems into trouble with the law. So they need to get help from both of those areas. I hope and think that that's what we can offer.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. I'm sure there are some questions. Just two things: At some point in the proceedings I know we heard from a delegation from John

Howard in Thunder Bay and we heard from a delegation from Kingston as well. We also received a letter as a committee saying, "We kind of feel left out of this as the John Howard Society." That certainly was not the intent of the committee. We felt we were hearing from you. Is that all cleared up now?

Ms. Paula Osmok: Thank you. I think you and I corresponded regarding that. The delegation in Kingston was a misunderstanding. I think our national director had been invited by the national mental health committee to present, and there was confusion, I think, when the person called and booked the appointment. He just assumed it was for the committee he had just received the letter for, so of course he came. I think he very clearly identified that he was not presenting in the context of the issues you were looking at but went ahead and spoke about the issues that he was concerned about in the federal prisons anyway. Yes, that was cleared up. That was unfortunate.

The Chair (Mr. Kevin Daniel Flynn): Good, so we're all on the same track.

We've heard two things, I think, going back to the very early presentations. I think we had a mother come in and say, "Thank God my son got charged, because he finally got the help he needed." We've had people come in and say, "My son can't get the help in jail. They just put him in jail and he gets no treatment at all." We've heard both sides of the story, so maybe in some of the questions you could answer that as well.

Are there any questions from members of the committee. Liz?

Mrs. Liz Sandals: Yes. A bunch of questions, actually. The statistic around 90% of women who are incarcerated having some sort of addiction issue is just astounding. Maybe on reflection it's not all that astounding. If you were going to redesign the system somehow, how would you redesign it? You tell us how you would redesign the system so that we're dealing with that more effectively.

Ms. Paula Osmok: I think two things. First, in terms of the women, the female population, I think that we need to be very cognizant that there is a specialized group, Elizabeth Fry, that also works with women. I don't know whether you've heard from Elizabeth Fry yet in your consultation process, but they are one of the community criminal justice organizations that we have worked with as a coalition and have sent you some material from. First of all, I would defer to them, although I know Bruce can speak to some of that—

Mrs. Liz Sandals: Excuse me; I wasn't specifically just talking about women, so talk about men and women, because I understand John Howard serves men.

Ms. Paula Osmok: Yes, and we do serve women as well. We just don't want to not have Elizabeth Fry recognized in the process.

I think Bruce's comments are very important ones regarding the background of a lot of women. Certainly the backgrounds, generally, in men and women who come into the system are different. There are some glaring similarities but there are also differences, and you will find the women to be of much higher need in many cases. Generally, people who come in—there is a disproportionate number with addiction problems, we know that. In terms of turning that system around, we are very pleased with some of the efforts this government has made in terms of trying to identify those needs. Someone who enters this system, who also displays mental health concerns—there's no question they need some specialized intervention or diversion at that early entry point. It could be something whereby there has not been a diagnosis, or there has been and somebody has gone off their meds and it's simply a matter of getting some supports in place quickly. So a diversion type of initial intervention is really what's quite appropriate. Otherwise it's completely criminalizing mental health behaviours or mental health issues, which is not something we want to do. And it's a very expensive way of responding through the criminal justice system.

Mrs. Liz Sandals: What about a person who is convicted and who is then either sentenced or released, or has been on remand forever and gets convicted and more or less instantaneously released? Then they end up on your doorstep. What sort of more extensive services would you like to see provided? Because there is, I presume, a huge need there that you're trying to meet but you don't really have the capacity to meet that huge need in an ideal way. What other services would you like to see in place for those folks when they are released?

1620

Ms. Paula Osmok: I'll start and then I'm going to hand that to Liisa because, again, coming from an agency that's on the ground, in the trenches, if you will, I think she has a list that's quite lengthy.

First of all, I'm sensing that you recognize that, as Bruce pointed out, the John Howard Society is the go-to place for anyone being released from prison.

Mrs. Liz Sandals: Actually, that's quite true in my community.

Ms. Paula Osmok: Yes, and it's true in the prison, because when there is a request made for someone to be seen, it's made through the institutional correctional officers to see John Howard Society. So we tend to be that first stop. Coming out, there is a range of things, from the ability to do even a brief assessment, again, to access to the information and supports to monitor, supervise in not necessarily a legal or a policing-type capacity, but to provide ongoing supports where people can access services that help them to reintegrate again. It's not saying that there won't be medical issues throughout that person's time back in the community; they're going to need ongoing medical care. But the other types of supports that would come from the John Howard Society are also critical to complete that reintegration and have them live successfully.

There is some data that was gathered some years ago but has been pulled together more recently by Don Andrews and Jim Bonta, who many of you will recognize in terms of leaders in the criminal justice field, that

recognized that once those initial mental health issues are dealt with, there is great success in integrating that particular population with, generally, the criminal justice population and offering the same services, that there isn't a need to specialize once those initial concerns are addressed, which is very interesting.

Liisa, I know that you have some things you'd like to say.

Ms. Liisa Leskowski: I think top of my list of what we need that's not being funded, we need services when a person gets released. I'm always shocked that as a society we have a system where you're incarcerated—you take away someone's freedom. That's how we choose to act when someone breaks the rules of our society—you're incarcerated. If you're incarcerated, the longer you're incarcerated, the harder it is for you when you get out. You've lost your job, you've lost your family, you've lost any source of income. If you went in with distress or mental health issues, you came out with even more baggage than when you went in. And the ministry wipes their hands of you the minute you walk out that door. We struggle to get services and funding to help the offenders when they get back in the community. There's no housing; there's no funding for housing. There's no funding for a reintegration worker. Corrections will give us a contract but it's always just a little bit of money. I think as a society we need to ask ourselves, when we release someone, isn't it better to release them with supports than to just let them walk out the door? I mean, there are cases where they walk out in that orange jumpsuit, they walk out with nothing, with the clothes they wear on their back. We struggle to make sure they have a winter coat when they get out in the wintertime, released from the district jail where they're sitting on remand. That is a piece that has to change if we're going to help individuals when they get released.

The huge portion of individuals have been in jail before—once, twice, three times. It's that revolving door. Of course, when they get out and they've lost all their supports and they're going to a shelter or an organization like the John Howard Society, the Elizabeth Fry Society or the Salvation Army that recognizes the need to help people move on with their lives and make the changes—for me, that's number one.

The other piece: The research clearly shows that therapeutic interventions are best done in the community. They don't work in institutions. When parole officers try to deliver programs—and they do, but it's almost like the police that arrested you, you're now then going to go to them for drunk driving lessons. We have to recognize that there are different roles for different folks to play, and that trusting therapeutic relationship is really crucial in helping people make those changes.

The Chair (Mr. Kevin Daniel Flynn): We've got a number of other questions. I'm going to go to Sylvia, then Bas, then Jeff.

Ms. Sylvia Jones: Thank you. First let me apologize for being a few minutes late. It seems that in this building there's always three things to do in the same hour. I know Christine is committed in the House right now, and France is attending a Franco-Ontario honouree. So it's not because of lack of interest that they're not here.

My question actually follows through on your last statement. You mentioned the interest on behalf of the John Howard Society in accessing health care funding for mental health. Knowing the chronic, continuous shortage that we have of health care professionals, and then multiplying that by mental health professionals, why do you feel it's so necessary to have the mental health dealt with within your agency? Why is the ability to open those doors, to make those referrals, not something that you would look at or recommend?

Mr. Bruce Simpson: I think there are two answers to that. Of course, in part, that is one of the things that's helpful. I know that in Ottawa, the Royal Ottawa Hospital is there. It has an excellent forensic unit, so it is possible to interact with people there. That's one way we can help our clients, by referrals.

But there are really two difficulties that our clients can have. One is that they're often not comfortable in the normal hospital setting because of their other issues that they come with and their other baggage, and having been in jail. And sometimes, quite frankly, the hospital staff aren't comfortable with them either. They'd rather not have to deal with them, because they're often not trained to deal with people with those kinds of problems and issues—the mental health part, yes. But many of our clients, in addition to having the mental health issues, also have some of the other issues that make people get into trouble with the law, and that other mental health patients don't necessarily have. They need help with their mental health issues, but they also need serious help with things like job readiness and basic life skills, and even just to understand, sometimes, why certain behaviours are forbidden and why people get upset with them. There's often a serious lack of understanding of some things.

There are people who are trained to deal with mental health issues but who also understand the other kinds of correctional issues that are involved. We have, for example, one very good psychologist on our staff at the John Howard Society of Ottawa. We need to have people like that, because then we can help people with both kinds of problems.

Of course, I don't think, in the long run, it costs a lot of money, because if we take some people away from the more traditional mental health problems, they're overbooked as well. That doesn't mean lack of coordination or lack of communication. That's important.

Ottawa is very lucky. We have an extremely good mental health centre there, and it's coordinated with the mental health centre in Brockville. But not every community has the same level.

Ms. Liisa Leskowski: If I could add to that, I'm not saying that community mental health organizations shouldn't be funded. I absolutely think they should. I think there's enough work for all of us. But the reality is, when they come through our doors—I'm unique in

Thunder Bay; I run a housing facility and they're living with me—I cannot get any support. They have two workers who will come and take a referral, and we do referrals all the time and do an assessment, but it's 9 to 5, Monday to Friday. I'm supporting this client 24/7. I use my United Way dollars to try to help me provide services.

The other issue is, I think, the traditional mental health system often refers clients to us because they're too violent. We're the ones with the expertise in dealing with the violent, criminogenic risk factors. We train our staff in that. We do serious risk assessments. Oftentimes, community mental health service providers aren't prepared to deal with this client group. This is where our expertise is. This is where we're delivering services.

But we struggle because it's so hard for us to get community funding. There's ministry funding while they're incarcerated, but it's hard to get community funding when they're released. Add on top of that the mental health concerns, and I just sometimes feel like it pushes us over the top.

We struggle to find services. I've got a staff that's got a caseload of 40. The mental health worker says, "Oh, I'm at my limit. I have five clients. I can't take your referral"—or whatever that ratio is in the health system, which is a totally different funding model. Nobody protects to make sure that I'm not over a limit, when you're in a community-based service and you're just getting foundations and United Ways to help you deliver services.

1630

Ms. Paula Osmok: If I can add as well, in response to the sorts of concerns that we're all raising with you: Our executive directors across Ontario—and that's a team of 19 people—met with a number of providers from our agencies and developed, along with our research staff, a model program that we wanted to pilot. We talked to the Minister of Correctional Services, who was quite keen on the program.

It's a post-release program, and it focuses on the high-risk, high-needs clients, many of whom have mental health problems. We wanted to pilot it for a year or two, follow it with a very rigorous evaluation and see what difference it made in terms of their recidivism, and also measure the cost savings based on a lit review that we've done and some research into service costing, because we believe that, with an ongoing worker and providing the kind of services that Liisa's talking about, we can prevent them from getting back into the system.

If you think about it—and I know you're well aware that oftentimes, a behaviour outbreak or outburst results in the police being called, and they are either formed, they're held in jail, or they're back-breached and they are in prison. The cost of those interventions, including a possible stay in emerg or a referral to another hospital, is huge.

We honestly believe that with the types of interventions we do, we can reduce that down to a very manageable number, and a program like that would pay for itself many times over in a very short time frame.

We met with the Minister of Finance as well, and we recognize the budget constraints, but we honestly think that if we could scale down and do this in a very small pilot way and perhaps look at Toronto and Thunder Bay, where, of course, with the disproportionate aboriginal problem in the Thunder Bay area and the diverse population in Toronto—and Toronto, as you know, is also, for lack of a better word, a bit of a dumping ground; a lot of people come to Toronto who have nowhere else to go or no supports at all—these would be two communities that would really lend themselves to being monitored and researched, evaluated around an intervention like that.

That's something we'd be very happy to submit to you, what we have put together in sort of an overview kind of way that wouldn't be too extensive for you to read, to let you know and partly answer a list of your questions: What kind of interventions would work and what are the alternatives to the traditional siloed approach that we're seeing right now?

As Liisa points out, there clearly is some resistance from the Ministry of Health-funded agencies in the community. Although there is some working together, and some referrals are accepted, there really is some resistance to what we would say is a very effective working relationship in the community with other community-based agencies.

The Chair (Mr. Kevin Daniel Flynn): We have a very short amount of time left, and we've got Bas and Jeff. If these can be really quick and short answers, that would be great. If not, we should just call it right here.

Mr. Bas Balkissoon: I've just got two quick ones. You talk about funding; can you tell us, other than the United Way, where you receive the majority of your funding or other funding from? On this document, you have some recommendations here. In the third bullet point, can you tell me what the abbreviation HSJCC stands for?

Ms. Liisa Leskowski: Yes. It stands for the Human Services and Justice Coordinating Committee. Those are committees that were set up under the last round of provincial funding that went for mental health that went to health-funded organizations. They coordinated these committees across the province.

It's all mental health, and I think, Kevin, what you've picked up on is, we've been trying to get to the table, and there's such resistance to include us in that because that's seen as health. They sent a provincial response—I chair our local committee, and my response that you see in that bullet point was saying, "Reject their recommendation that money for this initiative should only go through health." We're saying it needs—

Mr. Bas Balkissoon: Do you know which ministry conducted that?

Ms. Liisa Leskowski: Conducted the—?

Mr. Bas Balkissoon: The human services—

Ms. Liisa Leskowski: It was a joint committee of a number of ministries that got together, and I think all the funding now for this flows through the LHINs from the Ministry of Health.

Mr. Bas Balkissoon: Okay. And the other one is, who do you currently get your funding from, other than the United Way?

Ms. Liisa Leskowski: We have tried really hard to be part of that initiative. I've worked really hard. I'm really passionate about this, and we still feel like we're on the outside. For all of the services that are happening right now in the province of Ontario and the provincial dollars that have been allocated to mental health services, it all still flows to mental health agencies.

Mr. Bas Balkissoon: No, my question is, you've mentioned you receive funding from United Way. Is there any other source of funding to your particular organization?

Ms. Liisa Leskowski: We have numerous funding for all the various programs. For the discharge community-based pieces, it's only United Way for my organization.

Ms. Paula Osmok: If I can add a little bit to that, taking into account the funding situation with all of the John Howards across Ontario, that would be the case. But United Ways, as you may or may not have heard, are moving into a different model of distributing funds and allocating funds. First of all, it's a donor designation model. So motherhood organizations that are very easy to support tend to be pulling in lots more dollars from United Way, and they also are finding a level of discomfort around criminal justice populations; they have for a number of years. It's really a major effort that has to be made to convince them, so that United Way funding is slowly disappearing.

John Howard of Ontario has a direct mail campaign that we administer, and we distribute that funding back out to our affiliates for institutional pre-release work to try and do at least as much as they can in the institution and have things in place on the outside when they are released. But that amount of money is $65,000 that is distributed. Obviously, it's just a very small amount, and we distribute based on both need and institutional release populations across the province, so it's really insignificant.

There are two, I believe, discharge planning contracts that allow, through maybe looking the other way from the ministry, a minor amount of help in the community, but I think that's only two across the province.

The Chair (Mr. Kevin Daniel Flynn): Jeff, final question. If you could make it brief.

Mr. Jeff Leal: It will be two quick ones. The percentage of clients that are First Nations individuals?

Ms. Liisa Leskowski: In Thunder Bay? Across our programs it probably averages between 55% and 60%.

Mr. Jeff Leal: Between 55% and 60%.

And every group that has made their presentation to us over the last many months has talked about silos. Have you got any good suggestions on how to blow up these silos? Sorry to put you on the spot, but I want to know.

Ms. Liisa Leskowski: You know what I think? I think that it has to come from the ministry. I think it has to come from a government level. I think how you fund in a competitive environment, making agencies, number one, compete against one another for contracts—if we're going to fund social services that should be funded, "This is what we need to fund, this is the resources, this is who's doing the work, here's the funding for it." I think that silo structure is a by-product of how funding is distributed.

In terms of how do we—and at ground level now that we're not going to be able to change that very quickly, I would recommend that we take resources and we share the resources, we ask organizations to collaborate, but the resources are shared amongst organizations.

Mr. Jeff Leal: Do we have too many organizations?

Ms. Liisa Leskowski: No. There's more work that needs to be done. The work is huge. It's not like one of us can do it. One sector can't do it by itself. We all need to work together.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was really appreciated.

Ms. Paula Osmok: Would you like us to submit our remarks to you? I guess you've got them captured through Hansard.

Interjection: The gentleman at the back there has got it all down, word for word.

The Chair (Mr. Kevin Daniel Flynn): Thank you, and thanks for your patience.

Mrs. Liz Sandals: Can we figure out a way to open the windows so we can breathe?

Mr. Bas Balkissoon: They're open already. Nothing is blowing this way.

1640

SCHIZOPHRENIA SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Okay, our next presenters are from the Schizophrenia Society of Ontario. Have a seat anywhere you're comfortable. Thank you for your patience; thank you for waiting. We fell behind a little bit in our schedule today. If you could leave a little bit of time at the end for questions—you saw the last presentation. Often there's more—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yeah, they have a lot of questions. I'm not trying to tell you what to do, other than you've got a very curious group before you here. Having said that, it's all yours.

Ms. Vani Jain: Do you mind just giving us two minutes to get connected? Is that okay?

The Chair (Mr. Kevin Daniel Flynn): Are you the starting speaker?

Ms. Vani Jain: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, go ahead.

Ms. Vani Jain: In the interest of time—this might take a few minutes to set up—we're happy to go ahead with the handouts, if that's better for you.

The Chair (Mr. Kevin Daniel Flynn): Yes, if that works for you. It's just my fear is, we're a little bit behind already, obviously, and we don't want to fall any

further behind. But I don't want to make you uncomfortable in your presentation either.

Ms. Vani Jain: No, I'm fine, as long as everyone else is.

The Chair (Mr. Kevin Daniel Flynn): Okay. We're all yours. If you could introduce yourself for Hansard before you speak, that would be great.

Ms. Vani Jain: First off, we just want to thank you for inviting us here to present on the topic of mental illness and the correctional system. This is an issue that is of great concern and interest to us.

By way of introduction, my name is Vani Jain. I'm the manager of policy and community relations at the Schizophrenia Society of Ontario. I was here last September, presenting along with our executive director, Mary Alberti.

Sheila Deighton is our regional coordinator in the Ottawa office. She also sits on her local human services and justice coordinating committee. She's also a family member and will be speaking from that point of view today. Alistair Deighton is Sheila's husband, and has lived experience with both mental illness and the criminal justice system. So Sheila and Alistair will be sharing their experience with the correctional system.

To the next slide: briefly, just a little bit about our organization. Our mission is to improve the quality of life of those affected by schizophrenia and psychosis, through education, support programs, policy and research.

Our justice and mental health program works with families of people with mental illness who are in contact with the law. Mental health and justice is a priority area for our public policy department as well.

I should note, before we begin, that our presentation is based on our own experience with the correctional system as a mental health agency, and our own review of this topic. The data provided in the presentation are drawn from other sources, so while we will do our best to answer your questions, we may have to get back to you on a couple of things.

To the next slide: We wanted to start by giving you a snapshot of what the correctional system looks like. Overall, there are 31 institutions in the province. Ten of these fall into the category of correctional centres. These house individuals with sentences of 60 days up to two years less a day. Offenders in correctional centres are eligible for education, counselling and work experience programs.

Four of these 10 institutions also serve as treatment centres, which is where those with the most pressing mental health concerns go for specialized services and treatment. St. Lawrence Valley in Brockville, which you may have heard about, is an example of a treatment centre in the correctional system.

Finally, there are 21 jails and detention centres. Jails are typically older, smaller institutions, while detention centres are larger and more modern and serve the needs of an entire region. These institutions are for individuals who are sentenced to less than 60 days, are on remand or awaiting transfer to another facility.

Overall, these 31 institutions across the province serve 8,900 inmates.

To the next slide: We're just going to give you a little bit about the inmate population. The Ministry of Community Safety and Correctional Services estimates that approximately 63% of its inmate population is on remand, which means that they are in detention during their court proceedings, awaiting sentencing.

In their presentation to you, the ministry indicated that about 50% or more of these inmates on remand are released within eight days, which is certainly true. However, the other 50% or so can be there for any length of time. That can be quite long; we ourselves have seen remand periods of even 20 months. Inmates with mental illness may have longer remand periods if they have delays in their trial associated with their mental illness. The unpredictability of the length of remand time poses some serious challenges which we will discuss later. It should also be noted that the ministry estimates in their latest strategic plan that about 15% of inmates require clinical intervention for mental illness.

Moving along to some of the prevalence data, there has been a number of studies conducted worldwide looking at the prevalence of mental illness in correctional facilities. These all use different methodologies and different samples.

The data that we've provided for you here is based on a study from Dr. Greg Brown at Nipissing University, which specifically looked at provincial correctional institutions in Ontario, so it's the most relevant data that we have. In its face-to-face assessments conducted with 522 inmates, his study showed that 6% of men and 5.7% of women had a diagnosis of schizophrenia, and 12.7% of men and 24.5% of women had a diagnosis of mood disorder. An examination into the symptoms of mental illness, which may provide a more accurate picture of the prevalence of mental health issues than diagnosis, indicated that 5% of inmates demonstrated a high number of severe symptoms, and 35% of inmates demonstrated a moderate number of severe symptoms.

What we draw from that is that the prevalence of mental illness in correctional facilities is much higher than in the general population. For example, 1% of the general population has schizophrenia versus 6%. Substance abuse rates are also much, much higher, as much as eight times that of the general population.

That gives you an idea of who these inmates are with regard to mental illness. In terms of the correctional system's capacity to treat mental illness amongst inmates, there are 220 full-time health care employees, not including managers. This figure includes 11 psychiatric nurses, meaning that not all institutions have a psychiatric nurse on staff. Nine of the 31 institutions have designated special-needs units for vulnerable inmates with cognitive and/or mental health needs so that they can be housed separately from the rest of the population. Three out of the 31 institutions also have infirmary units, which are for people whose needs are much more intensive. Of the 31 institutions, nine provide mental health care

services 24 hours a day, seven days a week, while the rest have 16-hour-a-day mental health service.

At this point, we're going to turn to our understanding of what's actually happening in the correctional institutions. The first area that I will go over is screening. The importance of screening new inmates is clear, both for the purposes of inmate classification and to ensure that those who have pressing mental health needs are flagged so that these needs are addressed. In Ontario, new inmates do receive a medical assessment which is meant to screen for mental health issues as well. This assessment is supposed to happen immediately, but this may not always be the case, depending on when the inmate enters the facility. If the individual is flagged for mental illness, this may initiate a more in-depth mental health assessment, but this practice, to our knowledge, is not formalized, and it can vary from institution to institution.

The literature recommends a two-stage screening and assessment process as the best way to effectively identify those with mental health concerns, which would subsequently inform treatment and correctional plans. As an example, the Correctional Service of Canada has recently moved to a new formalized two-stage process called the computerized mental health intake screening system. Stage one involves a brief screening; it takes 30 to 40 minutes to complete, and it's self-administered. If the individual is identified as presenting symptoms of mental distress, they'll go on to stage two, which is a more in-depth assessment.

Really, what we're trying to say here is that unless we know which of our inmates have mental health concerns, we can't properly address those concerns, thus making mental health screening a really vital part of the whole correctional system.

1650

Moving along to treatment: In terms of treatment, as mentioned, all institutions have some health care professionals on staff, including psychiatrists and psychiatric nurses. The exact staff complement varies by institution. One good thing to mention is that all inmates have health care coverage through OHIP, and those who don't qualify can obtain temporary coverage.

In our view, one of the challenges is that psychiatrists really seem to only have the capacity to address pressing medical needs—in other words, basically prescribing and monitoring medication. They're not really able to go much further than that.

For those who enter the facility without a prescription or who have their medications confiscated for whatever reason, these individuals may not be able to access medication for several days. What we know for our folks is that this can mean significant decompensation over that period. The psychiatrist in the jail might also prescribe a new or different medication which the individual may have some difficulties adjusting to, especially given the setting that they're in, which is not a particularly supportive environment.

SSO certainly sees a need to provide greater access to comprehensive psychiatric care for its provincial inmates. Another interesting thing—and I'm drawing some parallels to the Correctional Service of Canada because there's quite a bit of movement at that level. One thing that they're doing is, they've recently introduced telepsychiatry for their federal inmates. This allows the inmates to be connected to a psychiatrist in the community via video conferencing. That type of video conferencing is frequently done for court proceedings. The technology may be very well available. The program is quite new, and our suggestion is that this be evaluated and monitored with a view of possibly instituting it in provincial institutions as well, as it may be quite promising as a way of providing access to psychiatric care.

Moving to mental health programming: As mentioned, programming is available in correctional centres for sentenced offenders. Inmates on remand, however, do not have access to this type of programming, which can be very problematic. While many of them are released quickly, others are there for a long period of time and would definitely benefit from the type of programming that is offered in other institutions.

One of the specific needs that has been raised with us with regard to programming is really a need for more psychosocial programming for inmates, such as behavioural therapy. Addictions counselling was another important need that came up, as so many of the inmates with mental illness also have co-occurring substance use issues. If the addictions issues are not addressed, the individual is much more likely to re-enter the community and use again, putting them at risk of reoffending. It's really important that those issues are addressed in the institution as much as possible. Overall, we feel that comprehensive programming is necessary for all inmates in order to help them gain insight into their behaviour and prevent recidivism.

Like in the community, medication is one part of treatment, but it's not the only part. Individuals with mental illness should have access to a more holistic approach to treatment and care. One way to facilitate this may be more community and corrections partnerships. This could include programs where a community mental health agency goes into the institution and delivers the service themselves. This would also help facilitate more communication between correctional staff and community agency workers. It's a model that we've seen to be really effective in the context of hospitals and community agencies, in the sense of facilitating that communication and making sure that the transition from the institution to the community is much easier.

The next slide is about suicide prevention. Recent incidents such as the Ashley Smith suicide, which happened at a federal correctional institution, have highlighted the need for corrections to better protect inmates from committing suicide. With suicide rates in jails and prisons at 10 times that of the general population, suicide amongst inmates simply cannot be ignored. We have concerns that solitary confinement is overused and may be seen as the only option for addressing inmates with mental illness who are exhibiting "bad behaviour." It

may also be used for people who are believed to be suicidal, as these strip cells, as they're called, do not provide the inmate with anything that they could possibly commit suicide with. So you're really seeing people put into six feet by six feet boxes, with nothing. What we know is that this type of setting is inhumane for people with mental illness in particular and that it can actually make the situation worse, not better.

A more appropriate suicide prevention policy would be based on risk management. New inmates should be assessed for their risk of suicide upon entry, and then again as red flags are raised. These individuals should be provided with counselling and possibly even a psychiatric bed, but not put into a strip cell.

Howard Sapers, the Correctional Investigator of Canada, has recommended that the federal segregation policy be amended to require psychological review and assessment of risk for anyone being put into solitary confinement, which we think should be applied at the provincial level as well. We've also supported recommendations that solitary confinement be used only as a last resort, and for as short a time as possible, and that inmates have access to mental health services which would more appropriately address their mental health needs and reduce correctional staff's dependence on solitary confinement.

Next is release planning. Proper release planning is essential if we expect people to be successful in the community upon their release. However, many institutions do not have the internal staff resources to commit to comprehensive release planning. They may also not be able to attend to the special needs of inmates with mental illness that they would have in the community. What we're seeing is too many people falling through the cracks as soon as they re-enter into the community because they were not connected to the appropriate resources or treatment supports.

One approach to address this issue is release-from-custody programs. These programs, offered through community mental health agencies such as CMHA and COTA, have staff that help develop release plans for inmates with mental illness. Typically, these release planners will obtain referrals from correctional staff as soon as the inmate enters the institution, or as soon as possible. They can be referred inmates on remand as well as sentenced offenders.

The release planner goes into the institution, meets with the individual, discusses what their charges were, what supports they have, what supports they would need in the community. This includes things like housing, treatment, even ODSP applications. For sentenced offenders, they would take into account the release date, and, for those on remand, they're still able to work with those clients. What they do is, they keep track of their court proceedings and try to kind of estimate when the person will be released. So it is a service that can be provided to those on remand. The release planner then continues working with the individual for up to six months in the community to ensure that they are connected with the services that they need.

On to the next slide: Release planning is only effective if the appropriate community supports are available. The main challenge for release planners is that there are not enough, or the right type of, community services for their clients. The system simply does not have the capacity to meet the needs of these individuals.

Another challenge is that individuals with criminal histories may be labelled as "high risk" and actually screened out of community programs and doctors' offices. So this is a stigma issue that needs to be addressed. However, we may also need to look at funding for programs that are geared specifically towards individuals with past criminal histories and have the right staff and resources to support those individuals.

Waiting lists for service as well as intake procedures that require face-to-face assessments in order for a person to be accepted into a program are also a barrier for inmates who need a release plan.

Just a couple of other quick issues of concern before we move on to our other presenters—two issues that we wanted to mention quickly. The first is victimization and abuse of inmates with mental illness in correctional facilities. In a jail setting, individuals who are visibly different or whose behaviours may be interpreted the wrong way may be at risk, especially if they're not properly identified during intake and actually put into the general population rather than a special-needs unit. The killing of Jeffrey Munro at the Don jail last November is an example of the worst possible consequence of what can happen with victimization.

The second issue is the lack of family involvement. Whether we're talking about the individual's time spent in the institution or their transition back into the community, family support or support from friends or anyone, when available, is crucial. Yet there are many barriers that families and friends face in staying involved with their family member in the correctional institution.

For example, a policy of collect calls only can be a huge financial burden on a family that really wants to stay involved with their family member. They may also have difficulty calling in to talk to their family member in the institution. They may also have challenges communicating with the correctional staff about how their family member is doing, just calling to see, "Is everything going okay? How's he doing?"—that kind of thing. It can also be frustrating to not be informed about important decisions, such as their family member's release, especially when that person is coming back to live with them.

Staying on the theme of families, I'll now turn it over to Sheila and Alistair to tell you about their personal experiences. I think we're going to start with Alistair.

1700

Mr. Alistair Deighton: Hi. My name's Alistair, and it started off in the Cornwall Jail, from January 31, 1995 to April 10, 1995. I should have taken extra medication before I came here.

I was remanded to the Cornwall Jail awaiting a psychiatric assessment bed at the Royal Ottawa Hospital.

The Cornwall Jail was built in the early 1800s. The cell was crowded: three people in a two-man cell. I slept on a mattress on the floor with my head right by the toilet. I was afraid that if I slept with my head by the bars, my head would be kicked, in that inmates kept threatening to get me.

At one point, I was given an antidepressant medication, but the guards would open the capsule and put the powder in a Dixie cup for me to take with water. The medication would burn my throat for about one and a half hours afterwards. I was only allowed two visitors a week, a maximum 20 minutes per visit.

I was paranoid, so I warned anyone who came to talk to me that they were listening in. I was very suspicious of one of my cellmates. He was writing things down all the time and I thought that he was spying on me. I was in a very bad state of paranoia. I did not see a psychiatrist while there.

Admission to the Royal Ottawa Hospital: April 10, 1995 to November 1995. On April 10, I was admitted to the forensic unit of the Royal Ottawa Hospital for a court-ordered assessment. I was so ill, I was found to be unfit for trial. I was diagnosed with schizoaffective disorder. I received treatment of antipsychotic medication. Within two months, with treatment, I became fit for trial. I remained at the Royal Ottawa until late November, when I was remanded to the Ottawa-Carleton Detention Centre, pending my trial in March 1996.

Ottawa detention centre, 10 days at the end of November 1995: When I was transferred there, I was placed in a segregation cell with no heat and given a silver sheet and nothing else. I was freezing. I stayed overnight like that. I was so cold that, in the morning, I told the guards I didn't care where they put me as long as it was warm.

I should have gone into segregation, but I went into the general population where the environment was threatening, violent and I feared for my safety. The stress of this environment caused me to relapse. On a court order, I was readmitted to the Royal Ottawa Hospital, where I remained until my trial on March 19, 1996, when I was found to be not criminally responsible due to a mental disorder.

When we talk about—

The Chair (Mr. Kevin Daniel Flynn): Take your time. There's some fresh water there and some glasses.

Mr. Alistair Deighton: When we talk about fear, when I went to the detention centre after the night of freezing, they put me in with the regular population. They gave me a roll, which was a mattress and a cloth blanket, and I was told to go to such and such a cell and such and such a bed. So I went in there, there was nobody there, but just like that, bang, a guy came running in and he said, "What are you in here for?" I said, "None of your business." He said, "What are you in here for?" I said, "None of your business." This went on for about five or six times. Then all of a sudden, two guys came by the door. So I'm facing this guy in front of me, and I'm facing two guys over here. What are you going to say? What are you going to do? So I said, "I'm here because of murder." The fellow turned around to me at the door and he said, "Oh, murder. Is that all? Well, that's okay. Pleased to meet you."

That made things a little bit easier.

Later, before I left, the fellow who first of all presented himself to me and demanded things of me said, "I was rather impressed with the fact that you stood up for yourself." Luckily, I had the sense to make sure that I did stand up for myself, because if I didn't, I would subsequently have been treated in a very poor way.

For example, one of the problems is my age. Most people who are in jail are much younger, so they assumed that I was a pedophile because of my age. Well, there was a pedophile in there, he was down at the end of the range, and whenever the guys felt like having a punching bag, down they went and they just punched the hell out of him.

Anyway, that's my story. I can only say that my wife helped me out, because when I was in the Cornwall Jail, I was sent back once from Ottawa. Dr. Bradford had given them—

Ms. Sheila Deighton: A list.

Mr. Alistair Deighton:—a list of what medications I was supposed to have. Well, while I was there, I wasn't getting these medications. So I had been medicated, brought to the point where I was no longer suffering from psychosis, sent back to jail, not given the medication, so I started to become psychotic again. Well, thank God, I called my wife and I told her what was happening, and she called Bradford, they called the jail and, just like that, I had my medication.

Anyway, that's my story. Thank you for listening.

The Chair (Mr. Kevin Daniel Flynn): Thank you for telling us. Sheila, did you have something to add?

Ms. Sheila Deighton: I'm here today to speak as Alistair's spouse and as a family member and the work I do with families at the schizophrenia society.

Alistair, as he shared with you, was charged with murder. He had a complete psychotic break and he killed our son. He was under the care of a psychiatrist at the time who was not treating him with medication. He was just using talk therapy. That's similar to a person who has type 1 diabetes not being treated with insulin.

In Alistair's family, there's a long history of psychiatric illness. His mother was diagnosed with schizophrenia when he was four. His grandmother had schizophrenia. Our son that died was displaying symptoms of mental illness; he was 18 and had made a serious suicide attempt. But the mental health system failed our family, because we were told, even with our son's suicide attempt, that he was 16, and he refused admission to a hospital. He jumped 30 feet, he hemorrhaged and nearly died. Six days later, they discharged him from hospital to a family who had no support, no education, nothing; to a father who was struggling to cope with work and family, and no treatment. So what did it take to get help and care for our family? It took this.

Unfortunately, our access to treatment came through the forensic mental health system and the criminal justice

system. He spent two and a half months incarcerated, sleeping on a mattress because of the waiting list to get into the forensic bed at the Royal Ottawa Hospital. There are so many people—there were 20 people ahead of him. Every day I would call to find out, "Where is he? Has he been transferred yet?"

1710

Finally, when he got transferred, and he was transferred into the hospital, that's when our life changed. That was a new chapter for us. He was in a therapeutic environment, provided care by professionals who didn't look at what he was charged with but looked at him as an individual, professionals who looked at our family as a whole, who provided support and education for myself and our two surviving children. And he got treatment.

I had an opportunity to read through your interim report, and I noticed in the report that I kept seeing that people need "a home, a friend and a job." Yes, they do. But first and foremost, they need medical treatment. Without that foundation, they're not going to be able to sustain a job or a home, and they're going to lose their family. So it's not one piece; it's a complex puzzle.

I can speak from personal experience. Alistair spent 18 months in the forensic unit at the Royal Ottawa Hospital. I was like Joe Public and had very limited knowledge of mental health, had a tremendous amount of fear. But spending that amount of time in that hospital, I had an opportunity to see traumatized families who were supporting loved ones who were not functioning, who were suicidal, some of whom had committed serious offences, others minor. I saw them go from a state of incapacity and poor quality of life to people who got their life back with treatment, with medication, with therapy, with support.

Thank goodness Alistair spent that time at the Royal because they were able to—as he said in his statement, he was so ill that he was unfit for trial when he was transferred to the Royal. With treatment, he responded well. But when he responded, he started to have insight into what he had done, and thank goodness he was in a therapeutic setting and we had that type of support as well.

Today, I'm sorry to say, I take the same calls from families. I take calls from families who have exhausted all avenues of trying to get their loved one into care, because we have a system that respects an individual's right to be ill until they become homicidal, suicidal or incapable. Sometimes, I have to tell them, "If there's an opportunity to charge this person, you might have to do that."

But at the same time, I prepare them for the fact that if they end up remanded in a correctional facility, they may be there for 10 weeks. I have gone to court with families where they've had to take that step, and the mother is crying because her son is in the prisoner's box, he's lost 20 pounds, he's unshaven, he's dirty, and she feels guilt. But at the end of the day, going through that system, it's painful at the time, but getting treatment through the forensic mental health system, you have good positive outcomes.

Mr. Alistair Deighton: One thing I would like to mention is that when somebody with mental illness does a criminal act, what happens is that the lawyer will tell him that he can get out quicker if he takes the criminal route. If he takes the mental health route, he's going to be incarcerated for a longer period of time under the ORB. It's a crime, because we have people being criminalized who shouldn't be criminalized.

The Chair (Mr. Kevin Daniel Flynn): Our committee is looking at what the new system is going to—what we need in Ontario. We're trying to look at it in some cases through the eyes of an average Ontario family. You must have met as a young couple, decided to get married and, at some point, had three kids. At some point before the children, did you know that you were going to be dealing with this, Alistair, when you were a younger person?

Mr. Alistair Deighton: I walked into Dr. Bradford's office, and all of a sudden he was telling me things I didn't know. He told me that I was in the hospital, at the Jewish General in Montreal; I had no memory of that. He told me that I had been at a psychiatric hospital here in Toronto; I had no memory of that whatsoever. Because my mother suffered from schizophrenia, my father and my stepmother—what's the word when they—

Ms. Sheila Deighton: Stigma.

Mr. Alistair Deighton: They stigmatized me, right? I felt stigmatized because of the fact that my mother suffered from schizophrenia. But I got by, and the reason I got by is I'd turn to my wife and I'd say, "Am I seeing this right? Is this what's happening?" and Sheila would say to me, "No, Alistair. That's not what's happening; this is what's happening." So this is how I was able to get along. This is how we were able to maintain the household as it was. It didn't come into our marriage in front of us until my son started to show signs of schizophrenia.

Ms. Sheila Deighton: It was when our son, at the age of 15, started to have, really, behaviour that was a major concern for us. We tried to get help for him, but we were told by the mental health professionals that we were controlling parents and that we had a communication problem and a power struggle in our home, despite the fact that we presented them with the family history of mental illness.

The Chair (Mr. Kevin Daniel Flynn): So as an individual, did you know that you were going to have to deal with this when you married Alistair?

Ms. Sheila Deighton: No.

The Chair (Mr. Kevin Daniel Flynn): This was something that just hit you like a ton of bricks?

Ms. Sheila Deighton: Well, I knew that Alistair had a very traumatic childhood as a result of his mother's illness. When he was four, she had tried to kill him and his sister. They lived in Montreal, and she had to be institutionalized. That was in 1949, when there was not very much treatment available. Alistair and his siblings were separated and sent off to different parts of the family, and they really had no family life, I would say, until he was about 16. So after I met Alistair, there were

some things that were different, but I had attributed that to his childhood.

As I said earlier, I really hadn't given much thought to this being a risk. In fact, Alistair's father and stepmother were visiting us, and they said, "Oh, if you're thinking of having children, don't worry. We had Alistair examined by Dr. Walter Penfield in Montreal"—this was in the 1950s—"and he said, 'Don't worry. The kids haven't inherited the mother's genes. They're not going to have schizophrenia.'" I said, "Okay; cool. That's okay."

Alistair did have some difficulty. The psychiatrist who was treating him did start seeing him in the mid-1970s, because he was having difficulty coping, and he was told at that time that he needed to grow up, that life wasn't black and white.

So our interaction with psychiatry, both at the youth and adolescent level and private psychiatry, was not good. In fact, Alistair didn't have an actual diagnosis until he was in the forensic unit and Dr. Bradford diagnosed him with schizoaffective disorder with a major anxiety disorder.

Mr. Alistair Deighton: That's why I should have taken more pills before I came here.

The Chair (Mr. Kevin Daniel Flynn): You did a very, very good job.

Are there any questions? Liz.

Mrs. Liz Sandals: If this is too personal, don't answer: If I'm understanding correctly, the reason that you weren't on meds was that somehow, the psychiatrist with whom you were working had totally missed the fact that you were schizophrenic and should have been on meds. They were sort of going after this very troubled childhood and treating it as some sort of therapeutic thing you needed to talk through, and he totally missed the fact you were schizophrenic?

1720

Mr. Alistair Deighton: I think he believed in Jung and he believed in Freud. That was what he saw as the answer and the way through. So he didn't realize that it is a mental disease—like, you break a leg; I broke my brain. If you break a leg, you get a cast. I broke my brain, you have to get medication.

Mrs. Liz Sandals: So this wasn't a case of—because a lot of the situations that we've heard of are perhaps more like the problems around your son: somebody refusing meds and nobody being able to say, "No, no, you need the treatment." This really wasn't a refusal of meds; it was just a total miss on the diagnosis.

Ms. Sheila Deighton: And actually, following my husband's trial and the trial of NCR, I filed a complaint with the Ontario College of Physicians and Surgeons. They brought in a private investigator to investigate, and the outcome was that they found the psychiatrist failed to meet their standard of care, which was fairly significant. That was a long, painful process, I have to tell you.

Mrs. Liz Sandals: Thank you so much for sharing with us. It's a very difficult story.

Ms. Sheila Deighton: This is why we're doing what we do. We all are working towards making this system the best we can make it. If in telling our story and putting a human face and a family face—because this affected Alistair and our entire community. We live in a rural community, and I have to tell you, I had strangers coming to my door to find out how he was doing. They would share a story about a daughter who lived in Toronto who was ill. Everybody—we're not immune to this illness.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: Just very briefly—and I guess I should ask Vani this question. You mentioned in your document about release planning: "Community 'release from custody' programs help develop release plans and support individuals in the community." That makes sense to me. Yet what surprised me was the organizations that you named.

I'll put this to you and Alistair. As you transitioned from sentencing and custody back into the community, was there ever a role that was played by other agencies—the John Howard Society? Can you sort of expand on what happened at that point?

Ms. Sheila Deighton: I can speak to that. Actually, because Alistair was found not criminally responsible, he then was transferred out of the justice system into the forensic mental health system. We didn't have any interaction with any agencies at all. The transition was managed through the forensic unit of the Royal Ottawa. Basically, following his finding, he was returned to the Royal Ottawa Mental Health Centre, where he awaited the outcome of the Ontario Review Board hearing, which determined where he would stay and what his treatment would be. So he was under an order from the ORB, and that was managed through the Royal Ottawa Mental Health Centre and the Royal Ottawa Health Care Group.

One of the things that is true with the forensic system is that you have accountability. The Royal Ottawa Health Care Group is therefore accountable for management of this individual. As he transitioned from the hospital into community living, it was a step-down process, where they felt he was stable, he was discharged to a supervised home, but he relapsed within five days. It was the anxiety of the move from the hospital to the home, and I was in Dr. Bradford's office with Alistair. Alistair was sitting there, and his hands were going, his tongue was going and he was rocking. Dr. Bradford looked at me and said, "If you and I were on the medications he's on, we'd be on the floor. I can see that he's really agitated, and I can't leave him in this condition." He picked up a phone and Alistair was back in a bed in five minutes.

Ms. Sylvia Jones: I appreciate your sharing this, because it clarifies a lot of questions that we've had over the last couple of months.

Ms. Vani Jain: Just if I could add very quickly with regard to the actual release-from-custody programs that I mentioned: There are a number of agencies that do offer them. CMHA and COTA are a couple of those, but they're specifically for people who are in correctional institutions. Sheila is talking about the step-down process for someone in the forensic system, which is actually

much more gradual. But for people in correctional institutions, this is sometimes the only way that they can really be connected with the services that they need. These programs are fantastic; they're just not offered everywhere.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was really appreciated.

Ms. Vani Jain: Thank you.

Mr. Alistair Deighton: Thank you all very much. We appreciate it.

DURHAM REGIONAL POLICE SERVICE

The Chair (Mr. Kevin Daniel Flynn): Our next delegation is from the Durham Regional Police Service. If you'd like to choose your chair. Thank you all for being here today. Before you speak, and when you speak, if you would each identify yourself so that the folks at Hansard know who's saying what.

We've fallen behind a little bit on the time because of circumstances out of our control. Everybody had something else to do in the House today, and the House is a busy place. Also, at 10 to 6, we're all going to have to go and vote. So if the bells start ringing and we jump up and run out of the room, it has nothing to do with what you've said; it has to do with what we need to do.

Can you give me some idea of what you're planning on doing, and maybe we can—you're going to give a presentation, obviously.

Ms. Wendy Stanyon: Right. We've come to show you an educational product that we've developed as a team to educate police. We really wanted to show you a demonstration of the simulation. That was our primary reason for coming.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. I don't want to break the presentation halfway through. How long would the opening part of the presentation take?

Ms. Wendy Stanyon: Five minutes or so. It's just a short intro.

The Chair (Mr. Kevin Daniel Flynn): Okay.

Mrs. Liz Sandals: Why don't we start, and if we get up, we'll look at the last part—

The Chair (Mr. Kevin Daniel Flynn): Okay, yes. You guys start, and then at the appropriate time, we'll run away and come back.

Ms. Wendy Stanyon: Okay. I'm Wendy Stanyon. I'm from the University of Ontario Institute of Technology. Thanks very much for having us today. We're here as a team to show you what we developed in terms of police education.

Just to highlight our partnership and how it happened: It's quite unique, in that the Durham Regional Police Service contacted me, as a nurse with a mental health background, and asked for some assistance because they had had some problems with how officers were responding to the mentally ill in the community. I thought it was a really courageous act on behalf of the police service.

We started working with them and educating front-line officers. Over time, we partnered and applied for funding, and this is the result of the funding that we received. We built some simulations that are to assist officers in learning how to interact with mentally ill people in our community.

1730

We've got all of our partners here. The novel part of this is that it was designed by front-line officers in conjunction with us. So they sat literally writing the scripts from real-life incidents that they experienced in the community. They are the police in the simulations. The clients in the simulations are role-played by nurses from Ontario Shores, who know the behaviours quite well. So what we found is that the level of realism from the police perspective was really good. I'm thrilled to be here with our partners, and I think it's quite a unique partnership we have.

Ms. Marjory Whitehouse: I know you're very anxious to see the simulations. My name is Marjory Whitehouse. I am the risk manager at Ontario Shores Centre for Mental Health Sciences. I just want to speak briefly. The product is a wonderful product, but maintaining this partnership had a major influence on how we did business. More importantly, it affected how responses to the mentally ill in crisis in the community were dealt with. It also afforded the opportunity for two different sectors to get to know each other, because often we did interface—health professionals and police—and not always on very pleasant circumstances. However, through this process, we got a greater understanding of our respective roles.

What we have heard anecdotally as a result of the education is that visits to ERs have been reduced in our area. So overall, we feel we've contributed not only to, from Ontario Shores' perspective, creating a stronger alliance with another sector, but being innovative and doing work out beyond our walls: certainly one of our core values as a community. Our business extends way beyond the walls of the centre that we work in. This afforded us the opportunity to help the mentally ill and address some of the challenges of stigma that exist today.

Mr. Dave Hookway: Good afternoon, ladies and gentlemen. Thank you very much for having us here today. My name is Dave Hookway. I'm a police officer with Durham regional police. I'm just going to briefly speak to the policing aspect of this.

I became involved in about October 2007, when Wendy and Marjory put on a course for our service. I became the mental health response officer, which is an officer who is on the front lines and has a little bit more training than the regular officer on the road. This was all brought about by a very simple phone call from our service to Wendy in regard to putting something together, hopefully to get a collaboration, a partnership, together with our mental health folks, which obviously happened. We've had great support from our executive leadership—our chief, deputies and downward. We've been allowed to put this product together. I think, when you see it, you'll be very pleased with it. It is a collaborative effort. We are a team. We do these presentations as a team.

Initially, I think, there was some apprehension between the police and the mental health services, which

is what happens quite often. Our main goal, though, for both of us, is to get people who have mental health issues the help that they require. All these scenarios are based on real-life events that happened to our officers. I'm not the only officer who participated in this; I was just lucky enough to be involved in it a little bit further. We wrote the scripts as they happened. It was a great learning experience for everybody involved: ourselves as the police and obviously for the folks from the mental health services.

They're easy to use. What we have done in Durham regional police is that we have put them into our e-learning program. Every officer on the road—I believe it was last year—had to go through this entire thing and complete it successfully. We like to do a debrief with these; this is not a stand-alone training package. As the police, we do other training throughout the year. We found that people have said that a debrief would be very important when we show and do these. It is currently being used. It's free, so that's always a good selling point for folks in the policing services and any other place. We currently have given this to several police services, and I believe some RCMP officers in British Columbia. We have some people in the east coast, Nova Scotia. Is that correct?

Ms. Wendy Stanyon: The Nova Scotia Department of Justice has the links and is using them in their education for officers in the province.

Mr. Dave Hookway: York Regional Police, I believe, and the Toronto police have a copy of this, and some OPP detachments are also using it. That's basically the policing aspect of it.

I'm going to hand you over to Erin Banit, and she can go through one of the scenarios with you. Hopefully, you'll enjoy what you see.

Ms. Erin Banit: Thanks. My name is Erin Banit, and I'm a multimedia specialist in the Innovation Centre at Durham College and UOIT.

I'm going to give you a demo of one of our scenarios. We have four different scenarios. The one that we're going to look at today is our suicidal scenario.

Audio-visual presentation.

Ms. Erin Banit: Each of the simulations starts with a dispatch call. All of our scenarios are based on real calls that have actually happened, and officers have identified them to us as ones that they would like to learn more about or that they thought other officers would benefit from learning more from.

After the officer listens to the dispatch call, they can use the navigation on the left to go through the simulation in whichever order they want. They can go back to sections if they want, or they can use the navigation on each screen to go through it in a more guided fashion.

Audio-visual presentation.

Ms. Erin Banit: I'm going to mute the voice narration for the sake of the presentation, but I did want you to see that it is actually there. There is voice narration throughout the entire simulation just to help guide the officers through it.

In our fact-gathering section—in this one in particular, we have three different areas. The first one is risk factors. When we met with police officers when we were designing the simulation, something they said they often do, or they usually do, when they're on their way to a call is run through all the risk factors in their head or they talk about it with their partner. So we've listed all of the risk factors for this call, and we've asked them to identify which ones would be relevant or might be relevant in a mental health encounter.

Another section we have in the fact-gathering area is a place where they can gather information. In this particular scenario, the officers were able to have a conversation with the subject's parents before having their main encounter with the subject. So we've broken it down into different sections. The officers can pick and choose what they'd like to find out more information about.

For example, details of incident:

Audio-visual presentation.

Ms. Erin Banit: I'm going to stop that, but that one was for what happened.

Another example is: Has he ever done this type of thing before?

Audio-visual presentation.

Ms. Erin Banit: So there are several different areas where the officers can pick and choose what they would like to find out more information about from the parents before they have that main encounter with the subject.

The other section in our fact gathering is mental illness. This is an area where there are various activities that the officers can complete to help them gather additional knowledge on the specific mental illness being dealt with in this scenario.

We have things like multiple choice, we have some drag-and-drop—this one, for example: "Which four statements below are facts about suicide?" The first one says, "Young people and seniors are least likely to consider suicide." I thought that this was a fact; however, it's a myth. Individuals between the ages of 16 to 24 and over the age of 65 have the highest rates of suicide. That one I found very surprising.

In the top right-hand corner, you can see that there's a link for psychosis. If the officer clicks on this, they are given a definition for psychosis. There's also a link to visit the library, where they can find out more information on psychosis, and there's a wide range of other information that they can get in there as well. We have these links throughout all of our simulations because there was so much information that we wanted to make available to the officers, but we didn't want it to be too overwhelming to them. This way, they can choose if they want to find out more information about that; they can click on the links and go in there.

1740

I think, for the sake of time, I'll skip through the other activities we have here. There's some more drag-and-drop multiple choice.

I'm going to jump to the next section, which is preliminary events. This particular scenario has some things

that happened before the officers had their main encounter with the subject. One of them was that one of the officers was at the girlfriend's house talking to her, and she received a text message from the subject. So we have a question around that.

Another preliminary event is a cellphone conversation which took place; the officers were able to call the subject on his cellphone. We have a little activity here, and we have asked the officers to choose how they would open up that cellphone conversation. We give them two choices. The first one is, "It's Officer Mike. I need to know where you are. I'm concerned for you." The second choice is, "Hi, Justin. It's Officer Mike. I would like to help you." I'm going to choose the first one.

Audio-visual presentation.

Ms. Erin Banit: We hear the response, and that's obviously not what we were looking for. The reason why I actually choose this one is because of the language that's in it. When we were first working on the project, there were some people who were hesitant about having that type of language in it, but it was something that, having the officers there helping us build them—they said, "You have to have that language in for it to be realistic. You can't substitute other stuff in."

I'm going to move on now to our main encounter, and this is where the bulk of our simulation really takes place. I'm just going to jump over to a flow diagram, just to give you an idea of what's happening in the background. When we go into it, it's not always obvious how many choices and pathways there are. With our main encounter, it involves conditional logic, where the officers watch a short video clip, and then they're given a couple of choices about how they might proceed. The officer decides which choice they would make, and then they're able to see how that scenario might have evolved based on the choice that they made. Then they're given feedback on that as well.

You can see that there are a number of different pathways. Down at the bottom, there are some little bubbles, and that shows the different outcomes. The least preferred outcome is self-injury. The most preferred outcome is the subject puts down the knife and agrees to continue discussion in a controlled environment.

I just wanted to show you that before we actually get into it so that you can see what's happening in the background, and all of the possibilities that there are.

Audio-visual presentation.

Ms. Erin Banit: From here, the officers are asked, "Which approach would you take? Would you maintain dialogue with a focus on the knife or maintain dialogue with a focus on Justin's feelings?" I'm going to choose to focus on the knife.

Audio-visual presentation.

Ms. Erin Banit: You can see that we have the resulting video clip of how that scenario might have evolved and the feedback on the scenario and the choice that they made.

From here, they're asked, "Keeping in mind Justin's increasing level of agitation, choose from the following responses: Attempt to minimize the risk by engaging with Justin and explaining why your gun is drawn or continue to focus on containing the situation by getting Justin to drop the knife." I'm going to continue to try to get him to drop the knife.

Audio-visual presentation.

Ms. Erin Banit: Obviously this is the least-preferred outcome, resulting in self-injury. The officer is told that they've reached the end of this pathway and they should press "continue" to start at the beginning and go through and make alternate choices.

We'll go through again, and this time I'll make choices to bring us out at one of the preferred outcomes.

Audio-visual presentation.

Ms. Erin Banit: I'm going to pause that because we've seen that already. I'm going to press "continue," and this time, I'm going to focus on Justin's feelings.

Audio-visual presentation.

Ms. Erin Banit: From here, "Keeping in mind Justin's increasing level of agitation, choose from the following responses: Officer will holster his firearm or officer will keep his firearm drawn." I'm going to choose to holster my firearm.

Audio-visual presentation.

Ms. Erin Banit: From here, the officer is asked, "What is the best option given that the officer successfully negotiated and de-escalated the situation—to apprehend under the MHA or refer to community resources?" I'm going to choose "apprehend."

Audio-visual presentation.

Ms. Erin Banit: From here, the officer is directed to the conclusion, where they are given a list of key concepts and helpful strategies and some "Did you know?" facts.

That gives you an overview of one of our scenarios. Like I said, we have three other ones created on top of this, but I won't take you through all of those because I think we're out of time anyway.

1750

The Chair (Mr. Kevin Daniel Flynn): I think the bell is going to ring any second.

Go ahead, Ms. Jones.

Ms. Sylvia Jones: Thank you for coming in and showing us that. You mentioned that a number of other police services have tapped into it. How long have you had this in Durham?

Ms. Wendy Stanyon: About 18 months, and we've given the files to many police services which then have put them on their own servers so the police officers in their area can access them.

Ms. Sylvia Jones: How do you decide which front-line officers have access to or are trained in this scenario?

Ms. Wendy Stanyon: For Durham region, they've made it mandatory training, so all Durham region officers have to go through this. Many of the other police services are looking at how to incorporate it: many OPP detachments; Toronto Police Service was looking at how they were going to incorporate it; York region. Many of them are putting them into their own e-learning, and we've had

requests to build more. We're consistently looking for funding because the response we have is that it's working with a variety of police forces. I guess we could say that we haven't had anywhere that has given us negative feedback. It has really continued to be extremely positive.

Ms. Sylvia Jones: The training itself: How long is that for individual officers? Is it a half-day?

Ms. Wendy Stanyon: When we were actually researching them and we had officers doing all four of them, they were probably on them for anywhere from half an hour—I would say?

Mr. Dave Hookway: I would say half an hour or 40 minutes, something like that.

Mr. Chris Hinton: It depended. They're very engaging; if you go down one avenue, you can go quickly, but typically you find that people want to go through all different avenues. By the way, my name is Chris Hinton. I'm director of the Innovation Centre, and I was also a partner in the research. We got funding from the Canadian Council on Learning to verify that these simulations were effective, that they engaged the officers and that they helped them in decision-making and confidence. Indeed, our research verified that these are as effective as face-to-face. It has been very positive.

The Chair (Mr. Kevin Daniel Flynn): The bells have just started ringing. I'm not sure if it's a five-minute or a 10-minute bell. If it's a five-minute bell, we need to go and come back and ask you questions, if you don't mind excusing us for about 10 minutes.

Mr. Jeff Leal: It's a 10-minute bell.

The Chair (Mr. Kevin Daniel Flynn): It's a 10-minute bell. Okay, why don't we try one question, then? Jeff?

Mr. Jeff Leal: When you're faced with a situation, and you provide the simulation, do you use the federal gun registry and see if guns may be present?

Mr. Dave Hookway: For an officer going to a call, dispatch would generally do checks on CPIC, that type of thing. I can't 100% say that that is something they would do. I believe that they might. Our dispatchers certainly try to get as much information as possible for us for that particular location.

The Chair (Mr. Kevin Daniel Flynn): France.

M^me^ France Gélinas: I will try to phrase this as delicately as I can. We all know that there's a lot of stigma surrounding mental health. We all know that a lot of seasoned officers have dealt with a lot of people with mental illness and sometimes have developed views that are very stigmatized of people with mental illness.

I'll backtrack a little bit and say that in a previous life I was the executive director of the community health centre in my community. We taught suicide prevention to police officers and a lot of other people.

To make it mandatory training, how do you make sure that your officers are at a time and place in their career where they are open to training? Sitting for half an hour in front of a little video clicking a mouse: Anybody can do this. Learning is a completely different aspect, whether the training is done with a human being or through a very well-laid-out program. Just your comments on that.

Ms. Wendy Stanyon: I'd just like to respond. I think one of the ways that we developed these was by including the officers. What we found was that most of the officers even in Durham region have an invested interest in these. They know how they were developed. They know that police were front and centre in developing them. It's colleagues who are in them.

We've had a similar response from other police services who are using them: There's an invested interest. It's not mental health experts coming to tell police what their job is. I think sometimes that's what happens when we partner: We want to tell other people what we know and what we think they should do.

We started by saying, "You tell us what your issues are. You help us build education for you as officers."

I would say that we have a lot of good support, and they're invested. This is their educational product that they helped to develop.

Ms. Marjory Whitehouse: If I could add too: The feedback that we got from officers is that you can fail and make a mistake without any dangerous things happening, without embarrassing yourself.

What we did learn through this collaboration is that a lot of what we're trying to promote in mental health, to reduce stigma, is counterintuitive to what officers are taught in terms of responding to crisis situations. We've been challenged before in mental health places, saying, "My goodness, the person's suicidal. Why would the officers draw a gun?" "The person was armed." So we have to interface different use of force with mental health aspects in terms of managing this.

That grassroots level, as mental health people trying to critique the dialogue that was suitable for police officers to be comfortable enough to use it, made it more real, made it more believable. The feedback we got in terms of the research was that the face-to-face learning and these electronic video learning interactive tools were equally as good. The research gave us information too that officers were learning as a result of using them.

The Chair (Mr. Kevin Daniel Flynn): I'm going to have to cut you off right there. Do members of the committee have more questions? If we have more questions, then we should come back. If we don't have more questions, then I should thank the delegates for being here.

Interjections.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. That was wonderful. Congratulations.

The committee adjourned at 1756.

CONTENTS

Wednesday 21 April 2010

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Chair / Président
Mr. Kevin Daniel Flynn (Oakville L)

Vice-Chair / Vice-Présidente
Mrs. Christine Elliott (Whitby–Oshawa PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mrs. Christine Elliott (Whitby–Oshawa PC)
Mr. Kevin Daniel Flynn (Oakville L)
M^me^ France Gélinas (Nickel Belt ND)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Ms. Sylvia Jones (Dufferin–Caledon PC)
Mr. Jeff Leal (Peterborough L)
Mrs. Liz Sandals (Guelph L)
Mrs. Maria Van Bommel (Lambton–Kent–Middlesex L)

Clerk / Greffière
Ms. Susan Sourial

Staff / Personnel
Ms. Elaine Campbell, research officer,
Legislative Research Service