Report to / Rapport au:

OTTAWA POLICE SERVICES BOARD
LA COMMISSION DE SERVICES POLICIERS D'OTTAWA

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SUBJECT: REPORT ON CONSULTATION APPROACH FOR MENTAL HEALTH RESPONSE STRATEGY

OBJET: RAPPORT SUR DÉMARCHE DE CONSULTATION POUR UNE STRATÉGIE D'INTERVENTION EN SANTÉ MENTALE

REPORT RECOMMENDATIONS

That the Board approve the consultation approach outlined in this report for the development of the Mental Health Response Strategy.

RECOMMANDATIONS DU RAPPORT

Que la Commission approuve la démarche de consultation décrite au sein de ce rapport pour l'élaboration de la Stratégie en santé mentale.

BACKGROUND

The purpose of this report is to seek the approval of the Ottawa Police Services Board (Board) for a consultation approach to develop a proposed community-driven framework to the way the Ottawa Police Service (OPS) supports community safety and well-being as it relates to people in our community with mental health challenges. This will include a review of and improvements to how police respond to people in mental health crisis. It will also include measures to build and support more coordinated systems that better-ensure access to appropriate mental health and substance use/addiction supports for people in our community.

This flexible framework is built around ongoing consultations with the community. The OPS will actively seek input and feedback to inform the design and implementation of this strategy. We will listen to the opinions and views of people in Ottawa – our partners, subject matter experts, people with lived experience, and the general public – and adapt our approach accordingly. We want all voices to be heard and a strategy to be created that both reflects and serves the diverse communities that make up our city, ultimately leading to better mental health outcomes.

The OPS understands how important the issue of mental health response is to community safety and well-being. We also recognize that we have a duty of care, and that we can do a better job responding to people struggling with mental health challenges. This is, at its heart, an issue of public trust. Some of the work will be implemented immediately by the OPS – we intend, for example, to focus this year on delivering training designed and administered based on input from the community so that we have an increasing number of officers with specialized mental health training embedded in every front-facing unit. This includes a review and expansion of our de-escalation training, evaluating the expansion of our Mental Health Unit and developing a better way of triaging calls through, 211, 311 and 911. But mental health and well-being is a complex, multi-faceted issue and we must work together with the community to develop strategies to address this issue.

Through this work, with community partnership and input, we seek to identify and address issues related to mental health, including those situations where mental health intersects with race, gender and health equity indicators, to ensure that the strategy is in line with the City of Ottawa's Community Safety and Well-Being (CSWB) plan. During our preliminary discussions with community partners, together we have already identified issues that need to be addressed, including gaps in the data around mental health and addictions, as well as in the coordination of, and access to, mental health services, and substance use and addictions supports for people who need help. The OPS is committed to this process and to working together with our partners in community safety and well-being towards better mental health outcomes. We must not only improve the OPS response to people with mental health challenges, we must also do a better job ensuring the public understands our role. We also understand that better crisis response is only part of the solution.

The OPS has been dealing with the issue of mental health for more than 50 years. Ever since mental health treatment began to move from a primarily institutional setting into community-based care, the number of calls we receive related to mental health has grown progressively, as has the number of hours officers spend on calls for service involving a person with mental health challenges. These types of calls have not only

added a layer of complexity to contemporary policing – particularly when mental health intersects with other issues like race, culture, health equity and gender – but they also demand an increasing amount of OPS time and resources. The calls we have received have increasingly come from mental health and health providers, which tells us that we cannot simply redirect the focus to the mental health system but rather we need to develop a community based response with all system partners being supported to assume their intended roles.

In October 2020, the OPS informed the Board of its intention to work with community partners in Ottawa to develop a new Mental Health Response Strategy. Our proposed approach is outlined in this report.

We have heard loud and clear from the community that the OPS must improve how we respond to people experiencing mental health crisis. We also recognize that the OPS cannot create, lead or direct this effort on our own. We must not lead but work collaboratively with mental health experts, and members of the community with lived experience, and do everything we can to work with and support them as, together, we determine the best way forward.

The consultation approach outlined in this report is the first step of a three-year strategy designed to build new capacity to deal with mental health and addiction issues in Ottawa. It will be developed and led by our partners in the mental health community, frontline agencies and other key community partners supported by the OPS. These partners will gather and share information, assess and educate us about the community's needs, and inform the role that the OPS should play in responding to and assisting people in mental health crisis. The community's mental heath sector has been in deficit for decades and it worsened with de-institutionalization. The key issue is lack of adequate resources. With more infrastructure and available supports, we could continue to find ways to coordinate, align and collaborate through the existing MHA coordinating tables/networks.

There are many different mental health, substance use, and addictions programs and resources available in Ottawa, and our hope is, ultimately, that these services will become better-aligned and supported so that people who are struggling have better access to the services they need. We also hope that we can be advocates and support the realignment of existing services and the establishment of services that better-support community members dealing with mental health issues.

The OPS responds to thousands of calls a year related to mental health.

Calling 911 and initiating a response by the OPS, the Ottawa Fire Department (OFD) or Ottawa Paramedics (sometimes all three), is a 24/7 option for anyone; but what is less understood is that this is often the only option families have when a loved one is in distress, or when a member of the public witnesses someone in our community in crisis. And because of the nature of mental illness, OPS members often respond multiple times to help the same people, the same families, over and over again. A study by the Canadian Mental Health Association, BC Division, found that more than 30% of people with serious mental illness had first contact with the police, earning them the nickname "psychiatrists in blue,"[1] a role police should not subsume and be instead redirected to those with professional training. While the OPS Mental Health Unit (MHU) officers have specialized training and are paired with mental health nurses from The Ottawa Hospital to attend homes where people are known to have had prior mental health emergencies – an arrangement that helps direct them to the support services they need – in many cases, people in crisis will call MHU officers directly because they know them. In addition to ensuring that OPS officers receive training so that they are better-able to understand and respond appropriately to people in mental health crisis, our hope is that one of the long-term outcomes of this work will be that a fourth option is available to 911 dispatchers who receive mental health-related calls where a person is not in immediate danger. In these cases, a response by member of a specialized community mental health team – rather than OPS, OFD or paramedics – may be appropriate.

The Mental Health Act (MHA) of Ontario requires and authorizes police to respond, interview and apprehend people under specified circumstances. An OPS response can help avert the immediate crisis, but it's only a stop-gap measure, with the person apprehended and taken to hospital, where officers remain with them – often for hours – until they are admitted or released, which often leads to follow-up calls, often on the same day.

Need for Better Data

While there are gaps in the data about mental health at police services across Canada, current OPS records indicate that there has been a year-over-year increase in calls for service relating to a person in mental health distress, as outlined in the following table.

Mental Health Act Reports	2017	2018	2019	2020
MHA - OTHER (8650-4)				

[1] Canadian Mental Health Association, BC Division (2005). Police and Mental Illness: Increased Interactions. https://cmha.bc.ca/wp-content/uploads/2016/07/policesheets_all.pdf

	2,121	2,147	2,181	2,354
MHA ELOPEE (8650-5)	17	12	18	8
MHA FORM 1 (8650-2)	315	291	331	297
MHA FORM 2 (8750-4)	235	258	265	280
MHA HOSPITAL VOLUNTARY (8650-3)	1,275	1,231	1,187	1,061
MHA SEC. 17 APPREHENSION (8650-1)	1,750	1,862	2,034	1,766
Other MHA reports not primary UCR	*981*	*950*	*828*	*632*
Total	**6,694**	**6,751**	**6,844**	**6,398**

*Definitions can be found in supporting documents attached.

In reality, the numbers in the table above may represent only a fraction of the calls for service where mental health was a contributing factor. There is currently no national standard governing the collection and reporting of calls for service records contained in Computer Aided Dispatch (CAD) system. Each police service defines its own call types, priority levels, and response protocols based on their operating environment, community concerns and human and financial resources. The way data is currently collected by most police services across Canada does not reflect the complex responsibilities of contemporary policing. The result is that the data around incidents involving people in mental distress is incomplete.

At OPS, data about mental health is limited to incidents specifically cleared with a Mental Health Uniform Crime Reporting Code (i.e., Section 17, Form 1, Form 2, Hospital Transport, etc.). While it's generally recognized that crime only accounts for about 20% of police reported incidents, if a person's mental health distress contributed to the alleged commission of a crime, the incident may not be captured as a mental health-related call. Current police data also does not include calls or support delivered through other partners (i.e., the Ottawa Distress Centre), nor does it capture the time and resources devoted to mental health calls outside the frontline response.

While the OPS will closely consult with community experts in mental health about improved data capture and governance as part of the development of our mental health response strategy, the approach taken by the Waterloo Regional Police Service (WRPS) may serve as a useful model. In addition to tracking calls for service specifically related to mental health, WRPS – which serves a population a little over half the size of Ottawa's – also captures all calls for service that involve people with mental health issues, as well as metrics including the number of re-contacts with mental health-involved individuals. In 2013, for example, WRPS recorded: 301,237 total calls for service; 6,176 mental health-only calls for service; and 22,195 calls for service involving a person with mental health issues (of these, 789 individuals had 10 or more contacts with police).

These data suggest that OPS is missing crucial information in cases where mental health is a contributing factor but not the primary reason for the service call. With more effective data capture and coordination of services, the OPS and its partners will be more able to triage people in mental health crisis to the agency best equipped to help them, and to tailor services to those in need.

DISCUSSION

It is clear that the OPS must improve the way it supports and equips its members to respond to calls for service where mental health and addictions are an issue, but better crisis response is only part of the solution. The Mental Health Response Strategy will take a holistic look at the mental well-being landscape in Ottawa, in an effort to provide better coordination and access to services for people in distress, redirecting to those services instead of having police as a first response, and working towards better mental health outcomes in our community.

Mental health is one of the priority areas in the City of Ottawa's Community Safety and Well-Being (CSWB) plan, and this Mental Health Response Strategy aligns with the direction the City is taking.

Governance

The OPS cannot – and should not – develop, lead or direct this new mental health and addiction strategy on its own. Mental health is a community issue that necessitates a whole-of-community response, supported by the OPS and aligned with both the City and provincial CSWB plans. This effort, while initiated by the OPS, will be co-created and led by an arm's-length Guiding Council, made up of representatives selectded by five community networks who will help us better-understand the needs of the community, gather and share information, and drive this initiative forward. These

networks will identify people who should be part of the Guiding Council (which will include representatives from the City of Ottawa and Ottawa Public Health (OPH)). The Guiding Council will also select a chair to provide leadership to the group. Additional networks may be added as the council progresses in its duties.

We will rely on this leadership group to advise us on everything from the initial set-up of the consultations to the final recommendations.

To-date, our network partners are:

- The Champlain Mental Health & Addictions Network;
- Kids Come First – Mental Health & Addictions;
- The Community Development Framework Coalition;
- The Ottawa Black Mental Health Coalition; and
- The Ottawa Local Immigration Partnership – Health and Well-being Sector Table (See supporting documents for a full list of network chairs and member organizations).

A secretariat co-funded by OPH, the City of Ottawa and OPS will be created to support the work of the Guiding Council, and will work under its direction. This approach represents unprecedented community involvement with the OPS. We are committed to working with these partners on an ongoing basis over the long-term to address this critical issue.

The OPS has also spoken with the Ottawa Aboriginal Coalition (OAC) and will continue this dialogue on an ongoing basis to ensure our efforts are aligned with the OAC's work with local hospitals on culturally sensitive responses to Indigenous people with mental health challenges, including the appropriate response from the OPS and community members.

Other groups, including those that represent Indigenous, LGBTQ+ and intersections of sexuality and gender identity will be consulted to ensure equitable representation and vital feedback to the project.

CONSULTATION

The OPS is only one part of the equation around mental health, and there are many other community organizations who contribute to a proactive, holistic response to people with mental health challenges. As such, we will be meeting with local stakeholders to solicit their input on where support is most needed, and how the OPS, given its legislated role, can work with our partners more effectively to respond to

people in crisis, sometimes determining that the OPS is not the primary response, and instead is redirected to mental health frontline agencies.

While the final consultation plan will be determined by the Guiding Council, it will include a broad mix of tools and techniques to ensure that both key stakeholders (including our partners, subject matter experts and people with lived experience) and the general public have the opportunity to submit their feedback. The following components may be considered to underpin the overall consultation strategy:

1. **Online questionnaire for community members:** To ensure accessibility, a web-based questionnaire soliciting feedback and opinions will be developed and posted. A special section of the OPS website will provide key data on the project such as updates, frequently asked questions, and important background documents. This information will be further shared through social media and other channels.

2. **Interviews, targeted outreach and focus groups:** Consultation meetings and interviews have been initiated and will be conducted on an ongoing basis with community members, academics, subject matter experts, mental health professionals, addiction specialists, and other groups for the duration of the project. The project team has reached out to a variety of groups to help inform the process to this point, including: the Champlain Mental Health and Addictions Network; Kids Come First (Mental Health & Addictions Working Group), Community Development Framework; the African, Caribbean & Black Mental Health Coalition; Ottawa Aboriginal Coalition; the Ottawa Local Immigration Partnership (OLIP); and the Community Equity Council (CEC). Board members can also participate in these discussions.

3. **Technical briefing:** While we typically include ride-alongs as part of the public consultation and education process, we are limited due to the impact of the COVID-19 pandemic. Instead, we will look at novel ways to connect with the community using technology.

4. **Discussions and updates to community partners:** A number of presentations and regular updates will be provided to community groups and partners.

5. **Communications:** Earned media (both in mainstream outlets and media targeted to diverse communities), paid advertising, multilingual communications, social media, and web-based information, as well as low-tech approaches like handbills and posters, will also be considered and utilized as required throughout this period.

6. **Internal consultations with members:** Briefings and consultation meetings, an intranet questionnaire, and regular updates (via email and the intranet) will ensure that OPS members are kept informed about this work and have an opportunity to provide their input.

The consultation approach described in this report has been informed through conversations with community stakeholders as well as chairs of the various networks that will make up the Guiding Council for the Mental Health Response Strategy, and the framework for this approach has evolved as a result of these meetings. In other words, it has been an organic, community-driven process, which mirrors our vision for the development and implementation of the strategy as a whole, which will soon begin its task to develop a fulsome plan that responds to the needs of our city's most vulnerable population.

Timelines

The first proposed step is the initiation of the Guiding Council, which will continue to work on the design of this community-led consultation plan. Once this group is formed they will be asked to establish key milestones for this work, and the OPS will report back to the Board at that time.

We anticipate that the public consultation phase will commence in the spring of 2021, after we have met with our Guiding Council to help develop the framework and assess process recommendations from each respective partner and/or stakeholder.

FINANCIAL IMPLICATIONS

The costing for this approach will be developed with our partners and the Guiding Council.

SUPPORTING DOCUMENTATION

Document 1 – Definitions

CONCLUSION

The OPS Mental Health Response Strategy will be a community-led initiative that seeks to provide better supports for those in mental health crisis. It recognizes that the police are not subject matter experts and looks to augment OPS response with support from mental healthcare workers, addictions specialists, and other professionals to ensure the right response at the right time for the person in need.

The consultation process will encourage participation from not only mental heathcare professionals, but community groups, academics, and the public at large. Mental health

response requires a whole-of-community approach in order to effectively develop a plan that supports the needs of some of the most vulnerable members of our society.

The three-year strategy will incorporate feedback from our stakeholder groups to develop best-practices to ensure an effective response that redirects those impacted away from the criminal process and toward supports that will provide a foundation for wellness.

Document 1 – Definitions

Definitions

MHA – Other (8650-4): This generally refers to calls for service where an officer has responded to a scene where there is some sort of mental health concern. Officers who respond to these calls may not be aware of the whole situation/circumstances before arriving on scene and dealing with the situation, as the person calling 911 has minimal information about the person/situation.

An example of this type of call could be, a person observes a man yelling/fighting with an inanimate object and bystanders call police to intervene and de-escalate the situation. At the time of the call, it is unclear whether the person is under the influence of drugs and/or alcohol or if the person is experiencing a mental health crisis. Through officer assessment and intervention, it may become clear that officers are responding to a Person In Crisis (PIC). During these calls officers determine if the person is well-supported or not a threat to themselves or others, which does not require apprehension and a trip to hospital. Rather, the officer is capable of de-escalating the situation and all people involved, and as a result the officer is able to leave the scene and PIC knowing the situation has been resolved and all parties are content and in agreement with the solution.

MHA ELOPEE – (8650-5): These calls for service refer to a PIC who has fled from a person/place after they were apprehended and placed on a Form 1, Form 2, or Form 47 that compels the PIC to be assessed by a mental health professional. The places where a PIC may flee from are often the hospital.

MHA Form 1 – (8650-2): A Form 1 is issued by a physician and it gives police the authority to apprehend a PIC, against their will, and take them to the hospital to be assessed by a mental health professional. Officers must remain at the hospital until the person is admitted or released by a physician. Usually a family member requests a Form 1 by contacting a physician, who knows the PIC, and explains the current state of the PIC. These calls are responded to by both frontline officers and the OPS' Mental Health Unit (MHU), which includes the assistance of a mental health nurse.

MHA Form 2 – (8650-4): A Form 2 is issued by a Justice of the Peace and it gives police the authority to apprehend the PIC, against their will, and take them to the hospital to be assessed by a mental health professional. Officers must remain at the hospital until a mental health professional has seen the PIC and releases or admits them to hospital. Usually a family member gets a Form 2 by appearing before a Justice

of the Peace and explaining the current state of the PIC. These calls are responded to by both frontline officers and the MHU.

MHA HOSPITAL VOLUNTARY (8650-3): A Voluntary MHA call for service means a family member, friend, or other person has called 911/OPS, concerned for their loved one's mental health. Often the caller will assist police in assessing and speaking with the PIC. During these calls, frontline officers will talk with the PIC to convince them to voluntarily go to the hospital and be seen by a mental health professional, instead of being escorted by police to the hospital. Although sometimes police will provide a drive to the hospital, these calls do not require police to stay on scene and supervise the PIC until they are seen by a physician at the hospital. In many cases, the PIC often contacts the police themselves. Ottawa Paramedics will attend most of these calls.

MHA SEC. 17 APPREHENSION (8650-1): A Section 17 apprehension is the result of a call to 911 with the PIC threatening to harm themselves or other people. Sometimes the PIC has a weapon when police respond on scene. In most cases of a Sec. 17 apprehension, the PIC refuses to go to hospital and police are obligated, under the Mental Health Act, to apprehend the PIC and take them to be assessed by a mental health professional. Officers are obligated to remain at the hospital to supervise the PIC until he or she has seen by a mental health professional and is either released from the hospital or placed on a Form 1.

Other MHA reports not primary UCR: These are reports that have been submitted/attached to a report/call that had a mental health component, but the mental health was not necessarily the main reason for the initial 911 call. For example, there may be domestic/partner dispute that has a mental health component and therefore a mental health report was also submitted.