ISSN 2368-7886

Legislative Assembly of Ontario

First Session, 41st Parliament

Assemblée législative de l'Ontario

Première session, 41e législature

Official Report of Debates (Hansard)

Friday 10 April 2015

Journal des débats (Hansard)

Vendredi 10 avril 2015

Select Committee on Sexual Violence and Harassment

Strategy on sexual violence and harassment

Comité spécial de la violence et du harcèlement à caractère sexuel

Stratégie de lutte contre la violence et le harcèlement à caractère sexuel

Chair: Daiene Vernile
Clerk: William Short

Présidente : Daiene Vernile
Greffier : William Short

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

SELECT COMMITTEE ON SEXUAL VIOLENCE AND HARASSMENT

Friday 10 April 2015

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA VIOLENCE ET DU HARCÈLEMENT À CARACTÈRE SEXUEL

Vendredi 10 avril 2015

The committee met at 1026 in the Nishnawbe-Gamik Friendship Centre, Sioux Lookout.

STRATEGY ON SEXUAL VIOLENCE AND HARASSMENT

The Chair (Ms. Daiene Vernile): Good morning, everyone. The Select Committee on Sexual Violence and Harassment will now come to order. We are very grateful to be here at the Nishnawbe–Gamik Friendship Centre, and we'd like to thank Marsha Favot for coordinating this for us. Welcome to all of the presenters and to the guests who are here with us.

Let me share with you the mandate of this committee. We are here to listen to your stories, to your experiences; to survivors, front-line workers, advocates and experts on the issue of sexual violence and harassment. You are going to inform us on how to shift social norms and the barriers that are preventing people from coming forward to report abuses. Your advice is going to help us as we make recommendations to the Ontario government on dealing with systemic sexual violence and harassment. However, I should stress that we do not have the power or the authority to investigate individual cases; that is better left to the legal authorities.

Again, we welcome you for adding your voice to this very important issue.

PACE LAW FIRM

The Chair (Ms. Daiene Vernile): To our first group of presenters, you now have 20 minutes in which to speak, and that will be followed by questions by our committee members.

Interjection.

The Chair (Ms. Daiene Vernile): You are joining with another group so that will increase to 40 minutes, and that will be followed by questions by our committee members. Please begin, each of you, by stating your names, and begin any time. Thank you.

Ms. Elaine Bright: My name is Elaine Bright. I'm a lawyer with Pace Law Firm. With me, to my right, are Patrick Copenace and Angela Flett; to my left are Monika Huminuk and Geneva Sainnawap. Mary Scott, who is on the agenda, was not able to attend.

We had planned to speak in three separate parts: myself as a presenter, then Patrick and Angela presenting, and then Monika presenting, with Geneva here to assist in answering questions regarding local services, if that is satisfactory to you, Madam Chair.

The Chair (Ms. Daiene Vernile): Yes, that's great. Thank you.

Ms. Elaine Bright: And I invite you to call me Elaine when you have any questions.

Madam Chair, committee members, thank you very much for travelling to Sioux Lookout to hear from Ontarians, in part, on how to improve our response to sexual violence. I realize your mandate is broader than that, but that's one thing that I'm here to talk about today.

I work with Pace Law Firm, and Pace Law Firm is based in Toronto. We have about 150 staff working out of eight offices across Ontario. I'm the lawyer at the newest office in Kenora, which opened in—I've been in the Kenora area since 2012 and we opened a permanent office there in 2013.

Our law firm is primarily a personal injury firm and the practice in Kenora is exclusively personal injury. But within that field—and I know some of you are familiar with the field of personal injury law—there's a subset of people who practise particularly in relation to victims of sexual assault, but also what we call historic personal injury, so historic sexual assault; that is, people coming forward to commence a civil action for an assault that occurred usually when they were children.

Let me just set the context a little bit for you here. I came up in 2012 just before the deadline for applying for compensation through the residential school program. At the invitation of a friend from a reserve in the area—they were looking for a female lawyer because most of the lawyers were men and some of the victims wanted to talk to a female lawyer to tell their story. Then, of course, there were a lot of other victims who came forward at that time, so there was a lot more work. Our practice grew and we decided to open an office here.

The residential school proceedings are—my own caseload is pretty well finished, but following that, in my view, there's an interesting and valuable increase in trust in Canada's civil justice system on behalf of a lot of the First Nations people that I've met, who have maybe in the past seen the law as something antagonistic and

something other and not necessarily something that was helping them.

There's a lot of people who have seen that the legal system, in the sense of the system that implemented the residential school settlement agreement, in a lot of ways worked for people. Most people told their stories, they were believed, and they got compensation. That's one reason I think that the timing of this committee in terms of the work you're doing in the north is very valuable and appropriate, because we can really seize the moment here and seize this opportunity. When people ask, "Is that the end of things?" I say no. Often people can make a claim for abuse they experienced in foster care or in what they call day schools or in other settings. As plaintiffs' counsel, we usually only take cases where there's an institutional defendant because, for practical reasons, that's the way we usually proceed.

I tell people about the Criminal Injuries Compensation Board. If the perpetrator is alive, we invite people to talk to the police, if they wish to do so, and a lot of people are saying, yes, they have some faith that the system is working for them, and they're willing to make that step; others aren't, but I think this is a very good time to be working on this issue.

When someone comes to me and wants to talk about abuse they experienced, the first thing I usually do is find out if they have access to counselling, resources or support that they need. If not, I always recommend and turn to victim services in my community and that's Monika Huminuk, who's the executive director and who will be speaking after us. They're funded by the Ontario government and they provide really valuable services in terms of knowing what's available in the community. I really rely on them to know; they seem to have knowledge of what's available both in terms of individual counselling, group programs that might available and other types of resources. That's something that is working well, in my view. If there are enhancements, I think that we can build on what's working well and build on existing services, leverage existing resources, and in my view, that's a system that's working well.

But there are gaps. There are actually three things I want to talk to you about today: gaps in terms of needs for services for male victims of sexual assault; gaps in services for victims who reside in more remote communities, First Nation communities; and the third thing I want to mention is the importance of following through on the Premier's commitment to work on eliminating the remaining limitation periods for civil actions for victims of sexual assault. So those are the three things, but I also hope that I can learn from you what issues you've heard about, what gaps there are in the information you're receiving and how we can help you, and encourage more people from the north to provide submissions to you, either in writing or by video conference.

In terms of services for male victims, right now the—Patrick Copenace is going to speak to that from his individual perspective. From my own perspective, I'd like to say that victimization of men in the communities where I'm working now is just as high as victimization for women, certainly from the perspective of historic sexual assault. My caseload, for example, has just as many men as women. When people come forward to me about other historic sexual assaults, I'm hearing from just as many men as women. I don't have all the research at my fingertips, but I think there's a lot of research that male sexual assault may be underreported, even more so than female sexual assault, and we all know that that is underreported.

When male victims come forward—the sexual assault centre in Kenora right now serves women, but there's no sexual assault centre that serves men. The sexual assault centre provides really good resources; they have strong, experienced staff that are available and supportive and go the extra mile for the clients. But there is a difficulty in terms of accessing those same kinds of services for men. That's one difficulty.

The second difficulty that I see is that there's only one registered psychologist in private practice in the area. First Nations people who have status may be eligible for some services, but if they've used those services in the past, then their number of hours may be up. The federal government has recently reduced the number of hours. In addition, if they're not a First Nations person with status, they don't have access to any of that coverage. As we all know, psychologist aren't covered by OHIP, for the most part.

Many people who are victims of sexual assault have severe psychological symptoms that result from that sexual assault and, in my view, need professional assessment and professional support, in addition to the type of support that's offered through community agencies by experienced support workers. In my view, they also need psychological or psychiatric support or support from people who are very experienced in dealing with things like post-traumatic stress disorder, which is very common in the north. In fact, the lawyers' association is having a continuing education conference shortly, and one of their main features of the conference is talking about PTSD within the communities up here. There's a real need for those kinds of services.

Secondly, people who live in remote communities have trouble even accessing the existing communities, but there are strong nursing stations on the communities, and there's a strong interest in volunteering. In my view, local resources could be leveraged by training volunteers, working through the nursing stations to provide additional services to people who can't afford to travel from the First Nations community to a community like Kenora where services might be available.

1040

Just to finish up my 15 minutes, I want to speak briefly to the issue of the limitation period—again, the three things that I think are important, from my perspective: also, services for male victims and additional services for people in remote communities.

Section 4, as you may know, of the Ontario Limitations Act, sets out a basic limitation period of two years

for civil claims. There's another section, section 10, that makes some exceptions for sexual assaults. They're saying that it doesn't run when the person is incapable of commencing the proceeding for a variety of reasons.

The problem with that is, we get into issues of, "Well, can a person be capable at one point and then not capable?" Sometimes victims come forward and they're ready to start saying something but then they change their minds because they get too scared and they back away. Then, maybe a little while later, they come forward again; they've had a little bit more support. So then the insurance company or the defendant is in the position of arguing, "Well, they were ready back then, so their limitation period has run out." Is that true or not true? Can you find an expert to say, "They may have been ready 10 years ago, but eight years ago they weren't?" How does the expert assess that? It's complicated, and it's hard to explain to the victim why they might not be able to proceed.

Again, section 16(h) also speaks to limitation periods for sexual assault, stipulating that there is no limitation period if the proceeding arose from something where one of the parties had charge of the person assaulted or was in a position of trust. Again, this gets complicated when you might have a situation where you want to make a claim against children's aid because they never went to visit a child who was in care and being assaulted. They're not exactly a party to the assault, but there's an argument to be made that they may have been negligent in supervising. So that section may not apply and then it gets complicated. There are complicated transitional provisions that are very hard for victims to understand—and hard for lawyers to understand sometimes, too.

I really urge the committee to follow through on Kathleen Wynne's commitment to eliminate the remaining limitation periods for civil sexual assault so that it's clear and understandable and fair to all the victims.

Subject to your questions, those are my submissions.

The Chair (Ms. Daiene Vernile): We begin our questioning with our Conservative MPP, Laurie Scott.

Ms. Laurie Scott: Thank you very much for your presentation. It was very concise. There is video conferencing or teleconferencing available, so when you mentioned utilizing the nurses' station paired with volunteers, are there enough psychologists even that they could—I mean, I think there is a shortage in Ontario; I'm not 100% sure. But are there enough that could provide services that you know of? I don't know if you can answer that question.

Ms. Elaine Bright: There's a shortage in Ontario. Some First Nations clients have told me that they have been able to access services by a psychiatrist, for example, through video conferencing. In fact, I've spoken to one psychiatrist; I can't remember his name now, but he does provide such services out of Toronto. His background is working with First Nations in northern Ontario. So there's a shortage, yes, but if you could leverage the resources in Toronto, where there's a little less of a shortage, then I think that's certainly an option.

Ms. Laurie Scott: And you said that they weren't covered by OHIP, the psychologists.

Ms. Elaine Bright: Correct.

Ms. Laurie Scott: So that's another problem.

Ms. Elaine Bright: Yes.

Ms. Laurie Scott: Is there a recommendation that if we couldn't move the ball all the way to the end of the field, then part way, say, in situations of sexual assault? Have you seen any of that before?

Ms. Elaine Bright: I think that one thing that sometimes is done is a certain number of hours is authorized for an assessment. In the world of private personal injury, for example, there might be an authorization for an assessment. That assessment can recommend: Does the client need access to a psychologist? Or might they do all right with peer support, with social workers who are trained in sexual assault? Or do they need the more intensive resources of a psychologist? Or, alternatively, they may need, instead, a psychiatrist, who would be covered by OHIP. If there was some way to authorize those types of assessments with recommendations for victims of sexual assault, those could be managed through sexual assault centres, health centres and those kinds of things.

Ms. Laurie Scott: Thank you very much.

The Chair (Ms. Daiene Vernile): Thank you. Our next questions for you are from NDP MPP Natyshak.

Mr. Taras Natyshak: Thank you, Elaine, for your presentation. One question regarding male victims and access to services: What would be the barriers to integrate male services into the existing victim services in Kenora or Lac Seul? In my area, in Windsor and Essex county, the sexual assault crisis centre has that integration. It's fairly new, but they are able to provide services to men. I'm wondering if that's been looked at or investigated.

Ms. Elaine Bright: I'm probably not the best person to answer that question, but—

Mr. Taras Natyshak: I figured that I should wait.

Ms. Elaine Bright: Yes. That's okay.

Mr. Taras Natyshak: I'll leave it at that and that will be my question for you.

Ms. Peggy Sattler: I had a question about the training for nurses and volunteers in these remote communities. Are these federally funded, the nursing positions?

Ms. Elaine Bright: Yes, the nursing positions are federally funded.

Ms. Peggy Sattler: Okay. I would imagine that those health professionals are dealing with a myriad of issues, from diabetes to mental health, all kinds of things. Do you see this kind of training—is it reasonable to expect these health professionals to take on that additional responsibility of providing this kind of support and service to a childhood sexual abuse victim?

Ms. Elaine Bright: I might let Patrick and Angela speak to that a little bit more because they both live in a First Nation and access those types of services, but I will say that it's my understanding that it's not just nurses there. The nursing station can be a centre for services where mental health professionals come in also and

nurses might be trained to triage those needs—that sort of thing.

Ms. Peggy Sattler: Okay.

The Chair (Ms. Daiene Vernile): Thank you. Our final questions for you are from MPP McMahon.

Ms. Eleanor McMahon: Hi. Thank you so much for your presentation and I look forward to the other ones as well.

I had a question for you, Elaine. Just to back up for a moment: I'm thinking that at least part of your caseload is—this is a class-action experience that you just had, I would think; perhaps not. Understanding that the burden of proof is different between the criminal and the civil process, can you talk to us a little bit about an emergent theme that we've been hearing in the last couple of days in particular about the barriers to people coming forward? We're hearing—and it shocks me a little bit, as I'm sure it does my colleagues—that victims throughout the legal process are being asked what they wore, about their comportment, about how much they had to drink, which feels like victim blaming, which really can be another barrier to people coming forward and talking. If the process feels like a juggernaut to them and a mountain, and it feels as though they're going to be blamed, arguably that's a big barrier, isn't it?

Can you talk to us a little bit, maybe, or give some suggestions around what might mitigate that? Is it training for our judiciary? Is it an increased training for lawyers? Is it sensitivity training? What does that look like?

1050

Ms. Elaine Bright: I believe it's training for the judiciary and lawyers. We've done a lot of work with training and police, but I think there's a lot of work to be done training the judiciary and lawyers—crown attorneys, particularly. Because in law, the question is, is the evidence relevant and also is it admissible? Whether it's relevant or not, that's a cultural question, to some extent. Can you make a reasonable inference that by wearing a short skirt a woman was inviting a man to do whatever? There's a cultural context to that. By allowing that question, a judge is accepting a cultural context that maybe we don't want to accept or should not be accepting or isn't true.

So I really believe that we should have more training of judges and of crown attorneys, so that the crown attorneys can successfully advocate on behalf of their witnesses, who are the victims, and that the judges are supported with of the social science research that they need to make rulings that support victims that come forward.

The Chair (Ms. Daiene Vernile): Thank you very much, Ms. Bright.

MR. PATRICK COPENACE

MS. ANGELA FLETT

The Chair (Ms. Daiene Vernile): Could the next presenters introduce themselves?

Mr. Patrick Copenace: My name is Patrick Copenace. My totem would be the Elk—I mean my clan. That's how we introduce ourselves, I guess. Whoever is an elk man is my blood relative, so that's how I know who my relatives are.

I'm the band member from Ojibways of Onigaming. I was sexually assaulted at the innocent age of six. I had blocked this out; I locked the door on it. I didn't know what was happening at that age. Anyway, 50 years later, another person thought he had seen this abuser. At that time, I could see the picture of what happened. From there, I could see it as clear as day, what had happened when that person—I wasn't the only one. This didn't only happen to me; there's other people in the community. Their ages would probably be about 50 to 70, so those are the adults, the elders of my community. At that time, it brought out awful feelings that I couldn't deal with.

In the past, I've had training and counselling. I took a two-year course in native community counselling, which deals with helping people, marriage counselling, whatever you can help them with. But in my work experience, I've always worked until today. I was a probation officer, so I helped people. That kind of helped me.

When this happened, I couldn't use the counselling that I had received—I couldn't help myself. What I did was, I knew that there was something wrong, so I saw a counsellor to deal with the issues I had. I did finish the counselling with a counsellor, but at that time, the only services I could get were 15 hours for a lifetime. I don't know; it's Indian Affairs or Health Canada that issues that. So I did that and with my counselling and all that, I achieved it faster—that counselling only did—for me to accept what had happened, to see the picture. I've accepted that, but I have other issues as a result of that. One would be the sexual part. I still have that problem. I also don't know what other issues I have that I have to deal with.

Hopefully, I'll find counselling. But I need to deal with those issues, because in my community, there is a lack of who I can see or the community doesn't have that service. Right now, if I went to my community and discussed this issue, there's nobody there who can professionally deal with me as to the issue, because either they don't know how or—so I had to go outside of town; 70 miles in either direction is where the next town is. But I have to come up with the gas money, the lunch, whatever it's going to take, because there's no funding available. I reached for help from the residential school, but we don't fall in that area because we're not people who were in a residential school. We're told, "No, we can't help you. Maybe later, if the day school comes in, maybe there." So that is one of the problems: There's nobody there.

We need professional assessments. I've never been professionally assessed by—I don't know who it is, what my problem is about. What I'm thinking is, I have one more problem that I have to deal with, but I can't move on because of the 15 hours I was there. Right now, I'm at a standstill as to what to do. I think for me and the other

people who are having the same problem, we need people who are experts to deal with the crisis, I'd call it.

For me, I'm ahead of the other people because of the counselling and training I had, but I know some of the other ones are just—I talk to them. You can just see the face shivering and the body language. They won't sit still until they stop talking about it. That's one of the areas I was hoping to bring up, the need for specialized experts to assist with what the problem is, specialized counsellors to deal with the people one-on-one at the reserve level, because there are none there right now.

The bottom line is to have the issues dealt with. I've done my 15 hours and I have no place to turn to. Who do I turn to? I really don't know who. So I've got to keep it in till I find a place or a person to deal with my problems. I think mine are not as severe as others. I get emotional talking about it because of the flashbacks.

So that's why I'm here today. Hopefully this will help me and the other people.

The Chair (Ms. Daiene Vernile): Thank you very much.

Mr. Patrick Copenace: Thank you.

The Chair (Ms. Daiene Vernile): We have some questions for you now. If you would like to take some questions from MPP Natyshak.

1100

Mr. Taras Natyshak: Thank you, Chair. Thank you, Patrick, for teaching us all today about the Elk. I didn't know that. When I think about the elk, I think about a majestic, beautiful, peaceful, intelligent and strong animal, and you certainly embody that in your presentation, so thanks for representing your family history and your lineage in that way.

My hope out of this committee is that a light will be shone on sexual assault and violence towards everyone. It will require men particularly to stand up and to have their voices heard so that the stigma around sexual abuse is eliminated. I think it's a first step in raising awareness about the need to support victims, and you're doing that right now. You have done that, and I'm incredibly proud to sit here as a member of the committee and hear your story. That's my comment. Thank you so much.

Mr. Patrick Copenace: I had to do that, because the other people—I always think of myself as strong. Whatever comes, I'll have to face it, and I think I'm strong enough now to face it. I'm not just speaking for myself, but for the people behind me.

Mr. Taras Natyshak: I see that. Thank you.

The Chair (Ms. Daiene Vernile): Thank you. The next set of questions for you is from MPP McMahon.

Ms. Eleanor McMahon: Thank you, Patrick. I think I speak for everyone by saluting your courage for being here. We're honoured that you feel safe enough to talk about what happened to you, and we're so sorry for what happened to you.

Mr. Patrick Copenace: Thank you.

Ms. Eleanor McMahon: One of the things that we're going to do as an outcome of our work—that is why your presence here today is so important, because you're helping us to learn what happens to people like you and how we can help you through the process and your healing journey. One of the things that we'll be looking at is how to provide those services.

In remote communities—this is a little bit of a remote community—where the services, as you've mentioned, weren't really there for you, one of the things that we'll maybe consider—I don't know that this will be the case, but getting someone to come to you is so valuable and important. What would it feel like, do you think, if we had someone who was maybe at the other end of a computer so that you could talk to a person? Would that still feel like help to you? Would that be okay? I'm just curious.

Mr. Patrick Copenace: Talking to me in regard to—

Ms. Eleanor McMahon: Helping you with your counselling, continuing past those 15 hours. Say you had more than 15 hours and you were continuing to receive services.

Mr. Patrick Copenace: For me, I think one-on-one would make me or other people more secure, because you're actually seeing a person talking to you. The counsellor I had was good. He was good. But he asked me if we were done and I said yes. He said, "I think you are too," but that was just for me to accept this happening and to deal with it. We didn't get into other issues. As far as this happening, I have kind of accepted that this happened; I can't do anything more. I have to proceed on, but with the other people that were involved in this, they're having a hard time.

The Chair (Ms. Daiene Vernile): Thank you. Our final questions for you are from MPP Scott.

Ms. Laurie Scott: Thank you very much for coming, facing what happened to you and dealing with it. It takes great strength. The fact that you want to help others—I can't commend you enough for that.

On that topic: How do you think is the best way that we can help male victims in those communities? It was mentioned that you'd rather have one-on-one as opposed to video, which was good to hear, but how do you see—I don't know the ages of the victims who are in your community, but if you could comment, giving us a bit of guidance going forward, on how we can best help.

Mr. Patrick Copenace: I think one of the things is the cultural part has a lot to do with it, on how you're taught growing up a native; you're not supposed to say anything.

I told my dad this happened. I remember being out in the trap line at least a week, so I must have told him, because they were very protective of me. That was the happiest time of my life because I was with my dad. But I locked this out for 50 years. Now it's out, and I have to deal with it.

What I would like to see is you have to have some counselling afterwards. I don't know what will happen with this lawsuit after it's done. Are they going to close the door and not ever talk about it again? What I would like to see is a get-together where I talk about what happened to me and then open up. Because the 12 who

are involved are only a third of my community; the other ones, the door is locked, they won't talk about it. How does the community heal if they can't heal themselves? That's my version.

The Chair (Ms. Daiene Vernile): Patrick, thank you very much.

Mr. Patrick Copenace: Okay; thanks.

The Chair (Ms. Daiene Vernile): We are now going to hear from the remaining people who are at the table, if you could mention your names please and begin anytime.

Ms. Elaine Bright: Can I just ask, Madam Chair, if Angela could speak very briefly, and without necessarily any questions to follow up. She's the spouse of Patrick, and she just wanted to add a little bit to what he said. Then we'll turn it over to—

The Chair (Ms. Daiene Vernile): Certainly. Just turn the microphone toward yourself. Thank you, Angela.

Ms. Angela Flett: Okay. My name is Angela Flett; my spouse here is Patrick. I'm here today to support him. I've been with my spouse for about 20 years. It was unknown to me that Patrick was sexually abused until five years ago; I've been with him for 20 years.

After this thing came out about him being abused, I have seen him go through changes: anxiety, depression, very unhappy with life—a totally different person. We had problems in our relationship because of the abuse. He has been seen by a counsellor. He only had so many sessions, but he still has other needs to be addressed. Right now he's sitting on a cloud, because he's halfway healing and he can't continue. It's been five years, and he's been sitting on that cloud.

He needs someone to come in to assess him, to pinpoint what areas they didn't deal with to help him finish his healing. Like he was saying about when they go to court, this group of people, what is there for them after when they get out? They could be going—traumatized. There's no set thing to help them.

The Chair (Ms. Daiene Vernile): Thank you, Angela.

Ms. Angela Flett: Thank you.

SUNSET AREA VICTIM CRISIS ASSISTANCE AND REFERRAL SERVICE

AH-SHAWAH-BIN SIOUX LOOKOUT/LAC SEUL VICTIM SUPPORT SERVICES

The Chair (Ms. Daiene Vernile): We're going to hear from our remaining presenters who are part of your group. Please say your names.

Ms. Monika Huminuk: My name is Monika Huminuk. I'm the executive director for Sunset Area Victim Crisis Assistance and Referral Service. With me today is Geneva Sainnawap. She's with Ah-shawah-bin Sioux Lookout/Lac Seul Victim Support Services.

I'm going to be speaking on behalf of both of us. Then, when it comes to questions, we'll both be responding. We combined what we wanted to say today just to speed things along, because I know time is of the essence.

I want to just give you a little bit of history. I'm pretty sure that most of you are aware of the victim services programs throughout the province of Ontario. They recently had a modernization, so we are now VCAO, which is Victim Crisis Assistance Ontario. They've consolidated some of our programs together.

The programs began in 1998, and we have consistently grown. Geneva's program and mine are some of the newest in Ontario. I believe Kenora was the second-last one to actually be opened. We've now been in operation for six years and working on our seventh. Geneva's program has been open for 10 years, now going into their 11th year. Combined, we have 16 years of experience within our region.

1110

Our programs are established to provide immediate, short-term emotional and practical support to victims of crime and tragic circumstance. We're given a 45-day limit in order to access any funding to help victims who have been affected by a crime and it has been reported to either a program or agency in the area or to police services. This really limits some of the victims, especially when they're not able to come forward as quickly as possible.

Our victims could be cases of a homicide, suicide, domestic violence, serious assault and sexual assault. Our highest numbers are in domestic violence, sexual assault and aggravated assault.

Within our two programs, the average of aboriginal people that we help, from our First Nations community, ranges between 75% and 80%. The reason for that is the lack of services in the communities. They really need more services directly available to them. We do the best that we can in order to make sure that we're reaching out to the communities.

To give you an idea of our geographic area: Between the two sites, we extend from the Manitoba border to Ignace to Hudson to Red Lake and up to Whitedog. Within that area, when you go end to end, we're looking at five and a half hours.

To provide immediate, one-on-one services to victims in our area is nearly impossible, so we do try to provide a lot of phone support and work with community partners in the areas, to make sure that supports are available as quickly as possible for victims when they come forward.

With regard to sexual assault specifically, we definitely have needs in that area that have been identified by our programs over the last few years, and not just our programs but provincially. I know that a lot of the smaller communities have the same challenges that we have. I am only speaking for our region at this time.

When it comes to prevention and awareness of sexual abuse and harassment, it is a real concern in our area that there isn't more education available and that we aren't able to get the resources that we need in order to meet those needs.

We also need to find ways to improve our response time in which we respond to victims. One of the things with sexual assault, as we all know, is that at the time of crisis, they need that reassurance that there are supports available and that they are not alone. They need to know where to go, where help is and how to get to that help. That's what our program does. If we get a call in the middle of the night for a sexual assault, we have a list of resources and programs, as Elaine mentioned, that we can in fact refer people to in the community, and it's their choice, which services they utilize.

With our small communities, although a lot of our communities are smaller in population, we have a huge geographic area, so, "Where can I go for this help?" We need to have that readily available, depending on where they're coming from, to the closest resources that we have available. We provide that to the victim, and then the victim chooses which supports work best for them.

We have no way of knowing whether there's a conflict of interest, because we are talking about small communities where there are lots of family relations, or they maybe have accessed that service once before and there was a conflict of interest or it didn't work out for them. We don't know that, so we have to be extremely careful that we're not directing victims to utilize a service that might not be what they want, need or really could access, because of limitations. Those are some of the problems that we have in our smaller communities.

With larger cities, they have more access to different services, and the chances that there's a relationship there, whether it be a friend, a family member or an old acquaintance or someone that they've accessed once before—we have to be extremely resourceful. When we look at our resources, we don't just look locally; we do regionally and then we do provincially because sometimes there are resources out there that we can access through other venues and different forms of communication in order to make sure that the victims are getting the support that they need.

Elaine also mentioned about counselling. It is a real concern for us. One of the things that were also talked about was videotaping and doing counselling that way. We have had a number of comments in regard to that. It has been used. What happens with that is, you lose that personal contact. People—whether they're in Windsor or Toronto doesn't really matter—don't understand the culture that we live in here in our region within our communities. They're not sensitized to that. They're not culturally sensitive. You can take one First Nation community and then another, and they have different beliefs, different elders and different spiritualities. There are differences in dialect. There are all kinds of things that need to be taken into consideration when you're providing services to individuals in the community.

I strongly feel that those things need to be taken into account when we're working with and trying to find solutions to help people heal and move forward in their life around sexual assault—and, as Elaine mentioned also, the historical end of things.

We definitely need more professional counsellors, either trained here in our region or more accessible. We need to make sure that we're identifying those conflicts of interest within the communities when we're providing that support. I've dealt with victims before where they don't want to go in their community for support because the family is all there. They don't even want to come into the city, the urban area, to get support because they're also utilizing that service and they have lots of friends and family that have left the reserve and now are living in the urban areas, and they don't want the support. They want outside resources. But how do we get them there? How do we connect them? How can they afford to go to these places and get the services that are available?

One of the things that really stands out for me is that they have established some really good male services throughout the province. Thunder Bay, which is four and a half to five hours away from us, is where most of those male services are to date. This might answer some of your questions. We do not have the funding or the means to transport a victim who desperately needs longer-term support from our region to Thunder Bay. Also, depending on whether housing is available while they stay there to get their counselling—that's another issue. We can't afford the transportation. We don't have the housing resolved. There are a number of different things. Being able to come back to their community, because they do have families, so that you're not just isolating them for three or four months getting counselling and them not seeing their families—that's another concern that has happened.

We have worked with funding programs to try and find immediate counselling services. For instance, we do have a victim quick-response program. If we see that victim within 45 days, we can actually approve up to 10 sessions, at $100 a session, per victim for sexual assault. That's great. That's wonderful to have that means available. However, we have one counsellor. The waiting list is anywhere from three weeks to months before they get in. What happens to that victim who needs that immediate support right after they've finally opened up and are able to express and are reaching out for help? Now you're saying, "We'll get you help, but it might take three months. We'll phone the counsellor." We help the counsellors do the intake.

Those are really important factors that we need to really work and play with. If we could resource some of those in Thunder Bay, that might help lessen that time frame and get people in for the counselling and services they need—or if we have more counsellors here.

Shelters are another problem. We do not have a male shelter. We've had a number of male sexual assaults—current, to date; not historic—who have nowhere to go. For safety reasons, through the VQRP program, we have been able to put them into a hotel for one or two nights just until we can find another placement for them.

1120

Lack of information about sexual assault and resources—we do all the research we can, like I said, and we

bring forward as much as we can and we provide victims with as much knowledge and information as we can possibly afford to hand out—and also available to us. I've brought some with me today. If somebody wants to see them later, I'll be at the back of the room. On a break you can come and see some of the resources that we have available.

Sensitivity training is another thing that Elaine alluded to—and absolutely, that needs to be done. It's not just for police services, lawyers and things like that. I think it's also the service providers within the agencies doing the counselling because we get desensitized after a while—and I can admit that because that's happened to me—where you have people coming to you for the same help and support, and you have to always be on and always be sensitive and empathetic.

Sometimes I need that little bit of a reminder that I'm being desensitized because I'm dealing with a lot of the same types of occurrences, like sexual assault, but they're so different based on everybody's personal emotional state, supports that they have in place, their culture. A number of things play a role in which way you are able to help people, and you're always having to make sure that you're able to do that.

Am I running out of time? Two minutes. Okay. I'm just trying to summarize this.

Partnerships are also very important and I'd like to encourage that here today. The more we can partner with our services and agencies, whether it be financially to get the services into the area or to share services, I think that's really an important piece in this day and age where funding is being cut. Services aren't quite readily available for regions like ours, but if we can start looking at finding ways to partner and the ministry supporting that partnership when we do put forward a request, saying that we're going to work on this together to meet this need in our community.

I want to thank you, Madam Chair, for your time.

Any questions?

The Chair (Ms. Daiene Vernile): Our questions for this round begin with MPP McMahon.

Ms. Eleanor McMahon: Thank you. Passionate, committed, devoted, caring—these are just some of the words that I think of when I listen to your presentation. I'm sure my colleagues would agree. When you talk about burnout and compassion fatigue—

Ms. Monika Huminuk: Yes.

Ms. Eleanor McMahon: —that's probably what you're talking about, and I salute you for recognizing that and want to honour what you said because I think it's so important that you—and it's not surprising. You're doing amazing work and helping people every single day. Congratulations and thank you for coming here today and for sharing all of this.

I'm so moved by your comments and I want, if I may, get a bit to the solutions piece.

Ms. Monika Huminuk: Yes.

Ms. Eleanor McMahon: So, your thoughts on how we can crack this piece around counselling—it was mentioned earlier; you've talked about it. Since there isn't the capacity here in the community—and please tell me if I make a mistake. I think that's what I heard from you. There's one counsellor here?

Ms. Monika Huminuk: In Kenora area and I believe—

Interjection: There's one private counsellor here.

Ms. Monika Huminuk: One private here.

Ms. Eleanor McMahon: So how do we get either more people here or how do we get a travelling counsellor that maybe is accessed through major centres? I don't know what that looks like, but would appreciate your thoughts on that. You mentioned resources in Thunder Bay and accessing those and if there was funding for you to access—what would that look like?

Ms. Monika Huminuk: For myself—and I can't speak for Geneva, but for myself, what I see happening is even with a publicly funded—through the mental health association, we do have counsellors. Again, the intake process is long. By the time we get into seeing counsellors, again, time has passed and the delay really impacts the victim. So if—

Ms. Eleanor McMahon: Sorry. Is that because you're getting assessed—is that what you mean, getting them assessed?

Ms. Monika Huminuk: Well, they go in for an assessment for the intake process and then they establish a counsellor to meet with them, again, depending on what's available or who's available.

Ms. Eleanor McMahon: Okay.

Ms. Monika Huminuk: So we do have publicly funded counselling services. If there's any way that we can expand on those and then also maybe look at prioritizing—when you go to the hospital, if you've got a cut on your throat, you're going to be the first one seen. If you have a cut on a finger, you're going to be the last one. You could sit there for six hours. So maybe prioritizing who the clients are: When there is a waiting list like that, who is at the top level? Should somebody with a sexual assault be up on the top list to be seen by a counsellor? A lot of sexual assault victims get depressed. That goes along with a lot of different types of victimization.

If you look at the stats, you'll also notice that when things are not dealt with at that level, and it's historic and it has been going on for years, suicide rates go up in that general demographic.

The Chair (Ms. Daiene Vernile): Thank you. Our next question for you is from MPP Scott.

Ms. Laurie Scott: Do you have anything you'd like to touch on that you didn't? I don't mind giving you my time for questions if you want to add anything on that you had to gloss over.

Ms. Monika Huminuk: No. I think that most of it will be covered between ourselves, and I know that Kathleen Fitzgerald is also here and she'll be touching on a lot of this.

Ms. Laurie Scott: Okay. Building on MPP McMahon's question about counselling, the priorities,

are they better to be counselled outside of their area? Do you see a stigma problem inside your communities? You know how big they are and I'm sure it varies, but is it better if someone is triaged—they need to be a priority—and they are actually sent out of their community for the counselling? Is that better or is that not?

Ms. Monika Huminuk: If there's funding available to bring them out of their community and if that's what they want, I think it's a victim's choice that we should make available. Some communities have the resources to have a counsellor come right to their community. Other communities may not have that resource or that safe place for people to come. I think it would have to be an independent survey of the different communities of what they think would be best suited for their needs and what is feasible in their community, because we do have different levels of band and council and resources available. Some of them have health nurses readily available, a clinic and all different kinds of things, so that might be a really good fit, to have somebody available to them directly, whereas others don't.

The Chair (Ms. Daiene Vernile): Thank you very much. Our final questions are from MPP Sattler.

Ms. Peggy Sattler: Thank you very much for that comprehensive presentation. I want to touch on where you ended, on the importance of partnerships. Early in your presentation you talked about some of the challenges in a small community when there are limited services and you can't direct people to a specific agency because of issues within a small community. At the same time, you need to build partnerships because these are important. So I want to hear from you if you have any thoughts on barriers to creating partnerships, and how those barriers can be overcome.

Ms. Monika Huminuk: Do you want to speak on that?

Ms. Geneva Sainnawap: Some of the barriers that I see here in Sioux Lookout: Because we're such a small community, a lot of people don't want to go see a family member or a friend. Those are the barriers of coming from a small community. Even when you go up north, they're very small communities so a lot of times it's their family and friends who are counsellors up there.

Ms. Peggy Sattler: How do we overcome those barriers?

Ms. Monika Huminuk: It's really challenging. I think that working with the communities is the best way to do that because they themselves know, and they recognize that, in having those options available.

The other barrier, as you might say, is that sometimes getting services into communities is difficult. You usually have to go through the band and council to get a BCR for approval to bring services in. That's why that research needs to be done anyway. Those are things that your committee could partner with, with an agency like myself or Elaine, to try and find ways in, working with a crisis team in the communities, working with the health team, working with the band and council. Those are things that we'd be more than willing to help with; again, developing that partnership and reaching out to the resources we have in one another to make sure that we're getting those services in a way that they need to be.

The Chair (Ms. Daiene Vernile): I'd like to thank you all for coming here today and offering your information and informing this committee with your important work and your experiences. You are now welcome to join our audience if you wish to listen to our following presenters.

1130

FIRST STEP WOMEN'S SHELTER
HOSHIZAKI HOUSE
DRYDEN DISTRICT CRISIS SHELTER

The Chair (Ms. Daiene Vernile): Our next presenter is from the First Step Women's Shelter.

Please begin by stating your name. You will have up to 20 minutes to speak to our committee, and that will be followed by questions from our committee members. Begin anytime.

Ms. Tana Troniak: Okay. My name is Tana Troniak. I live here in Sioux Lookout. I actually have two residences right now; I'm also in Dryden, Ontario, because I'm running both shelters.

Most of my experience and what I'm going to talk about is from Sioux Lookout, as I've been here eight years in this community. I have worked in the shelter/violence against women sector for 25 years. I worked in Thunder Bay at Faye Peterson House for 18 and then moved here. I've worked in Sioux Lookout for eight, and maybe six months in Dryden.

I have some papers for you. I'm going to skip the part about "What is sexual violence?" because I think we know that. In the package—my business card is there. If you get home and read it or have a question, you can email me or you can call me whenever you would like.

Basically, what I want to talk about is what we see in the shelter, working with women. Of course, some of the stuff you've probably heard through your travels with other shelter directors. Our women that we work with are fleeing abuse: 45% by their intimate partners—I'm really nervous, so excuse me—have experienced sexual abuse or sexual violence or harassment; 27% are by acquaintances or friends; 16% by strangers; 12% are non-spousal family members. Sexual crimes are by far most common offence against girls.

Child sexual abuse: It's reported that it's much higher than the corresponding share of violent crimes against women, 7%; but 47% of all violent crimes against girls under 12 reported to the police were sexual in nature—much higher than the corresponding share of violent crimes against women. Level one sexual assault accounted for the majority of sexual offences against girls, 69% of those, followed by child-specific sexual offences, 28%. So sexual assaults with women, with children—we see all of that working in the shelter.

Our experience, over the last 25 years, working in this field, is that women don't normally—they come into the

shelter; it takes time. You have to feel very safe before you start telling anyone your story. We found that most of our women do say that their husband either assaulted them or forced them to have sex. They never, ever felt that they had the right to say no.

In our shelter here in Sioux Lookout, I've changed some of the questions that we ask now. Instead of saying, "Have you ever been sexually assaulted? Have you ever been raped?", we'll say, "Did you ever have to have sex with your husband where you didn't want to?", because no one is going to say, "My husband raped me," at that point, in the shelter system. So sometimes it's about language and making them feel safe that they're going to say that. You can look at all the questions, all the questionnaires. I really think, sometimes we have to take a broader look at all of that and see what we're asking. Sometimes it's very clinical. That doesn't work for everyone because if you're asking these questions to a woman, she doesn't want to hear some of those words. So we really tried to change that.

Aboriginal women are at a higher risk to experience violence against women, sexual assault or harassment. We know this to be true. Many aboriginal women do not report sexual assault or abuse due to the fear of police and the courts. We have a high, high number of aboriginal people in our jails. The trust is not there. In our experience, when women have come in and told us they were assaulted, we say, "Would you like to report that?" Automatically, "No." They don't trust it anymore. They could have been picked up for drinking; they could have spent the night in the jail, and that's not a place where they're comfortable at that point to go to.

Racism and oppression towards aboriginal women and people in our community is high. I'm saying that from my experience. I am an aboriginal woman, so I've just seen it from that.

Many of the women we work with have disclosed that they have experienced child sexual abuse, either from a family member or an acquaintance. Most of the women feel their childhood was shattered by the lack of emotional response from a parent or caregivers, and that their basic needs were not met. Women who experience sexual abuse at the hands of family members or friends are more at risk of experiencing more abuse, including sexual abuse during their young adulthood and their adult life. The impact of this is atrocious because it does not allow them to live their lives as fully, and the women have mental health problems, eating disorders and, of course, substance abuse and addictions. There are more stats there. I'm not going to review all of those because, like I said, I do believe that you've probably heard a lot of that.

There's a smaller sheet there where I wanted to talk about First Step Women's Shelter here in Sioux Lookout. We're a non-profit organization governed by a volunteer board of directors, so our mission, our mandate is there. Our catchment area: There are 29 communities, including Sioux Lookout. We service 27 First Nation communities, and there's kind of a map on the second page—the dots. They say the area that we service is the size of France.

I have some recommendations. I called this my fact sheet because it's what I believe to be true. Of course, like I said, First Step services 27 First Nation communities. Most are remote and fly-in. Our occupancy rate here is always over 100%. First Step Women's Shelter is one of the only two shelters, I'm pretty sure, in Ontario that have to fly in their women for safety reasons. Of course, that doesn't happen all the time overight. We have to make sure we can book the flight. We have to make sure that we try to get them to a safe, secure place. I think that there are only two reserves that have shelters, so they sometimes have to go home and sometimes they go to the nursing station or a family or friend's house. Sometimes they take off. They can get to the airport when the partner is gone.

We work with between 120 to 150 women per year, 130 to 150 children, and 99% of the women we serve are aboriginal. Off the top of my head, I can say last year we served one non-aboriginal and the year before that we had two, so it's easier for us to count the non-aboriginal women. Violence against women is at an all-time high in our north. I like to say "our north" because northern Ontario doesn't have the limitations that we see here in our north. This is northern Ontario to me—Sudbury and that isn't northern Ontario to me.

Laughter.

Mrs. Marie-France Lalonde: Sorry, Glenn.

Ms. Tana Troniak: Sorry. Come and spend a winter here.

Women fleeing abuse are entering our shelter systems to feel safe and secure with their children. The mandate of shelters in Ontario is to provide women and children with a safe place to live, and shelters provide a safe and secure environment. We have cameras. We have security systems in place. The doors lock.

Sexual abuse survivors and sexual assault victims feel violated and unsafe. First Step Women's Shelter provides a safe and secure emergency shelter for physically, emotionally or sexually abused women and their children. Sexual violence, sexual abuse and harassment victims are survivors, and they need a safe and secure environment. Shelters are already providing this to women and children in Ontario—I'm not saying perfectly; I'm just saying that's what we do.

1140

First Step Women's Shelter is at full capacity, with a lack of funding due to high transportation costs and high cost of living, and we are also a remote northern community. Shelters can do this work together with our local agencies, our communities and our government, but we need to do this together.

I have some recommendations. I really strongly believe that the first priority of the government needs to be that aboriginal women and girls are being murdered and going missing, with higher rates of suicide, addictions, mental health issues, sexual abuse, sexual assault and harassment, and may have trauma-filled lives. We need to do this with other aboriginal agencies, communities, ONWA—the Ontario Native Women's Association—and the OFIFC. We need to do this together.

We need to make the connection between woman abuse, domestic violence and sexual violence. There can be no separation. Domestic violence equals sexual violence; sexual violence equals domestic violence.

Develop, understand and address the reporting barriers, also understanding and offering alternatives to reporting. Provide education on sexual violence, including information on the prevalence of myths, misconceptions and attitudes informed by misogyny. Use a gender-based analysis in all conversations and strategies dealing with sexual violence, including workplace harassment.

The last page is something I've become very passionate about: trauma-informed care. Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all trauma. Trauma-informed care also emphasizes physical, psychological and emotional safety for both consumers and providers to help survivors rebuild a sense of control and empowerment.

No one is immune to the impact of trauma. Trauma affects the individual families and communities by disrupting healthy development and adversely affecting relationships, and contributes to mental health issues including substance abuse, domestic violence, child abuse and sexual violence. Everyone pays the price when a community produces a multi-generation of people with untreated trauma by an increase in crime, lost wages and threats to the stability of families.

Becoming trauma-informed means recognizing that people often have many different types of trauma in their lives. People who have become traumatized need support and understanding from those around them. Often trauma survivors can be re-traumatized by well-meaning caregivers and community service providers. Understanding the impact of trauma is an important first step in becoming a compassionate and supportive community.

I talked fast; I did well. I've got eight minutes to gab.

I will say, I've been in this community for eight years. I first started working in the shelter system, like I said, in my early twenties—oh, no, I was 10; I forgot.

Laughter.

Ms. Tana Troniak: Because I'm only, you know, 30.

But anyway, it was an eye-opener. I also lived in a domestic-violence home for quite a few years. I am also a survivor of sexual abuse as a child. My stepfather—I'm just touching this lightly, because I'll tell you how I know about safety from my own experience as a young woman experiencing that.

Growing up, I was a little darker than my family. I have short hair. When my hair is long, it is long and stringy and coarse; I looked like a little aboriginal girl, and my family didn't. My stepfather—I'm not sure why he decided it was me that he abused, but never once in my life until in my twenties did I ever feel safe again. As the survivor here at the table said, it's something you feel for a very long time. There are still times in my life where something will impact me, and I have to step back and say, "Okay. That's okay."

I use one little story—this is not funny, but I will tell you; this is part of my healing thing. My stepfather was not an aboriginal man. He was a white man from Nova Scotia. He told me things in my head like I was not allowed to wear red, because aboriginal people wore red and I shouldn't look like an aboriginal person. So I wear red as much as I can. I didn't always do that, though.

What I'm saying is, the safety and security of being able to report, to talk about sexual assault, sexual violence and sexual abuse does not come easy to anyone. To say in this community that, "You have 10 hours, you can come in, you can fly in, you can go to counselling for a week and then you have to go home" does not provide that safety and that support to that victim.

I didn't grow up in a northern community. I grew up in a small town called Atikokan. I don't have the same experiences, but what I see from the women—I know that some of our women, with our staff, have gone to the hospital who have been sexually assaulted. There is no way you can have counselling for sexual assault survivors in a week. They get re-traumatized, just like me in my red dress or my red coat. There are times when I think, "Oh, I can't wear that." It's long-term effects. We have to think in the long term: How can we make this work? How can they feel safe? Where can people go to talk about this?

My experiences are with women but also, like I said, I understand that there is sexual abuse of males. I wish I could work with that, but I can't right now. I work with women. But there needs to be a lot more when you look, in these kinds of communities, at what can be done.

When I talked about the trauma, I think we need to look at that and work as a community. We need our communities up north to take that focus. I believe this with my soul, and I see this in Sioux Lookout: No one is wandering around this town, or living in our shelters—the homeless one, or this—who started off their life wanting to be an addict, a homeless person or have addictions. That is not something people set out to have.

It is somewhere in their life, in their past, that there was trauma, be it residential school or sexual abuse when they were a child. They are still in that trauma. They cope—well, some sexually abuse others. Some are drinking. We have a high number of addicts in our community. We need, as a community, to take a look at this and stop focusing on their addiction—we have to focus on that, but we have to get to the groundwork, and that is mainly sexual violence and the trauma they experienced in residential school, which also was sexual abuse for some.

It's a big, big job. I think shelters can be a big, big part of it. For women, I can provide that safe space—well, for some. I'm full all the time, but we can try. That's what I'm getting at.

The Chair (Ms. Daiene Vernile): Ms. Troniak, thank you very much for your presentation and for sharing your information. We're now going to put some questions before you, if we could. Our first set of questions will come from MPP Scott.

Ms. Laurie Scott: Thank you very much for being here today and for your dedication in helping women.

You've brought a lot of information, and I probably have a lot of questions. You've been doing this for a long time. You're a victim yourself, a survivor. How do you change the root causes? The parents don't seem to have the tools. How do you get the information to them that's actually working? Is it flyers? I agree with you about the limited counselling not working; I appreciate that. But how do we get in to change the deep cultural settings that this is occurring in—because it's not getting less, right?

Ms. Tana Troniak: No.

Ms. Laurie Scott: So we have to do something.

Ms. Tana Troniak: I think we need to do it as a community—and bigger. As Ontario, we need to work at this, as a community, getting the agencies together, figuring out what is going to work, figuring out how to keep people safe, how to provide an effective service to men, women and children that is going to be safe and supportive and will be there. We can't have funding for a sexual abuse counsellor—we had one through ONWA who was working out of a building. That's unstable. That's one year. So they decided it's not good to do sexual abuse counselling because, after the year is up, then what? All those people are left stranded. It has to be consistent. It has to be there.

1150

Ms. Laurie Scott: Are those communities willing to have that there constantly? Say it's an office. Say it's three people who aren't from that community. Is the community willingness actually there to realize what's taking place?

Ms. Tana Troniak: We have that. Nodin goes up north. They have counsellors. I don't know if they have ones who are specifically sexual abuse counsellors, but they do go up there.

Again, are they safe in their community to do that? A lot of organizations try to hire within the community. Is it safe for that person? Is there a family member? Is the confidentiality there? Some of them want to come out. Some of them do. That's how we get our women in our shelter. They want to be there. Some want to go home, but—

Ms. Laurie Scott: Some don't.

Ms. Tana Troniak: Some don't; yes.

The Chair (Ms. Daiene Vernile): Thank you very much. Our next questions for you are from MPP Sattler.

Ms. Peggy Sattler: Thank you so much for coming today to present to us. Your shelter is at 100% capacity all the time. What happens to women who come to the doors of the shelter when the shelter is full? Where do you refer them? Do they have to go back home?

Ms. Tana Troniak: No. Any woman who fits in our mandate, we fly out to our community and then we send taxis from here to Dryden or to Atikokan. There's no bus service so we taxi them, at about a $200 cost, to Dryden. I think it's a $500 expense to Atikokan. Some may transfer to Thunder Bay, but it's mainly the two shelters in Atikokan and Dryden.

Ms. Peggy Sattler: So there's typically capacity in those other shelters to handle—

Ms. Tana Troniak: Yes. They are a little slower and a little smaller than us, so that helps, but now they're busy too. Sometimes if they're really busy, we move people around. One time, we put someone in a hotel. We just make it work.

Ms. Peggy Sattler: And the travel costs, the costs of flying women in, would be considerable. Do you have a separate funding envelope for that, or do you have to use your operational budget to fund—

Ms. Tana Troniak: We have to use our operational budget.

Ms. Peggy Sattler: So there's no recognition from the province that you incur these additional costs for transporting women?

Ms. Tana Troniak: No. Kenora, which is funded the same as we are, doesn't have to pay travel costs, has more staff and more counsellors, and we don't.

The Chair (Ms. Daiene Vernile): Thank you very much. Our final questions for you are from MPP Lalonde.

Mrs. Marie-France Lalonde: Thank you very much for being here.

Ms. Tana Troniak: Thank you.

Mrs. Marie-France Lalonde: I really appreciated your presentation. We had the great pleasure, actually, yesterday—I don't know if you know her, but Debbie Zweep was presenting yesterday from the Faye Peterson Transition House in Thunder Bay. I'm sure you're continuing the good work that you've done there, so thank you.

I look at your stats, and there's an all-time high in our north for sexual violence—and the issue of safety, feeling safe. If you were to give this committee a recommendation to help the women who come to you in the shelter, what would that be so that we can help with that feeling of safety?

Ms. Tana Troniak: For our shelter, you're saying?

Mrs. Marie-France Lalonde: Yes.

Ms. Tana Troniak: I think we need more beds here and more funding. One of the main things we need in this community, for us, is transitional housing. We need a place to go for at least a year or two where they still can be with us and work with us but be on their own also and have that support. In our community we need transitional housing for many things—addictions, mental health issues. We need more housing, but supportive housing also.

Mrs. Marie-France Lalonde: You've also referred, in your recommendation, to understanding and addressing the reporting barrier. Can you elaborate a little bit for us on the ideal vision you have as to how we can help with that aspect?

Ms. Tana Troniak: For reporting sexual violence, I think sometimes if you go to the hospital it's very medical. We don't have the staff 24 hours a day. We have one staff working at our shelter, so I can't just send somebody there. Having a better relationship with the hospital—we're small; we all get working in our little groups and struggle within, but we need more support in

the hospitals just with the women when they come out so that they feel that safety—like I said, safety is so important—that they get that and then feel they can go there and they can report it and have that person standing beside them.

Mrs. Marie-France Lalonde: Would you say that when there's an incident, they would call—I guess travelling is almost impossible. So where do they go when a sexual assault occurs and how do they have access, let's say, to a hospital or your shelter?

Ms. Tana Troniak: The nursing stations—

Mrs. Marie-France Lalonde: Okay, on the reserve.

Ms. Tana Troniak: If they've reported it to the nursing stations. We've had women walk to the shelter. We had a woman who walked into the shelter, was intoxicated so we had to sober her up a little bit. A lot of shelters don't do that. Once she sobered up, she told us she had just been assaulted, so we waited. The dayshift staff came on, and one staff went over to the hospital with her and reported it.

Mrs. Marie-France Lalonde: And you mentioned that, maybe, your relationship with the hospital is not where you would like to be. Why? Why is that relationship not as present—

Ms. Tana Troniak: A lot of it I think has to do with the fact that we're small; we're busy. I'm running two shelters right now. It's time too, and being small and not having the staff to do stuff like that, they're also very busy too. That's a whole other—

Mrs. Marie-France Lalonde: And if I may, I know in my notes here I see that telephone support is available 24 hours a day. We heard yesterday from Talk4Healing. Is that part of a service that you're able to offer or are you—

Ms. Tana Troniak: There again, it's on the telephone.

Mrs. Marie-France Lalonde: Okay.

Ms. Tana Troniak: It needs to be one-on-one.

Mrs. Marie-France Lalonde: But for those who are in remote locations, do they have access to that phone line?

Ms. Tana Troniak: Oh, yes. Yes, they do.

Mrs. Marie-France Lalonde: Okay.

The Chair (Ms. Daiene Vernile): We want to thank you very much for coming and speaking to this committee and informing us of the important work that you do. Thank you very much.

Ms. Tana Troniak: Thank you.

The Chair (Ms. Daiene Vernile): If you would like to join the audience now and hear the other presenters.

MS. BRENDA DOVICK

The Chair (Ms. Daiene Vernile): We now would like to call forward Brenda Dovick.

Please have a seat at our presenters' table. Make yourself comfortable. You will have up to 20 minutes, if you require it, to speak to our committee and that will be followed by questions from our committee members. Please state your name and begin any time. Thank you.

Ms. Brenda Dovick: Good morning, everyone. Welcome to our beautiful community of Sioux Lookout. My name is Brenda Dovick and I live here in Sioux Lookout.

First, I'd like to acknowledge you as members of the Select Committee on Sexual Violence and Harassment and the efforts that you're making in hearing the voices of communities in our province. I feel very grateful to be given the opportunity to speak about this important issue and have the deepest intention to make a positive contribution which will help find solutions.

I'm more nervous than I thought I'd be. All right. So here we go.

Interjections.

The Chair (Ms. Daiene Vernile): Would you like some water or a cup of tea or a cup of coffee?

Ms. Brenda Dovick: No, I'm okay. Thank you, though.

I've been taught that it's really important to set the landscape of where we're coming from when we talk. I was taught that through my experience with elders and my education. So that's what I'm going to do.

I come to you today from the perspective of different roles I have in my life. I'm speaking as a woman and for women, as that's what I know best. In saying this, I acknowledge that boys and men experience sexual violence and this needs to stop. I fully support and advocate for all initiatives that work towards ending sexual violence for all people.

I come to you as a woman who has experienced sexual violence in my childhood and in my adolescence.

1200

It has been a long process of remembering the experiences I've had, and there are still some blank spots. I mention this because it's important for the committee to know the various implications of this issue. You've asked people to come forward to speak from their own experiences, which is a very difficult thing to do in itself, and I want to publicly acknowledge the people who have chosen to do that.

It's also important to mention that there are many people who have not yet come to realize that they have experienced sexual violence because they've repressed the memories, as I have, or they do not understand what sexual violence really means. This instills the importance of public education in the definition of sexual violence so that people can put together the puzzle pieces which will explain the internal struggles they have which are a result of being violated in the worst possible way.

I also come to you as a social work professional with credentials as a registered social worker with a Master of Social Work in the aboriginal field of study from Wilfrid Laurier University. I have over 20 years of experience working in the non-profit sector in our community, including direct service work as a mental health counsellor for individuals, including those who have experienced sexual violence. This work in particular has involved travel to remote First Nation communities, and I have been involved in coordinating community initiatives to bring awareness to violence against aboriginal women in

particular. This is an area of work and study I have a strong commitment to.

I also come to you as a community member of Sioux Lookout who is concerned about the issue of sexual violence and the safety and well-being of all people. This issue is one that affects us all and is not spoken about locally, and I recognize that this needs to change. I consider myself a strong voice in ensuring this is an issue we address in our community.

Lastly and most important to me, I come to you as a mother and a grandmother who deeply desires healing for her own family. I did not know how to talk about this issue as a young mother with my children, and it has affected their lives. I want to change this for our future generations. That is why I do the work that I do.

This is obviously a very important discussion and one that has various components and directions in which conversations can flow, so it's interesting that the last question that came to the previous presenter was about reporting, because that's what I've come to talk about today, low reporting.

I want to talk about the low reporting stats and lack of disclosures made by girls and women in our region. Recently, we've had the second restructuring of our local hospital-based assault care and treatment program in a relatively short time, and those who have been part of making these decisions have indicated that the program is underused. Knowing the landscape of our region quite well in my professional capacity, I can verify that sexual violence is happening at high occurrences, so there's definitely a disconnect between the victims and service system. This is happening for a variety of reasons, some known and others that still need to be clarified.

I'd like to refer to the statistic that only 10% of sexual assault victims report to the police. Through my experience supporting victims, there are many contributing factors to this. There are systemic breakdowns which have left victims feeling a lack of trust in the judicial processes. These are well documented in academic research. There are also poorly trained personnel at service agencies who are not professionally equipped or simply lack the compassionate nature to work in this specialized field.

The reluctance to report is especially evident by First Nations women I have supported who often express the lack of confidence that they hold in systems that claim to support them. I've had experiences with women from remote communities who disclose that going through the court process often is not worth the pain that it brings. This is especially the case when they are made to testify in the same room as the perpetrator and the perpetrator's family and friends who will make even worse problems for them, whatever happens in the court case and whatever the outcome is. There are women who do start the court process yet often withdraw partway through, which results in a reputation of lacking credibility should they file other charges in the future.

Another scenario is the woman who decides to visit the local emergency room, preferably with a community social service provider, if possible, because she doesn't know what to expect there. I can remember one woman in particular who asked me to go with her to have a follow-up for the head pain she was experiencing due to a brutal sexual assault in her community that had left her unconscious. The treatment she received from the attending physician was inhumane. I witnessed it myself. To put it bluntly, it resulted in the woman experiencing unnecessary additional trauma when she was looking for help, simply because of his lack of compassion towards her. In this case, I was able to encourage her to file a complaint with the hospital, and I walked through those steps with her. It was very empowering for her. However, I can assure you that there are many cases similar to this that go unreported, and women likely do not return for help when they need it the most.

These negative experiences women have with support systems as victims of sexual violence not receiving the support they need often result in them returning to harmful situations where the assaults continue, and other perpetrators are added into the mix. It's a heartbreaking situation which leaves victims feeling helpless and caught in a world of victimization, often leading to addiction and even death by suicide. These things I'm disclosing demonstrate the need to improve systems of response for those who experience sexual violence. These systems must be monitored and evaluated continually to ensure that victims are able to access initial treatment and ongoing supports to heal from their experiences while being able to safely and effectively navigate the judicial system to hold perpetrators responsible.

There's an additional factor that I'd like to bring forward which keeps reporting stats low and one that we don't often consider in service systems. This is the burden that women and girls carry with them in the form of a belief that the sexual violence that they have experienced is something that they're to blame for. Often women will not recognize sexual violence as a crime due to the environment that they've been raised in or that they're currently living in. Many women and girls I've spoken to believe the sexual violence that they experienced is something they brought upon themselves, either the way they behaved at a party, the way they spoke to a man or the amount of alcohol that they consumed that night. Women have told me that they agreed with their ex-partner's claim of ownership when he came into her home late at night unannounced and repeatedly sexually assaulted her. She has come to believe that she is his property, and unless someone intervenes and teaches her otherwise, this will continue. I have so often heard the internal message that women carry with them, all those messages that perpetrators have told them. They believe them; basically, they believe that they deserve exactly what they got.

How are we going to change this? What influence do we as a society and professionals have in changing women's internal messages? In all our efforts to address this issue, I feel that this is the huge piece of the puzzle that we're missing and one that needs to be addressed

should we truly want to tackle the problem of sexual violence in our communities head on.

I believe that we as a society must take responsibility for the messages that we're giving to one another about sexual violence. Just as importantly, we need a government that will support public policy that will ensure that schools, workplaces and other public institutions have to adhere to zero tolerance measures to address all types of sexual violence, which include words, attitudes and behaviours.

Currently most schools enforce dress codes for students. If a young woman comes to school dressed in a tank top and a short-cut mini-skirt, she's sent home with the message that she's dressing inappropriately, that maybe she's asking for something. What is this message? Is it a message of safety or is it a message saying, "You're asking for what you're going to get, and you're going to be blamed for what you're going to get"? How can schools still endorse appropriate student attire, yet not perpetuate messages that hold females accountable for being assaulted due to their appearance?

We have a curriculum in our schools which includes sexual education. In this curriculum, are we really teaching young people how to respect each other's bodies and how to respect each other as human beings? Do we have healthy adult role models in our education system who can teach this to children and adolescents properly and with honour?

What happens to teachers who abuse their privileges as trusted adults and cross the lines of appropriate conduct? Yes, they're usually dismissed, but why do we see them working in other capacities in our communities? Why do we see them teaching in remote communities? Why is their history not being tracked? Why is their inappropriate behaviour not known? Who is checking into the history of perpetrators who continue to be in contact with vulnerable populations?

1210

In the social work field, as registered social workers and registered social service workers, we are legislated to maintain the boundaries of appropriate relationships with clients we work with. When these lines are crossed, the consequence is a review by our peers and a hearing which will likely result in a suspension of membership, and our registration is revoked.

However, despite these actions, there are many organizations that will hire people without checking into their backgrounds, without checking that they are indeed registered as a social worker or social service worker. If they were to do so, they would see the history of these individuals. This places responsibility on organizations to ensure that they are keeping citizens safe, and perhaps the government needs to consider a monitoring system to remind administrators to check the history of their employees, as well as implementing standards of practice in hiring registered professionals.

We also need to think about community members who are in positions of authority and need to be held accountable for their behaviours, their words and their attitudes. This includes sports coaches, church leaders—anyone who is in contact with the public in this way. These organizations need to have policies in place to prevent sexual harassment and protect the vulnerability of young people, especially, who come into contact with these people.

I want to refer to the term that is used in the document that the government has put out about rape culture. This talks about societal norms which can contribute to the epidemic of sexual violence. Media messages from advertisers always bombard us with these messages, and we are well aware of this. Despite the progress of teaching children "no means no" and to be wary of unwanted touch, there remains a disproportionate number of young women experiencing sexual violence in our communities.

This is a widespread problem, and it's challenging to address when citizens express their own rights of what movies and music videos they choose to watch, the sexual lifestyles they are involved in and accusations of limitations of freedom that are expressed when sanctions are potentially implemented which limit access to media and information available.

So what is the solution? I agree that ad campaigns, such as the province's It's Never Okay initiative is a good start to have members of the public take responsibility, so I suggest having these ads placed in locations and atmospheres that will influence a target group that needs this education, and that includes sporting events, television channels that men watch frequently and perhaps on YouTube, where they will—

The Chair (Ms. Daiene Vernile): It's already there.

Ms. Brenda Dovick: Okay, good. Good to know.

I also feel that the government's support of involving voices of survivors is especially important. When working in my role as a Sioux Lookout aboriginal sexual assault counsellor with the Ontario Native Women's Association, I coordinated a PhotoVoice project, which was created by young First Nations women sharing their perspectives and personal experiences of sexual violence. I've sent the link to this PhotoVoice via email to be distributed to all of you, and you can watch it when you're able to. That would be appreciated.

This project is an example of how empowering it can be when victims of sexual violence are given an opportunity to participate in something that can create change on a larger scale. Over the time we spent together, young women learned about the history of violence towards women and girls in aboriginal communities and how colonization has contributed to this. They explored their own identities as indigenous women and what that truly meant to them. Finally, they were encouraged to reflect on what they felt leaders in their communities, organizations and at a government level needed to learn from them.

The results were evident through the participants' evident pride at the community event they hosted to premiere the video and the photo display. The video is now on YouTube for public viewing, and the photo display is located in a main hallway of the Sioux Lookout Meno Ya Win Health Centre. I'd like to read the words of a participant who has given her permission to share her reflections about the project. She says:

"During my experience through the PhotoVoice project from the end of August to the middle of November, I have learned a lot about sexual violence.

"I learned that sexual violence is something that nobody wants to talk about but it happens to everyone in the world, happens to women, men, girls and boys. It can happen to anybody, your brothers, sisters, cousins, aunts, uncles and friends.

"This particular project is focused on aboriginal women because it's more likely that an aboriginal woman may be sexually assaulted or abused or experience sexual violence.

"This PhotoVoice was a great way to express my feelings. Adrienne and Brent," who were the photographer who mentored us, "gave us lessons on how to take different kinds of pictures, from different kinds of angles and such. It wasn't just about taking photos around Sioux Lookout, there were a lot of other things we had to do to bring this project to life. We had meetings every week and were kept busy with many different activities to do. We chose the title 'The hurt of one is the hurt of all; the honour of one is the honour of all' because when someone hurts it doesn't just affect them, it affects many people in the community. 'The honour of one is the honour of all' means if someone celebrates a joyous occasion, it is felt not by just them; it is felt by many.

"I am only 14 years old and have already experienced two sexual assaults. Because of this I have low self-esteem and I feel worthless. This PhotoVoice project has helped me open up and share my problems with other girls that went through the same thing as me. Counsellors have helped me understand that it wasn't my fault, it was the abusers' fault. I still have problems communicating with boys because I don't know what they expect of me and I don't want to be forced to do something I don't want to. I was born with cerebral palsy and don't have the full use of my left hand. Because of this, I don't want to be taken advantage of. I was born this way and have come to terms with it. I found my traditional way of life and it has made me feel stronger and more confident in myself.

"In conclusion, changes are hard, but we have to start somewhere, even if we have to take baby steps. Because of being involved in this project, I can now hold my head up high with dignity and help others who are struggling with sexual violence. I can empathize with them. So I encourage all women, aboriginal or non-aboriginal, to get help right away if you are struggling with sexual violence in your life. I know it's not the prettiest thing to talk about. Nobody wants to talk about it. I never wanted to talk about it myself, but we've got to start somewhere. Thank you for your time."

The Chair (Ms. Daiene Vernile): Thank you very much for your presentation. We're going to give you some questions now. Our first set of questions will come from MPP Sattler.

Ms. Brenda Dovick: I thought I had 20 minutes—oh, I have. Okay.

Ms. Peggy Sattler: Thank you very much. Instead of questions, did you have a couple of other concluding thoughts?

Ms. Brenda Dovick: I just have a little closing part. Sorry. I thought I had timed myself.

Ms. Peggy Sattler: Please conclude.

Ms. Brenda Dovick: I just want to share that this is a young woman who needed to speak through me through the first sessions that we started together, this young woman who wrote this and who's now 16. She wasn't able to look anybody in the eye at that point. It was partway through the project that she was able to begin speaking out loud. At its completion, she actually facilitated a school assembly and shared her experiences. I don't take credit for that. I give all that credit to her and to her peers. It just shows how powerful these things are.

The final point that I want to stress is the whole community approach to prevention, intervention and post-vention. We need to stress the message that it's not an individual issue, as was the message of this PhotoVoice. How can the government support us? It can be through family healing initiatives that work towards addressing underlying issues of trauma, that Tana has mentioned, that perpetuate violence in families and interpersonal relationships. We need to support research initiatives to find out from victims themselves what interventions work and what types of supports they require. We need more public ad campaigns that are located in all spaces where everyone can see, hear and learn from them. We need legislation which forces employers to adhere to policies that address sexual harassment in the workplace and community organizations to follow strict measures in selecting employees and volunteers.

We have a long road ahead of us, yet there are people and organizations that are doing good work and they're really making a difference. There are champions in the field of sexual violence who can act as mentors and guide communities in the direction of becoming safe places for us all to live.

I want to acknowledge Premier Wynne and her government in recognizing the need to address this issue and reaching out for help from the communities to help us all to move forward.

Thank you for taking the time.

The Chair (Ms. Daiene Vernile): Thank you. MPP Sattler, you may continue. We have a few minutes.

Ms. Peggy Sattler: Thank you very much. First, I want to say how much we appreciate you coming and sharing both your personal and professional experiences with this committee. You acknowledged how difficult it is for people to share those personal stories. We benefit so much, but it is very difficult for people, so thank you for sharing.

You mentioned at the beginning of your remarks something about the hospital restructuring that had taken place here and how that is having a negative impact on victims. I missed what you were saying. Can you tell us a little bit more about what's happening with the hospital restructuring for victims' services?

Ms. Brenda Dovick: I don't feel that this is the proper venue to really talk about that in respect to the program. Just out of a community perspective, when these

programs are restructuring in a general perspective, there's a breakdown in service—

Ms. Peggy Sattler: A ripple effect.

Ms. Brenda Dovick: It just shakes everything up again. We as a community need to be able to advocate and to be part of that change process.

1220

Ms. Peggy Sattler: Okay.

Ms. Brenda Dovick: In our community, there has been restructuring twice in a very short time, with limited input from community. We're working to improve that.

Part of my comment was, it's not because the service isn't needed. We don't want that message to be put out. I'm not saying that's the message that the program has, yet we're concerned that funders will get the message, "It's not a service you need in your community, so we're going to pull it." It's needed. It's just, why isn't it working?

Ms. Peggy Sattler: Yes.

The Chair (Ms. Daiene Vernile): Thank you very much. The next question for you is from MPP Thibeault.

Mr. Glenn Thibeault: Thanks, Ms. Dovick, for being here today and sharing your story. I know you talked a lot about issues relating to reporting and revictimization. I was able to take the time and go through the photo journal, or the PhotoVoice project, as you call it. There was a very powerful statement in it, and I'd like to read it. It says, "We look to a system that keeps letting us down. A system designed to protect us has become one that hurts us even more. The system needs to be changed, to do what it is supposed to do." That is a pretty powerful statement, when you read that.

I guess, when looking at the individuals who you talked about, who were involved in this, I'd really like to delve into that a little more and get your opinion on what you think are the changes that are needed to make the system work.

Ms. Brenda Dovick: We need to go to the victim-survivors themselves to get those answers.

For me, as someone who has experienced sexual violence, it really is about that first point of contact. That is so important. So if it's police, if it's hospital emergency staff, they need to be specialized in that field.

I had the sad experience of going through the last days of my father-in-law's life on an oncology ward in the Health Sciences Centre in Winnipeg, and the care and the love that he was given. We need to bring that same kind of compassion and love to people who have experienced sexual violence. I was surprised that I nearly broke down myself. It was difficult, as a survivor, to write this. That survivor, she didn't want to come here today. So it doesn't end. I guess that's what I want to say.

We need that love and that compassion, as communities, to welcome—those are the changes. How we bring those together—we work together and find that out, like you're doing here. You're hearing from survivors. That's so powerful. I just want to really acknowledge that. Thank you.

Mr. Glenn Thibeault: Thanks.

The Chair (Ms. Daiene Vernile): Thank you very much. Our final questions for you are from MPP Scott.

Ms. Laurie Scott: Thank you very much for appearing here today. It was tough for you, and we all appreciate the fact that you found the strength to come here, and that you work in the field that you work in.

You work closely with aboriginal communities, so I'm just going to focus on that. What tools are we not giving or what awareness are we not putting out there for the chiefs or the elders? Maybe they already do see how prevalent it is in aboriginal communities. What is it that we're not providing? I know we don't want to talk about it, but we have to.

Ms. Brenda Dovick: Right. I think the mechanisms to have victims leave the community when they need to—we have huge struggles with Health Canada, with non-insured health benefits, getting victims out of communities at times. It continues to be a battle.

I believe that people who work on their own healing become advocates. If we support victims and survivors to use their voices in their own communities, that can be a really powerful first step—including leadership. There are a lot of people in leadership who have not addressed the pain that they've experienced. Everyone needs a safe place to do that. So creating that safe place—if it means, like I said, being able to transport people out of communities and not go through a whole intense questioning. It's like revictimizing people all over when we're not giving them that honour of doing their healing in the way they need to, which includes often leaving their own communities.

Ms. Laurie Scott: On an acute level, I totally agree, but on a systemic level, do they realize what has occurred in the communities, what continues to occur? They could be victims themselves; I'm not saying they're not. I'm just saying that the comfort of these small communities with their leadership, their chiefs, their elders being there for them: Do you see any movement in that at all?

Ms. Brenda Dovick: In some communities, and others not. I've worked with women at our local shelter who are not being supported by leadership. So leadership needs to acknowledge this. There are many leaders who do, and there are others who don't. It's a tightly held secret, one that could really open up a lot of pain in a community. So that support is needed.

Ms. Laurie Scott: Okay. Thank you.

The Chair (Ms. Daiene Vernile): Thank you very much, Ms. Dovick. Thank you for coming and informing this committee of your important work and your experiences. I invite you now to join the audience, if you wish to listen to the next presenters.

Ms. Brenda Dovick: Thank you.

SIOUX LOOKOUT
MENO YA WIN HEALTH CENTRE

The Chair (Ms. Daiene Vernile): I will call the next presenters, from Sioux Lookout Meno Ya Win Health Centre, if you could please come forward.

If you could introduce yourselves. You'll have up to 20 minutes to speak to our committee, and that will be followed by questions by our committee members. So please begin by stating your names, and begin any time.

Ms. Amy Chamberlain: Okay. My name is Amy Chamberlain and I'm speaking today as the survivor of sexual assault and in my role as an advocate working as a registered nurse in the Assault Care and Treatment program at our hospital here.

Ms. Glendene Schardt: I'm Glendene Schardt. I'm also an RN who works in the ACT program. I'm a childhood survivor of sexual assault and domestic violence from the age of one to 17, when I went into nursing. I've been nursing for 39 years, 10 of them up on northern reserves and 17 of them here in Sioux Lookout.

Ms. Amy Chamberlain: We're going to start by just talking a little bit about the details of our structure in our programs. We're set up as 4.5 full-time RN positions. We provide on-site care and telephone support to the northern communities 24 hours a day, seven days a week. Each RN is on duty alone. We don't have a call component to our program currently. On-duty-alone can create some challenges as we're working almost in a silo. It makes it difficult to initiate projects and public awareness projects because we're expected to juggle competing priorities hospital-wide.

Part of this goes with our role as also being a resource. We're not strictly dedicated to the ACT program. We are, at times, reassigned to other areas in the hospital due to staffing shortages and limited human health resources. It often leaves our ACT program with no coverage or limited coverage, whether this be going to the emergency department to help with trauma, going to the maternity department to help deliver babies, or going to the medical surgical unit to help new grads with deteriorating patients or starting IVs. Like I said, it does make it difficult when we're trying to do community outreach.

Currently in our hospital, we have four RNs hospital-wide right now who are qualified to work in this program. We don't have a casual staff pool to pull from to cover gaps or replace staff.

Part of what I just wanted to touch on as far as the limited human health resources: Glendene actually got a subpoena to go to a court date, which, for us serving some of the northern communities—her court appearance was actually up in one of the communities. That was supposed to be scheduled for today. She's also scheduled to be the ACT nurse today to respond to acute cases. If she had actually had to go up to the community, we wouldn't have coverage to respond to something like that.

1230

Our staffing setup and funding have prevented us from accomplishing the public awareness projects that we'd really like to do, and we're going to talk about more of those a little after.

Just about our background information: We serve a population of around 30,000 people. We service 32 communities; 28 are First Nation communities. We also service four southern municipalities. We cover 33% of Ontario's land mass. Our geographical location is large for a relatively small population. All of the communities we serve are in remote and rural areas. There's also a map included for you as well, if you want to take a look to see how far our service area spans.

Talking about some of the challenges to health care delivery because of some of this background information: Many of our patients have limited access to care. Only 15% of the people we see have immediate access, meaning that they can have some kind of available and timely transport to get to a service area in a reasonable amount of time. With that being said, the rest of the patients have the need for extensive travel, like what Tana was saying with aircrafts and the winter roads from January to March.

Like I mentioned before, we also have limited health human resources and higher costs per capita. The cost of living is significantly higher in this area, and they get even higher as we go further north.

Our program is very unique due to these challenges. As you'll see as we continue, it will be very important going forward that the action plan reflects some of these unique challenges. There are some food prices available for you to look at and some pictures of the travel methods that are used.

When accessing services, often our patients and families are traumatized by the logistics of just getting to our service area in addition to having to deal with the presenting health issues and the foreign context in which they're met.

When we look at the health realities of our patients, 80% of the patients we see at our hospital are First Nations people, while 80% of the staff are non-First Nations. Many of our patients speak one of the three Anishnawbe languages, which have 19 dialects.

That being said, First Nations people across Canada suffer a disproportionate burden of disease and ill health when compared to their non-First Nations counterparts.

Health is influenced by a mix of historical and contemporary issues which include poverty, unemployment, inadequate housing, poor access to programs and services, discrimination and a loss of traditional lifestyles. As a result of some of these factors, we see people experiencing higher rates of chronic and infectious diseases, things like blood-borne infections, hep C, tuberculosis and sexually transmitted infections.

We also see suicide rates which are disturbing. For children under the age of 15, suicide rates are 50 times higher than the national average, and five times higher for those between 25 and 44.

We also see disability and addictions being major issues. Alcohol-related deaths are twice as high as they are in the general population, and deaths due to illicit drugs are three times as high.

Family violence and injuries have equally disturbing high rates. Spousal homicide for First Nations women is eight times higher than that of non-First Nations women.

I have a population distribution graph here. It just illustrates the difference in the population when we're

speaking specifically of aboriginal individuals in the North West LHIN area. Their population is mostly between the ages of zero and 29 when compared to the rest of the North West LHIN and Ontario, which follows more of the bell curve with the baby boomers aging. This has impacts when we're looking at how we address issues regarding sexual violence and harassment, because we know this happens in that age group of zero to 29.

When we look at violent crimes, 48% of First Nations women who experience intimate partner violence report the most severe forms of violence—being sexually assaulted, beaten, choked, threatened with a gun or a knife—and are more likely to state that they feared for their life as a result.

We also have a graph here depicting violent crimes, which includes sexual assault, robbery and physical assault. One includes spousal violence; one doesn't. But you can see in comparison that aboriginal female victims suffer significantly higher rates of both.

Ms. Glendene Schardt: This coincides with the national inquiry for missing and murdered aboriginal women. Women are leaving northern communities for various reasons, and often sexual assault and domestic violence at the community is one of them. They are not always aware of programs and options available; therefore, a lot are living on the streets, becoming more vulnerable to unhealthy lifestyles and predators.

It is important that the ACT program provides reliable, consistent, qualified, supportive, non-judgmental services not only to women, but to men and the LGBTQ community, as these individuals are also facing similar vulnerabilities and high-risk situations as the women.

It has already been brought up: We have no place for men. We see men in our program. Our problem is housing. If they are First Nations men, we have the hostel that provides them—non-insured pays for that. If they are not First Nations men, we have nowhere to send them except Thunder Bay. We work very closely with counselling. They help. We provide that service.

Our program needs to be involved in promoting and providing education about the options that we offer, and other services offer, so individuals are aware there are choices other than living on the streets.

Ms. Amy Chamberlain: We also included a flowchart to give you an idea as to the process that needs to happen for our patients to actually come to our service point. You can see that in order for someone to get service, after the sexual assault or domestic violence event happens, they have to go to the nursing station. The doctor needs to be contacted. We get a referral. But even after that, transportation needs to be arranged from the northern community. They have to take a flight out to Sioux Lookout. They go through the ER department to get triaged and then they get a consult by us. That can take anywhere from 24 to 72 hours before we even see a patient come through our doors.

Just from conversations with police and northern nurses, we're not even aware of everything that goes on in the northern communities in regard to sexual assault, domestic violence, elder abuse and other issues of sexual violence, because they are not even aware of the programs and services that exist—due to the isolation and the minimal funding to overcome the unique access to care challenges, which is the norm in our area. Even health care professionals don't know that these programs exist, so how can a patient know and understand the options that they have available to them?

To get travel—our patients in the north are unable to self-refer. They have to go through the nursing station to get to our program and through several different means to try to get out to even just get a consult to hear what kind of options we have available.

The next page has a series of cross-cultural barriers, which I've also placed on the flowchart just to give you an idea of which ones—

Mrs. Kathryn McGarry: It's awesome.

Ms. Amy Chamberlain: Thank you—of which ones really impact at each various level. Of course, each barrier has the potential to completely block or delay treatment and care during every encounter or process within the health care system.

1240

In particular, we're seeing major issues that stem from systemic and contextual barriers in our area, so this will be very important when we consider addressing issues in relation to sexual violence in the Sioux Lookout zone.

I've also included a case study that happened last year so you can have an idea as to what a typical case would look like. We're seeing, like the rest of Canada, that there's a delay in the reporting of the actual event to any kind of health care service. You can see that from the time they come to the nursing station and make the referral, we don't see them for another 26.5 hours.

When we look at why this is happening, we can see from this situation that there is a five-hour lapse in time because our sexual assault and domestic violence nurse assigned to the program was actually reassigned to the ER department. That created a little bit more of a lapse. But we're also looking at the travel time.

Ms. Glendene Schardt: Our program and why we are here today: We want to improve patient care. We want to address the systemic and contextual barriers affecting the care and treatment of patients coming from northern communities. We want to improve community resources available to patients in northern communities—awareness of options available, improved communication, better follow-up and safety planning, and supports in the community. I'll talk briefly. You've heard a lot about that today, that there is a lack of support at the community level.

Continue to build project initiatives which are based on participatory methods of inquiry and culturally responsive care. We certainly want the community to help with these projects. One of the ones that Brenda spoke to, PhotoVoice—we actually included a few of the pictures from that, where the community members are involved in this. We have to start at the community level if we want to help do prevention and stop these types of behaviours.

Ideas for northwestern Ontario that we came up with: We did prices. Our funding has no funding for any of this. There are radio shows, Facebook and social media. I worked in emerg the other night. We had four young teens from 11 to 14 who did a Facebook suicide pact. All four of them were flown out, all from different communities.

Lots of people and lots of our patients don't have phones. Follow-up is difficult for us. Amy did a grant and she received $15,000 from Women's Xchange at Women's College Hospital. She's doing a project where she's going to get cellphones and minutes. When we have acute crises we have criteria that they will receive these phones so that we can phone them. A lot of them have to go to friends' houses or the nursing station and follow-up does get missed.

We want forensic bags. We do things with underwear. People come up with nothing. Soap, that kind of stuff.

Prevention programs for children in northern communities and Sioux Lookout: We want to get to the young children and do education that this is all wrong. In some communities we have to do a lot of research and work with the communities, whether they will let us come in and do education or if someone can come in, those types of things, because it is isn't always just open for all of that.

We want to do youth retreats. They had done them in the past. They went over very well. They did them with girls. We'd like to expand that to help with self-esteem, to be able to talk about their issues.

We want to do community partner education—nursing stations, police, child and family services, victim support. We had an advisory committee when we changed this program, so that has been very helpful. There is a community group and what the group was meant to be was that all the community members—because the one woman from Ah-shawah-bin said they didn't know what was out there. We can do resources. That was what the committee was meant to do, that we'd get together and say, "This is what you do."

People have funding. I did a fair; RBC was across from me. I said that we're getting into elder abuse. She said, "I have money to do some workshops for the finances for elders." Our gerontology group here said, "We have funding that we could help put it on." Ah-shawah-bin said, "We have some funding for it." So when we go to do it, once we find what the nursing model of elder abuse is—because our program is going to be involved in that; it's starting up the network in Toronto—and what it's going to look like, we can offer that.

And then once we get that up and running, we want to have a community and these people who have the funding to join and we can do a good workshop. We're looking at other places and groups for funding.

The next thing is staffing needs. We need accessible training opportunities for the nurses to give this care—pediatrics, elder abuse, trauma-informed care. We have one doctor who's trained for pediatrics. None of us nurses are trained yet. If she's away, we have to send pediatric clients to Thunder Bay. Thunder Bay does not provide the pediatric clients with counselling; we do. We have four pediatric female counsellors in our program. Community counselling is out of the hospital. They have 14 counsellors. If patients come through ACT, they get instant counselling—there's no question. When we get a referral for an ACT patient, we phone community counselling and they can have them in counselling that day. We have dedicated ACT counsellors, which Ah-shawah-bin may not know. That's why we need to get this information out, because we have this.

So what happens? Our team gets all our information from IAFN. It's an international out of the States. Amy did a poster presentation. She went to Phoenix to present it. We have a Canadian forensic group. It isn't up and running. We have to get our SANE training out of the States. I believe it's $800 each for the exam. There isn't a lot of funding that the hospital has for that.

Pediatrics: We need all 4.5 of us to be trained in pediatrics and in elder abuse—all of these things, and that means going away somewhere else.

Available human health resources: We certainly need more. We're working alone. It's really hard—I wouldn't have been able to come today if I had gone to Round Lake. So then these opportunities are being missed because of our resources. We need relationships with our community partners, and we need funding to meet our full capacity.

This is the camera that we take forensic pictures with. That's what we use.

It's Never Okay: According to the ACT program, the following points from the action plan will be especially important in helping address the unique challenges faced in the Sioux Lookout zone: more training for professionals; raising public awareness; more help and better supports for survivors in the community.

It's complicated. Their supports—a lot of times the NADAP worker and the mental health worker could be the perpetrators; the brothers, sisters, family members. There is a lack of training. So a position is filled. They need to get it filled. They have the funding. There isn't formal training. They're not trained to be social workers, so people have issues. Then it's safety: "We want to get out of the community. We trust someone else. We're not looking at the perpetrator's brother"—

The Chair (Ms. Daiene Vernile): I should tell you that you have one minute left in your presentation.

Ms. Glendene Schardt: Leadership and accountability: We want joint working groups on violence against aboriginal women and in things like the national inquiry and in groups like this, so we can get the message across to give better care.

We'd like to thank you for having us here to speak about our issues, and we are happy to be included in this.

The Chair (Ms. Daiene Vernile): We thank you for making this presentation. Our first question for you will be from MPP Anderson.

Mr. Granville Anderson: Thank you very much for coming. A very excellent presentation. I can see the

passion you put into this. I was able to follow it page by page in a few minutes. It was very detailed and well put together. So thank you, and I'm sure the committee will find this information very helpful.

Ms. Glendene Schardt: Thank you.

Mr. Granville Anderson: Could you elaborate a bit on the ACT program? You did say that there are only four nurses who have training. Why are there only four, and could you tell us what type of training you got and how the training was provided? It's a two-part question. Do you know if this program is available in other hospitals or in other communities at the moment?

Ms. Glendene Schardt: Yes. There are 34 sexual assault—

Ms. Amy Chamberlain: Thirty-five.

Ms. Glendene Schardt: —35 across the province: Thunder Bay, Dryden, Kenora, ourselves and then southern Ontario.

The training consists—we do an online portion and we have to go through—what's the word I'm looking for?

Ms. Amy Chamberlain: It's online modules.

Ms. Glendene Schardt: Modules. It's modules, and then we do the testing. Once you've finished your modules, we go to Toronto in October and we do in-class training for a week. Then you have to go on to the IAFN, and after you've been an ACT nurse for a year, then you can write the SANE training, and there's a SANE examiner, which we are. Then there's pediatrics. They go in different levels. Unfortunately, that's all through the States, not through Canada. That's the training portion. We get trained on the kits and we help each other.

1250

Why there are only four of us—that is what the funding is for. There was only funding for four nurses to be trained—well, 4.5. It's really hard in Sioux Lookout to get part-time people to come and stay and work just part-time. So we've been running with four of us. That's why we work 12-hour shifts. It's 24 hours. There's someone there days and there's someone there nights. When we go on vacation, the rest of the group have agreed that we will fill in for each other, so if someone wants a day off, we give up our days off and we fill in and do that.

Ms. Amy Chamberlain: I'll just add to that really quickly: For the training portion of that, for us here, we don't have the number of cases to keep our competencies up if we're training new people. Part of what that is, is to be able to do this on your own, you have to be able to complete two sexual assault kits and a domestic violence. For us, that could take months before we have all three—and on the shifts when you're training someone else. So it does take a longer period of time. That's why we ended up going to Toronto to do the kits, because they average about one a day. It took about a week for all of us to go down and get our training to be able to do this here. But it's a lot more difficult to have it done all in Sioux Lookout, and we're finding that with everything. All of the training is available in major cities. It's Toronto, Vancouver, Ottawa. It's really difficult when we're struggling with funds already for our hospital to fund all of us to go down to all of these places to get all that training.

Mr. Granville Anderson: Is there more time?

The Chair (Ms. Daiene Vernile): Unfortunately, I'm trying to stay on schedule for everyone. Maybe you can chat afterward, if that's okay.

Our next question for you is going to come from MPP Scott.

Ms. Laurie Scott: Thank you very much. MPP Granville asked about the training. I just wondered: Going to the bigger centres, do you find it easier to do that because they have more, I guess—when you do your consolidations, it's easier for you to go to Toronto. Is that what you were saying?

Ms. Amy Chamberlain: Yes. At this point, that's what we have available.

Ms. Laurie Scott: Does it make sense for the training to come up here if it's an issue of money? What is it?

Ms. Amy Chamberlain: It could, but then again, if we're doing the hands-on portion of the training, the cases would be in the major cities.

Ms. Laurie Scott: So you need separate funding. The hospital needs to get the funding for the training.

Ms. Glendene Schardt: It would be helpful, yes.

Ms. Amy Chamberlain: Yes.

Ms. Laurie Scott: That's basically how it flows. So you're saying: more funding so that more nurses—how many nurses are in your hospital? How big is your hospital?

Ms. Glendene Schardt: We have 72 RNs.

Ms. Laurie Scott: So in a practical sense, how many would you like to see trained, and are they willing to be trained? Do you have the numbers of those willing?

Ms. Amy Chamberlain: I'm not really sure—

Ms. Glendene Schardt: That would be something that we'd have to see. How many nurses would be trained to do it casually? Again, it's very difficult because all of the nurses we have work full-time. We don't have a casual pool.

Ms. Laurie Scott: But in those settings, you really need cross-training, right, because you have to cover.

Ms. Amy Chamberlain: Yes.

Ms. Glendene Schardt: Yes.

Ms. Laurie Scott: So is there an appetite for cross-training of nurses in different—

Ms. Glendene Schardt: Yes.

Ms. Amy Chamberlain: Absolutely. Absolutely, there is.

Ms. Laurie Scott: So again it goes to a funding issue.

Ms. Amy Chamberlain: It's a funding issue; absolutely.

Ms. Laurie Scott: Right. My other quick question, because I know we have time limits on questions—excellent answers. You guys made an outstanding presentation. I was a nurse in my other life before I came in—outstanding presentation for all of us to follow.

When you say that health care providers don't know what programs are going on, so how can the victims—I think I've asked this in different ways all morning: How in the heck are we getting the message out there then? What is it that we're not doing? If they can form a

suicide pact on Facebook, what is it we're not doing for prevention?

Ms. Glendene Schardt: One of the things we'd like to do is get a Facebook page and do it so that, "This is what we do." We have an article in the SOS magazine that the kids get. It's out of Alberta. It comes out four times a year. Amy did a beautiful article for our program. It's to get the message out. We try to do in-services with the nurses going up north to say, "We're here. Here are resources for you." We're trying really hard. We want to take it a step further, to physically get out there and do this, but again, because we work alone and other things, it's not happening. And funding—it's expensive.

Ms. Laurie Scott: For sure—and can I do one quickly? Self-referrals: Would that work, because if they don't know the programs exist in the nursing station—is self-referral really going to work?

Ms. Glendene Schardt: No.

Ms. Amy Chamberlain: No. I think the point I was bringing up with that is just that for someone in, say, southern Ontario, someone who lived in Toronto, who knew the programs existed, they would be able to walk right into Women's College Hospital and say, "Hey, I've been sexually assaulted. I want to see the nurse who is dedicated to this."

We have to use different ways of doing that. They've got to go to the nursing station, tell the nurse at that nursing station, have the courage to go to the nursing station and say, "This is what happened," and then the nursing station nurse has to tell the doctor. Then the doctor and the nurse have to contact non-insured; the non-insured has to book their flight. Then they've got to come see us and tell their entire story all over again.

So it's just the self-referral part that—it's the power and control that are taken away because of the system that we have in place.

Ms. Glendene Schardt: And patients are getting weathered. We had a case; she was weathered for four days and said, "Enough." She went home, she showered, and couldn't get out. That's happening also. It's the logistics of—

The Chair (Ms. Daiene Vernile): Thank you very much. Final questions from our NDP caucus.

Ms. Peggy Sattler: Thank you so much for such a rich and detailed presentation. I was really impressed by the flow chart and the use of icons to categorize the barriers that women, and men, I guess, experience when they are reporting. I think that's very helpful.

The flow chart obviously describes the current state. I'm astonished at what you are able to do while you're juggling all of your other responsibilities in the hospital or in the health centre. Have you been able to map out a future state that would have a flow chart that would be more patient-centred, that would get the victim to supports more quickly and more appropriately?

Ms. Glendene Schardt: I don't see how the present system would change when they have to go through non-insured. There is no different system available for northern patients.

Ms. Peggy Sattler: So this flow chart is the reality?

Ms. Glendene Schardt: That is our reality for many years.

Ms. Peggy Sattler: And there's nothing that can be done about it?

Ms. Glendene Schardt: Unless the federal level, with the feds, intend to do non-insured differently. They are supposed to use us as resources so that we can medevac. That means at 2 o'clock in the morning, they may be sending a medevac plane in to get these patients out sooner. But again, weather dictates it; there's nothing you can do about the weather. It's tricky.

That really is the presentation. Amy has a huge poster that she did in Phoenix. That was part of her poster presentation.

Ms. Peggy Sattler: Were there recommendations attached in the poster?

Ms. Amy Chamberlain: It's more about getting it out there that these issues are systemic issues. They're not issues that we can readily change. Getting those flights more available or in a more timely manner: That's out of our control, right? They stem from very deeply rooted and federal government pieces. But I think the recommendations going forward would be to really listen to what the community needs, having community-based initiatives and going from there with what you can—and listening to the community members.

The Chair (Ms. Daiene Vernile): I thank you both very much. We really appreciate your information.

Ms. Glendene Schardt: Thank you for having us. And we're nurses; we could talk for a week.

The Chair (Ms. Daiene Vernile): It's important work that you're doing. You may join our audience, if you wish, to listen to our final presenters this afternoon.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

ONTARIO NETWORK OF SEXUAL ASSAULT/DOMESTIC VIOLENCE TREATMENT CENTRES

The Chair (Ms. Daiene Vernile): I will call forward now our next presenters: Registered Nurses' Association of Ontario—Ontario sexual assault/domestic violence network. You will have up to 20 minutes, if you need it, to speak to our committee. Our committee will then follow up with questions for you. Please start by stating your name, and begin any time.

Ms. Kathleen Fitzgerald: Good afternoon. My name is Kathleen Fitzgerald. I'm presenting today on behalf of the Registered Nurses' Association of Ontario, as well as part of the Ontario sexual assault/domestic violence centre, of which I am a member.

RNAO, just so you know, is the professional association for registered nurses, nurse practitioners and nursing students who practise in all roles and sectors across Ontario. RNAO's mandate is to advocate for healthy public policy and for the role of the nurse in enhancing the health of Ontarians.

1300

RNAO appreciates this opportunity to be at this committee, and we know that you're looking for ways to prevent and improve the response to Ontarians who have experienced sexual violence and harassment. RNAO has a comprehensive submission that they are making. Today, I'm just going to kind of give some view to those remarks that they're doing and try to put a regional slant to these, since this is where I am living and working.

I have been a sexual assault nurse for over 25 years at this point, throughout various locations in Canada, starting in Ontario, all throughout the Northwest Territories and Manitoba and then back here in Ontario. For the last 15 years, I've been managing the Sexual Assault/Partner Abuse/SafeKids Program at the Lake of the Woods District Hospital in Kenora. This program was one of the first ones in the northwest to exist after the Toronto and southern Ontario programs. We have literally helped, nurtured and supported the other programs throughout the region as they've come on, including Sioux Lookout's, over the years.

As you've heard, our catchment area is quite huge—geographically, the size of France. Many of our programs serve as an expert resource to health, social and law enforcement colleagues around the region, including the many First Nations communities, as the example of the Sioux Lookout program has outlined.

We congratulate the government of Ontario for all the work that they're doing to champion It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment that was recently released. I want to speak to one specific commitment in the action plan, number 7, which is to "strengthen supports provided by hospital-based sexual and domestic violence treatment centres to maintain 24/7 access to excellent, appropriate and timely care."

Our programs are hospital-based. They were funded by the Ministry of Health and Long-Term Care. You've heard that there are 35 of the programs and four throughout this northwest region. They were originally established and monitored under the priority programs, and that was done to ensure that there were standardized services and financial stability. Since 2004, when the programs were transferred to the regional offices and then to the LHINs, as budgets from hospitals have become increasingly more challenged by the need to balance, our programs have been experiencing deep cuts. Most of our cuts have occurred in the education and outreach that we provide and the follow-up services such as counselling, as well as nursing positions being decimated.

It's really important that you see that this current situation of access to 24/7 care is not a reality at all of these sites. It is certainly not always the reality here in the northwest, as my colleagues from Sioux Lookout just pointed out to you most effectively, I believe.

The programs provide acute health care services, forensic services, emotional support, counselling, crisis intervention, mental health assessments where we can, follow-up care and sexual health education. We have also been part of research on a provincial level, as well as doing outreach with community partners. Part of that education also has involved the education of professionals, health care providers, justice, law, as well as the general public.

Given the complexity of the clinical situation and the multitude of skills and knowledge that are required to provide this highly specialized service and education, the training of these individuals is paramount upon their hiring and throughout their role. It's important because the skills need to be updated so that best practices are being used; the knowledge, based on emerging research, is current; and forensic evidence is sound, to ensure that it's properly admissible in a court of law and that we can avoid errors and adverse events.

I know that when I first started, over 30 years ago, there was no evidence kit. It has grown to that, and the use of that, to aid the victim in the law system. These kits are just undergoing another change, but this change is heavily influenced by what the nurses from the network are saying. The forensic labs are working with us, whereas 30 years ago, it wasn't the case.

We know that the victims want client-centred care that includes non-judgmental, sensitive, compassionate, empowering, one-on-one care, such as what can be provided by the sexual assault nurse and examiner. Our network has developed evidence-based standards of care that have set the bar in this specialized area, recognizing the clinical, organization, program, education and outreach standards that need to be met.

Health services that are provided through emergency departments have been known to cause revictimization and further trauma to a client due to sexism, insensitivity, judgmental attitudes, victim-blaming, to name just a few things. That is like a second rape, all over again.

The Ontario Hospital Association has worked with our network to update the hospital guidelines for treatment of persons who have been sexually assaulted, as a way to help the emergency departments further standardize the care that's provided and create collaboration with our programs.

Just to illustrate an example that I am very much aware of—prior to the latest guidelines coming out, we had an ER doc in one of our smaller communities, in an emergency department, refuse to allow an evidence kit to be collected, because he did not believe the victim. This is the reality that sometimes still happens. I applaud the RN in that emergency department and the police officer present at the time, who were so absolutely outraged that they advocated for that victim and got in touch with me in Kenora. We made arrangements to drive that individual, with supports, for three hours in to my program so that we could provide care. My understanding is the officer volunteered to do the driving, because he technically could not do it in his capacity.

We don't have transportation mechanisms to collaborate with other emergency departments in communities. Here in the north, the transportation isn't a taxi drive—and a taxi ride may be over $500 and not always avail-

able. None of our programs or the hospitals have the funds to do that transportation aspect. None of us have the funds for flights, as you've so eloquently heard from my colleagues here in Sioux Lookout—which is the reality for this region.

1310

From the research, we know that SANEs were implemented to provide superior and specialized care that gives all the right kind of supports and forensic evidence collection, not only for sexual violence but for domestic violence as well. We have lots of research evidence that has consistently documented that SANEs, once they're in an area, do provide a higher quality of care for the victims that often does lead to better outcomes. It reduces wait times. It gets them accessing health services so that their needs are being met—and better photo documentation for the courts for that case.

We know that sexual assault does not happen in isolation, and survivors need support from a variety of community partners. SANEs are better able to give additional information and support to clients and refer people to additional services, simply because we have the ability and a mandate to develop relationships with community partners such as the rape crisis centre, the community counselling services, schools, definitely the police, and the courts, to ensure, in as seamless a manner as we can, that people are given what's available and receiving the care and ongoing supports.

A key barrier to the SANEs is this 24/7 basis to do with staffing. A majority of the SANEs work on an on-call basis. My own team, in which there are 10 RNs and RPNs, is mainly on call. We may have centres that have higher volumes, and they certainly are able to have full-time staff on, or even part-time, but for most of us, the reality is on-call. It makes it very difficult to recruit and retain nurses, because the on-call rate is only $3.30 an hour for just being on call.

If a nurse is called in to see a survivor, she will receive her current rate of pay at time and a half, as per the ONA contract. It's a minimum of four hours. Sometimes you're there with the person for six or more, but you are paid for that time.

But again, that really is dependent on volumes, which are very unpredictable. In order to meet the basic needs, the nurses in these programs work elsewhere, outside, in other departments in a hospital and other departments within the community. They have a difficult choice: to choose between working a hospital shift, where they may get $31.02 an hour for 12 hours, compared to a total of $26.40 for an eight-hour on-call. On-call scheduling often causes large gaps when no service is available in a timely manner, simply because there is nobody to do it. Not having access to specialized care is literally poor-quality care for victims and survivors.

Just to further outline this, often the team coordinators or managers, such as myself, are picking up the slack. Some of us work an additional eight to 100 hours per month to fill blanks on a schedule, and this is on top of our managerial roles. I not only manage, in Kenora, this program; I have four other programs. They're small, but I manage those as well. It's unacceptable, unfair and dangerous to demand that one person take on the job of over three people. Despite coordinators' attempts, sometimes the clients are still asked to wait unreasonably long hours until the next SANE is available.

In the south, where there are more programs, they may be able to literally redirect them to another program across town. We don't have that luxury here in the northwest at all. The victim has to wait, no matter what, because there is no funding. I can't refer someone up here to Sioux Lookout—no funding; no public transportation.

I can tell you from experience that on-call work is precarious. It can be toxic. It's often associated with burnout, job dissatisfaction, depression, exhaustion, stress, and mental health concerns and issues. Your own quality of sleep becomes decreased. I've been on call for over 30 years, working in the north as well as these programs. God help me when I get to retire and I don't have to be pinned to a pager or a cellphone. I'm looking forward to that day. Being on call takes a toll on a nurse's overall happiness and personal and family life, and reduces their quality of life.

With the ill health effects, along with the additional high prevalence of burnout, compassion fatigue, precarious trauma and secondary trauma that these nurses experience, it's very unfortunate, unfair and short-sighted to expect highly-qualified professionals to jeopardize their health and well-being to provide what we know is needed. The way the system works, it really impedes the ability of a SANE to provide the high-quality care that survivors need and contributes to the attrition of valuable health human resources.

Long-term effects can include depression, anxiety, post-traumatic stress disorder, personality disorders, addiction—that's a huge issue in this area—aggression, delinquency, poor social skills, academic performance issues and relationship problems. There is just so much that the survivor is trying to deal with on an ongoing basis. Getting them through the initial crisis is one thing, but the long-term effects, like I've just outlined, are sometimes instrumental barriers for the individual.

Follow-up services to help prevent, support and treat the effects that the survivor endures as a result include sexual-reproductive health, mental health, emotional health, dealing with the police, the judicial system and the challenges with referrals to community services, social services, mental health providers, shelters, community housing and community supports. No one health provider offers the clients all of these services, resulting in multiple providers being involved, and sometimes there is a fragment in the care that costs the system more.

The Chair (Ms. Daiene Vernile): You have one minute left in your presentation. Thank you.

Ms. Kathleen Fitzgerald: Okay. Basically, no one deserves to be sexually assaulted or harassed, and the services that are provided through our programs are imperative to their care and recovery. Unless there is

sustainable funding to address the staffing needs of the SANEs at our centres, it's going to be more and more challenging to meet the consistent care standards in Ontario that we have set and that are also influenced by the international standards.

We also have to make sure that we have ongoing training and education, and I think my colleagues outlined the challenge with that. I cannot reinforce that as much as they've already done. That is a major barrier for the education for the nurses in this area alone.

On behalf of the Registered Nurses' Association of Ontario and the programs here in the northwest, I thank you again for the opportunity. I am delighted to respond to any questions.

1320

The Chair (Ms. Daiene Vernile): Thank you, Ms. Fitzgerald. Your first questions will come from MPP Scott.

Ms. Laurie Scott: Thank you very much for appearing here today. Thank you for your dedication to the nursing profession because, as you've stated in the paper, lots of times you go above and beyond the hours that are actually clocked on your paycheque. That's very evident when you get to these communities with less resources. When the SANE program has come: Do you see or are there other examples in the province, because you've worked different areas, where that funding could be different?

Hospital budgets are frozen. I think northern Ontario has to be looked at differently because there are not a lot of community resources to fill in the changes that are occurring in health care delivery. What's the working relationship with the hospital in applying for money differently? Have you seen it done in other areas? Can you expand anything on that just to give us a little bit of a hint of how to help you?

Ms. Kathleen Fitzgerald: One of the things is, when the programs were initially established over the years, like my own in Kenora, we were a priority program and the hospital had to accept, "That was that amount of money; that's the program," and they couldn't touch it. I could provide community outreach and education to send nurses to workshops out of town, because there's nothing. I could more easily link with a hospital three hours down the line to help strengthen their nursing department, ER and how they respond.

Since that has gone out of protection, the hospitals, in all their wisdom, see, "Okay, that's a pool of money. We're not doing education at all for staff, or only if it's local, where it's minimum cost." That meant the same with us. So that education money is literally gone, and it's lost in the overall hospital budget.

Being able to have secured, protected funding for what we do that includes sufficient funds to do the education, recognizing that education alone for the staff is predominantly out of town: It would be a very welcome change so that it doesn't get eroded.

Ms. Laurie Scott: That's a fair enough ask. Okay.

The Chair (Ms. Daiene Vernile): Thank you very much. Our next questions for you are from MPP Sattler.

Ms. Peggy Sattler: Thank you so much for your presentation. When you began, you mentioned that you were going to be speaking from a regional perspective. I just want to make sure that I understand clearly. The issues around SANEs and the on-call basis of staffing: Is that a specific regional issue or is that common across all 35 programs?

Ms. Kathleen Fitzgerald: The provincial programs, 35 of them, have different components of how they've set it up that are unique to that community and the needs there. But a majority of us are on on-call basis or a combination of someone dedicated Monday to Friday during the day who would see you if there are any cases and on call for the rest of the hours, like evening and night. It's a variety.

Ms. Peggy Sattler: Even in the larger urban centres?

Ms. Kathleen Fitzgerald: Even in the larger urban centres, they run it on an on-call basis, often overnight.

Ms. Peggy Sattler: Okay. So this is not a unique northwestern Ontario issue. This is a provincial challenge.

Ms. Kathleen Fitzgerald: It is a provincial challenge, but what makes it unique for us here in the north is that we don't have the same pool of numbers of registered nurses who are available. To be able to live, they need to have another full-time job or another part-time job that they can make fit with on-call. When you have a very small pool of people, you end up wearing many, many hats, and it makes it very hard. You don't necessarily retain them. I'm an oddity. I've been doing it for over 30 years. I am an oddity, and I admit to it.

The Chair (Ms. Daiene Vernile): Thank you very much. Our final questions for you today are from MPP McGarry.

Mrs. Kathryn McGarry: Thank you very much, and bless you for being an oddity. I relate. I am also a nurse and have walked in your shoes for many, many years in other capacities. One of the reasons I didn't take a proffered on-call sexual assault nurse specialist was because it was on-call and I couldn't provide for my family, so I went to other areas. I understand precisely the kinds of issues that are being faced in such a large geographical area.

I know you've thought about this a lot, so I'll put it to you again—I think I know what your answer is going to be. In order to provide better care for those victims here in the north, and longer care, your number one priority to accomplish that would be what?

Ms. Kathleen Fitzgerald: Being able to have the right resources, the nursing from the health care point of view for that first entry point to the system and having the teams in areas where we can most utilize them, but also having the skill not only to provide the care but there is a real skill to literally be on the phone to a nurse in a nursing station at a fly-in—the weather is down. She has an evidence kit but she has never done one before, and it is an art to talk someone through what you need to do. I've learned that not through any education but by

experience—the seat of my pants. Being that other nurse on the other end of the line, not knowing what I'm doing but now I'm that nurse calling through and giving expert advice and direction—but here in the north we don't always have that kind of experience set up to educate the SANEs on how to do things from a distance.

Mrs. Kathryn McGarry: So your training and education component would be part of it, and funding you've mentioned over and over, which I think is probably very helpful.

Training and education: Is it for nursing staff, or what other parts of this multi-disciplinary team that is necessary to assist survivors? Who else would be a priority to receive more training and education?

Ms. Kathleen Fitzgerald: Counselling and the services of the counsellors who are trained in how to work with sexual assault victims, and trauma-informed care. Both the nurse and the counsellor have to be skilled in that, and that is something that is kind of lacking. I've taken it on my own to learn about that so that I've developed, and I'm sharing that with my team, but that's an initiative we've done. Not all counsellors in our services in the region have trauma-informed care, and that's something that needs to be expanded.

Mrs. Kathryn McGarry: And I think I heard that from your previous presenters—

Ms. Kathleen Fitzgerald: Yes. From the shelter, Tana.

Mrs. Kathryn McGarry: So that would make a drop in the bucket, then, to train more nurses along those lines for the north?

Ms. Kathleen Fitzgerald: Yes.

The Chair (Ms. Daiene Vernile): Okay. Thank you very much. We appreciate you coming and speaking before our committee today.

That concludes our public hearings for the Select Committee on Sexual Violence and Harassment at the Nishnawbe-Gamik Friendship Centre in Sioux Lookout.

We will reconvene next Wednesday, April 16, at 4 p.m.

Interjection: Fifteenth.

The Chair (Ms. Daiene Vernile): Fifteenth? The Clerk knows—at the Ontario Legislature. We stand adjourned.

The committee adjourned at 1328.

CONTENTS

Friday 10 April 2015

SELECT COMMITTEE ON SEXUAL VIOLENCE AND HARASSMENT

Chair / Présidente
Ms. Daiene Vernile (Kitchener Centre / Kitchener-Centre L)

Vice-Chair / Vice-Présidente
Ms. Laurie Scott (Haliburton–Kawartha Lakes–Brock PC)

Mr. Han Dong (Trinity–Spadina L)
Mr. Randy Hillier (Lanark–Frontenac–Lennox and Addington PC)
Mrs. Marie-France Lalonde (Ottawa–Orléans L)
Ms. Harinder Malhi (Brampton–Springdale L)
Mrs. Kathryn McGarry (Cambridge L)
Ms. Eleanor McMahon (Burlington L)
Mr. Taras Natyshak (Essex ND)
Ms. Peggy Sattler (London West ND)
Ms. Laurie Scott (Haliburton–Kawartha Lakes–Brock PC)
Ms. Daiene Vernile (Kitchener Centre / Kitchener-Centre L)

Substitutions / Membres remplaçants
Mr. Granville Anderson (Durham L)
Mr. Glenn Thibeault (Sudbury L)

Clerk / Greffier
Mr. William Short

Staff / Personnel
Ms. Carrie Hull, research officer,
Research Services