# Alternatives for a Safer Ottawa:

NON-POLICE MENTAL HEALTH
CRISIS REPONSE STRATEGY

PREPARED BY VIVIC RESEARCH
SPONSORED BY 613-819 BLACK HUB

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# Vision Statement[1]

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

Firstly, the mental health strategy will be driven through a public health and community development approach, thus, moving away from criminalization and institutionalization. The public health approach operates with the understanding that to maintain and improve the health of the city's population, the social and environmental determinants of health, social justice and equity must be addressed. The community development framework is an integrated model of community cooperation between residents, service providers, agencies, researchers, and funders in order to improve the well-being of residents, and create positive change in neighbourhoods.

Secondly, the non-police mental health strategy is tangible, practical and human. The strategy focuses on immediate needs, and ensuring the safety, security, comfort, and respect of all people.

Thirdly, the strategy must be accessible. It must also be administered through a trauma-informed approach that is culturally appropriate with an understanding of the ethics of care and Indigenous ethics of mutuality and relationality, and Pan-African philosophies of care. The ethics of care is the notion that the act of genuine caring gives rise to actions that address actual needs[2]. The ethic of mutuality suggests that service providers and persons receiving care should think of themselves as members of a dyadic relationship, rather than as two distinct and separate individuals[3]. The ethic of relationality posits that individuals "are always individuals-in-relation, and that actions are always interactions"[4]. Indigenous relationality teaches that "human lives are interdependent with and contingent on living in ethical relations with other people, ancestors, with plants and animals, and with the natural world"[5]. Similar to ethics of care, on example of Pan-African philosophies is Ubuntu, which is advocated for by Archbishop Desmond Tutu, and encourages service providers to work with community services to maximize their skillsets and develop an appreciation for individual differences[6]. Ubuntu is a proponent of the notion that one should be open and available, affirming to others, and to always act with humanity when providing care[7].

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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.

2 Burton, B., Dunn, C. (2013). "Ethics of Care: Ethics & Philosophy" Encyclopedia Britannica.

3 American Psychological Association (2020). "Mutuality"

4 Praandini, R. (2014). "Relational sociology: a well-defined sociological paradigm or a challenging 'relational turn' in sociology?" International Review of Sociology, 25:1, 1-14.

5 Elliott-Groves, E., Hardison-Stevens, D., Ullrich, J. "Indigenous Relationality is the Heartbeat of Indigenous Existence during COVID-19" Vol. 9 No.3 (2020): Indigenous Communities and COVID-19: Impact and Implications

6 Eze, M. O. (2008). "What is African Comunitarianism? Against consensus as a regulative Ideal". South African Journal of Philosophy. 27 (4): 386–399. doi:10.4314/sajpem.v27i4.31526. S2CID 143775323

7 Tutu, Desmond. No Future Without Forgiveness. Manhattan: Penguin Random House, 2000.

## Mission Statement

The non-police mental health strategy strives to serve the community, and address gaps in the existing mental health crisis response. Current models of mental health care do not take into account the lived experiences of Black, Indigenous, People of Colour (BIPOC) communities, who are currently overrepresented in systems of criminalization and institutionalization. For more on this, see section 2 of the report.

The proposed mental health strategy will not involve any systems of policing, including the police service, social work, or children's aid society. The mental health strategy is committed to addressing the stigmatization of mental health in BIPOC communities, created by previous harmful experiences with mental health care, cultural understandings of mental health, lack of access to adequate and affordable mental health services, and fears of personal and professional consequences. The strategy works to build and maintain relationships and trust in communities where there may be a valid fear of existing systems. Current health care models often involve police which can be traumatizing, especially for young BIPOC men and women. This has led to an absence of trust and safety for many racialized communities. See section 2.1.1 in the report for more detail. The strategy connects with the community to amplify existing natural leadership, responding efficiently and skillfully through transparent communication and outreach.

> *"As a youth I was told that if I ever saw a psychiatrist, I could never become a doctor (my dream job at the time), as a homeless youth, a steady career path and education were my only way out of poverty, so I could not take this risk."*

The strategy recognizes there is a gap in culturally competent resources made accessible to marginalized community members. Numerous services are hard to reach with limited funding and temporary project-based possibilities of support. This inevitably leads to high barrier services which include but are not limited to; barriers such as inaccessible information, financial, and transportation barriers. See sections 1.2 to 1.5 in the report for more information.

Additionally, current models of mental health crisis response use tools of criminalization and institutionalization to punish behavioural responses which are likely symptoms resulting from mental illness. The emphasis on criminalization and institutionalization results in many BIPOC communities hesitating to interact with existing mental health supports due to potential and previously experienced harmful consequences. See section 2.2 of the report for details. The strategy strives to shift from a criminalization response to one of public health and community development, rooted in the understanding of a human rights-based approach to address the social determinants of mental health. See section 1 of the report for more information.

## Goals and Objectives

The non-police mental health strategy aims to bridge gaps in current mental health crisis response, and work with communities to provide meaningful, accessible, and culturally competent care to communities. The proposed strategy is designed by the community, with the understanding that this

strategy is not contingent on systemic change, but rather, has been designed to be implemented within a year in Ottawa.

The mental health strategy will be guided through the following strategic objectives. These strategic objectives are foundational to the strategy as they frame priorities and focus on actionable efforts.

## Awareness: Communicate the Reason for Change

The first strategic objective is to create awareness and use transparent communication to highlight the need for a change to existing mental health crisis responses. A cultural evolution is needed in order to shift mainstream understandings of mental health away from stigma and judgement, towards compassionate, holistic, human-centred care. Along with increasing safety for all, this shift is an important step in validating the experiences BIPOC communities have had with existing mental health crisis responses.

## Desire: Empowerment and Engagement

The second strategic objective focuses on building meaningful trust and relationships within the community. It is important to build relationships with stakeholders, grassroots organizations, bystanders, BIPOC communities, and decision makers to share knowledge and experiences. Actively engaging in meaningful dialogue increases the desire to support change, and holds people accountable for their role in bringing a healthy mental health crisis response to fruition.

Interaction with persons receiving care will often be taking place during times of extreme vulnerability, widening the already large gap in power between the first responder or bystander and the individual in need of care. The power dynamics between two individuals are informed by numerous confounding factors including but not limited to; housing status, income, employment, race, gender identity, sexual orientation, age, language, immigration status, previous trauma, previous institutionalization, situation and circumstances, and turf. We acknowledge that in most if not all cases, persons receiving care will be in positions where they hold less power than the service employees they are interacting with. To mitigate any feelings of fear, mistrust, or disempowerment, consent-based care and effective communication will be made the status quo when interacting with persons receiving care.

## Knowledge: Culture of Learning and Capacity Building

The third strategic objective aims to develop and share effective and innovative knowledge designed for all types of learning styles, through education, skills, and training. This objective is rooted in the principle of transparency to identify and address barriers to change in the current mental health crisis response. This objective targets three different populations; those who are effecting change, those who want to effect change, and those who do not know there is a need for change in the current mental health crisis response.

## Ability: Implementing Desired Skills and Behaviors

The fourth strategic objective focuses on translating the knowledge needed for change into the ability to actually make change. Additional emphasis is placed on being flexible and accommodating of the ever-evolving needs of communities. The objective is to focus on what skills and behaviours can be implemented to meaningfully contribute to a public health-driven mental health strategy, with the understanding that this is an evolving and organic process which will change with time.

### Reinforcement: Sustaining Change

The fifth strategic objective is planning ahead to address broader systemic changes, and continually evaluating the strengths and weaknesses of the mental health strategy through public accountability mechanisms and reporting. In order for a mental health crisis response to be effective, it is necessary to communicate goals, assess approaches, and implement corrective actions where required.

## Action Plan

In all mental health crisis responses, the first responder should ensure that their presence is wanted. The person in crisis does not need to be managed, and is often capable of determining what type of care they need. Care will be led by the person receiving care, meaning that, working within the bounds of the Health Act, first responders will not proceed with administering care without first receiving consent. The values of self-determination, and bodily integrity will be prioritized alongside ensuring the physical health and safety of the person receiving care. Persons receiving care are considered as experts on their own needs and will be treated as such. It is the first responders job to listen and operate using contextual fluidity to determine what interventions are necessary to meet the needs of the person receiving care. Contextual fluidity is an anti-oppressive model of care that recognizes the unpredictable, evolving, adaptable, and resilient nature of both life and individuals. It rejects the notion that service providers must adhere to a strict set of operational guidelines and instead allows space for situationally relevant responses, leading to more personal and effective care[8].

### Immediate Crisis Response: De-escalation

#### Who Should the First Responder be?

People who are experiencing or witnessing a mental health crisis can either call, text, or send a Facebook message to a community-run mental health crisis response program. The request for a crisis response will be answered by trained and experienced BIPOC mental health professionals, Elders, and Knowledge Keepers with various lived experiences. The request for a crisis response will be triaged through a receptive trauma-informed agent.

All efforts will be made for support services to be made available in English, French, Arabic, Somali, Mandarin, Cantonese, Italian, Farsi, Urdu, and Spanish.

#### Training and Education

First responders will be expected to demonstrate a high degree of empathy, de-escalation skills, listening, non-judgemental communication, and more. Lived experiences of racism, drug use, classism, ableism, incarceration, gender based violence, and more will be considered assets.

Nurse practitioners will be employed to provide direct medical care to persons receiving care as a means of limiting exposure to traditional healthcare settings while not sacrificing any scope of care.

Drivers will be employed to accommodate first responders who cannot for any reason, safely operate a vehicle. Drivers will accompany these first responders to crisis calls but will not be responsible for providing care to the individual in need.

8 Smith, P. (2010) "The origins of 'contextual fluidity'". Northern Communities Transitioning to Resilience.

All first responders will strive to engage in Indigenous ethics of mutuality and relationality, Pan-African philosophies of care, and will receive decolonization, anti-racism, and anti-oppression training. Anti-racism training will include a clear focus on anti-Black racism, anti-Indigenous racism, and Islamophobia. First responders will also have experience and training in first aid and in administering Naloxone. Additionally, first responders will have updated knowledge of relevant social and mental health resources for referrals or assistance.

A primary responsibility for first responders will be to provide the person(s) in crisis with temporary relief and care. Trust and rapport building are important components of a crisis response and can be more easily achieved through a one-to-one response. To this point, when appropriate, a single first responder will be dispatched.

### Physical Resources

The first responder will arrive at the crisis scene with access to a car so as to be able to offer transportation to the person(s) in crisis. The first responder will also carry items such as water, cigarettes, and food to ensure the most basic human needs of the person(s) in crisis are being met. The first responder will also have a cell phone for safety purposes, and to connect the person(s) in crisis with their loved ones or necessary supports. The first responder will also carry first aid supplies, including Naloxone and oxygen (O2) monitors in case an overdose is suspected. Lastly, the first responder will have a community resource list they can provide to the person(s) in crisis to access continued care.

## Continuous Care: Follow Up

### Role of First Responder in Continuous Care

Continuity of care is necessary for building rapport and trust between the first responders and the persons in crisis. The first responder should ensure that the person in crisis has access to appropriate resources and services, and is provided with accurate information to assist in their follow-up care. The follow-up can come in many forms such as a phone call or a visit.

### Role of Loved Ones

In the continuous care of a person who has experienced a mental health crisis, loved ones may play a role in their follow-up care. Loved ones should never be contacted unless explicitly requested by the individual. If the individual has asked for their loved ones to be involved in their continuous care, they should be approached in a holistic manner to incorporate their support in a meaningful way while remaining respectful of the loved one's individual boundaries and capacity. It is the service's job to equip loved ones with the tools and resources necessary to be strong support systems. This is especially important in instances of intergenerational trauma and/or family breakdown where loved ones may be dealing with trauma and/or mental illnesses of their own. Approaches to serve both the individual and their loved ones can include interrupting unhealthy communication patterns within families, connecting individuals and their loved ones with culturally relevant healing practices, strengthening cultural identity as a means of healing, and framing care as a family responsibility that includes the strengthening of personal relationships.

Integrating an individual's loved ones in their continuous care can be cathartic, and a valuable tool in building trust. If they cannot involve their loved ones in their continued care, the first responder can present the option to speak to an Elder, spiritual leader, or Knowledge Keeper.

## Best Way to Share Information

First responders will make every available effort to share relevant information in accessible manners, tailored to various populations. Social media, for example, is fantastic for many, but is inaccessible to those without internet or access to a smartphone or computer. Within communities living without stable housing, peer based word of mouth is a great way to share resources. Additionally information can be posted in local businesses, places of worship, and other community gathering places.

## Alternative Mental Health Approaches

Culturally responsive approaches are highly valued in the proposed mental health strategy. First responders will facilitate access to various forms of mental health supports, as determined and preferred by the people involved.

## Community Organized Programs and Services

The mental health strategy will strive to be well integrated into established systems of support. Integration within existing programs and services will allow for the provision of much needed supports including; public showers and bathroom facilities, free counselling resources with BIPOC and LGBTQ2S+ counsellors, access to technology, and affordable medication.

## Civic Engagement

A cultural shift in understanding is required in order to bring forth effective change and create conditions of safety for all members of our city. In order to share community responsibility for wellbeing, the community must consider that a person(s) in crisis might be experiencing a variety of trauma symptoms. A more compassionate and informed community creates the conditions needed for safety and well-being to increase for all community members.

The guidelines of the ethics of care ask the community to be attentive, to share the responsibility of care, to call for help when a crisis is occurring, and to offer direct support to persons in crisis. In order for bystanders to feel comfortable calling for support, the mental health system should create avenues and opportunities for learning and unlearning. The mental health strategy will provide bystander awareness training and resources to both increase capacity for addressing mental health crises that occur in public spaces, and to shift the narrative to view compassionate community intervention a moral imperative. The onus of a community's well-being is a shared responsibility and can only be addressed through holistic public health approaches and solidarity.

In order to be effective, this strategy must address all forms of racism. Educating members of the Ottawa community on how their perception of crises may be viewed through a racist lens is crucial to ensure that community-wide healing can occur. Dispelling stereotypes is crucial for Ottawa residents to better understand the experiences and actions of those in their community. This includes fostering broader awareness of different communication and conflict styles and how they differ across cultures and genders. Cross-cultural solidarity requires that all communities address their biases in order to ensure that no group is bringing harm to another under the pretense of wanting to help. Education on racism will be two-fold: Ottawa residents will be educated on how to distinguish between their own discomfort and danger, as well as on how to contact the appropriate responders for a stranger's care.

## Broader Systemic Considerations

While the mental health strategy has only provided actions that can be implemented within a year in Ottawa, to properly and effectively address mental health, there needs to be broader systemic changes.

Firstly, all people should have access to affordable and supportive housing. A housing first approach creates stability and allows persons experiencing a mental health crisis to access programs and services that can only be received through a home address. Lack of safe housing makes accessing care and maintaining well-being incredibly difficult.

There is a need for mental health parity to ensure that mental health issues, particularly those relating to substance use are given the same treatment and level of care as physical health issues. The parity also speaks to the need for accessible universal pharma care to address financial barriers in accessing mental health care.

# Appendix 1: Philosophy of Service

Persons receiving care and staff should feel safe, cared for, valued, and respected at all times

- We acknowledge that interactions with persons receiving care will often take place during times of extreme vulnerability and will do our best to create an atmosphere of compassion, trust, dignity, and respect when administering care.
- Persons receiving care will be treated as valued members of our community.
- We resolve issues as a collective and by consensus. No voice is positioned above another.
- We acknowledge that work is not and should not be the centre of an individuals' life. We support our staff in all aspects of their lives and allow for flexible work hours and time off to accommodate individual needs.
- We acknowledge that staff are working in trauma exposed environments. We offer supports for staff experiencing new trauma, re-traumatization, and/or compassion fatigue stemming from their employment responsibilities. We encourage open communication of needs, boundary setting, and self-care practices (mental, physical, and spiritual) amongst all staff.
- We provide safe spaces for person receiving care to seek care and be amongst peers.
- We provide safe spaces for staff to do the same.

Our approach to care will be trauma informed and led by the person receiving care

- We understand that crisis is often caused, exacerbated, and/or prolonged by non-medical factors including; trauma, poverty, insecure housing, food insecurity, incarceration, institutionalization, racism, sexism, ableism, homophobia, transphobia, and more.
- We take a holistic approach to care where a person's needs extend beyond just their medical needs, and care extends beyond just providing medical care.
- Persons receiving care will be treated as experts on their own needs.
- We encourage persons receiving care to work in collaboration with staff and first responders to create and maintain a strong sense of control and autonomy over decisions pertaining to their own care.
- First responders will require verbal consent before proceeding with any and all care.
- We work to create an atmosphere that is safe, friendly, and free of stigma, discrimination, and judgement.
- We regularly facilitate and engage persons receiving care in conversations surrounding how their care and the service more broadly can be improved to better meet their needs and the needs of the greater community.
- We take a trauma-informed approach to care, respecting individuals' lived experiences and placing harm reduction at the centre of all decisions.
- We understand and acknowledge that no two persons receiving care are alike and reject a one-size-fits-all approach to care.
- We utilize contextual fluidity in emergency response situations, allowing first responders' approaches to vary based on the unique needs of the individual and their circumstances.

We strive to be as accessible as possible & to eliminate barriers to accessing care

- All efforts will be made for support services to be made available in English, French, Arabic, Somali, Mandarin, Cantonese, Italian, Farsi, Urdu, and Spanish to ensure that persons receiving care and their loved ones are able to articulate themselves as clearly and as comfortably as possible.
- Our services are and will always be free of charge to persons receiving care.
- We work in collaboration with other community organizations to bridge gaps in service.
- We help persons receiving care and their loved ones to navigate other services whose scopes of care extend beyond our own.

We see ourselves as being a part of the community we serve, not external to it

- We see community connection as being a key component of successful care. We strive to foster meaningful relationships with persons receiving care, their loved ones, and members of the communities in which we work.
- We know that individuals do better when their support systems are engaged in their care. We encourage loved ones to be involved and do our best to equip them with the tools necessary to do so.
- We understand that individual needs often vary by location and adapt our physical locations accordingly.

## Appendix 2: Scope of Practice

- The delivery of emergency mental health services to individuals in crisis provided either in person, or remotely via phone or text messaging.
- The delivery of wraparound services to support individuals and their loved ones following a crisis situation.
- Linking individuals and their loved ones to suitable community resources and extended care options based on their own needs and preferences.
- Collaboration with other groups and organizations in the field to extend care and bridge gaps in service.
- Continuing consultation with community members to ensure care is being delivered in a culturally competent, anti-oppressive manner.
- Ongoing analysis of community needs.
- Advocacy work aimed at combating stigma and eliminating barriers to mental health care for all individuals and communities.
- Management, leadership, and oversight of the program, its employees, and services.
- Education, training, and professional development in the field of crisis response.

# Appendix 3: Funding

## Reallocation of Resources and Responsibilities from the Ottawa Police Service (OPS)

Funding for this alternative mental health crisis response will come from reallocations from the police budget. We maintain that this is the best course of action as funding for crisis response is already present in the municipal budget.

We anticipate that OPS and the Police Services Board will recommend an increase in the OPS budget for 2022-23 equal to inflation. Rather than accept this increase, we recommend that the OPS budget remain at its 2021-22 level. Assuming OPS has strategic priorities they are hoping to meet with their anticipated increase, they can reallocate funding internally from mental health crisis response and other areas towards those strategic goals.

It is important to note that the recommended process for reallocating funding from the Ottawa Police Service towards an alternative mental health crisis response is contingent on the willingness of City Council. Ottawa residents have the power to lobby their municipal representatives if they wish to support these changes.

The main legislation that governs the relationship between municipalities and police services boards in Ontario is the Police Service Act (PSA). The provincial government has; however, signalled that they will bring the Community Safety and Police Act, 2019 (CSPA) into force in the near future. Once the CSPA is brought into force, the PSA will be repealed the same day. We anticipate this change occurring prior to June 2022.

The following section discusses the need to reassign the responsibility of mental health crisis response and 9-1-1 dispatch, as well as the funding for those responsibilities.

## Reallocation of 9-1-1 Dispatch Service

In order to contact the alternative response, we recommend that callers be able to access help through 9-1-1, as in any other emergency. The only caveat being that the alternative response will only operate through 9-1-1 on the condition that dispatch is operated independently from the Ottawa Police Service. In addition to accessing the service through 9-1-1, Ottawa residents will be able to call or text an independent phone number or send a message to the service via Facebook. All channels will be monitored 24/7.

This recommendation follows from community consultation where respondents from all surveyed groups overwhelmingly stated they would ***not*** feel comfortable calling 9-1-1 for a loved one or having 9-1-1 called for them if they were experiencing a mental health crisis ***if*** the dispatch remained under the purview of OPS, but ***would*** feel comfortable calling 9-1-1 for an emergency ***if*** dispatch was operated outside of the police services.

There are no legal barriers preventing the City of Ottawa from choosing another service provider to handle 9-1-1 dispatch. The City of Ottawa may; however, face some penalties under contract law for changing providers, depending on the terms of the contract with the Ottawa Police Services Board.

## De-tasking OPS from Mental Health Crisis Response

De-tasking the Ottawa Police Service ensures that vulnerable residents experiencing a mental health crisis are not interacting with police while in distress. Provisions in the CPSA do not specifically mandate that OPS must be involved in mental health crisis response.

According to the CPSA, "a municipality that maintains a municipal board shall provide the board with sufficient funding to provide adequate and effective policing in the municipality and pay the expenses of the board's operation (…)"[9].

"Adequate and effective policing" is defined at s.11 of *CSPA, 2019* as:

1. Crime prevention.
2. Law enforcement.
3. Maintaining the public peace.
4. Emergency response.
5. Assistance to victims of crime.
6. Any other prescribed policing functions.[10]

This is not an exclusive list. Police service boards are permitted to provide policing or other services that "exceed the standards for adequate and effective policing", for example enforcing by-laws.[11] It is important to note that the OPS does not need to be the exclusive provider of these services; however, they can contest that their budget needs to enable them to provide these services even if others are providing the same service.

In order to remove the responsibility of mental health crisis response from the OPS, two primary options exist. If action were to be taken immediately, the municipality can obtain a legal ruling under the PSA on whether or not mental health crisis response is a part of the policing "needs" in the municipality. The *PSA* says that municipalities are permitted to ask a body called the Ontario Civilian Police Commission to investigate and rule on the "police needs" of the municipality.[12]

Under the CPSA, the police service board has the duty to develop policies respecting "the provision of adequate and effective policing in accordance with the needs of the population of the area for which it has policing responsibility."[13] The police service board must also develop a strategic plan which will address both "how the police service board will ensure the provision of adequate and effective policing in accordance with the needs of the population of the area" and "interactions with persons who appear to have a mental health condition", among other topics.

## Reallocation of Resources from the Ottawa Police Service

From a legal perspective, to establish the Ottawa Police Service budget, the police services board develops and submits estimates of the capital and operational expenses it deems necessary to provide adequate policing in the municipality and pay for the board's own operations.[14] In practice, the Board

[9] CSPA, 2019. s. 50
[10] CSPA, 2019. s. 11(1)
[11] CSPA, 2019. 68 s. 11(3)
[12] *PSA* s.25(1)(d)
[13] CSPA, 2019 s. 38(1)(b)
[14] CSPA, 2019. s. 50(1),(2)

plays a more strategic role, rather than an operational one. To establish the budget, the Board sets the strategic direction for policing in Ottawa. The Chief of Police and their staff then prepare an estimate and present it to the Board. The Board reviews the estimate to ensure that it meets the strategic direction, at which point they can strike line items for the proposed budget.

The municipality considers the estimates and presents the Board with a budget. The municipality does not need to set the budget to match the estimates presented, meaning the municipality does not need to grant the police services board all its requests. Under the CPSA, "the municipality does not have the authority to approve or disapprove specific items in the estimates."[15] The municipality has the authority to set the format of the estimates, the period they cover, and the timetable for their delivery.[16] Municipalities are not permitted to explicitly cut the funding police services boards receive for specific line items.

If the budget the municipality presents to the Board is lower than the estimate the Board has provided, they can make the argument that they would be unable to meet their responsibilities. Because the municipality cannot actually target any specific line item, this would mean that absolutely everything they fund would need to be essential. In that sense, a reduction in the police budget would not necessarily remove cops from responding to mental health calls, as they can choose internally to reduce spending elsewhere.

In the case where the board and the municipality disagree, the CSPA outlines that municipalities and police services boards may agree to a conciliation procedure to try and agree on a resolution to their dispute. If this fails, or if they do not want to attempt conciliation, the matter goes to arbitration.[17] The arbitrator in this case would be either someone that the municipality and police service board agree to, or, if they can't agree, someone who is appointed by the Commission Chair ("Chair") of the Ontario Police Arbitration Commission.[18] The Chair is appointed by the Minister, who is obliged by the CSPA to consult with police service bargaining agents and employer representatives when making the appointment.[19]

## Next Steps

Various pathways to secure funding for a non-police mental health crisis response through reallocation from the police service budget exist. Firstly, the municipality can grant the police service less funding than the estimate provided by the board. This generates two complications, firstly that the Board may contest the budget which would require conciliation and potentially arbitration. In addition, the municipality cannot mandate where the funding is allocated internally, meaning OPS could continue to fund mental health crisis response. In addition, the municipality is within its rights to ask the police service board to provide an estimate on how much of the OPS budget is spent on policing mental health crisis in a year. This is relevant in the developing a budget to present to the Board.

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[15] CSPA, 2019. s. 50(5)
[16] CSPA, 2019. s. 50(3)
[17] *CSPA* s.50(6)
[18] *CSPA* s. 50(9)(10)
[19] *CSPA* s. 147(9)

Secondly, the municipality could act quickly to submit a request that the Ontario Civilian Police Commission investigate and rule on the “police needs” of the municipality and whether those include mental health crisis response.

Thirdly, those involved in the strategic planning that will occur under the CPSA can argue that police response to mental health is not a police responsibility. Although this would not immediately impact funding, it would make cutting spending to only fund responsibilities outlined in the strategic plan much more convincing.

Finally, advocates can push for changes to this provision of the CPSA to reshape the degree to which municipalities can influence police budgets.

## Appendix 4: Governance

The service will be governed by a coalition of grassroots community organizations. This governance structure was determined by way of community consultation. Here is one example of feedback we received:

> *" I believe that leadership should be balanced and inclusive, with a prioritization on Indigenous leadership, both due to the high representation of Indigenous peoples in Ottawa's mental health client-base, and due to the land on which we reside. After this, leadership must include community members who are women, members of the LGBTQ2S+ community, Black, Brown, Asian, and other people of colour, ethnic and religious minorities, refugees, and newcomers."*

The service will be provided by the community, for the community. Persons receiving care will see themselves and their lived experiences reflected in those providing care. A board of directors will be comprised of people with lived/living experience in the mental health system, including psychiatric survivors and people living with mental illness. Individuals who have experienced, or who currently experience homelessness, substance use, incarceration, and/or forced hospitalization will also be prioritized as board members. Individuals from racialized groups, particularly Black and Indigenous individuals, will be prioritized in leadership positions. Like other EMS services, the board members will be compensated; however, they will be selected from within the community[20].

Indigenous leadership was articulated as being a priority across all groups consulted. Additionally, the desire for Indigenous ethics, problem solving techniques, and healing practices to be well integrated into the program was commonly expressed. For more on the Indigenous ethics of mutuality and relationality, see the vision statement. Overarching governance principles will be in-line with Indigenous principles of governance, including the prioritization of sovereignty of individual organizations and the sovereignty of individuals. As a result, organizations and individuals will have autonomy to determine the scope of care they wish to provide and receive.

Organizations with experience in service delivery will take the lead in terms of program administration. These organization will be responsible for hiring, defining the scope of interventions, establishing medical protocols and other responsibilities related to crisis intervention. In addition, organizations that already provided a specialized crisis intervention for a specific community can continue to do so. In such a case, the role of this program will be to serve as a contact point between the broader Ottawa community and the service provider. For example, a by-stander will have the ability to reach out to this larger program and the person in need of care will still receive the response best equipped to respond to their community.

Organizations that represent various communities without a specific mental health focus will play a more peripheral role, working as intermediaries between community members and program leadership. These organizations will be the first point of contact for community members seeking information on

[20] Board of directors for non-profits cannot be compensated, however, board of directors of emergency medical services are compensated. The legislation dictating appointment structures for board members of emergency medical services are unique to each service, therefore, consultations are ongoing to determine what legislation would capture this service. These consultations will confirm the appointment process, compensation rates, and the number of directors.

the service, those wanting to provide feedback, and those needing to express a frustration or concern. Community representatives will be integral to ensuring that all Ottawa residents are aware of the services available to them through the program, and to ensuring that over time the program adapts to meet the ever-evolving needs of the community. Furthermore, community reps will play an important role in holding the service accountable to persons receiving care and the community, and in creating avenues for community feedback that are timely, accessible, and culturally relevant.

Beyond identifying gaps in service delivery and provision, community organizations will have the exceedingly important role of addressing racism and mental health stigma within their community. For more details on the educational components of this strategy, refer to the action plan.

Documents that provide broad strategic direction, such as the philosophy of service (appendix 1) are living documents and will be changed to reflect the direction and processes the board and overarching governance structure lays out. Decisions regarding which groups and individuals will comprise the coalition have not yet been finalized.

## Appendix 5: Costing

The program will undergo a 5-year expansionary period in which increases in service capacity will occur through the onboarding of additional staff and the purchasing of additional vehicles. The goal is for service expansion to take place at a similar rate to increases in community demand over time as the service gains more awareness.

Table 1: 5 year expansion period

| Year | Estimated Total Cost | Total no. of employees | Total no. of vehicles |
|---|---|---|---|
| 1 | $5,142,594.36 | 42 | 10 |
| 2 | $6,464,494.37 | 57 | 15 |
| 3 | $8,200,205.48 | 72 | 20 |
| 4 | $10,512,164.16 | 94 | 25 |
| 5 | $11,666,978.70 | 104 | 30 |
| 6+ | $11,438,230.69 | 104 | 30 |

Figure 1: Program Costing

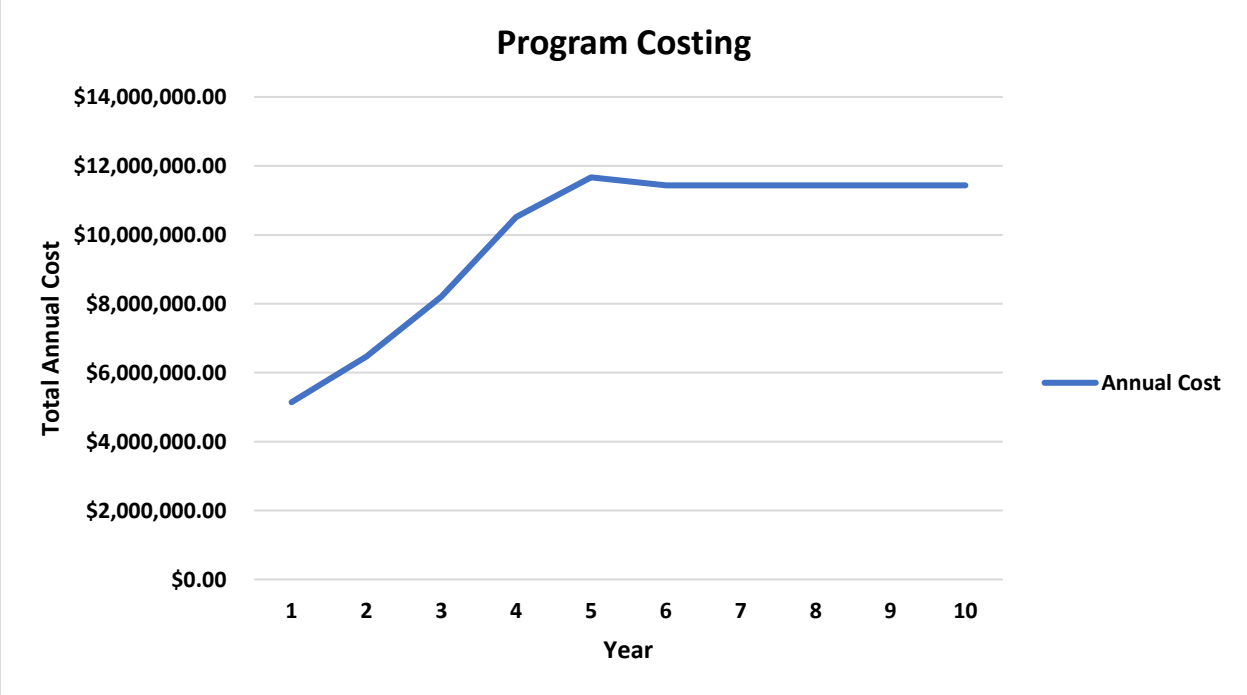


Figure 2: Cost Breakdown by Area: Year 1

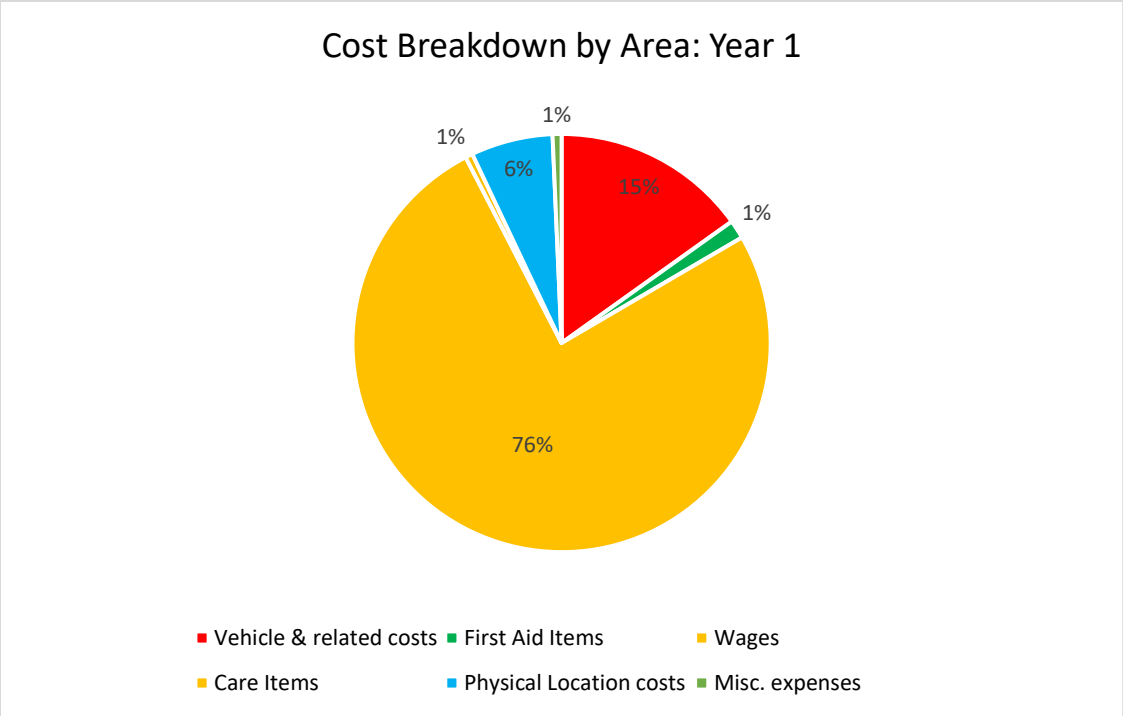
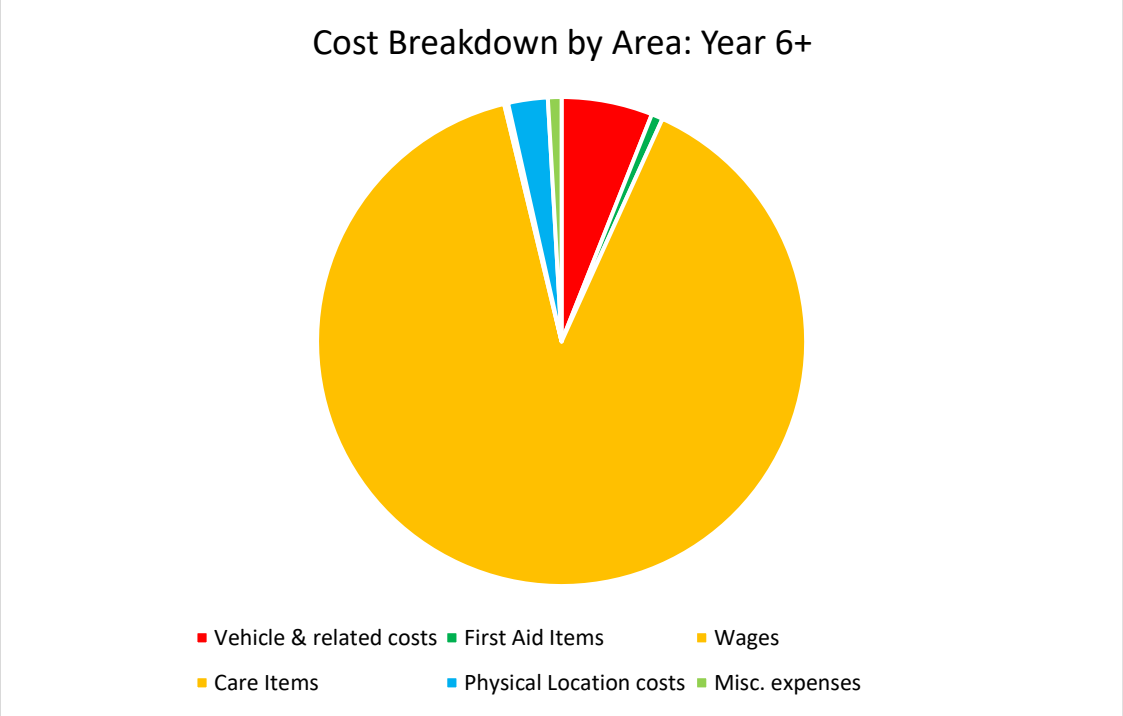



Figure 3: Cost Breakdown by Area: Year 6+



## Primary Areas of Expense:

### Wages

Wages will account for 76% of total program cost in year one, increasing to 89% of total cost by year 6. All wages are inclusive of benefits.

Table 2: Wage breakdown by job title:

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

### Vehicle and related costs

Vehicles and related costs (vehicle maintenance, gas, and commercial auto insurance) will account for 15% of total spending in year one, dropping to only 2% once the service fleet has been paid off. Within this subheading of costs, gas will be the most costly expense at $20,000 per vehicle per year.

### Physical location costs

The service plans to acquire three physical locations throughout Ottawa to be used as multifunctional facilities housing the program's administrative offices and nursing stations, as well as acting as a gathering place, community kitchen, emergency overnight shelter, and general refuge for our staff, persons receiving care, and members of the community. We plan to seek out large residential spaces (zoned for public use) so as to avoid the additional cost of having to install a kitchen, shower facilities, bedrooms etc., as well as to mitigate any hesitation of accessing the spaces stemming from fear and/or stigma surrounding more traditional medical or social service based spaces.

| Item | Annual Cost (unless otherwise specified) |
|---|---|
| Rent & related costs* | $66,290 |
| Food & drink | $25,000 |
| Personal care items | $5,065 |
| Furniture (one time cost) | $4,915 |
| Entertainment | $1,720 |
| Home goods (misc.) | $2,671 |
| Office supplies | $2,889 |
| TOTAL annual cost per location (excluding custodial wages) | $108,549 |

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

### First Aid Items

Each new vehicle purchased will need to be equipped with a set of bigger ticket first aid supplies (ex. AED, oxygen therapy unit, blood pressure monitor etc.) totalling $4,625 per vehicle. These items will need to be re-purchased very infrequently and are categorized in this budget as one-time or infrequent

costs. Recurring cost first aid items are those such as PPE, bandages, and emergency blankets. There costs we estimate to total approximately $2,800 per vehicle per year.

| First Aid Item | Cost |
|---|---|
| One-time or infrequent purchase | $4,625* |
| Recurring cost items | $2,800** |

*per vehicle, **per vehicle per year

## Care Items

Care items includes items not traditionally carried by first responders, but items which the community expressed may aid in providing comfort and building trust between a first responder and an individual requiring care. Costs in the table below are per vehicle.

| Care Item | Annual Cost |
|---|---|
| Food & drink | $13,347.78 |
| Cigarettes | $15,748.50 |
| Ceremonial items | N/A |

Year 1 Complete Costing

| **Start Up Costs** | **Estimated Price** | **Estimated Quantity** | **Estimated Price** |
|---|---|---|---|
| Vehicle (commercial cargo van) | $40,000 | 10 | $400,000 |
| **TOTAL** | | | **$400,000** |

| **First Aid Items (one time/ infrequent cost)** | **Estimated Price (per unit)** | **Estimated Quantity** | **Total Cost** |
|---|---|---|---|
| AED | $2,195.00 | 1 | $2,195.00 |
| Oxygen regulator | $133.39 | 1 | $133.39 |
| Oxygen therapy unit | $398.49 | 1 | $398.49 |
| Oxygen tubing | $2.19 | 4 | $8.76 |
| Oxygen wrench | $8.49 | 1 | $8.49 |
| Rescue-vac suction unit | $78.00 | 1 | $78.00 |
| V-vac starter kit | $157.00 | 1 | $157.00 |
| MDI spacer | $18.59 | 1 | $18.59 |
| Infrared thermometer | $55.00 | 2 | $110.00 |
| Pulse oximeter | $94.19 | 2 | $188.38 |
| Tourniquet | $39.95 | 4 | $159.80 |
| Sharps container | $17.29 | 2 | $34.58 |

| | | | |
|---|---|---|---|
| Head immobilizer | $11.25 | 1 | $11.25 |
| Spine board | $299.00 | 1 | $299.00 |
| Stretcher | $232.59 | 1 | $232.59 |
| Stethoscope | $139.95 | 2 | $279.90 |
| Blood pressure monitor | $47.49 | 2 | $94.98 |
| CPR mask (reusable) | $12.50 | 2 | $25.00 |
| First Aid Blanket | $14.99 | 2 | $29.98 |
| Bag valve mask (adult size) | $40.19 | 2 | $80.38 |
| Bag valve mask (child size) | $40.19 | 2 | $80.38 |
| **TOTAL** | | | **$46,239.40** |

| **Operational Cost: Market Goods** | **Estimated Price (per unit)** | **Estimated frequency of purchase** | **Estimated Price (per annum)** |
|---|---|---|---|
| NARCAN | Provided free of charge in Ontario | - | - |
| Granola bars (case of 120 bars) | $39.61 | 52 | $2,059.72 |
| Trail mix (case of 108 single serve pouches) | $113.78 | 52 | $5,916.56 |
| Water (case of 24 500mL bottles) | $1.97 | 150 | $295.50 |
| Gatorade (case of 24 20oz bottles) | $33.84 | 150 | $5,076.00 |
| Cigarettes (carton of 200 cigarettes) | $104.99 | 150 | $15,748.50 |
| Ceremonial objects | - | - | - |
| Safe Consumption Kits | Provided in partnership with local harm reduction group at cost | - | - |
| Gas for vehicle | $20,000 | 10 | $200,000.00 |
| Vehicle maintenance | $800 | 10 | $8,000.00 |
| Auto insurance ($1M in annual commercial coverage) | $1,700 | 10 | $170,000.00 |
| Liability insurance ($2M in annual commercial coverage) | $500 | 10 | $5,000.00 |
| Phone Plan | $600 | 51 | $30,600.00 |
| Driver wage | $65,000 | 3 | $195,000.00 |

| | | | |
|---|---|---|---|
| Nurse practitioner wage | $120,000 | 3 | $360,000.00 |
| First Responder Wages | $100,000 | 30 | $3,000,000.00 |
| Administrative Wages | $65,000 | 3 | $195,000.00 |
| **TOTAL** | | | **$4,192,696** |

| **First Aid Items (recurring cost)** | **Estimated Price (per unit)** | **Estimated quantity & frequency of purchase** | **Estimated Price (per annum)** |
|---|---|---|---|
| Standard First Aid Kit | $38.86 | 10 | $388.60 |
| Disposable gloves (100 units) | $15.99 | 24 | $383.76 |
| Surgical face masks (20 units) | $22.00 | 24 | $528.00 |
| Face shield | $9.99 | 24 | $239.76 |
| Antiseptic swabs | $5.79 | 24 | $138.96 |
| Disinfectant wipes | $14.99 | 24 | $359.76 |
| Hand sanitizer | $12.99 | 12 | $155.88 |
| Disposable resuscitator (adult size) | $241.50 | 1 | $241.50 |
| Disposable resuscitator (child size) | $241.50 | 1 | $241.50 |
| CPR barrier with one-way valve (single use) | $1.39 | 10 | $13.90 |
| Emergency Blanket | $2.19 | 50 | $109.50 |
| **TOTAL** | | | **$28,011.20** |

| **Physical Location Start-Up Costs** | **Estimated Price (per unit)** | **Estimated quantity & frequency of purchase** | **Estimated Price (per annum)** |
|---|---|---|---|
| Rent | $5,000 | 12 | $60,000 |
| Utilities | $400 | 12 | $4,800 |
| Internet | $60 | 12 | $720 |
| Security system | $20 | 12 | $240 |
| Insurance | $1,250.00 | 1 | $1,250.00 |
| Maintenance worker wage | $50,000.00 | 1 | $50,000.00 |
| Desk | $300.00 | 2 | $600.00 |
| Desk chair | $200.00 | 2 | $400.00 |

| | | | |
|---|---|---|---|
| Office supplies (misc.) | $200.00 | 1 | $200.00 |
| Printer/Scanner | $200.00 | 1 | $200.00 |
| Safe/lockbox | $439.00 | 1 | $439.00 |
| Location phone | $50.00 | 1 | $50.00 |
| Desktop computer | $400.00 | 5 | $2,000.00 |
| Cable subscription | $600.00 | 1 | $600.00 |
| TV | $200.00 | 2 | $400.00 |
| Couch | $500.00 | 3 | $1,500.00 |
| Lounge chair | $100.00 | 3 | $300.00 |
| Shelving | $35.00 | 3 | $105.00 |
| Home items (misc.) | $500.00 | 1 | $500.00 |
| Mattress | $200.00 | 6 | $1,200.00 |
| Beds | $200.00 | 6 | $1,200.00 |
| Bed sheets | $40.00 | 6 | $240.00 |
| Pillows | $4.00 | 12 | $48.00 |
| Comforters | $40.00 | 6 | $240.00 |
| Shampoo | $5.00 | 120 | $600.00 |
| Conditioner | $5.00 | 120 | $600.00 |
| Body wash | $5.00 | 120 | $600.00 |
| Soap | $5.00 | 120 | $600.00 |
| Menstrual products | $7.99 | 60 | $479.40 |
| Toothbrush | $5.00 | 120 | $600.00 |
| Toothpaste | $5.00 | 120 | $600.00 |
| Towels | $25.00 | 25 | $625.00 |
| Laundry detergent | $14.99 | 24 | $359.76 |
| Dining table | $150.00 | 3 | $450.00 |
| Dining chairs | $30.00 | 12 | $360.00 |
| Pots & pans | $70.00 | 1 | $70.00 |
| Cutlery | $20.00 | 1 | $20.00 |
| Dishes | $150.00 | 1 | $150.00 |
| Food pantry items (misc.) | $25,000.00 | 1 | $25,000.00 |
| Coffee Maker | $49.00 | 1 | $49.00 |
| Kettle | $24.00 | 1 | $24.00 |
| Toaster | $30.00 | 1 | $30.00 |

| | | | |
|---|---|---|---|
| Cleaning products (misc.) | $100.00 | 1 | $100.00 |
| **TOTAL** | | | **$158,549.16** |
| | | | |
| **Total # of physical locations** | 3.00 | | **$475,647.48** |

**Year 1 Total Cost: $5,142,594.35**

Year 6+ Complete Costing

| **Operational Cost: Market Goods** | **Estimated Price (per unit)** | **Estimated frequency of purchase** | **Estimated Price (per annum)** |
|---|---|---|---|
| NARCAN | Provided free of charge in Ontario | - | - |
| Granola bars (case of 120 bars) | $39.61 | 52 | $2,059.72 |
| Trail mix (case of 108 single serve pouches) | $113.78 | 52 | $5,916.56 |
| Water (case of 24 500mL bottles) | $1.97 | 150 | $295.50 |
| Gatorade (case of 24 20oz bottles) | $33.84 | 150 | $5,076.00 |
| Cigarettes (carton of 200 cigarettes) | $104.99 | 150 | $15,748.50 |
| Ceremonial objects | - | - | - |
| Safe Consumption Kits | Provided in partnership with local harm reduction group at cost | - | - |
| Gas for vehicle | $20,000 | 30 | $600,000.00 |
| Vehicle maintenance | $800 | 30 | $24,000.00 |
| Auto insurance ($1M in annual commercial coverage) | $1,700 | 30 | $51,000.00 |
| Liability insurance ($2M in annual commercial coverage) | $500 | 30 | $15,000.00 |
| Phone Plan | $600 | 143 | $85,800.00 |
| Driver wage | $65,000 | 3 | $195,000.00 |
| Nurse practitioner wage | $120,000 | 3 | $360,000.00 |
| First Responder Wages | $100,000 | 90 | $9,000,000.00 |
| Administrative Wages | $65,000 | 5 | $325,000.00 |

| **TOTAL** | **$10,684,896** |
|---|---|

| **First Aid Items (recurring cost)** | **Estimated Price (per unit)** | **Estimated quantity & frequency of purchase** | **Estimated Price (per annum)** |
|---|---|---|---|
| Standard First Aid Kit | $38.86 | 10 | $388.60 |
| Disposable gloves (100 units) | $15.99 | 24 | $383.76 |
| Surgical face masks (20 units) | $22.00 | 24 | $528.00 |
| Face shield | $9.99 | 24 | $239.76 |
| Antiseptic swabs | $5.79 | 24 | $138.96 |
| Disinfectant wipes | $14.99 | 24 | $359.76 |
| Hand sanitizer | $12.99 | 12 | $155.88 |
| Disposable resuscitator (adult size) | $241.50 | 1 | $241.50 |
| Disposable resuscitator (child size) | $241.50 | 1 | $241.50 |
| CPR barrier with one-way valve (single use) | $1.39 | 10 | $13.90 |
| Emergency Blanket | $2.19 | 50 | $109.50 |
| **TOTAL** | | | **$84,033.60** |

| **Physical Location Start-Up Costs** | **Estimated Price (per unit)** | **Estimated quantity & frequency of purchase** | **Estimated Price (per annum)** |
|---|---|---|---|
| Rent | $5,000 | 12 | $60,000 |
| Utilities | $400 | 12 | $4,800 |
| Internet | $60 | 12 | $720 |
| Security system | $20 | 12 | $240 |
| Insurance | $1,250.00 | 1 | $1,250.00 |
| Maintenance worker wage | $50,000.00 | 1 | $50,000.00 |
| Office supplies (misc.) | $200.00 | 1 | $200.00 |
| Cable subscription | $600.00 | 1 | $600.00 |
| Shampoo | $5.00 | 120 | $600.00 |
| Conditioner | $5.00 | 120 | $600.00 |

| | | | |
|---|---|---|---|
| Body wash | $5.00 | 120 | $600.00 |
| Soap | $5.00 | 120 | $600.00 |
| Menstrual products | $7.99 | 60 | $479.40 |
| Toothbrush | $5.00 | 120 | $600.00 |
| Toothpaste | $5.00 | 120 | $600.00 |
| Towels | $25.00 | 25 | $625.00 |
| Laundry detergent | $14.99 | 24 | $359.76 |
| Food pantry items (misc.) | $25,000.00 | 1 | $25,000.00 |
| Cleaning products (misc.) | $100.00 | 1 | $100.00 |
| **TOTAL** | | | **$147,974.16** |

| | | |
|---|---|---|
| **Total # of physical locations** | 3.00 | **$443,922.48** |

**Year 6+ Total Cost: $11,438,230.69**