Alternatives for a Safer Ottawa:

NON-POLICE MENTAL HEALTH
CRISIS REPONSE REPORT

PREPARED BY VIVIC RESEARCH
SPONSORED BY 613-819 BLACK HUB

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Introduction[1]

The topic of mental health has become much more broadly discussed in recent years. In high schools, university campuses, workplaces, and community organizations, people are being reminded to take care of their mental health and that services are available to help them. Part of the conversation on mental health includes the recognition that people living with a mental illness cannot always access the resources and help they need. In the most dire situations, persons living with mental illnesses find themselves in violent and sometimes deadly interactions with police. We begin the following report detailing how policies at the national, provincial, and municipal level impact individual and collective mental health outcomes.

The call for additional mental health and preventative social services is not new. Widespread dialogue on police budgets, however, has seen a drastic increase since the murder of George Floyd in May 2020. As a result, calls for improved social services have been intrinsically linked to the concept of reallocating that funding from police budgets. For many, the idea of enhanced service availability to people in need is well-received, although they may remain unclear as to why the suggested alternatives cannot be implemented to complement existing services, such as police forces. In the second section of this report, we discuss the role of police as frontline mental health responders, prisons, emergency rooms and psychiatric facilities in creating and exacerbating carceral feedback loops. To break those cycles of mental illness, poverty, incarceration, homelessness, and trauma, we must rethink the institutions that play a role in creating crisis conditions.

The commonly held belief that police play a role in preventing crime is false. Police are emergency responders, meaning that they can only respond once a crime has occurred. In addition, police often respond to non-criminal incidents such as mental health crises and non-violent situations such as public intoxication and loitering. Social services that reduce the need and incentives for people to commit crime keep people safe. Reallocations from police budgets are therefore required for two reasons. Firstly, police services receive a major portion of city funds at the expense of other social services which are greatly underfunded. Secondly, police interventions have been found to harm marginalized community members, predominantly Black and Indigenous residents. The third section of this report dives into the history of policing to better explain how we have come to today's situation and why reform efforts including increased training, diversity, surveillance, and accountability are not sufficient to create transformative change.

In a community, everyone uses public services, such as healthcare, waste disposal and snow clearing. Not all residents will use the same services, and some will use more than others. The provision of social services, even specialized ones such as safe consumption sites, subsidized housing, and mental health crisis services are as beneficial to service users as to those who do not personally use those services. Preventative services are less expensive than policing and emergency services. Efficient city spending on public health means that more funding can be redistributed to parks, road maintenance, public art, and other features that enhance a city. The combination of accessible services and reduced contact between police and marginalized community members creates a healthier community for everyone to live in.

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 that engaged in the consultation and feedback process. Emails: inez.hillel@vivicresearch.ca, nora.ottenhof@vivicresearch.ca, saamia.ahmad@vivicresearch.ca.

Some jurisdictions have already begun to introduce alternative responses for persons experiencing mental health crises. In the fourth section of this report, we delve into non-carceral alternative approaches to mental health crisis intervention including mobile crisis response teams, co-responder, Indigenous-led, and community response models. We highlight the pros and cons of various alternative programs operating within Canada and the United States, using them as a guide to inform a proposed strategy for the city of Ottawa. In the fifth section, we survey the current state of affairs in Ottawa. We examine the Ottawa Police Service's role in mental health response, along with community-based alternatives.

Throughout the report, the reader will be reminded of Canada's colonial history, as well as the history of policing and psychiatry. We do this to acknowledge the harms that have been done by these systems and the role they have played and continue to play in inequality today. Understanding the history of these institutions is the only way to grasp why they operate as they do today, as these truths are more deeply entrenched than the actions of any one individual working inside these institutions.

This report concludes with the acknowledgement that a safer Ottawa is achievable for all residents. For this to be possible, bold action is required from residents and municipal representatives alike to mobilize and advocate for the development and expansion of life-saving social services and the reduction and reconfiguration of services that hinder public safety and health.

1. Social Determinants of Mental Health

Mental health refers to a person's psychological and emotional well-being[2]. Much like physical health, it is impacted by genetic factors, life experiences, environment, and other co-occurring health conditions. An individual can exhibit signs of poor mental health or mental illnesses in various ways[3]. Policies rooted in moral judgment, dated scientific information, and racism create the conditions that exacerbate cycles of crisis, criminalization, poverty, and marginalization for persons living with mental illnesses (PMI). Intersectionality, a term coined by Kimberlé Crenshaw refers to the overlapping of social categorizations such as race, gender, and class[4]. Understanding that a person can never disentangle their race from their gender, or sexual orientation is crucial to provide the appropriate, personalized responses to individuals in crisis. Prior to the introduction of the concept of intersectionality, research either focused on race or gender, but did not consider how they interact. As a result, Black women's experiences were largely left out of research as a non-intersectional lens cannot capture their realities. This concept has since been expanded and applied more broadly. For a person with multiple stigmatized identities, stigma will also intersect in various ways and impact a person's health outcomes. Incorporating an intersectional perspective is crucial to understanding how a person with multiple marginalizing identities experiences mental health care, and how that care can be made more appropriate.

Marginalizing identities compound to create more severe barriers to appropriate care, and this reflects in the proportional over-representation of persons with marginalizing identities in situations of poverty, homelessness, and mental distress. For example, Indigenous peoples make up 24% of Ottawa's

2 Government of Canada. 2020. About Mental Health, https://www.canada.ca/en/public-health/services/about-mental-health.html

3 In this document, we use the term "mental illnesses" to recognize the various mental illnesses that exists and avoid using aggregate terms. In addition, we use person-first language to describe individuals with a mental illness.

4 Crenshaw, K. (1989). "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Anti-discrimination Doctrine, Feminist Theory and Antiracist Politics". University of Chicago Legal Forum. Volume 1989. Issue 1. Article 8.

homeless population despite only comprising 2.5% of the city's population[5]. It should be noted that not all individuals in crisis will have a marginalizing identity, and not all marginalizing identities are outwardly visible. No one group is exempt from experiencing adverse mental health outcomes and needing appropriate care. Nominally white individuals make up 66% of individuals living in poverty in Ottawa[6]. Furthermore, former members of the military or Royal Canadian Mounted Police (RCMP), a demographic that is predominately white men, are over-represented in Ottawa's homeless population, comprising 5% of the aggregate total[7]. In this section, we illustrate that mental health crisis is a product of policy choices. We define the social determinants of mental health and discuss how these determinants are shaped by public policy. We examine the impacts that national and provincial policy has at individual and household level.

1.1 WHO Conceptual Framework

A person's mental health is largely contingent on their environment. The World Health Organization (WHO) uses a conceptual framework to highlight that factors outside the individual or families, notably government policy are core determinants of mental illness and mental health crisis [8]. Policy choices are structural determinants which operate though intermediary determinants of health such as material circumstances, psychosocial circumstances, behavioral factors, and biological factors to shape mental health outcomes[9]. In the following sections, we elaborate on the role of policy at each level of government in shaping these determinants.

Social determinants of health include socioeconomic status, abuse and violence, stress and trauma, housing, access to healthcare, education, and racism, amongst others[10]. Social determinants will begin to impact an individual prior to their birth due to the ways they influence that person's family and community[11].

It is important to note that the social determinants of health are also the social determinants of criminal behaviour. Improving health outcomes is an effective crime prevention strategy, including reductions in violent crime[12]. This concept will be elaborated on throughout the first two sections of this report.

5 Ranta, M. (2018). Survey details Ottawa's homeless population

6 National Council of Welfare Reports. 2009. Poverty Profiles: Special Edition

7 Ranta, M. (2018). Survey details Ottawa's homeless population

8 Solar, O, Irwin A. (2010). "A conceptual framework for action on the social determinants of health: Social Determinants of Health Discussion Paper 2 (Policy and Practice)." https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

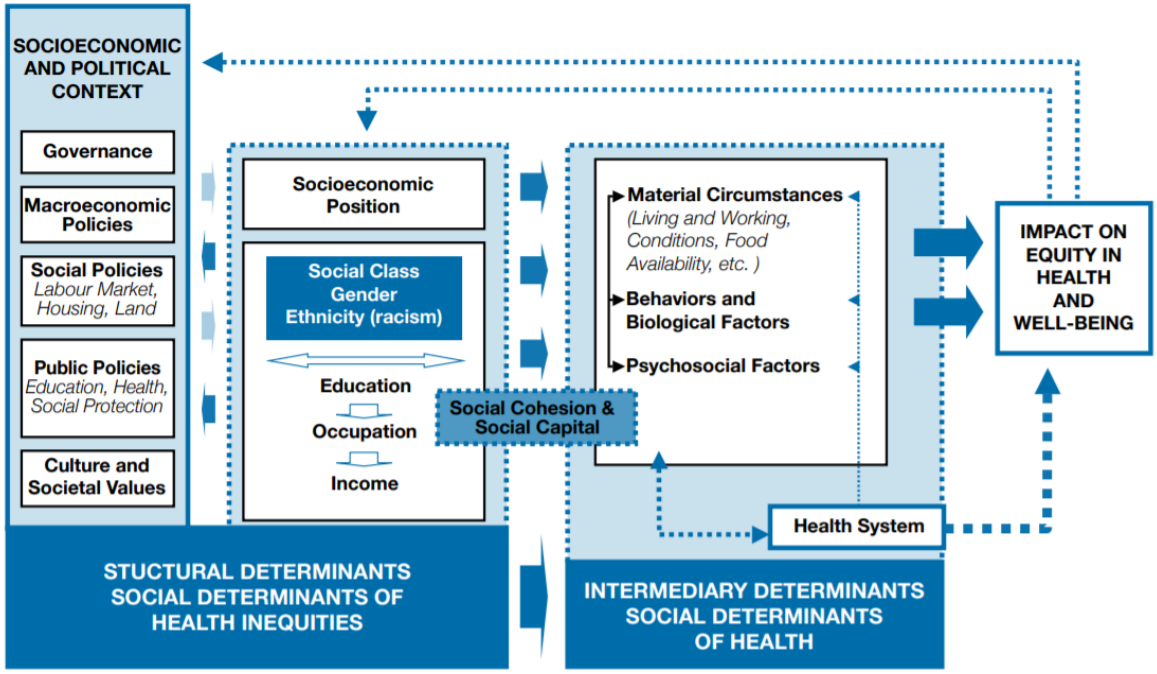
9 World Health Organization. 2010.

10 Caruso, G. D. 2017. Public Health and Safety: The Social Determinants of Health and Criminal Behavior. UK: ResearchersLinks Books. https://core.ac.uk/download/pdf/131215565.pdf

11 Cohen, A.K., & Le-Scherban, F. 2015. Invited Commentary: Multigenerational Social Determinants of Health—Opportunities and Challenges, American Journal of Epidemiology, 182:7. https://academic.oup.com/aje/article/182/7/579/107789

12 Sipsma HL, Canavan ME, Rogan E, et al, 2017. Spending on social and public health services and its association with homicide in the USA: an ecological study. https://bmjopen.bmj.com/content/7/10/e016379

Figure 1. World Health Organization's Conceptual Framework on the Social Determinants of Health



Source: World Health Organization. 2010. A Conceptual Framework for Action on the Social Determinants of Health.

1.2 Federal and Provincial Level Social Determinants

At the federal and provincial level, the primary social determinants of mental health are income and wealth inequality, historical factors, and government policies[13]. Government policies include those targeting poverty, education, healthcare, inequality, the environment, and housing. Policy that only focuses on intervention at the household level fails to consider the role that governments at all levels play in manufacturing the conditions that leave people in crisis. The following section provides an overview of policies pertaining to health care, drugs, social assistance, child protection, and the environment.

Colonization can be defined as "the policy or practice of acquiring full or partial political control over another nation, occupying it with settlers, and exploiting it economically"[14]. By this definition, we conclude that colonial policies are those which were passed to exert control over Indigenous peoples, one such example being the Indian Act. The Indian Act and related policies are still in place today. We therefore assert that colonialism in Canada is ongoing and not merely a dark chapter in Canada's history. The *Indian Act* plays a role in mental health outcomes as it governs health funding and service delivery available to Indigenous peoples with Status and individuals living on reserve[15]. More broadly, legislation that saw the creation and funding of residential schools, the banning of traditional ceremonies, suppressed political power, and forced relocations resulted in pervasive individual and collective

13 World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014.

14 Clogg, J. (2020). "Colonialism Is Alive and Well in Canada" https://www.wcel.org/blog/colonialism-alive-and-well-in-canada

15 First Nations, Health Care, and the Legacy of the Indian Act.

trauma[16]. Among Indigenous peoples, high suicide rates, substance use, and poverty can be linked to past and present policy[17].

Capitalism is defined as "an economic and political system in which a country's trade and industry are controlled by private owners for profit"[18]. This means that under capitalism, those who own property and resources accumulate profit, rather than the individuals who sell their labour for production. Capitalism relies on the fundamental assumption that self-interested individuals will seek to maximize their own short-term profits, and the supply and demand mechanism in the free market will regulate prices to benefit the common good[19].

This principle fails; however, because although profit might be accumulated by one person, the spillover effects are shared amongst everyone. For example, building a pipeline might bring in revenue for an oil company, federal and provincial governments, and people who work in the industry, yet everyone has to share in the negative consequences of greenhouse gas emissions[20]. High lumber prices are currently leading to the logging of old growth forests in British Columbia, despite their ability to capture carbon for everyone[21]. The free market is meant to regulate the negative consequences brought on by self-interest; however, wealth can rapidly be converted into power which means the market is no longer self-regulated, but rather controlled by a wealthy elite and large corporations[22]. For example, Microsoft has enough wealth to be able to lobby for weaker patenting regulation, effectively increasing their ability to generate extreme wealth[23]. More locally, Seamus O'Regan, Minister of Natural Resources and Pierre Gratton, President and Chief Executive Officer (CEO) of the Mining Association of Canada recently collaborated on an op-ed justifying mining exploration[24]. This displays the power that corporations can exert over public officials to champion their private gains.

This short-term profit motive undervalues sectors which are not directly profit generating, but can save money long-term. For example, investing in preventative health care can lead to having workers take fewer sick-days as well as leading to fewer costly emergency health care visits[25]. More generally, the profit motive of capitalism ends up commodifying basic human needs, such as housing, food, and healthcare, viewing them not as human rights, but areas of profit-generation. This can lead to the partial privatization of these sectors, and people are no longer able to access their basic human needs without

16 Lavallee, L. F., & Poole, J. M. 2010. Beyond Recovery: Colonization, Health and Healing for Indigenous People in Canada. International Journal of Mental Health and Addiction, 8, pp. 271–281. https://link.springer.com/article/10.1007/s11469-009-9239-8

17 Lavallee, L. F., & Poole, J. M. 2010.

18 "Capitalism: Definition of Capitalism by Oxford Dictionary on Lexico.com Also Meaning of Capitalism." Lexico Dictionaries | English, Lexico Dictionaries, www.lexico.com/definition/Capitalism.

19 Smith, Adam. An Inquiry into the Nature and Causes of the Wealth of Nations. By Adam Smith, LL.D. Reprinted from the 6th Ed., with an Introduction by Ernest Belfort Bax. G. Bell and Sons, 1887, 1887.

20 Jomo, K.S., Chowdhury, A. PPPs: Public Costs and Risks for Private Profits. Development 61, 89–93 (2018). https://doi.org/10.1057/s41301-018-0188-z

21 Hunter, J. "Fairy Creek Blockade 2021: What You Need to Know about the Anti-Logging Protest in B.C." The Globe and Mail, 27 May 2021, www.theglobeandmail.com/canada/british-columbia/article-fairy-creek-blockade-2021-what-you-need-to-know-about-the-anti-logging.

22 Sachs, J. D. "Self-Interest, without Morals, Leads to Capitalism's Self-Destruction." Financial Times, 18 Jan. 2012, www.earth.columbia.edu/sitefiles/file/Sachs%20Writing/2012/FinancialTimes_2012_SelfInterestWithoutMorals_01_18_12.pdf.

23 Lee, Tim. "Software Patent Reform Just Died in the House, Thanks to IBM and Microsoft." Washington Post, 20 Nov. 2013, www.washingtonpost.com/news/the-switch/wp/2013/11/20/software-patent-reform-just-died-in-the-house-thanks-to-ibm-and-microsoft.

24 Gratton, P., & O'Regan, S. "Seamus O'Regan Jr. and Pierre Gratton: This Is Mining's Moment, and Canada Will Lead." Theprovince, 1 June 2021, theprovince.com/opinion/op-ed/seamus-oregan-jr-and-pierre-gratton-this-is-minings-moment-and-canada-will-lead.

25 Maciosek, Michael V., et al. "Greater Use Of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost." Health Affairs, vol. 29, no. 9, 2010, pp. 1656–60. Crossref, doi:10.1377/hlthaff.2008.0701.

paying. However, for those who are not able pay, this can lead to hunger, homelessness, and an increased need to access emergency services, all of which creates longer-term public spending.

1.2.1 Health care

Chronically underfunded mental health care services lead to the continued stigmatization and underdiagnosis of mental illnesses[26]. Issues arising from mental illness affect one in five Canadians, with the total cost to the economy, including lost productivity and direct service provision, estimated at more than $50 billion annually[27]. When compared to other Economic Co-operation and Development (OECD) countries, Canada's mental health budget, at 7%, is well below the 13-18% average of total health spending other countries allocate[28]. A 2018 study by CAMH reported that "the historical underfunding of mental health has been most pronounced in community-based mental health services," [29]. In Ontario alone, mental health care is underfunded by approximately $1.5 billion[30].

1.2.2 Drug policy

Mental health, trauma and substance use are strongly linked and often compound each other. Drug and alcohol use can provide temporary relief from physical or emotional pain, traumatic stress, and other trauma-related symptoms[31]. Substance use disorders refer to the conditions where a person uses substance despite harmful consequences to themselves. Not everyone who uses substances has an addiction, regardless of the substance they are using[32]. Dependence refers to a physical dependence on a substance and is distinct from addiction, which refers to biomedical changes in the brain after ongoing substance use. Drug addiction is classified by the United Nations as "complex multifactorial health disorder characterized by chronic and relapsing nature"[33].

Drug use in Canada was first criminalized in 1908 with the Opium Act[34]. The increased criminalization of drugs is rooted in anti-Chinese and anti-Black racism rather than scientific understanding of drug use and the associated harms[35]. In the 1960s, research on the linkages between public health and drug use began to emerge; however, in 1961 the Narcotic Control Act was introduced to reinforce legislation

26 Livingston, J. D. (2020). Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review. Ottawa: Mental Health Commission of Canada.

27 Bartram M, Lurie S. Closing the mental health gap: The long and winding road? Can J Commun Ment Health 2017;36:1–14.

28 Canadian Mental Health Association. According equitable funding for mental health care. N.d. Retrieved from https://www.camh.ca/en/camh-news-and-stories/according-equitable-funding-for-mental-healthcare

29 Canadian Mental Health Association. Mental Health in the Balance: Ending the Health Care Disparity in Canada. 2018. Retrieved from https://cmha.ca/wp-content/uploads/2018/09/CMHA-Parity-Paper-Full-Report-EN.pdf

30 Canadian Mental Health Association. According equitable funding for mental health care. N.d. Retrieved from https://www.camh.ca/en/camh-news-and-stories/according-equitable-funding-for-mental-healthcare

31 International Society for Traumatic Stress Studies, Traumatic Stress and Substance Abuse Problems, https://www.istss.org/ISTSS_Main/media/Documents/ISTSS_TraumaStressandSubstanceAbuseProb_English_FNL.pdf.

32 Juergens. J., & Hampton, D. 2021. Understanding the Dependence vs. Addiction Debate. https://www.addictioncenter.com/addiction/addiction-vs-dependence/

33 Volkow, N. D., Poznyak, V., Saxena, S., & Gerra, G. 2017. Drug Use DisordersL Impact of a Public Health Rather than a Criminal Justice Approach. World psychiatry, 16 (2), p.213-214, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5428163/

34 Carstairs, C. 1999. Deporting If Ah Sin" to Save the White Race: Moral Panic, Racialization, and the Extension of Canadian Drug Laws in the 1920s. https://www.utpjournals.press/doi/pdf/10.3138/cbmh.16.1.65

35 Maynard, Robyn. 2020. Drug Policy and Racism, Canadian Drug Policy Coalition, https://www.drugpolicy.ca/about/racism/

criminalizing drug use[36]. The Controlled Drugs and Substances Act (CDSA) was introduced in 1996 and criminalizes the possession, cultivation, production, import, and export of controlled substances[37].

The outcomes of prohibition drug policy are devastating. The most obvious negative outcome is the increasingly toxic drug supply as there are no rules governing the production and distribution of drugs[38]. Since 2016, drug-related deaths have skyrocketed following the introduction of unregulated fentanyl in the illicit drug supply[39]. In Ottawa, figures from Ottawa Public Health find an 89% increase in drug deaths[40] from 2019 to 2020[41]. Alerts issued by public health authorities warning of contaminated and unpredictable drug supply have become increasingly common due to high concentrations of fentanyl, carfentanil, and benzodiazepine in unregulated drug markets. A report focused on opioid-related death in Ontario during the COVID-19 pandemic found that 96% of drug deaths were accidental[42].

The violence associated with the drug trade is an outcome of prohibition[43]. Illegal drug markets are extremely profitable, to the point where the perceived profits outweigh the risks of criminalization. Disputes within the illegal market cannot be resolved through official channels leading to increased community violence. High prices of drugs exacerbate criminal behavior which further increases the likelihood of incarceration. Periods of incarceration disrupt individuals' lives which place them at greater risk of homelessness, social exclusion, poverty, and drug use[44]. Eliminating prohibition would effectively eliminate the community violence that occurs as a result of illicit drug markets. Police and court resources are largely allocated to targeting low-level offences and in 2016 data showed that 73% of drug arrests were for possession[45]. The funds spent on criminalizing drug users and dealers is funding that could instead be put towards effective prevention and harm reduction programs.

Harm reduction services such as safe consumption sites (including safe inhalation), drug testing services, harm reduction supply distribution, naloxone distribution, and public education on how to use drugs more safely can reduce the number of deaths but cannot effectively protect against an increasingly poisoned drug supply[46]. Toxic-drug deaths can be immediately prevented with the widespread access of safe supply and drug treatment programs. Provincial governments can increase access to diversion programs and alternative justice strategies. Municipalities can repeal bylaws that restrict harm reduction services and access to opioid agonist therapy (OAT)[47]. Pilot projects and treatment

36 Boyd, S. 2017. History of Drug Policy in Canada,, summarized from Busted. Canadian Drug Policy Coalition. https://www.drugpolicy.ca/about/history/

37 Government of Canada. 2021. Controlled Drugs and Substances Act (S.C. 1996, c. 19), https://laws-lois.justice.gc.ca/eng/acts/c-38.8/

38 Canadian Drug Policy Coalition. 2017. The Case for Reform, https://www.drugpolicy.ca/our-work/case-for-reform/

39 Canadian Centre on Substance Use and Addiction. Opioids, https://www.ccsa.ca/opioids

40 Commonly referred to as overdoses, we use the term "drug deaths" to acknowledge that these deaths are largely due to drug toxicity rather than consuming a too-large dose.

41 Trinh, J. 2021. Opioid-related deaths in Ottawa nearly double during pandemic , Ottawa Citizen, https://www.cbc.ca/news/canada/ottawa/opioid-related-deaths-pandemic-ottawa-1.6033377

42 The Ontario Drug Policy Research Network, The Office of the Chief Coroner for Ontario/Ontario Forensic Pathology Service, Public Health Ontario Centre on Drug Policy Evaluation, 2020, Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic, https://www.publichealthontario.ca/-/media/documents/o/2020/opioid-mortality-covid-surveillance-report.pdf?la=en.

43 Miron, J. A. Drug Prohibition and Violence. Reforming Criminal Justice, https://law.asu.edu/sites/default/files/pdf/academy_for_justice/6_Reforming-Criminal-Justice_Vol_1_Drug-Prohibition-and-Violence.pdf

44 Canadian Drug Policy Coalition. 2017.

45 Canadian Drug Policy Coalition. 2017.

46 Nowell, M. 2021. Safe Supply: What is it and What is Happening in Canada?, Canada's Source for HIV and Hepatitis C Information, https://www.catie.ca/en/pif/spring-2021/safe-supply-what-it-and-what-happening-canada

47 Canadian Drug Policy Coalition. 2013. Getting to tomorrow: A Report on Canadian Drug Policy, https://www.drugpolicy.ca/wp-content/uploads/2013/01/CDPC2013_en.pdf

approaches for people with diagnosed substance use disorders, such as OAT, have been empirically found to be effective[48].

1.2.3 Social assistance

Linkages between poverty and mental health are empirically proven[49], yet government programs that are intended to address poverty are inadequate[50,51,52]. For example, research done on Ontario's social assistance programs Ontario Works (OW) and the Ontario Disability Support Program (ODSP) shows that benefit rates were too low to reduce the stress associated with income insecurity[53].

Beyond benefit rates, social assistance recipients are bound to a series of responsibilities and punitive measures. In order to receive benefits, individuals considered employable must continuously search for work and participate in upskilling courses and programs[54]. Although these measures do not appear outwardly harmful, the stress associated with the absence of assured income has devasting health impacts[55]. Additionally, strict work requirements for these programs mean recipients are frequently exposed to precarious labour market conditions which further worsen health outcomes. Increased benefit rates reduce the psychosocial stress associated with financial insecurity and support independent living[56].

The primary reasons stated by government officials justifying the excessively low benefit rates is a faulty understanding of fairness: a person who receives benefits should not have a higher income than an individual that is employed[57]. This logic highlights the interaction between social assistance and minimum wage but fails to consider that both policies fall clearly within the scope of the provincial government. In Ontario, the minimum wage is currently $14.25 per hour. In Ottawa, the current living wage is calculated at $18.42 per hour[58]. No one deserves to be poor, regardless of employment status. Raising the minimum wage would allow increased benefit levels, therefore it can lift employed and unemployed individuals receiving social assistance out of poverty[59].

48 Oviedo-Joekes E, Guh D, Brissette S, et al. Hydromorphone compared with diacetylmorphine for long-term opioid dependence. JAMA Psychiatry. 2016;73(5):447–55. https://doi.org/10.1001/jamapsychiatry.2016.0109

49 Qingsong, C., Chenhong, P., Yingqi, G., Ziyi, C., & Yip, P.S.F. 2020. Mechanisms connecting objective and subjective poverty to mental health: Serial mediation roles of negative life events and social support, Social Science & Medicine, Vol. 265, https://www.sciencedirect.com/science/article/pii/S027795362030527X

50 For a family with two adults and two children total welfare income is $31,485 per year. The poverty line in Ottawa in 2019 was $48,391, therefore welfare incomes only bring a family to 65% of the official poverty line.

51 Laidley, J, & Aldridge, H. 2020. Welfare in Canada, 2020. https://maytree.com/wp-content/uploads/Welfare_in_Canada_2019.pdf

52 Statistics Canada. Table 11-10-0066-01 Market Basket Measure (MBM) thresholds for the reference family by Market Basket Measure region, component and base year

53 Golberstein, E. (2015). The effects of income on mental health: evidence from the social security notch. The Journal of Mental Health Policy and Economics, 18(1), 27–37. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4494112/

54 Ministry of Children, Community and Social Services. 2021, Social assistance policy directives, https://www.mcss.gov.on.ca/en/mcss/programs/social/directives/index.aspx

55 Golberstein, E. (2015).

56 Golberstein, E. (2015).

57 Green, D.A. & Harrison, K. 2009. Minimum Wage Setting and Standards of Fairness, University of British Columbia, https://economics.ubc.ca/files/2013/05/pdf_paper_david-green-racing-middle-minimum-wage.pdf

58 Ontario Living Wage Network. Living Wage By Region, https://www.ontariolivingwage.ca/living_wage_by_region.

59 Hillel, I. 2020. "Holes in the Social Safety Net: Poverty, Inequality and Social Assistance in Canada," CSLS Research Reports 2020-06, Centre for the Study of Living Standards. http://www.csls.ca/reports/csls2020-06.pdf

1.2.4 Child protection policies

Child protection policies and services, as they are currently designed, fail to remedy the harms done by adverse childhood experiences[60]. In some cases, they may even be the cause of childhood trauma[61]. Policies that increase interactions with the foster care system worsen health outcomes – youth involved with the child welfare system had increased rates of homelessness, substance use, incarceration, and unplanned pregnancies, as well as experienced poorer mental and physical health outcomes[62]. Placement in foster care often results in the permanent mistrust of institutions; however, children with mental illnesses are overrepresented in the foster care-to-prison pipeline, further compounding the trauma of institutionalization [63]. The parents of apprehended children see significant increases in mortality following the apprehension of their children, as well as significantly higher rates of mental illness diagnoses, hospitalizations, and psychotropic medication use[64].

Policies on child protection, both at a federal and provincial level, have directly contributed to the over-representation of Indigenous children in foster care. The historical context that has led to such a drastic overrepresentation of Indigenous youth in foster care can be linked to colonialization, and the inter-generational impacts of the residential school system and the 60's scoop[65]. Today, systemic racism, health inequities, and economic and social disadvantages further disadvantage Indigenous families and increase their likelihood of interacting with the foster care system. Systemic racism within the child welfare system in Canada increases the likelihood of apprehension and exacerbates negative outcomes for Indigenous and Black children. In Ottawa, there were 2,091 children in care in 2018, of which 7% were Black and 14% were Indigenous. The proportion of Indigenous children admitted into care was 5.7 times higher than their proportion in the overall child population.

Birth alerts are a clear example of ways provincial policies directly result in higher numbers of children in care. Birth alerts involve hospital staff notifying child welfare agencies that a newborn may be born into a risky situation, without notifying the parents or providing additional prenatal support[66]. The practice of issuing birth alerts disproportionately targets Indigenous women, many of whom have been in foster care and are already known to child welfare agencies[67]. Furthermore, the fear of having a doctor issue a birth alert is a barrier for some pregnant parents to access prenatal care and other critical services.[68] In

60 Ramsay-Irving, M. 2015. The Foster Care Systems are Failing Foster Children: The Implications and Practical Solutions for Better Outcomes of Youth in Care, Canadian Journal of Family and Youth, 7(1), 2015, pp 55-86.

61 Ramsay-Irving, M. 2015..

62 Barker, B. 2019.

63 Calero, Samantha, Kristina Kopić, Annie Lee, Taylar Nuevelle, Marlies Spanjaard, Taryn Williams. (2017). "The Ruderman White Paper: On the Problematization and Criminalization of Children and Young Adults with Non-apparent Disabilities." Ruderman Family Foundation.

64 Wall-Wieler, E. (2018). "Maternal Responses to Having a Child Taken into Care," https://mspace.lib.umanitoba.ca/bitstream/handle/1993/33070/Elizabeth_Wall-Wieler.pdf;jsessionid=1CDA2E5DB7EC2A54D5B2C5DB36AC321C?sequence=3

65 Barker, B. 2019. Young people who use drugs and the child welfare system: Evidence to improve outcomes, A Thesis Submitted In Partial Fulfillment Of The Requirements For The Degree Of Doctor Of Philosophy, https://open.library.ubc.ca/cIRcle/collections/ubctheses/24/items/1.0378523

66 Ministry of Children, Community and Social Services. 2020. Policy Directive: CW 005-20 Ceasing the Practice of Birth Alerts in Ontario. http://www.children.gov.on.ca/htdocs/English/professionals/childwelfare/CYFSA/policy_directive_CW005-20.aspx

67 Duff P, Bingham B, Simo A, Jury D, Reading C, et al. (2014) The 'Stolen Generations' of Mothers and Daughters: Child Apprehension and Enhanced HIV Vulnerabilities for Sex Workers of Aboriginal Ancestry. PLoS ONE 9(6): e99664. doi:10.1371/journal.pone.0099664

68 Duff P, Bingham B, Simo A, Jury D, Reading C, et al. (2014).

Ontario, the practice was only terminated in October 2020, based on the recommendations from the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls[69].

Apprehensions to foster care are prioritized over policies that support family preservation. Neglect is a common reason children are placed in care, yet evidence shows that conditions deemed neglectful often arise from poverty[70]. Preventative care includes economic support to parents, better access to mental health care, access to safe housing, supports for parents who experience intimate partner violence, and for parents who have spent time in foster care[71]. The initial apprehension of a child can be very damaging to a parent's mental health, so immediate and extensive supports are needed ensure timely reunification[72].

1.2.5 Environmental policy

Environmental policy relates to mental health in various ways, notably the exposure to pollution and stress associated with environmental degradation worsens mental health outcomes[73]. For Indigenous persons, spiritual and cultural importance attributed to access to the land increases the linkage between environment and mental health outcomes [74].

Environmental inequality is defined as an environmental burden that is borne primarily by disadvantaged populations[75]. Environmental inequalities in Canada disproportionately impact Black and Indigenous communities, therefore they are more likely to live in communities without access to clean water, have housing with mold and asbestos, and live near toxic waste facilities. Heavily cited examples include the high levels of mercury contamination in Grassy Narrows and toxic air pollution impacting Aamjiwaang First Nation[76]. In-utero shocks related to environmental factors have lasting impacts[77]. High blood lead levels were correlated with lower proficiency in reading[78]. Air pollution and contaminated drinking water have been linked to increases in the likelihood of infant mortality and premature births[79], and reduced lifetime income[80]. Exposure to carbon monoxide during pregnancy has been linked to lower math and language test scores among primary school aged children[81].

69 National Inquiry into Missing and Murdered Indigenous Women and Girls. "Reclaiming Power and Place: Vol. 1a." https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf

70 Ontario Human Rights Commission. 2018.

71 Wall-Wieler, E. 2018.

72 Wall-Wieler, E. 2018.

73 Filipova T., Kopsieker L., Gerritsen E., Bodin E., Brzezinski B. and Rubio-Ramirez O. (2020) "Mental health and the environment: How European policies can better reflect environmental degradation's impact on people's mental health and well-being". Background paper by the Institute for European Environmental Policy (IEEP) and the Barcelona Institute for Global Health (ISGlobal).

74 Hatala, A.R., Njeze, C., Morton, D. et al. Land and nature as sources of health and resilience among Indigenous youth in an urban Canadian context: a photovoice exploration. BMC Public Health 20, 538 (2020). https://doi.org/10.1186/s12889-020-08647-z

75 Gobert. 2019.

76 Dhillon, C, & Young. M. G. 2010. Environmental Racism and First Nations: A Call for Socially Just Public Policy Development. Canadian Journal of Humanities and Social Sciences, 1(1), pp. 23-37. https://www.researchgate.net/profile/Michael-Young-46/publication/228226535_Environmental_Racism_and_First_Nations_A_Call_for_Socially_Just_Public_Policy_Development/links/568aa6f808ae1e63f1fbe044/Environmental-Racism-and-First-Nations-A-Call-for-Socially-Just-Public-Policy-Development.pdf

77 Almond. D., Currie, J. and Valentina Duque. (2018). Childhood Circumstances and Adult Outcomes: Act II. Journal of Economic Literature, Vol 56. No. 4, pp. 1360-1446. Retrieved from https://www.aeaweb.org/articles?id=10.1257/jel.20171164

78 Alzier, et al . 2016

79 Currie and Walker (2011).

80 Isen, Rossin-Slater, and Walker (2017)

81 Bharadwaj et al. (2017)

1.3 Community and Local Level Context

Within an Ottawa context, the erosion of social services can be a driving factor in mental health crisis. In April 2019, the City of Ottawa declared a climate emergency, and in January 2020 declared a housing and homelessness emergency, in addition to facing an ongoing overdose and drug toxicity crisis[82,83]. At a community-level, neighborhood trust and safety, community-based participation, violence and crime, and neighborhood deprivation are determinants of mental health. At this level, resources that improve mental health include early childhood education, primary and secondary schools, youth and adolescent services, health care, social services, clean water, and sanitation[84]. This section will look at areas under which the City of Ottawa could enhance service delivery to improve health outcomes for all residents.

1.3.1 Housing

Access to safe housing is a fundamental factor in mental health. Exposure to housing affordability stress has a negative impact on mental health[85]. Programs such as Housing First have found to be extremely beneficial and are not any less effective for persons who use substances[86]. Despite having declared a housing emergency, the City of Ottawa has continuously underfunded social housing programs, creating barriers to safe housing such as extremely long waiting lists to access low-rent housing and insufficient rent supplements[87]. Access to safe housing is positively correlated with health and wellbeing for entire communities, by improving health outcomes for individuals who are housed and reducing the health care costs associated with the absence of adequate housing.[88]

Without access to safe housing, individuals find themselves trapped between cycles of homelessness and incarceration. People living with mental illness are overrepresented among those who oscillate between services which prevents them from accessing the stability that is crucial to adequate physical and mental health. Many people cannot access shelters due to lack of income to pay nightly fees, drug or alcohol usage, or past criminal convictions. In addition, shelters that do not permit pets and/or that limit the amount of personal belongings one can bring can also be too restrictive. Shelters are often not cleaned regularly and are dangerous, so the threat of violence and theft also keeps people away[89]. When asked why they avoid shelters, one study summarized the following findings: 37% of people were deterred by shelters being too crowded, 30% cited the presence of bugs, 28% mentioned there were too many rules, 22% mentioned they wouldn't accept pets, 19% said they could not store their items, 18%

82 Porter, K. 2019. Ottawa Declares Climate Emergency, CBC News. https://www.cbc.ca/news/canada/ottawa/city-of-ottawa-declares-climate-emergency-1.5109378

83 Britneff, B. 2020. Ottawa City Council Declares Housing, Homelessness Emergency. Global News, https://globalnews.ca/news/6477415/ottawa-city-council-declares-housing-homelessness-emergency/

84 https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=6B6BEBA07664A81910FE34BA9198A32A?sequence=1

85 Baker, E., Lester, L., Mason, K. et al. Mental health and prolonged exposure to unaffordable housing: a longitudinal analysis. Soc Psychiatry Psychiatr Epidemiol 55, 715–721 (2020). https://doi.org/10.1007/s00127-020-01849-1

86 Urbanoski, K., Veldhuizen, S., Krausz, M., Schutz, C., Somers, J. M., Kirst, M., Fleury, M.-J., Stergiopoulos, V., Patterson, M., Strehlau, V., and Goering, P. (2018) Effects of comorbid substance use disorders on outcomes in a Housing First intervention for homeless people with mental illness. Addiction, 113: 137– 145. doi: 10.1111/add.13928.

87 Denley, R. 2019. A Roof Over our Heads- Ottawa's Approach to Social Housing Isn't Solving the Problem. Ottawa Citizen, https://ottawacitizen.com/opinion/columnists/denley-a-roof-over-our-heads-ottawas-approach-to-social-housing-isnt-solving-the-problem

88 Taylor, L. A. 2018. Housing and Health: An Overview of the Literature. Health Affairs Health Policy Brief, https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/

89 Harvard Health. "The homeless and mentally ill." https://www.health.harvard.edu/newsletter_article/The_homeless_mentally_ill

said they were too far away, 23% because they couldn't stay with a partner or family, and 13% because they couldn't stay with friends[90].

So long as a person remains unhoused, that individual will continue to be in a state of crisis as their most basic human need of stable shelter is unmet[91,92]. In the absence of appropriate shelter options, people resort to staying in tent cities or the streets. It is for this reason that when providing care to persons with mental illnesses experiencing homelessness, finding stable and secure housing must be an integral part of the care plan.

1.3.2 Mental health care

Calls to improve mental health care in Ottawa have been growing over the years. In order to truly improve community wellbeing, mental health care requires investment in "prevention, support services, counselling and clinical treatment, and intensive case management. To get better, people facing mental health challenges need access to supportive and affordable housing, basic incomes, community services and the supports that lead to a greater sense of security and inclusion"[93].

Increasingly, Ottawa-based organizations are calling for a reallocation of public funds from the Ottawa Police Service (OPS) to better fund alternative forms of public safety and community-level social supports[94]. Culturally appropriate social services that foster healthy communities include; universal child care, free transit, supportive housing, and food security initiatives[95]. While police spending increases annually by millions, the same is not true for mental health care funding[96]. In 2021, the Ottawa Police Service net operating budget was $332.5 million, which is 3.4 times larger than the Ottawa Public Health budget[97].

1.3.3 Public transit

Access to public transit has been found to improve mental health outcomes by reducing the risk of depression by allowing individuals to have a more active social life[98]. Public transit is essential in that it provides a baseline level of mobility to all community members, especially individuals who do not have access to a private vehicle. From both a sustainability and a public equity perspective, accessible public

90 National Alliance to End Homelessness. "The Emergency Shelter Learning Series". April 2017, https://endhomelessness.org/wp-content/uploads/2017/04/ES-Webinar-2-Keys-to-Effective-Low-barrier-Shelter_Webpage.pdf

91 Government of Canada. "Housing First." https://www.canada.ca/en/employment-social-development/programs/homelessness/resources/housing-first.html

92 Harvard Health. "The homeless and mentally ill." https://www.health.harvard.edu/newsletter_article/The_homeless_mentally_ill

93 Tonner, K., & Lafrenière, N. 2021. We Need More Mental Health Care, Not Necessarily More Police. Ottawa Citizen, https://ottawacitizen.com/opinion/tonner-and-lafreniere-we-need-more-mental-health-care-not-necessarily-more-policing

94 Dorimain, V. 2021. Defunding Ottawa Police Would better Serve Racialized Groups. Ottawa Citizen, https://ottawacitizen.com/opinion/dorimain-defunding-ottawa-police-would-better-serve-racialized-groups

95 Coalition for a People's Budget. 2020. https://mcusercontent.com/d74005846bef8cd39c3346d23/files/340904a2-cc49-46f3-bc85-2d2d456be6a3/Alternative_Budget_Report_FINAL_NOV_02_2020.pdf

96 Bud, Thomas K. "The rise and risks of police body-worn cameras in Canada." Surveillance & Society 14.1 (2016): 117-121.

97 Ottawa Police Services Board. "2021 Draft Operating and Capital Budgets." 2020, https://www.ottawapolice.ca/en/news-and-community/resources/EN-2021-Budget.pdf

98 Melis, G.; Gelormino, E.; Marra, G.; Ferracin, E.; Costa, G. The Effects of the Urban Built Environment on Mental Health: A Cohort Study in a Large Northern Italian City. Int. J. Environ. Res. Public Health 2015, 12, 14898-14915. https://doi.org/10.3390/ijerph121114898

transit is an essential service in urban centers[99]. Advocates in Ottawa have called to expand bus lanes, community routes and reducing bus fares[100].

1.4 Household and Family Level Context

The outcomes and consequences of policy at all levels of government strongly influence household-level conditions. Household-level social determinants of mental health include material conditions (income, access to resources, nutrition, clean water, housing), employment conditions, parental health, prenatal care, parental toxic stress, intergenerational trauma, and access to social supports[101].

1.4.1 Pre-natal

The impacts of policies at all levels of government, shape the conditions into which a child is born. For example, high maternal stress levels contribute to higher cortisol levels during pregnancy and can result in an increased likelihood of birth abnormalities and a higher chance of the child being prescribed ADHD or anti-depressants over the course of their life[102]. Factors that influence stress levels during pregnancy include financial and housing insecurity, the experience of intimate partner violence, and the death of a loved one[103]. Substance use during pregnancy is another pre-natal factor that impacts the mental health of the child. By extension, policies like birth alerts or limited maternity leave may contribute to higher cortisol levels during pregnancy and, in this way, contribute to mental illness. All these in-utero shocks carry on throughout an individual's life course.

1.4.2 Life course

Adverse early childhood experiences increase the risk of substance use, mental illnesses, low educational attainment, and unemployment throughout the individual's life course[104]. Effective public policy can alter these trajectories by providing adequate economic, housing, and mental health supports.

Exposure to poverty increases the likelihood of early childhood adverse experiences[105]. People living with mental illnesses are more likely to live in poverty[106]. The consequence of growing up in poverty not only predisposes children to experiencing more trauma, but also provides them with fewer resources to navigate that trauma[107]. Stress plays a foundational role in health; therefore, the uncertainty associated with living in chronic poverty cannot be overstated in exacerbating negative mental health outcomes.

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99 Baig, K., & Hersh, S. "Baig and Hersh: Ottawa needs a budget for everyone, not just the privileged." Ottawa Citizen, December 8 2020.

100 Grover, N., & Matkovsky, T. (2021). On-demand Bus Service Won't Fix Ottawa's Transit Woes. Ottawa Citizen, https://ottawacitizen.com/opinion/grover-and-matkovsky-on-demand-bus-service-wont-fix-ottawas-transit-woes

101 World Health Organization. 2010.

102 Almond, D., Currie, J., & Duque, V. 2017. Childhood Circumstances and Adult Outcomes : Act II, NBER Working Paper No. 23017, https://www.nber.org/system/files/working_papers/w23017/w23017.pdf

103 Almond, D., Currie, J., & Duque, V. 2017.

104 Barker, B. 2019.

105 Doyle, J. J., & Azier, A. 2020. Economics of Child Protection: Maltreatment, Foster Care, and Intimate Partner Violence. Annual Review of Economics.

106 Canadian Mental Health Association, 2007. Poverty and Mental Illness, https://ontario.cmha.ca/wp-content/uploads/2007/11/cmha_ont_poverty_backgrounder_112007.pdf

107 Nikulina, V., Czaja, S., & Spatz Widom, C. 2011. The Role of Childhood Neglect and Childhood Poverty in Predicting Mental Health, Academic Achievement and Crime in Adulthood, Society for Community Research and Action. https://onlinelibrary.wiley.com/doi/pdf/10.1007/s10464-010-9385-y?casa_token=6NHrb5n4zm0AAAAA:KTTwt25RXJj4yAIRD-0-2aMdzf_yk46G249vd1KOmdwO5uxpV4M5EAGjAyIjsjZ-wV890c4RFQKI6g

Public and institutionalized stigma and discrimination is a significant barrier to employment and education, and therefore limit an individual's ability to earn an adequate income. Gaps in service provision increase the risk of chronic poverty[108].

1.5 Stigmatization

Stigma surrounding mental health contributes to ineffective policy where the stated goals do not match the outcomes. The narrative that mental illnesses are personal shortcomings results in policies that do not target the root causes of mental illness. Due to mental health stigma and discrimination, most prominent precursors of mental health are discussed at the individual and familial level and fail to consider the impact broader policies have on an individual's health[109].

Stigma manifests itself in various ways, as public stigma, self-stigma and institutional stigma, all of which pose a barrier to accessing appropriate care[110]. Studies show that news outlets and media sources display dramatic and distorted images of people living with a mental illness which emphasize dangerousness, criminality, and unpredictability[111]. Persons living with a mental illness are often used as scapegoats in news reports, as media reporting greatly contributes to public misconception about the relationship between violence and mental illnesses. Mental illness often ceases to be viewed as a medical condition and instead becomes a sign of violent threat[112]. Understanding where mental health stigma originates from and how it is perpetuated is essential to understanding the underlying notions that inform policies that impact mental health.

The notion that mental illness is the core cause of violent or unpredictable behaviour is incorrect. Studies conclude that indicators for violence among PMI are the same as for the general public: demographic and socioeconomic status, age, substance use, and trauma are much stronger factors in predicting violence than mental illnesses alone[113]. The Canadian Mental Health Association (CMHA) states persons with a mental illness are two and a half times more likely to be victims of violence than the general public[114]. CMHA states that the risk of violence is "confined to a small subgroup of people with severe and persistent mental illness and with specific kinds of symptoms which are not being appropriately treated" [115].

108 Canadian Mental Health Association, 2007.

109 Aden, H., Oraka, C., & Russell, K. 2020. Mental Health of Ottawa's Black Community Research Study. https://www.ottawapublichealth.ca/en/reports-research-and-statistics/resources/Documents/MHOBC_Technical-Report_English.pdf

110 American Psychiatric Association. Stigma, Prejudice and Discrimination Against People with Mental Illness, https://www.psychiatry.org/patients-families/stigma-and-discrimination.

111 Stuart H. Media portrayal of mental illness and its treatments: what effect does it have on people with mental illness? CNS Drugs. 2006;20(2):99-106. doi: 10.2165/00023210-200620020-00002. PMID: 16478286.

112 Metzl, Jonathan M, and Kenneth T MacLeish. "Mental illness, mass shootings, and the politics of American firearms." American journal of public health vol. 105,2 (2015): 240-9. doi:10.2105/AJPH.2014.302242

113 Stuart, H. (2003). Violence and mental illness: an overview. Journal of World Psychiatry. June, 2003, 2(2). Pp. 121-124.

114 Canadian Mental Health Association, British Columbia Division. Police and Mental Illness: Increased Interactions. 2005. Retrieved from https://cmha.bc.ca/wp-content/uploads/2016/07/policesheets_all.pdf

115 Canadian Mental Health Association, British Columbia Division. Police and Mental Illness: Increased Interactions. 2005. Retrieved from https://cmha.bc.ca/wp-content/uploads/2016/07/policesheets_all.pdf

1.6 Key Takeaway

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.

At a federal and provincial level, chronic underfunding of mental health services, particularly community-based services has led to severe gaps in care, especially for already marginalized and under-served Canadians. Weak environmental protection laws which fail to acknowledge, let alone actively address, environmental inequalities leave many living in unsafe conditions. Prohibition drug policy has resulted in a drug toxicity crisis and community violence due to illicit drug markets. Finally, intergenerational trauma and poverty leads to a high frequency of interaction with Child and Family Services, resulting in extreme stress for both parents and children who fear separation.

At a community level, an additional lack of resources being put towards community services such as affordable housing, public transportation, and other community support services leads to an even greater number of individuals who are unable to access the care they require. All the while annual increases in funding for police services further affirms carceral intervention as being the best or only avenue for responding to social inequities, in the eyes of institutions.

Policy decisions made at the national, provincial, and municipal level greatly impact the functioning of a household, as well as the attitudes and stigmas members of the household will have to face. Family access to economic resources, coupled with in-utero and early childhood experiences are amongst the strongest predictors of mental health as an individual ages. Mental health crises are the result of poor policy making. The good news is, 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.

2. Criminalization as a Crisis Response

As previously highlighted, mental illness is in large part an outcome of the social context in which a person lives, and is highly influenced by policy decisions. Not only do governments implement policies that contribute to mental health crises, the current services that exist to address these crises are inadequate[116]. The criminalization of mental illnesses is not a new phenomenon, and demonizing portrayals of people living with mental illnesses exist throughout history. In this section, we address how police as first responders and the healthcare sector contribute to the overrepresentation of persons with mental illness in settings where they are deprived of their autonomy.

Criminalization refers to "laws that prohibit or severely restrict one's ability to engage in necessary life sustaining activities in public, even when that person has no reasonable alternative"[117]. When individuals cannot access appropriate mental health care, their resulting actions are punished and treated as

116 Centre for Addiction and Mental Health. (2020). Mental Health and Criminal Justice Policy Framework. Toronto: CAMH.

117 Rankin, Sara K. "Punishing Homelessness." New Criminal Law Review, vol. 22, no. 1, 2019, pp. 99–135., doi:10.1525/nclr.2019.22.1.99.

criminal. The overrepresentation of persons living with mental illness in jails and prisons is often attributed to long-term deinstitutionalization from psychiatric hospitals. A more accurate statement would be that the overincarceration of persons living with mental illness is a result of an eroded social safety net and lack of effective community supports. People with mental illnesses are at an increased risk of being arrested for various minor and nonviolent crimes including causing a disturbance, mischief, minor theft, or failure to appear in court[118]. Furthermore, those risks are amplified for individuals with undiagnosed or untreated mental illness[119]. Children with undiagnosed and/or untreated mental illness may struggle academically from early on, and adults may struggle to retain employment, which further amplifies the likelihood of living in poverty[120]. As detailed in the previous section, experiencing poverty can worsen mental health outcomes.

Many people who struggle with their mental health never receive a wellness check or any sort of treatment from health care professionals[121]. For some individuals, their contact with the police and the criminal justice system may occur outside of a crisis intervention setting. Higher rates of poverty, social exclusion and adverse childhood experiences correlated with mental illness may result in criminal behaviour[122]. Examples of criminalized behaviour that is linked with untreated mental illness and trauma include street-level (gang) violence[123], intimate partner violence[124], and drug dealing[125]. Despite the link between crime, material deprivation, and structural social exclusion; anti-social behaviour is portrayed as personal failing that can only be remedied through punishment. To decriminalize mental health, it is imperative to decriminalize behaviours that stem from inadequate mental health care, notably substance use and addiction[126]. This section demonstrates that the social services and response mechanisms we currently have in place are not sufficient to adequately support individuals living with mental illnesses.

2.1 Police as First Responders

In this section we delve deeper into the criminalization of mental health; namely, the impact of having police as the primary responders to mental health crises. We examine the impact of police interactions in crisis situations and in schools, as well as the over-representation of PMI in Canada's jail and prison populations. The current carceral approaches to mental health intervention are ineffective, and above all, inhumane.

118 Centre for Addiction and Mental Health, British Columbia Division. Criminalization of Mental Health. 2005, https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn34078-2005-2-eng.pdf

119 Centre for Addiction and Mental Health, British Columbia Division. Criminalization of Mental Health. 2005, https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn34078-2005-2-eng.pdf

120 Insel, T. R. (2008). Assessing the Economic Costs of Serious Mental Illness. The American Journal of Psychiatry. https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2008.08030366

121 Henderson C, Evans-Lacko S, Thornicroft G. Mental illness stigma, help seeking, and public health programs. Am J Public Health. 2013;103(5):777-780.

122 Caruso, G. D. (2017).

123 Ross L, Arsenault S. Problem Analysis in Community Violence Assessment: Revealing Early Childhood Trauma as a Driver of Youth and Gang Violence. International Journal of Offender Therapy and Comparative Criminology. 2018;62(9):2726-2741. doi:10.1177/0306624X17734798

124 Graham-Bermann, S.A., Cater, Å.K., Miller-Graff, L.E. and Howell, K.H. (2017), Adults' Explanations for Intimate Partner Violence During Childhood and Associated Effects. J. Clin. Psychol., 73: 652-668. https://doi.org/10.1002/jclp.22345

125 Semple SJ, Strathdee SA, Volkmann T, Zians J, Patterson TL. "High on my own supply": correlates of drug dealing among heterosexually identified methamphetamine users. Am J Addict. 2011;20(6):516-524. doi:10.1111/j.1521-0391.2011.00173.x

126 NIDA. "Part 1: The Connection Between Substance Use Disorders and Mental Illness." National Institute on Drug Abuse, 13 Apr. 2021.

Across Canada, when people experience a mental health crisis, police officers are usually first on the scene. A study by the CMHA found that over 30% of persons with serious mental illness had contact with police while making, or trying to make, their first contact with the mental health system[127]. Unfortunately, police officers are typically ill-equipped to safely treat those experiencing mental health crises. Police officers are trained to respond to crises with force first, treating every individual as a potential threat[128]. The shortcoming of this approach is reflected in the disproportionate number of people suffering with mental illness killed by police every year. The presence of armed, uniformed officers in marked police vehicles can intensify feelings of distress and escalate situations particularly in Black, Indigenous, LGBTQ2S+, homeless, and other marginalized communities where relationships with law enforcement have historically been strained and plagued with distrust.

2.1.1 Police killings and community trauma

The shift from institutional care to 'community policing' of persons living with mental illness forced the police to adapt their service model beginning in the late 1980's[129]. The increased emphasis on community care has brought on more interactions between police and persons with mental illnesses[130]. In recent decades, approximately 7% to 30% of calls the police receive involve a person living with mental illness[131].

A CBC News investigation into police-involved fatalities in Canada found that 461 police encounters had resulted in death, from the period 2000 to 2017[132]. The investigation revealed that more than 70% of victims had co-occurring mental illnesses or substance use charges, though this is a conservative estimate since the data is not available for all call-types[133]. In Ottawa, the 2016 death of Abdirahman Abdi and the 2019 death of Greg Ritchie are local examples of deadly interactions between police and Black and Indigenous men living with mental illness[134].

Police response is known to cause trauma in racialized and low-income communities. Marginalized individuals living with mental illness and their loved ones are more likely to experience trauma as a result of police interventions, as well as trauma from the subsequent outcomes of incarceration or forced hospitalization[135]. When these interactions happen frequently in a community, entire communities may be traumatized by the services intended to provide support[136]. In March 2021, 10

127 Canadian Mental Health Association, British Columbia Division. Police and Mental Illness: Increased Interactions. 2005. Retrieved from https://cmha.bc.ca/wp-content/uploads/2016/07/policesheets_all.pdf

128 Stoughton, S. "How Police Training Contributed to Avoidable Deaths." The Atlantic, December 12 2014.

129 Cotton, Dorothy, and Terry G. Coleman. "Canadian police agencies and their interactions with persons with a mental illness: A systems approach." Police Practice and Research: An International Journal 11.4 (2010): 301-314.

130 Canadian Mental Health Association, British Columbia Division. (2013). Study in Blue and Grey, Police Interventions with People with Mental Illness: A Review of Challenges and Responses., http://2010.cmha.bc.ca/files/policereport.pdf

131 Coleman, Terry G., and Dorothy H. Cotton. "Reducing risk and improving outcomes of police interactions with people with mental illness." Journal of Police Crisis Negotiations 10.1-2 (2010): 39-57.

132 Nicholson, K., & Marcoux, J. (2018). Most Canadians Killed in Police Encounters Since 2000 Had Mental Health or Substance Abuse Issues, CBC Investigates, https://www.cbc.ca/news/investigates/most-canadians-killed-in-police-encounters-since-2000-had-mental-health-or-substance-abuse-issues-1.4602916

133 Nicholson, K., & Marcoux, J. (2018). Most Canadians Killed in Police Encounters Since 2000 Had Mental Health or Substance Abuse Issues, CBC Investigates, https://www.cbc.ca/news/investigates/most-canadians-killed-in-police-encounters-since-2000-had-mental-health-or-substance-abuse-issues-1.4602916

134 Crawford, B. 2019. Mall shooting, Abdi trial put police handling of mental illness under scrutiny. Ottawa Citizen, https://ottawacitizen.com/news/local-news/mall-shooting-abdi-trial-put-police-handling-of-mental-illness-under-scrutiny

135 Canadian Mental Health Association, British Columbia Division. (2013).

136 Ang, D. 2020. The Effects of Police Violence on Inner-City Students. Harvard University, https://scholar.harvard.edu/files/ang/files/PoliceViolence_Ang.pdf

armed OPS officers were dispatched to the wrong home to respond to a wellness check[137]. In their wake, the intervention left a Black family traumatized and a person in distress did not receive the help they needed.

2.1.2 Police in schools

Police presence in schools has been found to increase arrest rates for Black and Indigenous students[138]. Although little research has been conducted to explore the impact of police presence in schools, preliminary studies show that police presence in schools increases the arrests of Black students over every other minority group[139]. The school-to-prison pipeline is defined as "the causal link between educational exclusion and criminalization of youth" and is the by-product of strict disciplinary measures in schools which have been found to be ineffective[140]. The constant surveillance of children in school under these programs enforces a punitive culture of compliance and removes the safety that schools can provide. The school-to-prison pipeline is also a root cause of the disproportionate numbers of Black, Indigenous and people of colour (BIPOC) in the Canadian criminal justice system[141].

Based on our consultations, we have found that there is a deep mistrust of police among BIPOC communities in Ottawa. The presence of armed officers in a learning environment negatively impacts students' ability to learn. We found that Black students are more likely to be disciplined, suspended, and arrested in school when police are present. Data gathered from our consultations showed that police officers in schools do not have training on adolescent development, racial equity, trauma-informed care, or de-escalation techniques.

2.1.3 Incarceration

Mental illnesses are more common in incarcerated persons than the general population[142]. In Canada, there are more than 250,000 adult admissions and 14,000 youth admissions each year to correctional facilities[143,144]. The growing number of incarcerated people living with mental illnesses has created a need for extensive mental health treatment options within carceral institutions, while the design of prisons and jails worsens mental health[145]. Research shows that persons with mental illness are arrested for minor offenses at higher rates than the general population[146]. The link between mental illness and incarceration is heightened by the direct correlation between poverty and criminalization, where individuals are criminalized for minor offences such as unpaid fines or missed court dates[147].

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137 Duffy, A. 2021. Ottawa cops enter wrong home in response to distress call, woman says her boyfriend awakened by officer with gun drawn. Ottawa Citizen, https://ottawacitizen.com/news/local-news/ottawa-cops-enter-wrong-home-in-response-to-distress-call-woman-says-her-boyfriend-awakened-by-officer-with-gun-drawn

138 Homer, Emily & Benjamin W. Fisher. (2020). Police in schools and student arrest rates across the United States: Examining differences by race, ethnicity, and gender, Journal of School Violence, 19:2, 192-204, DOI: 10.1080/15388220.2019.1604377

139 Homer, Emily & Benjamin W. Fisher. (2020).

140 Wilson, Harry. "Turning off the school-to-prison pipeline." Reclaiming Children and Youth 23.1 (2014): 49.

141 McGowan, Jordan & Concepcion, Felisa. (2020). Decolonize The Classroom Pt. 1: School to Prison Pipeline. The Medium, https://coach-jmcgowan.medium.com/decolonize-the-classroom-pt-1-school-to-prison-pipeline-3cb808bcf0e6

142 Fazel, Seena, and Jacques Baillargeon. "The health of prisoners." The Lancet 377.9769 (2011): 956-965.

143 Perrault S. Admissions to youth correctional services in Canada, 2011/2012. http://www.statcan.gc.ca/pub/85-002-x/2014001/article/11917-eng.htm?fpv=2693. 2014.

144 Perrault S. 2014.

145 Dvoskin, J. A., Knoll, J. L., & Silva, M. 2020.

146 Ghiasi N, Azhar Y, Singh J. Psychiatric Illness And Criminality. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2021 Jan.

147 The criminal justice system inherently overrepresents minorities, especially Indigenous peoples. Indigenous adults account for 5% of the general population, but account for over 30% of federally sentenced offenders (Department of Justice). The criminalization of Indigenous people is a lasting effect of colonial values underlying Canadian criminal

According to the Centre for Addiction and Mental Health (CAMH), the lack of access to mental health care, racism and inadequate housing are some one of the reasons why people with mental illnesses are overrepresented in the criminal justice system[148]. The lack of resources available to people living with mental illness, particularly psychosis, has created the conditions of trans-institutionalization, which refers to the link between deinstitutionalization and the increasing rates of people living with mental illness in jail and in prison[149]. Without access to care and supports, some people with mental illnesses may commit crimes or behave in ways that draw police attention. CAMH states; "how police respond to these interactions is an early predictor of the likelihood of further involvement in the criminal justice system and how the court system reacts further sets the course" [150].

2.2 Traditional Healthcare Settings

Traditional health care settings, such as emergency rooms and psychiatric care, contribute to the criminalization of persons with mental health through the use of coercive measures such as involuntary hospitalization[151]. Furthermore, hospitals may be hostile environments for people from marginalized communities and past negative experiences may present legitimate barriers to care[152]. Literature suggests that the healthcare system fails to meet the needs of certain groups, including members of the LGBTQ2S+ community, persons using substances, individuals experiencing homelessness, or those who have experienced ongoing or historical trauma due to discrimination or inaccessibility[153].

2.2.1 Hospitals

In 2021, healthcare spending represents 38% of provincial spending in Ontario[154]. In 2019-20, the Ottawa Hospital spent $1.4 billion on wages and service provision[155]. Although costly, expenditures on healthcare yield significant positive returns. For every dollar invested in mental health and addictions, $30 in lost productivity and social costs is saved[156]. In Ontario, studies show that experiences with hospitals among the unhoused and vulnerably housed do not meet the standards of universally accessible patient-centered care[157]. This disincentivized unhoused or vulnerably housed people from accessing preventative healthcare services. As a result, people who experience homelessness are likely to rely more frequently on emergency services[158]. Individuals who belong to several disadvantaged

laws, policies, and practices, which have been proven by many inquiries, commissions, task forces and research studies conducted since the 1980's. Colonialism has subjected Indigenous peoples to assimilation practices that have created intergenerational trauma, and when that is compounded by housing instability, lack of education, and poverty, it results in more and longer experiences with the criminal justice system (Department of Justice) 147.

148 Centre for Addiction and Mental Health. (2020). Mental Health and Criminal Justice Policy Framework. Toronto: CAMH.

149 Dvoskin, J. A., Knoll, J. L., & Silva, M. 2020. A Brief History of the Criminalization of Mental Illness. CNS Spectrums, 25, 638–650

150 Centre for Addiction and Mental Health. (2020).

151 Jones, N., Gius, B.K., Shields, M. et al. (2021). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. Social Psychiatry and Psychiatric Epidemiology. https://doi.org/10.1007/s00127-021-02048-2

152 Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city, Social Science & Medicine, 178, pp. 87-94.

153 Purkey, E., MacKenzie, M. Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care. Int J Equity Health 18, 101 (2019). https://doi.org/10.1186/s12939-019-1004-4

154 Bethlenfalvy, P. 2020. Ontario's Action Plan: Protecting People's Health and Our Economy. https://budget.ontario.ca/2021/pdf/2021-ontario-budget-en.pdf

155 2020. Consolidated Financial Statements of the Ottawa Hospital. https://www.ottawahospital.on.ca/annualreport/pdf/TOH%20Consolidated%20wFS%20Eng.pdf

156 Ottawa Public Health. (2021). "What We Do," https://www.ottawapublichealth.ca/en/public-health-services/what-we-do.aspx

157 Purkey, E., MacKenzie, M. (2019).

158 Evans, J., Collins, D. & Anderson, J. (2016). Homelessness, bedspace and the case for Housing First in Canada. Social Science & Medicine, 168, pp. 249-256.

groups may experience unique and intersecting forms of discrimination due to racism and prejudice within the healthcare system. Discrimination by healthcare providers can function as a key barrier to obtaining necessary services, resulting in "avoidance or delays in treatment seeking, underdiagnosis and mistreatment, nonadherence with standard medical advice, and/or an unwillingness from general practitioners to provide care"[159].

For example, hospital discharge for many marginalized individuals can be traumatic and dangerous. Individuals experiencing homelessness are frequently discharged to shelters or the street without being connected to housing and community supports[160]. Patient discharges are overseen by health care providers who do not have the training to address the non-medical needs that accompany homelessness. Research undertaken in Ontario found that complicating factors that occur at discharge include "discontinuity between health care providers, changes to medication regimes, new self-care responsibilities, stressors to available resources and complex discharge instructions"[161]. Better coordination between support workers and health care workers, and access to safe housing upon hospital discharge is essential to reducing the chance of costly re-hospitalization and lessening the trauma of hospitalization. Furthermore, the measures to prevent drug use in hospitals combined with inadequate pain and withdrawal management results in persons who use drugs leaving hospital against medical advice[162]. Discharge against medical advice is correlated with higher risk of mortality and readmission[163]. Patients are frequently denied the pain medication to treat their primary diagnosis, let alone to treat withdrawal symptoms. The assumption that individuals were hospitalized with the intention to seek out free drugs is amplified for people with Indigenous ancestry and highlights the prevalence of systemic racism in healthcare. In order to improve care outcomes for people who use drugs and reduce the frequency of hospitalization, "evidence-based drug and pain treatment services, augmented by comprehensive harm reduction services, have significant potential to promote health equity by reshaping the environmental context of hospital care"[164].

2.2.2 Psychiatry

In matters of prejudice, psychiatry is a field that has been complicit. While we acknowledge that psychiatry has evolved significantly since the days of its inception, and psychiatrists as individual practitioners are almost always operating with the best intent, we must also reckon with the reality that psychiatry is, and always has been, used to control divergent or neuro a-typical behaviors[165]. During the time of slavery, "American psychiatrists pathologized enslaved people who attempted to risk their lives by running away or who refused to work, diagnosing them with illnesses such as drapetomania or dysesthesia aethiopica. The prescribed treatment being whipping"[166]. For over 200 years "female hysteria" was the diagnosis given to women experiencing issues ranging from depression, intimate

159 Keen, J. "Managing drug misuse in general practice. New department of health guidelines provide a benchmark for good practice." BMJ (Clinical research ed.) vol. 318,7197 (1999): 1503-4. doi:10.1136/bmj.318.7197.1503

160 Buccieri, K., Oudshoorn, A., Frederick, T., Schiff, R., Abramovich, A., Gaetz, S. and Forchuk, C. (2019), "Hospital discharge planning for Canadians experiencing homelessness", Housing, Care and Support, Vol. 22 No. 1, pp. 4-14. https://doi.org/10.1108/HCS-07-2018-0015

161 Buccieri, K., Oudshoorn, A., Frederick, T., Schiff, R., Abramovich, A., Gaetz, S. and Forchuk, C. (2019).

162 McNeil, R., Small, W., Wood, E., & Kerr, T. (2014). Hospitals as a 'risk environment': An ethno-epidemiological study of voluntary and involuntary discharge from hospital against medical advice among people who inject drugs, Social Science & Medicine, 105, pp. 59-66.

163 Choi, M., Kim, H., Qian, H., & Palepu, A. (2011). Readmission rates of patients discharged against medical advice: a matched cohort study, 6 (9). pp. e24459

164 McNeil, R., Small, W., Wood, E., & Kerr, T. 2014.

165 Ventriglio, A., & Bhugra, D. 2015. Psychiatry's Social Control and Patients' Rights, East Asian Archives of Psychiatry, 25, https://www.researchgate.net/publication/289507179_Psychiatry's_Social_Control_and_Patients'_Rights.

166 Legha, Rupinder Kaur, and Jeanne Miranda. "An anti-racist approach to achieving mental health equity in clinical care." Psychiatric Clinics 43.3 (2020): 451-469.

partner violence, sexual desire, to infertility. Treatments varied widely and included marriage, sexual intercourse, forced hysterectomies, and admittance to an insane asylum[167]. Beginning in the 1960s, a lack of cultural understanding coupled with limited social supports in the Indigenous population resulted in staggering numbers of Indigenous parents (particularly Indigenous mothers) being deemed unfit to parent, confusing endemic poverty with an inherent incapacity to provide care, and resulting in the forced removal of Indigenous children from their homes[168].

Today the field of psychiatry continues to inflict harm through the forced medication and/or hospitalization of individuals in crisis, with racial minorities being significantly more likely to be admitted involuntarily as compared to their white counterparts[169]. The field of psychiatry continues to contribute to the perpetuation of health disparities in clinical practice and health policies that negatively impact marginalized communities[170]. Psychiatry has repeatedly attempted to link violence to individual biology rather than address the pressing social conditions like poverty, unemployment, and surveillance that may lead to violent behaviour, perpetuating the narrative of racial differences[171]. The tendency to associate racialized minorities as violent still exists through the overdiagnosis of disruptive behaviour disorders among racialized children, and the over-policing of these children in school settings[172].

Research shows that psychiatric patients are at a heightened risk of suicide in the first 90 days following their discharge from the hospital[173]. That risk is heightened for individuals that were hospitalized for treatment of a depressive disorder, followed by bipolar disorder. Forced apprehension of people with mental illnesses to psychiatric facilities continues to be hailed as an essential component to healthcare, despite evidence that suggest patients feel alienated and dissatisfied with treatment, and are unlikely to continue with treatment once they are able to decide for themselves[174]. Survivors of psychiatric care report feeling dehumanized and punished rather than cared for. Once discharged, evidence suggests that patients who found their treatment to be coercive were more likely to make a suicide attempt and be diagnosed with depression[175]. Coercive treatments create lasting feelings of distrust, with one 2021 study on involuntary hospitalization on youth and young adults finding that "70% of participants described negative impacts on their ability or willingness to trust others— most frequently mental health providers, but in some cases extending to broader authority figures and peers"[176].

Healthcare spending that worsens health outcomes for patients is not an effective use of funding. Anti-racist care integrates cultural aspects and elements that allow for "some form of reparation for the

167 Cohut (2020). "The controversy of 'female hysteria.'" Medical News Today, https://www.medicalnewstoday.com/articles/the-controversy-of-female-hysteria#Female-hysteria-in-the-18th-century.

168 Kirmayer, L., Macdonald, M., Brass, G. 2000. "The Mental Health of Indigenous Peoples." McGill University.

169 Centre for Addiction and Mental Health. (2016) "Study reveals ethnic differences in mental illness severity when hospitalized," https://www.camh.ca/en/camh-news-and-stories/study-reveals-ethnic-differences-in-mental-illness-severity-when-hospitalized.

170 Gordon-Achebe K., Hairston D.R., Miller S., Legha R., Starks S. (2019). Origins of Racism in American Medicine and Psychiatry. In: Medlock M., Shtasel D., Trinh NH., Williams D. (eds) Racism and Psychiatry. Current Clinical Psychiatry. Humana Press, Cham. https://doi.org/10.1007/978-3-319-90197-8_1

171 Shamoo, Adil E., and Carol A. Tauer. "Ethically questionable research with children: the fenfluramine study." Accountability in Research: Policies and Quality Assurance 9.3-4 (2002): 143-166.

172 Legha, Rupinder Kaur, and Jeanne Miranda. 2020.

173 Olfson M, Wall M, Wang S, et al. 2016. Short-term Suicide Risk After Psychiatric Hospital Discharge. JAMA Psychiatry. 73(11):1119–1126.

174 Monahan, John, et al. "Coercion and commitment: understanding involuntary mental hospital admission." International Journal of Law and Psychiatry 18.3 (1995): 249-263.

175 Jones, N., Gius, B.K., Shields, M. et al.

176 Jones, N., Gius, B.K., Shields, M. et al.

harm caused by racial discrimination, racial profiling, microaggressions, and racism"[177]. Institutions that stem from harmful origins may be particularly ill-equipped to introduce new standards of care.

2.4 Key Takeaway

This section demonstrates that our current response to mental illness is one of criminalization. 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 PMI 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.

Police presence in schools means that criminalized responses to 'bad behaviour', which for children is typically a sign of emotional distress, starts early. Police in schools eliminates critical safe spaces for children, increases disciplinary action, suspensions and arrests amongst Black and Indigenous students, and contributes to the school-to-prison pipeline.

Previous negative experiences in healthcare settings, such as instances of discrimination or involuntary hospitalization are barriers to accessing necessary care and support. Members of the LGBTQ2S+ community, persons using substances, and individuals experiencing homelessness are particularly susceptible to medical discrimination. Inadequate discharge procedures and the absence of harm reduction services while hospitalized lead to rehospitalization and higher risk of mortality among homeless patients and people who use drugs following hospitalization. Those negative outcomes are amplified for Black and Indigenous people who are discriminated against along multiple axes. Involuntary psychiatric hospitalization creates lasting feelings of distrust between patients and service providers, harming their ability to feel safe while accessing services upon release.

Relying on police officers as first responders increases the likelihood of incarceration among people living with mental illness. Incarceration is expensive, and further increases the likelihood of homelessness and substance use which require additional expenditure in social services and emergency medical services. When the healthcare services provided do not meet the needs of individuals, they are likely to be re-hospitalized. By failing to prevent crisis situations and responding with services that do not lessen the likelihood of crises, we spend large amounts of money trying to undo harms we have caused. Over time, reallocating funds from police budgets towards preventative services can reduce the instances of crises in the community. Effective public spending not only improves the quality of care for persons in crisis, but also allows for additional funding to be reinvested in the community.

3. Policing in Canada

The following section justifies why police-led police reform, such as the Ottawa Police Service's proposed new mental health framework, will fail to meet the needs of the community. This section is threefold. First, it addresses the history of policing and how historical precedents have shaped the police forces that exist today. Acknowledging and understanding the failures of modern policing is a crucial

177 Cénat, Jude Mary. "How to provide anti-racist mental health care." The Lancet Psychiatry 7.11 (2020): 929-931.

step in determining why an alternative response is needed. Next, we illustrate the shortcomings of reform when addressing a crisis that requires systems change, acknowledging that police failures extend far beyond response to mental health crisis. Finally, building off the understanding that social determinants of health compound to create crisis, we present a brief introduction to police abolition to remedy various structural harms.

3.1 History of Policing in Canada

News cycles today constantly report incidences of police violence and police killings in both Canada and the United States. With this uptick in media coverage comes the illusion that police brutality is a relatively new problem. A very brief refresher on the history of policing in Canada will show; however, that violence at the hands of police has been a feature of the institution since its inception, one that continues to operate as it was intended to this day.

Police benefit from the portrayal of officers as heroes. Long running television shows such as Blue Bloods, Criminal Minds, Law and Order, and Brooklyn Nine-Nine place police on pedestals and reduce police work to solving major crimes[178]. In reality, police are civil servants. Their scope of work is much more varied and often extends beyond what they are equipped to handle. Similarly to how we would not expect a general practitioner to perform the specialized tasks of a brain surgeon, we should not expect police to have the capabilities to handle all forms of crisis intervention. When dealing with mental health crises in particular, more dedicated care is required in order to achieve positive outcomes.

Canadian history has also been over-simplified and idealized with narratives that suggest European settlers arrived on the land to engage in mutually beneficial relations with the Indigenous population, gaining access to the land through a series of signed treaties. This pastoral version of history is then used to dismiss and marginalize Indigenous accounts of land theft and genocide[179]. The understanding that false narratives are used to present the settler state as lawful and police forces as heroic first requires individuals to grasp their origins[180].

Throughout the early days of colonization, policing was seen as a predominately local concern in Canada. Regional police systems were established following either a French watchmen or English constabulary and watch-and-ward model[181]. The purpose of these systems were similar to those in the United States at the time, to control “inconvenient populations”, namely labourers and Indigenous peoples.

In the early 19th century, following the founding of London, England’s Metropolitan Police Department, Canada’s police forces underwent major systematic changes in order to conform with the new “Peelian principles”[182]. Sir Robert Peele, England’s then Home Secretary set out a vision for policing in which the

178 Grady, C. (2021). “How 70 years of cop shows taught us to valorize the police” https://www.vox.com/culture/22375412/police-show-procedurals-hollywood-history-dragnet-keystone-cops-brooklyn-nine-nine-wire-blue-bloods

179 Starblanket, Gina, Dallas Hunt. "Storying Violence: Unravelleing Colonial Narratives in the Stanley Trial." ARP Books. May 26th 2020.

180 This section focuses on the history of policing. For a more complete portrayal of the history of policing and how it interacts with the Canadian state, The Skin We’re In and Storying Violence are excellent places to start.

181 Brodeur, Jean-Paul, William F. Walsh, George L. Kelling, Michael P. Banton, Thomas Whetstone. "The Development of Police in Canada". Britannica Encyclopedia. https://www.britannica.com/topic/police/The-development-of-police-in-Canada.

182 Wilfred Laurier University. (2019). The History of Policing. https://online.wlu.ca/news/2019/08/13/history-policing-canada

public's participation was a key priority and communities were asked to accept the use of force in exchange for safer neighbourhoods and the maintenance of societal order. The public, who had feared that large, highly organized police forces were being established as a means of limiting their civil liberties were put at ease through the use of this community focused language. Using the Peelian principles as a guide, Toronto, Montreal, and Quebec City formed their own police departments in 1835, 1838, and 1840 respectively. In 1868, the Dominion Police Force was established with jurisdiction over the entire country (though it focused its operations in Eastern Canada) and was responsible for state security.

The North-West Mounted Police (NWMP) was established in Canada in 1873 following Canada's acquisition of Rupert's Land and the North-West Territories. The NWMP was created to act as a token symbol of Canada's occupation of the newly seized Western territory, policing present-day Manitoba, Saskatchewan, Alberta, and later growing to include the northern territories[183].

Colonial policing of Indigenous peoples became an intrinsic part of establishing Canadian settlements on Turtle Island[184]. The region was populated by First Nations and Métis peoples, and the purpose of the NWMP was to coerce Indigenous leaders to sign away their territories and traditional means of living. The goal was to forcibly relocate Indigenous peoples onto reserves, and in doing so, reduce Indigenous peoples to a state of government dependency as a means of advancing white settlements and the construction of the Canadian Pacific Railway[185]. The colonial government relied on the NWMP to facilitate the signing of treaties that were never honoured, and that were defined by concepts of private property foreign to Indigenous language. Within years of signing treaties, the constant influx of white settlers and the criminalization of Indigenous peoples' traditional lifestyles contributed to rising unrest[186].

The establishment of the NWMP coincided with construction on the Canadian Pacific Railway. The NWMP worked closely with the Department of Public Works to ensure the railway's successful completion[187]. This included guarding tools and raw materials, as well as overseeing labourers. Additionally, the NWMP were responsible for the forcible removal of Indigenous peoples from the intended rail path. Protecting private property and profits, and facilitating the unfettered development of Indigenous lands has always been a key mandate of policing in Canada. 140 years later, police continue to occupy this role with striking parallels to the past. In February of 2020, for example, RCMP officers arrested dozens of protestors from Wet'suwet'en lands to allow for construction to begin on the Coastal GasLink pipeline[188]. In a capitalist system, profits and property are prioritized above people. Police defend and uphold this system and the individuals who benefit from it.

183 Butts, Edward. 2016. "North-West Mounted Police". The Canadian Encyclopedia, Historica Canada. https://www.thecanadianencyclopedia.ca/en/article/north-west-mounted-police.

184 Nettelbeck, Amanda, and Russell Smandych. "Policing Indigenous Peoples on Two Colonial Frontiers: Australia's Mounted Police and Canada's North-West Mounted Police." Australian & New Zealand Journal of Criminology, vol. 43, no. 2, Aug. 2010, pp. 356–375, doi:10.1375/acri.43.2.356.

185 Butts, Edward. 2016.

186 "Defending the Law: The North-West Mounted Police, 1873-1920." Historic Places Canada, Parks Canada. https://www.historicplaces.ca/en/pages/45_rcmp_grc.aspx

187 Government of Canada. "A long-lasting relationship with the Royal Canadian Mounted Police". (2020). https://www.tpsgc-pwgsc.gc.ca/apropos-about/canada150/GRC-RCMP-eng.html

188 Bogart, N. (2020). "What you need to know about the Wet'suwet'en protests, arrests" CTV News.

In 1920, the NWMP merged with the Dominion police force to create the Royal Canadian Mounted Police (RCMP)[189]. Clear evidence suggests that the RCMP continued the NWMP mandate to control and intimidate Black and Indigenous populations. In 1986, the Marshall Inquiry, a Royal Commission, was ordered by the Government of Nova Scotia[190]. It found the police and justice system guilty of systemic bias towards Black and Indigenous people. In the decades since the inquiry, not much has changed.

Provincial and municipal police forces also continue this legacy of control in every jurisdiction they police. We see this in the ways Indigenous resistance is criminalized at 1492 Land Back Lane and on Wet'suswet'en territory[191], with street checks (carding) in Ontario[192], and the deaths of Greg Ritchie, Abdirahman Abdi, Regis Korchinski-Paquet, Eishia Hudson, D'Andre Campbell, Machuar Madut, Rodney Levi, Stewart Kevin Andrews, Ejaz Choudry, Chantel Moore, and so many others[193].

It is important to highlight that violence towards marginalized communities extends beyond interactions with frontline police operations and extends into police priorities and investigations. Examples that highlight these failures include police response in searching for Missing and Murdered Indigenous Women and Girls across Canada and the McArthur-related investigations in Toronto[194]. It is vital to consider how racial disparities in societal institutions are often supported by institutional policies and unconscious biases[195]. For this reason, systemic racism in policing is interconnected with systemic racism in health care, education, urban planning, financial institutions, social assistance provision, foster care, employment, and housing, among others[196]. Like policing, systemic inequities in these areas can create the conditions that result in worse mental health outcomes for marginalized peoples, which reinforces their need to interact with these broken systems.

3.2 Pervasive Discrimination of Marginalized Communities

Indigenous resistance to colonial violence began upon first contact, when the white settlers claimed Turtle Island as a "discovery" and declared the Indigenous inhabitants subject to colonialization by way of unfair trade and missionary work[197]. Resistance to policing began immediately upon the introduction of the NWMP which was mandated to control Indigenous populations and facilitate settlement in the Prairie provinces.

189 Butts, Edward. "North-West Mounted Police". The Canadian Encyclopedia, 06 December 2016, Historica Canada. https://www.thecanadianencyclopedia.ca/en/article/north-west-mounted-police.

190 Conn, Heather. "Marshall Inquiry". The Canadian Encyclopedia, 02 September 2020, Historica Canada. https://www.thecanadianencyclopedia.ca/en/article/marshall-inquiry.

191 Forester, Brett. 2021. OPP Spent MoreThan $16M Policing 1492 Land Back Lane: Records. APTN National News, https://www.aptnnews.ca/national-news/opp-spent-more-than-16m-policing-1492-land-back-lane-records

192 Legal Aid Ontario. 2016. Racialization of Carding and Street Checks, http://beta.legalaid.on.ca/strategic/wp-content/uploads/sites/4/2016/06/infographic-RCS-carding-2016-05-EN.pdf

193 Cole, Desmond. 2020. Remembering 27 Black, Indigenous, and racialized people killed by Canadian police, https://thatsatruestory.wordpress.com/2020/04/17/remembering-27-black-indigenous-and-racialized-people-killed-by-canadian-police/

194 Epstein, G. J. 2021. Missing and Missed: Report of the Independent Civilian Review into Missing Person Investigations. https://8e5a70b5-92aa-40ae-a0bd-e885453ee64c.filesusr.com/ugd/a94b60_eb1b274e75764885b9bf5a2347b5fad1.pdf?index=true

195 Williams, David R., and Toni D. Rucker. "Understanding and addressing racial disparities in health care." Health care financing review vol. 21,4 (2000): 75-90.

196 Baciu, A., Negussie, Y., Geller, A., et al., ed. 2017. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press.

197 Taylor, John Leonard. "Indigenous Peoples and Government Policy in Canada". The Canadian Encyclopedia, 09 December 2020, Historica Canada. https://www.thecanadianencyclopedia.ca/en/article/aboriginal-people-government-policy.

Constant oversight from the Canadian Pacific Railway surveyors increased unrest among the Métis as the disappearance of the bison herds and crop failures began the era of starvation[198]. The Métis were dispossessed after the Red River Resistance in 1869-70 and were still petitioning the colonial government for formal title of their lands in the northwest[199]. The aftermath of the Northwest Resistance of 1885 saw the introduction of the pass system[200], which, despite never being formally written into law, had devastating impacts on Indigenous communities and severely hindered their ability to resist colonization[201].

Police violence towards Black Canadians has its roots in slavery. Black communities have been demonized, criminalized and dispossessed to benefit white settlers. The history of Africville (Bedford, Nova Scotia) highlights the way predominantly Black communities are prevented from thriving as evidenced by environmental racism and the municipal neglect that led to its deconstruction in the late 1960's[202]. That history is recreated time and time again, and similarities can be drawn to the 2018 Heron Gate evictions in Ottawa[203].

Police and colonial governments have "found a way to exclude both the racialized immigrants seeking to come here since Confederation and the racialized Indigenous peoples who were here millennia before white European settlers"[204]. Despite this, Black peoples, Indigenous peoples, and other marginalized persons have laid the foundation for resistance and police abolition. Black and Indigenous abolitionists across North America have continued to fight against slavery, segregation, incarceration, colonialism, and capitalism in order to advance the goal of liberation for all marginalized peoples.

3.3 Shortcomings of Police Reform

When instances of police violence are brought into public discourse, mainstream media often appeals to the need for police reform. Even police services themselves have recognized a need for reform. Common calls for police reform include better training, diversity in hiring and promotion, and increased accountability measures in the form of police body cameras and legal consequences for their actions. These calls might be well intended; however, they always implicitly require additional funding to police services in municipalities where all other social services are increasingly underfunded.

In a statement recognizing the existence of systemic racism within the OPS, Chief Sloly wrote "to dismantle systemic racism (along with all forms of discrimination) in policing, we need to make positive investments in police culture, police operations and the broader institutional ecosystem that the police

198 Butts, Edward. 2016.

199 Indigenouspeoplesatlasofcanada.ca. 2021. 1885 Northwest Resistance. https://indigenouspeoplesatlasofcanada.ca/article/1885-northwest-resistance

200 The pass system was used to control the movements of Indigenous peoples by requiring First Nations peoples living on reserve to have signed documentation from the Indian Agent in order to leave their reserve. The pass system was used to prevent parents from visiting their children at residential schools and from leading organized resistance beyond the confines of their reserves. The system was implemented following the Northwest Resistance in 1885 and enforced by the NWMP, despite the system never being lawfully enacted. The pass system was largely phased out in the 1930s, but some documentation shows passes being issues as late at the 1040s.

201 F. Laurie Barron, "The Indian Pass System in the Canadian West, 1882–1935" Prairie Forum vol. 13, no. 1 (1988).

202 Lunianga, A. 2020. Just How Systemic Is Anti-Black Racism in Canada? Part 1: Africville, Nouvelle, https://nouvelle.news/2020/06/just-how-systemic-is-anti-black-racism-in-canada-part-1-africville

203 Crawford, B. 2018. It's Hurtful to See – Rally Protests Heron Gate Evictions, Ottawa Citizen, https://ottawacitizen.com/news/local-news/its-hurtful-to-see-rally-protests-heron-gate-evictions

204 Cole, Desmond. 2020.

operate in"[205]. The following section seeks to justify why police-led police reform will not have the desired outcome of dismantling systemic racism.

3.3.1 Training

One of the most commonly called-for trainings following racist or racially insensitive police interactions is implicit bias training. There is little empirical evidence that these programs are effective, despite being considered a best practice[206]. In addition, police training often heavily emphasizes officer safety and the potential dangers on the job. If police officers see the people they are meant to help as a threat to themselves, they are more likely to respond with force.

Police training when responding to mental health calls is both insufficient and harmful. Various accounts suggest that it perpetuates the narrative that persons experiencing a mental health crisis are violent and unpredictable[207]. Studies show that on average, Canadian police academies receive ten hours of basic training to prepare them for interactions with persons experiencing a mental health crisis, with no standard curriculum in place[208]. One study concluded that the hours of training offered were simply not enough to cover all course topics thoroughly, let alone the more commonly accepted essential topics such as verbal strategies or suicide prevention, like the academies stated that they had[209].

These shortcomings cannot be remedied by increasing the training that officers receive. Police training reinforces the deeply ingrained sentiment that police operate in such a dangerous world that their primary duty is to make it home safely at the end of their shift[210]. As a result, trainings often reiterate that police officers need to make decisions within split seconds of responding to situations and operate under the assumption that they can be harmed.

3.3.2 Accountability

Police accountability cannot reduce police violence because it does not reduce contact between police and marginalized persons[211]. Punishing police officers after a violent or deadly interaction implies that the system has already failed to keep a resident safe and does little to protect other people from experiencing a similar outcome with a different officer.

Police Service Boards are designed to ensure civilian governance over police forces. Their two primarily roles are to prevent political interference and act as an oversight body of police services to maintain the standards of the communities they serve[212]. Those intentions are; however, undermined by the lobbying power of police associations that influence decision making at the board and municipal council level.

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205 Sloly, Peter. 2020. Systemic Racism in Policing in Canada. Presentation by OPS Chief Peter Sloly to the Standing Committee on Public Safety & National Security, https://www.cacp.ca/index.html?asst_id=2208

206 Huey, L. 2018. What Do We Know About In-service Police Training? Results of a Failed Systematic Review, Sociology Publications, 40. https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=10432&context=sociologypub

207 Cotton, D.H. & T.G. Coleman. 2010. Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing. Ottawa: Mental Health Commission of Canada.

208 Cotton, D.H. & T.G. Coleman. 2008. A Study of Police Academy Training and Education for New Police Officers Related to Working with People with Mental Illness. Ottawa: Mental Health Commission of Canada and the Canadian Association of Chiefs of Police.

209 Cotton, D.H. & T.G. Coleman. 2008.

210 Zoukis, C. (2018). What is the Number One Duty of a Police Officer? https://www.criminallegalnews.org/news/2018/jan/19/what-number-one-duty-police-officer.

211 Electoral Justice Project of the Movement for Black Lives. Breathe Act. https://breatheact.org/

212 Anand. A. Police Service Boards and Widening Oversight Gap. https://fcpp.org/2020/03/28/police-services-boards-and-the-widening-oversight-gap/

The Special Investigations Unit (SIU) is a civilian oversight agency that investigates any police incident where there may have been criminal conduct from an official in Ontario. Despite being independent from any police service, 97% of officers are cleared by the SIU[213]. In February 2020, the SIU laid no charges against OPS officers Thanh Tran and Daniel Vincelette for the killing of Greg Ritchie[214]. In October of the same year, OPS officer Daniel Montsion was found not guilty on all charges in the death of Abdirahman Abdi[215].

When police-involved deaths do occur, the justice that is sought is generally a carceral response: we want to see police who kill innocent people be found guilty of those murders and not held above the law. In reality, justice would resemble deadly situations never occurring again, which cannot be achieved through prosecution. This is demonstrated by the reality that while Derek Chauvin's guilty verdict was being delivered, Ma'Khia Bryant was killed by police[216]. The list of families awaiting justice for their loved ones who were killed by police grows every day. Prosecuting murder does not prevent murder in the general population[217] – it is unlikely that prosecuting police officers would have a different outcome. This is not to suggest that police officers should not be held accountable for their actions, instead we are arguing that increased legal repercussions will not reduce the amount of violence that marginalized peoples face at the hands of police.

3.3.3 Surveillance technology

The effectiveness of surveillance technology is highly debatable considering that multiple studies suggest that while it might have a moderate impact on solving crime, marginalized communities bear the impact of these technologies which as a result, exacerbate existing social inequities[218].
Calls to outfit police officers with body cameras often come in response to publicized incidents of police violence, even ones where the interaction is already recorded by eyewitnesses with cellphones.

Research from Australia, where the use of body cameras is increasingly common, found that "the intersection of technology and human behaviour is highly complex and unpredictable, but a camera that can be switched off, or wilfully turned away from a police interaction with an assailant without consequence, cannot increase accountability or reduce poor policing practice"[219]. Furthermore, the actual cameras and technology to store the recorded footage are extremely costly and would require increases in police funding. Introducing body cameras for RCMP officers is expected to cost $131 million over the course of the next five years[220].

213 Cole, Demond. 2020. The Skin We're In: A Year of Black Resistance and Power.

214 APTN National News. 2020. SIU Says No Charges for Ottawa Police Officers who Killed Ojibwe Man. https://www.aptnnews.ca/national-news/siu-says-no-charges-for-ottawa-police-officers-who-killed-ojibwe-man

215 Raymond, T., Keyes, S., & Griffin, K. 2020. Ottawa Police Officer Daniel Montsion Found not Guilty on all Charges in Death of Abdirahman Abdi. https://ottawa.ctvnews.ca/ottawa-police-officer-daniel-montsion-found-not-guilty-on-all-charges-in-death-of-abdirahman-abdi-1.5151377

216 Black Lives Matter. 2021. Ma'Khia Bryant. https://blacklivesmatter.com/makhia-bryant/

217 Johnson. B. 2019. Do Criminal Laws Deter Crime? Deterrence Theory in Criminal Justice Policy: A Primer. https://www.house.leg.state.mn.us/hrd/pubs/deterrence.pdf

218 Hollis, ME. Security or surveillance? Examination of CCTV camera usage in the 21st century. Criminology & Public Policy. 2019; 18: 131– 134. https://doi.org/10.1111/1745-9133.12427

219 Taylor, E. 2016. Lights, Camera, Redaction… Police Body-Worn Cameras; Autonomy, Discretion and Accountability. Surveillance & Society 14(1): 128-132. http://ojs.library.queensu.ca/index.php/surveillance-and-society/index

220 Wodrich, N. 2021. RCMP National Body-worn Camera (BWC) Program and Digital Evidence Management System (DEMS), Legislative Costing Note. https://pbo-dpb.s3.ca-central-1.amazonaws.com/artefacts/923dc79bc80be0f3342e33fb8d6b637f84f7e3e525498fcb101331a8c07d3fac

3.3.4 Diversity

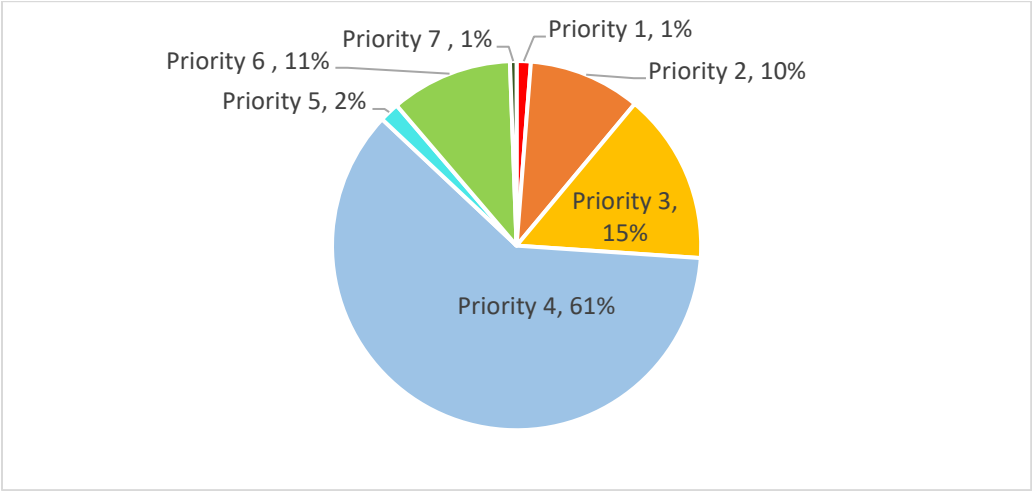
The Ottawa Police Service has stated multiple times that they are committed to improving policing and intend to increase the diversity within the force to achieve that outcome. Improving Equity, Diversity & Inclusion is one of the four key areas of OPS strategic directions in the 2021 budget[221]. Funding has been committed to hiring new recruits with a focus on increasing diversity within the force.

Increased diversity within the police force will not improve policing outcomes because police violence is not exclusively the actions of individual officers. The history and culture of policing creates a setting such that no individual officer can enact broad enough changes to alter the current reality of policing. Having a police force that mirrors the community does not detract from the reality that policing is inherently anti-Indigenous, anti-Black and classist[222]. Communities remain deprived of crucial social services at the expense of increasing funding to hire their peers to police them. Distrust in police extends beyond individual officers, and a person in crisis can be triggered by the uniform or the vehicle even if they have shared social characteristics with the officer[223].

3.4 De-tasking and Defunding

Depictions of police officers portray them as constantly fighting and preventing violent crime. In reality, police do not have the capacity to prevent crime as they are a responsive service and not a preventative one. Furthermore, the majority of calls that police respond to are not crisis situations. In 2019, OPS was dispatched to 346,300 calls[224]. OPS uses a 7-tier system to classify calls, where Priority 1 are emergency calls and Priority 7 calls are non-emergency. Of those calls, 1% were Priority 1 calls, defined as calls in which there was an actual threat to life or a crime in progress.

Figure 2: OPS Calls for Service by Priority Level, 2019



Source: Ottawa Police Service. 2019. Calls for Service, https://www.ottawapolice.ca/en/annual-report-2019/calls-for-service.aspx

221 Ottawa Police Service. Budget 2021. https://www.ottawapolice.ca/en/news-and-community/resources/2021-draft-budget.pdf

222 Fifield, B. Does Diversifying Police Forces Reduce Tensions? https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/22/does-diversifying-police-forces-reduce-tensions

223 Canadian Association of Police Governance. 2014. The Psychological Influence of the Police Uniform. http://capg.ca/the-psychological-influence-of-the-police-uniform/

224 OPS. Calls for Service, https://www.ottawapolice.ca/en/annual-report-2019/calls-for-service.aspx

Crime does not occur randomly. As a result, even violent crime, is preventable through better access to resources and strengthened community ties. In Ottawa in 2019, 63% of violations were property crimes, 35% were theft of under $5,000, and 7% were assaults[225] . Rather than responding to all violations with the same solution, designing specific and tailored responses aimed at eliminating and preventing these instances is more effective.

In addition to violence committed by community members, police violence is an everyday occurrence. Conventional reforms will not eliminate the harms caused by police, as decades of police reform have failed to curb police violence[226]. Calls to defund and dismantle current forms of policing seek to address the power imbalances between police and community head-on by replacing police with community-based alternatives[227]. The Yellowhead Institute put it simply, "the notion of police being there to serve and protect in times of need often does not apply to Indigenous, Black, or other racialized minorities in Canada. The notion of 'help' more often resembles harm" [228].

Given the racist history of policing in Canada and the limitations of reform, defunding and de-tasking the police is the best way to ensure the safety of marginalized communities and ensure there is sufficient funding to provide comprehensive alternatives[229]. Solutions that divest from carceral systems and don't exacerbate cycles of trauma and violence must be developed at a municipal level to meet the needs of the community. Money reallocated from police budgets could rebuild the social safety net by providing comprehensive health care, affordable and supportive housing, free transit, universal childcare and other life-affirming social services[230]. A society without police, and by extension other carceral systems, where social services and mutual aid can meet the need of community members, would be a less violent society than the one we currently live in.

Police abolition is best explained as the "process of strategically reallocating resources, funding, and responsibility away from police and toward community-based models of safety, support, and prevention"[231]. Police abolition requires transformative justice. Transformative justice gets at the root causes of harms in the society and works to transform communities to prevent that harm from reoccurring[232]. Community-based models of safety require social services and mutual aid. Mutual aid is defined as a practice that emphasizes solidarity rather than charity, recognizes that well-being, health, and dignity are all bound up in each other and that survival depends on cooperation, not competition[233].

Calls to defund the police are simply calls to reinvest in community. De-tasking the police refers to re-assigning tasks to other service providers who are better equipped to respond to certain situations. In saying this, we recognize that police are never the appropriate responders in community. For mental

225 Statistics Canada. Table 35-10-0180-01 Incident-based crime statistics, by detailed violations, police services in Ontario

226 Akbar, A. An Abolitionist Horizon for (Police) Reform (August 10, 2020). California Law Review, Vol. 108, No. 6, 2020, Ohio State Legal Studies Research Paper No. 560.

227 Ibid.

228 Stelkia, Krista. "Police Brutality in Canada: A Symptom of Structural Racism and Colonial Violence." Yellowhead Institute, 15 July 2020.

229 Wilt, J. 2020. Abolishing the Police is the only Reasonable Response to Winnipeg Police killings. Canadian Dimension,

https://canadiandimension.com/articles/view/abolishing-the-police-is-the-only-reasonable-response-to-winnipeg-police-killings

230 Cole, D. "Disarm and Defund Police" and Give Money to Communities. Youtube, uploaded by CBC News. June 1, 2020.

https://www.youtube.com/watch?v=IIkOG2vtE1g&ab_channel=CBCNews

231 MPD 150, FAQ. https://www.mpd150.com/faq/

232 Paielle. G. How Would Prison Abolition Actually Work? GQ, June 11 2020. https://www.gq.com/story/what-is-prison-abolition?fbclid=IwAR2BMea4cpwLE2IFWMibXq95E3V-LEuZnLwB74ukq6vpZSBCHhqDXuTk74k

233 De Loggans, Regan. Let's Talk Mutual Aid. https://dochub.com/rloggans/jo3xELpR3ZO8yz8wJBa7nr/loggans-mutual-aid-zine-pdf?dt=Ls_myQXhz6RrrzS59DVW

health calls, non-police mental health crisis teams are generally accepted as being more effective[234]. For finding missing persons or preventing serial violence, community groups that know the concerned individuals and who are invested in their return/safety could better serve communities if they were given the resources to investigate[235]. Survivor support systems and transformative justice can do more to prevent and heal individuals following sexual violence than police action ever could[236]. Defunding the police allows for investments in new and existing social services that would reduce crime and increase public safety. De-tasking the police means that even in the event of a crisis, a response tailored to the situation is available to the community.

3.5 Key Takeaway

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 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 therefore 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 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.

4. Mobile Crisis Response Teams

Mobile crisis response teams (MRCTs) were established in the 1970s to provide safe, on-site mental health care[237]. MCRTs usually consist of medics, social workers, community elders, and/or peer support workers. Alternative crisis responses never look the same community to community and are grounded in anti-oppressive principles and trauma-informed approaches to care. MCRTs respond predominantly to calls for welfare checks, mental health crises, conflict de-escalation, substance use and suicidality[238]. Studies describe the main benefits of MCRTs as improved access to care, reduction of severe crises, decreased hospitalization rates, and decreased public safety spending for municipalities[239]. Reduced police involvement decreases interactions with the criminal justice system. This leads to more supportive counselling for people living with mental illness in familiar settings[240]. Mobile crisis teams

234 Watson, A. C., Compton, M. T., & Pope, L.G. "Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities." Vera Institute of Justice, October 2019, p. 29.

235 Black Lives Matter Canada. 2021. Alternatives to Police Services. https://defundthepolice.org/alternatives-to-police-services/

236 Chrysalis Collective. 2013. Beautiful, Difficult, Powerful in What About the Rapists? https://dysophia.org.uk/wp-content/uploads/2014/09/Dys5-WhatAboutTheRapistsWeb2.pdf

237 Watson, A. C., Compton, M. T., & Pope, L.G. 2019

238 CAHOOTS, 2020. Media Guide, https://whitebirdclinic.org/wp-content/uploads/2020/06/CAHOOTS-Media-Guide-20200624.pdf

239 Watson, A. C., Compton, M. T., & Pope, L.G. 2 2019.

240 Zealberg, Joseph J., Alberto B. Santos, and Richard K. Fisher. "Benefits of Mobile Crisis Programs." Hospital and Community Psychiatry 44, no. 1 (1993), 16-17.

work closely with community health care providers, allowing for linkages in care and referrals for follow-up care.

Evaluations of MCRTs find that people living with mental illnesses are more likely to be receptive to care, less likely to be apprehended under Section 17 of the Mental Health Act, and less likely to experience trauma due to the crisis response[241]. Other benefits of MCRTs include the inclusion of loved ones in the PMI's care through opportunities to learn coping and de-escalation skills, which help reduce mental illness stigma and lead to a higher chance of continued care[242].

The safety risk for mobile crisis intervention workers is often brought up in conversations surrounding mobile crisis response teams, as crisis workers are generally unarmed citizens and their safety is pertinent. A CMHA study on nine crisis intervention programs in North America found that the annual rate of injury or harm to first responders by PMI ranged from 0.00% to 0.00076%, with some response services reporting no staff injuries[243]. The study also concluded that when injuries to crisis intervention workers did occur, they were very minor in nature. Similarly, the rate at which police back-up was requested was very low, ranging from 0.14% to 0.79%[244]. The findings indicate that responding to mental health calls pose no risk to crisis intervention workers.

Although the feedback for MCRTs is overwhelmingly positive and demand is high, community-based crisis response services are usually underfunded[245]. The resulting supply shortage leaves many citizens and loved ones of PMI with no choice but to turn to police services for wellness checks. Cost savings from introducing MCRT programs are considerable.

4.1 Crisis Assistance Helping Out On The Streets (CAHOOTS)

The CAHOOTS community-based public safety program in Eugene, Oregon is one of the most well-known services. It was established in 1989, and has been replicated in many cities. The program mobilizes teams consisting of a medic (a nurse, paramedic, or EMT) and a crisis worker who has substantial training and experience in the mental health field. The model involves no police officers, though the CAHOOTS team is dispatched by a 911 operator who is trained to recognize non-violent situations with a mental health component[246]. The CAHOOTS program budget is about $2 million annually, while the combined annual budgets for Eugene and neighbouring Springfield police departments are $90 million[247]. In 2019, CAHOOTS handled about 20% of the Eugene Police Department's calls which allowed the police to focus their efforts on responding to calls for police service[248]. The dependence on CAHOOTS in Eugene has led to its budget nearly tripling in the last 10 years, especially as it expands to serve neighbouring Springfield, with indications of future growth[249]. The program saves the city of Eugene an estimated $8.5 million in public safety spending annually[250].

241 Reach Out Response Network. Mobile Crisis Teams and Frontline Staff Safety: An Analysis of Existing Data. 2020.

242 Watson, A. C., Compton, M. T., & Pope, L.G. 2019.

243 Reach Out Response Network. Mobile Crisis Teams and Frontline Staff Safety: An Analysis of Existing Data. 2020.

244 Reach Out Response Network. Mobile Crisis Teams and Frontline Staff Safety: An Analysis of Existing Data. 2020.

245 Watson, A. C., Compton, M. T., & Pope, L.G. 2019.

246 CAHOOTS. (2020). What is CAHOOTS? White Bird Clinic.

247 CAHOOTS. (2021). "What is CAHOOTS?" White Bird Clinic. Retrieved from https://whitebirdclinic.org/what-is-cahoots

248 CAHOOTS. (2020). What is CAHOOTS? White Bird Clinic.

249 Andrew, S. 2020. "This town of 170,000 replaced some cops with medics and mental health workers. It's worked for over 30 years,". CNN News. July 5 2020.

250 CAHOOTS. (2021).

4.2 24/7 Diversion

The 24/7 Diversion team in Edmonton, Alberta is a partnership between Boyle Street Community Services, the Canadian Mental Health Association, Hope Mission, and REACH Edmonton. The program, established in 2013, has worked closely with Alberta Health Services, and Emergency Medical Services. The program is a 24/7 service that responds to calls from citizens, businesses, and community agencies. 24/7 Diversion occasionally works in association with the Edmonton Police Services to coordinate crisis situations, though it does not receive funding from the department. 24/7 Diversion staff come from diverse backgrounds with various levels of training; teams consist of university students from social work, psychology, EMT, and nursing programs, chaplains, former RCMP, and front-line shelter and drop-in workers. The primary goal of the program is to provide for people who are experiencing mental health or medical non-emergency crises, are intoxicated, or otherwise impaired.

4.3 Gerstein Crisis Centre

The Gerstein Crisis Centre in Toronto, Ontario was established in 1989 and is supported by funding from the Ministry of Health. Its mobile crisis team operates in downtown Toronto. The Centre provides community-based support for adults experiencing mental health or substance use challenges. Gerstein is staffed by community crisis workers with a broad range of experience and education, but does not include police officers, doctors, or social workers. All staff are trained in "crisis intervention, suicide intervention, harm reduction, and work from a trauma-informed perspective"[251]. The mobile crisis team can be accessed through their crisis line by individuals themselves or through referrals. Teams travel in vans to aid and assist those in need, whether that be to de-escalate crises or to transport members of the community to safe spaces. The centre offers crisis beds and follow-up support, as well as other social services.

4.4 Indigenous-led Models

Indigenous-led models incorporate traditional knowledge, healing practices, and work to strengthen cultural ties that were damaged by colonialization[252]. Indigenous peoples benefit from these models by regaining access to and strengthening traditional ways of life. The models are trauma informed and are centred around the person receiving care.

The Bear Clan Patrol originated in Winnipeg due to distrust of the police and works to provide personal security in the community in a non-threatening, non-violent and supportive way[253]. The Wiindo Debwe Mosewin program is an Indigenous-led community safety patrol and emergency response team in Thunder Bay. The program was established in 2017 due to frustrations with the local police's investigation efforts of Indigenous children's deaths in the city.

Their patrol is rooted in the Anishinaabe clan system and Indigenous governance principles which include harm-reduction approaches. Initially modelled after Winnipeg's Bear Clan Patrol, Wiindo Debwe Mosewin has restructured their model as they do not associate or cooperate with the police in any capacity. The Wiindo Debwe Mosewin patrol is run by volunteers in Thunder Bay and the surrounding areas. The patrols are conducted in pairs on foot, bus, or bike, providing first aid, naloxone kits, traditional medicines, and general public safety activities. The patrol is also known to deliver meals and hot beverages to those in need, as well as referring those in crisis to community resources like shelters

251 Gerstein Crisis Centre. (2020). Philosophy. Gerstein Crisis Centre.

252 Allen, S., Andrew Hatala, Sabina Ijaz, Elder David Courchene, Elder Burma Bushie. Indigenous-led health care partnerships in Canada. CMAJ March 2020, 192 (9) E208-E216; DOI 10.1503/cmaj.190728

253 Bear Clan Patrol Inc. History. Bear Clan Patrol Inc. https://bearclanpatrol.org/#about

and detox centres. The patrol is active 24/7, and is accessible by phone (call or text), or through social media.

In terms of their approach to triage, the patrol uses a problem-solving method called contextual fluidity to assess and act on options when aiding PMI. Contextual fluidity is an anti-oppressive model of social work that squarely addresses the goal of sensitivity to the needs of others based on their unique situation[254]. Instead of using the Western positivist approach as the unspoken standard, the model emphasizes Indigenous approaches to helping by engaging in person-to-person dialogue to provide more meaningful assistance[255]. The success of the patrol is difficult to judge empirically because data is not collected, but the patrol finds approval within their community.

4.5 Co-responder Models

Co-responder models are a joint partnership between police departments and community-based agencies or psychiatric facilities. The models feature at least one officer and one mental health professional responding to situations in which a mental health crisis is involved[256]. The team travels together in a ride-along fashion and is dispatched to incidents directly or is dispatched after police officers survey the scene. Other co-responder models include a mental health worker assisting police officers remotely via telephone or police radio[257].

Communities have seen marginal benefits from implementing co-responder models, like decreases in arrests and jail admissions for PMI[258]. Co-responder models also allow for patrol officers to resume their regular duties quickly by allowing the co-responder team to take over at crisis scenes that have been deemed non-violent, and thus is cost-effective for police departments to implement. In addition, co-responder models have the ability to provide clinical support on scene, conduct mental health screenings and assessments, review the history of the person receiving care, and provide referrals to community resources[259].

Despite these benefits, evaluations of co-responder models have not produced clear findings on program efficiency. The mere presence of police officers can heighten feelings of distress, causing PMI to be more aggressive and overwhelmed[260]. Front line responders from Hamilton and Toronto shared their experiences with us, mentioning that the sight of police at a wellness check leads to discomfort and escalation for the person in crisis. A Toronto study found that PMI who had experiences with police wellness checks remarked that the presence of police in bulletproof vests and marked vehicles can be triggering, particularly for persons who have experienced trauma[261]. The study also stated that family members of those who had experienced wellness checks shared their perception that police were

254 Shera, Wes. (2003). Emerging Perspectives on Anti-Oppressive Practice. Canadian Scholars Press.

255 Shera, Wes. (2003). Emerging Perspectives on Anti-Oppressive Practice. Canadian Scholars Press.

256 Krider, Ashley., Regina Huerter, Kirby Gaherty & Andrew Moore. “Responding to Individuals in Behavioural Health Crisis via Co-Responder Models.” Policy Research Inc. and National League of Cities. (2020).

257 Puntis, Stephen et al. “A systematic review of co-responder models of police mental health 'street' triage.” BMC psychiatry vol. 18,1 256. 15 Aug. 2018, doi:10.1186/s12888-018-1836-

258 Krider, Ashley., Regina Huerter, Kirby Gaherty & Andrew Moore. “Responding to Individuals in Behavioural Health Crisis via Co-Responder Models.” Policy Research Inc. and National League of Cities. (2020).

259 Krider, Ashley., Regina Huerter, Kirby Gaherty & Andrew Moore. “Responding to Individuals in Behavioural Health Crisis via Co-Responder Models.” Policy Research Inc. and National League of Cities. (2020).

260 Adhopia, V. (2020). “It’s time to rethink police wellness checks, mental advocates say,”. CBC News. July 4 2020.

261 Reach Out Response Network. Final Report on Alternative Crisis Response Models for Toronto. 2020.

focused on criminalization and punishment rather than de-escalation. Many reported instances of loved ones being taken to jail instead of the hospital, even for PMI as young as thirteen years old[262]. The presence of an additional non-police responder on scene cannot undo these experiences.

A common criticism of wellness checks done under co-responder models is the lack of follow-up care or case management offered, with the users finding no effective pathways to further treatment following the intervention[263]. Police co-responder units usually have short operational times, with most services only being available to cover evening and night-time hours only, which makes them less consistent and reduces the chances of PMI being treated in an appropriate time frame. Other criticism includes the lack of follow-up care and case management, which left users of the service without effective pathways to further treatment following the intervention[264].

The COAST program in Hamilton is a partnership between mental health workers at St. Joseph's Healthcare and officers of the Hamilton Police Service. The program's Mobile Crisis Rapid Response Team (MCRRT) dispatches teams of mental health professionals and uniformed police officers in marked cars to conduct wellness checks. The program's police officers undergo 40 hours of mental health training before being eligible to join the COAST team[265]. The team is dispatched through emergency 911 calls and cannot be specifically requested by the public. In the first year of operation, MCRRT resulted in a 49% reduction in apprehension rates to hospital[266]. A 2019 report by the Hamilton Police Service found that COAST provided both financial savings and time efficiencies for the department[267].

From our community consultations, we found that the COAST program in Hamilton was not an effective model as it had the most barriers to success of all the programs we surveyed. The major barrier is the inclusion of uniformed police officers. Furthermore, the dispatch system is problematic because the service is not widely available and cannot be requested. In the case that the dispatcher does not see the need of the MCRRT, a standard police dispatch will be sent. Other barriers mentioned were the lack of follow-up care options for PMI and lack of consultation between the program leadership and the Hamilton community. A positive aspect of the COAST program is its partnership with St. Joseph's Healthcare, which allows a direct flow of information from the responding officers to the psychiatric department to provide better care for the person in crisis.

4.6 Key Takeaway

Carceral approaches to mental health crisis intervention amplify feelings of distress and leave PMI feeling as though they are being criminalized as opposed to cared for. Fortunately, carceral approaches are not the only options. MCRTs are an alternative solution that can be Indigenous-led, independent of police or operate jointly as co-responders. 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

262 Reach Out Response Network. Final Report on Alternative Crisis Response Models for Toronto. 2020.

263 Puntis, S., Perfect, D., Kirubarajan, A. et al. A systematic review of co-responder models of police mental health 'street' triage. BMC Psychiatry 18, 256 (2018). https://doi.org/10.1186/s12888-018-1836-2.

264 Puntis, S., Perfect, D., Kirubarajan, A. et al. A systematic review of co-responder models of police mental health 'street' triage. BMC Psychiatry 18, 256 (2018). https://doi.org/10.1186/s12888-018-1836-2.

265 St. Joseph's Healthcare & Hamilton Police. Working Together to Improve Services for Those Experiencing Mental Health Crisis: Mobile Crisis Response Team. 2015.

266 St. Joseph's Healthcare & Hamilton Police. Working Together to Improve Services for Those Experiencing Mental Health Crisis: Mobile Crisis Response Team. 2015.

267 Weisner, P. (2020). Hamilton Police Service. Crisis Response Branch Community Mobilization Division 2019 Annual Report. Hamilton; June 2020.

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.

5. Mental Health Responses in Ottawa

The Ottawa Police Service (OPS) are the primary responders for mental health crises. In terms of mental health response, OPS is tasked with conducting wellness checks, persons in crisis calls, and apprehensions under the Mental Health Act. In addition, OPS officers interact with persons living with mental illness in various states of crises when performing all tasks related to community policing as well as certain criminal directorates. The OPS interacts with persons with mental illness through multiple complex avenues; however, they also have a designated mental health unit. Operating under the Community Relations and Frontline Specialized Support (CRFSS) Directorate, Mental Health Crisis Services is staffed by six sworn officers. 89 sworn officers are assigned to the Neighbourhood Resource Teams, 18 sworn officers are assigned to Community Policing, and there are 28 School Resource Officers (SROs). The Frontline Operations directorate includes six platoons (A-F) of 87 sworn officers each for a total of 522 sworn officers. Both directorates fall under the supervision of the Chief of Police and the Deputy Chief Operations. In addition, the directorates are under the authority of the Superintendent Frontline Operations and the Superintendent Community Relations and Frontline Specialized Support, respectively[268]. OPS also has an external partnership with the Ottawa Hospital Mobile Crisis Team (MCT) to assist with cases that fall under the Mental Health Act (MHA). The MCT is comprised of social workers, nurses, and a consulting psychiatrist. The OPS Mental Health Crisis Unit program (MCU) is staffed by four Constables[269]. To receive services through this outreach program, an individual needs to be referred by a health professional or community service worker. MHA forms include referrals for involuntary admission to the hospital, and apprehension and transport of a person to a physician for a psychiatric examination. Additional information on the MHA is available in the Appendix.

5.1. Volume of Mental Health Calls for Service

Reporting on the volume of calls for mental health crisis are not transparent. Unfortunately, there is no national standard protocol for call reporting, so each police service is able to set their own data collection standard. OPS calls for service can only be categorized under one call type in the Computer Aided Dispatch (CAD) system. This results in incomplete data collection concerning people in mental health crises[270].

According to publicly available data from the OPS, OPS received 245,518 calls in 2019 that required on-scene police presence[271]. In 2019, OPS reported receiving 6,844 calls for service for a person in mental health distress and 6,398 in 2020[272]. By their own admission, this data does not include calls related to an alleged crime where mental health distress was a contributing factor.

268 At the time of writing, the Chief of Police is Peter Sloly and the Deputy Chiefs are Steve Bell and Uday Jaswal. Jaswal is currently suspended over allegations of sexual harassment and sexual misconduct. The Superintendent Frontline Operations is Mark Ford and Superintendent Community Relations and Frontline Specialized Support is Jamie Dunlop. http://ottwatch.ca/meetings/file/674298

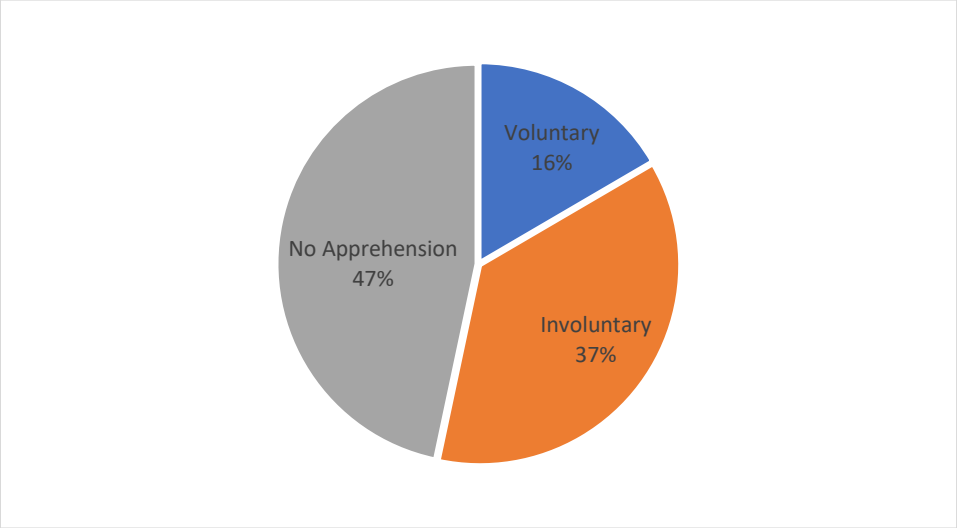
269 Ottawa Police Service. Mental Health Unit, https://www.ottawapolice.ca/en/about-us/Mental-Health-Unit.aspx.

270 Ottawa Police Service. (2021). Consultation Approach for Mental Health Response Strategy. https://www.ottawapolice.ca/en/news-and-community/resources/FINAL-V2-Mental-Health-Response-Strategy-Consultation-Report.pdf.

271 Ottawa Police 2019 Annual Report, https://www.ottawapolice.ca/en/annual-report-2019/calls-for-service.aspx

272 Ottawa Police Service. https://www.ottawapolice.ca/en/news-and-community/resources/FINAL-V2-Mental-Health-Response-Strategy-Consultation-Report.pdf

Figure 3: Mental Health Act Calls for Service Apprehensions, 2020



Source: Ottawa Police Services Board (2021). Consultation Approach for Mental Health Response Strategy, https://www.ottawapolice.ca/en/news-and-community/resources/FINAL-V2-Mental-Health-Response-Strategy-Consultation-Report.pdf

Mental health calls for service can be coded in seven different ways, notably:

Mental Health Act Section 17 Apprehension (8650-1): Frontline officers respond to calls where a person is threatening to harm themselves or others. These calls result in the forced apprehension of the individual under the Mental Health Act. These calls account for 27.6% of all mental health calls for service.

MHA Form 1 (8650-2): Frontline officers, OPS' MHU and a mental health nurse will apprehend an individual against their will to be taken to the hospital for a psychiatric evaluation. Generally, a Form 1 is requested by a family member and issued by a physician. These calls account for 4.64% of all mental health calls for service.

MHA Hospital Voluntary (8650-3): Frontline officers (including Ottawa Paramedics) respond to calls to service from loved ones or the person in crisis themselves and convince the individual to voluntarily go to the hospital. These calls account for 16.58% of all mental health calls for service.

MHA Form 2 (8650-4): Frontline officers, OPS' MHU and a mental health nurse will apprehend an individual against their will to be taken to the hospital for a psychiatric evaluation. Generally, a Form 2 is requested by a family member and issued by a Justice of the Peace. These calls account for 4.38% of all mental health calls for service.

MHA – Other (8650-4): Officers respond to a call from bystanders for a person they deem to be in crisis. The responding officers are tasked with assessing the situation to determine if the person is under the influence of drugs and/or alcohol, and if the person is experiencing a mental health crisis. The targeted outcome is for the officer to de-escalate the situation. These calls account for 36.8% of all mental health calls for service.

MHA Elopee – (8650-5): Calls for service to re-apprehend a person who has fled, generally from the hospital. These calls account for 0.13% of all mental health calls for service.

Other Mental Health Act reports not primary UCR: Calls to service where mental health was not the reason of the call, but a mental health report is later submitted to the initial report. These calls account for 9.9% of all mental health calls for service.

Monthly data provided by Statistics Canada further breaks down calls for service. In 2020, 91 calls for service pertained to a suicide or attempted suicide and 182 pertained to overdoses in Ottawa[273]. Combined mental health apprehension calls, general mental health crisis calls, suicides and attempted suicides, and overdoses accounted for 15% of all violations and calls for service in 2020. In addition, 9% of violations and calls for service were failures to comply with orders and 18% were for domestic disturbances. A 2011 study found that half of police interactions with persons with mental illness involved alleged criminal behaviour, generally minor offenses such as theft, property damage, disorderly conduct, and drug possession[274].

5.2 OPS Expenditure on Mental Health

In 2021, the OPS budget was $376 million[275]. While not exclusively focused on mental health, the operating resource requirement for the Community Relations & Frontline Specialized Support (CRFSS) was $39.9 million and for Frontline Operations was $93 million. New spending in 2021 includes $1.5 million on mental health services and $222 thousand on additional de-escalation and Gender Based Analysis+ training[276].

Within the Community Relations and Frontline Specialized Support Directorate, detailed expenditure by program shows that SROs received $3.7 million and the NRTs received $9 million[277]. Spending on the Mental Health Crisis Services program is not listed, but instead agglomerated into a budget line listed as Community Safety Services which encompasses multiple programs. Assuming the size of each program and associated spending is proportional to the number of sworn officers, $1.2 million is allocated to the Mental Health Crisis Services program.

Of all the spending in the CRFSS directorate, 80% is accounted for by salaries, wages and benefits. Within the Frontline Operations Directorate, each platoon's operating resource requirement was roughly $11.5 million. 97% of spending in the directorate was salaries, wages and benefits[278]. Given that OPS data indicates that 15% of calls are specifically for mental health, this would account for 15% of the budget allocated to platoons, equivalent to $10.83 million. We do not know how many calls coded as other violations have a mental health component, therefore it is nearly impossible to conclude how much money is spent policing mental health in Ottawa, especially given the reality that many

273 Statistics Canada. Table 35-10-0169-01 Selected police-reported crime and calls for service during the COVID-19 pandemic, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510016901

274 Brink, J., Livingston, J., Desmarais, S., Greaves, C., Maxwell, V., Michalak, E., Parent, R., Verdun-Jones, S., & Weaver, C. (2011). A study of how people with mental illness perceive and interact with the police. Calgary, Alberta: Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/sites/default/files/Law_How_People_with_Mental_Illness_Perceive_Interact_Police_Study_ENG_1_0_1.pdf

275 OPS Budget 2021.

276 OPS Budget 2021.

277 OPS Budget 2021.

278 OPS Budget 2021.

criminalized behaviours are the outcomes of inadequate mental health care but are seldom recognized as such.

5.3 Mental Health Response Strategy Consultation

The Ottawa Police Service is currently in the consultation phase of their Mental Health Response Strategy (MHRS). The strategy is expected to take three years to design and will be co-developed with mental healthcare and addictions professionals, community-based organizations, academics, and those with lived experience[279]. The information outlined in Section 3.3 of this report detail why this reform will not be able to meet the needs of the Ottawa community.

5.4 Alternatives Outreach Programs

The shortcomings of police response to community needs are not recent developments, nor is the existence of alternatives to police. Community-led alternatives have always had a presence and are generally much more successful in meeting the needs of individuals they are designed to help. Due to systemic failures to meet the needs of people who experience mental health crises, alternatives to the police have already found themselves in Ottawa. This includes programs such as the Street Team OutReach Mobile (STORM) team operated by Minwaashin Lodge[280] and the Homeless Crisis Outreach Project operated through Somerset West Community Health Centre (SWCHC)[281] which assist with crisis intervention. In addition, more recent mutual aid groups such as Ottawa Street Medics[282] and Hit the Streets[283] have been established to meet the various needs of vulnerable community members.

Non-police crisis outreach services in Ottawa remain limited as they are largely underfunded. The Ottawa Hospital has a mental health mobile crisis team; however, services are only provided to individuals 16 years and older[284]. The service also includes 11 crisis beds that persons experiencing mental health crisis can be voluntarily brought to if they do not require hospitalization. The service works in partnership with the Ottawa Police, and based on communications with frontline workers, involuntary apprehensions are commonplace and are conducted at the discretion of the responders.

Homeless individuals can contact the City of Ottawa by dialing 3-1-1 if they need transportation to places for shelter. Street Outreach staff from the Salvation Army will be dispatched in a van to transport to a shelter or hospital[285]. Based on communication with the Salvation Army front desk, the service is high-barrier and only offers transportation to pre-established locations. Transportation is always voluntary, but outreach staff do collaborate with OPS when they consider it necessary.

The Homeless Crisis Outreach Project operated through Somerset West Community Health Centre operates daily from 1pm – 9pm to provide additional support to street-involved persons experiencing crisis. Additional outreach services provided by SWCHC include Rooming House Outreach, Needle Exchange and Safer Inhalation (NESI) and Drug Overdose Prevention and Education (DOPE) Response

279 Ottawa Police Services. "Mental Health Response Strategy Consultation Approach for Board Approval, https://www.ottawapolice.ca/Modules/News/index.aspx?newsId=26f6a00f-d604-4882-9aac-f6b316da2bcd

280 Minwaashin Lodge. 2020. https://www.minlodge.com/storm

281 SWCHC, https://www.swchc.on.ca/programs/homeless-crisis-outreach-project

282 Ottawa Street Medics, Instagram Account, https://www.instagram.com/ottawastreetmedics/?hl=en

283 Hit the Streets, Instagram Account, https://www.instagram.com/hitthestreets.ca/?hl=en

284 The Ottawa Hospital. The Mobile Crisis Team (MCT) - Community Based, https://www.ottawahospital.on.ca/en/clinical-services/deptpgrmcs/departments/mental-health/our-services/mobile-crisis-team-mct/

285 The Salvation Army. Street Outreach, http://www.ottawaboothcentre.org/?ID=56.

Team[286]. Service provision at SWCHC appears to be unique as outreach staff provide informal case management. In addition, DOPE and NESI are peer-based harm reduction supports, staffed by Community Workers who have lived experience or living experience of substance use.

The Street Team Outreach Mobile (STORM) operated through Minwaashin Lodge provides assistance to street-involved women, including crisis intervention, harm reduction services, safety planning, emergency transportation and community referrals[287]. STORM staff also offer an Indigenous-focused discussion space for women in need. The Oshki Kizis Lodge is a 21-bed shelter for Indigenous women and children fleeing abuse. All services provided by Minwaashin Lodge are anchored in cultural beliefs and guarantee a holistic approach. Outreach workers have Indigenous ancestry and lived experience with homelessness, substance use and/or trauma. During a crisis intervention, the person has the right to determine the care they receive and have the right to refuse care.

5.5 Key Takeaway

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.

Conclusion

In conclusion, current policies and existing crisis responses have exacerbated the mental health crisis we find ourselves in today. Fortunately, good policies and alternative services can begin to rectify some of these problems. Federal and provincial policies shape the social determinants of health which have impacts at the community and household level. Municipalities therefore have the responsibility to allocate funding to mitigate, rather than reinforce the inequalities created by higher levels of governance. Prohibition drug policy, social assistance policy, and child protection policy interact and reinforce one another to create mental health crisis. At a municipal level, police funding is prioritized over housing, transit and social services and therefore fails to support those experiencing crises.

By using police response as the default, one-size fits all solution to all complex social issues, persons who experience crisis are often criminalized. When police are the first point of contact for mental health care, feelings of distress are amplified. This response begins early, with police in schools and police interventions for youth in care. In addition, we closely examine the institutions of healthcare and foster care to identify where these services fail the very people they are mandated to help. Discrimination by health care providers contributes to narratives which position PMI as violent and unpredictable and results in individuals receiving inadequate care when hospitalized. These realities are compounded by race and other factors including homelessness, drug use and sex work.

Historically, police have been used to control marginalized populations. Although policing has evolved considerably since its inception, the tools available to police officers, such as a uniform, lethal weapons, the ability to restrain people against their will, create the conditions that lead even the best-intentioned

286 Somerset West Community Health Centre. Programs & Services, https://www.swchc.on.ca/programs.

287 Minwashin Lodge. STORM, https://www.minlodge.com.

officers to replicate harms inherent to the system. As a result, incremental reforms cannot transform police services into the appropriate first response to mental health crisis.

Alternatives to police response are empirically proven to be more successful, in that they result in fewer deaths, hospitalizations, and arrests. Indigenous-led models, mobile crisis response teams and community response models have been found to provide the most appropriate care. In Ottawa, the Ottawa Police Service remains the first point of contact for mental health crisis. They perform wellness checks, person in crisis calls and forced apprehensions to hospital under the Mental Health Act. The alternatives that exist are underfunded, and have fewer resources as compared to OPS. Reallocating funding from the OPS allows the city to invest in preventative care such as housing, health care and other community services, including a non-police mental health crisis response.

In this report, we argue it is crucial to re-assign the responsibility of addressing mental health crisis and the associated funding to people who have the appropriate tools and training. In his book *The Skin We're In*, Desmond Cole describes attending the National Black Canadians Summit where he observes that the three days at the event were "sadly were not about dreaming and reimagining but about working within the existing restraints of systemic racism and calling it progress". The suggestions in this report seek to help explain and justify alternatives. What might outwardly appear to be radical, impossible changes are in fact practical and tangible ways to make our community safer.

Our current approach to addressing violence, crime and crises is reactive as opposed to preventative. Reimagining community safety is not abolishing help. Reimagining community safety is providing people with the adequate supports to keep them housed, fed, healthy and safe. When a person is experiencing a mental health crisis, they deserve services that can be called to respond and provide care in that moment. They deserve care before the crisis becomes acute and requires an emergency response. By reallocating funding from the police budget, we have the capacity to provide services that can actively reduce the frequency and severity of crises experienced by members of our community.

Rather than continuing to invest in police services, we can fund preventative services, community care and crisis response that reduce the likelihood and severity of future crises. Non-police response could break cycles of incarceration and criminalization, effectively reducing harm. For this to be possible, we cannot continue to increase the OPS budget annually. Diverting money slated for the anticipated annual increase is an excellent starting point, but incremental de-tasking of OPS would allow for hundreds of millions to be invested in the community. All Ottawa residents are deserving of a safe community where they can access the services they need, without barriers. In turn, we all benefit from a safer, healthier, happier society.

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Appendix I: Mental Health Act

The Ontario Mental Health Act (2000) regulates the administration of mental health care for persons residing in Ontario. The Mental Health Act regulates the powers and obligations that physicians, justices of the peace, police, and members of the general public have to ensure that people suffering from a mental illness receive appropriate treatment. There are three sections within the Ontario MHA that relate specifically to how responders should manage a mental health crisis call, namely, Section 16, 17 and 33 (Mental Health Act, 2000)[288].
The following excerpts are taken from Ontario Mental Health Act, 2001[289].

> Section 16 MHA
>
> *An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficiently authority for any police officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he or she may be detained for examination by a physician (Ontario Mental Health Act, 2000).*
>
> Section 17 MHA
>
> *Where a police officer has reasonable and probable grounds to believe that a person: is acting or has acted in a disorderly manner and has reasonable cause to believe that the person a) has threatened or attempted or is threatening to cause bodily harm to himself or herself; b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her or; c) has shown or is showing a lack of competence to care for himself or herself, and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in: d) serious bodily harm to the person; e) serious bodily harm to another person; or serious physical impairment of the person, and that it would be dangerous to proceed under Section 16, the police officer may take the person in custody to an appropriate place for examination by a physician (Ontario Mental Health Act, 2000).*
>
> Section 33 MHA Duty to remain and retain custody
>
> *A police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner.*

Section 16 of the MHA allows someone who has been subject to compulsory treatment to have their case reviewed by a judge, in the case that they were transported against their will, for instance. Section 17 of the MHA outlines the criteria that allow police officers to apprehend a person and take them to

288 Dougall, Sarah C. (2014). "Response to mental health calls: The frontline perspectives of police officers, communicators and administrators." Theses and Dissertations (Comprehensive). 1649. https://scholars.wlu.ca/etd/1649

289 Government of Ontario. (2001) Ontario Mental Health Act. Ontario: Government of Ontario.

the closest mental health facility for an assessment[290]. Officers may encounter this situation when responding to a mental health crisis call or come across a person who is exhibiting certain behaviours. If an officer believes that a person in crisis has the means to harm themselves, the officer is able to bring that person to a designated facility without their consent for a psychiatric assessment[291]. Studies have found that persons with a mental illness are more likely to fear involuntary hospitalization, which makes them hesitant to access mental health care services, assuming they are able to access it to begin with[292]. Data on mental health care patients in Toronto found that those from high socioeconomic statuses are more likely to access mental health care than those from lower socioeconomic statuses, further broadening mental health stigma in people experiencing chronic poverty[293]. Matthew Bonn, a harm reduction advocate at the Halifax Area Network of Drug Using People, found his treatment to be the most effective when mental health care professionals treated him based on his needs and on his own terms, as opposed to the failed treatment he would receive when he was taken to health care facilities against his will, proving that forced apprehensions can cause stigma within the community[294].

Section 33 of the MHA states that "a police officer shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner"[295]. This section clearly states that the officer must remain with the person in crisis until they are assessed by a medical professional, which delays how quickly officers are able to return to duty. For this reason, police officers may choose to deescalate the crises themselves and turn to physical or violent means of restraint in order to avoid the potentially long process of seeking consultation from a medical professional.

290 Dougall, Sarah C. "Response to mental health calls: The frontline perspectives of police officers, communicators and administrators" (2014). Theses and Dissertations (Comprehensive). 1649. https://scholars.wlu.ca/etd/1649

291 Kitchener Human Services and Justice Coordinating Committee. (2010). Mental health the justice system and you: Understanding the process and the people that can help. Kitchener, Ontario: Kitchener Human Services.

292 Sareen, J., Jagdeo, A., Cox, B. J., Clara, I., Have, M., Belik, S., Stein, M. B. (2007). Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. Psychiatric Services 58: 357–364. http://doi.org/10.1176/ps.2007.58.3.357.

293 Sareen, J., Jagdeo, A., Cox, B. J., Clara, I., Have, M., Belik, S., Stein, M. B. (2007).

294 Bonn Matthew, Giulia Di Giorgio, Sara Wuite, Ryan Sommers. "Addressing Substance Use Stigma." Doctors Nova Scotia. April 2020, . Vol 19, Number 10.

295 Dougall, Sarah C., "Response to mental health calls: The frontline perspectives of police officers, communicators and administrators" (2014). Theses and Dissertations (Comprehensive). 1649. https://scholars.wlu.ca/etd/1649