Alternatives for a Safer Ottawa:

NON-POLICE MENTAL HEALTH CRISIS REPONSE EXECUTIVE SUMMARY

PREPARED BY VIVIC RESEARCH
SPONSORED BY 613-819 BLACK HUB

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Executive Summary[1]

The document below summarizes the content found in the final report and strategy. The report details why a non-police mental health crisis response is essential in the City of Ottawa and why a police co-response, which would include non-police and police responders, will fall short of meeting the community's needs. Currently, the Ottawa Police Service's budget is $370 million annually. Reallocating funds from their budget is possible and would allow to see greater investments in services that benefit all Ottawa residents.

The report begins by providing a systemic overview of how purposeful policy decisions have created the current social conditions we see today. We refer to these policy decisions and their outcomes as the social determinants of mental health. The social determinants of mental health are the social and economic conditions which shape our lives including but not limited to; in-utero and early childhood experiences, race, gender, sexual orientation, freedom from discrimination and violence, social inclusion, access to economic resources, and more. The social determinants of mental health interact on a national, community, and household level to contribute to societal ideas of what mental health crisis means and looks like, along with the policies aimed at addressing the problem. Mental health crises are the result of poor policy making. Improvements in policy across all levels have the ability to improve the mental health outlook for all Canadians by bettering the social and economic conditions in which they live.

Despite policy playing a significant role in creating crises, our current response to mental illness is one of criminalization. Criminalization refers to laws and by-laws that make survival for some individuals illegal, by criminalizing the only alternatives available to them. Criminalized behaviors including substance use and addiction often stem from inadequate mental health care and are a reason why we see an over-representation of persons with mental illness in jail and prison populations. Police are often the first point of contact for persons with mental illness seeking out care. When police respond to a mental health crisis, regardless of their intent, the tools available to them are apprehension or use of force. Their response contributes to carceral feedback loops, can exacerbate feelings of distress for the individual seeking care, and have severe repercussions on the individuals and their loved ones.

The history of policing is especially relevant as this report is not a critique of individual officers, but rather of the systems of policing and the legislation that fail to keep them accountable to their communities. Control of populations deemed "inconvenient" has been a cornerstone of modern policing since its inception. During colonization, the police were used to advance the goals of European settlers by systematically stripping Indigenous populations of their lands, culture, resources, loved ones, and rights. Today, the institution of policing in Ottawa continues to act as protectors and upholders of the dominant social class, while simultaneously oppressing marginalized groups. In short, the system of policing is not broken. It is operating precisely how it was designed to. With this in mind, we conclude that in order to prevent systemic state violence, increased training, diversity, spending and legal battles are not the solution. Police defunding and de-tasking is not a new idea. It has always been and continues to be led by Black and Indigenous voices whose lives depend on the policies we have been discussing. Furthermore, the benefits of defunding and de-tasking do not accrue only to those who face violence

1 This report was written by Vivic Research Economists; Inez Hillel, Nora Ottenhof, and Saamia Ahmad. The authors thank sponsor 613-819 Black Hub for their continued support. The authors are especially thankful for the organizations and organizers engaged in the consultation and feedback process. Emails: Inez.hillel@vivicresearch.ca, nora.ottenhof@vivicresearch.ca, saamia.ahmad@vivicresearch.ca.

and discrimination at the hands of police. Divesting from carceral institutions means more funding is freed up for social and preventative services, as well as community building events & infrastructure. This means more money for not only safe consumption sites, affordable housing, and subsidized transit, but community centres, green spaces, and arts & culture events as well.

Carceral approaches to mental health crisis intervention amplify feelings of distress and leave persons with mental illness feeling as though they are being criminalized as opposed to cared for. Fortunately, carceral approaches are not the only options. Municipalities across North America have already established alternatives to police for mental health crisis interventions. Mobile crisis response teams (MCRTs) are an alternative solution that are community-led and independent of police. These models are examples of how creative policy making has led to higher quality care in their respective regions. This being said, no program is without its shortcomings. In the case of non-police response models, chronic underfunding and a lack of governmental support have historically limited program scope and awareness. Co-responder models are negatively impacted by the presence of uniformed police on scene. We use these examples to inform on the benefits and shortcomings of alternatives responses that could be introduced in Ottawa.

Ottawa does not have a non-police alternative that responds to mental health crises and services the entire community. Currently, mental health crisis response in Ottawa is under the purview of the Ottawa Police Service (OPS). Despite increased investment in mental health and de-escalation trainings in recent years, OPS remains ill- equipped to provide effective care to those in crisis. Alternative avenues for crisis outreach in Ottawa exist; however, limitations exist often in the form of under-funding, and other capacity limits. An effective mental health crisis response strategy for the city of Ottawa will draw on the expertise of front- line harm reduction workers and will ensure that the needs the city's most vulnerable are being prioritized.

By reallocating funding from the OPS budget towards preventative and wraparound care, and de-tasking the OPS from responding to these calls, Ottawa residents will be able to receive specialized care. Furthermore, the cost savings associated with non-police models of care allow for greater investments in services that create strong social ties. Such services include targeted social services such as safe and affordable housing, childcare, youth services, victim support services, and harm reduction services. In addition, investments into public spaces, such as roads, parks, arts, and recreation facilities are also essential components of a safe and healthy community. As a result, a non-police crisis response benefits everyone in Ottawa, by both ensuring the safety of the most marginalized residents and making the city a more comfortable space for all.

The ideal non-police mental health strategy in Ottawa is designed, administered, and overseen by communities for the communities it serves.

Who are the First Responders?

Every effort will be made to hire first responders whose image and lived experiences mirror those of the persons receiving care. Lived or living experience in the mental health system will be considered an asset. Individuals who have experienced or who currently experience homelessness, substance use, incarceration, and/or forced hospitalization will be prioritized in the hiring process, along with individuals from racialized groups, particularly Black and Indigenous individuals.

Education and Training Required for First Responders

First responders will receive anti-racism, anti-bias and anti-oppression training. First responders will also receive training in first aid and Naloxone administration so as to be equipped to handle any immediate health crises that may occur/being occurring as a result of an individual's mental health. Nurse practitioners will also be employed as a means of limiting individual exposure to traditional medical settings while not sacrificing any scope of care.

Physical Resources Required for First Responders

Drivers will be employed as an accommodation for first responders who cannot, for any reason, safely transport themselves to and from the scene of a crisis. First responders will carry basic care items including; water, sport drinks, cigarettes, food or food vouchers, and emergency blankets for the person in crisis. The first responder will also have a cell phone to connect the person in crisis with their loved ones. Finally, the first responder will be equipped with first aid supplies including Naloxone and oxygen (O2) monitors in case of an overdose.

Soft Skills for First Responders

First responders need to operate with soft skills needed to build relationships and trust with the person in crisis. These soft skills include empathy, being open minded, using body language to signal trust and safety, patience, tolerance, attentive and effective listening skills.

Social Categorizations of First Responders

First responders will bring their current or lived experiences as BIPOC, with mental health, substance use, incarceration, institutionalization, with sexual and gender based violence, with homelessness and with 2SLGBTQIIA+ communities to better serve their communities and alleviate fears around the lack of trust in systems that do not represent the persons in crisis.

Philosophy of Service

- Persons receiving care and staff should feel cared for, valued, and respected at all times
- Our approach to care will be trauma informed and led by the person receiving care
- We strive to be as accessible as possible & eliminate barriers to accessing care
- We see ourselves as being a part of the community we serve, not external to it

Continuous Care - Follow Up

Community engagement in anti-stigma, anti-racism, and anti-discrimination education will be integral to the service's continued care plan. Community training will position care as a community responsibility and equip community members will the tools necessary to respond to individuals in distress with compassion and empathy. If the person in crisis had positive experiences with a first responder, efforts should be made to connect the individual with the same first responder for any subsequent crisis calls, and to provide any continued care. Loved ones should be involved in continuous care if requested. The first responder should offer alternative culturally appropriate mental health services. The first responder should also work with communities to share information and community resources and services.

The program will undergo a five-year expansionary period in which increases in service capacity will occur through the onboarding of additional staff and purchasing of additional vehicles. The goal is for service expansion to take place at a similar rate to increases in community demand over time as the service gains more awareness. In year one the estimated total annual cost is $5,112,201.20. This figure accounts for the salaries of 42 employees 10 vehicles and three physical locations. By year 6, we estimate the total annual operating cost to be $11,698,363.54. This figure accounts for the salaries of 104 employees, 30 vehicles, and three physical locations.

Wages will account for 79% of total program cost in year one increasing to 95% of total cost by year six. Wages listed below include benefits.

Job Title	Annual Wage
Driver	$65,000
First responder	$100,000
Nurse practitioner	$120,000
Administrative worker	$65,000
Custodian/ maintenance worker	$50,000

The program will include three 24-hour drop-in locations that will act as both as a community gathering space, emergency shelter, community kitchen.

Item	Annual Cost (unless otherwise specified)
Rent & related costs*	$66,290
Food & drink	$25,000
Personal care items	$5,065
Furniture (one time cost)	$4,915
Entertainment	$1,520
Home goods (misc.)	$2,671
Office supplies	$1,689
Clinic supplies (recurring annual cost)	$10,972
Clinic supplies (one time cost)	$50,085
TOTAL annual cost per location (excluding custodial wages)	$169,607

**related costs include utilities, internet, insurance and building security*

Each new vehicle purchased will need to be equipped with a set of bigger ticket first aid supplies (ex. AED, oxygen therapy unit, blood pressure monitor etc.) totalling $4,625 per vehicle. These items will need to be re-purchased very infrequently and are categorized in this budget as one-time or infrequent costs. Recurring cost first aid items are those such as PPE, bandages, and emergency blankets. There costs we estimate to total approximately $2,800 per vehicle per year. Care items includes items not traditionally carried by first responders, but items which the community expressed may aid in providing comfort and building trust between a first responder and an individual requiring care.

First Aid and Care Item	Cost
One-time or infrequent purchase	$4,625 (per vehicle)
Recurring cost items	$2,800 (per vehicle)
Food & drink	$13,346

Cigarettes	$15,748
Ceremonial items	N/A

The service will be governed by a coalition of grassroots community organizations. The board of Directors for this service will be comprised of people with lived/living experience in the mental health system. Individuals who have experienced or who currently experience homelessness, substance use, incarceration, and/or forced hospitalization will be prioritized as board members along with individuals from racialized groups, particularly Black and Indigenous individuals. Roles and responsibilities between the involved parties will be divided as follows:

Group	Roles & Responsibilities
Indigenous Governance	• The service will respect Indigenous principles of governance, including the prioritization of sovereignty of individual organizations and the sovereignty of individuals
Organizations with experience in service delivery	Program Administrators: • Connect their membership with the service • Offer guidance on service delivery • Staffing • Medical directives
Organizations that represent various communities who do not have a specific mental health focus	Community-Program Intermediaries: • Communicate information about the service to community members • Help create accessible avenues for community feedback • Leaders in anti-racism and anti-stigma campaigns for the broader Ottawa community
Board of Directors	• Will reflect the image & lived experiences of the persons receiving care • Will be responsible for strategic decision making including budgeting, financial management, determining compensation rates, creating job descriptions etc.

The service will be accessible through 9-1-1 once it is no longer under the responsibility of the Ottawa Police Service (OPS). There is no legislation that mandates that the City of Ottawa is obliged to rely on OPS as the service provider to handle 9-1-1 dispatch. Although penalties for switching providers could possibly be incurred by the City of Ottawa depending on the terms of the contract with the Ottawa Police Services Board (OPSB), this change will allow for more community members to feel safe to access emergency services.

According to the Community Safety and Police Act (CPSA)[2], any municipality that maintains its own police force must receive sufficient funding in order to provide adequate and effective policing. Services provided by the police can overlap with other emergency service providers. The CPSA states that in

[2] The CSPA is expected to come into force soon, therefore, this section details the procedures under this new legislation. Currently, the Police Service Act (PSA) is still in force but set to be repealed.

order to determine police budget, the OPSB presents City Council with estimates required to meet the "policing needs" in Ottawa. City Council then drafts a budget under no obligation to match the estimates provided by the Board. In practice, due to capacity constraints at the OPSB level, they only set the strategic direction rather than providing estimates. The Police Chief and their staff draft a budget that responds to the strategic direction outlined by the Board. Once the Police Chief and staff have drafted a budget, the OPSB can strike line items that they do not agree with. Once the OPSB approves of the budget, City Council votes to approve or reject the budget that has been overseen by the Board and costed by the OPS. City Council cannot strike line items, but a rejection of the budget is very powerful and can effectively force a decrease in the police budget.

Avenues for reallocation from the OPS include advocacy for the OPSB to set the strategic directions to exclude responding to mental health related calls and to strike line items from the draft budget that allocate funding towards those response. Additional advocacy pathways include encouraging City Councilors to vote against any increase to the OPS budget. The only downside of this alternative is that the resulting budget that is approved from the OPS can be used at their discretion.