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Chair

Mr. Garry Breitkreuz

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● (1110)

[*English*]

The Chair (Mr. Garry Breitkreuz (Yorkton—Melville, CPC)): I'd like to bring this meeting to order.

This is the Standing Committee on Public Safety and National Security, meeting number 42. We are being televised, and we have a large number of witnesses. We're going to allow them some time to make introductory comments.

From the Rideauwood Addiction and Family Services Centre, we have Mr. James Budd, the Senior Director of Corporate Services.

On a point of order.

Mr. Mark Holland (Ajax—Pickering, Lib.): On a point of order, Mr. Chair, could I ask the other individuals who are in the room to vacate the room so we can continue with the meeting?

The Chair: Okay, all cameras have to be turned off except for the ones that have permission to be on here, please.

Mr. Mark Holland: Also, could the people who are having other meetings move outside?

The Chair: Okay, we'll continue with our meeting.

We have, from the Department of Justice, Mrs. Margaret Trottier, a Senior Analyst with the Drug Treatment Court Funding Program. We'll probably start with her presentation. We also have, from the Royal Ottawa Health Care Group, Dr. Helen Ward, the Clinical Director and Forensic Services Champlain. From the Ontario Court of Justice, we will have the Honourable Madam Justice Heather E. Perkins-McVey. She's not at the table yet. From the Ministry of the Attorney General of Ontario, we have Mr. David Moffat, Crown Attorney. From the Edmonton Drug Treatment and Community Restoration Court, we have Mr. Doug Brady, the Director.

I understand that the Honourable Madam Justice Heather Perkins-McVey is not here yet.

We have quite a long agenda today, so I will ask if Ms. Margaret Trottier is ready to begin with her presentation.

Please go ahead, Madam.

Mrs. Margaret Trottier (Senior Analyst, Drug Treatment Court Funding Program, Department of Justice): Thank you.

My name is Margaret Trottier, and I'm a Senior Policy Analyst with the Policy Implementation Directorate of Programs Branch within the Department of Justice. I am responsible for the drug treatment court funding program.

In recognition of the link between drug use and crime, the drug treatment court funding program was established in 2005. It is a policy partnership between the Department of Justice and Health Canada that enables federal Justice and Health officials to test horizontal approaches to addressing the challenges created by drug-addicted offenders in the criminal justice system.

The objectives of the drug treatment court funding program are to promote and strengthen the use of alternatives to incarceration for drug-addicted offenders; to build knowledge and awareness among criminal justice, health, and social service practitioners and the general public about drug treatment courts; and to collect information and data on the effectiveness of drug treatment courts so that we can promote best practices.

As a component of the national anti-drug strategy treatment action plan, the drug treatment court funding program supports six drug treatment court pilots across Canada. They are in Toronto, Vancouver, Edmonton, Winnipeg, Ottawa, and Regina. The annual budget is $3.6 million.

Drug treatment courts operate within the criminal justice system. They combine judicial supervision with substance abuse treatment in a concerted effort to break the cycle of drug use and criminal recidivism for repeat offenders whose crimes are motivated by drug addiction.

Persons with drug charges are not automatically referred to a drug court. Drug treatment courts, for example, will not accept the violent accused or persons who are involved in commercial drug trafficking. If the accused have used a young person under the age of 18 in the commission of the offence, or if they are charged with a residential break and enter, they do not qualify to enter a drug treatment court.

Participation in the drug treatment court program includes court attendance up to twice a week, random and frequent drug testing, and attendance in a treatment program. Attendance at court on a regular basis allows the participant to inform the court of his or her progress and allows the court to reward compliance, sanction non-compliance, or impose new conditions or interventions to help the participants break the cycle of crime and addiction.

Drug treatment court clients continue to participate in the program, typically for more than a year, until they meet the criteria for graduation. To graduate, they must achieve a prescribed period of abstinence from drugs while abiding by all conditions and establishing stability in the community.

Not all DTC participants graduate. Some will be terminated from the program for incurring new charges, for being dishonest with the court, for repeatedly not complying with conditions, or for failing to attend treatment. Drug treatment courts aim to reduce the harm people cause to themselves and others through their drug use and to reduce the risk that these individuals will continue to use drugs and thereby continue to come into conflict with the criminal justice system.

The pilot sites supported by the drug treatment court funding program require strong collaboration between legal and treatment professionals at the local level. The drug treatment court funding program does not specify a model for the pilot sites to follow. As a result, each pilot site has its own unique characteristics that take into account the needs of the offender population in that particular city.

● (1115)

As mentioned, another objective of the drug treatment court funding program is to provide the opportunity to build knowledge and awareness among stakeholders and the general population about drug treatment courts. Efforts in this regard have included support to the Canadian Association of Drug Treatment Court Professionals for national conferences in 2006 and 2008, as well as round table events in 2007 and 2009. We also support an electronic bulletin board that facilitates exchange of best practices and lessons learned among drug treatment courts in Canada.

Finally, we are focusing efforts on national data collection as we implement the summative evaluation recommendations. As part of ongoing program management, Justice Canada is committed to further review and evaluation as we determine the effectiveness of this innovative approach to dealing with drug addicted offenders in the criminal justice system.

As the majority of pilot sites have been operating for fewer than four years, it's not possible at this time, based on the data available, to determine if drug treatment courts are the most appropriate criminal justice intervention for drug addicted offenders or if they are the most efficient or cost-effective way of dealing with substance abuse issues in the criminal justice system.

The Minister of Justice has recently announced that the drug treatment court funding program will continue to provide funding support until March 31, 2012, to the existing six drug treatment court pilot sites, in an effort to continue to study the effectiveness of DTCs in Canada.

That concludes my opening remarks on the drug treatment court funding program. I'd be happy to answer any questions.

The Chair: Thank you very much.

We'll go through all the presentations first before we open it up for questions and comments.

I believe Mr. Doug Brady will be the next presenter. Any time you're ready, sir, go ahead.

Mr. Doug Brady (Director, Edmonton Drug Treatment and Community Restoration Court): Thank you.

My name is Doug Brady and I am the Executive Director of the Edmonton Drug Treatment and Community Restoration Court, as we are called, and also the Interim National Director for the Canadian Association of Drug Treatment Court Professionals.

The Canadian Association of Drug Treatment Court Professionals is a recently incorporated organization dedicated to the development and sustainability of drug treatment courts in Canada, and it demonstrates this effectiveness through a comprehensive and consistent national evaluation. I'm going to tell you a little bit about the organization, or the origin of drug courts.

The first drug court began in Dade County, Miami, in 1989 as a result of drug addicts repeatedly coming before the court system—also known as a revolving door system—and overburdening the jail system. What they found was that under the traditional court system, drug addicts continued to commit crime and never adequately dealt with their drug addiction. Traditional treatment, court, and correctional methods did not show success. They found a solution by combining drug treatment with the structure and authority of a judge. Working as a team, they were able to effect lasting change in the lifestyle and behaviour of drug court participants.

Since 1989 drug courts have grown in the U.S. to over 2,369—that's as of October 2009—of which over 1,250 are adult drug courts. In 2009 President Obama increased funding to the U.S. drug courts by 250%, and he is allocating $103 million in the coming year. This was preceded by a 50% increase the year before by the Bush administration.

The first drug treatment court outside the United States began in December 1998 in Toronto, and since then more than 27 programs have been implemented in 10 countries worldwide. Apart from the six federally funded drug treatment courts, there are three other drug treatment courts that operate independently, and they have their funding from various sources. That would include Durham, Calgary, and Moose Jaw, which has one person in their program at the present time.

Drug treatment courts operate under what is called therapeutic justice. It is a program that provides intensive treatment and services for participants who need to get and remain clean and sober. We regularly randomly test for drug use, often once a week, or more times depending on the person's need. We hold each participant accountable by the drug treatment court judge for meeting their obligations to the court, society, themselves, and their families. It requires participants to appear in court frequently so that the judge may review their progress, and it rewards participants for doing well or sanctions them when they do not live up to their obligations.

How effective are drug treatment courts? Only 11.6% of those who complete the drug treatment court program run into trouble again with the law. That's a Canadian statistic from the UN Office on Drugs and Crime. Break-even analysis showed that to provide a net economic benefit to the wider society, only 8% of offenders seen by the courts would need to stop taking drugs for five years or more following the completion of their sentence, and only 14% in order to provide a net economic benefit to the criminal justice system. Many of our statistics come from the U.S. because they've been operating now for over 20 years. So when I'm quoting some statistics from here on in, it will be from the U.S. statistics. They have learned how drug courts work and they're constantly reviving their programs and making sure they get the best information out there.

In February 2005 the Government Accountability Office issued its third report on the effects of adult criminal drug courts. Although upfront costs for drug courts were generally higher than for probation, drug courts were found to be more cost-effective in the long run because they avoided law enforcement efforts, judicial case processing, and victimization resulting from future criminal activity. In Canada, those who participate in drug treatment courts would not be eligible for probation as a court disposition. The same extensive review of drug courts concluded that adult drug court programs substantially reduce crime by lowering rearrest and conviction rates among drug court graduates well after program completion.

● (1120)

In recent years researchers have continued to uncover definitive evidence for both the efficacy and cost-effectiveness of drug courts. The most rigorous and conservative estimate of the effect of any program is derived from meta-analysis in which scientists statistically average the effects of the program over numerous research studies. Four independent meta-analyses have now concluded that drug courts significantly reduce crime rates on an average of approximately seven to fourteen percentage points. In some evaluations, the effects on crime were as high as 35 percentage points.

Importantly, the effects were greatest for high-risk offenders who had more severe criminal histories and drug problems. This suggests that drug courts may be best suited for the most incorrigible and drug-addicted offenders who cannot be safely or effectively managed in the community or on standard probation. Some of the statistics from Canada include that 50% to 60% of the crime is done by 15% of the offenders.

One of the facts from the National Association of Drug Court Professionals is that unless drug-addicted offenders are regularly supervised by a judge and held accountable, 70% drop out of treatment prematurely. Drug courts are six times more likely to keep offenders on treatment long enough for them to get better. For every $1 invested in drug courts, taxpayers save as much as $3.36 in avoided criminal justice costs alone. When considering other cost offsets, such as savings from reduced victimization and health care service utilization, studies have shown benefits up to $12 for every $1 invested. Drug courts produce cost savings ranging from $4,000 to $12,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.

For methamphetamine-addicted people, drug courts increase treatment program graduation rates by nearly 80%. When compared to eight other programs, drug courts quadrupled the number in terms of abstinence from methamphetamine. Drug courts reduce methamphetamine use by more than 50% compared to outpatient treatment alone.

That's my presentation. I will be open to questions.

● (1125)

The Chair: Thank you very much.

Who would like to present next? Go ahead, Mr. Budd.

Mr. James Budd (Senior Director, Corporate Services, Rideauwood Addiction and Family Services): *Madames et monsieurs*, honourable members, I'm very pleased to be able to address this committee on behalf of the Ottawa Drug Treatment Court. My name is James Budd, and I'm a Senior Director with Rideauwood Addiction and Family Services, which provides the treatment to the Ottawa Drug Treatment Court.

We offer a very unusual program in drug treatment courts. It's a unique feature not only within the treatment world but within the corrections world. Treatment is very intensive and very regular. Participants in the Ottawa Drug Treatment Court attend the treatment centre on a daily basis. They appear in court at least once a week, and at the beginning they appear twice a week before the judge.

They are held accountable for any problems they may have had in terms of their participation or attendance or other issues in the community, but they are also rewarded and encouraged for their successes in the program. The interaction with the judge is really a key feature of drug treatment courts. They literally have a chat with the judge every week and talk about how they're doing. It helps to forge a whole new relationship with the criminal justice system. They start to see the courts as helpers instead of punishers.

I'm going to keep my comments very brief, because I suspect that you'll have a fair number of questions for us. So perhaps I'll leave it at that.

The Chair: Thank you.

Who would like to present next, Ms. Ward or Mr. Moffat?

Okay, we'll have Mr. Moffat and then Ms. Ward.

Go ahead, sir.

Mr. David Moffat (Assistant Crown Attorney, Ministry of the Attorney General, Government of Ontario): I just want to take the time to say thank you.

I want to correct that I'm an Assistant Crown Attorney, not a Crown Attorney, and I'm a prosecutor. My niece has asked me what I do for a living, and I say that I put people in jail. I have six years of experience. I started in the United States, in Colorado, a state known for its mandatory minimums and stiff penalties, and I'm here if you have any questions about drug treatment courts.

I am the provincial crown attorney in the Ottawa drug treatment program, and I'm here to tell you that it works.

Thank you.

The Chair: Thank you, Mr. Moffat.

Ms. Ward.

Dr. Helen Ward (Clinical Director, Forensic Services Champlain, Royal Ottawa Health Care Group): Thank you.

My name is Dr. Helen Ward. I'm a psychiatrist. I'm in charge of the forensic program at the Royal Ottawa Mental Health Centre, which is the local psychiatric facility. I'm also a member of the Ottawa Mental Health Court organizing committee and I'm here to talk to you about mental health courts. I think I'm the only one to speak about this issue today.

Essentially, mental health courts came along subsequent to drug treatment courts when it was realized that problem-solving courts had a role to play and that mental health could also be addressed in this manner. We're a little further behind in terms of outcomes and structure.

They started in the United States. The first mental health court in Canada started in Toronto. In the last three to four years there's been a profusion of mental health courts erupting across the country in pretty much every city, and in some sense, quite small centres have started to get involved with mental health.

The reason for this is that there has become a recognition of the criminalization of the mentally ill and of the Penrose effect. You're probably familiar with the idea that there has really been a trans-institutionalization. Back in the 1950s we had all these psychiatric beds and now we have all these correctional beds. As the psychiatric beds have gone down, the correctional beds have gone up, and the same numbers of the mentally ill are institutionalized, just in the wrong place.

The idea behind mental health courts is to try to address some of these issues. Particularly, mental health courts should recognize that, but for the person's mental health condition, they wouldn't have come to the criminal justice system in the first place. That's the kind of person we're trying to treat at a mental health court. We're not trying to capture every criminal who claims a mental illness, but we are trying to capture people whose mental illness was in some way a strong contributor to their being in trouble at all.

One of the ways this is done is by diversion, and that's one of the purposes of mental health courts. As we've gone along, we've come to recognize that the crowns' offices and the courts are pretty good at diversion on their own. They've been doing diversion for a long time.

Shoplifters who might have a depression don't need a mental health court for the most part, but there are more serious cases and more serious offences where mental health has been involved, where the Criminal Code in terms of a section 16 or a not criminally responsible offence doesn't apply, or a fitness to stand trial issue doesn't apply, but there's still a serious mental illness that needs to be addressed. These people may well not be eligible for diversion because they may have committed a level two offence. They're not going to necessarily end up with a stay of their charges or anything like that; there's going to be some penalty, but there can be an improved outcome if they are connected with mental health services.

One of the big purposes is to connect people with mental health services. It's a real patchwork out there. There's some improvement, but it's very difficult for the mentally ill and the families of the mentally ill to get access to the services they need in the civil psychiatric system. They often end up in this funnel called a mental health court.

Another thing that's important to consider, especially for the seriously mentally ill, is that they may not have much of an idea about why they're in court at all. They may not have much of an idea about how the whole thing works and they can often be highly intimidated. They often come across defence attorneys who really don't have a good sense of how to communicate with them, or may not understand their problems, or may not understand the questions to ask them about their problems. All of this plays a role in how they're treated by the court.

As you probably know, people with a mental illness who are convicted for an offence end up serving more time than people without a mental illness convicted for the same offence. This is probably for a few reasons. One of them is that the seriously mentally ill may not have supports. Another is that when they're in jail they may end up with poor institutional behaviour that ends up with their having the maximum sentence or being re-sentenced.

Because there isn't really as big a movement yet with mental health courts, and because it's not as clearly a federal matter as the drug treatment courts, there's been a real diversity in what has sprung up across the country in terms of mental health courts. They tend to come up quite informally.

● (1130)

For example, in Ottawa we started our mental health court without any additional funding. We basically focused our resources. We took some resources that had been provided to the hospital to provide outreach clinics, and we started running an outreach clinic at the courthouse. The Canadian Mental Health Association had been paid by the province to put in outreach workers, and we kind of expanded the role of that intake worker. The crown attorney assigned a particular assistant crown attorney to the mental health court. So we all basically pooled our resources and put them together in one court, but with no extra money. That's fairly common across the country. People just saw there was a need and started to do it.

In Toronto the model they run uses a lot of bail appearances, similar to what you've heard about drug treatment courts, where the accused appears in front of the judge very frequently, and there are court support workers based at the courthouse. For those people, they did get extra funding in order to help those people access resources in the community. That's the model they use.

In New Brunswick there's a model in which they set up a program and the person signs on. They follow this program, and at the end of the program they get X, Y, or Z outcome. That's similar to one of the very interesting courts—even though it's outside Canada—the Brooklyn Mental Health Court, which is a felony mental health court. This is a court that offers people with a mental health condition who have committed a very serious offence a placement and treatment for their mental health, rather than jail. That's the kind of thing we want to try to offer here when we can.

In Ottawa, we very much run a court that is intentionally quite flexible. You don't have a lot of requirements to sign on. It set the requirement that there has to be a mental health condition and that the mental health condition has contributed substantially to the offence, and you have to have some willingness to participate in some treatment. We basically take it from there. We try to engage people in treatment. Then we have special pretrials, where people from all kinds of mental health agencies participate with the attorneys in deciding on the legal outcome. It may end up being a section 810 or peace bond, but it also may end up being a conditional sentence served in their home, and further probation, but this is less than what they would have gotten otherwise.

When we're looking at what makes up a mental health court—there are some good documents out there, so I won't try to go through the whole thing—I would say you really do need people who are specialized. You have to have teams that have some familiarity and get some training, so crown attorneys, and ideally legal aid, duty counsel, should have special training. You want to make training available across the board. You really need to have the treatment people engaged in the court. As I said, we run a clinic at the courthouse. People can see me and my team and start to get treatment from the courthouse. You need to have a judiciary that are willing to consider these issues as well, of course, and are educated.

Funding is pretty important. You don't need a lot of funding, though. As I've shown, you can do a lot with pretty much no extra funding, but very small amounts of funding in terms of coordinators would really make a big difference across the country.

Concerning outcomes, what we know about mental health court outcomes is less than with drug treatment courts, and basically what we know comes from the States. Justice Schneider, who runs the Toronto Mental Health Court, wrote a book on mental health courts that came out last year. In that book he said there aren't good outcomes yet, particularly from Canada, and I would concur. But there is some good preliminary information from the United States that shows that if you compare people's interaction with the criminal justice system in the year before they went into the mental health court with the year after, you'll see that it reduces their arrest rate by four times, which is a significant improvement. It also would show that people who complete the program are much less likely to recidivate than people who did not complete the program.

There are also, of course, mental health outcomes you can measure. It's quite clear from our court that there are improved mental health outcomes. People get better. They stay well. They get into treatment. They get into housing, which is often a very important component. And these people are much less likely to end up in the mental health system, which is even more expensive. If they end up in an in-patient bed, it's even more expensive than ending up in corrections.

It is not clear yet whether there are financial benefits. One of the things you have to consider is that you are taking people from a corrections system and potentially shifting them to a mental health system, and of course, both of those are still state-funded. Really, it is about making sure people are getting the right treatment, and if people get the right treatment and get established on treatment, then they're going to stay well and stay out of hospital. Of course, we're a provincially operated treatment system, so it makes it difficult, but in my opinion, there should be better community treatment provisions in place, in terms of legal provisions, to treat the seriously mentally ill. This would help to make the Mental Health Court successful.

● (1135)

Finally, what are the challenges? You have to have buy-in. You have to have buy-in from the crown. You have to have buy-in from defence counsel. Defence counsel will often shy away from the mental health court because they can make pretty good deals on the side with a crown attorney in another court. So they don't always take people through a mental health court if they think it won't be of use.

My colleagues aren't always pleased with me for going to mental health court. They think I'm case-finding and bringing them more business. And you know what? I might be, but it's business they should be dealing with anyway. It does put pressure on these people when my patients, whom I've picked up in mental health court, show up in their emergency rooms and are now connected with people who are advocating for them. It makes a difference in who gets treated.

Those are my comments. I can answer any questions later.

The Chair: Thank you, Dr. Ward.

That brings an end to our presentations, and we will begin with questions and comments from the Liberal Party.

Mr. Holland.

Mr. Mark Holland: Thank you, Mr. Chair, and my thanks to the witnesses. That was very informative.

Mr. Brady, you talked about the efficacy of the drug treatment courts, but there are a couple of things I wanted to know.

First, you reference the cases in which these courts are most effective, cases in which there's a persistent problem or nothing else seems to be working. We have a limited number of drug treatment courts. How many more should we have to fill present needs? What's the unmet demand, in your estimation?

● (1140)

Mr. Doug Brady: I can speak for the Edmonton drug court, but it is a little different. We're the only court in Canada that brokers out treatment. We rely on the treatment providers in the communities to provide the treatment for us. There is a real problem in finding treatment space. Right now we have 24 people in our program. We have 22 people on a waiting list. They're waiting in custody, trying to get treatment beds, housing in some cases. I think housing is a major concern across Canada. Those are some of the challenges we face.

Mr. Mark Holland: I'd like to hear about some of the additional challenges you're facing. We know that some 80% of inmates are facing addiction issues, and we know that one of the problems is the continuity of care. People who turn down a dark path and commit a crime generally experience a lack of access to community resources. Then, after they come out of the system, they have trouble re-establishing contact with a community that's going to help them stay on the rails.

Can you tell us about your experience in extending the continuity of care? What support does the community offer, beyond the courts and prison?

Mr. Doug Brady: We have learned that any treatment program under 90 days for drug-addicted offenders is apt to be ineffective. In Alberta, most of our programs are about 42 days long. About 70% to 80% of our people go through residential treatment, to begin with. They come out of treatment on a high. They think they can do it. But almost immediately they're facing challenges that they never imagined. At that point, we deal very closely with them. Our treatment team sees them once a week. They attend the court at least once a week. We keep them honest by doing frequent and random urine tests to make sure they're staying on board. We reward them when they're doing well. We get them hooked up with 12-step programs, which are important. We connect them with relapse prevention programs in the community and with other outpatient programming. We try to get them back on track. We work to put back in their lives some of the things they've lost, like ID. We try to interest them in education. Some of these people have great potential, but they don't have much education, so we're trying to get them back into the educational system so they can return to the workforce.

Mr. Mark Holland: Would it be fair to say it's the exception and not the rule that the kind of treatment you were just describing is being administered—in other words, that today most are not getting that continuity of care, that support to make sure the person is given the skill set they need to not reoffend, not go and commit another crime, and not constantly be in and out of the system?

Mr. Doug Brady: I would say that's true. Most people coming out of the jail system, of course, come out and there's nothing for them. In our system, this is where we are putting them. We're programming and putting them into different programs right away, so they're busy when they come out of treatment. Generally, they go from jail to treatment and us.

And we keep in contact while they're in treatment. We try to meet any needs they have while they're in treatment, as well. So we try to really connect with them, so they know they have support out there in the community; they know they have an arm to lean on; they know they can trust us. That sometimes takes a little longer, but those are the things we do to get them going again and put a foundation underneath them so that, when they finally graduate from our program, they have the skills so they can focus on their recovery, continue to focus on their recovery and other areas, as well.

The Chair: Mr. Budd, do you have a comment? You indicated you might.

Mr. James Budd: If I may, your question goes very much straight to the heart of what drug treatment courts are about, in my opinion.

First, I should make it clear, just in case it's not, that the drug treatment court is really an alternative to incarceration. While the vast majority of our participants come to us from custody, and they may have an extensive history of incarceration, they're coming to us after a brief period.

What is particularly beneficial about the drug treatment court program is that the participants receive treatment in the community in which they live. They learn to stay clean and avoid committing criminal acts in the community in which they live. They're not sent to an artificial environment or to an institution to do that. They learn how to refuse the drug associates they've been using; they learn how to avoid them. They learn how to avoid those situations in their community.

● (1145)

Mr. Mark Holland: If I could, I'll ask this question of Ms. Ward.

I'm interested because we hear varying statistics on the prevalence of serious mental health issues within our prison system, some that peg it as high as 20% for male inmates and 60% for female inmates. You reference the American model, with mental health treatment courts, and the efficacy it's demonstrated.

I'm wondering if you can compare the models that are being used in the U.S. to the couple of different models you referenced that are being used here in Canada. Is there a model you think is working particularly well? How do we contrast against the models being applied in the United States?

Dr. Helen Ward: I don't think you can really draw clear parallels with the United States, because sentences are so much longer for what we would consider often relatively minor offences in Canada. Obviously there's a much greater incentive in a court that says, if you do this, you won't go to jail. There's much greater incentive for people than there may be in the mental health courts.

I would say that I actually am not an advocate of a particular model. I think it's important that the model fit the community. Different communities have different strengths in terms of treatment, and you'll never make treatment and treatment options universal. So I think it's fairly important to allow particular communities to set up the models that work for them, but you have to give them guiding principles. The principles really need to be that you've got specialized people, that you've got treatment available, that you have housing available when you need it, and that you have some way to ensure that participation is voluntary and participation results in a better outcome than they would otherwise get.

One of the criticisms of mental health courts has been that people sometimes are made to jump through more hoops than they would if they weren't mentally ill. So you really have to be careful in Canada not to do that, which is why I'm saying I think the focus should be really on the level two offence rather than just the level one non-violent offences. I think there should be an emphasis on level two offences because that's where you get more bang for your buck.

Mr. Mark Holland: Thank you.

The Chair: Okay, time is up on that.

We'll now move to the Bloc Québécois.

Monsieur Ménard, are you going to lead off?

[*Translation*]

Mr. Serge Ménard (Marc-Aurèle-Fortin, BQ): Are there drug treatment courts in the province of Quebec?

[*English*]

Mr. Doug Brady: No.

[*Translation*]

Mr. Serge Ménard: Do you know the Portage Centre?

[*English*]

Mr. Doug Brady: I'm sorry, I'm not aware of it.

Mr. James Budd: Yes.

[*Translation*]

Mr. Serge Ménard: Could you compare drug treatment courts with Portage?

[*English*]

Mr. James Budd: My understanding of Portage—and we have had clients attend there previously—is that they're not a drug treatment court according to the strict model; they are a treatment centre that accepts people who are in conflict with the law, which is something that is difficult.

I can't speak to Quebec, I'm sorry. But in Ontario it's very difficult for people who are in conflict with the law to get into addiction treatment until those matters have been resolved. My understanding is that Portage is one that will accept people who are in conflict with the law.

[*Translation*]

Mr. Serge Ménard: Portage was not created for people who are in conflict with the law, but for people with very serious drug addition problems, mostly with heroin. When I talk about it, I ask people to think of Alcoholics Anonymous, but at a higher level. Obviously, some of the people who go to Portage are in conflict with the law but others were not yet in that situation.

I know that it is a completely different approach and that to become eligible to drug treatment courts, the person must have been charged by a criminal court.

● (1150)

Mr. David Moffat: If you will allow me, sir, I would like to say that I was Crown Attorney in Gatineau for almost three years. In the province of Quebec, you have the benefit, as a crown attorney, to deal with provincial crimes, like in most parts of Canada, but also with drug crimes and offences related to the Controlled Drugs and Substances Act.

Having worked in Quebec, I have some experience in that area. We do not have any drug treatment courts. So we are forced to find other means of diversion as it is the case with mental health problems. We use conditional sentencing. We find partners who are willing to hire drug addicted offenders and we are trying to adapt the sentence in order to allow them to get a treatment. This goes against a law requiring that the sentence be executed immediately after the guilty plea—

Mr. Serge Ménard: I am sorry to interrupt, Mr. Moffat, but I only have seven minutes. I understand, from what you are saying, that you know the Portage Centre.

Mr. David Moffat: Yes.

Mr. Serge Ménard: You are probably aware that in Quebec, several organizations have been created based on the Portage model. They are not as strict as Portage, but they are trying to rehabilitate those people.

Mr. David Moffat: Yes.

Mr. Serge Ménard: You can see that many defence counsels are trying to refer their clients to those centres in order to obtain lesser sentences.

Mr. David Moffat: This is right.

Mr. Serge Ménard: I did not know the drug treatment courts model.

Should I understand that one of their features is that the person must have been charged with a criminal offence?

Mr. David Moffat: It starts not only with a criminal charge, but also with a request being submitted to us by a defence attorney.

Mr. Serge Ménard: A judge must also intervene, correct?

Mr. David Moffat: Absolutely.

Mr. Serge Ménard: In the documentation you sent us, there is a reference to bipolar disorder. I feel compelled to ask you a question.

I thought that bipolar disorder was easy to treat with lithium, but that the major difficulty was to convince people suffering from that disorder to continue with their treatment. Once they feel well again, they believe that they do not need it anymore and their problems reappear. You probably know that Pierre Péladeau was bipolar and that great artists also have the same condition.

It seems to me that for people suffering from that disease, the solution is quite simple: we could simply tell them to continue with their treatment.

[*English*]

Dr. Helen Ward: Well, it's straightforward in a way to tell someone with bipolar illness just to take their medication, but it's difficult to actually have them do it when they don't have insight. Some of the things you put around them in the mental health court are support workers, housing, help to solve some of the other stresses and problems. You help them develop an alliance and start to develop a sense that they can improve their lives, and then they start to include medications as part of it. I often will prescribe people medications that help them in some other way, such as helping their sleep, etc. Then gradually, as they get better, their insight will improve.

You're quite right that many people with bipolar disorder do very well, but there's also a small group who are difficult to treat. We can't get them to stay on their medications, and they often are using substances, so that there is a really vicious cycle in play.

[*Translation*]

Mr. Serge Ménard: From what I understand, you do not accept people accused of drug trafficking. Yet, I would think that a large number of heavy users who are very addicted resort to drug trafficking in order to finance their addiction. I believe that this form of addiction is a problem that you should treat.

● (1155)

The Vice-Chair (Mr. Mark Holland): You have 25 seconds left.

Mr. David Moffat: We are accepting people who are charged with drug trafficking. It is the Crown who decides after studying each case individually. It establishes if the traffic was for personal use or for commercial purposes. People charged with commercial drug trafficking are excluded from the program.

The Vice-Chair (Mr. Mark Holland): We shall now go to Mr. Davies.

[*English*]

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chairman.

First of all, I want to thank each and every one of you for appearing before us today, and more importantly, for breathing a really strong breath of fresh air into what can be a very difficult problem. It seems that what you're telling us is that there are progressive and innovative alternatives to prison that are not only better for the people coming through but also have some success in treating the underlying causes. I want to thank you for the work you do.

My first question is probably due to my bad notes, but I want to clarify something.

Ms. Trottier, if I understood correctly, you indicated that funding has been extended to March 2012 for the existing six drug treatment courts. But I thought I heard you say that there was no real way to gauge the effectiveness of that program. Did I have that right?

Mrs. Margaret Trottier: Recently we've completed the summative evaluation on the initial four years of the program, 2005 to 2009. The summative evaluation concluded that we still needed more time to evaluate whether or not this is an effective or cost-efficient approach.

Mr. Don Davies: If I could drill into that a little bit, are you looking to see whether it's cost-effective or whether it's effective?

Mrs. Margaret Trottier: We will be looking at both. There is an opportunity to determine whether or not it's cost-effective, but when we're dealing with issues around high-needs clients, besides cost-effectiveness or is the question of its being an efficient or effective program. There will be elements we explore involving cost issues, and there will be elements we explore around effectiveness as well.

Mr. Don Davies: What I'm hearing from the rest of the testimony here is—at least I'm getting a pretty broad swath of testimony—that these programs, both mental health courts and drug treatment diversion programs, are very effective. Does anybody want to comment on this and tell us whether or not we should be expanding this program to include more of these courts across the country?

Mr. Doug Brady: I can attest that the drug treatment courts across Canada have varying results, and I think that's what Margaret was alluding to. We're seeing very promising and encouraging results, moving forward. We're seeing a great cost saving. I can speak a good deal about Edmonton, because that's where I'm from. We did a social return on investment piece in our program evaluation, and for every dollar we spent, there was a $5.90 return on investment.

We also know that we've had success rates in Canada of up to 32%. I guess “completion rates” is a better way to put it, because success is really hard to measure when you have people who maybe don't graduate from the program but have benefited from it and have decided to opt out near the end of their term with the drug courts. That happens across Canada. They have, for some reason, decided that they would now just want to get it over with and move on. Many of these people remain clean as well. We would want them in the program longer, but they have decided that they want to get out, because it's not an easy program.

Mr. Don Davies: Mr. Budd, did you want to comment?

Mr. James Budd: The people who come into drug treatment courts typically are some of the most disadvantaged people in society. They're very often homeless when they come in. They have very high needs, and because of their history, they have quite a high risk of reoffending.

One of the difficulties in doing a national evaluation and coming to some kind of conclusive data is how different each court is. As Dr. Ward expressed, they really are built on community models that respond to the unique needs and structure of each community. I can say that in Ottawa the average participant who comes into our program—we assess them very carefully before they come in and we do some extensive interviews with them—uses, on average, $500 a day worth of drugs before coming into our program. All of this, of course, has to be supported by criminal activity. And you understand, of course, that you don't commit $500 worth of crime to buy $500 worth of drugs. The cost is much higher than that.

We did some analysis within our program and found that in a one-year period, approximately $3 million in drugs were not consumed in our community. That doesn't even consider the crime required to support that amount of consumption. So I think the courts are very effective.

In terms of reducing criminal activity, in our first year of operation we operated differently. You have to remember that drug treatment courts have been running in Canada for about three years, during the most recent funding agreement anyway, and we're learning as we go. In our first year, about 40-some per cent of our clients reoffended while being involved in the program. We increased the intensity. We brought in some criminal thinking. And we dropped that down to about 14%. It's gone lower since.

You have to remember that there are two types of reoffending: the one they get caught for and the one they don't get caught for. If somebody's using $500 a day, they're committing a criminal act every day—many, many criminal acts. I spoke to one client recently who told me that he would shoplift all day, until the stores closed, and then he would start breaking into cars. I like to think that any day a client is in drug treatment court and not using and not committing crime is a good day and is a benefit to our community.

● (1200)

Mr. Don Davies: Thank you.

In terms of the mental health court, which I think is an excellent idea as well, I wanted to know if you could tell us, conversely, what the effect is of having mentally ill offenders in prison. We're talking about diverting them out of prison. What is the cost of having those people in prison, untreated or treated, as the case may be?

Dr. Helen Ward: There are a few costs. One of them is that they are involved in more institutional issues, so in fact, you end up with an increase in segregation and an increase in altercations with guards, which results in sick time, injury time, and so on. You end up with potential suicides. You end up with people who need quite expensive psychiatric medications while in the correctional facility, and probably more of them than if they were out. You also end up with people who come out without any treatment established, so they rapidly go back in. I've had a few people who I can't even get my hands on before they're back in again. Those are the kinds of things we really need to fix, because in the end, you're ending with really increased stays.

The Vice-Chair (Mr. Mark Holland): Thank you.

We'll go to Mr. Rathgeber, for seven minutes.

Mr. Brent Rathgeber (Edmonton—St. Albert, CPC): Thank you very much, Mr. Vice-Chair.

Thank you very much, all of you, for your excellent presentations today.

I'll begin with Ms. Trottier.

You indicated that not all your participants graduate, but you didn't tell us what percentage do. I was wondering if you have that statistic.

Mrs. Margaret Trottier: As was mentioned, national evaluation is challenging in that we bring together the results from the different programs across the country. What the current statistics show is that we have a range of graduation rates, from 6% to 36%, in the various programs. There's an obvious need for us to collect better data to better understand what the graduation rates are.

Mr. Brent Rathgeber: Mr. Brady, do you keep statistics on graduates from the Edmonton program?

Mr. Doug Brady: Yes, I do.

Mr. Brent Rathgeber: What's your rate?

Mr. Doug Brady: When we did our original evaluation, it was 27.5%, and that has increased now to a 32% graduation rate. All the graduates come back and see us. There are people who didn't graduate who come back to us as well. Even after they've been removed from the program, they come back to us and tell us how well they're doing.

Mr. Brent Rathgeber: Sure. So for the 68% or so who don't graduate, they're ultimately sentenced, I take it. Their sentences are initially suspended, but if they don't make it through the program ultimately, there is some disposition of a fine, probation, perhaps a custodial sentence. Is my understanding correct?

Mr. Doug Brady: That's correct, and I think across Canada most of the people who come to drug courts would be receiving a custodial sentence. So they would return to the original sentence that was set out at the beginning, usually. That's an early case resolution. In our provinces, they would be receiving somewhere between 18 months and three years in jail, and that varies up to two years less a day, I think, in Ottawa. So it varies across Canada, but they would be stuck with their original sentence.

● (1205)

Mr. Brent Rathgeber: Mr. Brady, I have to challenge you on one of your stats. You said 11.6% of your graduates are not recidivists. I'm just curious as to how you measure that, because unless you're tracking them all the way until the end of their lives, there's no real way of coming up with that. Is that one year out, is that two years out? Where does that 11.6% come from?

Mr. Doug Brady: I got that out of the UN Office on Drugs and Crime. So 11.6% of those who complete drug treatment court programs ran into trouble with the law again, and of course you can't measure it. I agree, it's probably two years out. That is what I would think.

Mr. Brent Rathgeber: Two years, okay. Do you have a way of finding out for me?

Mr. Doug Brady: I will check that out and get back to you.

Mr. Brent Rathgeber: I should disclose that I spent half a day with Mr. Brady and Judge Wong at the Edmonton drug court, and it was a very fascinating afternoon. I learned a lot, and I encourage all members to do that, especially since there is one in Ottawa.

Ms. Trottier, you talked about funding for the program being extended to 2012. Bill C-15, which has been stuck in the Senate for about six months, creates some provisions with respect to an expanded role for drug treatment courts, and we haven't talked about that. I'm assuming you know what those are and what it means for the program should Bill C-15 ever become law. I was wondering if you could educate the group on those provisions.

Mrs. Margaret Trottier: Within Bill C-15 there is an exemption for individuals to avoid the mandatory minimum sentences if they are accepted into a treatment program. That treatment element of the MMP legislation is twofold. It does make specific reference to drug treatment courts, but it also makes reference to drug treatment generally. So it will be up to the provincial attorneys general to determine what other levels of treatment would be appropriate in that context.

Mr. Brent Rathgeber: I'm assuming I must be close.

The Vice-Chair (Mr. Mark Holland): You have another three minutes.

Mr. Brent Rathgeber: Getting back to Mr. Brady and my summer day in July, I found it very fascinating. I have a legal background, and I'm used to a more adversarial legal context, and I think that members of this group can probably appreciate my adversarial nature. Of course, it's quite different.

The word “restorative”, quite frankly, threw me off, because when I think of “restorative” and “justice”, they're almost oxymoronic, especially for an old-school guy like me. I was wondering what, if anything, you or your counterpart from Ottawa do to market your court. I do agree that, anecdotally at least, there are many success stories. But I was not familiar with your program, and I practised law in Edmonton for 17 years. What do you do or what can you do to market your program, to convince funders like Parliament and members of the bar associations to buy in, as Dr. Ward suggested?

Mr. Doug Brady: We do get out in the community quite often. In fact, one year I got out 52 times in one year. So that means I'm getting out an average of once a week. We go to speak to different organizations. We go to speak to universities and colleges. We've spoken at the Criminal Trial Lawyers Association. The Alberta Criminal Justice Association had an entire day just on drug courts, for Alberta courts, in Red Deer in October. We go out to probation officer conferences.

Anywhere we can go, we go out. We take participants with us. We take graduates with us, because our graduates are very supportive of our program and they continue to work with us through the alumni group. We have barbecues. We do all sorts of different things with them, which I won't get into.

Mr. Brent Rathgeber: In your program, the participants attend weekly, correct?

Mr. Doug Brady: Once a week.

Mr. Brent Rathgeber: Mr. Budd, did I hear you correctly that initially they attend daily?

Mr. James Budd: Twice per week. They attend our treatment centre daily and they attend court twice per week.

Mr. James Budd: Can I add just one thing finally in response to your question?

Mr. Brent Rathgeber: In 15 seconds, yes.

● (1210)

Mr. James Budd: The other thing is that we have formed an association of courts across Canada. We have incorporated, and we have elected Mr. Doug Brady as our spokesperson for it. That's our other way of getting the message out.

The Vice-Chair (Mr. Mark Holland): Mr. Kania for five minutes, moving on to the second round.

Mr. Andrew Kania (Brampton West, Lib.): Thank you, Mr. Vice-Chair.

I thank you all for coming and being here. Obviously I support both courts. We're here today to see what we can do to try to improve things.

So I will first focus on mental health.

Dr. Ward, the most concerning thing I've heard today from anyone is one of your initial comments that the persons who are incarcerated have increased as hospital beds have gone down. So I'd like to discuss that first and to find out from you, if you have this expertise, what might be done to reverse that and to get the system back on track, really, the way it should be. It could be as simple as saying we need *x* number more beds, but I assume there's a little more to it than that.

Dr. Helen Ward: I wouldn't get very far to say we need *x* number more beds. I do think there is disproportionate money put into mental health as opposed to other types of health. The Mental Health Commission of Canada, I think, has been fairly clear about that. That's fairly well established.

The issue about trans-institutionalization is also pretty well accepted. That is what has occurred. What we need, I think—and the Mental Health Commission has started to look at this—is more housing for people with mental illness. We need more affordable housing for people with mental illness. You can't put treatment in place in communities unless you have proper housing. That's what we really don't have. If you don't want people to be in hospital beds, that's fine. But I can't keep people well when they're in rooming houses full of drugs or in shelters where they have to be out throughout the day. So that's probably one of the main things that could be done: housing programs specifically targeted at the mentally ill.

The other thing would be looking at funding or models that would encourage mental health practitioners, including physicians, to treat mentally ill people. There's really no incentive to try to help this population when pretty much any psychiatrist in the country could close their practice tomorrow and be living comfortably. Sorry, I'm a little blunt. You need to be creating incentives for us to work with this population other than our own values.

Mr. Andrew Kania: Do you have studies or written proposals that are very specific in terms of what you might suggest should be implemented for both, both affordable housing...?

Dr. Helen Ward: I don't know that I can give you specifics. There are projects out there. There are models out there already. Certainly on a provincial level, there is housing for the mentally ill out there. There are, for example, safe beds in Ontario that are designed as crisis beds for people with mental illness involved with the justice system. Those things exist. There are just not enough of them.

I'm not sure how much of a study needs to take place. More specifically with mental health courts, though, we don't have outcomes. That's because there's been no money targeted towards outcomes. We can all come at it with our clinical resources, but every mental health or health organization has been slashed to the bone. So we don't have a lot of analysts sitting around ready to do studies. Those are the things that probably should be funded here.

Mr. Andrew Kania: I have four different points in terms of mental health courts before I move to the drug treatment courts, if I have time.

First, the crown acts as the gatekeeper. The crown decides whether somebody goes into the mental health court.

Dr. Helen Ward: Yes, they do, but usually there is assistance from mental health professionals as to whether or not that person should be there. So in Ottawa we screen people who have been arrested by police and who have been identified as having a potential mental health issue. We also offer an out-of-custody clinic, which can also screen. So that can assist the crown.

Mr. Andrew Kania: I've just been told I have one minute.

I'm going to go to point number three. During your presentation you mentioned something about better community legal provisions needed. That's what I wrote down. Can you describe in full what you meant?

Dr. Helen Ward: There are different provincial things for community treatment—civil orders—to get someone with a mental illness who needs treatment, but doesn't recognize that they need treatment, to remain in treatment. This is usually for people with schizophrenia or related illnesses who need anti-psychotic medications. They can often be delivered injectably every two weeks. But if they exist, most of the community treatment provisions are weighted towards the rights of the person with the illness and not weighted very well towards the interests of the person's family, or the people who actually can see that the person is ill, or in fact the community if the person has been committing offences against the community.

● (1215)

The Vice-Chair (Mr. Mark Holland): Mr. MacKenzie, for five minutes.

Mr. Dave MacKenzie (Oxford, CPC): Thank you, Chair, and thank you to the panel members here today. I've got so many questions I wish we could have each of you for two hours.

A couple of things have arisen, I suppose, over the last few years, particularly with drugs. Methadone is an area that is quite interesting because it seems that opiates being legally prescribed has taken off in leaps and bounds. As a result, not only the legal use of them but the illegal use—or the improper use—has spurred all kinds of methadone clinics in our communities. What I'd really like to know is, do you see any improvement with those people addicted to opiates in the methadone, or do we just trade the opiates for methadone and it goes on forever?

Mr. James Budd: Thank you.

No, we see significant improvement with people participating in methadone maintenance programs. It is medically monitored. It's prescribed in a setting where they come into daily contact with service providers. It does not result in the same type of high, if you will, that street opiates do.

You are correct, we are seeing a lot of participants who are addicted to illegally obtained prescription medication. For us, methadone maintenance has been a very successful route for many of our participants.

Mr. Doug Brady: I have one comment regarding that.

We don't have many in our program. I know Vancouver has quite a few and I don't know how many James does in Ottawa. We have a couple in our program and we have found success with them as well, but it is a lifelong drug that they're going to be on with methadone. It is harder to get off than any other drug. It is very similar to something like insulin for a diabetic. Once they're on it, they're on it for a lifetime.

Mr. Dave MacKenzie: Okay.

Mr. Moffat, I appreciated Mr. Kania's questioning with respect to the crown attorneys, but certainly it's been my observation over the years that crown attorneys and the police will collectively work together to find a solution without the court having to order it. My question to you would be, as a crown attorney, do you see the programs as being far more effective since people are going into them on a voluntary basis rather than having to be ordered by the courts?

Mr. David Moffat: If you're asking about my experience, I'm now going on to year seven as a prosecutor in various jurisdictions. The follow-through that you have in court and the ability for the crown to come to court twice a week...now in Ottawa, we might be going to once a week. But once or twice a week and that follow-through, and getting them hooked up in that intensive way with treatment while at the same time having that sentence hanging over their heads, seems to be working.

Certainly, I would think that if people went voluntarily on their own—and we talk about going on their own to in-treatment—that works as well. But then the problem is always that they go to in-treatment and then they come back into the community that they came from and they haven't gotten those skills as to how to not use. The advantage of drug treatment court in Ottawa, for instance, is that they're teaching people not to use in the community that they're going back to at the end of their sentence.

Mr. Dave MacKenzie: I guess what you're saying is that if they're in the court system, there's an incentive for them to take part in the programs, right?

Mr. David Moffat: Absolutely. The more severe the sentence they're looking at, the more incentive they have.

Mr. Dave MacKenzie: Thank you.

Dr. Ward, as the study is in mental health and addictions, it certainly seems, I think, to most of us that the custodial system in the justice system has taken over a role that it was never intended to do. People with mental health issues whom society has somehow missed are ending up in custody. Is there a magic bullet out there that we should be looking at to try to get that fixed sooner?

● (1220)

Dr. Helen Ward: I still think it comes down to giving us stronger tools. We need to be able to enforce treatment for people as a civil measure, particularly if someone has been involved in the criminal justice system. That may take a lot of twists and turns legally, because ordering treatment for someone is a very serious thing to do legally. But honestly, that's what we need to be able to do.

Mr. Dave MacKenzie: Thank you.

[*Translation*]

The Vice-Chair (Mr. Mark Holland): Thank you.

I shall now go to Ms. Mourani.

Mrs. Maria Mourani (Ahuntsic, BQ): Thank you, Mr. Chair.

Good morning everyone. I thank you for being here.

As concerns mental health courts, I would like to know if there are several in Canada or if it is found only in Ottawa.

[*English*]

Dr. Helen Ward: There are many mental health courts in Canada. There are probably eight or ten in Ontario, and they are right across the country. There's one in Montreal that recently came to visit us here. I'm sure there are more in Quebec, but I'm not aware of them.

[*Translation*]

Mrs. Maria Mourani: In the document that was distributed to us, it is said that those courts deal essentially with offences for which there can be a diversion from the regular justice system. They seem to deal with a certain type of offence related to mental health. What type of offences are these exactly?

If an individual suffering from mental health problems commits a theft, sells drugs or kills someone, on what criteria will he be referred to a mental health court rather than a regular court?

[*English*]

Dr. Helen Ward: Again this is my personal opinion, but a mental health court could be used in areas that wouldn't traditionally be considered to be divertible, for example, domestic assault. It's very common in our court to see a couple who both have mental health issues. They've been living together. There may have been previous incidents and the police have been called. The person, even though he or she was obviously ill, was arrested instead of being hospitalized, perhaps because it didn't work before. Now we have someone who needs special provisions, because both partners want the person to be back in the home. But we need to be able to make sure that person's mental health is treated and monitored.

So this is a good example of the kind of thing a mental health court would do that another court wouldn't necessarily be willing to do.

[*Translation*]

Mrs. Maria Mourani: Do you mean that this type of court will mostly deal with the less serious cases, those that can be treated within the community?

[*English*]

Dr. Helen Ward: Are you asking what types of mental health problems we deal with?

[*Translation*]

Mrs. Maria Mourani: No, but I might be mistaken. I need some more details. I am under the impression that this kind of court is, in fact, for people suffering from a mental health problem but who are charged with minor offences.

We are not talking about vicious murders or extreme cases of child sexual assault, are we?

[*English*]

Dr. Helen Ward: We wouldn't deal directly with those crimes in terms of a positive legal outcome, but we might deal with them in the court. There's a provision for someone to be assessed for criminal responsibility for all severities of offences. My program would assess someone who had committed murder, if the court ordered an assessment, and would go back and bring provisions. But if the person wasn't NCR there wouldn't be a diversion, because there would be minimum sentences involved, etc. It would make no sense for it stay in mental health court then.

For things like pedophilia, our program does assessments of people for the court. But a mental health court isn't needed to then apply these recommendations, or for sentencing issues or risk assessments. For the more serious things, there are already fairly good mechanisms in place. The less serious level two offences where there's assault, assault with a weapon perhaps, criminal harassment, or threats are where there's a gap we're trying to address.

● (1225)

[*Translation*]

Mrs. Maria Mourani: My understanding is that, like drug treatment courts, these courts only deal with minor offences.

Mr. David Moffat: It varies. In Calgary, we accept people sentenced from one to three years. However, in Ottawa, our program is only for people with a less than two-year sentence. In general, this is for rather minor offences.

Yes, we have recently discovered, in Vancouver and Winnipeg, that the success rate was higher for people charged with more serious offences. It is related to the motivation issue mentioned by Mr. MacKenzie. According to that theory, the more serious the sentence is, the more people are motivated .

The Vice-Chair (Mr. Mark Holland): Thank you very much.

Mr. Norlock, you have the floor.

[*English*]

Mr. Rick Norlock (Northumberland—Quinte West, CPC): My thanks to the witness panel.

We're certainly learning a lot about the effectiveness and efficiencies of your various programs, but I was intrigued when Dr. Ward, I believe, indicated that her work or her collaboration with the Mental Health Commission was of great assistance.

Could you explain how you work with the Mental Health Commission?

Dr. Helen Ward: Actually, I referred to their work. I'm not working with them directly. Some of my colleagues are, as chairs. What I was doing was commending the work of the Mental Health Commission. I think they have it right in terms of looking at stigma and in terms of looking first at housing in some of the preliminary work they're doing.

Mr. Rick Norlock: Does any of the preliminary work from the commission have a relationship to the forensic side of the treatment of mental health?

Dr. Helen Ward: Yes, there's a law and mental health subcommittee as part of the Mental Health Commission, and I know that they've put out a call for proposals to evaluate certain areas of the mental health and justice system. It was a pretty big call for proposals, so they're not really looking at it at the micro level yet. I haven't seen anything, and of course they themselves don't have a lot of money to implement programs.

Mr. Rick Norlock: I believe it was in the 2008 budget. It was $110 million over five years, I believe.

Dr. Helen Ward: Right.

Mr. Rick Norlock: It's good that we've got a start, and we can build on that.

Dr. Helen Ward: Absolutely.

Mr. Rick Norlock: Dr. Ward, you can perhaps share my next question with some of the others. It has to do with mental illness, and in particular my experience, primarily in Ontario.

In our travels recently across Canada in various provinces, we saw that each province has its own mental health act. I'm wondering if you or any of the other witnesses have heard of issues concerning the mental health act as those issues relate to treatments, incarceration, or a combination of the two. What would be your suggestion to us? We're looking for answers as to how we can make that work in a federal system, because the federal system is pan-Canadian, and we actually have 10 provinces and three territories, each with its own mental health act.

Could you comment on that?

Dr. Helen Ward: I wish I had something brilliant to suggest. I don't think I can really give direction at this point in time. It is important to have some minimums, and if it comes from looking at crime federally, then maybe it can be transmitted that way through requirements from the courts. However, I don't know how you're going to touch the mental health acts of the provinces. I think that's part of the problem.

Mr. Rick Norlock: Thank you.

Mr. Moffat, have you had any experiences with respect to the differences in jurisdictions as they relate to the mental health act and the court system?

Mr. David Moffat: With apologies, I've dealt with a couple of committal issues in which I've had to advise police on what they can do with civil commitments, but I really don't have enough experience to be able to speak to a difference.

Mr. Rick Norlock: Okay. Thank you very much.

I think my next question actually was to do with that, but Dr. Ward could comment.

The committee is yet to make recommendations, but my personal preference has to do with the fact that in some of the jurisdictions, partnerships are formed with academia. I'm thinking in particular of Saskatoon, where they actually changed the focus from a custodial or prison-type approach to more of a mental health or hospital approach, and there seemed to be some successes. They partnered with the province, they partnered with academia, and they partnered with other health care professionals.

Could you comment on your experiences surrounding that, so that we can formulate a good report?

● (1230)

Dr. Helen Ward: I think it is really important to have those links. You're talking about RPC in Saskatoon. That's a real model. The bottom line is that you have to be able to get money from different sources to make this work. You have to be able to encourage that collaboration.

We see it here. We're running projects on a smaller level for housing for people involved in the not criminally responsible system. The provincial government has mandated an evaluation from the University of Ottawa, and it has our involvement as well as community agency involvement. I think that is very important.

Mr. Rick Norlock: In Saskatoon, we noticed—

The Vice-Chair (Mr. Mark Holland): I'm sorry, Mr. Norlock. There's another round coming up in just a moment, but right now I'm going to go to Mr. Oliphant for five minutes.

Mr. Robert Oliphant (Don Valley West, Lib.): Thank you, Mr. Chair, and thank you to all our witnesses.

Probably unlike Mr. Rathgeber, I think “restorative” and “justice” are actually intimately bound, and I think you're probably getting that these days too. I would say that justice without restoration is not justice. I'm glad you're doing what you're doing.

One of the witnesses we saw a few weeks ago echoed the thought that Dr. Ward had around the criminalization of mental health, but also talked about prison having become a risk factor for mental health and addictions. The incarceration actually worsens the situation. I wondered if anybody wanted to comment on that statement that was given to us.

Dr. Helen Ward: I certainly would see it anecdotally. Often it interrupts a course of treatment. People are also exposed to environments that worsen their mental health, so they come out of it often untreated and in a worse psychosis or a worse depression than they were previously. They may have become criminalized, unintentionally. I see all of that anecdotally.

Mr. Robert Oliphant: What we're trying to do is look at mental health in our prisons, but keeping them out of prison is probably the best step, if we can do that.

Dr. Helen Ward: Yes, and that's why I emphasize that we should really be focusing on people who, but for their mental health, wouldn't be in there. And that isn't everyone, but it's important.

Mr. James Budd: I'm sorry, I can't cite the specific authors, but there is a body of literature referring to corrections, to the fact that the more frequently people come in contact with the criminal justice system, they become, in effect, criminalized. If people are coming in contact with the system because of their addiction or because of their mental health, there's a very good likelihood it will continue to become worse in the future.

Mr. Robert Oliphant: My experience with addiction actually started at Rideauwood about 25 years ago in a training program that I took there for clergy, to help us understand addictions. In those 25 years my thinking has changed somewhat from what I learned at Rideauwood into more of an understanding of harm reduction as well as abstinence. Most of what I've been hearing today has to do with abstinence, and I'm wondering where you are at in your thinking on harm reduction.

Dr. Helen Ward: I'd like to comment on that from the point of view of mental health. It hasn't been said yet, but the proportion of our clients in the mental health courts who have addictions is probably about 80%. But we are nowhere near expecting them to go into abstinence-based programs. In fact, best practices in concurrent disorders, which is mental health and addiction, suggest that harm reduction is the way to go.

So we rely on agencies—in our case, the Canadian Mental Health Association—that offer harm reduction programs, and we find it a fairly successful model for our particular clients.

Mr. James Budd: I would like to say that in order to ultimately complete the drug treatment court at the highest level, abstinence is required. However, along the way we work with people where they're starting from.

It's important to understand—and it seems odd to people at first—that participants in drug treatment courts are not sanctioned by the court for drug use. They may be sanctioned for dishonesty about them, but we understand that they have many, many years with this problem and that this is an ongoing process.

The Vice-Chair (Mr. Mark Holland): You have one minute and thirty seconds.

Mr. Robert Oliphant: I'm actually quite familiar, and have been, with drug treatment courts. That's something I know a fair amount about. Mental health courts are new to me. I just need a little bit more information.

The government is supporting a pilot project with the six drug treatment courts. It was started in 1998 or 1999 in Toronto, so we had some experience. What's the funding arrangement for mental health courts? How does that work? The government has said they'll keep funding the drug treatment courts until 2012. Where are we at with mental health courts?

● (1235)

Dr. Helen Ward: The short story is that there isn't one, the main difference being that the Controlled Drugs and Substances Act is federal, so it makes it much easier, whereas none of the mental health stuff comes in there. It's quite ad hoc, although I'm starting to see signs at a provincial level. Recently Ontario appointed a deputy crown attorney for mental health and they're looking at proposals, so I hope to start seeing money—but I'm not holding my breath—but at least proposals or standardization at the provincial level.

Mr. Robert Oliphant: Perhaps we could start with the recommendation from this committee that mental health courts should be part of a funding plan to help mental health in prisons.

Dr. Helen Ward: Yes, and it's the whole cross-ministry thing at the provincial level. There are so many ministries involved, and it makes it very difficult for anyone to step up to the plate.

The Vice-Chair (Mr. Mark Holland): Thank you very much.

Mr. McColeman for five minutes.

Mr. Phil McColeman (Brant, CPC): Thank you, Chair, and thank you very much for being here. It's been a great learning session from all committee members' points of view, I think.

I just want to do a little bit of further exploration and perhaps wrap up on the issues of outreach, because certainly you've reinforced what we've heard from a lot of people, and on a couple of levels. I know my colleague was talking about post-secondary institutions and such, and some of the most successful partnerships happen that way. I think, Dr. Ward, you referred to the challenges that are faced, and we've heard of these challenges of keeping professionals in the system.

Is there anything you could recommend in terms of how we do that, how we bring new professionals like you and others in the professions to work within the correctional system? What would those recommendations be?

Dr. Helen Ward: I think it's important to get behind anti-stigma measures. I would also be looking at curriculums in various training programs for social workers, for criminologists, etc., and what they have to offer. You might want to be looking at supporting more co-op placements. We do co-op placements for criminology students, and it's very successful. Then that, of course, widens things.

I think for professions where people are scarce—and we're going into this baby boomer retirement where we're going to have a real shortage of professionals—we physicians are often pretty much free agents, so there need to be incentives for the kinds of practice we need, and then disincentives for the kinds of practice we don't need quite so much of. That's obviously probably at a provincial level, but I think there needs to be some thought given to how we move people into these areas. Some of it may be financial as well as training.

Mr. Phil McColeman: Are you talking financial or are you talking professional development? We had one psychiatrist say to us when we were touring—I'm not sure if it was Kingston—saying this was the best lab there was, and you could just see the challenges they were looking at, and the stimulation, I suppose, from a practical point of view of what that would mean. So you mean on both fronts?

Dr. Helen Ward: I do, and I think that is a place to encourage people. I also think, though, that at a more grunt level, doing the actual clinical work, we would do well to follow some of what's been done in Quebec in terms of CLSCs and getting more and more mental health resources into the community and community health centres and family medicine centres, and giving those people incentives to pick up difficult populations. We're doing some of that, but we could do more.

Mr. Phil McColeman: One thing I don't think I've heard from any of you today is a peer mentoring system. I'm sure you probably have those systems in place. Does anyone want to comment on that, how effective that is? It strikes me from what we've heard, that if you can develop a peer mentoring system, it is a very powerful tool.

Mr. Doug Brady: When we talk about peer mentoring, we talk an awful lot about our graduates getting involved with our participants. Right now we're having a meeting every two weeks with the participants and graduates, which the graduates wanted us to do, to talk to them about their problems and to help them out along the way. Many of our graduates become sponsors of our participants in different things in the community because they keep coming back to court. It's not unusual to see one or two or three people who are graduating from our program in our court every week to support one another.

● (1240)

Mr. Phil McColeman: So it is something that you're developing and you see a future in it. Can I take that away from your comments?

Mr. Doug Brady: Most definitely.

Mr. Phil McColeman: Is there any further outreach on which any of you have suggestions to our committee? I'm talking about outreach within communities. You say they're all different and I concur on that. But are there any other areas where you can see, as you speak to us, recommendations that we can bring forward in terms of how you do the proper reintegration of people with both addiction and mental health issues? Do you have any comments that way, if you had a wish list?

Mr. James Budd: Housing is very important. As Dr. Ward mentioned, there are housing programs available, and it was an understatement when she said there weren't enough of them. There are, by far, not enough of them. It's very difficult for somebody to remain clean or maintain their mental health program while living in a shelter system. So that remains a significant issue that would be of great assistance to us.

Mr. Phil McColeman: Thank you for that.

The Vice-Chair (Mr. Mark Holland): Thank you very much.

Mr. Kania, for five minutes, in the fifth round.

We should have time to finish the fifth round if we keep everybody to time.

Mr. Andrew Kania: Thank you.

Dr. Ward, we had briefly discussed the fact that the crown is the gatekeeper. I'd like your comments about that, because to me it would appear that perhaps it should be the judge or somebody else who's the gatekeeper.

Dr. Helen Ward: I might actually have to ask Mr. Moffat to comment. I think ultimately the way most of these courts are set up, in the end, the crown is going to be the one that agrees or that pilots the diversion piece or the favourable legal outcome. In mental health court, we don't have a lot of judicial involvement at the front end, and I think it's difficult legally sometimes to figure out how to have that involvement.

That's the only comment I have.

Mr. David Moffat: The crown is responsible for public safety. Ultimately, that's what we see as our job. When I started in mental health court, the direction I got from the crown attorney was, “Here's the drug treatment court; this is the way it works. Don't ever forget that your number one priority is protecting public safety.”

As such, the crown discretion is something that we're just not willing to give up. That's what we see as our job and our responsibility and our role in the system. We use our discretion to decide whether someone is screened in or not, and then from there we go with treatment and judges and the rest.

Mr. Andrew Kania: There's a comment here about “deemed fit to stand trial”, in terms of going through the system to make that determination. Correct me if I'm wrong—I'm not familiar with the system—but that has nothing to do with whether somebody was actually fit at the time they committed the crime. Is that correct?

So they could have not been fit at the time they committed the crime, yet fit to stand trial after the fact, and they wouldn't be part of this.

Dr. Helen Ward: Right, and I apologize; I don't know what material you were given. I didn't see it.

There are two different issues. One is the person's mental state at the time of the offence, and that is related to criminal responsibility. The second is their fitness to stand trial, which is whether they understand why they're there and what's going on.

Those are very, very basic tests, but they can be completely unrelated. The offence could have happened two years ago; they could have been perfectly well, but now they've developed a dementia or psychosis and they're not fit to stand trial. So they have to be dealt with separately.

Mr. Andrew Kania: On drug treatment courts, why is there the distinction with respect to violence? There are a couple of things here. There's the violence, and there's the guilty plea—because I understand that you need to plead guilty in order to have the benefit of this. Secondly, there's a distinction in that if you commit a really serious offence, you don't have the benefit of this rehabilitative program. In my view, if somebody is addicted and has committed an offence, whatever it may be, because of drugs and that addiction, that person needs help, period.

So can you please discuss that?

Mr. David Moffat: The starting point is public safety, and the crown won't screen someone in if we're concerned.

This is someone who is in custody now. We're allowing them out of custody to go to treatment, and there's a risk involved. If there's a risk to public safety that involves violence, then we're less prone to do that.

The other incidence with the violence is—and this was brought to our attention by the judges—that we're court-ordering people to do this. We're ordering someone to spend time in this program, which in Ottawa is for at least nine months, often 12 months. If we're going to court-order accused persons to do this, then they have to be in a safe environment, and it's not a safe environment if we're allowing people into that atmosphere where they have committed crimes of violence and are likely to commit crimes of violence again.

● (1245)

Mr. Andrew Kania: It's not even crimes of violence, because there are other more serious crimes. For example, with break and enter into a residence, you don't get to be part of this program, correct?

Mr. David Moffat: There is no drug treatment program in Canada that will allow someone in with a residential break and enter, the exception being, say, a case-by-case basis for a new home being built, no one's there, it's a residential home development. Then they'll allow people in.

Mr. Andrew Kania: So let's take that non-violent offence. They have a serious drug problem. They cannot go into this program. What do you do to help that individual? Isn't the point of rehabilitation to try to make them better so they don't reoffend?

Mr. David Moffat: For instance, I just had someone not available for drug treatment court. I talked to the defence counsel and said, if he's not suitable for drug treatment court because of the violence, let's look at other options. He went in with a two-year conditional sentence, and he agreed to do a two-year residential in-treatment program, followed by three years of probation. That was an appropriate sentence, and that was for a series of break and enters.

So there's the option.

[*Translation*]

The Vice-Chair (Mr. Mark Holland): Thank you very much.

Mr. Ménard.

Mr. Serge Ménard: I would like you to tell me exactly how you select people admitted to your program.

Mr. David Moffat: Personally, I do some publicity. I spread the word to my colleagues. I encourage them to find people with drug addiction or mental health problems and who meet our eligibility criteria. These are the people who make the requests; we do not do the selection. Afterwards, we decide if we shall use our discretionary power to allow them to take part in the program.

Mr. Serge Ménard: What are your eligibility criteria?

Mr. David Moffat: In Ottawa, we talk about people who might be sentenced to less than two years. We do not accept people who are found guilty of violent crimes, domestic violence, impaired driving or residential break-and-enter.

Mr. Serge Ménard: But you accept those who break and enter in commercial premises?

Mr. David Moffat: Yes.

Mr. Serge Ménard: I would think that it largely limits the number of people who might be eligible. At first, I thought that you did not accept drug traffickers. I understand the difference between those who are trafficking for commercial gain and others. Usually, they are not drug users themselves, but in fact, a large number of those who traffic for commercial gain are also addicted to cocaine.

It does not seem to leave many possibilities for eligibility considering that there are not many offences that are only punishable with two years of imprisonment.

Mr. David Moffat: At the provincial level, in Ottawa, the fact is that this is limiting.

Mr. Serge Ménard: Do you have programs in which you have in-patients?

Mr. David Moffat: Yes. However, our system does not provide for that at the present time in our program in Ottawa. However, if, as the program develops, our treatment supplier decides that it might be beneficial for these people, they could become in-patients and go back to the program later.

Mr. Serge Ménard: What we are talking about here are housing resources. How do you intend to get the funding required?

[*English*]

Mr. James Budd: We work with what is available in the community, but we have also managed to arrange some special partnerships, with the Homelessness Partnering Secretariat, for example, and we've partnered with the John Howard Society and the Elizabeth Fry Society to manage supervised transitional housing for our participants. That has been very helpful to our program and to our participants. Unfortunately, the funding for that will be coming to an end on March 31 of 2010, and we will have to be seeking other resources to accommodate that.

● (1250)

[*Translation*]

The Vice-Chair (Mr. Mark Holland): Excuse me, Mr. Ménard, but I want to make sure that there will be enough time left for all questions in the fifth turn.

Can you conclude your question now or in the next 10 seconds?

Mr. Serge Ménard: Yes.

I know that Correctional Services Canada was sending people to Portage and was paying for the cost. Is it still the case?

[*English*]

Mr. Doug Brady: No, they're not involved with us at that stage, because they're guilty pleas, and they're looking at a sentence that could relate to it. So they're sentenced after the fact. They're not sentenced right away. They plead guilty right away, but they're not sentenced until after they complete the program.

The Vice-Chair (Mr. Mark Holland): Thank you.

We'll go to Mr. Davies, for four minutes.

Mr. Don Davies: Thank you.

First of all, on dual-diagnosis patients, I wonder if you can give me 45 seconds on the efficacy of this program for people with a dual diagnosis.

Dr. Helen Ward: Do you want me to comment on cognitive delay impairments and mental health?

Mr. Don Davies: It's usually mental health and addictions. That's how I understand it.

Dr. Helen Ward: Okay, you mean mental health and addictions. I won't comment then... Well, actually, I will comment.

We often have people we would like to see be part of a drug treatment program, but we don't think, with their mental health issues, they can manage to handle that program. We end up with people from that program who seem to be better served by the mental health court approach.

Mr. Don Davies: I'm still a little unclear about the violence aspect. I have three different notes here. One is that people who commit violent offences cannot participate. Another is that those who have committed violent offences can participate, provided they're not at risk of committing a violent act again. What is the deal for people who have committed an act of violence and their eligibility?

Dr. Helen Ward: In mental health court it's very different. It depends on the court. We will take all comers, pretty much. Drug treatments are different because they're dealing with the federal funder.

Mr. Doug Brady: The federal guidelines say that we cannot take violent offenders. That's where our guidelines come from as far as our funding agreement goes. That's what it basically boils down to.

We take a look at people on a case-by-case basis. We don't necessarily exclude them. If it's a one-time thing or if it's someone who doesn't have a history of violence, we may look at them. In our court, the crown brings these people to court and asks if we can work with them. We make a decision as a court team, along with the treatment team, on that basis.

Mr. Don Davies: I'll get a tad political.

Not to make anybody uncomfortable, but on conditional sentences, this government has moved to restrict the availability of conditional sentences. This sounds like a poster child program for conditional sentencing. You get a sentence, but you're serving it in the community, in effect, under very tight conditions, such as drug treatment and so on.

Would you agree, at least with respect to mentally ill offenders and people who are addicted, that this conditional sentencing is perhaps a better way to go than incarceration?

Mr. James Budd: Just to be clear, drug treatment court is not a conditional sentence. The participants are not under sentence when they come into the program.

I would point out that we do have quite a number of participants in our program who are also mentally ill and who are not faced solely with addiction problems. We only have the resources, really, to work with those who are at the mild to moderate levels—

Mr. Don Davies: I'm sorry, could I get you to explain that more?

I don't understand why that's not a conditional sentence. A person has been charged. He or she is in court and either faces going to jail or being diverted out of it. Whatever you want to call it, that sounds, in practice, as if it is a form of conditional sentencing.

Mr. James Budd: In practice it is very similar to a conditional sentence. In many ways, I believe it's better than a conditional sentence, because we have such consistent monitoring of the participant who's in the program. The resolution, if there's some sort of breach, is not simply that they're back in jail or that they get to stay out of jail. There's room to work on modifying their behaviour along the way so that the behaviour doesn't repeat.

● (1255)

Mr. Don Davies: Mr. Moffat, did you want to comment on that?

Mr. David Moffat: You know what? This is a little close to the political bone. I'm very happy with all the tools the government is giving us, and drug treatment is one of them, and drug treatment works. But I'd say that it's very different from a conditional sentence.

The Vice-Chair (Mr. Mark Holland): We'll go to Mr. MacKenzie now for four minutes.

Mr. Dave MacKenzie: Thank you, Chair.

Dr. Ward, I know you're very young, but I expect from what we've heard that you have a wide range of experience dealing with forensic psychiatry.

One of the areas that certainly as a committee we're wrestling with, and we heard from the correctional investigator, is segregation. Is there a place for segregation in the short term, in your mind, for the extreme end of people who have mental health issues, for the protection of themselves and others? Do you know of something totally different that we have not seen in Norway, Britain, or here?

Dr. Helen Ward: You're asking a lot, but thanks for the compliment at the beginning.

What I would be advocating for is that there are facilities where... and there's one in Ontario, the Secure Treatment Unit. It's a provincial psychiatric hospital within a correctional facility.

Now, one of the original proposals, I understand, was to actually have a remand section for that. What I would be advocating for is that you need a remand section of a correctional facility that has schedule one hospital status so that you can also have professionals in there doing the treatment. Then, if segregation is done, it is done in a medically safe manner, with treatment there to address the underlying cause so the person can come out of segregation.

That's how I would see it.

Mr. Dave MacKenzie: My recollection—and I've been in a number of institutions—is that the psychiatric facilities also have segregated facilities available to them.

Dr. Helen Ward: Some do, but we don't.

Mr. Dave MacKenzie: Whereabouts?

Dr. Helen Ward: Here in Ottawa.

We deliberately don't, because in my opinion, when you're dealing with a psychiatric issue you can deal with that person by chemically and physically restraining them and one-on-one supervision without shutting them in a room by themselves. We have been able to manage that when we're dealing with mental illness.

Mr. Dave MacKenzie: How do you administer the chemical?

Dr. Helen Ward: You need to be able to use the provisions under the Substitute Decisions Act or emergency provisions that allow you, as the person's treating physician, to act in their best interest. You need things available to you as a hospital facility to do that legally.

Mr. Dave MacKenzie: Now, you mentioned there's a correctional facility in Ontario—

Dr. Helen Ward: That is a hospital, yes. It's the St. Lawrence Valley Secure Treatment Unit in Brockville. It's a provincial facility, but our organization runs it, runs the psychiatric piece of it within Corrections. It is actually a psychiatric facility.

Mr. Dave MacKenzie: Are you aware of the correctional facility in Saskatoon that also has status?

Dr. Helen Ward: Yes, and they run it similarly, except that it's one big conglomerate with small pieces with various types of offenders within it. But yes, it's a very interesting model.

Mr. Dave MacKenzie: Would that equally fit what you're seeing or suggesting with the Brockville one?

Dr. Helen Ward: They're pretty much equivalent. I've been to both. They're similar.

It depends. In Saskatoon, you want economies of scale by putting everything together. Here we don't necessarily need that, because we have larger populations.

Mr. Dave MacKenzie: Thank you.

The Vice-Chair (Mr. Mark Holland): Thank you.

I have two quick matters before we adjourn.

First of all, Mr. Davies, I notice that you have with you today your wife and daughter. We welcome them to the committee as special guests.

Let me thank the witnesses for appearing today. Your testimony was deeply appreciated and no doubt will be invaluable to our production of a study on this matter. Thank you for appearing today.

Quickly, before we adjourn, because we have one meeting left before we recess for the Christmas break and we have one witness who will be appearing on Thursday, it would be my suggestion that we take the last half hour of the meeting on Thursday to tie up any loose ends, leave it open for discussion of future business, if the committee's amenable to that.

An hon. member: Fair enough.

The Chair: Does the committee agree with that? Okay.

Thank you again to the witnesses, and we'll see everyone Thursday.

We stand adjourned.

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