Special Commitee on

Reforming the Police Act

Draft Report of Proceedings

1st Session, 42nd Parliament

Tuesday, February 23, 2021

Victoria

Draft Transcript — Terms of Use

The committee met at 9:33 a.m.

[D. Routley in the chair.]

D. Routley (Chair): Good morning, everyone. My name is Doug Routley. I'm the MLA for Nanaimo–North Cowichan and the Chair of the Special Committee on Reforming the Police Act, an all-party committee of the Legislative Assembly.
I'm thankful to be joining today's meeting from the traditional territories of the Malahat First Nation. I would like to welcome everyone listening and participating in this meeting.
This committee has been tasked with undertaking a broad inquiry with respect to policing and public safety in B.C. We are taking a phased approach to this work and have a number of presentations with subject-matter experts, community advocacy organizations, Indigenous communities and others scheduled over the next several weeks.
We also invite British Columbians to participate by providing written submissions beginning Monday, March 1. We will review those submissions with a view to inviting individuals and organizations to present to the committee at a later date.

[9:35 a.m.]

Details are available on our website at www.leg.bc.ca/cmt/rpa. The deadline for written submissions is 5 p.m. on Friday, April 30. Further opportunities to participate will be available at a later phase of the consultation.
The meeting format for today

The deadline for written submissions is 5 p.m. on Friday, April 30. Further opportunities to participate will be available at a later phase of the consultation.
The meeting format for today — the presenters have been organized into small panels. We'll be kicking things off today with presentations related to mental health and addictions as well as social services. Each presenter has 15 minutes for their presentation, and we kindly ask that the presenters be respectful of this time limit.
Following presentations from the panel, there will be time for questions from committee members. At that time, I'll ask the members to raise their hands to indicate that they have a question, and we will keep a speaking list. I also ask that everyone please put themselves on

mute and wait until you are recognized before speaking. All audio from our meetings is broadcast live on our website, and a complete transcript will also be posted.
I'd now ask the members of the committee to introduce themselves.

R. Singh: Rachna Singh, MLA for Surrey–Green Timbers.

K. Kirkpatrick: Hi there. I'm Karin Kirkpatrick, MLA for West Vancouver–Capilano.

G. Begg: Good morning, everyone. I'm Garry Begg, the MLA for Surrey-Guildford.

D. Davies: Good morning, everyone. Dan Davies, the MLA for Peace River North.

D. Routley (Chair): And Deputy Chair of the committee.

A. Olsen: Adam Olsen, MLA, Saanich North and the Islands.

H. Sandhu: Good morning, everyone. I'm Harwinder Sandhu. I'm MLA for Vernon-Monashee.

D. Routley (Chair): MLA Trevor Halford and MLA Rick Glumac will be joining us shortly, I believe.
Assisting the committee today are Karan Riarh and Stephanie Raymond — they are from the Parliamentary Committees Office — and Dwight Schmidt from Hansard Services.
Our first panel includes the Canadian Mental Health Association, VANDU and the British Columbia Schizophrenia Society. I'll now turn it over to the Canadian Mental Health Association for their presentation and introductions.

Presentations on Police Act

CANADIAN MENTAL HEALTH ASSOCIATION, B.C. DIVISION

J. Morris: Good morning, everyone, and thank you, Chair. A pleasure to meet the Deputy Chair and other committee members. Thank you very much indeed for the opportunity to present to your committee this morning.
My name is Jonny Morris, and I work as the chief executive of the provincial office of the Canadian Mental Health Association. I'm joining you this morning from unceded Lək̓ʷəŋiṅəŋ-speaking territories.
You may have slides in front of you. We got them in quite close to the wire, so if you don't, I'll be as visually illustrative as I can be this morning. The presentation that I'm sharing with you is entitled *A Study in Blue and Gray: 20 Years On*. It's really to acknowledge that CMHA, almost 20 years ago, released a report — a seminal report at the time — calling for many of the changes that you as a committee are studying earnestly together.
During the course of my presentation, I have two main objectives — this shows up on the second slide of your decked titled "Objectives": to illustrate and demonstrate the rates of contact between police and people experiencing mental illness in crisis — you've heard from subject-matter experts in the Ministry of Mental Health and Addictions about ten days ago, so likely

we'll echo some of those comments but from a community sector perspective. And then at the tail end of the presentation, I intend to spend a bit of time, for committee members and fellow panelists, to recommended amendments specific to the Police Act to enable a wider range of protective and proactive responses to mental health crises.
So those are my two aims over the course of the next 13 minutes or so.
You likely are familiar with our organization. I won't linger here for too long. We were established in and around 103 years ago. We are a settler organization here in Canada. We operate provincially and have 14 regional offices throughout the province, many of them sitting alongside your constituencies and ridings.

[9:40 a.m.]

We serve over 100 communities to meet local needs. That where a lot of a work we do is — in local partnership around crisis care and response.
In your package, if you see it now or see it later, I've highlighted three reports, just to, again, demonstrate the arc of history

DRAFT SEGMENT 011

and we serve over 100 communities to meet local needs. That's where a lot of the work we do in local partnership around crisis care and response….
In your package, if you see it now or see it later, I've highlighted three reports just to again demonstrate the arc of history of our engagement with these issues. We've worked in partnership with the province, police agencies, community agencies in really trying to reckon with how we can shift mental health and substance use care out of a crisis care response only and into a much more health-driven response here. We are practically moving forward and mobilizing work, actually in a number of constituencies that you represent, working with municipal governments to provide them with advice. We've submitted grant proposals to look at implementing civilian-led crisis teams as an alternative to sole police-involvement teams and would be happy to report on that work to yourselves at a later date as it progresses.
Importantly, I start with three perspectives here that I'll read for the record. At the heart of CMHA's work is this notion of person-centred, the idea of "nothing about us without us" — that we need to start with the perspective of lived and living experience. The perspectives I'm going to read were collected during some crisis care reform work, where there was a strong focus on police involvement in crisis care in the United Kingdom, led by an organization called Mind, which is a sister organization to us.
The first person-centred perspective I invite committee members to listen to is as follows: "When I need urgent help to avert a crisis, I and people close to me know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgment when I say I am close to crisis, and I get fast access to people who help me get better." So a lot in that statement around speed and pace and the right kind of care.
The second perspective I'll bring to the attention of committee members is this notion of: "If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available." I would argue that, for committee members, this is an aspirational state currently here in the province of B.C., notwithstanding the current efforts of the province to improve crisis care in this regard.

Finally, for committee members, the final quote I'll read is: "I get support and treatment from people who have the right skills and who focus on my recovery in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service, this is arranged without unnecessary assessments. If I need longer-term support, this is arranged. Again, this idea of care after crisis, what we need to have in place — and again, I would argue, an aspirational state here in many contexts, in the province, although there is progress underway.

I switch gears slightly here just to provide…. I won't go through every slide, if you have them in front of you, in detail — but a brief explainer of the context, and likely, it will echo testimony that you have heard during your proceedings.

Recent work by Dr. Jamie Livingston…. He's a well-known expert in this space, in this country, and works at Saint Mary's University out east. He conducted a survey that showed that one-quarter of people with mental illness have a history of police arrest in this country. That's one-quarter, and 10 percent have police involved at some point in their pathway to mental health care. One in 100 police encounters involve people living with mental illness. This is according to a police review.

Now, you heard recently, in testimony submitted to you, that the B.C. Ministry of Health reports that one in five interactions with police involves someone with a mental health or substance use problem right here in this province, which appears to be 20 times the average rate of other jurisdictions. So we applaud the work of this committee because, clearly, there is a scale of issue here that we need to attend to.

The next slide is quite busy, if you've got it in front of you. It's got a graph, and it's reporting recent data from the RCMP documenting Mental Health Act occurrences. These are contacts between the police and a person in distress or crisis, subject to section 28 of the province's Mental Health Act.

[9:45 a.m.]

Actually, the data is more broad than that. It looks at data across the country, beyond B.C. You'll see, whilst this data is incomplete, it doesn't factor other calls by police to respond to mental health crises. You'll see, in 2020, B.C. trailing above other

Mental Health Act. Actually, the data is more broad than that. It looks at data across the country, beyond B.C. You'll see, whilst this data is incomplete, it doesn't factor other calls by police to respond to mental health crises. You'll see, in 2020, B.C. trailing above other provinces in this regard.

The punchline here for committee members, under the key findings slide, is that there is a significant discrepancy between the number of calls that the RCMP respond to for a Mental Health Act occurrence and the number of people that actually end up involuntarily admitted into a hospital. We are not calling, for a moment, to say that we want more and more people admitted to hospital. Given that less than 34 percent of RCMP occurrences lead into an involuntary admission, it would beg the question of what happens to the balance. We would hazard a guess that ultimately, those folks end up without care or without the right kind of care post-discharge.

There is a question here. Are the police the most appropriate response to a mental health crisis? Likely, in some cases, but the heart of this presentation is a call to de-emphasize and decentre that, given this discrepancy in the volume of police responses.

A couple of final comments here. We see in data that there are general factors that show a driver that increases the likelihood of an encounter with police: being male; being racialized; being a Black, Indigenous or person of colour; living with bipolar disorder or manic symptoms, schizophrenia being one of them — glad to have Dr. John Gray here this morning; homelessness; and unemployment. Systemic factors are driving some of these rates of police contact.

Finally here, it's important to note that police interactions disproportionately involve Indigenous people. They're ten times more likely to have been shot or killed by a police officer and 56 percent more likely to be victims of crime. That stat is contained on the slide focused on Indigenous people.

There's a busy slide in the middle. You'll see a diagram here. This was based upon some work we did for the Ministry of Health, which defines a visual pathway, which — really, again, the punchline here for committee members — demonstrates that when a police officer responds to someone in a crisis, they have a couple of options in that pathway available to them: arrest and detain and transport to a jail cell, which we would argue is absolutely one of the most problematic experiences that someone in crisis can experience; or transport to hospital. So there are very limited pathways in the option here, and much of this is enshrined in legislation, namely the B.C. Mental Health Act.

Underneath this, though, there is a reality that, for people experiencing police contact, there is an essence of experiencing trauma. You are dealing with a member of law enforcement and public safety, where the stakes are high. We would say here, for the committee's reference, that we need to diversify these pathways and increase the likelihood of health response.

Recognizing that I've got about four and half minutes remaining here for the committee, a couple of final comments here. I think the committee's heard that not all police officers are comprehensively trained to respond and provide stabilization. We would argue that the pendulum has swung too far with police being positioned as mental health responders. People don't always receive the care that they need as the result of a police encounter, and we need to start thinking about deepening that continuum of care. This shows up in Minister Malcolmson's mandate letter as well, which we're encouraged to see.

What would we propose to the committee to consider? Some of this sits outside of your mandate, but we encourage you to have conversations with other folks in government. We would encourage government to ensure a health response for health conditions; mandate and expand on alternatives to police response to people experiencing a mental health crisis — this is on the slide "Ensuring a health response"; identify opportunities for coordination between health authorities, law enforcement and designated community agencies; and examine the implications of the B.C. Mental Health Act, section 28, where there is a driver for police contact with people in distress.

On one of the later slides, you'll see a document that says "Mental health crisis care concordat." This is an example of government intervention in this space in the United Kingdom. So 22 national bodies in the United Kingdom signed on — police, fire, emergency and community agencies — to radically improve crisis care.

[9:50 a.m.]

There are a range of recommendations there: focus on peer supports; establish civilian-led response teams and meet Minister Malcolmson's mandate commitment there; and ensure that co-response models remain a small element of the response system but sole police — i.e., police on their own, responding — are phased out as much as possible.

When it comes to the Police Act and the mandate of

civilian-led response teams and meet Minister Malcolmson's mandate commitment there; and ensure that co-response models remain a small element of the response system but sole police — i.e., police on their own responding — are phased out as much as possible.

When it comes to the Police Act and the mandate of your committee, we have some very specific recommendations for your consideration too.

Under part 2.1 in the act, there's language around provincial policing priorities. What we would call for here is for the legislation to mandate municipal police boards and other policing authorities to align their priorities, goals and objectives more tightly with those established by the minister. This could include strategic directions around mental health care. We would encourage the committee to consider the mandate of developing and periodically reviewing municipal police mental health strategies to guide operational deployment.

In your slide deck, you'll see a capture of the Vancouver police department's mental health strategy released in 2016 — arguably, one of very few strategies in the country that describes a more proportionate response to avoid violence escalation and fatal use of force. We would encourage the committee to find ways for the act to mandate police boards and police departments to really strategically define how they're going to respond to people in crisis.

Finally, two other pieces that we would encourage the committee to consider too. Under part 8.40 of the act, examine the functions of the director of police services and see if the act can legislate and drive standards of police education on how best to interact with people in crisis. We absolutely recognize that the province has implemented mandatory training, but there is an opportunity to regularize the evaluation of that training and make sure that the level of quality is there to ensure that the best response, if police are the only resource available, is conveyed.

Finally — you heard this from the B.C. commissioner on human rights last week — we would also encourage all police forces in B.C. to collect, analyze and disclose race-based and other demographic disaggregated data for the purposes of really examining the systemic issues underpinning police response to people in crisis. This echoes a recommendation I made almost two years ago to the special committee taking a look at the police complaint commission process. It actually ended up in that report. I would encourage committee members to see that link, an important step to systemically understand the scale of the problem here in B.C.

With 12 seconds to go, I thank the committee for listening to my presentation material. It's a lot of content to add into 15 minutes, but I look forward to the opportunity to respond to your questions in a few moments.

D. Routley (Chair): Thank you, Mr. Morris. That's very informative.

Now we have presenters, Mr. O'Donnell and Mr. Tao, from VANDU.

VANDU

V. Tao: Hello. My name's Vince. I'm an organizer at the Vancouver Area Network of Drug Users.

B. O'Donnell: Brian O'Donnell. I'm a community activist with VANDU. I've been there for about four years now, but I've spent 22 years in the Downtown Eastside. So I've seen a lot of

situations with the police, and I'm really concerned with the way things are being run in the Downtown Eastside.
We have a lot of problems here with the policing and how things are, especially with the Mental Health Act and with drug users and mental health. They are completely different. They need a lot more attention, different attention.
Just taking somebody and putting them in jail, especially if they have mental health concerns or drug concerns…. They already have an idea of what the police and the stigma of the police is. They are already the enemy. We have to change the attitude of how people look at the Mental Health Act and the drug addicts on the street. They are people. They're human beings. They need different attention.
There was a concern with a gentleman that was living in the Downtown Eastside. He was antagonized in the middle of the night. It was about 4:30 in the morning. The police were called, and he ended up being shot and killed.
It could have been a lot better, a lot different situation if…. Apparently, there's supposed to be this Car 87. It's been around since 1979. But their response was that they don't run in the nighttime. Now, it should be a 24-hour situation if we need more peer involvement on the street.

[9:55 a.m.]

The police already see us as enemies. If we could have more peer involvement, people responding to people…. It would have been a different situation if the

on the street.
The police already see us as enemies. If we could have more peer involvement, people responding to people…. It would have been a different situation if the person had been more community-based — people who understand what this person would have needed. He wouldn't have been shot. I mean, it would have been a completely different situation.
We know how to communicate with people on the street, people who know the difference between when someone's having a drug crisis or a mental health situation. We see it on a daily basis. We know the difference. Police are trained to see us as the enemy, and we want to change that. We want to see a big, different approach on how the police…. If they show up and pull the guns out immediately, it's going to be a black-white, bad guy–good guy situation. We want to change that.
We're all humans. We're all living in this city. We're all living in society. We want to change how we're looked at, the stigma of how we…. We're taught at a young ago to respect the police. You know, we need the police. In a violent era — right? — people are armed. We want to be able to…. But if you fight fire with fire, it's always going to be disastrous. It's going to be…. We're going to lose, always, in the end. The poor are always looked at as the enemy. It's going to be the end-all problem, right? We want to change that.
We're looking at it as if we were…. If we had some more funding here at VANDU, or if we were called first, before the police were called, we could respond a lot faster and it would be a lot more dignified response for the person, so that they'd feel more comfortable, having a community-based person respond, as opposed to a uniform. It's basically…. That's what I'd feel would be a much better situation — having peer-to-peer, as opposed to control. You know what I mean? "Here's the warden and the inmate." That's the way you feel, right?

If you have the police come after you, you're automatically looked at as the enemy, and we want to change that. The only way to do that would be to have more community-based leadership so that we can have a lot more attention on how…. It's because we know the community. We live with them daily, and the police have a completely different attitude on how they feel about us.

V. Tao: Brian raised a great point here: peer leadership is what we need, not just consultation. We really applaud and appreciate this invitation to this panel, but 15 minutes is not enough. We need 15 weeks or 15 months to work on something like actually reforming the Police Act with you.

It's such a wide-scale…. As Brian was pointing out, the stigmatization doesn't come from just the training. No amount of sensitivity training for an individual officer will change, essentially, the function of the police. As Brian was saying, this kind of distinction of seeing people in crisis — people with addictions, people using on the streets — as nuisances or, at worst, as enemies, is actually a function of what the police does with that rights side.

A lot of what we do here is that we try to bring out, to the rest of the city and the rest of the public, a real image of what actually happens. How do police interactions play out on the streets? What we hear from our members at VANDU is that the police, their presence, is felt as an invading army here, and that every person on the street — who's, let's say, sleeping on a corner, who's trying to have a survival tent — is again, in the eyes of the police, seen as a problem, right? That's a deep, structural stigmatization that can't be blown away by just a few trainings.

We wanted to kind of get into a few issues here, specific to the Police Act. I think that the last presenter did a fantastic job with laying out a lot of the priorities that we want to also push. But at the level of the police board, I would say…. We looked into our municipal police board, and it's ten unelected, appointed people that have four-year terms. If you look at their résumés, it's not the people from the community, let's say, right?

[10:00 a.m.]

It's real estate developers and lawyers. There's a crime fiction writer on there — people with, let's say, property interests in our neighbourhood. They are the ones that are deciding the priorities of the police in this neighbourhood, and of course they will have this skewed kind of perspective, right?

DRAFT SEGMENT 031

There's a crime fiction writer on there — people with, let's say, property interests in our neighbourhood. They are the ones that are deciding the priorities of the police in this neighbourhood, and of course they will have this skewed kind of perspective, right? Ultimately it comes down to property over people.

So if there was a reform of part 5 of the Police Act on the police board that we would have, at the very least, an elected seat from the community…. I would say that we need more than that. We need a civilian board to be able to counter and review the police budget that the municipal police board comes up with every year, the annual provisional police budget.

Otherwise, the interests, the direction, the strategy of the police will be decided by, unanimously, a board of people that have an interest in clearing the Downtown Eastside, clearing the streets — people that want to gentrify the neighbourhood to make profit. Essentially, they will never have our interests in mind.

The other thing is that…. Brian brought up the situation. There was a man named Chester who was shot and killed by the police early in the morning on January 5. It was the beginning of the year. We asked the questions of why police were the first to be called. Where was Car 87? You know, it's meant to be a collaboration between the health authority and the police. Why was it not on scene? Why was the first response, seeing this man, who was naked and in distress on the street at four in the morning…? Why was he shot four times in the chest and killed?

There's a lot to say about the response, I guess the tactics and strategy around response. The last presenter, again, laid out some very important points on how to reform that. But then there are all the questions of: how did we get there? What are all the conditions that led Chester to have that crisis on the streets? There must have been weeks, months, of distress, of poverty, of isolation. He was living in supportive housing. How did they let the situation get to that point?

When Brian talks about what we want to see, it's peer leadership in crisis response. Again, we know each other here. If you know the Downtown Eastside, it's a notorious neighbourhood, and people like to paint it in a lot of ways, but really, this is the only neighbourhood where everyone knows each other's names. Really, people know each other here, and this comes from decades of struggle and neglect, state neglect. It pushes people together and forms a solidarity and community. Nowhere else in the city, nowhere else in Vancouver….

B. O'Donnell: If not the planet.

V. Tao: If not the planet.

As such, if someone like Chester was going into crisis and we had a close-knit, supported community, if a lot of the funds going right now to the police were going into getting people paid and trained up to be able to do this work in the community, maybe it wouldn't have led to the murder of this man by the hands of police, right?

B. O'Donnell: No, and that's how we feel in this community. It feels like murder. Even though it's an extreme, horrible statement to say, it feels like that. In the community, it really felt we were let down. We need more community involvement. If people from the community could have responded, the person would not have died. I know this for a 100 percent fact.

It was painted up that they were armed and had to detain the situation, but it was never that situation. The person was antagonized, and he was completely naked. He had some piece of metal in his hand. It got painted up that he had a sword. It was all painted up wrong. He was not a villain. He was not a danger. He was in distress, and he needed some serious help, and he never got it. He got killed instead.

That's just one example of many things that I've seen in the Downtown Eastside, if not all over Vancouver, but more so. The police are trained to treat us as enemy, and that's got to be changed. Even though we can't retrain everybody, training in a new situation, like having us have more funding or at least some funding so we can see a future that will be less of a fight, of a war…. If we call it that, it's going to be that. If we call it black-white, enemy, hero, it's always going to be like that. We have to find a medium ground. Human beings are unpredictable, and we need more of a polite or safe situation for people so they can feel not fear but safety, actual safety in this community.

[10:05 a.m.]

V. Tao: I think that brings us to our last…. If we can focus in on one part, another part of the Police Act is about the complainant investigation system, part 7.1. People on the street here face daily harassment from the police. They have things taken from them.

actual safety in this community.

V. Tao: I think that brings us to our last…. If we can focus in on one part, another part of the Police Act is about the complaint investigation system, part 7.1. People on the street here face daily harassment from the police. They have things taken from them. They're being pushed around. They're having their tents ripped down. Their home has been taken away. We're often told: "Hey, you should just use the police complaint system."
Of course, it's like said, Brian….

B. O'Donnell: You're painting a target on yourself, basically, if you go, because the police complaint is with the police department. So you can't go to the Ombudsman or even to an MLA, because they will tell you to go to the police. You have to go through the protocol with that situation.
Police stick together. They're not going to be sticking with us. So if we complain, they're the only ones who are going to see the complaint, and we're in fear of that. We need a better situation to express our opinion.

V. Tao: Yes. We need a better complaint and investigation situation, because again…. With Chester's death, it will be [inaudible recording] investigation system within the police that will be looking into it. We looked into it as well. As soon as we found about Chester's death, we launched a community investigation to find out what his name was, what people had seen and how to find his family, because none of this was released.
There was a traumatic event in the Downtown Eastside, but there was silence from the police, and so we took it upon ourselves to look into it. I think that this is what we need. We need peer-led, community-led forms of complaint systems, investigation systems, that are, again, not embedded into the police system already but actually can act as a civilian counterpower to it.
I think that's our time.

B. O'Donnell: It's pretty close. We appreciate everything. Thank you very much.

V. Tao: And thank you to our last presenter. You did a good job.

B. O'Donnell: A very good job. Thank you.

V. Tao: Also, we may have to switch computers because this one's running out of batteries. But thank you guys so much. We might pop out and come back in.

D. Routley (Chair): Thank you. If you pop out, I hope you come back if you've got questions.
Our next presenter is Mr. John Gray, from the B.C. Schizophrenia Society.
Go ahead, Mr. Gray.

B.C. SCHIZOPHRENIA SOCIETY

J. Gray: Good morning, committee, and thank you for this invitation. I'm John Gray. I'm vice president of the British Columbia Schizophrenia Society, and I'm very grateful to live and work on the unceded traditional territories of the Esquimalt Nation and the Songhees Nation. We very much appreciate this opportunity for input into your important work.

The police are very important in our mission to improve services for those with schizophrenia and psychosis, especially in applying the Mental Health Act. An influential member of our board was former chief of police Jamie Graham, whom some of you I'm sure will know, and we currently have a member of the police department on our public policy committee.

The police are being called by many family members to help with a loved one whose behaviour caused by serious mental illness is also causing safety concerns. Attached to your presentation, hopefully, is a survey that we did of over 50 families. This is the one that….

Is it attached, Mr. Chair, to your presentation?

D. Routley (Chair): It has been forwarded to us.

J. Gray: Excellent. It's really quite gripping, because it describes these incidents where the police have been called. Most of the incidents were resolved satisfactorily, especially the ones where the police officer was accompanied by a nurse.

What I want to do in my presentation is to discuss why the police are involved with serious mental illness, why BCSS is involved and interested in this review, what the current challenges are of police under the Mental Health Act — some of them — improving wellness checks, reducing police time waiting and escorting, a few other issues and then finish with comments on planning and coordination of services.

[10:10 a.m.]

So why are the police involved with serious mental illnesses, because they're not involved with cancer or those other very serious illnesses? Police, at times, are directly involved with people with serious mental illnesses such as schizophrenia and bipolar because their psychotic symptoms can cause the person to act out, act bizarrely or endanger

with serious mental illnesses because they're not involved with cancer or those other very serious illnesses.

Police, at times, are directly involved with people with serious mental illnesses, such as schizophrenia and bipolar, because their psychotic symptoms can cause a person to act out, act bizarrely or endanger their own safety or the safety of others. That is when the police are involved.

If the police cannot persuade a person to obtain help voluntarily, a police officer, under the Mental Health Act, can apprehend the person if they meet that criteria and take the person to a physician for an examination. Even when the threat to safety is not present, police are called to deal with individuals in crisis because they are often the only ones who respond 24-7. That's an issue that people have been raising. This is at the heart of what needs to be addressed.

Why is BCSS interested in this particular police review? Well, the major issues are to support the current Mental Health Act police powers, such as wellness checks, to support the idea of police and mental health teams as a means of reducing police involvement and to suggest some changes to help reduce the time police spend in escorting patients, thus freeing up police for other duties.

How does the police apprehension work under the Mental Health Act? The criteria that you're probably familiar with are that a police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person is acting in a manner likely to endanger that person's own safety or the safety of others and that the person is apparently a person with a mental disorder.

The safety criteria is an issue. The safety issue appears to be narrower than what the physician, who makes the ultimate decision, has, because the physician's criteria is to prevent his or her substantial mental or physical deterioration or for the protection of the person or the protection of others. Safety is interpreted by some police officers to mean only severe physical safety, and we've had reports from a number of clinicians and family members that this narrow definition of safety has led to great difficulty because a person wasn't taken to hospital.

There appears to be two ways to address this interpretation of the safety issue. The first is to define it broadly so that it's more like the protection concept used by physicians. This would not require a change to the Mental Health Act, and as the MacCaucle Supreme Court of B.C. said, in this context: "In this context, the word 'safety' goes beyond mere protection from the infliction of physical injury."

Some other provinces deal with the safety issue and the physician issue by having exactly the same criteria but that the physician must be more certain of the criteria than the police officer. That's in Newfoundland and various other provinces.

Wellness checks — we hear a lot about wellness checks. Some of them have gone very wrong. BCSS advocates for more police and mental health worker teams modeled after Car 87 in Vancouver. As you've heard, the major complaint we hear about them is that they're not there when people need them.

You may ask: why not use two mental health workers instead of a mental health worker and a police officer? Firstly, there are often safety concerns with these calls, and if a person does need to be examined under the Mental Health Act, those two staff don't have the authority to do that, so a police officer would have to be called, or a physician, and therefore it makes more sense to have both a police officer and a mental health worker.

[10:15 a.m.]

As was pointed out by other people, the police receive a very sizeable number of mental health calls. For example, in the Kelowna area, 760,000 people live there, and there were 15,000 calls. In terms of what happened to those calls, 17 percent were apprehended under the Mental Health Act. So it's a good point that Jonny was making before about what happens to those other

people live there, and there were 15,000 calls. Now, in terms of what happened to those calls, 17 percent were apprehended under the Mental Health Act, so it's a good point that Jonny was making before about what happens to that other, large number of people who had police attend.

Recently, the chief superintendent of the RCMP in southern B.C. issued a statement in support of police mental health professional teams. He wrote: "I want to commend Interior Health and our detachments for creating the program" — that's the police nurse — "which has proven to be very effective in the response to mental health calls, de-escalating people in crisis, and when treatment is necessary, easing their referral into the health care system to obtain the best health care. My goal is to greatly expand this needed service at existing locations, as it is not always possible, and introduce it into as many of our communities as possible."

He makes this other important point. "If there is an inability to provide a dedicated Interior Health nurse for every call, then I want to implement an information-sharing model. I want to build a sustained corporate-based infrastructure for all mental health calls."

This police mental health professional service, which has been advocated by a number of people, has been in place for a long period of time in Vancouver, for example. It doesn't require any change in the Mental Health Act in order to expand it. BCSS would recommend to expand the police mental health response model to all B.C. communities and create a database of information and resource sharing.

Another big issue that police have is reducing the amount of time that they use in waiting and escorting people. Here are a few suggestions.

The first one: transporting from a first certificate, which is made by the physician, to the facility. The Mental Health Act says that a medical certificate that the physician has completed "is authority for anyone to apprehend the person to be admitted, and for the transportation, admission and detention for treatment…." The act allows for anyone, and this could include mental health staff, sheriffs, relatives, ambulance personnel, etc. Of course, if it's not safe, then the police would be involved, but the advantage is that it can reduce police resources.

Another issue that police have in terms of escorting people is returning them when they have left the hospital without authority or returning them from extended leave, which should be becoming more of an issue. People are required to, let's say, take medication, and then they don't show up, and the police can be asked to do that. It's done on what's called form 21. It's used to bring someone back to hospital if they left without permission, or to return a person from extended leave. It's directed to all peace officers, and it's completed by the director of the psychiatric unit.

What we recommend is that form 21 be modified to include all peace officers and others designated by the director. That would reduce the need for police time. A number of other provinces do exactly that. In Saskatchewan, for example, it says that the certificate is sufficient authority for any peace officer or other person named or described in the order to apprehend.

Another big issue is long waits for police officers with a person in emergency waiting to be admitted. Once at the hospital, the officer or other person must maintain control until the physician has examined the person. This can take hours. BCSS and the B.C. Psychiatric Association have completed a report calling for more acute and long-term beds, and that's referenced at the bottom of your document. If implemented, that would certainly help. There are a number of initiatives throughout the country on this issue, and the one that's well described and referenced at the bottom of your document showed a 57 percent decrease in wait times when there was good cooperation.

[10:20 a.m.]

There's another excellent document by BCSS, which is on the federal government's website, entitled *Police Intervention in Emergency Psychiatric Care: a Blueprint for Change*. That describes a number of initiatives

times when there was good cooperation. There's another excellent document by BCSS, which is on the federal government's website, entitled *Police Intervention in Emergency Psychiatric Care: A Blueprint for Change*. And that describes a number of initiatives across the country that would be of interest to you.

Training has been mentioned. BCSS has trained some police departments, especially emphasizing how a psychotic illness can influence the person's behaviour and a good police response to it.

Another issue that is not involved in this family review that we did is police case finding. Police go to places where mental health workers often don't go — tent cities when people are arrested and police cells and so on. So I think this is a very important issue for training and for sensitization for police.

An issue which is not an issue now…. There's a charter challenge to the Mental Health Act that would allow involuntary patients to refuse a treatment that they need in order to recover and be released. That may have some impact on police departments later on.

Let me finish, then, with some thoughts about planning and cooperation and coordination. Planning, in many ways, starts at the health authority and by developing ACT teams, more beds, selective training, especially emphasizing the needs of people with serious mental illness. At the joint level, the police community and hospital mental health staff are essential. In Vancouver, as was pointed out before, their police board there, their health board and the province's health board developed what's called Project LINK, and there's good literature on that. This is what they concluded: that these teams, these mental health and police teams, have greatly reduced negative contacts with the police, emergency room visits, victimization and criminal justice involvement for those living with mental health and substance abuse. The problem, as I mentioned before, is that it's an excellent service but there's not enough of it.

The ministry itself has put out a document called *Interfaces Between Mental Health and Substance Use Services and Police*, and that is very helpful as well.

At the provincial level, obviously there has to be coordination there. We would echo the comments made to this committee by the Assistant Deputy Minister of Public Safety when he expressed the need for cross-ministerial strategies, and we quote him at the end of the paper.

In conclusion, BCSS is committed to the families and our loved ones who live every day with brain illnesses that sometimes require police support. Our hope is that your efforts as a special committee will find ways to support and expand coordinated services and retain mental health legislation that is essential to the well-being of the most vulnerable, seriously mentally ill and addicted individuals in our province. Thank you.

D. Routley (Chair): Thank you, Mr. Gray. Much appreciated, and to all the presenters, thank you very much. At this point, we will move to questions from members. If members would indicate their desire to ask a question.

K. Kirkpatrick: Hi there. Thank you all very much. Those were all very powerful presentations. My first question to Jonathan Morris. You were talking about those quotes being aspirational. Now, are they aspirational just for British Columbia, or were they aspirational across the country? It sounded to me like British Columbia is a little bit behind some of the other jurisdictions.

J. Morris: Thank you, MLA Kirkpatrick, for your questions. I think, in the context in which these quotes were generated, they were definitely aspirational, which was the United Kingdom.

[10:25 a.m.]

I think from the experiences we hear from, people who are accessing our services, there's absolutely a clear road to go here in B.C. around joining up all of the systems that are required to coordinate care. Dr. Gray made this comment. Brian and Vince made this comment as well. I would say this is felt across the country too.

experiences we hear from people who are accessing our services.
There's absolutely a road to go here in B.C. around joining up all of the systems that are required to coordinate care. Dr. Gray made this comment. Brian and Vince made this comment as well.
I would say this is felt across the country, too. I think the interesting part is that the rates of police involvement here in B.C., at least at face value, appear to be higher than other jurisdictions, which points to something. Also, the rates of involuntary admission here have continued to increase.
I would say, across Canada, we absolutely have a road to go to get to a level of crisis care where people can ask for the right care and get that care at the right time. So I wouldn't say it's restricted to B.C., but I would say definitely that there's opportunity here to continue working together. Thank you for your question.

K. Kirkpatrick: Thank you. Mr. Chair, may I ask another question to a different group? Okay. I've got a question for Brian and Vince. I had a couple, but I'm just going to focus it to one.
You talk about the ability for this peer leadership and for an organization within the community to be the first point of contact or the first call. Now, I've spent time in the Downtown Eastside. I've worked with some groups down there. One of the things I found is that it's really hard to navigate in terms of the many non-profits in the community and the work that they do. Do you have in mind a group that would be appropriate to build this function around? Would it be your group, or a collaboration, rather than creating yet another group within the Downtown Eastside?
I don't know if that's a fair question, but it does get a bit complicated down there.

V. Tao: Thank you for that question I think you're right. There are a lot of non-profits here. Brian, what would you…?

B. O'Donnell: I say for us, definitely…. VANDU is definitely at the heart of the community. [Audio interrupted] start another one. We already have a community base and education group here, and we're very supportive of our community. We could start right here. We're going to do [audio interrupted.]

V. Tao: I think why VANDU and its sister organizations like the Western Aboriginal Harm Reduction Society and the BCAPOM, which is the B.C. Association of People on Opiate Maintenance…. Why our model is different from others in the neighbourhood….
There used to be organizations more like VANDU. We're membership-based. That means that our members are all users, all underhoused or unhoused people. We have a democratic structure run by a board of peers. That leadership structure is really what's key to the strength of VANDU and other organizations that use the same model. It's not like a board of a non-profit — people outside the neighbourhood governing over an organization of peers. It's a peer-led organization.
If there is a possibility in the future of other organizations coming up, other organizations across B.C. that have the same model, we would look to them as, I think, the leaders of this kind of….
Thank you so much for that question. Really appreciate it.

D. Routley (Chair): We have MLA Begg and then MLA Singh.

G. Begg: Not a question but a comment, particularly aimed at Dr. Gray. That is that you capsulized, at least in my mind, the importance of the coordination of services. This is a vast province, and the ability to respond in Vancouver is quite different from the ability to respond in Vanderhoof or whatever. I think that this committee is interested in any other ideas that you might have, Dr. Gray, on how we can address those issues.
The B.C. Police Act applies all across the province, but obviously, various jurisdictions don't have the resources necessary. The challenge for us, of course, is to find that…. Middle ground is not the right word, but that sweet spot where we can have legislation introduced into the Police Act that accounts for those variabilities. I know I'm stating the obvious, but it's important to recognize that we have a global responsibility to many areas that are underserved not only in mental health but in policing and other things as well.

[10:30 a.m.]

Thank you very much for helping us focus provincewide and not only in those areas that may account for the biggest examples of negative interactions between the police and

things as well.
Thank you very much for helping us focus provincewide and not only in those areas that may account for the biggest examples of negative interactions between the police and those persons with mental illnesses. Thank you.

J. Gray: Could I make a quick comment?

D. Routley (Chair): Of course.

J. Gray: Yeah, it is a problem. It's a problem in all provinces. The only thing I can think of, apart from increasing the numbers of police officers and mental health workers in Vanderhoof or wherever, is the use of technology. I mean, now we're all Zooming, for example, and telepsychiatry, as it has been called, has been around for quite awhile. It has been shown to be effective, as good in terms of therapy as face to face. But I think that the situations we're talking about are more a crisis, and the idea that you might have, let's say, an on-call psychiatrist who….
A police officer who is in Vanderhoof or wherever can then very quickly get a consultation on that. Now, it may not be that practical, but I can't think of, apart from increasing the numbers of staff, which isn't practical, anything other than the use of some sort of technology.
That's a good question, a very important question.

R. Singh: Thank you so much, and I would really like to thank all the presenters for giving such important information about this very complex issue.
Jonathan, one question for you. When you talk about…. We have heard from a lot of…. In my work as an MLA, I hear from a lot of the community members who are at a loss when they have a family member who has mental health issues. And when they are in a state…. It was mentioned in your presentation and other presentations as well, but when a person is in a state of distress and the family members just don't know where to go, the police are their only resource. This is

becoming very obvious. We need to have more resources. Car 87 is a great example. But at that time, in the middle of the night especially, when the other services are not available, the police are the only resource.
What would you suggest? We are hearing of partnering with community organizations, which is great, and that is, I think, examples like Car 87. They need to be expanded. What are we looking for, just from the practical point of view? When a person is in distress and calling the police, what extra are we looking for here?

J. Morris: Thank you, MLA Singh, for your excellent question. The advice I'd offer to the committee is threefold, and I'll be brief, recognizing time. First, each of the presenters today, and I think you've heard this before, have talked about coordination. I don't think we will tinker our way out of the problem. Changing things at the edges is not going to work. We've tried that for a long time. Seismic reform can be achieved through the coordination across B.C., and I think MLA Begg's comment is incredibly important, because we need to ensure equity for rural and remote communities.
It has been achieved in the United Kingdom and has been achieved elsewhere where that coordination means that the right arm knows what the left arm is doing, and there can be a very clear publicly available resource that people can call at two in the morning or five in the morning. Through those agreements, people can know where to turn, whether it be a crisis line, whether it be police, whether it be 211 or 811. We need to harmonize things so that you can ask once and can get that help fast.

[10:35 a.m.]

The second piece, I think, is to leverage imagination around the plurality of responses that are available. Sweden, 18 months ago, launched the first-ever mental health paramedic service in the world. They've launched an ambulance service that looks like a therapy room on wheels, and the early results have demonstrated, like elsewhere, that police have not needed to be called. The mental health response or mental health paramedics have been enough to resolve, de-escalate and reduce the likelihood of injury or fatal encounter. I think that's remarkable — to see that, and what we could explore here.

results have demonstrated, like elsewhere, that police have not needed to be called. The mental health response, or mental health paramedics, have been enough to resolve, de-escalate and reduce the likelihood of injury or a fatal encounter. I think that's remarkable to see that and what we could explore here.
I think, third, MLA Singh, we hear that too. Actually, despite the fact that agencies like mine and VANDU and B.C. Schizophrenia…. We offer a vast array of public services. We have a range of public services. But we actually, I think, collectively have to do better to make sure that that message proliferates into communities that you serve and people have that awareness of where they can go before crisis.
Hopefully, those three points start to answer your excellent question, MLA Singh.

R. Singh: I'm really thankful for that. I really, really appreciate that. Also, I want to comment about, especially in our communities and in other communities as well, the stigma attached with mental health, right, and the resistance by so many of our community members to seek out the

services that are available. The police is the one that comes to mind, but these services that you are offering do not come to mind for many people. So thank you so much for that.
I just have one comment for Brian and Vince — not a question, just a comment. The passion that you bring in here, the way you talked about the lived experience…. That tells a lot to us. It really talks about the challenges that are being faced by the people who are in the Downtown Eastside — and many other parts of the province — and what they are going through. Thank you so much.

A. Olsen: Thank you to the three presenters — very important information. I really appreciate the work you do. I have had the opportunity and the benefit of visiting VANDU sites, and I want to thank you for the important work that you do in one of the toughest neighbourhoods in our province. The compassion and the love that you show our fellow citizens and human beings is…. I was going to use the word "remarkable," but that would be, probably, the wrong word to use. Thank you. I'll just leave it at that.
I have a question for Jonny, just in terms of the Mental Health Act. Perhaps you didn't come prepared for this, but maybe you can answer it. Maybe you can't. If you can't, perhaps you can provide some information in the future.
I'm just wondering where the Mental Health Act and the Police Act intersect. We've heard a lot about the wait times. Is there anything on the other side of this that maybe, perhaps, we can recommend to the Ministry of Mental Health and Addictions? In terms of making that act — the Mental Health Act, that is…. If we're making recommendations to PSSG, Public Safety and Solicitor General, to make some changes to the Police Act, are there any changes that need to be made to the Mental Health Act to ensure that there is that smooth relationship between these two pieces of legislation that currently people are finding themselves caught in between? We want to make sure that there is just a smooth transition between the two.

J. Morris: MLA Olsen, I appreciate your question very, very much. I do appreciate the comments of my colleague, Dr. John Gray, with his commentary on the Mental Health Act, too. In my materials, at the very least, we would actually….
We've been on record, calling upon the government, as you're doing with the Police Act, to take the opportunity to do a similar close look at the Mental Health Act, given that it is dated 1996 and beyond. There is an opportunity to bring the Mental Health Act into this century with systemic reform and review. I would reserve those comments to, hopefully, another special committee or a separate submission to the province. There are many of us looking closely at that, with the interests of keeping people safe but also ensuring that that act reflects modern mental health and substance use care.

[10:40 a.m.]

To your comment, I would draw committee members' attention to section 28 in the Mental Health Act. The act lays out, as Dr. Gray explained very eloquently and clearly, a driver that positions police as the conveyor to hospitals and places of safety. Other jurisdictions, including the United Kingdom and elsewhere, have taken a close look at that. They've really mandated who can transport people to hospitals. Is it okay, when you're experiencing a health condition where there is no safety issue present, to be transported in a police vehicle? Surely, an ambulance would be the better way.

I think you're on to something, MLA Olsen. You could make all of the

or people to hospitals.
Is it okay when you're experiencing a health condition where there is no safety issue present to be transported in a police vehicle? Surely, an ambulance would be the better way.
I think you're on to something, MLA Olsen. You could make all the reforms you make to the Police Act, but I would say that there is a need to cast an eye over to that piece of legislation, the Mental Health Act. Some of the changes you make over here may not have the reform pace that you're looking for given that there are some changes needed in the Mental Health Act.
I would call for some parallel explanation — I know a committee hasn't been struck — and to think about the effects of a piece of legislation, like the Mental Health Act, that specifically defines the role of police officers. Maybe there is a widening there if we're all collectively behind the idea that we want to see more of a health response for mental health conditions — a response, as MLA Singh says, that does not further stigmatize people.
I think your question is powerful, MLA Olsen, and would be happy to speak further about that in the future.

D. Routley (Chair): Thank you, all. I don't see more questions, but I would add, from my own perspective, that this has been all about perspective. We appreciate the national and provincial context that's been brought, as well as the very local context that we've seen here.
With that, Members, I'd like to thank the guests for their appearance and contribution and ask them if they might be willing to contribute further, if necessary. Thank you very much.
I know that Mr. Gray was the principal author of *Canadian Mental Health Law and Policy* and has much to say in terms of context, and Mr. Morris has these relationships with other organizations.
I know I've sort of said thank you and good bye, but a question just comes to mind. Either one of your might want to answer it. Which do you consider to the leading jurisdiction in Canada when it comes to mental health law and policy and evolution, and where should we look?

J. Morris: Dr. Gray, you go first.

J. Gray: Paradoxically, I think, and many people in Ontario agree, that B.C. in fact has a progressive mental health act. The reason that I say that is because…. Two reasons. There are two big issues in mental health acts, not to prolong this. The first is the criteria that are used. B.C.'s now is — other provinces have followed us — relatively broad. It doesn't have to be physical danger as the only way you can be admitted and treated.
The other thing about B.C. is that it allows for treatment of people who are involuntarily detained. In Ontario, for example, a person can be involuntarily detained and refuse treatment. We've got examples — in fact, it's in our brief there — showing people being kept in isolation, seclusion, for 404 days, and other people in hospital for five years, because they could refuse treatment. That can't happen in B.C.
There are certainly…. As Jonny pointed out, it's an oldish act. There are some wording things. There is probably more oversight that needs to be there, etc. But in terms of the fundamental issues of if a person is involuntarily detained, they can refuse treatment, that's not a good thing for many people.

J. Morris: Chair Routley, an excellent question. I know you're drawing to a close, so I'll be brief too.
I would say the conversations that are happening here in this province, the fact that we have an established Ministry of Mental Health and Addictions — in full transparency, I used to work there, briefly — I think point to such an opportunity for progressive leadership in this province.

[10:45 a.m.]

I think the diversity of perspectives, as you said, Chair Routley, at this table, point to the dialogues and the seismic changes that are required. I would say this committee stands to not tinker with the problem but stands to support that reform.
As you conduct your work, I would call attention to work done in Ontario in this space.

as you said, Chair Routley, at this table, pointing to the dialogue and the seismic changes that are required. I would say that this committee stands to not tinker with the problem but to support that reform.
As you conduct your work, I would call your attention to work done in Ontario in this space. There has been some very, very powerful work, in alignment with VANDU's recommendations around peer-assisted crisis teams. We're looking at that model, actually, in North and West Vancouver. MLA Kirkpatrick, you may be interested in our work, and we could brief you separately.
I would take a look at the United Kingdom's work — they've engaged in legislative reform within their current political space — at Sweden and at New Zealand. I think New Zealand is notable because in their legislative reform, they've done a remarkable job of integration of Indigenous ways of knowing, doing and being, alongside their mental health–based legislation. Those would be some examples.
I would say I leave these presentations, Chair Routley, feeling a significant amount of hope for the policy change that you're charged with leading as Members of the Legislative Assembly. Thank you for the gift of that question, Chair.

D. Routley (Chair): Thank you. Just as a concluding comment to Brian and Vince, my sister lives in East Van. Being an Island boy, when she moved to East Van, we were concerned, but it has been a closeness of community. I went to community events in her neighbourhood at Main and Kingsway, and there was this really tight-knit community sense. That obviously is a huge strength, which you referred to.
Thank you all very much. We appreciate your contribution to our committee, and thank you for presenting.

J. Gray: And we thank you as well, I'm sure.

D. Routley (Chair): Members, we have another presentation scheduled at 11 o'clock. We'll take a short break until then. If people could come back a couple of minutes before 11, that would be much appreciated.

The committee recessed from 10:47 a.m. to 10:59 a.m.

DRAFT SEGMENT 086

The committee recessed from 10:47 a.m. to 10:59 a.m.

[J. Routley in the chair.]

D. Routley (Chair): Welcome, our presenters. My name is Doug Routley. I'm the Chair of the Special Committee on Reforming the Police Act in British Columbia. I'm joined by a number of MLAs on the committee. The Deputy Chair is MLA Davies.
Could members introduce themselves?

D. Davies (Deputy Chair): Good afternoon, where I'm calling you from. Good morning, probably, where you're at. I'm Dan Davies, the MLA for Peace River North and Deputy Chair of the committee. Thanks for joining us today.

[11:00 a.m.]

G. Begg: Good morning. I'm Garry Begg. I'm the MLA for Surrey-Guildford.

R. Singh: Good morning. I'm Rachna Singh, MLA for Surrey–Green Timbers.

K. Kirkpatrick: Hi. I'm Karin Kirkpatrick. I'm the MLA for West Vancouver–Capilano.

DRAFT SEGMENT 091

G. Begg: Good morning. I'm Garry Begg. I'm the MLA for Surrey-Guildford.

R. Singh: Good morning. Rachna Singh, MLA for Surrey–Green Timbers.

K. Kirkpatrick: Hi. I'm Karin Kirkpatrick. I'm the MLA for West Vancouver–Capilano.
You probably know, Tim, Terry Anne Boyles, who used to be my board chair at Family Services.

T. Halford: Trevor Halford, MLA Surrey–White Rock.

A. Olsen: Adam Olsen, MLA Saanich North and the Islands.

D. Routley (Chair): Thanks very much, everybody.
Oh and MLA Sandhu, I've missed. MLA Sandhu will be joining us.
With that, I'd ask the presenters to go ahead, with the understanding that our committee at this stage is made up of panels and each presenter given 15 minutes to present. The committee hopes that panelists can respect the 15-minute time limit. Then, following that, there will be questions from members.
I'd also ask that all members of the meeting put yourselves on mute and wait until you're recognized before speaking. All audio is being broadcast live on our website and a complete transcript will also be posted.
I'll ask the presenters to go ahead and introduce themselves, beginning with the B.C. Association of Social Workers — Mr. Michael Crawford and Dr. Craig Norris.

B.C. ASSOCIATION OF SOCIAL WORKERS

M. Crawford: Good morning, Mr. Chair and committee members. I'm Michael Crawford, I'm the president of the B.C. Association of Social Workers.
I'm joining you today from Kamloops, which is the unceded territory of the Secwépemc Peoples.
I'm joined today by Dr. Craig Norris, a member of our association who will be the main speaker.
I just want to tell you very briefly about our association.
The British Columbia Association of Social Workers is a not-for-profit membership-based association, and we support and promote the profession of social work in British Columbia. The BCASW is one of the provincial and territorial associations, and together we have a partnership, nationally. That's the Canadian Association of Social Workers. Through that, we support the work of the International Federation of Social Workers.
We've been around a while. We were incorporated in 1956. We have branches throughout the province, and our members work in a variety of areas. Perhaps of concern for today would be mental health, addictions, poverty, housing, crisis response, etc.
I want to thank you for the opportunity to meet with your committee today, and thank you, also, for that one item in your terms of reference where you focus on the role of police with respect to complex social issues, including mental health and wellness, addiction and harm reduction.
Now I'll turn this over to you, Dr. Craig Norris.

C. Norris: Morning. My name is Craig Norris. I'm a registered clinical social worker in the province of B.C. I'm also a proud member of the BCASW.
I want to acknowledge that currently I'm a settler on the traditional and unceded territories of the Songhees and Esquimalt First Nations.
I'm thankful to Michael and the BCASW for inviting me to be part of this presentation to the Special Committee on Reforming the Police Act. But I want to make clear that my presentation is going to focus on findings from independent research that was not funded nor directed by the BCASW, and while I appreciate their invitation to present, I'm making no claims that my findings necessarily speak for the organization, its members or my employers.
Would you like me to just continue and go through with the presentation, or were you asking me to introduce myself?

D. Routley (Chair): Please continue.

C. Norris: Okay.
By way of background, I hold a PhD in public health from the faculty of health sciences at Simon Fraser University. I have a master of social work degree from UBC. I also hold an undergraduate degree in criminology from Simon Fraser University.
So my vocational experience has been both as a clinician and a researcher, mostly in the field of mental health, and so I've worked in a variety of contexts, ranging from emergency room psychiatry and correctional health care, as well as tertiary and community mental health.

[11:05 a.m.]

I've also worked on mental health treatment teams that were in some way partnered with the police. For example, I was the first social worker to ever work in the Car 87 emergency mental

health services. I also worked on assertive community treatment, or ACT, teams that had embedded police officers.
The focus of my PhD research was

I've also worked on mental health treatment teams that were in some way partnered with the police. For example, I was the first social worker to ever work in the Car 87 emergency mental health services. I also worked on assertive community treatment or ACT teams that had embedded police officers.
The focus of my PhD research was an exploratory investigation, looking at experiences of both service providers and consumers on police-embedded ACT teams in the Lower Mainland. I want to emphasize exploratory because it is important to note that although the ACT model itself is over 40 years old, the police-embedded adaptation in B.C. is unique, and it had yet to receive scientific scrutiny when I started my research. So my hope was that my research would begin that process of evaluating the model that we have here.
I've included some slides that were sent out that have some demographic information about the ACT consumers or clients who participated in my research. I also included a slide with some basic information about what the ACT model is. I'm not going to be able to have time to go through that, but I just wanted it as some basic information for the committee members. I also included a couple of data excerpts from two of my participants because I thought it was important for you to have some of the words of some of my participants, as well, that relate to the findings I'm going to talk about today.
It ended up that my research was quite timely. Since I embarked on it, discussions about the roles that police take with regards to mental health and social issues have intensified in B.C. I also highlight that there's been increasing acknowledgement that structural racism is present, both in our criminal justice and health care systems, and that some people are overrepresented with regards to criminal justice involvement and underserviced by our health care system.
We now are seeing opening questioning with regards to alternatives to police being the de facto, 24-7 a day responders to people experiencing mental health crises. There have been increased calls for things like the decriminalization of drugs and a public health rather than criminal justice response to people who use substances.
Why is ACT important, and why should my research matter to this committee? In part, because in B.C., ACT provides an example of partnership between policing and mental health treatment. I want to emphasize treatment because previous partnerships in this province have been in the realm of crisis response. So programs like I've talked about before, Car 87 in Vancouver, Car 67 in Surrey, Fox 40 in Richmond, Car 60 in Prince George and Car 40 in Kamloops — all these programs are crisis response model that pair a mental health clinician with a police officer and respond to calls that would otherwise be police alone.
While these crisis response partnerships have proliferated in this province, there's actually been relatively little research to justify their use or their efficacy. In other jurisdictions — I can point to Portland, Oregon, for example — alternative models exist where 911 dispatchers can triage mental health calls and send them directly to mental health services to respond independently. Then they are the ones who assess, themselves, whether police presence is necessary.
In B.C., we've flipped it on the head, so crisis response partnerships that are used in B.C. assume that police are necessary. In these other jurisdictions, it's the opposite. We assume it's a health response, and if they need police, they will ask for it.

In my research, I sought to investigate how embedding police officers and the ACT model impacted treatment experiences and health-related outcomes. I drew information or data from both in-depth interviews with services providers and consumers or clients in these teams. I also conducted in-depth ethnographic fieldwork and informal interviews in the field.

My research findings are important because policies such as the decision to embed police officers in ACT are a choice.These choices embody sets of beliefs and assumptions that exist about the role of policing with regards to mental health treatment, as well as stereotypes about people with mental illness, that the presence of police officers is necessary for the safety of that individual and for the clinician to be providing treatment.

That choice to embed police in ACT also highlights an emergent narrative that mental health treatment teams should be some way used to address delinquency and street disorder. This is for things that don't quite meet the grounds of the Criminal Code of Canada. It's also a decision that actually creates a new realm for police interactions with individuals struggling with mental illness that did not exist previously.

The ACT model, like I said, is very old. It's existed since basically the late 1970s around the world. B.C. has actually been a slow adopter of this evidence-based treatment model. Interestingly, the emergence of ACT and its growth in B.C. has been largely due to advocacy from municipal police departments.

[11:10 a.m.]

They've raised concerns that they were becoming the go-to responders for a wide variety of health and social needs after the closure of Riverview Hospital. Through their reports, they argued that we were experiencing a mental health crisis and they argued for the creation and then expansion of a police-embedded ACT model. Again, I want to emphasize that

becoming the go-to responders for a wide variety of health and social needs after the closure of Riverview Hospital. Through their reports, they argued that we were experiencing a mental health crisis, and they argued for the creation and then expansion of a police-embedded ACT model.

Again, I want to emphasize that ACT has existed around the world for over 40 years. It's an evidence-based treatment that's shown robust findings for providing treatment to individuals with high-use of emergency services and to keep them engaged in treatment long-term. But traditional ACT doesn't involve police officers. This is a B.C. adaptation and our decision, policy-wise.

Research has shown that even ACT, without police officers, can be experienced as intrusive, paternalistic and coercive. I want to talk a bit about my specific research findings into this police-embedded ACT model. I found a very strong theme of coercion.

Service providers were concerned that there was a blurring of the roles of health care providers towards being agents of social control. In other words, because of that partnership with police, they felt that they were being called on to influence or control the behaviours of clients. Often, these behaviours were seen in the result of intersecting issues such as poverty, substance use, mental illness, housing instability, homelessness — in other words, systemic issues, things that could not be addressed through mental health treatment alone.

Many service providers describe feeling burnout and moral fatigue related to concerns that they were policing their clients' lives. They described how this role of agent of social control clashed

with their health care values to do good and to increase consumer autonomy into their own treatment.

My findings also highlighted that having police officers at episodes of mental health treatment brings with it expectations and also duties that the officer has with regards to public safety and enforcing the criminal code. Several participants described situations where there was an escalation in behaviour that a service provider, if they were alone, could have walked away from, but because the officer was there, they had certain duties and obligations and so there was an escalation in the use of force that would not have existed if that clinician had gone alone.

I know there could be an argument that the officer's use of force prevented harm to the clinician, but I want to be clear that none of my participants described even a single incident of violence directed from a consumer towards a health care practitioner.

Another important finding of my research was that the presence of police officers in these partnership teams had an impact even if the officer was not actually present at a given interaction or instance of service delivery. Just that the police officer could be there impacted perceptions of power imbalance between the clinicians and consumers at every interaction that they had.

I want to talk a little about my consumers' perceptions of this treatment that they were receiving. They often use criminal justice terms to describe their treatment through these police-embedded ACT teams. For example, some use the term "being imprisoned" in these ACT teams or "being punished" for their substance use or mental health concerns. Consumers also described a general lack of personal agency or choice in their health care decisions and this almost omnipresent threat that they could be detained and forcibly taken to hospital by police if they didn't comply with their treatment team's demands. This, again, created an inherent power imbalance between consumers and the treatment providers, and this was despite the intentions of service providers to create therapeutic trust.

Consumers also described perceptions of being continually monitored by their treatment teams and the embedded police officers. This finding actually isn't surprising because previous research into the ACT model, even without police, has really highlighted how intrusive it can be and how much it goes into multiple domains of a client or consumer's life. What I did find is that the presence of police on these teams enhanced those perceptions of being surveilled and of being monitored.

The extensive powers of B.C.'s Mental Health Act were also prominent in my findings, and these actually appear to be inextricably linked with perceptions of coercion associated with the police officers embedded on these teams. In part, this was probably due to the large percentage of consumers who are under the provisions of extended leave at the time of their interviews. Every single one of my participants who was a consumer had, at some point, been the subject of involuntary treatment in the community.

Although a B.C. Ombudsperson review was done on the provisions of the Mental Health Act, what was actually absent was any real critical analysis of the provisions of extended leave. It focussed almost entirely on involuntary hospital care. So we didn't look at mandated treatment community and whether there were adequate safeguards to ensure accountability in its use.

[11:15 a.m.]

I think this is an important part, when thinking about partnerships between police and mental health treatment, given the powers and responsibilities that that legislation gives to police. Another important finding of my research was that partnership between police and mental health

treatment was likely influencing the actual profiles of the consumers who were enrolled in these police

important part when thinking about partnerships between police and mental health treatment, given the powers and responsibilities that that legislation gives to police.

Another important finding of my research was that partnership between police and mental health treatment was likely influencing the actual profiles of the consumers who were enrolled in these police-embedded ACT teams. Service providers overwhelmingly perceived that criminal justice characteristics, such as level of delinquency or negative police contacts, were privileged over health and social needs in the consumers who were enrolled in the service. Further, the fact that police were embedded in these teams enhanced stigmatizing narratives that these consumers were inherently dangerous and that people needed to be protected from them.

It's difficult to convey the extent of my research in the short period of time that I have. But I'm hoping that some of the findings that I've presented will raise some questions for committee members as they look at reforming B.C.'s Police Act. At this time, there are huge gaps with regard to our knowledge, regarding the potential impacts of partnering police with mental health services. But despite this, our province has moved forward with partnership models.

The assumptions that inform these partnership models speak to how we as a province think about people who struggle with mental wellness, how we intend to provide health care to some of our most marginalized and stigmatized citizens. I believe that this committee also has an opportunity to question some of these assumptions.

In closing, I'd like to thank this committee and the BCASW for providing me with this opportunity to share some of my research findings.

D. Routley (Chair): Our next presenter is from the Federation of Community Social Services, Mr. Varesh.

FEDERATION OF COMMUNITY SOCIAL SERVICES OF B.C.

T. Varesh: Thank you for the opportunity to be here this morning and also the opportunity to present with Dr. Norris and Michael Crawford and the B.C. Association of Social Workers.

I, too, would like to acknowledge the unceded and ancestral territories of the Coast Salish peoples, specifically the Musqueam, Tsleil-Waututh and Squamish peoples, on whose land I work today.

Thank you for the opportunity to participate in the special committee's important work. My name is Tim Varesh, and I sit on the board of directors of the Federation of Community Social Services of British Columbia. The federation represents a group of over 140 community-based social service organizations, serving more than 250 communities across B.C., both on and off recognized First Nations territories. Our member organizations span the entire province and offer a broad range of services and programs that support B.C. families; people living with physical and mental challenges; vulnerable children, youth and seniors; new immigrants; people living with addictions or mental health issues; those living in poverty; and much, much more.

I'd like to begin by acknowledging the context in which we find ourselves during these consultations. The provincial state of emergency regarding the COVID-19 pandemic has been extended. Our province's other public health emergency, the ongoing opioid epidemic, has been

devastating to British Columbians for almost five years and has just had its deadliest year to date. Six years after being released, the Truth and Reconciliation Commission of Canada's calls to action remain largely unanswered. Perhaps most importantly, a year of social unrest has renewed a desire to re-imagine how we recognize, fund and keep safe our communities and each other.

Police and community social services. In preparing our submission, the federation surveyed our member organizations about their experiences and perceptions of police forces in British Columbia. Many organizations have long-standing, formal partnerships and working relationships with their local police. Many have very positive things to say about their police colleagues. Some of our members described high levels of trust, integrated and community-based teams doing great work, consistent allies helping to support victims, and strong advocates in community social services.

However, there were also many problematic interactions and patterns identified across a wide range of situations and service areas. Our members explained that too often, there are examples where officers are ill equipped to be first responders and lack appropriate training. Many enter situations with bias and prejudice against both the perpetrators and the victims, and rather than keeping people safe, make a difficult situation even worse. Many of these problems are exacerbated in rural and remote communities, where there are even fewer officers with less experience and less specialization.

Our recommendations to the committee here fall into four main topic areas: reconciliation and anti-racism, accountability, police in the community and then systemic change.

Reconciliation and anti-racism. In their most recent mandate letters, all ministers were told that lasting, meaningful reconciliation was a foundational principle of their work. The simple truth is that you can't be in favour of reconciliation and continue the practice of street checks that predominantly target Indigenous people.

[11:20 a.m.]

You can't be in favour of reconciliation and continue to treat poverty, homelessness and addiction as criminal issues and turn a blind eye to the disproportionate victimization of Indigenous women and girls. Addressing the systemic barriers is a big part of what reconciliation looks like. Our Indigenous friends, colleagues and community members deserve action, not just words.

The good news

and treat poverty, homelessness and addiction as criminal issues and turn a blind eye to the disproportionate victimization of Indigenous women and girls.

Addressing the systemic barriers is a big part of what reconciliation looks like. Our Indigenous friends, colleagues and community members deserve action, not just words.

The good news is that there are tools and processes that work. There are clear directions and calls to action that have already been laid out. We just need the motivation, the resources and the political will to start doing things differently.

One of those items is the Truth and Reconciliation Commission of Canada's call to action, specifically item No. 57, which calls upon federal, provincial, territorial and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations declaration on the rights of Indigenous peoples, treaties of Aboriginal rights, Indigenous law and Indigenous-

Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights and anti-racism. When the federation surveyed our membership, this recommendation was supported 100 percent.

Several calls to action in the justice and truth and reconciliation commission report also address the urgent need to address the overrepresentation of Indigenous People in custody. We recommend three pieces in this area, the first being an alternative measure such as diversion and restorative justice being developed and expanded throughout the Police Act.

Mandate anti-racism training — it becomes required for all officers under the jurisdiction of the Police Act — and a modernized Police Act is made up of consistency with the United Nations declaration on the rights of Indigenous peoples.

On the accountability side, policing in this province has come a long way in the past few decades. The role of women in police forces has markedly improved in the last 20 years. As well, people from diverse communities are increasingly common among the ranks of officers. However, at the same time, there has also been an increase in the militarization of policing in British Columbia.

To counter both structural militarization — increased use of body armour, shields, heavy guns and intimidating vehicles — and the increasingly aggressive responses to non-violent crimes such as issues of homelessness, drug use, sex work and mental health struggles, oversight bodies such as the independent investigations office require more funding, more capacity and more authority.

Accountability is about taking responsibility, doing right by the people you serve, learning from your mistakes and doing better. Bad things do happen, unfortunately, but the IIO needs to be able to hold police forces accountable, to look at a situation from a neutral perspective and say: "Here's what went wrong, and here's what needs to change as a result." There is also a need to have standardized and strong mechanisms in place to enforce the changes that oversight bodies such as the IIO put forward.

At the same time, we also want to acknowledge this committee to think about the responsibility to individual police officers. When you combine the front-line work of responding to calls, the toll of attending court proceedings and the overtime officers are often required to put in, the demands of this job can be extremely overwhelming. If they're stressed and otherwise unwell, police will make unsafe decisions. Adequate mental health supports and psychological assessments after critical incidents will help ensure officers can act in the best interests of their communities.

We recommend funding and training for the independent investigations office are increased to ensure timely and comprehensive civilian investigations and oversight of police forces; significant investments are made to hire additional IIO investigators, specifically from marginalized, Indigenous and diverse populations; the province of B.C. creates diverse and consistent civilian advisory committees that are reflective of communities they serve in each jurisdiction across the province with a population greater than 20,000 people; mandatory psychological assessments after critical incidents; and investments in mental health services and supports for officers.

Police in our community. Many of our member organizations have interactions with police forces where officers are required to assist a person whose behaviour has become dangerous to themselves or others. In these situations where they serve to keep staff, volunteers and family safe, the police are necessary and very much appreciated. However, in many cases, our members

describe police as storming in aggressively, without any attempt to de-escalate the situation or cooperate with staff or the needs of a client or the organization.

[11:25 a.m.]

While many police officers in B.C. have post-secondary degrees, in our experience, most of them rarely have enough specific education or training to respond to the needs of victims or individuals who they are dealing with, especially when responding to social rather than criminal issues — for example, homelessness, mental health, substance use challenges. As a result, their response can be stigmatizing and sometimes dangerous to both the alleged victims and the perpetrators.

In addition to increasing the purview and power of B.C.'s accountability bodies and mechanisms, we also need to ensure that police stop doing things they shouldn't be doing and stop responding to situations in our community that they shouldn't be responding to.

DRAFT SEGMENT 116

the response can be stigmatizing and sometimes dangerous, both to the alleged victims and the perpetrators.

In addition to increasing the purview and power of B.C.'s accountability bodies and mechanisms, we also need to ensure that police stop doing things they shouldn't be doing and stop responding to situations in our community that they shouldn't be responding to. That will require to have an alternative ready to fill in the gaps, such as assertive community treatment teams, specialized integrated police cars such as youth cars with social workers, and mental health cars with mental health professionals; the expansion of provincial support of child and youth advocacy centres providing best practices for interviewing child witnesses and understanding trauma-informed approaches.

Again, we recommend in this section that the province adopt the use of child and youth advocacy centres and develop provincewide standards for child interviewing in collaboration with representatives from the community social services sector and creating child interviewing centres with Indigenous and/or community social services organizations throughout the province; mandatory training for police officers on topics including trauma-informed approaches, de-escalation techniques, anti-racism, as well as techniques for interviewing women and children who have been victims of domestic violence, abuse and/or sexual assault; transition full control and operation of provincial restorative justice programs from the police to community-based or Indigenous organizations; and through increased funding and training, expand the use of culturally appropriate, community-based restorative justice to manage minor crimes outside of the criminal justice system.

Number 4 is our systemic change beyond the act. While we've listed several recommendations to improve and modernize the Police Act, the most important ideas have to do fundamentally with changing our approach to policing and the role police play in society. Investments need to be made in expanding the role of community and health workers, who are better suited and trained to respond to the issues and the situations police often find themselves in. As such, we recommend investments in expanding and developing community programming supports infrastructure, such as supportive housing, safe supply programs, basic income for neglected populations, and mental health supports. This kind of systemic change goes beyond the Police Act. In addition to the decriminalizing of non-violent matters that have had to be treated as criminal for too long, such as the possession and the use of drugs and sex work, it would also

result in a tremendous reduction in harm, suffering economic costs across the province, and is a change that we really need.

Our four requirements here are: expand the role of specialized, integrated resources, such as ACT teams, and invest in expanding and developing community programming and infrastructure such as affordable and supportive housing, safe supply programs, and mental health supports; the decriminalization of non-violent offences, such as the possession and the use of drugs and sex work; end the discriminatory practice of street checks; and in addition to immediate reforms, we recommend a timeline for replacing the Police Act with a new piece of legislation that represents the modern needs and values of our society and how to help police fit within them.

In conclusion, the police can't solve poverty, joblessness, mental illness, addiction and the housing crisis — the social problems that they are tasked with responding to with increased frequency. We need to give the police better and different tools, and we need to create more space for people with different skills to go in and solve these problems instead of requiring the police to. De-tasking the police may sound like a difficult pill to swallow, but the other option is continuing to have a militarized police force responding inappropriately to social and public health issues. And it's interesting. One of our members raised the question that you wouldn't have a youth worker go and respond to a car crash, and you wouldn't expect a registered nurse to go and handle a home invasion. So why are we expecting the police to manage substance use and mental health issues?

We understand there will be a lot of work ahead of us, and while this work unfolds, we can focus on strengthening accountability bodies and improving oversight mechanisms. We can invest in training and education, especially around the topics of anti-racism. And throughout this process, the federation of B.C.'s community social services sector will be fully committed to working with our government colleagues to achieve the kind of lasting, positive change that this province needs. We all understand that safe, supported communities make good economic sense, and we look forward to working and building together on a very successful, happy future.

Thank you for the opportunity to present today.

D. Routley (Chair): Thank you very much for the presentation. Members, any questions?

[11:30 a.m.]

D. Davies (Deputy Chair): Not really a question, but I do want to bring up…. Thank you all for your presentations today. I appreciate it. I really want to commend Tim there for mentioning restorative justice. It is a program I think is

D. Davies (Deputy Chair): It's not really a question, but I do want to bring up…. Thank you all for your presentations today. I appreciate it.

I really want to commend Tim there for mentioning restorative justice. It is a program that I think is completely underutilized in the province and would be something that I love to see in every community across B.C. — across Canada, for that matter. Like I say, it's great to hear. I think, in our multiple presentations we've head, I've only one other organization mention it. So I am glad that you did raise the awareness around the positive impact that that could have on so many of these situations that do not need to go through the criminal justice system. I appreciate that.

The other comment — I just lost my train of thought — was around…. No, you're going to have to come back to me, Chair. It totally fell out of my head just now.

D. Routley (Chair): Thanks, Dan.

A. Olsen: Thank you both for these important presentations. I'm turning first to Dr. Norris. I think it's easy for us to say: "Oh, we need more of those ACT teams." The information that you provided today, I think, provides more of that nuanced information that we need in order to be able to ensure that the unintended consequences that, perhaps, the untrained person, like myself, has when it comes to suggesting a solution prior to understanding what the outcomes of that are….

I'm just wondering. You noted, I think, a couple of times that the work that you have done perhaps needs more research to be done. Can you perhaps provide a little bit of context to that, just in terms of what resources might be necessary to understand how we can support the public safety aspects of this as well as an individual who's experiencing challenges with mental illness?

C. Norris: They're complicated questions. I guess the main point I'll just start off with is: when we look at the totality of mental health interventions that have existed, ACT itself is probably one of the most well-researched models that we have in existence.

One of the reasons why that's so good is that, with the changes that B.C. has made with this type of partnership model, it actually gives us a very good comparison to look at what we've done, what's been done before, and how our adaptation may have changed the model in a certain direction — certainly more towards this idea that we're controlling delinquency, that we're in some way responding to street disorder, and that somehow this is a much friendlier version than police going.

Like I said, this model has been used with the same population around the world, but not with police officers, and it has functioned extremely well. There really hasn't been a randomized, controlled trial or a this-or-that type of study with this. I would say that would be basic in looking at it.

Really, getting at some of the data that's out there on the use of extended leave, how many of these patients, of these consumers, are actually being mandated to treatment? Are we actually reducing costs to the health care system and the criminal justice system? There have been stats that have been given out, but really, there hasn't been an independent investigation looking at those stats and seeing them. What happens with regard to tertiary care?

We don't have Riverview anymore, but we do have decentralized tertiary care in the different health authorities. How many of these clients who are on the ACT team might be better serviced in that type of environment? How many of them end up going to that type of environment? Those are basic questions, and really, no one has really started even probing that open and looking at it. We're looking at the assumptions that are informing those decisions.

[11:35 a.m.]

Another thing I wanted to mention for the committee is: ACT is new to B.C., but we've seen an explosion of ACT in other provinces and also around the world. I'll give an example. England had hundreds and hundreds of ACT teams at one point. They were seeing results. It was very enthusiastic. It's a model where you could say: "This is working great. We're doing things."

But then when they actually started doing their analysis and doing their research, they weren't finding the cost savings that they thought they would. They weren't seeing the results. They ended up

hundreds of ACT teams at one point. And then they were seeing results. It was very enthusiastic. It's a model where you can say: "This is working great. We're doing things."
But then when they actually started doing their analysis and doing their research, they weren't finding the cost savings that they thought they would. They weren't seeing the results. So they ended up culling their ACT teams, going from hundreds to literally a very small number of ACT teams that service the most high-needs consumers in their area. They came up with other alternative forms.
We've seen that ACT is a very…. If we look at community treatment, it's probably the most expensive model you can have. If we're going to invest in that and we're going to expand it, my argument would be that we want metrics that you can evaluate. Determine what those metrics are and some way to find out if you're meeting those metrics. I think that needs to be done independently, through research. I hope that answers your questions.

R. Singh: Thank you so much to the presenters. Those were very informative presentations — both the presentations. I really appreciate the intersectional lens on the complex issues that we're dealing with — mental health and the systemic discrimination that is embedded and very deep-rooted.
My question is for Dr. Norris. You mentioned in your presentation about a model in Portland. When people call 911, the operators there are able to assess what kind of service is needed and then direct them to the mental health resources. Are those operators, then…? Are they very well trained in how to recognize mental health issues? Is there formalized training being given to them?

C. Norris: I should probably provide a little bit more clarification. The model they use is called CAHOOTS, the CAHOOTS model. When a call comes into 911 dispatch, at that moment, they are assessing. This would happen, for example, in Surrey or in Victoria — anywhere here as well. They do have a certain level of understanding of whether this is…. It would be called an EDP, or emotionally disturbed person, call. Even now, in here, without that model, they have a certain level of knowing how to prioritize that — is it a priority 1, a priority 2 or a priority 3? — and also what kind of services should go to it.
In Portland, they don't actually direct the person to whatever service it would be. What they do is decide who the best person or best organization is to go. They have this option that if this does sound like something to do with emotional distress, if this has to do with substances, if this might be better…. There are no safety concerns. There isn't someone committing a crime. Let's send the health response.
One of the things that it does is turn those assumptions on their head. Why are we sending a police officer? Let's look at Surrey. You have Car 67. You have one car on the road for that entire municipality. How is that one car going to be able to respond to all the calls going on?
What CAHOOTS does is have multiple clinicians who are out there. They have a vehicle that they can take. They can park like an emergency vehicle anywhere within the city. They can go and respond, and they can assess, at that point: "This is too dangerous for me. This building is one I don't want to walk into. This person, perhaps, has been using some type of substance that makes it difficult to communicate. Things are escalating. I need to withdraw." Then they can assess, at that point: "Do I need a police response? Do I need EHS? Do I need fire here? What can happen?"

So they do have a…. I mean, all dispatchers have a certain amount of training. But really, you don't need a ton of knowledge just to say that the person to go to assess this or decide what this needs is a health person or that the person who needs to go to this is a firefighter. It's that kind of thing. They do have a certain level.
I'll give you an example. When I worked in Car 87, we would see, on the police dispatch, all these calls on the call board for the different districts. We would look at them, and a lot of them would be flagged "EDP." A lot of them would be flagged "check well-being."

[11:40 a.m.]

Well, if something is a check well-being, why are we sending a police officer with a gun, with certain obligations, to go and speak to this person? Why aren't we sending a clinician who is trained in that, who can not only assess what's going on but knows the resources to find this person help? What are the shelters? Do they need to go to Insite? All these options are available for a clinician who knows that community and knows the health and social resources that are available.
I hope that answers what you were asking.

R. Singh: That answers really well. Thank you so much for

not only suss what's going on but know the resources to find this person help. What are the shelters? Do they need to go to Insite? So all these options are available for a clinician who knows that community and knows the health and social resources that are available.
I hope that answers what you asking.

R. Singh: That answers really well, and thank you so much for that explanation. We heard from a previous presentation also, in a different jurisdiction. In Sweden they have, rather than the ambulance going, the psychiatric staff going there, the paramedics. That is a really, really good example.
What you were saying…. I just want to clarify this. One thing which you say that the dispatchers here would be able to assess, like what kinds of services they need…. They're fully equipped to do that. But it is also the access to those services even after hours.

C. Norris: Absolutely, yeah. One of the reasons we rely on police is because police are reliable. They're in their cars. We have them out 24 hours a day in every community. They're always nearby. They end up going to all sorts of calls that probably they have no business going to, or someone else would be better, but that's the resource and that's how we funded it to happen there.

R. Singh: Absolutely. Thank you so much.

C. Norris: People don't get sick during bankers' hours.

R. Singh: Right. And it is also talking about the challenge that the police are facing at the same time, like how much training you can give to them. Thank you so much. I really appreciate that.

D. Davies (Deputy Chair): Thanks again, and Rachna pretty much took most of my wind there. That was exactly the avenue I wanted to follow as well.
I guess, Dr. Norris, in your research, did you look at e-com in B.C. and how the dispatches — the correlations directly with some of the issues that we're looking at? Was that any part of your research?

C. Norris: No. I'm not aware of any research there is, to be honest.

D. Davies (Deputy Chair): Okay, which is interesting in itself. I'm really looking forward…. We are meeting, I believe, with them sometime down the road, so I've already got a pile of questions that I've been compiling.
The other piece that I wanted to just touch on, and again, it was already talked about…. I think a great example is Sweden, the mental health paramedics. I think that is something that really ties in well. I know there's lots of talk about the teams perspective, Car 87s — a challenge in smaller rural communities, obviously, with the shortage of practitioners and professionals.
I did have one final question here. You really touched very lightly on it — the tertiary care. You talked a little bit about when Riverview was shut down. What is your opinion on institutionalization versus the bundle of tertiary care?

C. Norris: Are you asking centralized tertiary care versus decentralized tertiary care?

D. Davies (Deputy Chair): Yeah. Well, I guess…. We have heard quite a bit about Riverview being shut down and, obviously, some of the problems that that has propelled into today. I know there has been lots of discussion that that model isn't a good model. I'm just wondering what your thoughts are, and knowing your background, I think it might be valuable.

C. Norris: I want to acknowledge that we as a society — I'm talking about North America — decided years ago that we were moving away from an institutional model to support people to be in their communities. Not just mental health. We're also talking about people with disabilities, people who are in the latter stages of their life. All of these different models…. We used to have centralized institutional care, and we made a decision that that was not how we as a society wanted to treat some of the more vulnerable people in our society. What we wanted to do was support them to be in communities. B.C. is not the only jurisdiction that has done this, but we deinstitutionalized Riverview without providing adequate supports to people who left there or would have been there.

[11:45 a.m.]

I'm talking about…. Let's just start with housing, and let's talk about supported housing. Really, you can't even start to talk about wellness, about being integrated and part of the society if you don't have adequate housing. Adequate housing is not always independent housing. It can sometimes be supported

talk about supported housing because, really, you can't even start to talk about wellness, about being integrated and part of this society, if you don't have adequate housing. Adequate housing is

not always independent housing. It can sometimes be supported with either on-site staff or even peer run. So there's a variety of things there.

What I think is that our policy decisions around the closure of Riverview were not informed by evidence. They were not informed by research. They were political decisions, and they were probably money decisions. What we should have done, and what we can still do, is support those folks who were there or would go to that kind of treatment to actually be able to thrive and be a part of our communities.

We're still not doing that. What we have done is that we have these decentralized models of tertiary care. We have some run by PHSA, like Burnaby Centre for Mental Health and Addiction and B.C. psychosis program. These are all time-limited tertiary programs now. We go on the assumption that a person will go to some of these programs for specialized care for a finite period of time, and then they will come back to our community. And yet we probably don't know enough about what actually happens to these consumers when they leave our short-term tertiary. Do they go back to homelessness? Do they go back to living on the streets? Is the money that we invest in this care actually helping them?

I didn't speak about this, but one of the things that did come out in my research was the number of consumers that do go to tertiary care, and they do get some level of sustained improvement in their symptoms. They get their medications optimized. They haven't been using substances in a way that interferes with their mental health. They actually have food in their bellies. They have nutrition. They have exercise. But then there's no option for where they will go when they're discharged from these tertiary facilities, so they end up in a shelter.

You give someone two years of stability, you give someone two years of good treatment and getting to the point where they recognize where they're at, and then we send them to a shelter, we send them to the street. It's not okay, but that's where we're at. We don't have enough housing. We don't have enough supports. So if I have to look at the difference between that and Riverview, I'll take Riverview all day long.

I'll also say unequivocally, in the decades that I've worked in this field, there are some folks who can't manage in community, but it's a really small number of people. It's really, really small. We have to be aware that when we say that that small group of people needs institutional care for life, and they haven't committed a crime, they haven't done something to justify infringing on their rights…. I think we have to be really, really clear, as a society, as policy makers, that we are taking away that person's liberties and Charter rights and putting them into a place to take care of them and be mindful of everything that goes along with that.

I hope that answers. It's a huge kettle of fish. I'm glad you guys are asking those questions.

T. Halford: Thank you to the presenters. Dr. Norris, just curious if you've had a chance to share your findings with RCMP or municipal forces. If so, what was the overall reaction?

C. Norris: No, I haven't. No. It went through peer review, and I defended it the summer. Unfortunately, I had a family member who was ill and then passed away in the fall, and then with COVID…. No. We're in the process of cutting up the larger dissertation into actual publishable papers for journals, and then it will go out the door. I do know that there were some municipal police leadership people who were at the defence, but I haven't had any opportunity that I've pursued to present the findings to police forces, no.

D. Routley (Chair): Thanks, everyone. Seeing no one else on the list, I'll ask a single question myself. That would be….

[11:50 a.m.]

Dr. Norris, your presentation really highlights the fact that so much of what we're trying to understand is based on people's perspectives and opinions and derived through personal experience, which is vitally important. But there's so little data available, and so much of what we're asked to consider is….
In the example you gave, a police officer was present when a situation escalated, and the outcome

derived through personal experience, which is vitally important. But there's so little data available.
So much of what we're asked to consider is…. In the example you gave, a police officer was present when a situation escalated, and the outcome was negative. What we can't measure is how often that doesn't happen for the same reason. It's like so many things with health and social services. Measuring what didn't happen is often how we have to defend decisions, funding decisions and that sort of thing, which is so hard to account for.
My question would be: what data was available to you beyond personal reflections and interviews?

C. Norris: There are a lot of reasons why I chose a qualitative investigation, and one of the main reasons is because of the exploratory powers that it provides.
When you really don't know much about something, one of the best ways to start asking questions and decide what future research could look like is to try and understand what the model is, what it's doing and what's it's like for the people who are giving it and receiving it; then also, what it's like to actually watch instances and service delivery as an outsider, and see what's happening and sort of evaluate it at the time.
I made that choice early on, that that was the way I wanted to go, because no one had really done much research into this area. I did reach out trying to get data on the number of people in this province on extended leave, for how long. I honestly was not able to get any data on those. I'm not sure whether we actually have those kind of data. Actually getting information on how many consumers end up going to tertiary care — I was not able to get that either.
Those are basic questions that, I think, quantitatively can be looked at and actually analyzed in some ways.
Like you said, it gets very messy. There's a lot of discretion when you talk about reducing police contacts, for example. If someone goes onto one of these police-embedded ACT teams and their level of prime contacts goes down, is that actually what's happening? Or are they actually having more contact with the police through the embedded officers who are not charting it in PRIME, who are not entering a GO?
It gets quite complex. You have to be careful what you actually are getting data on, what you're measuring and what you can actually infer from that.
I hope that gives you some….

D. Routley (Chair): Yeah. It's been a very common theme from many presenters, that there's a lack of data available.

H. Sandhu: Thank you so much, presenters. I thoroughly liked your presentations.
It's a comment to Dr. Norris. Thank you so much for the work that you do and for highlighting the gaps and the last comments that you made — very powerful and true comments, that we would rather take Riverview over the way…. There's no follow-up, and we leave these marginalized people.
I can say that from my 16 years experience in health care. I've seen those gaps. Waiting time in emergency and having police officers be there. Then, at the end, even after that, what we've been witnessing, even up until today, is those patients often end up in other units, where there are no specialized psychiatric nurses, because of a lack of beds and the funding and mental health resources. They could stay there for days. Then they're not getting the specialized care on the unit.
The same for RCMP officers. I heard, from background, that a lot of RCMP officers…. It's not fair some of the types of calls they have to respond to. The same with the health care workers, nurses and doctors. They are being put in a place where they don't have that mental health background. They have other specialized nursing backgrounds or whatnot. Those gaps I witnessed.
I think what we also witnessed: there is no follow-up after that, even when they leave the psych unit or they get the treatment.

[11:55 a.m.]

Housing is the other one. I believe that these mental health patients have been compliant, sometimes even for two years and who knows for how long. They absolutely deserve it. They did their part. They absolutely deserve that follow-up and proper housing.
What's disheartening lately that's happening, in my very own riding too…. When government is making those efforts to build affordable housing

been compliant, sometimes even for two years — who knows for how long. They did their part; they absolutely deserve that follow-up and proper housing.
What's disheartening lately that's happening, in my very own riding too…. When government is making those efforts to build affordable housing, us people in power, whether at the municipality-level, bring these motions forward that we shouldn't build. There are barriers being thrown in, and that's very discouraging.
I really appreciated your comments. I hope some of those people are watching and will get to hear those comments, because we're battling that. There are efforts being put in by the government, but then there are people — "not in my backyard" sort of response. Again, from my personal experience, it's really disheartening to see such attitudes.
Thank you so much to all the presenters.

D. Routley (Chair): I don't see anyone else on the list, and we're nearing our time. I'd like to thank our presenters, Mr. Crawford and Dr. Norris. That's very helpful. I hope we can count, as a committee, on being able to call on you should we have further questions. We'd invite you to contribute should you go away and say: "Darn. I wish I'd presented that piece to the committee."

In any case, we are very grateful for your appearance here today. Thank you for the insight you've given us.
Thank you, everyone in the meeting. Thank you, Members. It was a good meeting. As usual, lots to process. On that note, I'll mention that I won't be chairing the meeting tomorrow. Deputy Chair Davies has agreed to chair the meeting, and I'm sure it'll go a lot smoother than….

D. Davies (Deputy Chair): Was that tomorrow or on Thursday, Doug?

D. Routley (Chair): Sorry. Thursday. That's right.

D. Davies (Deputy Chair): Okay.

D. Routley (Chair): Thank you. See?

D. Davies (Deputy Chair): You're trying to rush through this week.

D. Routley (Chair): Do I have any other appointments I should know about, Dan? Thanks.
Thanks, everybody. I'd take a motion to adjourn at this point — Trevor Halford and MLA Kirkpatrick, second.

Motion approved.