British Columbia

JUSTICE SUMMIT

SEVENTH JUSTICE SUMMIT

Justice, Mental Health, and Substance Use II

NOVEMBER 25, 2016

REPORT OF PROCEEDINGS

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Executive summary

Further to direction from the Minister of Justice and the Minister of Public Safety, the Seventh BC Justice Summit was held at UBC's Allard Hall on November 25th 2016, with a focus on "Justice, Mental Health and Substance Use." The Seventh Summit was the second of two events in 2016 on this theme, with the following scope:

Many who enter the criminal justice system have a mental health and/or substance use (MHSU) diagnosis; this Summit discussion focuses on those whose condition is understood to drive their contact with the criminal justice system.

The agenda was focused on those elements identified in the Spring which required the most active collaboration and joint innovation from the justice and public safety sector and the mental health and substance and social service sector working in tandem. The goal of the Summit was to consider in draft, and formalize, a recommendation that an action plan be established to address two key issues raised at the Sixth Summit:

- coordination of response to those with MHSU disorders who are in crisis in the community, and
- ensuring continuity of care regarding treatment of MHSU disorders where the justice and mental health systems intersect.

Following a keynote address by the Chief Justice of Canada, and a moderated discussion of lived experience of MHSU disorders, participants considered each of the two key issues in turn, as they related to the development of an agreed action plan. Participants endorsed the overall recommendation and its key elements, making some clarifications and constructive suggestions, and calling for Ministerial leadership and related steps to achieve an agreed action plan by November 2017.

Sixty-six people participated at the Summit, with representation from the leadership of the justice and public safety and health sectors, Indigenous organizations, police agencies, health authorities, health clinicians, non-governmental organizations and service agencies, the professions, and other subject matter experts.

Preparation of report of proceedings

This Report of Proceedings was prepared for the Honourable Suzanne Anton, Attorney General and Minister of Justice; the Honorable Mike Morris, Minister of Public Safety and Solicitor General; the Honourable Chief Justice Robert Bauman, Chief Justice of British Columbia; the Honourable Chief Justice Christopher Hinkson, Supreme Court of British Columbia; and the Honourable Chief Judge Thomas Crabtree, Provincial Court of British Columbia.

Figure 1: Allard Hall, Peter A. Allard School of Law, site of the first seven BC Justice Summits

British Columbia Justice Summits

Under the provisions of the *Justice Reform and Transparency Act*, Justice Summits are convened by Ministerial invitation at least once a year to facilitate innovation in, and collaboration across, the justice and public safety sector. As set out in Section 9 of the Act, a Summit may:

a) review and consider initiatives and procedures undertaken in other jurisdictions in relation to the justice system in those jurisdictions;
b) provide input to assist the Justice and Public Safety Council of British Columbia in creating a strategic vision for the justice and public safety sector;
c) make recommendations relating to priorities, strategies, performance measures, procedures and new initiatives related to the justice and public safety sector;
d) assess the progress being made in justice reform in British Columbia; and
e) engage in any other deliberations that the Justice Summit considers appropriate.

On the conclusion of its meeting, the Summit must report to the Minister(s) on the outcome of those deliberations. By agreement between the executive and judicial branches of government, the Summit report is simultaneously submitted to the Chief Justice of British Columbia, to the Chief Justice of the Supreme Court of British Columbia, and to the Chief Judge of the Provincial Court of British Columbia.

Background to the Seventh BC Justice Summit

The *Justice Reform and Transparency Act* of 2013 requires that a British Columbia Justice Summit be convened by Ministerial invitation at least annually. Summits are intended to encourage innovation and facilitate collaboration across the justice and public safety sector, by providing a forum for frank discussion between sector leaders and participants about how the system is performing and how it may be improved. The Act also established a Justice and Public Safety Council, appointed by Ministerial order, to develop a vision and an annual plan for the sector across the province; in addition to generating ideas and support for specific innovations in the sector, Summits also represent a key source of input and recommendations into the Council's planning process. See Appendix 6 for a listing of the current Council membership.

Planning the Seventh Summit

Steering committee

At the direction of the Minister of Justice and the Minister of Public Safety, the Sixth and Seventh BC Justice Summits focused on issues associated to mental health and BC's justice and public safety sector. The Steering Committee for both Summits was drawn from the Ministries of Justice, Public Safety, Health, Children and Family Development; BC Housing; Vancouver Police; RCMP "E" Division; the Aboriginal Justice Council of BC; the Canadian Mental Health Association; Vancouver Coastal Health; Corrections Canada; the Legal Services Society; the Canadian Bar Association; and the academic community. The Steering Committee's meetings were attended by observers from the Court of Appeal for British Columbia, the Supreme Court of British Columbia, and the Provincial Court of British Columbia. The Steering Committee was chaired by Dr. Allan Castle, BC Justice Summit Coordinator.

The Steering Committee met between February and June 2016 in preparation for the Sixth Summit, and again between September and November 2016 leading up to the Seventh Summit. Its principal tasks were to develop an agenda for the Summit; settle on a representative list of participants; and reach agreement on facilitation, location, and other planning matters. As at previous Summits, the Committee agreed that, consistent with protocol in similar gatherings in other jurisdictions to encourage free expression, no comments made by participants during the Summit would be attributed to those individuals or to their organizations in the Summit report, without explicit consent being granted to the Committee to make such attribution. Similarly, those attending are asked subsequently not to attribute any specific comments made by any participant at the Summit.

The Committee was supported by a cross-sectoral working group under the guidance of the BC Justice Summit Coordinator.

Agenda development and Summit goals

In its initial consideration of the subject matter, the Steering Committee reviewed the deliberations from the Sixth BC Justice Summit in June, 2016, which focused on the subject of "Justice, Mental Health and Substance Use."

The Summit process

Seven Summits have been held since 2013, with topics including criminal justice, family justice, violence against women, and justice and mental health. Topics are chosen by the Ministers. To allow more sustained focus and develop informed recommendations, in 2015 the Summits were redesigned to spread each topic over two events each year. The Spring Summit is a broad initial discussion between sector leaders, subject-matter and community experts, and leaders of other sectors where required. The Fall Summit allows participants to review one or more proposals from earlier deliberations, make concrete recommendations and consider leadership responsibilities.

The Summit process continues to rest on the voluntary participation of those representing various independent roles, positions and responsibilities within the sector, many of whom are sworn to champion and uphold the integrity and fairness of our adversarial system of justice. It is recognized that the constitutional, statutory or operational obligations of some participants may require that important caveats or restrictions be attached to any particular recommendation.

The Sixth Summit took as its scope the following statement: *Many who enter the criminal justice system have a mental health and/or substance use (MHSU) disorder; this Summit discussion focuses on those whose condition is understood to drive their contact with the criminal justice system.*

At the Sixth Summit, participants identified key areas of concern and expressed a desire to see proposals brought forth for consideration during the Seventh Summit, in order that an action plan could be recommended. These areas included:

1. A province-wide mental health strategy
2. A framework for collaboration
3. Systemic, empirical understanding of risk and opportunity
4. A coordinated crisis response protocol
5. Measures to combat stigma and promote culturally safe services
6. Expansion of existing approaches which have been shown to work
7. Early intervention, navigation and transition support
8. Enhanced case-based access to information to assist MHSU clients

Strategic considerations for the Seventh Summit

The Steering Committee and its Working Group considered several factors which served to narrow scope in planning the agenda for the Seventh Summit.

First, Committee members were conscious that parallel consultations on a broad mental health strategy for the province and other significant health initiatives were underway. The Committee viewed the Summit's mandate as complementing such

Figure 2: Elder Larry Grant welcomes participants to Musqueam lands

What is the justice and public safety sector, and who attends?

The justice and public safety sector, as defined in statute, is "the justice system, including, without limitation, programs or services, funded in whole or in part by public money, that contribute to the administration of justice or public safety in British Columbia," including the formal processes and institutions of criminal, civil, family, and administrative justice. The work of the Summits, however, would be impossible without expertise from public and private service providers, professional bodies, non-governmental organizations, community groups, researchers, and sector partners whose contributions are necessary for the proper functioning and development of the sector as a whole .

Invitees, according to statute, may include the Chief Justice of British Columbia, the Chief Justice of the Supreme Court and the Chief Judge of the Provincial Court and, through them, any other members or officers of their courts that they consider appropriate; members of the Justice and Public Safety Council; and any other individuals the Ministers consider qualified to assist in improving the performance of the justice and public safety sector.

discussions and making a specific contribution to areas where coordination is required between the criminal justice system, mental health and substance use services and the social sector, in order to improve outcomes for offenders with MHSU disorders.

Second, Committee members recognized that certain topics of potential importance (such as interventions to promote the mental health of children and adolescents) were beyond the scope of the Summit.

Finally, Committee members emphasized that both research and outcome measurement regarding the MHSU client population in the justice system were highly necessary, but could and should be supported by relevant resources in processes parallel to the Summit as opposed to forming part of the Summit discussion.

The agenda was therefore focused on those elements identified in the Spring which required the most active collaboration and joint innovation from the justice and public safety sector and the mental health and substance and social service sector working in tandem. The two areas which were tabled by the Steering Committee for Summit recommendations around an action

plan were (a) coordination of response to those with MHSU disorders who are in crisis in the community, and (b) ensuring continuity of care regarding treatment of MHSU disorders where the justice and mental health systems intersect.

Summit and report methodology

As at previous Summits, the methodology employed involved brief presentations by leaders and subject-matter experts, followed by deliberation in small groups and then reporting-out in plenary guided by the Summit facilitator.

Participants were provided in advance with a workbook of background materials. These materials included contextual information on the Summit process; draft recommendations centered on the two principal topics of coordinated crisis response and continuity of care; discussion questions to aid dialogue; and a summary of progress made further to deliberations at previous Summits.

Following the opening, a keynote address, and a moderated discussion regarding lived experience of persons with MHSU disorders and their families, participants turned to each of the two substantive issue areas in turn, concluding each discussion with reports from each table in plenary. In the final substantive session, participants discussed questions of timeframe, leadership and accountability, reporting out once again in plenary.

On the conclusion of the Summit, the Working Group compiled notes and written materials from the event and prepared a draft Report of Proceedings for the initial consideration of the Steering Committee in the month of December. A subsequent draft was then circulated to all participants for review and comment in January 2017, prior to delivery of the report in final form to the Ministers, Chief Justices and Chief Judge.

The full agenda for the Seventh Summit may be found in Appendix 2 below.

Summit opening

Opening ceremony

The Summit was brought to order by Ms. Caroline Nevin, the Summit Moderator. Participants were welcomed to Musqueam territory by Elder Larry Grant, of the Musqueam Indian Band, who offered a prayer for the success of the Summit, and were welcomed to the University of British Columbia by Dean Catherine Dauvergne of the Allard School of Law.

Figure 3: Chief Justice Bauman introduces the keynote address

The keynote speech at the Summit, "Towards a Better Justice System," was delivered by the Right Honourable Beverley McLachlin, Chief Justice of the Supreme Court of Canada, who was introduced by the Honourable Robert Bauman, Chief Justice of British Columbia. The full text of Chief Justice McLachlin's remarks may be found in Appendix 1 below.

The Honourable Mike Morris, Minister of Public Safety and Solicitor General, offered thanks to the Chief Justice for her remarks. Minister Morris then gave a welcoming address to the Summit, in which he encouraged participants to join with his Ministry in exercising the leadership required to address the issues being considered, and declared the Seventh Summit open.

The need to act: remarks from lived experience

The Summit program commenced with a moderated conversation with two guests of the Summit (referred to here as "PQ" and "EF") with direct lived experience of some of the key issues being considered. The conversation was moderated by Mr. Jonny Morris of the Canadian Mental Health Association.

Figure 4: Chief Justice Beverley McLachlin addresses participants during her keynote address

PQ's experience included bipolar disorder and an eating disorder, as well as periods of foster care; as a youth, her life was characterized by constant crisis and a lack of prevention, exacerbated once she "aged out" of foster care by a loss of services previously available to her as a youth.

EF spoke as a parent whose teenage daughter had disclosed abuse, which manifested in harm; her daughter was suffering from acute PTSD, but had no support and she was introduced to drugs, with a downward trajectory following.

EF was told that the best that could happen would be for her daughter to be arrested because then her parents could get her adequate care using services available through the criminal justice system. Eventually her daughter was arrested on a minor charge, and started to receive some support from an excellent team of professionals. The Court placed conditions on her daughter under the youth justice legislation, but there were still gaps in the available services, resulting in continued problems. EF said that what turned the tide for her daughter was that ultimately, while in custody, her daughter had a moment of clarity which resulted in increased motivation to achieve a positive change.

The conditions that have been applied are now helping her, but many of her friends' circumstances have continued to worsen. EF felt that from a parent's perspective the criminal justice system should not be the first responder to mental illness.

PQ, commenting on the gaps in available services suggested there needs to be accountability for foster youth who have aged out of care. There need to be more streamlined services to connect them before they age out, earlier responses to crisis, and provisions for housing. There also needs to be ongoing education for those working in the field.

The most obvious gap that EF identified is that there can only be voluntary treatment. There is also a gap in organization and collaboration. Her family dealt with 20 agencies. They were all good, but they were not familiar with each other. There are assumptions about what each can do and they are not always accurate. For her, the strength in the system is the individual people she has worked with. All have been dedicated, skilled, and compassionate.

Figure 5: Minister Mike Morris officially opens the Seventh Summit

Both EF and PQ agreed it is the structure under which they work that is problematic. EF focused on the need to for service to transcend individual agency mandates. An example would be location that is always open and able to provide a continuum of services.

PQ said prevention, or early intervention, was necessary, and that this is an investment that needs to be funded. There is also a need to have policies that are informed by lived experience, both of the individuals affected and that of their families. EF noted that her

life had been completely turned inside out. She suffered from loss, grief, and her whole way of life had changed.

A question was asked as to why people should "age out" at the age of 18 or 19 years old. PQ mentioned a current campaign to increase the age to 24. It is not realistic to expect persons in care to become fully independent simply because they reach the age of 19. Individual needs must be assessed on a case-by-case basis so that services and supports are in place as they leave the youth system.

Participants expressed their warm appreciation to PQ and EF for sharing their own experiences and for providing such a meaningful start to the day's discussion.

Discussion of draft recommendation

The remainder of the Summit agenda was dedicated to specific consideration of a draft recommendation, developed in advance by the Steering Committee on the basis of the deliberations at the Sixth BC Justice Summit.

Text of draft recommendation

The text considered by participants is set out in Appendix 3.

In order, participants discussed Objective A, Objective B, and finally matters of leadership, timelines and reporting associated to implementation.

Discussion: Coordinated Crisis Response

Presentations

To lead off the discussion of coordinated crisis response, participants heard from two presenters: Superintendent Daryl Wiebe of Vancouver Police, speaking from the perspective of police service delivery, and Mr. Scott Harrison of Providence Health, speaking as an expert in the delivery of mental health care services in the field.

Superintendent Wiebe argued that for police, the problems are provincial in scope, and are not simply reducible to urban, rural, or other contexts. In recent decades, all police agencies have found themselves increasingly required to manage and respond to crises with a significant MHSU component. Recent data for Vancouver show that 17.5% of police incidents contained a mental health component (whether related to suspects, victims, or other persons involved), and 80,000 hours of police response time annually. These data do not include substance use figures.

Localised responses and partnerships have, however, been making a difference, with closer work with Health Authority services – including Assertive Community Treatment (ACT) teams and Assertive Outreach Teams (AOT) – showing marked reductions since introduction for clients in terms of negative police contacts (down 47% and 80%,

respectively), MHA apprehensions (down 54% and 65%), and overall criminal justice involvement (down 44% and 52%). Steps have also been taken towards more effective information sharing, in consultation with the office of the Privacy Commissioner.

Figure 6: Superintendent Daryl Wiebe and Mr. Scott Harrison make the case for coordinated crisis response

However, significant challenges remain, particularly regarding transition points between systems, with inefficiencies and insufficient coordination remaining a problem both for client care and use of resources. Approaches are still isolated by jurisdiction, and have not yet made the leap from thinking about the different responses of two systems to a genuinely systemic approach which puts the client at the centre, prioritizes diversion away from the justice system wherever appropriate, and engages other important players such as the Courts and Corrections to a greater extent.

Mr. Harrison, speaking from the perspective of those delivering MHSU services in the field, noted that BC is facing an increasingly complex and demanding environment, compounded this year by an unprecedented substance use crisis involving fentanyl. St. Paul's Hospital in Vancouver saw an 89% increase from 2012-13 to 2013-14 in emergency admissions related to MHSU disorders – including concurrent disorders, primary substance use, primary mental health disorders, and drug induced psychosis – straining to extremes the capacity of staff to cope with the increase.

As a result, while crisis management should be a last-resort intervention for health, police and justice, it has instead become the norm, the primary involvement for these systems. These systems – law, health, police – have been thrust into ever closer working relationships but still function with different philosophies which creates further challenge. There is an urgent need for a shared philosophy, better communication, better information sharing, and planning for prevention. But similarly, health providers have struggled to address the need to balance individual rights with the safety of the community, as traditional core service philosophies are built around managing single clients.

A systemic approach is required to tackle the complexities of crisis, particularly where diagnoses are difficult, bringing the necessity of trauma-informed practice to the fore. Often, patients with a need for shared Crisis Response may not be easily diagnosed (*e.g.*, traumatized personality vs anti-social personality disorder) and require a combined approach. For some, there is little that health can do alone: complex cases in crisis are a jigsaw puzzle that involves pieces from all organizations. Hospitalization is not always the answer, as containment in hospital for dangerous cases is not usually an option.

But trauma is a major issue amongst the MHSU population, and particularly amongst Indigenous clients as the Truth and Reconciliation Commission made clear. There is a difference between someone with a trauma history and someone who is dangerous. One case example provided was that of "Jason," a 21-year-old Indigenous man from a northern BC reserve, with a trauma history, parental drug use, and a pattern of suicide in the community. Jason's father had been incarcerated, and his brother and cousin had both recently died from suicide involving a stolen firearm. Jason attempted suicide by

firearm, was arrested on a firearm charge, and sent to jail with no mental health care. His experience in jail increased his trauma and mental health needs post-incarceration. This case highlights a simple system failure in which a traumatized person was dealt with solely in terms of perceived danger.

Insufficiently coordinated information can also lead to unintended negative outcomes. In a second case example, a 44-year-old man with schizophrenia had recently been presenting in a manner more consistent with anti-social personality disorder, and was deteriorating in the community. This resulted in a community action plan involving police, under which he was to be hospitalized further to crisis response. However, the admitting doctor decided due to his knowledge of the client's forensic history that he did not want to follow the plan to hospitalize, highlighting how this community plan almost failed due to poor information sharing, a failure in the health system. Both systems are capable of failing both clients and the community through the lack of an appropriately systemic approach to client crisis response.

Small group discussions

Following the presentations, three questions were posed to participants for small group discussion:

(1) *This proposed objective draws on the Summit deliberations in June regarding crisis response. Does it meet your expectations; are there principles or elements you would change?*

(2) *What specific practices, programs or approaches, established in BC or elsewhere, do you believe should be included as explicit elements of a provincial agreement?*

(3) *What measures would be the best indicators of success in this area?*

These discussions were followed by each table reporting out to the plenary.

Plenary discussion: key points

Key points emerging from the discussions, as reported in plenary, were as follows:

The objective received broad support as an element of the action plan

Participants reported that, with caveats and comments noted below, an agreed action plan to implement this objective would represent a needed step forward for British Columbia, and that as a whole the room was in favour of moving forward. Further to this sentiment was the idea that this should be a Provincial-level agreement which acknowledged shared responsibility for MHSU clients, an agreement which should then cascade to the community level for implementation.

The objective can only be achieved with strong community participation structures

Participants in multiple interventions made it clear that community-level participation must be integral to the objective. Community-level networks, structures, partnerships and capacity involving both public sector and NGO organizations, are critical to successful crisis intervention and stabilization. Indigenous leadership, including advocates for urban Indigenous people, must be involved in developing workable, culturally safe approaches at the community level. Similarly, while lead agencies at the community level will be justice and health agencies, in addition Education, Housing and MCFD resources must be involved to coordinate ongoing prevention and support.

Shared responsibility must replace silos as the approach to crisis response

Participants repeatedly made clear that a system of shared responsibility for crisis response must replace the current process where front line workers have to "sell" patients or clients to other agencies to get services. Instead, the default position must be of a shared problem to be addressed in a common framework, with the onus on serving the client in a manner agreed by all participating agencies. Shared responsibility in facilitating transitions, not falling back on mandate restrictions, must be the expectation.

Proactive coordination and client advocacy should assist transition decisions

The challenges of information management, complex diagnoses and treatment options, and public safety, led many participants to advocate a specific function which would ensure sensible choices in transitions and increase accountability for client and community welfare. This was described by some as a named person in agencies that

crisis response staff can call to learn from in order to understand the problem, a person with established networks and trust. Such a step was seen as a way to overcome mandate and transition issues, enhance discretion, and ensure that there is "no wrong door" by providing proactive coordination. It would reduce the default reliance on ER staff and police officers to make transition decisions and referrals. Under such a model, funding dollars could follow the individual client in an integrated approach at the community level, overseen via a team approach.

MHSU crisis response must be culturally safe and trauma-informed

Participants repeatedly stressed the need for culturally appropriate responses to Indigenous people in MHSU crisis. Appropriately trained responders (trained via *e.g*. the Sanyas Cultural Safety training approach) and strong linkages to community, should be characteristics of crisis response. Crisis response should exhibit a stromg commitment to Truth and Reconciliation and the Indigenous experience, acknowledging historical trauma and the impact of colonialism, and with provision of supports and treatments in a culturally supportive environment.

More broadly, given the prevalence of trauma histories amongst those with MHSU disorders including but not limited to Indigenous clients, and the complexity this adds to diagnosis and treatment, all crisis response should be trauma-informed via appropriate training. Priority should be given to education of front line responders whose first assessments are of great significance.

Figure 7: Chief Superintendent Dave Attfield makes a point in plenary on behalf of his table

Well-structured information sharing is necessary for successful implementation

Participants, as at the Sixth Summit, saw information sharing and information management provisions as critical elements for the success of coordinated crisis response. There was particular attention paid to the mechanism for information sharing. Recommended approaches included:

- A legal, client-owned/authorized document to allow for information sharing; the provision of key information about client movements between geographic and institutional jurisdictions;
- Better information being provided routinely to the Courts about (a) client circumstances and needs and (b) treatment and support referral options;
- Pathways to information sharing built on client consent/opting-in;
- Provincial-standard sharing memoranda between different agencies applicable at the community level, supported by overarching policy and leadership support; and
- Overcoming technical barriers to information sharing including a move to common systems wherever possible.

The necessity of Provincial standards to underpin implementation

Participants repeatedly made clear that while implementation must occur at the community level, a framework of Provincial standards is needed to guide and structure local expectations. These would include, but not be limited to, statements of best practice (not simply minimum standards); standards-based care; appropriate use of resources in specific circumstances; expectations of core service provision by and accountability from participating agencies; and appropriate roles and responsibilities of police, ambulance services, physicians and others involved in crisis response.

A Provincial approach must involve lived experience at all levels

The importance of incorporating insights from lived experience, including the experiences of the families and support network of those with MHSU disorders, was underscored repeatedly by participants. This approach should apply not only to the development of service agreements and operations, but also to the review and oversight functions of any Provincial plan of action.

A focus on shared, "bottom line" outcome measures is necessary to drive success

Participants were clear that performance measures associated to implementation of coordinated crisis response needed to be simple, intuitive indicators which spoke to the client outcomes being sought. These might include:

- Absolute decrease of all those with MHSU disorders (and of Indigenous people with MHSU disorders) coming into contact with justice system;
- Similar to the approach of the UK Crisis Care Concordat, the use of appropriate resources (*i.e.,* decreased use of cells in the course of crisis intervention);
- Reduced readmissions into acute care;
- Further to the World Health Organization's work, assessment of client wellbeing over time;
- Stability (health, housing, treatment compliance) post-crisis; and
- Reduction in MHA Section 28 apprehensions.

Other feedback

Broader prevention efforts remain important

Recognizing that the Justice Summit was focused on the specific question of the MHSU population at the intersection of health and justice, participants pointed out that preventative work beyond the justice environment was a critical success factor. This work included diversion programs, early intervention, pre-crisis and post-acute work, education services, and work in early childhood development, and broader supports for families outside crisis situations.

Involuntary care options should be revisited

In light of the complexities of concurrent mental health and substance use disorders, and the remarks of lived experience presenters, some participants recommended attention be paid to exploration of the appropriate use of involuntary care options.

Technology will be required to create more equitable access for remote communities

A number of participants expressed concern that equitable, timely access to services in rural and remote communities would only be possible through greater access province-wide to technology-assisted delivery of health services.

Discussion: Continuity of Care

Participants then turned to a discussion of the second proposed objective within the action plan, concerning continuity of care. Two further presenters set the context for this discussion: Dr. Julian Somers of Simon Fraser University explored the question of who might be considered priority clients for a piloted approach to continuity of care, and Provincial Director Elenore Arend of BC Corrections reviewed the challenges for MHSU continuity of care under the *status quo*.

Dr. Somers noted that some potentially hard decisions regarding the MHSU population were approached with caution historically, leading to a degree of frustration at the pace of change. By contrast, the new *Corporate Plan for the BC Public Service* (2016) issues a challenge to those serving the public to accept risk, and innovate:

> *We need to become less risk averse and more experimental while also respecting our obligation to be accountable and prudent. We need to be more responsive and adaptable while ensuring stability and continuity of service. We need to deliver a simpler experience for citizens despite the often deeply complex nature of our work. We need to deliver services that are shaped more by the needs of citizens than by our own administrative priorities. We need to work more collaboratively despite our traditionally siloed accountability models. We need to be more open even as we maintain our obligation to security and privacy protection.*

Adopting an approach which favours experimentation, adaptability, clarity, placing people at the centre, and collaboration should drive our approach to continuity of care. Key questions to ask will be: Where are the benefits of experimentation greatest? Where does complexity undermine outcomes by making progress unclear? Where do our "normal" services, delivered normally, disrupt continuity for the actual client? Where do silos cause harm by inhibiting collaboration?

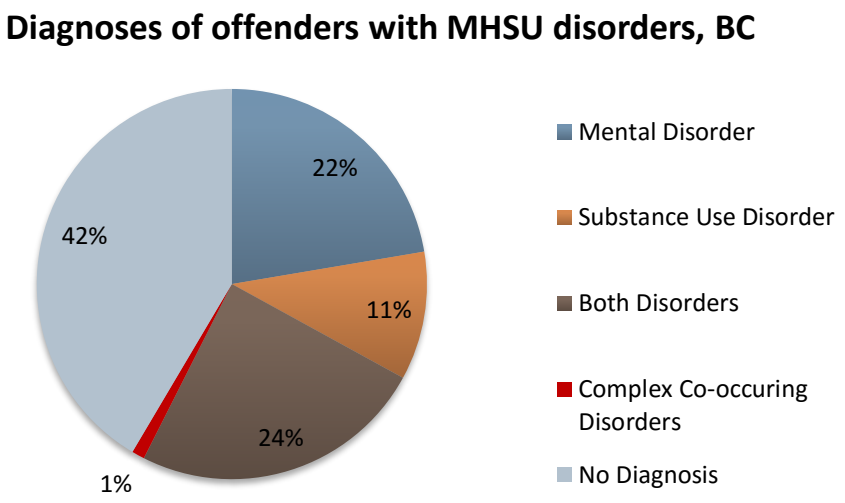

Figure 8: Data introduced by Dr. Somers shows the prevalence of mental disorders and substance use disorders amongst the BC correctional population. See Rezansoff SN, Moniruzzaman A, Gress C, Somers JM. (2013). Psychiatric Diagnoses and Multiyear Criminal Recidivism in a Canadian Provincial Offender Population. Psychology, Public Policy, and Law. Vol 19(4), Nov 2013, 443-453.

Dr. Somers provided a series of statistics, showing that the majority of the BC Correctional population from a recent multi-year sample exhibited one or more mental disorders, including substance use. The justice and social costs of these disorders are not evenly distributed, however, with the 1% of offenders with complex, co-occurring disorders (CCD) being sentenced, jailed and incurring hospital days at a rate nearly eight times that of other offenders, and being far more likely to receive income assistance.

In her address, Ms. Arend provided an overview of the mental health profile of the Corrections population (custodial and community), noting the rapid turnover of individuals in custody (averaging 33 days remanded and 60 days sentenced). As inmates cycle in and out of custody, continuity of care is both crucial and challenging to achieve. Example cases provided included that of "Josh," a crystal methamphetamine user arrested for assaulting a peace officer and breach of bail conditions. An order for a psychiatric assessment for fitness was made, but over the course of the following weeks a variety of diagnostic assessments and interactions with Josh yielded a conflicting picture,

Figure 9: Dr. Julian Somers and Provincial Director Elenore Arend introduce the Summit's discussion of continuity of care

based on observations of the client and on his self-report. Josh's condition fluctuated through periods of segregation and hospitalization, and inconsistent course of medication, and a pattern emerged in which few of his interactions with either legal or health professionals were fully informed by the client's history, or by his capacity to engage with external supports such as housing and drug treatment should he be released.

Ultimately released, Josh soon descended back into substance use and crisis. His story is not dissimilar to that of other inmates with serious mental health and substance use needs. While there are processes in place to assess the physical and mental health needs on admission, too often limited resources and insufficient information result in reliance on the client to provide information regarding any existing mental health supports or medications; Corrections is often starting from square one in these circumstances.

Steps are being taken to resolve some of these challenges, develop a more robust approach for addressing the health, mental health and substance abuse issues faced by individuals in Corrections, and establish information protocols to guide transitions between the two systems. Other work is in place to promote reintegration post-custody which has strong potential for application to support inmates with Mental Health needs.

But significant gaps remain. In particular, system navigators would be invaluable, as in the case of Josh, who didn't understand how the two systems worked together and how to get the help he needed. A navigation function can provide support as people are coming into jail, help make sure that the best possible care is provided while the person is in

custody, and find and connect inmates to existing resources (such as housing, mental health services, family doctors, or counselling) as they prepare for reintegration.

Small group discussions

Following the presentations, three questions were posed to participants for small group discussion:

(1) *This proposed objective draws on the Summit deliberations in June regarding continuity of care. Does it meet your expectations; are there principles or elements you would change?*

(2) *What specific practices, programs or approaches, established in BC or elsewhere, do you feel should be included as explicit elements of a provincial agreement?*

(3) *What measures would be the best indicators of success in this area?*

These discussions were followed by each table reporting out to the plenary.

Plenary discussion: key points

Key points emerging from the discussions, as reported in plenary, were as follows:

The objective received broad support as an element of the action plan

Participants indicated their general support for an agreed action plan to implement this objective in British Columbia, whether this was achieved through coordination between existing systems of care or through a new system approach. It was noted that positive steps are occurring and it is possible to build on what is working already. However, as things stand having separate systems of health care for Corrections and for the general population presents issues which must be addressed; and any solution must place the needs of the client, not of the administrative structures, at the centre. Continuity of care requires, at the most senior level, agreement between the health and justice systems to improve case management coherence accountability to a significant degree.

A navigator function may assist in overcoming the effect of silos on continuity of care

To the degree that the two separate systems of care endure, many participants endorsed the introduction of a navigator function to resolve issues of case management and manage transitions. Complementing such an approach would be an expansion in numbers of employees with shared knowledge of processes and options in both systems: people who can recognize and facilitate early transitions and ensure continuity of care. This knowledge should exist at the operational, managerial and executive levels. System navigators may also assist with transitions back into the community: making health connections, securing housing, identifying barriers, and engaging community partners. Reintegration and attention to continuity of care is required not just for those emerging from custodial sentences, but from remand as well.

Information sharing should be client centered and based on need-to-know

Participants noted the significant challenges associated to the information requirements of continuity of care. Corrections and health systems records are separate, and health transactions during periods of custody are not recorded on the general system, impacting communication and exacerbated by repeated, short sentences. Participants identified a number of areas where improved, appropriate sharing of information would promote continuity of care:

- Every agency is governed by its own set of ethics. Transition points therefore present particular challenges regarding need-to-know and use. For example, when preparing offenders to reenter a community and ensure continuity of care between Corrections and community MHSU service providers and treatment, access to information and the practical realities of managing this transition may bring mandates into conflict. Information sharing and limitations can normally be managed with appropriate protocols, provided they are anchored on what is required to be known.
- The criminal justice system, nationally and provincially, has made significant strides in the past 15 years in terms of consistency and sharing of information as a response to well-publicized prior information failures. Health information sharing is improving but is not yet at the same level; steps to improve the flow of

information between the civilian and correctional mental health systems would represent a significant gain.

- Integrated strategies which focus on the client (in and out of custody) and which necessarily bring multiple agencies to the table (AOT, ACT) have often been able to overcome information barriers. Adopting a client-centered approach on a more systemic basis, beyond localized teams, may yield the same benefit in terms of consistent use of information.

A client-centered systemic approach is required, regardless of structure

Participants frequently supported the idea that MHSU services and treatment should follow the person, and not suffer disruptions for administrative reasons irrelevant to the conditions being treated and the circumstances of the client. Currently, the unfortunate idea of one or the other system "owning" a client is prevalent, and the smaller Correctional health system is sometimes fragile due to the larger relative impact of specific staff absences on service capacity. An improved approach to continuity of care, regardless of the structure, requires a business model that justifies all arrangements based on service to the client and client outcomes (including client outcomes related to public safety).

Participants made numerous observations to the effect than an improved approach would need to address several impediments to continuity of care within existing institutional arrangements. These included:

- Cultural challenges for the Corrections and general health systems in working together and the need for cross training;
- The challenge of ensuring continuity of care in the difficult remand period; necessitating greater collaboration and therapeutic coordination regarding criminogenic needs and health needs;
- Managing the complexities of youth transitions, which in general has been addressed more fully in justice than in the health system, and is an area where MCFD's expertise could be engaged;

Figure 10: Summit participants in plenary during the afternoon

- The need for better informed risk assessment, with the provision of more well-rounded knowledge about the people getting into the system; and
- Further development of the skills necessary to distinguish a "danger issue" from a "health issue."

The importance of incorporating lived experience into system redesign

As in the discussion of coordinated crisis response, participants made clear that any strategy to improve continuity of care to the MHSU population through criminal justice transitions should incorporate insights from lived experience, including the experiences of the families and support network of those with MHSU disorders as well as offenders themselves.

Consistent standards of culturally safe and trauma-informed services in transitions

As in the discussion of coordinated crisis response, participants recommended that there should be no break in the standard of culturally safe and appropriate responses to Indigenous people regarding continuity of care for MHSU clients between systems.

Similarly, given the prevalence of trauma histories amongst those with MHSU disorders including but not limited to Indigenous clients, and the complexity this adds to diagnosis and treatment, trauma-informed practice should be the accepted standard across and during transitions.

Suggested performance indicators

Participants suggested performance indicators related to continuity of care which were generally similar to those suggested for coordinated crisis response, including:

- Indicators of recovery such as increased continuity of medication, uptake and compliance with treatment and supportive services, fewer bed days in hospital, decreased use of emergency services;
- Indicators of stability such as physician attachment, education, housing, and employment success;
- Decreased negative contacts with police/incidents within Corrections, and decreased recidivism; and
- Connection/reconnection to family and culture.

Discussion: Leadership, timelines and reporting

Participants turned in the final substantive session to consideration of the practical steps necessary to get to the agreement contemplated in earlier discussions.

Small group discussions

Three questions were posed to participants for small group discussion:

(1) *Who needs to be at the table in the coming year to ensure this work progresses? What is your own organization's role?*

(2) *What will need to happen in the next year to turn the final version of this recommendation into reality?*

(3) *How should Summit participants, and stakeholders regarding justice and MHSU issues, expect to hear back about progress?*

Following discussion in small groups, participants reported back in plenary.

Plenary discussion

Key points made in the plenary discussion were as follows.

Achieving an agreement must be championed at Ministerial level

Participants repeatedly emphasized that even the best ideas require a champion in order to become reality, and in this circumstance such a champion should be identified at the senior political (*i.e.* Ministerial) level. In plenary discussion, the common view was that leadership and direction to reach an agreement on coordinated MHSU crisis response and continuity of care, grounded on the Summit's deliberations, should involve one or more – and ideally, all three – of the Minister of Public Safety and Solicitor General, the Minister of Health, and the Minister of Justice and Attorney General. The need was also identified to have such leadership established shortly after the publication of the Seventh Summit's recommendation.

The approach to the UK Crisis Care Concordat is a model for getting to agreement

Many participants reflected on their knowledge of the United Kingdom's "Crisis Care Concordat," discussed at the previous Summit, noting that the Concordat's simple aim – the intuitive and necessary outcome of reducing the use of police cells subsequent to crisis response – was nevertheless complicated in terms of the different agencies and government Ministries involved. This required clear Ministerial direction. From the UK Cabinet level, the shared vision statement and mandate developed then created momentum, encouraging (and/or liberating) a variety of agencies to take more rapid steps to align. The Concordat approach of advocating simple outcomes (coordinated response, and continuity of care), championing these first at the senior level to accelerate agreement on detail, and then getting to agreement in a timely manner, was seen as worthy of adoption in British Columbia.

The approach should complement the forthcoming Provincial strategy on mental health

Participants noted the ongoing development of a Provincial strategy on mental health in British Columbia. Numerous participants expressed their expectation that the

recommended steps discussed at the Summit would complement and align with other elements of the Provincial strategy in light of the common theme of client-centered, continuous care.

Drafting an agreement will require both specific leadership and broad involvement

Participants felt that to get to an agreement by the end of 2017, early Ministerial direction should include establishment of a senior leadership group to steer (a) the development of the agreement over the coming year, and subsequently (b) the implementation of the elements of the agreement. Senior executives from Public Safety, Health, and Justice would be involved in central roles. However, participants also felt that the Ministries could and should not be expected to shoulder the full responsibility alone. Speakers identified numerous other organizations vital to include from the beginning in a planning capacity, to provide advice regarding the establishment of a provincial agreement, and as essential players in community-level adaptations of the agreement, implementation, and coordination. These would include (in no particular order) the Ministries of Children and Family Development, Education, and Social Development; BC Housing; Indigenous organizations such as the First Nations Health Council and the BC Aboriginal Justice Council; police agencies and organizations; Health Authorities and MHSU treatment specialists; federal Corrections; the Bar Association; and others. There can and should be nothing token about this inclusion, given that implementation will occur at the community and local operational level and involve many players in two systems. The judiciary should be invited to participate in an

Figure 11: Minister Suzanne Anton makes closing remarks to Summit participants

advisory capacity to the extent appropriate, and should in any event remain apprised of all developments.

Inclusion of lived experience in agreement design and ongoing decisions

Participants made clear in plenary that learning from lived experience – of those with experience of MHSU disorders and involvement with the justice and health systems, and of their families and support networks – should be considered necessary rather than optional in getting to an agreement and its subsequent implementation. Those with lived experience should not simply be consulted, but be incorporated into the decision-making framework going forward. Some participants felt this might include some form of advocacy function, both for those with MHSU disorders and for their families.

A coordinating/secretariat function is necessary to support arrival at an agreement

In addition to political direction, and a steering group and advisory functions drawn from major stakeholders, participants identified the need for a working level group to assist in advancing consultation and negotiation of the agreement. It was noted that there are structures already existing within government that are logical places to take on key pieces, having been developed for the elaboration of the Provincial mental health strategy. It was also suggested that the Summit working group, which had developed the materials to this point, might be empowered to carry some of its work forward. However this is done and resourced, participants noted the necessity of such a function given the very significant number of stakeholders.

One year is a realistic period of time in which to get to agreement

Noting the scheduled provincial election in May 2017, in general participants did not believe that a time frame of less than a year to deliver an agreement was practical, and that a report-back at the June Summit should not be required. Noting that the deliverable for November 2017 is an agreement, but not full implementation, participants did not identify any alternative time frame and felt that this goal was achievable.

Simple, common metrics of success are necessary

Participants felt that as part of any agreement, clear performance measures shoud be included to show progress. Formal reporting should occur back to the Summit, and to the

Justice and Public Safety Council, in the period after implementation. Such reporting may start with pilot projects, and/or provincial and regional benchmarks, depending on the agreed plan for implementation.

Final recommendation

Based on the feedback from participants in plenary discussion at the Summit, in its preparation of this report the Steering Committee has developed a revised version of the Summit recommendation.

Further to deliberations in 2016 at the Sixth and Seventh BC Justice Summits on the issue of "Justice, Mental Health and Substance Use," the Summit makes the following recommendation:

Call for an action plan on crisis response and continuity of care

The Summit calls for an action plan to be developed and agreed upon between leaders of BC's justice and public safety sector and of BC's mental health and substance use and social services sectors by November 2017, to guide the development and or redevelopment of services and supports for people with mental health and or substance use (MHSU) disorders in contact with the criminal justice system.

The Summit respectfully calls for the development of this action plan to be championed at the Ministerial level by one or more of the Ministers of Public Safety, Health, Justice, and Children and Family Development, and to be aligned with any Provincial Strategy on Mental Health.

The Summit calls for the immediate establishment of a steering group formed from the Ministries of Public Safety, Health, and Justice, with required support, to oversee the development of the agreement by November 2017; and for the ongoing involvement in planning, advisory services and implementation of other Ministries, authorities and agencies, Indigenous leadership and organizations, experts, non-profit and community organizations, and those with lived experience, as specifically suggested elsewhere in this report.

The Summit noted various initiatives already underway consistent with this work and supported ongoing development while highlighting the need for ensuring alignment with the Provincial Mental Health Strategy and the priority work areas identified by the Summit.

The intent of such an action plan would be to improve outcomes for high-risk members of the MHSU population, and to protect public safety, through implementing two specific objectives with respect to those with MHSU disorders:

A. Coordination of MHSU crisis response between mental health and criminal justice services; and
B. Continuity of mental health and addictions care across transitions involving criminal justice.

These initiatives would further be characterized by:

- Measures to reduce discrimination regarding MHSU clients (combatting stigma, ensuring Indigenous cultural safety, and promoting trauma-informed practice), and
- The timely and appropriate sharing and use of information, as enabled by current legislation, to support decision-making.

The Summit requests a report back in November 2017 regarding progress made on this recommendation.

Objective A: Coordination of MHSU crisis response between the mental health and criminal justice systems

What would be created?

By November 2017, an agreement to coordinate MHSU crisis response between the Ministries of Public Safety, Justice, and Health, implicating all relevant stakeholders involved in the support of clients who may engage (or who are in) the criminal justice system, for the purposes of crisis prevention, response, and post-crisis support.

Principles

- Commitment to ensure people with MHSU disorders are treated with dignity and respect at all times.
- Commitment to shared responsibility for the outcomes of clients in crisis.
- Commitment to practices that eliminate stigma-based discrimination, ensure Indigenous cultural safety and healing consistent with a commitment to Truth and Reconciliation, and promote trauma-informed practice.
- Commitment to deliver services that are shaped more by the needs of citizens than by administrative priorities.
- Expectation that lived experience is incorporated into all stages of planning and implementation.
- Expectation that local community protocols created under the agreement will differ depending on community demographics, needs and resources.
- Expectation that community resources will play a significant role in the design and implementation of this agreement.
- Expectation that provincial minimum standards regarding crisis response would be established notwithstanding regional and community differences.
- Understanding that clusters of higher prevalence of MHSU disorders per capita are found in northern and rural British Columbia.
- Understanding that effective crisis response to acute circumstances is built on evidence-based interventions including (a) preventative measures to mitigate risk of MHSU crises; (b) immediate response during a MHSU crisis; and (c) support following a MHSU crisis.

Elements

1. An agreement to support the action plan signed by all agencies that may be involved at any point in activities related to prevention, response to a MHSU crisis or post-crisis support. Parties should include but are not limited to: police, mental health and substance use services, emergency health, public health, corrections, social services, and community-based services. The agreement would be shared with the MHSU service sector, the social sector, and the justice and public safety sector (including prosecution services, the defence bar, the courts and court services), to inform their decisions and roles.

2. The agreement would provide explicit guidance to the development of community-based protocols articulating the agreement at the local level including:

2.1. Commonly-agreed definitions, terms of reference, and shared vision;
2.2. Expected procedures of each agency that will occur during a MHSU crisis including but not limited to agency roles; staff roles; and expected staff response;
2.3. Expected procedures regarding pathways for information to be shared, received or otherwise utilized among the agencies implicated in crisis response;
2.4. Expected approaches to ensure that services are delivered in a manner respectful of Indigenous cultural safety, and in ways which combat and reduce the effects of mental health stigma;
2.5. Guidelines for when information sharing is to be mandatory when focused on client care or public safety;
2.6. Expected mechanisms for how to identify and ensure the inclusion and involvement of partner agencies in all stages of the process;
2.7. Expected means of determining specific lead responsibility for the client at the various stages of prevention, crisis and post-crisis, including accountability for ensuring that necessary information is provided;
2.8. Standards of practice regarding how agencies will support the transfer or discharge of a person into or out of their care;
2.9. Expected performance measures and associated reporting schemes to determine progress towards the shared vision; and
2.10. Mechanisms for speedy resolution of any identified barriers to a timely, coordinated response will be resolved across agencies.

Objective B: Continuity of mental health and addictions care across transitions involving criminal justice

What would be created?

By November 2017, an agreement between the criminal justice system, the health sector, and the social service sector, to take the collaborative and/or institutional steps necessary to ensure coordinated care plans, transition point support, and continuity of care across these sectors for individuals with MHSU disorders.

Principles

- Commitment to ensure people with MHSU disorders are treated with dignity and respect at all times.
- Commitment to practices that eliminate stigma-based discrimination, ensure Indigenous cultural safety and healing consistent with Truth and Reconciliation, and promote trauma-informed practice.
- Commitment to deliver services that are shaped more by the needs of citizens than by administrative priorities.
- Understanding that crisis intervention services for MHSU clients need to reflect urban, rural and remote needs.
- Expectation that lived experience is incorporated into all stages of planning and implementation.
- Expectation of 'equivalence of care' in health service delivery to those involved with the criminal justice system, including clear, well-understood pathways for individuals to access services based on need.
- Expectation that MHSU care and interventions are modelled on best evidence-based practices, and are accessible regardless of transitions involving the justice system.
- Expectation that interventions correspond with and are responsive to the individual's assessed criminogenic and determinants-of-health needs.
- Expectation of a shared responsibility between the criminal justice system and the health care system to share information as is appropriate according to current legislation.

Elements

1. An agreement to support the action plan signed by representatives of the criminal justice system, the mental health sector and the social sector, committing to an integrated collaborative approach to care, ensuring continuity of relevant clinical and social services for individuals with MHSU disorders.

2. The agreement would provide explicit guidance to criminal justice and health sector agencies and social service providers regarding:

2.1. Commonly-agreed definitions, terms of reference, and shared vision, including specification of key transition points expected to be included within the agreement;
2.2. Overall organizational roles, responsibilities and accountabilities regarding continuity of care for individuals with MHSU disorders engaging the criminal justice system, with an overriding assumption of client-centered care;
2.3. Specific expectations of care provision and responsibility at key transition points between the criminal justice system, the mental health and substance use sector, and the social service sector, to promote successful reintegration into the community;
2.4. Expected approaches to ensure that services are delivered in a manner respectful of Indigenous cultural safety, and in ways which combat and reduce the effects of mental health stigma;
2.5. Mechanisms for effective information sharing at transition points and/or during care provision, necessary to ensure continuity of care for individuals with MHSU disorders and reduce risk of harm, including active consideration of a navigation function or method which places the client's interests at the centre;
2.6. Mechanisms integrated with coordinated crisis response for early intervention and navigation support, at the initial diagnostic stage and/or upon initial contact with the criminal justice system or health care system;
2.7. Mechanisms integrated with coordinated crisis response for effective intake and streamlined access to care, the purpose of which would be to increase diversion to supports, and to mitigate the unintentional harms, public safety concerns and negative trajectories created through a client's experience of multiple transitions; and
2.8. Expected performance measures and associated reporting schemes to determine progress towards the shared vision.

Summit closing

Closing remarks and theme of 2017 Summits

Participants heard a closing address from the Honourable Suzanne Anton, Minister of Justice and Attorney General of British Columbia. Minister Anton, echoing the words of Minister Morris earlier in the day, expressed her appreciation to participants, and to the Chief Justice of Canada for her keynote address, and challenged her Ministry and others in the room to take leadership roles in agreeing and implementing the action plan discussed during the day. Minister Anton further announced that the theme of the 8th and 9th Summits in 2017 would address Indigenous justice issues.

Special thanks were offered by Moderator Ms. Caroline Nevin, followed by a warm round of applause from participants, to Mr. George Thomson of the National Judicial Institute, who had returned as Facilitator for the seventh time. Remarks of appreciation to participants and organizers were also offered by the Moderator, who then declared the Summit adjourned.

Steps following the Seventh BC Justice Summit

A progress report further to the Summit recommendation will be provided on or before the date of the 9th Summit in November, 2017.

Appreciation

The Steering Committee would like to express its thanks to the participants at the Seventh British Columbia Justice Summit, whose continuing commitment and goodwill contributed greatly to the event.

The Steering Committee would like to express its appreciation to the Chief Justice of Canada, the Right Honourable Beverley McLachlin, PC, for her attendance and keynote address, and to the Chief Justice of British Columbia, the Honourable Robert Bauman, for his introductory remarks. The Committee would also like to thank the Musqueam Indian Band, and Elder Larry Grant, for the warm welcome and good wishes extended to Summit participants, and also wishes to thank the Honourable Suzanne Anton and the Honourable Mike Morris for their remarks of welcome and appreciation.

The Committee would also like to extend its appreciation to Ms. Elenore Arend, Mr. Scott Harrison, Dr. Julian Somers, and Superintendent Daryl Wiebe for their contributions to the dialogue, and to Mr. Jonny Morris of CMHA-BC and his two guests, EF and PQ, for being willing to share their highly personal and moving experiences with the Summit.

The Steering Committee would also like to thank Dean Catherine Dauvergne and staff of the University of British Columbia, Faculty of Law, for their generosity and flexibility in once again creating an excellent setting for the Summit.

Finally, the Steering Committee would like to thank the Summit facilitator, George Thomson, for reprising his role; the Summit moderator, Caroline Nevin; Michelle Burchill and Dan Silverman of UBC Faculty of Law; and the many individual employees of public, private and not-for-profit justice and public safety organizations, agencies and firms in British Columbia who made direct personal contributions to the success of the Justice Summit.

Summit feedback

Comments on this *Report of Proceedings* and the Summit process are encouraged and may be emailed to the Justice and Public Safety Secretariat at justicereform@gov.bc.ca.

Written communication may be sent to:

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Coordinator, BC Justice Summit & BC Justice and Public Safety Council
c/o Ministry of Justice
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1001 Douglas Street
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Attention: Justice Summit

Appendix 1: "Toward a Better Justice System" – Remarks of the Rt. Hon. Beverley McLachlin, PC, Chief Justice of Canada

Elder Larry Grant, Chief Justice Bauman, Minister Anton, Minister Morris, Dean Dauvergne, distinguished participants:

Thank you for allowing me to be part of the Seventh B.C. Justice Summit. I have looked at reports of the first six summits. What I have read has left me deeply impressed. Too often when it comes to the justice system, people work in silos. As a result their work does not have impact beyond their own small sphere. What these summits have done is to bring diverse actors in the justice system together, so they may work in harmony instead of isolation. I congratulate you on this. It is the only way to really respond to the crisis in our justice system.

I have been talking about access to justice and the failings of our system of justice for a long time. The Canadian justice system is a good justice system. It is fair and free from corruption. It takes the rights of accused persons and victims seriously. But it is not perfect. Today I would like to use the few minutes allotted to me to share with you my thoughts on the challenges we face and how we can move forward.

Two Preliminary Points

Before I get into my personal list of challenges, let me make two meta-points about how we should approach reform in the justice system.

The first point is that *the criminal justice system is complex*. It embraces a host of processes – policing; preliminary procedures relating to detention and bail; trials; sentencing; jails and prisons. The *Criminal Code* and the federal and provincial laws that cluster around it constitute a formidable suite of intertwining laws. The matrix of the law is rendered yet more complex by thousands of judicial decisions applying, defining, and sometimes striking down or limiting the laws passed by Parliament and the Legislatures.

Mixed into all this are social problems of abuse, addiction and mental health, each demanding its own individualized treatment.

Not only is the system complex, it is polycentric. The various processes, laws and specialized problems are intertwined in a way that rules out simple solutions. Legal philosopher Lon Fuller likened complex problems like this to a spider web[1] – if you pull on one strand, you shift the others out of position, perhaps break them. When you devise a solution for one problem, you may create a new problem somewhere else. The law of unintended consequences bedevils every effort of reform.

But that does not mean we should give up. It means that we must try to look not only at our little piece of the web, but the whole intertwined structure. It means we must be smarter to figure out solutions that will actually work. And it means those in charge of different strands of the web must be willing to work together.

The second preliminary point I want to make is that to move forward, *we must confront the failings of the justice system honestly and fully*. In a recent bestseller, *Black Box Thinking*,[2] author Matthew Syed points out a fundamental truth: to make things better, you first have to identify why you are failing. He uses the aeronautics industry as an example. If a crash occurs, the black box is recovered and minutely examined to determine the precise causes of the crash. Then steps are taken to eliminate those causes. Instead of covering up or minimizing failure (as we so often do in disciplines like law) instead of telling yourself the system is pretty good and some failures are inevitable, you acknowledge it squarely and root out its causes. The result is a better system – one that operates as successfully as humanly possible.

I believe the Justice Summits have taken these two meta-ideas to heart. You recognize that the justice system is complex and that improving it therefore requires us to be smart

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1 Lon Fuller, "The Forms and Limits of Adjudication", 92 *Harv. L. Rev.* 353.

2 Matthew Syed, *Black Box Thinking: Why Some People Never Learn From Their Mistakes – But Some Do* (Portfolio/Penguin, 2015).

and to work together. And you recognize that the only way forward is to honestly look at where we are failing and where and how we can do better.

The Challenges

1. Delays

I will not say much about delays – the Supreme Court addressed the matter in a case familiar to you: *R. v. Jordan*.[3] The Charter guarantees a right to a trial within a reasonable time. Courts from *R. v. Askov*[4] on have been struggling to define what constitutes a trial within a reasonable time. During the same time period, trials and pre-trial procedures have been adding to the complexity and length of trials, making delivery of prompt justice more difficult. Over the years the almost impossible task of honouring the *Charter* guarantee in an era of increasing complexity had led to what Justice Moldaver in *Jordan* referred to as a culture of complacency.

It has become apparent that the culture of complacency cannot be tolerated. It has also become apparent that to honour the guarantee of a trial within a reasonable time in an era of increasingly complex trials, the justice system must insist on expeditious procedures and increased resources. Across the country, police, Crown attorneys, governments and courts are mobilizing to ensure that persons accused of crimes are tried within a reasonable time. It is difficult work. Yet it is being undertaken with energy and indeed enthusiasm. In the spirit of "black box thinking," we have taken stock of this failing in the justice system and resolved to eliminate it. The result will be a better justice system for all.

2. Addiction and Mental Health

According to the Centre for Addiction and Mental Health, each year, one in five Canadians experiences a mental health or addiction problem or illness, either individually, within

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[3] *R. v. Jordan*, 2016 SCC 27, [2016] 1 S.C.R. 631.

[4] *R. v. Askov*, [1990] 2 S.C.R. 1199.

family, or in the workplace.[5] That's over 7 million people. In a speech this last April to the Canadian Educators Conference on Mental Health, Her Excellency Mrs. Sharon Johnston remarked that "[t]he mental suffering is a national tragedy in a country with so much wealth and opportunity." Her sentiment was recently echoed by three leading national mental health organizations, who called on federal and provincial governments to make mental health the top priority in healthcare investments.[6]

I once asked the Police Chief of a large Toronto precinct what his biggest problem was. I thought he might complain of lack of funding or overbearing judges. He surprised me. "Mental illness", he said. He went on to describe his jail filling up each night with addicted and ill people arrested on minor charges, warehoused for a while, maybe sent to court, only to be released to reoffend, in an unending cycle.

Addiction poses similar challenges. Addicts are picked up for crimes, processed by the system, kept in jail for a while, and returned to the street, where, untreated, they re-offend.

Often mental health problems and addictions are intertwined in a complex downward trajectory, complicating the picture. Mental health in the justice system often goes hand in hand with substance abuse and homelessness.[7] In Vancouver's Downtown Eastside, the interaction between crime, mental illness, substance abuse, and poverty has created a public health crisis.

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[5] Centre for Addiction and Mental Health, Mental Illness and Addictions: Facts and Statistics, online: http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx.

[6] http://www.camh.ca/en/hospital/about_camh/newsroom/news_releases_media_advisories_and_backgrounders/current_year/Pages/open-letter-organizations-health-accord.aspx.

[7] Tim Riordan. (2004). *Exploring the Circle: Mental Illness, Homelessness and the Criminal Justice System in Canada.* Parliamentary Information and Research Service at the Library of Parliament. http://www.parl.gc.ca/content/lop/researchpublications/prb0402-e.pdf.

To address this issue, we must examine this particular "black box". We need to examine the causes of mental illness and addiction, and their relation to crime.

At least two causes of the addiction/mental health crisis emerge. The first is illness. Just as some people develop cancer, some people will develop serious mental illnesses like schizophrenia, bi-polar disorder and depression. The second cause is social dysfunction. A person who is abused or who grows up in a dysfunctional home or community may develop mental illness.

The answer to reducing mental illness and addiction can be summed up in three phrases – reducing family and social dysfunction; early intervention; and effective treatment. We need to do a better job of addressing problems in the home and in the community that may lead to or trigger pre-existing mental illness. Great advances have been made in the treatment of mental illness. But too often, the illness goes undetected until too late, and even then, untreated.

The result is that the justice system is left to deal with problems of mental health and addiction, when afflicted people commit offences and end up in court. Mentally ill persons are disproportionately represented in the criminal justice system at all levels – more police contact, more arrests, more criminal charges, more custodial sentences. The Office of the Correctional Investigator estimates that mental health issues are 2-3 times more common in Canadian prisons than in the general population.[8] And a recent study found that among those who were judged not criminally responsible on account of

[8] Sapers, H. (2014). *Annual report of the Office of the Correctional Investigator 2013-2014*. Ottawa, Ontario: The Correctional Investigator of Canada. http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf. Significantly, In the U.S., the percentage of inmates in state and federal prisons with serious mental illnesses is three to four times higher than the rate of mental illness in the general population: *How are civil courts meeting the challenge of mental health? Processing mental health cases fairly and efficiently in the courts*. Thomson Reuters, 2016.

mental disorder, most had been previously hospitalized in a psychiatric ward.[9] Sadly, once someone is embroiled in the system, their situation tends to worsen. Practices rooted in punishment and control – like the imposition of strict bail or probation conditions, or segregation and isolation in prison – can further criminalize them.

It comes as no surprise, then, that people who suffer from mental illness and addiction consume a large chunk of the resources, human and material, that society allocates to the criminal justice system. Mental health and addiction issues pose a major challenge to the Canadian justice system. Reducing mental illness and addiction is a huge and complex problem, beyond the resources of the justice system. But the justice system bears full responsibility for two things – first that it does not exacerbate the problem, and second, that it deals with those who suffer from mental illness and addiction in a positive, humane and just fashion.

We have come some distance in discharging this responsibility. The *Criminal Code* once approached mental health and addiction through a 19th century lens, both in terms of the substantive law and the procedures that applied to mentally ill people. Mentally ill people who committed crimes were treated like common criminals or held in detention for life. In 1991, the Supreme Court of Canada held that this violated the right to liberty guaranteed by the *Canadian Charter of Rights and Freedoms*.[10]

In response, Parliament enacted Part XX of the *Criminal Code*. Under this new process, mentally ill offenders are now channeled into a treatment/carceral regime under the supervision of boards staffed by lawyers, psychiatrists and lay people. The boards are charged with the dual task of ensuring appropriate medical treatment for the mentally ill

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[9] Crocker A.G., Nicholls TL., Seto M.C., Charette, Y. Côté, G., and Caulet, M. (2015). "The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder in Canada. Part 2: The People Behind the Label." *Canadian Journal of Psychiatry*, 60, 3, 106-16. Cited in *Unlocking Change: Decriminalizing Mental Health Issues in Ontario*. Report of the John Howard Society of Ontario (2015), at p. 8.

[10] *R. v. Swain*, [1991] 1 S.C.R. 933.

person and making appropriate orders having regard for his liberty and for the security of the public.

The system has worked. Incarceration has been reduced, and recidivism rates have fallen. Public safety has been maintained. The problems have by no means been eliminated, however. A recent report by the John Howard Society of Ontario reports that because treatment is unavailable in the community health system, the criminal justice system is sometimes viewed as the only way for some to secure treatment.[11] Yet prisons are not treatment facilities.

The creation of specialized mental health and addiction courts throughout Canada represents a second step in the right direction. These courts, championed by leaders like the late Chief Judge Hugh Stansfield of this Province, have spread across the country, and provide an alternative to criminal prosecution by diverting accused with mental health problems to treatment programs in the community. As Brian Lennox, Chief Justice of the Ontario Court of Justice, said at the opening of the Mental Health Court in Ottawa:

> *The goal is to satisfy the traditional criminal law function of protection of the public by addressing in individual cases the real rather than the apparent causes that lead to conflict with the law*.[12]

These courts, with their focus on rehabilitation rather than punishment, are working. They are treating people appropriately. They are breaking the cycle of court, jail, reoffending, and back-to-court. They are making our streets safer and relieving pressure on the regular courts. And they are cutting public costs by reducing re-offending and incarceration. A 2006 evaluation of the Brooklyn Mental Health Court indicated significant improvements in several outcome measures, including substance abuse, psychiatric

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[11] *Unlocking Change: Decriminalizing Mental Health Issues in Ontario*. Report of the John Howard Society of Ontario (August 2015), at p. 9

[12] "Court for Mentally Ill to Open" *Kitchener-Waterloo Record* (June 15, 2005), online: Canadian Mental Health Association http://www.ontario.cmha.ca/content/mental_health_system/public_issues.asp?cID=5834

hospitalizations, homelessness and recidivism.[13] Speaking about the mental health court in Saint John, New Brunswick, Provincial Court Judge Michael McKee stated a few years ago that "90 per cent of its clients had completed the requirements of the program in the mental health court and out of that number, 85 per cent of those never returned to court."[14] This is encouraging.

Still, we need to do more. A 21st century approach to mental illness and addiction in the criminal justice system would use what we know to prevent addictions through education, to help the mentally ill through early and effective treatment, and to assure that the justice system works to rehabilitate them.

3. Indigenous Offenders

In 1996, then Justice Minister Allan Rock deplored the fact that while aboriginal people represented about two per cent of the Canadian population, they represented 10.6 per cent of persons in prison. To deal with the problem of prison over-representation, Parliament passed a law requiring judges to take into account the particular circumstances of aboriginal offenders when sentencing. Two decades later, the figures have not improved. Last year, aboriginals were four per cent of the Canadian population but made up 24 per cent of federal inmates. Among women inmates, the imbalance was even worse: 36 per cent were aboriginal. The Prime Minister has instructed the Justice Minister to develop "initiatives to reduce the rate of incarceration amongst indigenous Canadians."[15] Similarly, the Truth and Reconciliation Commission of Canada in its *Calls to*

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[13] Kelly O'Keefe, *The Brooklyn Mental Health Court Evaluation: Planning Implementation, Courtroom Dynamics, and Participant Outcomes* (New York: Centre for Court Innovation, 2006), online: http://www.courtinnovation.org/_uploads/documents/BMHCevaluation.pdf.

[14] CBC News, "Judge Optimistic Over Mental Health Plan: Judge Michael McKee Hoped More Attention Would be Paid to Mental Health Courts" (May 5, 2011), online: http://www.cbc.ca/news/canada/new-brunswick/story/2011/05/05/nb-mental-health-mckee.html.

[15] Graeme Hamilton, *National Post*, "Aboriginal offenders: 'There's a problem here'" (August 6, 2016).

Action, called upon the federal, provincial, and territorial government to commit to eliminating the overrepresentation of Aboriginal people in custody over the next decade.[16]

In *R. v. Gladue*[17] and *R. v. Ipeelee*,[18] the Supreme Court issued instructions to judges on how to implement the new provision of the Criminal Code that required judges to take into account the circumstances of aboriginal offenders. The Court directed judges to consider the enduring impact of colonialism, displacement and residential schools when fixing sentences, even in cases involving violence. Justice LeBel in *Ipeelee* wrote that this does not amount to "a race based discount on sentencing".[19] Rather, the special circumstances of aboriginal offenders are to be considered as a means to fixing a proper sentence in the individual case.

Three problems have arisen in our attempt to implement *Gladue* and reduce the disproportionate number of indigenous people in prison.

The first problem is that it is often difficult for a judge to ascertain the special circumstances tied to the aboriginal origin of a particular offender. Pre-sentence reports may be absent or incomplete. The load of cases simply doesn't allow case workers to properly document the file. So judges are often unable to effectively implement the *Criminal Code* directive. More funding is required in order to provide judges with the documentation they need to make just and appropriate orders for indigenous offenders.

The second problem is that even if a judge does have the necessary information, the judge may have no alternative except to send the offender to jail or prison, because, quite simply, there is nowhere else. The judge may be forced to choose between the bad and the worse. Full implementation of *Gladue* sentencing requires alternative justice models –

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16 Truth and Reconciliation Commission of Canada, *Truth and Reconciliation Commission of Canada: Calls to Action*, item 30.
17 *R. v. Gladue*, [1999] 1 S.C.R. 688.
18 *R. v. Ipeelee*, 2012 SCC 13, [2012] 1 S.C.R. 433.
19 At para. 75.

models that will permit issues related to aboriginal factors to be effectively addressed. The Prime Minister's directive to the Justice Minister also instructs her to look into aboriginal justice models. This is essential to effectively dealing with the over-representation of aboriginal persons in our prison system.

Jonathan Rudin, program director at Aboriginal Legal Services of Toronto, says that critics tend to exaggerate the number of people getting shorter sentences because of *Gladue*. The larger problem is that offenders are getting no treatment in prison to prevent them from re-offending. "All jail is able to do is warehouse people. For almost all offenders, they're going to be released at some point."[20]

And Federal Correctional Investigator Howard Sapers, pointing out that aboriginal inmates are more likely to have a history of substance abuse and mental illness and to come from backgrounds of domestic violence, says that programs are required to address "the unique circumstances and social histories"[21] of aboriginal inmates. We know what is needed. Research has shown that aboriginal offenders fare better after release "when they are reconnected with their spiritual and cultural traditions"[22] while incarcerated. In short, it is not enough to consider aboriginal factors in sentencing – the sentence itself must seek to deal with those factors and rehabilitate the offender.

The third problem lies outside the justice system. To reduce the disproportionate number of aboriginal offenders in our justice system, society must address the past wrongs, social dysfunction and alienation that lead too many indigenous people into conflict with the law. This is a complex long-term project; it is part of the process of reconciliation between indigenous peoples and other Canadians upon which Canadians are now embarking. The ultimate promise of reconciliation is healthy indigenous communities and families. It will

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[20] Graeme Hamilton, *National Post*, *supra.*

[21] H. Sapers (2015). *Annual report of the Office of the Correctional Investigator 2014-2015*. Ottawa, Ontario: The Correctional Investigator of Canada. http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20142015-eng.aspx.

[22] *Ibid.*

take some time. But it is essential. As former Chief Justice Lamer said in *Delgamuukw*, "Let us face it, we are all here to stay."[23]

While we go about the complex work of reconciliation, there are immediate things we can do. We can provide better housing and education for First Nations families. And we can ensure that the justice system itself does not inadvertently contribute to the criminalization of young aboriginal offenders. Time after time, judges see a familiar pattern – an Aboriginal youth commits a minor offence; he is granted bail subject to conditions; he breaches a condition, perhaps a minor one; he is imprisoned for breach of the condition; while in prison, he is criminalized; he is released and re-imprisoned, this time for a violent offence. In effect, the system in these cases has contributed to transforming the individual from a petty offender to a hardened criminal. We can and should do better.

Conclusion

I am grateful for this opportunity to share with you my thoughts on three challenges that face the Canadian criminal justice system. I hope I have not left you feeling disheartened and discouraged. Our justice system is a good one. The problem is that it faces unprecedented issues – issues that have been left to fester for too long. The issue of delay in court proceedings, too long left to half-hearted measures. The issue of mentally ill and addicted offenders, who need help if they are to escape the syndrome of the revolving prison door. The issue of abuse, neglect, and well-meaning imposition of alien values and systems on Canada's aboriginal peoples. The good news is that we are now taking stock of where we have failed, and are taking up these issues with renewed understanding and purpose.

I am heartened by the dedication of the diverse participants in this Justice Summit to the cause of justice. Your deliberations and hard work can make a difference. We all stand to gain from what you are accomplishing together today.

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[23] *Delgamuukw v. British Columbia*, [1997] 3 R.C.S. 1010, at para. 186.

Appendix 2: Summit agenda

0730 Registration and coffee

0800 Welcoming Ceremony, Franklin Lew Forum

- Moderator's welcome: Ms. Caroline Nevin, Canadian Bar Association
- Welcome to Musqueam territory: Elder Larry Grant, Musqueam First Nation
- Welcome to Allard School of Law: Dean Catherine Dauvergne
- Keynote address: introduction by Hon. Robert Bauman, Chief Justice of British Columbia
- Keynote address: Rt. Hon. Beverley McLachlin, Chief Justice of Canada
- Appreciation and Summit opening: Hon. Mike Morris, Minister of Public Safety and Solicitor General of British Columbia

0900 The need to act: remarks from lived experience (Roundtable)

- Panel
    - Chair: Mr. Jonny Morris, Canadian Mental Health Association
- Q&A/comment - plenary

0930 Facilitator's remarks: the day's objectives

- Facilitator: Mr. George Thomson
- Remarks: overall premise and context of the day's discussion; the mandate from the Sixth Summit; confirming the Summit's willingness to move towards a recommended plan in the day ahead.
- Summit ground rules and methodology for preparing report.
- Opportunity for plenary comment (if participants wish).

945 Break

1000 Objective 1: Coordinated Crisis Response

- Panel remarks: why this matters (20 minutes)
  - Superintendent Daryl Wiebe, Vancouver Police
  - Mr. Scott Harrison, Providence Health
- Table discussions (60 mins)
- Report outs and plenary discussion (40 mins)

1200 Lunch

1300 Objective 2: Continuity of Care

- Panel remarks: why this matters (20 mins)
  - Dr. Julian Somers, Simon Fraser University Faculty of Health Science
  - Ms. Elenore Arend, BC Corrections
- Table discussions (60 mins)
- Report outs and plenary discussion (40 mins)

1500 Break

1515 Leadership, Timelines and Reporting

- Facilitator's overview of what is being asked of participants (5 mins)
- Table discussions (40 mins)
- Report outs and plenary discussion (30 mins)

1630 Facilitator's summary of the day's results

1640 Closing

- Closing remarks: Hon. Suzanne Anton, Minister of Justice and Attorney General of British Columbia
- Adjourn Summit: Moderator

Appendix 3: Draft recommendation considered by participants

Call for an action plan on crisis response and continuity of care

The Summit calls for an action plan to be developed and agreed between leaders of BC's justice and public safety sector and of BC's mental health and substance use and social services sectors by November 2017, to guide the development and or redevelopment of services and supports for people with mental health and or substance use (MHSU) disorders in contact with the criminal justice system. The action plan would complement broader provincial strategies in either sector, including any provincial strategy on mental health.

The intent of such an action plan would be to improve outcomes for high-risk members of the MHSU population, and to protect public safety, through implementing two specific objectives with respect to those with MHSU disorders:

A. *Coordination of MHSU crisis response between mental health and criminal justice services; and*
B. *Continuity of mental health and addictions care across transitions involving criminal justice.*

These initiatives would further be characterized by:

- *Measures to reduce discrimination regarding MHSU clients (combatting stigma, ensuring Indigenous cultural safety, and promoting trauma-informed practice), and*
- *The timely and appropriate sharing and use of information, as enabled by current legislation, to support decision-making.*

Objective A: Coordination of MHSU crisis response between the mental health and criminal justice systems

What would be created?

Within one year, an agreement to coordinate MHSU crisis response between all relevant stakeholders involved in the support of clients who may engage (or who are in) the criminal justice system, for the purposes of crisis prevention, response, and post-crisis support.

Principles

- *Commitment to ensure people with MHSU disorders are treated with dignity and respect at all times.*
- *Commitment to practices that eliminate stigma-based discrimination, ensure Indigenous cultural safety and healing consistent with a commitment to truth and reconciliation, and promote trauma-informed practice.*
- *Commitment to deliver services that are shaped more by the needs of citizens than by administrative priorities.*
- *Expectation that local community protocols created under the agreement will differ depending on community demographics, needs and resources.*
- *Expectation that provincial minimum standards regarding crisis response would be established notwithstanding regional and community differences.*
- *Understanding that clusters of higher prevalence of MHSU disorders per capita are found in northern and rural British Columbia.*
- *Understanding that effective crisis response to acute circumstances is built on evidence-based interventions including (a) preventative measures to mitigate risk of MHSU crises; (b) immediate response during a MHSU crisis; and (c) support following a MHSU crisis.*

Elements

1. *An agreement to support the action plan signed by all agencies that may be involved at any point in activities related to prevention, response to a MHSU crisis or post-crisis support. Parties should include but are not limited to: police, mental health and substance use services, emergency health, public health, corrections, social services, and community-based services. The agreement would be shared with the MHSU*

service sector, the social sector, and the justice and public safety sector (including prosecution services, the defence bar, the courts and court services), to inform their decisions and roles.

2. *The agreement would provide explicit guidance to the development of community-based protocols articulating the agreement at the local level including:*

    2.1. Commonly-agreed definitions and terms of reference;
    2.2. Expected procedures of each agency that will occur during a MHSU crisis including but not limited to agency roles; staff roles; and expected staff response;
    2.3. Expected procedures regarding pathways for information to be shared, received or otherwise utilized among the agencies implicated in crisis response;
    2.4. Guidelines for when information sharing to be mandatory when focused on client care or public safety;
    2.5. Expected mechanisms for how to identify and ensure the inclusion and involvement of partner agencies in all stages of the process;
    2.6. Expected means of determining specific lead responsibility at the various stages of prevention, crisis and post-crisis;
    2.7. Standards of practice regarding how agencies will support the transfer or discharge of a person into or out of their care; and
    2.8. Mechanisms for speedy resolution of any identified barriers to a timely, coordinated response will be resolved across agencies.

Objective B: Continuity of mental health and addictions care across transitions involving criminal justice

What would be created?

Within one year, an agreement between the criminal justice system, the mental health and substance use sector, and the social service sector, to take the collaborative and/or institutional steps necessary to ensure coordinated care plans, transition point support, and continuity of care across both sectors for individuals with MHSU disorders.

Principles

- *Commitment to ensure people with MHSU disorders are treated with dignity and respect at all times.*
- *Commitment to practices that eliminate stigma-based discrimination, ensure Indigenous cultural safety and healing consistent with Truth and Reconciliation, and promote trauma-informed practice.*
- *Commitment to deliver services that are shaped more by the needs of citizens than by administrative priorities.*
- *Understanding that crisis intervention services for MHSU clients need to reflect urban, rural and remote needs.*
- *Expectation of 'equivalence of care' in health service delivery to those involved with the criminal justice system, including clear, well-understood pathways for individuals to access services based on need.*
- *Expectation that MHSU care and interventions are modelled on best evidence-based practices, and are accessible regardless of transitions involving the justice system.*
- *Expectation that interventions correspond with and are responsive to the individual's assessed criminogenic and determinants-of-health needs.*
- *Expectation of a shared responsibility between the criminal justice system and the health care system to share information as is appropriate according to current legislation.*

Elements

1. *An agreement to support the action plan signed by representatives of the criminal justice system, the mental health sector and the social sector, committing to an integrated collaborative approach to care, ensuring continuity of relevant clinical and social services for individuals with MHSU disorders.*

2. *The agreement would provide explicit guidance to criminal justice and health sector agencies and social service providers regarding:*

    2.1. Commonly-agreed definitions and terms of reference, including specification of key transition points expected to be included within the agreement;
    2.2. Overall organizational roles, responsibilities and accountabilities regarding continuity of care for individuals with MHSU disorders engaging the criminal justice system, with an overriding assumption of client-centered care;
    2.3. Specific expectations of care provision and responsibility at key transition points between the criminal justice system, the mental health and substance use sector, and the social service sector, to promote successful reintegration into the community;
    2.4. Mechanisms for effective information sharing at transition points and/or during care provision, necessary to ensure continuity of care for individuals with MHSU disorders and reduce risk of harm;
    2.5. Mechanisms integrated with coordinated crisis response for early intervention and navigation support, at the initial diagnostic stage and/or upon initial contact with the criminal justice system or health care system.
    2.6. Mechanisms integrated with coordinated crisis response for effective intake and streamlined access to care, the purpose of which would be to increase diversion to supports, and to mitigate the unintentional harms, public safety concerns and negative trajectories created through a client's experience of multiple transitions.

Leadership, timelines and reporting

Accountabilities

The action plan, encompassing both objectives, would include:

- *Governance arrangements appropriate to agency participation and resource support, with the presumption that any governance arrangements are co-chaired by representatives of the criminal justice, mental health and substance use and social services sectors;*
- *A vision statement, containing a clearly operationalized expression of the future state sought: what would success look like?*
- *A manageable composite of key cross-sector performance indicators that account for the activities across all agencies and provide feedback about outcomes, with an explicit reliance on measuring progress through available data sources; and*
- *Short and long-term targets and timelines for progress reporting and goal attainment, and specific expectations for reporting progress back to governance and advising future summits.*

Recognizing that the health, justice and social service sectors have longstanding commitments to jointly measuring the effectiveness of new programs and interventions, it is expected that activities introduced under the strategy would be subject to high quality evaluation with results reported to stakeholders.

Participation

Implementation of the action plan would be co-chaired by senior representatives of the criminal justice, mental health and substance use, social service sectors, and community organizations. Participants in the action plan would be established through negotiation, but would be assumed to include:

- *Leadership of organizations responsible for the administration and delivery of justice or public safety functions, and of organizations responsible for the delivery of care and treatment of MHSU disorders, and those responsible for social services,*

having a meaningful role to play in cases where the MHSU population enters the criminal justice system or is at risk of doing so;

- *Representatives of people with lived experience;*
- *Indigenous community representation, particularly drawing on expertise in the intersection of the criminal justice system and mental health and substance use sector;*
- *Representatives of other organizations and functions deemed necessary to the successful implementation of the strategy – particularly, those providing key social supports and resources – as may be identified through consultation.*

Appendix 4: Summit participants

Anderson, Lisa	Executive Director, Policing and Security Programs Branch, Ministry of Public Safety and Solicitor General
Anton, Hon. Suzanne	Minister of Justice and Attorney General
Arend, Elenore	Provincial Director, BC Corrections Branch, Ministry of Public Safety and Solicitor General
Attfield, Dave	Chief Superintendent, Royal Canadian Mounted Police
Bauman, Hon. Robert	Chief Justice of British Columbia
Benton, Mark	Executive Director, Legal Services Society
Boyle, Patricia	Assistant Deputy Minister, Community Safety and Crime Prevention Branch, Ministry of Public Safety and Solicitor General
Callens, Craig	Deputy Commissioner, Royal Canadian Mounted Police
Campbell, Jim	Executive Lead, Mental Health and Addictions Program, Northern Health Authority
Cavanaugh, Lynda	Assistant Deputy Minister, Court Services Branch, Ministry of Justice and Attorney General; Justice and Public Safety Council
Chyzowski, Trudy	VICOT Team Leader, Island Health Authority
Connell, Kelly	Kelly K. Connell Law; Downtown Community Court
Conner, Deborah	Executive Director, BC Schizophrenia Society
Crabtree, Hon. Thomas	Chief Judge, Provincial Court of British Columbia
Crossin, David	President, Law Society of BC

Dandurand, Yvon	Professor, School of Criminology, University of the Fraser Valley
Deitch, James	Executive Director, Justice Services Branch, Ministry of Justice and Attorney General
Farnworth, Mike	MLA, Critic for Public Safety and Solicitor General
Fisher, Nigel	Director and Regional Department Head of Mental Health and Substance Use, Fraser Health Authority
Flanagan, Dominic	Executive Director of Supportive Housing & Programs, BC Housing
Fyfe, Richard	Deputy Attorney General, Ministry of Justice and Attorney General; Justice and Public Safety Council
Gallagher, Joe	Chief Executive Officer, First Nations Health Authority
Gerhart, Todd	Chief Federal Prosecutor, Public Prosecution Service of Canada, Vancouver
Griffiths, David	Manager, Legal Services Society of BC
Hackett, Terry	Assistant Deputy Commissioner Correctional Operations (Pacific), Correctional Service of Canada
Harrhy, Dave	Executive Director, Mental Health and Substance Use Services, Interior Health Authority
Harrison, Scott	Director of Urban Health & HIV/AIDS, Providence Health Care
Hinkson, Hon. Christopher	Chief Justice, Supreme Court of British Columbia
Hughes, Doug	Assistant Deputy Minister, Health Services Policy Division, Ministry of Health
Hulme, Samantha	Crown Counsel, Criminal Justice Branch, Ministry of Justice and Attorney General

Juk, Peter	A/Assistant Deputy Attorney General, Criminal Justice Branch, Ministry of Justice and Attorney General
Kelly, Grand Chief Doug	Stó:lō Tribal Council; Chair, First Nations Health Council
Krog, Leonard	MLA, Critic for Justice and Attorney General
Lampard, Rob	Director, Child and Youth Mental Health Policy, Ministry of Children and Family Development
Leung, Karen	Legal Officer, Office of the Chief Judge, Provincial Court of British Columbia
MacInnis, Jeannette	Director of Health and Ending Violence Initiatives, BC Association of Aboriginal Friendship Centres
MacPherson, Stephanie	Provincial Director, BC Corrections Branch, Ministry of Public Safety and Solicitor General
McBride, Heidi	Legal Counsel, Office of the Chief Justice, Supreme Court of British Columbia
McCauley, Tarnjit	Regional Leader, Mental Health and Substance Use, Vancouver Coastal Health
McGee, Tim	Executive Director, Law Society of BC
McLachlin, Rt. Hon. Beverley	Chief Justice, Supreme Court of Canada
Miller, Mark	Executive Director, John Howard Society of the Lower Mainland
Morley, Jane	Coordinator, Access to Justice BC
Morris, Hon. Mike	Minister of Public Safety and Solicitor General
Morris, Jonny	Director of Policy, Canadian Mental Health Association BC
Nielsen, Diane	Supervising Lawyer, Community Legal Assistance Society

Olley, Maureen	Director, Mental Health Services, BC Corrections Branch, Ministry of Public Safety and Solicitor General
Pelletier, Lynn	Vice President, Mental Health and Substance Use Services, Provincial Health Services Authority
Rankin, Laurence	Deputy Chief Constable, Vancouver Police Department
Riar, Kulwant	Provincial Clinical Director, Youth Forensic Psychiatric Services, Ministry of Children and Family Development
Robertson, Wayne	Executive Director, Law Foundation of British Columbia
Ross, Ian	Executive Director, Strategic Policy Branch, Ministry of Social Development and Social Innovation
Rudolf, Sally	Legal Counsel, Office of the Chief Justice, Court of Appeal for British Columbia
Sandstrom, Kurt	Assistant Deputy Minister, Justice Services Branch, Ministry of Justice and Attorney General; Justice and Public Safety Council
Sandy, Nancy	Chair, British Columbia Aboriginal Justice Council; Executive Director, Denisiqi Service Society
Shackelly, Darlene	Executive Director, Native Courtworker and Counselling Association of BC
Sieben, Mark	Deputy Solicitor General, Ministry of Public Safety and Solicitor General; Justice and Public Safety Council
Somers, Julian	Associate Professor, Faculty of Health Sciences, Simon Fraser University
Spier, Colleen	Lawyer, Spier & Company Law; Member, BC Aboriginal Justice Council

Tollefson, Claire	Lawyer, Claire Tollefson Law
van der Leer, Gerrit	Director, Mental Health, Ministry of Health
Welsh, Michael	President, Canadian Bar Association BC
Wiebe, Daryl	Superintendent, Vancouver Police Department
Wiehahn, George	Psychiatrist, Forensic Psychiatric Services Commission, BC Mental Health and Substance Use Services, Provincial Health Services Authority
Wilson, Bonnie	Director, Home Support, Complex Rehabilitation and Supported Housing, Vancouver Coastal Health
Wishart, Hon. Susan	Associate Chief Judge, Provincial Court of British Columbia

Appendix 5: Summit organizing team

Steering Committee

Elenore Arend	Provincial Director, Strategic Operations, Corrections Branch, Public Safety and Solicitor General
Dave Attfield	Chief Superintendent, Royal Canadian Mounted Police
Allan Castle (Chair)	Coordinator, BC Justice Summits and BC Justice and Public Safety Council
James Deitch	A/Assistant Deputy Minister, Justice Services Branch, Justice and Attorney General
Dominic Flanagan	Executive Director, Supportive Housing & Programs, BC Housing
David Griffiths	Manager for Criminal, Appeals & Immigration, Legal Services Society
Samantha Hulme	Crown Counsel, Criminal Justice Branch, Justice and Attorney General
Tarnjit McCauley	Regional Leader, Regional Mental Health & Addiction, Vancouver Coastal Health Authority
Jonny Morris	A/CEO, Canadian Mental Health Association BC
Andre Picard	Youth Justice & Forensic Services Division, Children and Family Development
Julian Somers	Associate Professor, Faculty of Health Sciences, Simon Fraser University
Colleen Spier	Lawyer and Mediator, Spier & Company Law, and Member, Aboriginal Justice Council of BC

Claire Tollefson	Claire Tollefson Law, Canadian Bar Association BC member
Gerrit van der Leer	Director, Mental Health and Substance Us, Integrated Primary and Community Care, Ministry of Health
Daryl Wiebe	Superintendent, Vancouver Police Department

Observers

Sally Rudolf	Legal Counsel, Office of the Chief Justice, Court of Appeal for British Columbia
Heidi McBride	Legal Counsel, Office of the Chief Justice, Supreme Court of British Columbia
Karen Leung	Legal Officer, Office of the Chief Judge, Provincial Court of British Columbia

Summit Facilitator

George Thomson	Senior Director, National Judicial Institute

Summit Moderator

Caroline Nevin	Executive Director, Canadian Bar Association BC Branch

Working Group

Rozi Debreci	Strategic Initiatives Advisor, Justice Services Branch, Ministry of Justice
Samantha Hulme	Crown Counsel, Criminal Justice Branch, Justice and Attorney General
Stephenie Lewis	Policy and Program Analyst, BC Corrections, Ministry of Public Safety and Solicitor General
Victor Liang	Co-op Student, Maintenance Enforcement & Locate Services, Justice Services Branch, Ministry of Justice
Michael Lucas	Manager, Policy and Legal Services, Law Society of BC
Rhonda Mead	Executive Assistant to the Assistant Deputy Minister, Justice Services, Ministry of Justice
Lynn Noftle	Sergeant, and Supervisor, Mental Health Unit, Vancouver Police Department
Taylor Quee	Corporal, Surrey Detachment, RCMP "E" Division
Asha Sundher	Administrative Assistant, Justice Services, Ministry of Justice
Gerrit van der Leer	Director, Mental Health, Ministry of Health
Holli Ward	Senior Policy Analyst, Justice Services Branch, Justice and Attorney General

Appendix 6: BC Justice and Public Safety Council

Under provisions of the *Justice Reform and Transparency Act*, Council members are appointed by Ministerial order and may include those in senior leadership roles in the government with responsibility for matters relating to the administration of justice in British Columbia or matters relating to public safety, or any other individual the Minister considers to be qualified to assist in improving the performance of the justice and public safety sector. The Council is supported by the Coordinator, BC Justice Summits and BC Justice and Public Safety Council. The current membership includes:

Lori Wanamaker (Chair)	Deputy Minister, Ministry of Children and Family Development
Richard Fyfe (Vice-Chair)	Deputy Attorney General, Ministry of Justice and Attorney General
Patricia Boyle	Assistant Deputy Minister, Crime Prevention and Community Safety Branch, Ministry of Public Safety and Solicitor General
Lynda Cavanaugh	Assistant Deputy Minister, Court Services, Ministry of Justice and Attorney General
Brent Merchant	Assistant Deputy Minister, BC Corrections, Ministry of Public Safety and Solicitor General
Clayton Pecknold	Assistant Deputy Minister, Policing and Security Programs, Ministry of Public Safety and Solicitor General
Bobbi Sadler	Chief Information Officer, Ministry of Justice and Attorney General and Ministry of Public Safety and Solicitor General
Kurt Sandstrom	Assistant Deputy Attorney General, Legal Services, Ministry of Justice and Attorney General
Mark Sieben	Deputy Solicitor General, Ministry of Public Safety and Solicitor General