City of Ottawa Alternate Response to Mental Health Crises

Phase 1: Alternate Response Models

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Executive Summary

Under the direction of the Guiding Council and the scope of work provided by the City of Ottawa, this report examines Ottawa's current intake processes and response methods for mental health crises, along with alternate response models implemented in four comparator cities. The comparator cities were provided by the Guiding Council and include the Niagara Region, Toronto, Vancouver, and Eugene and Springfield, Oregon. The purpose of this report is to provide information on the models in use, and not to provide analysis or recommendations for Ottawa to implement. This report is the first stage of a multi-stage process and will be followed by community consultations to be led by the Guiding Council.

Ottawa Findings and Gaps

Throughout this report, several key findings emerge on the current Ottawa response to mental health crises. First, MNP found that 911, including the Ottawa Police Service and Ottawa Paramedic Service, and the Distress Centre of Ottawa and Region currently serves as the primary intake points for persons experiencing a mental health crisis. The police and paramedic services, along with The Ottawa Hospital Mobile Crisis Team (accessed through the Distress Centre) serve as the primary in-person responses to mental health crises in Ottawa. Of these in-person responses, only the police and paramedic services are staffed 24/7 with the mobile crisis team operating 12 hours per day. Further, the police are often the only option for responding to situations where an individual is a risk to themselves or others, there is a suicide risk, a person is highly distressed, or where the person is experiencing acute psychosis. Police are also required to attend when a person requires involuntary transport to hospital.

Several important gaps were identified through our evaluation of the current model in Ottawa. First, emergency responders including the police and paramedics are the only agencies with the resources, staffing capacity, and operating hours to send real-time resources to an immediate crisis. This response is typically led by general patrol officers or paramedics, as the current police and paramedic programs specializing in mental health do not have the resources to respond to most crisis calls in real-time. We also found no specific services, of those reviewed, tailored to any racialized, ethnic, or minority community and only the Distress Centre and Youth Services Bureau (YSB) even track ethnicity data for their clients.

The police data we reviewed for this report only included calls where mental health was the primary complaint as mental health is not tracked at a secondary level. As a result, the police data within the report contains some limitations. If the primary complaint for a call was not mental health, a call would likely be recorded using a different occurrence label and the presence of a mental health concern would not be captured. This results in the police data likely significantly understating the true extent of mental health as a contributing factor to police involvement. While the call notes on individual reports often indicate the presence of mental health factors, this is not captured in a data search or call statistics reports. To capture the scope and presence of mental health issues in other occurrences more fully, a keyword search and individual file review would need to be conducted.

Alternate Response Models

The first alternate response model evaluated in this report is a co-response team pairing a police officer with a mental health professional. Examples of this model include MCRRT in the Niagara Region and Car 87 / 88 in Vancouver. The second model evaluated is a co-response team pairing a paramedic and mental health professional. Examples include MHART in the Niagara Region and the Ottawa Mental Wellbeing Response Team, a pilot project between the paramedic service and The Ottawa Hospital Mobile Crisis Team. The third model evaluated is a community agency response which is dispatched by 911 or transferred by 911 to another agency for immediate dispatch. Examples include CAHOOTS in Eugene, Oregon, and the City of Toronto's pilot projects with four community agencies. All three models examined showed positive results in reducing the rate of hospitalizations resulting from mental health crisis calls and are described in detail throughout the report.

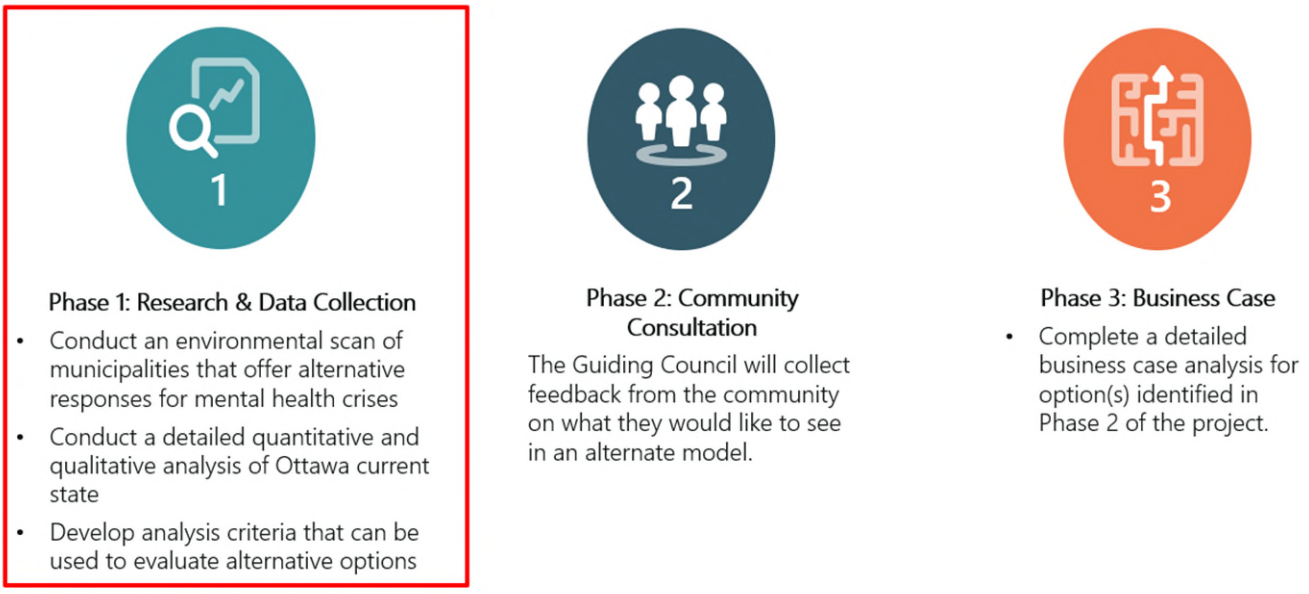
In practice, all the alternative response models evaluated in this report are under-resourced relative to the demands in their jurisdiction. Most alternative response models currently operate as a single team serving a large metropolitan area. As such, police and paramedics still frequently respond to mental health crises in these jurisdictions. Several programs are limited in the geography that they serve with access only in specific police districts, and only CAHOOTS operates 24/7.

When considering potential model options, we saw the flexibility for several of the alternative response models to be "layered", such as the use of MCRRT and MHART in the Niagara Region. One benefit of this approach is that it enables different responses for varying levels of risk and crisis acuity. We also saw the use of mature, existing community agencies when implementing a community-based response model. For example, the Gerstein Centre in Toronto, and the White Bird Clinic in Eugene, Oregon previously delivered crisis response services on a smaller scale before receiving city contracts and connecting to the 911 call flow.

Introduction

The Guiding Council for Mental Health and Addictions is currently undertaking significant efforts to identify and evaluate options for an enhanced or new mental health and substance use crisis response system. Specifically, the Guiding Council is considering the development of an alternative call referral program identifying how and to whom low-risk, low-acuity 911 calls involving mental health and substance use factors should be re-directed. The project is broken down into three phases which are outlined in the figure below.

Figure 1: Alternative Response Model Development Phases



This report is the result of the first phase which includes detail on the current system for mental health crisis response in Ottawa, a detailed description of the mental health crisis response model in four comparator jurisdictions, and a sample of evaluation criteria for determining what the new model in Ottawa should look like or contain.

Project Overview

Phase one of this project includes a systematic environmental scan of municipalities that offer alternative responses to mental health crises. The Guiding Council, of which the City of Ottawa is a member, has selected the following four jurisdictions which are examined and compared in this report:

- Niagara, Ontario
- Toronto, Ontario
- Vancouver, British Columbia
- Eugene, Oregon

In addition to the comparator jurisdictions, this report examines the current emergency response model in Ottawa.

Where available across the jurisdictions evaluated, MNP requested and compiled the following data:

- A detailed qualitative and quantitative analysis of current 911 dispatch activity, and effectiveness and appropriateness of response (as data and information was available)
- A detailed qualitative and quantitative analysis of other call centre dispatch activity, including the effectiveness and appropriateness of response. Examples include providers such as 311, 211, paramedics and other community service agencies (as data was available)

The final component of this report is an example framework of evaluation criteria that can be used by the Guiding Council to identify which alternative options or components of the model options meet the goals and objectives of this initiative and should be explored further in a business case.

Approach and Methodology

MNP worked with the City of Ottawa project team to identify subject matter experts to assist in collecting the necessary data and understanding the mental health crisis response system in the City of Ottawa. A standard question guide was developed and primarily based on the key questions specified by the Guiding Council as outlined in the project Scope of Work Appendix B: Analysis Requirements. Question guides were provided to interviewees in advance, and interviewees were asked to answer as many of the questions as possible in their experience. Not every question was relevant to each stakeholder.

Within the four comparator jurisdictions, the City of Ottawa assisted MNP in identifying and connecting with a primary point of contact within either the jurisdictional City structure or the jurisdictional police service. Additional stakeholders were then identified from these preliminary conversations and subsequent interviews were arranged. The following table outlines the full list of organizations consulted in the data collection phase. Many organizations included multiple individuals in their interviews to cover their participation in mental health crisis response, and in some cases, more broadly across the mental health and substance use services continuum of care.

Table 1: Stakeholder Organizations Interviewed

City of Ottawa	Niagara Region	City of Vancouver	City of Toronto	CAHOOTS
• Ottawa Police Service • Ottawa Paramedic Service • CMHA Ottawa • Eastern Ontario 211 • Ottawa Distress Centre • AccessMHA • Ottawa Inner City Health • Ottawa Hospital • City of Ottawa 311 • Youth Services Bureau • The Royal Ottawa Hospital	• Niagara Regional Police • CMHA Niagara • Niagara EMS • Niagara Region Community Services	• Vancouver Police Department • CMHA BC • E-Comm	• Toronto Police Service • City of Toronto Policing Reform • Gerstein Crisis Centre • FindHelp/211 Central	• White Bird Clinic

In addition to conducting interviews with stakeholders, MNP requested and collected any available model data. These data requests included:

- Call taking scripts
- Annual calls including time required to handle calls
- Call distribution by race, ethnicity, age, and geolocation
- Outcomes
- Performance metrics
- Misdirected calls
- Any available program or service documentation (processes, call classifications, definitions, call flows, etc.)

Data Limitations

The prescribed questions provided by the City of Ottawa on behalf of the Guiding Council included several data requests. The data requested would be incredibly helpful in understanding the size and scope of service provision, who the clients served are, and how effective the different models are at serving their communities. Unfortunately, the data MNP was able to collect was extremely limited. Except for the Distress Centre of Ottawa and Region, most organizations detailed in this report do not collect demographic data like age, race, or ethnic background.

Outside of the Ottawa Paramedic Service, no other service providers included in the stakeholder consultation were able to share 911 or emergency services call taking scripts either because they do not use a structured script, or they use scripts from external service providers that are proprietary and not shareable.

Meaningful outcome data is also difficult to collect and track because it requires following individuals across a longer period and often across a network of service providers. Information privacy legislation like the Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act, 2004 (PHIPA) can create barriers for service providers and prevent them from sharing information about their clients. This limits individual service providers' ability to know how their client is doing with another service provider.

An additional challenge with mental health crisis response is the varying definitions of what constitutes a mental health crisis call for service. The Ottawa Police Service, like other police services across Canada, only have two occurrence types that clearly include a mental health component to them including occurrences that reference the Mental Health Act and those that are categorized as suicide. The police are the only emergency service provider that can take an individual in custody under the Mental Health Act. Section 17 of the Mental Health Act in Ontario states the following:

> *"Action by police officer*
>
> *17 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 or attempting 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

(f) 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. 2000, c. 9, s. 5."

The Ottawa Police Service tracks occurrences relating to the Mental Health Act including outcomes such as apprehensions under the act, voluntary transport to hospital, and Mental Health Act related occurrences that do not result in transport to hospital. This is a consistent data collection practice across police services in Canada as they are included in the Uniform Crime Reporting (UCR) data set that all police services must report to Statistics Canada on an annual basis. Uniform Crime Reporting was designed to measure the incidence of crime in Canadian society and its characteristics. The information is used by federal and provincial policymakers as well as public and private researchers.

Although these are the only police occurrences that have an obvious mental health element to them, there are several other occurrences or calls for service that can involve individuals struggling with their mental health, but which are categorized by the primary nature of the call. For example, a theft or assault call for service could involve an individual in mental health crisis, but the call type would not include any reference to this, and this detail may never get tracked in the data collected by police. Often, the data indicating a link to mental health concerns is in the notes of a police report which makes it very complicated to extract this detail in aggregate and determine the number of police interactions where mental health was a factor.

A study at the University of Western Ontario entitled *Shedding Light on the Dark Figure of Police Mental Health Calls for Service* conducted a manual review and text search of qualitative data for calls for service in 2019 of a Canadian police service to identify the true proportion of police calls for service that involved individuals with perceived mental illness. The researchers used a keyword search of the qualitative data available for the events (e.g., dispatcher's notes, event synopsis, occurrence report). The study identified calls as "mental health" related through the keyword search and the calls were reviewed in full before final categorization. The findings of the study showed that calls with an official "Mental Health" classification (Mental Health Act and suicide) accounted for 0.9% of calls but the keyword search analysis indicated that the actual volume of calls with a mental health component was 10.8% of total calls. Their findings revealed certain call types were more likely to involve a person with perceived mental illness than others. The call types and their proportion of calls that involved people with perceived mental illness (PwPMI) are detailed in the table below[1].

Table 2: University of Western Ontario Study Crosstabulation Results of Police Calls for Service Involving PwPMI[1]

Calls for Service Classification	PwPMI Involvement %	Total Annual Calls (% of Total Calls)
Medical/Check Welfare	19.9%	9,436 (21.9%)
Missing Person	16.1%	2,033 (4.7%)

[1] *Shedding Light on the Dark Figure of Police Mental Health Calls for Service. (2022) Jacek Koziarski, Lorna Ferguson, Laura Hu. University of Western Ontario.*

Calls for Service Classification	PwPMI Involvement %	Total Annual Calls (% of Total Calls)
Weapons	9.2%	892 (2.1%)
Property Damage	7.4%	1,237 (2.9%)
Trouble with Persons	6.7%	14,375 (33.4%)
Assault/Battery	4.7%	2,136 (5.0%)
Domestic	3.9%	991 (2.3%)
Disturbance	2.4%	1,925 (4.5%)
Theft	0.9%	7,031 (16.4%)
All Other Calls	35.9%	2,940 (6.8%)
Total	**10.8% (4,646 calls)**	**42,996**

Similar challenges result when analyzing paramedic data as calls are tracked according to the most acute medical issue. An individual presenting with a more acute injury (chest pain, laceration, etc.) could be in mental health crisis but the call would be recorded or tagged as the most acute medical need. Like the police data, paramedics' notes may have details that describe a mental health component to the call, but these details are not easily used to analyze the call volume or trends.

The data tracked by each service provider is driven by their mandates and goals in service provision. The police generally collect information and generate files for investigatory purposes which may ultimately be needed by the court system to charge and convict individuals of a crime. This, therefore, directs the type of information they collect. The police have a mandate to respond to calls that have a public safety risk element or where a crime may have been committed. The paramedics have a primary mandate to respond to medical emergencies and deliver medical treatment for life-threatening medical emergencies including heart attacks, strokes, respiratory and traumatic injuries. Mental health response forms a secondary component of their response and is thus not tracked in a way that can be easily measured.

Current State – City of Ottawa

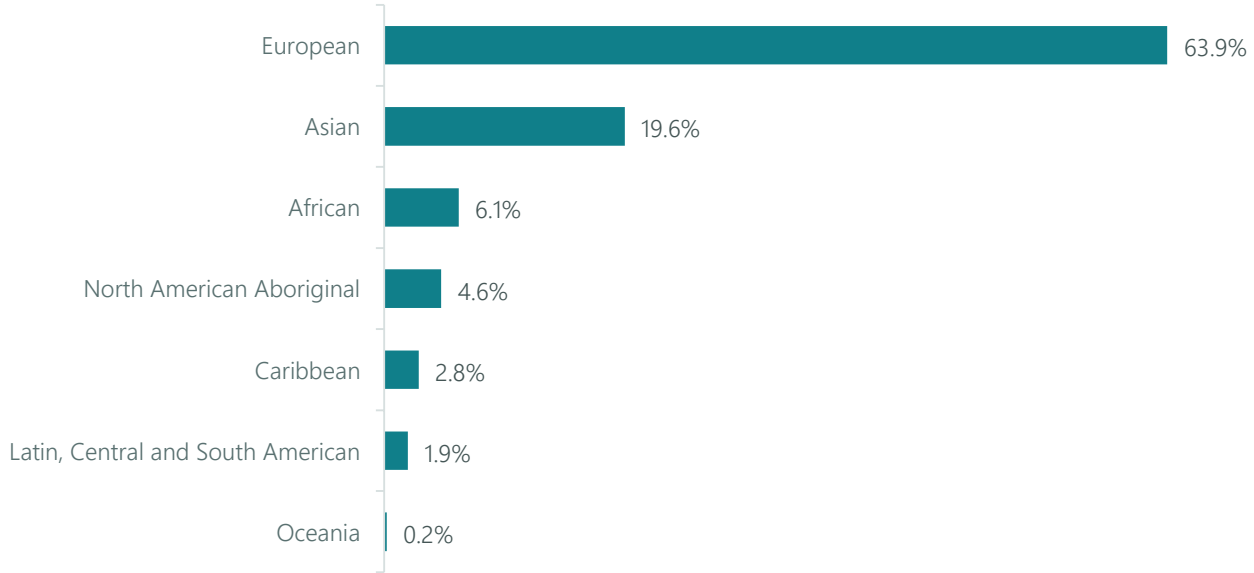
Community Profile

The City of Ottawa has a population of 1.02 million with an approximate land area of 2,788 square kilometres, larger than the cities of Toronto, Vancouver, and the Niagara Region combined.[2]

Figure 2 illustrates an approximate composition of the City's ethnic backgrounds[3]. 2016 Census data indicates that about 64% of the population have European origins while the remaining 36% identify as visible minorities. The largest ethnic group is Asian in background, contributing to 20% of the total visible minority group. Most of the Asian demographic in Ottawa are ethnic Chinese, East Indian, and Lebanese, which together make up almost 56% of the total Asian demographic. Ottawa also records the highest representation of Indigenous people out of the comparator cities in this report, at almost 5% of the total population.

2016 Census data shows 61% of the City's population are native English speakers with an additional 14% of the population indicating French as the mother tongue. This proportion of native French speakers is much higher than the comparison cities in this report. 22% of the population indicated a mother tongue other than English or French, with Arabic the highest reported at 3.7%[3].

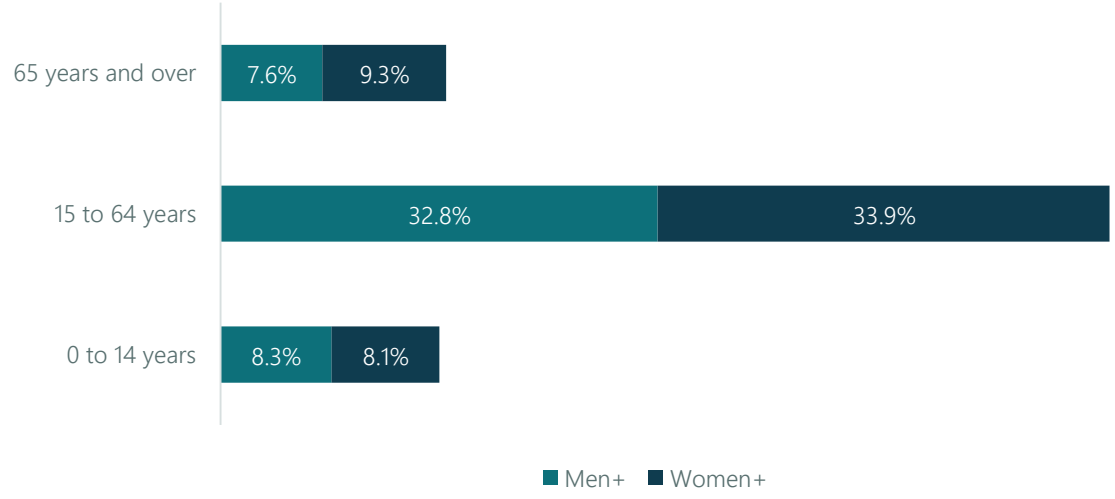
Figure 2: 2016 Census Profile, Ethnic Origin – City of Ottawa



[2] *Statistics Canada. 2022. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released April 27, 2022.*
https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E
[3] *Statistics Canada. 2017. Ottawa, CV [Census subdivision], Ontario and Ontario [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017.*
https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

Figure 3 shows the City's population distribution by age group[4]. While the median age of the total population is 40.0 per the 2021 Census, the highest proportion of individuals falls within the range of 25 to 29 years old at 10.7% of the total 15-to-64-year group.

*Figure 3: 2021 Census, Population Distribution by Age Group – City of Ottawa**



**(+) indicates inclusion of some non-binary respondents*

Figure 4 is a map outlining the urban and rural areas of the City of Ottawa[5]. Figure 5 is the Ottawa Police Service district map for the City of Ottawa to provide insight into the scope of service the police provide for urban and rural areas[6]. Approximately 80% of the city's total area is rural with about 10% of the city's population living in rural areas[7]. The urban area of Ottawa is mostly concentrated along the Ottawa River bordering Gatineau.

[4] *Statistics Canada. 2017. Ottawa, CV [Census subdivision], Ontario and Ontario [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017.*
https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E
[5] *https://documents.ottawa.ca/sites/documents/files/rural_res_land_survey_2018_2020_en.pdf*
[6] *https://www.ottawapolice.ca/en/news-and-community/resources/projects/web-english_-_final_changing_to_serve_you_better.pdf*
[7] *https://documents.ottawa.ca/sites/documents/files/rural_ss_en.pdf*

Figure 4: City of Ottawa - Urban and Rural Area Map

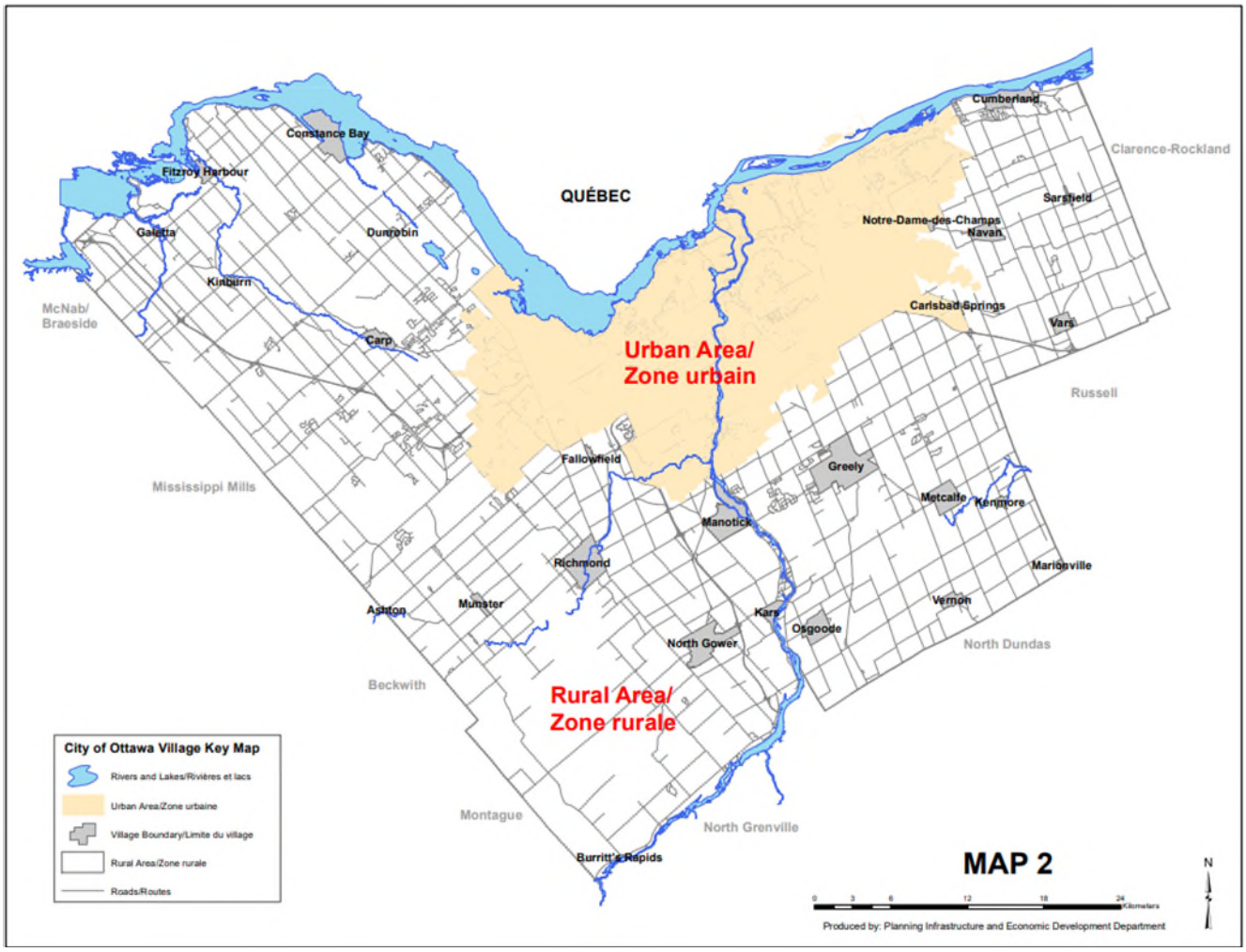
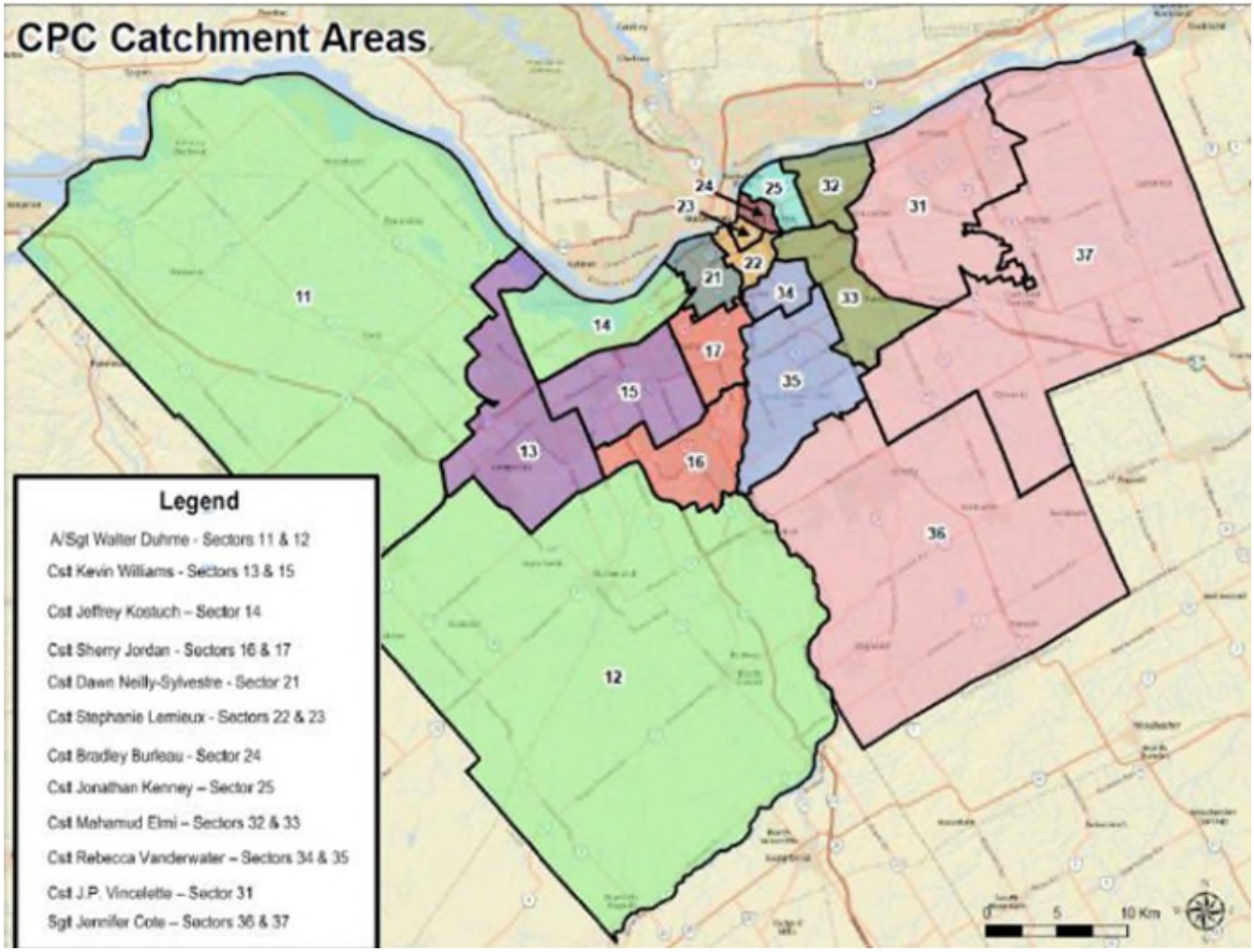


Figure 5: City of Ottawa – Ottawa Police Service District Map

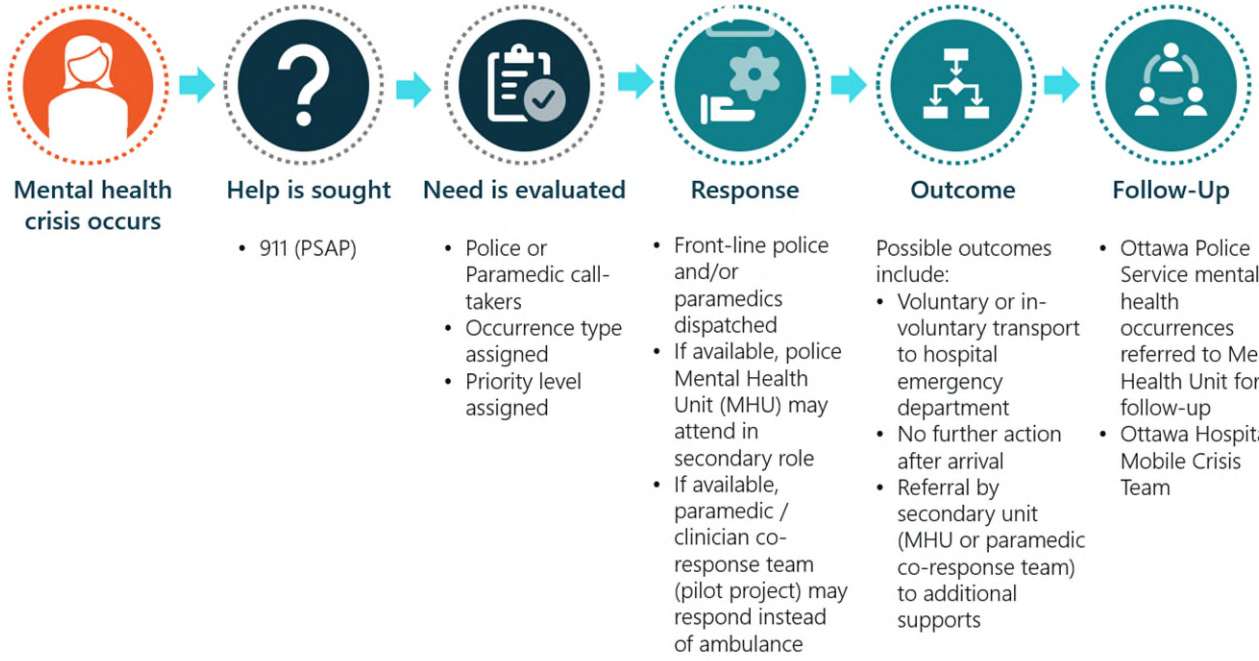


Ottawa Mental Health Crisis Response Model

The research and data collection for this project focus on the mental health crisis response. For this project, a mental health crisis is defined as an individual seeking immediate assistance because they are in an emergency where mental health is at the core. Requests for assistance may come from the individual in crisis, someone close to them or even a stranger passing by who is concerned about another's wellbeing.

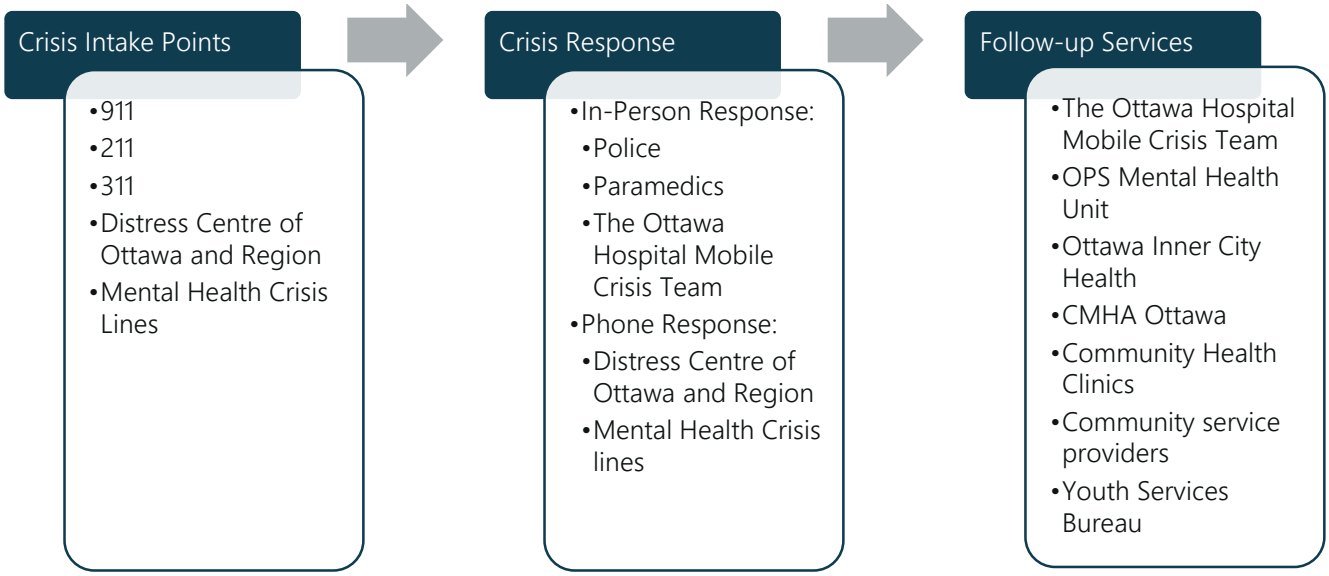
The figure below outlines the steps involved in a typical mental health crisis call to 911. When crisis calls are directed to providers other than 911, their call flow is different but still follows the broad stages of intake, response, and follow-up.

Figure 6: Mental Health Crisis Response Flow Diagram



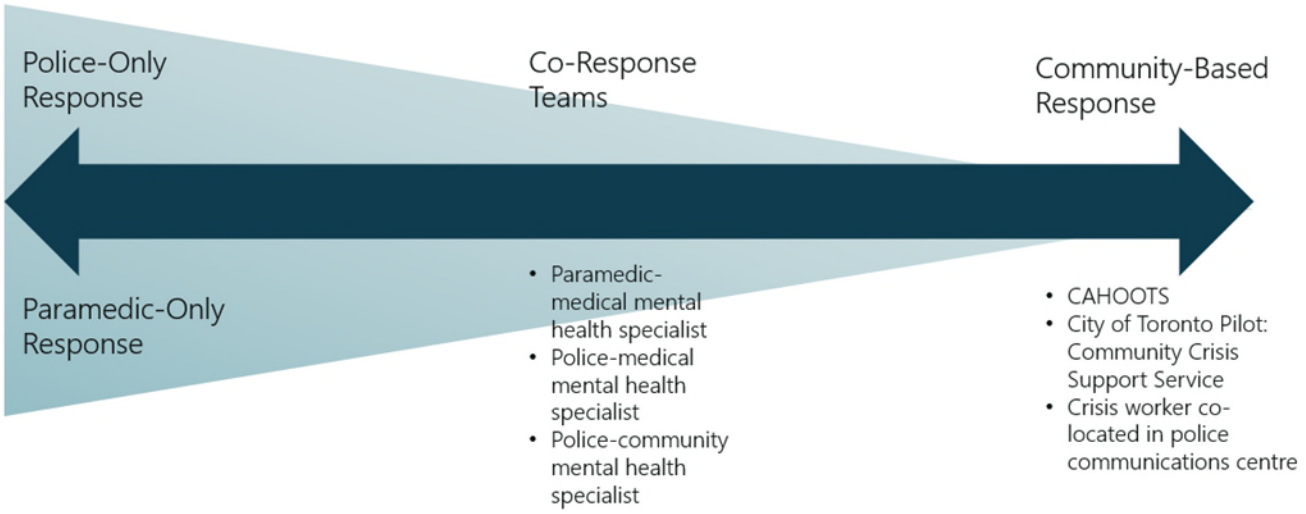
The current Ottawa mental health crisis response model includes several service providers that operate at the intake, response, and follow-up stages of a mental health crisis. The figure below outlines these mental health crisis response system partners and in what aspects they are involved. Of the agencies shown below, only the police and paramedic service are currently able to provide a time-sensitive in-person response, while the other agencies provide over-the-phone services or follow-up services with delayed and often wide-ranging response times. As a result, these other agencies will direct emergent calls to 911 including calls involving the risk of harm to oneself or others, and in cases where callers are very distressed or acutely psychotic.

Figure 7: Current Ottawa Mental Health Crisis Response Model



In Ottawa and the comparator jurisdictions, the physical response to a mental health crisis through 911 is predominantly provided by police and paramedics. In addition to this traditional response, there were two primary alternative response models seen across the jurisdictions explored. The first is a co-response model where a multidisciplinary team responds together to an individual in crisis. The team members generally have interdisciplinary backgrounds and training, and often work for different organizations. For example, a co-response team could include a police officer paired with a psychiatric nurse or a paramedic with a community-based mental health crisis worker. The second alternative response model seen was a strictly community-based response. The community-based responses do not generally include "traditional" emergency service providers such as police, paramedics, or medical staff from hospitals. They are typically trained individuals or clinicians that work for community-based service providers. The diagram below demonstrates the spectrum of service responses and some examples of service providers that would fit into the three categories of response.

Figure 8 – Spectrum of 911 Mental Health Crisis Call Responses



The agencies involved in responding to mental health crises in Ottawa currently include a combination of traditional emergency services and community-based organizations, along with a co-response model involving both types of agencies. The table below outlines the type of agencies involved in the current response model.

Table 3: Current Spectrum of Traditional and Community-Based Responses to Mental Health Crisis in Ottawa

Traditional Emergency Services	Co-Response	Community-Based
Frontline policing services	Mental Wellbeing Response Team - Paramedic and Ottawa Hospital (Pilot Project)	Distress Centre of Ottawa and Region
Frontline paramedic services		Mental Health Crisis lines

The scope of this project is focused on the emergency response to mental health crisis and specifically on the development of an alternative call referral program. This makes up a very small portion of the overall service provision for individuals struggling with mental health challenges. The continuum of mental health services begins much further upstream with prevention and intervention services. These are provided beforehand and may prevent an individual from reaching a crisis point. The other end of the continuum of mental health services includes the ongoing support services provided once an individual has moved through the crisis stage to assist them in addressing the root causes of their individual, unique challenges. Access to services at both ends of the continuum of care is imperative to reducing the need for the crisis response that is in the middle. Even the best models for mental health crisis response are limited in their ability to create good outcomes if there are limited follow-up services available to assist in addressing the root causes of the mental health crisis. While this report details the intake, response, and immediate follow-up connected to a crisis call, the crisis response and follow-up processes are integrated into a larger mental health services system and should be viewed in that context.

Ottawa Call Intake Channels

The sections below outline the intake channels through which a person in crisis can initiate a mental health crisis response. These intake channels can be utilized by a person in crisis or by another person such as a bystander or a caregiver who perceives the need for a crisis response.

Public Safety Answering Point (911)

In the City of Ottawa, the Ottawa Police Service holds a contract with the City of Ottawa to provide the Public Safety Answering Point (PSAP) or 911 answering service for the area. Call takers are civilian employees who report to and are overseen by a sworn officer. Call takers ask "911 Emergency – do you need police, fire, or ambulance?" This is the standard PSAP question for most centres across North America and the question is mandated in the contract. The PSAP contractual obligations end after the call is handed off to one of the three services.

Most mental health callers ask for police since there is not a fire and they do not need an ambulance. At the PSAP, approximately 4% of calls go to fire, 33% go to paramedics, and the remaining 63% of calls are directed to the police.

Once the PSAP has transferred the call to one of the three service provider options, a call taker employed by the service provider will gather additional information to determine the risk and acuity of the situation and determine the resources required when responding. If a call is transferred to one service provider and additional data is collected indicating that the call would be better served by one of the other providers, the call can be transferred at that time. There may also be a need for multiple types of response. For example, if a call is determined to be medical and has a public safety risk identified by the paramedic service, the call taker can request a police response attend with the paramedic response to jointly address both needs.

Table 4: Ottawa PSAP Data Collection Summary

Information Request	Response Detail
Script	One-question script mandated in PSAP contract: "911 Emergency – do you need police, fire, or ambulance?"
Service Languages	All operators are fully bi-lingual. The city has a contract with LanguageLine Solutions for translation services. LanguageLine is used 4 to 15 times per month. Top three languages used are Somali, Spanish, and Arabic
Specialized response for youth and children mental health and substance use calls	No
Training	Training is provided by the Ottawa Police Service to provincial standards. Call takers are not provided any specific mental health training
24/7 service provision	Call taking service is provided 24/7
Referral for follow-up process and alternatives	Calls are transferred to another emergency service provider (Police, Fire, or Paramedics. No other referrals are made at this point in the call process
Classification of call types related to mental health and substance use	None. Call-takers only differentiate between whether a caller needs police, fire, or paramedics, and if the call is an emergency or non-emergency
Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	None
Call Tracing Technology	The OPS use an analog-based system to track whether they are receiving landline or cellphone calls. Most are now cell-phone calls
Collection of race, ethnicity, age, geolocation	Only geolocation is tracked
Constraints	The one-question script does not include a mental health option and call-takers do not ask follow-up questions
Outcome	Call is transferred to police, fire, or paramedics

Gaps	Call takers only have the three options for transfer
Performance metrics	Speed answering calls and speed of transfer to service provider. 97% of calls to the PSAP must be answered in 6 seconds
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	Both administrative and serious complaints are tracked. The OPS investigates serious complaints
Misdirected call tracking	No

Ottawa Police Service Communications Centre

The Ottawa Police Service serves a dual role as both the PSAP for Ottawa and the call taking and dispatching function for the police service. Police resources are dispatched using a four-priority system (Priority 1 to Priority 4), with a Priority 5 assigned for call-back by the Police Reporting Unit (PRU). The PRU responds to incoming non-emergency phone calls and online reports. The PRU receives many calls from people with mental health issues. PRU staff and call takers are all civilians other than the Staff Sergeant and Inspector who oversee their work. Dispatchers and the PRU may consult with the Mental Health Unit before dispatching officers in cases where there are repetitive calls on the same day and potential concerns around mental health. Additional information about the Ottawa Police Service Mental Health Unit is provided in the Follow-up Services section later in the report.

Table 5: OPS Occurrences Originated Through 911 System

	2019	2020	2021
Combined Mental Health Act Occurrences Originated through 911 System (% of all occurrences)	3,095 (2.7%)	3,416 (2.7%)	3,918 (2.6%)
All Occurrences Originated through 911 System	116,630	125,033	151,505

The above table provides a summary of OPS occurrences originating through the 911 system including the combined occurrences relating to the Mental Health Act, and all occurrence types. As noted throughout this report, mental health can often be a contributing factor in non-Mental Health Act occurrences but there is currently no means to indicate which other occurrence types included these factors.

Table 6: Ottawa Police Service Communications Centre Data Collection Summary

Information Request	Response Detail
Script	No script used
Service Languages	All operators are fully bi-lingual. The city has a contract with Language Line for translation. Language line is used 4 to 15 times per month. Top three languages used are Somali, Spanish, and Arabic.
Specialized response for youth and children mental health and substance use calls	No
Training	ASSIST training (2-day suicide prevention course) is provided to call takers, dispatchers, and PRU members.
24/7 service provision	Call taking and dispatching service is provided 24/7
Referral for follow-up process and alternatives	Calls identified as mental health related are referred to the Mental Health Unit for follow-up.
Classification of call types related to mental health and substance use	Dispatchers focus on the circumstances around the call in determining the appropriate priority level and resources to dispatch – this includes the presence of weapons, drinking, drugs, mental health issues, etc. The Ottawa Police Service Mental Health Unit reviews all reports identified as mental health occurrences. Events involving substance use are managed at the discretion of the responding officer(s).
Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	The police response dispatched is based on the criminal act being reported and the urgency of the situation rather than the level of acuity of the person calling. The age of the person and their level of acuity could impact the priority, but no tool is implemented to measure the level of acuity.
Call Tracing Technology	The OPS use an analog-based system to track whether they are receiving landline or cellphone calls. Most are now cell-phone calls.
Collection of race, ethnicity, age,	Only geolocation is tracked

geolocation	
Constraints	Limited mental health specific response and referral options, limited training dedicated to mental health triage and support
Outcome	Response is dispatched or call is transferred
Gaps	No tools available to measure or indicate call acuity outside of priority system. Limited access to mental health specific resources.
Performance metrics	Call activity, service level objectives
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	Currently only undertaken on a reactive basis
Misdirected call tracking	No

Ottawa Paramedic Service Communication Centre

The Ottawa Paramedic Service operates the paramedic communication centre, including call-taking and dispatch, through a Transfer Payment Agreement with the Province of Ontario. The Ministry of Health establishes the legislative requirements which govern its operation. The communication centre utilizes the Dispatch Priority Card Index II system which uses an approved algorithm to dictate the questions asked of callers. Currently, dispatch uses four priority levels including Priority 4 which is life-threatening, and Priority 3 which is 'urgent' and does not require a response with lights and sirens.

Calls involving mental health and substance use factors are classified as either 'behavioural' or 'overdose' under the dispatch priority card. Mental health and substance use calls are typically classified as behavioural where there is no injury or indication of overdose.

The set of questions asked is determined based on the primary issue described by the caller. There are two sets of questions that are used when a call is determined to be primarily related to mental health or substance use. As more details are gathered, the call taker may end up transitioning between different sets of scripted questions to utilize the more appropriate script. The first set of questions for mental health and substance use calls is shown in the Behavioural Problem Card in the figure below. As shown in the script details, "Yes" answers to questions could lead the call taker to transition to other question sets and the collection of additional information.

Figure 9: Ottawa Paramedic Service Behavioural Problem Call Taker Script (Card 16: Behavioural Problem)

1. Does the person have a weapon?	→ Yes → No / Unknown	→ Inform All Responders
2. Is the person violent or dangerous to self or others?	→ Yes → No / Unknown	→ Inform All Responders
3. Is the person a diabetic?	→ Yes → No / Unknown	→ Diabetic Card 13 → Code 3 (PCP)
4. Has the person overdosed?	→ Yes → No / Unknown	→ Overdose Card 25 → Code 3 (PCP)
5. Has the person injured themselves?	→ Yes → No / Unknown	→ Trauma Card 27 Or 28 → Code 3 (PCP)

Geographical Assistance: [Obtain directions if required]

Pre-Arrival Instructions:

[All Persons]

- Approach the scene only if safe to do so. If you feel in danger leave the scene.
- If the scene is safe:
  - Reassure the person.
  - Gather all the person's medications, including empty bottles and give them to paramedics when they arrive.

Closing Statement: If safe to do so, make the person comfortable and call back if their condition changes or you find out more information.

Figure 10: Ottawa Paramedic Service Overdose Call Taker Script (Card 25: Overdose / Poison)

1. Is the person drowsy or confused?	→ Yes / Unknown → No	→ Code 4 (ACP) → Code 3 (PCP)
2. Is the person violent or dangerous to self or others?	→ Yes → No / Unknown	→ Inform All Responders
3. What did the person take?	→ Document	
4. When was it taken?	→ Document	

Geographical Assistance: [Obtain directions if required]

Pre Arrival Instructions:

[All Persons]

- Approach the scene only if safe to do so. If you feel in danger leave the scene.
- If the scene is safe:
  - Reassure the person.
  - If person begins to choke or vomit, lie or roll the person onto their side and observe their breathing.
  - Gather all the person's medications, including empty bottles and give them to paramedics when they arrive.

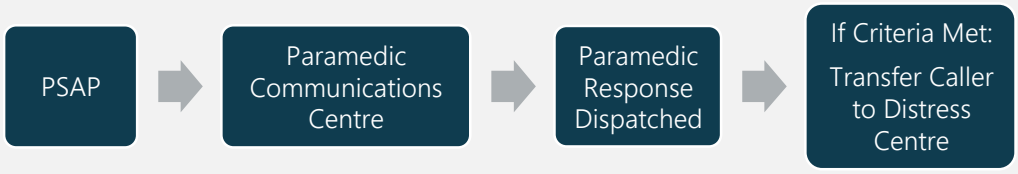
Closing Statement: If safe to do so, make the person comfortable and call back if their condition changes or you find out more information.

Call takers can transfer non-urgent mental health calls to the Distress Centre's distress line where a specialist can provide referrals to the client or identify future needs. This partnership can sometimes result in the cancellation of a paramedic to a call, but more frequently the paramedics are not cancelled and still provide an in-person response. Typically, 1 to 2 calls are transferred to the Distress Centre daily.

Another response option for mental health calls is the Mental Wellbeing Response Team, a new partnership through The Ottawa Hospital that pairs a paramedic with a crisis worker from The Ottawa Hospital Mobile Crisis Team. This pair can be activated by paramedics on scene attending to an individual or self-refer based on their own assessment of incoming 911 calls. The Mental Wellbeing Response Team cannot currently be dispatched directly to 911 calls, but work is underway to add this option in the future. Medical treatment is provided by the paramedics who then transfer care to the mental health professional for mental health treatment and referral to community resources. The Mental Wellbeing Response Team currently operates 9am to 9pm, five days per week.

Table 7: Ottawa Paramedic Service Communications Centre Data Collection Summary

Information Request	Response Detail
Script	Dispatch Priority Card Index II is utilized with a call-taking algorithm. This system is regulated by the Ministry of Health. Overdose and Behaviour Problem cards are included above.
Service Languages	Communications centre staff are fully bi-lingual in English and French with access to

	LanguageLine translation services for additional languages.
Specialized response for youth and children mental health and substance use calls	No
Training	Communications Officer training is provided by the province over a 6 month period.
24/7 service provision	Call taking and dispatching service is provided 24/7
Referral for follow-up process and alternatives	Individuals are seen in hospital if transported. The Ottawa Hospital Mobile Crisis Team does the follow-up and monitors the patient on an ongoing basis after visits to hospital.
Classification of call types related to mental health and substance use	Mental health and substance use calls are classified and dispatched as either Behaviour or Overdose. Triage is based on the complaints of the individual. The Behaviour card would be selected in the Dispatch Priority Card Index if there is no injury.
Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	Mental health and substance use calls are classified as either Behaviour or Overdose. Dispatch only has two priorities to indicate the level of urgency or acuity: Priority 4 – life threatening Priority 3 – urgent, no lights and sirens
Call Tracing Technology	Information not available
Collection of race, ethnicity, age, geolocation	Only geolocation is tracked
Constraints	Call taking algorithm prescribed by the Ministry of Health
Outcome	Response is dispatched or call is transferred
Gaps	Mental Wellbeing Response Team is a pilot project and limited to one team, 12 hours per day, 5 days per week.

Performance metrics	Track individuals that are repeat users, individuals seen in hospital after being visited by a team Track calls dispatched for behaviour and overdose calls, geolocation of calls and times of day Track treatment and referrals (diversions) Paramedic paperwork indicates if the final complaint was mental health or substance use as the primary complaint
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	Yes. Calls are recorded and audited with feedback and coaching provided to call takers.
Misdirected call tracking	No

211 Eastern Ontario

211 Eastern Ontario provides community navigation services via the 211-phone number, text, and chat, connecting individuals to the appropriate resources and service providers for their needs. 211 Eastern Ontario serves an area spanning from Belleville to the Quebec border, including the Ottawa region. The service provider for 211 Eastern Ontario is Community Navigation of Eastern Ontario (CNEO). In total, there are six regional service providers across Ontario that comprise the Ontario 211 network. CNEO employs community navigators from 7am to 7pm, with evening and night services provided by 211 Central based out of Toronto to provide 24/7 coverage.

Community navigators are trained using the Alliance of Information and Referral Systems (AIRS) Information and Referral (I & R) Community Resource Specialist training manual. The I & R process has 5 stages including Contact, Assessment, Clarification, I & R Provision, and Closing. Community navigators utilize a database of community resources and service providers and use their assessment process to refer the caller to the best organization. The referral can take the form of a warm hand-off or could involve providing the caller with a phone number for the organization. Community navigators can provide insights on how to access resources including the intake procedures at various agencies. Navigators are also trained to conduct assessments for mental health factors using a CMHA assessment.

211 Eastern Ontario operates with an annual budget of approximately $900,000. Over the year spanning April 1, 2021, to March 31, 2022, 29,309 total needs were identified in the Ottawa region. Of these total needs, 3.58% (1,050) were identified and labelled as related to mental health or substance use.

In addition to the referrals that are made, 211 Eastern Ontario tracks the number and type of unmet needs that are encountered. The table below lists the top 15 unmet needs from April 2021 through March 2022. Mental health calls were mostly referred to one of the listed providers in the 211 database and only 20 mental health or substance use

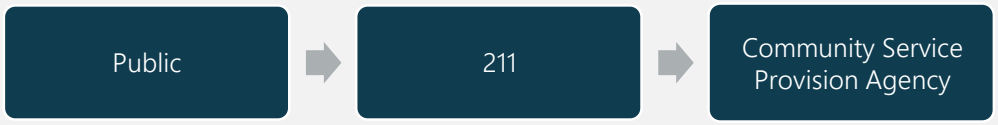
calls were classified as an unmet need.

Table 8: Top 15 Overall Needs Tracked by 211 Eastern Ontario in Ottawa: April 1, 2021, to March 31, 2022

Ranking	Need Classification	Total Needs Identified
1	Christmas Programs	3,116
2	Holiday Gifts/Toys	3,057
3	Vaccine Information	1,263
4	Tax Preparation Assistance	1,056
5	Food Banks	891
6	Medical Information Services	772
7	311 Services	654
8	Utility Assistance	636
9	Non-Emergency Medical Transportation	559
10	Grocery Ordering/Delivery	450
11	Gift Card Distribution Programs	391
12	Undesignated Temporary Financial Assistance	370
13	Provincial/Territorial Social Assistance Programs Applications	351
14	City Government Information Services	348
15	Medical Expense Assistance	303

Table 9: 211 Eastern Ontario Data Collection Summary

Information Request	Response Detail
Script	Use the referral process outlined in the Alliance of Information and Referral Systems (AIRS) Information and Referral (I & R) Community Resource Specialist training manual
Service Languages	Service is provided in English and French with access to translation service for additional languages
Specialized response for youth and children mental health and substance use calls	No specialized response: referrals are provided to youth agencies using the same process as for adults
Training	6 Week onboarding and training process including training on AIRS I & R Community Resource Specialist processes. Community navigators are also trained to conduct a CMHA assessment relating to mental health.

24/7 service provision	Yes. 211 Eastern Ontario provides community navigation services from 7am to 7pm. Calls are routed to 211 Central between 7pm and 7am to provide 24-hour coverage.
Referral for follow-up process and alternatives	Calls relating to mental health and substance use are referred to community agencies that can provide the appropriate services
Classification of call types related to mental health and substance use	CMHA assessment is used to determine the presence of mental health or substance use factors. These factors are noted in the data collection process and influence the referral that is offered to the caller.
Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	If a situation is deemed to be an emergency or there is a risk of harm, 911 will be contacted. Otherwise, lower levels of acuity are not distinguished in the referral process.
Call Tracing Technology	None
Collection of race, ethnicity, age, geolocation	No
Constraints	Lack of feedback on referral outcome effectiveness, limited referral options in certain categories
Outcome	Referral to an appropriate service provider that can meet the caller's need
Gaps	Limited hours of service (7am to 7pm) provided locally by 211 Eastern Ontario
Performance metrics	Wait time: Target a wait time of 90 seconds or less. Length of call: Average is 6.5 minutes Caller needs and unmet needs are tracked to identify gaps
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	Calls are recorded and kept for 30 days in case of complaints. There is a code of conduct in place and a rigorous complaint process.
Misdirected call tracking	No

City of Ottawa 311

The mandate of 311 is to provide information on Ottawa city services and to submit service requests to city services. Ottawa 311 receives an average of 600,000 calls annually. The highest call volumes to 311 come from solid waste. Calls about roads are the second most common call type, followed by bylaw-related calls including noise complaints and parking. 311 rarely receives calls where an individual is directly requesting mental health support. Rather, call takers typically identify a mental health need based on how a call is progressing. Callers in crisis are provided with a warm transfer to 911 if the situation is an emergency. If there is not an emergency, callers with an identified mental health need are offered a phone number to one of the four agencies below. 311 Call takers are not given any direction on which of the following agencies is best for a referral and are not able to provide any details on what to expect or the services provided by these lines:

- Ottawa Distress Centre
- Tel-Aide Outaouais
- Mental Health Crisis Line
- Ottawa Police Non-emergency

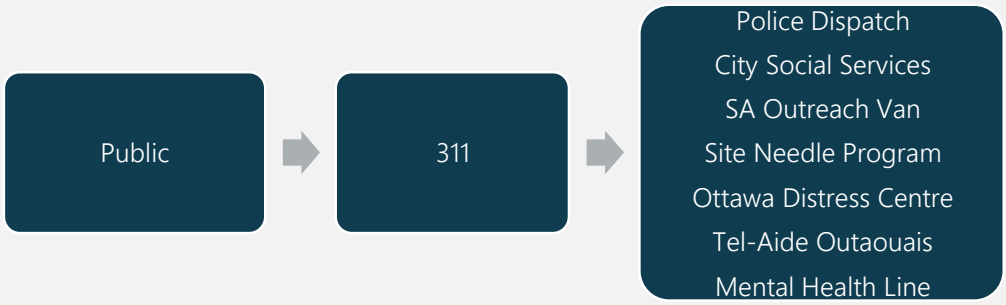
Of the above agencies, the Ottawa police is the most common transfer point for mental health calls.

For wellness checks where, for example, a member of the public calls and reports someone who appears cold outside, 311 refers to the Salvation Army (SA) outreach van during their hours of operation. SA van hours are typically 6am to 3am, Monday to Friday, and 11am to 3am on weekends. These hours are subject to change based on staffing availability or operational decisions by SA.

When calls are received relating to a person without housing and in need of shelter, they are typically transferred to the City of Ottawa's Social Services Housing Services phone line. 311 can process requests for the Site Needle & Syringe Program which operates a van between 5pm and 11:30pm providing harm reduction supplies. 311 can also transfer to the Street Team OutReach Mobile (STORM) program run by Minwaashin Lodge which assists street-involved women. The STORM program operates 5pm to 12am Wednesday through Friday, and 5:30pm to 11:30pm Saturday through Monday.

Table 10: City of Ottawa 311 Data Collection Summary

Information Request	Response Detail
Script	No script. Software enables knowledge search for appropriate city resource based on the caller's request.
Service Languages	All agents are bi-lingual in English and French with translation service available for additional languages.
Specialized response for youth and children mental health and substance use calls	None
Training	No training provided in connection to mental health calls.
24/7 service provision	Yes

Referral for follow-up process and alternatives	Callers with mental health concerns or is crisis are referred to one of the following agencies: • Ottawa Distress Centre • Tel-Aide Outaouais • Mental Health Crisis Line • Ottawa Police Non-emergency No follow-up is provided after the referral.
Classification of call types related to mental health and substance use	No call labeling or identification of calls for mental health issues or crisis
Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	If a situation is deemed to be an emergency, 911 will be contacted or a warm transfer to 911 is facilitated. Non-emergent situations are not assessed for acuity.
Call Tracing Technology	None
Collection of race, ethnicity, age, geolocation	None
Constraints	311 Call takers are not able to provide any details on what to expect or the services provided by external agencies such as the Ottawa Distress Centre or Mental Health Crisis Line.
Outcome	Place request for city service or refer caller to external agency
Gaps	No mental health training for call takers Call takers are given a list of agencies and phone numbers to refer people to but no direction on which agency is best for each situation (e.g., Ottawa Distress Centre or the Mental Health Crisis Line)
Performance metrics	Detailed performance metrics for individual agents including calls per hour, and time on not-ready mode. Metrics for 311 include average wait time and longest wait time. Their mandate is for 311 to answer 80% of their calls in 120 seconds or less. Midway through 2022, they are

	sitting at 83%.
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	All calls are recorded and 311 currently selects a small number of calls (< 1%) for each call taker and grades them
Misdirected call tracking	None

Distress Centre of Ottawa and Region

The Distress Centre of Ottawa and Region is a non-profit charitable organization that operates both a distress line and crisis line in the City of Ottawa and Champlain region. The Distress Centre offers 24/7 access by phone, with chat and text options available from 10am to 11pm. The Distress Centre operates with a core team of eight full-time employees who comprise the organization's management and administrative staff. An additional thirty part-time employees function as wellness check specialists, service assistants who conduct quality assurance tasks, overflow call takers, and experienced call takers who handle priority lines. The Distress Centre is reliant on its 216 dedicated volunteers for regular service provision and call taking. At minimum, there are always two to three responders working, with one individual answering chat and text messages and at least one bilingual support service worker.

Over the 2020 - 2021 fiscal year, Distress Centre volunteer responders replied to over 60,000 interactions. The Distress Centre is primarily funded by the City of Ottawa and United Way East Ontario with additional funding also provided by Ottawa hospitals. Outside the Ottawa region, the Distress Centre also provides services to the Northwest Territories and Nunavut through dedicated programs and crisis lines.

In addition to the Distress Centre's inbound crisis and distress lines, Distress Centre staff offer wellness checks in the form of a telephone outreach service. These wellness checks are offered to patients who were recently discharged from an Ottawa hospital or following a visit to an Emergency Department for a mental health issue. The goal of the wellness checks is to ensure patients are functioning well, following their discharge plan, and have access to the necessary resources and support networks.

The Distress Centre partners with The Ottawa Hospital Mobile Crisis Team and calls can be transferred to the mobile crisis team when in-person support is needed. The mobile crisis team can respond in person without the intrusive presence and lights and sirens that accompany the police or/and paramedic response. The Distress Centre serves as the primary public intake point for the mobile crisis team and approximately 10% of Distress Centre calls are transferred to the mobile crisis team.

The Distress Centre works closely with the Ottawa Paramedic Service. Calls may be transferred to the Distress Centre from the paramedic service and responders at the Distress Centre will talk to the caller while paramedics are dispatched. Paramedics are dispatched for all calls referred from the Ottawa Paramedic Service to the Distress Centre unless the caller requests that they be cancelled.

In addition to the mobile crisis team, the Distress Centre can make a wide range of referrals. Where suicide intervention is required, calls are directly transferred to police. In other situations, callers can be referred to

Counseling Connect which provides free access to same-day or next-day phone or video counselling sessions. The Distress Centre can also make a referral to one of their many community partner organizations with approximately 4,000 resources across all the regions they serve.

Table 11: Distress Centre of Ottawa and Region Data Collection Summary

Information Request	Response Detail
Script	No script used
Service Languages	English and French with access to a translation line for additional languages
Specialized response for youth and children mental health and substance use calls	Responders take calls from both youth and adults and have youth specific resources available for referrals.
Training	Volunteer call takers are provided 60 hours of training including de-escalation, diversity, and cultural training. Volunteers are asked to donate a minimum of 200 hours of service in a year, or four shifts per month. Volunteers undergo a rigorous recruitment process which includes reference checks. Only about one in three applicants successfully complete the training and are approved for volunteer work.
24/7 service provision	Yes
Referral for follow-up process and alternatives	Approximately 10% of calls to the Distress Centre are transferred directly to The Ottawa Hospital Mobile Crisis Team for in-person crisis support. Calls requiring suicide intervention are transferred to police. Referrals are provided to a range of community partner organizations. The Distress Centre also provides wellness checks and follow-up calls when individuals are discharged from the hospital or an Emergency Department for a mental health related visit.
Classification of call types related to mental health and substance use	Calls are classified by type of call including distress, crisis, support, information, and third person. Presenting issues are tracked such as mental health issues, suicidality, abuse / violence, relationships, isolation / loneliness, and more. Call diagnostics break down mental health related calls further and include the category of mental health issue presenting such as anxiety / panic disorder, eating disorder, mood disorder, and more. Suicide prevention is tracked using categories including self-abuse / harm, attempt commenced, moderate-to-high risk, ideation, prior suicidal behaviour, and survivor of suicide.

Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	Suicide prevention is tracked using categories including self-abuse / harm, attempt commenced, moderate-to-high risk, ideation, prior suicidal behaviour, and survivor of suicide. Presenting issues such as suicidal attempts or violence would trigger a police response. Other issues are not tracked on a basis of acuity.
Call Tracing Technology	Information not available.
Collection of race, ethnicity, age, geolocation	Age and race are collected. Select data from the 2020 – 2021 fiscal year includes: • Almost 3% of callers were Indigenous, Metis, or Inuit • More than 8% were from multicultural communities • More than 53% of callers were women • 7% of callers were youth between the ages of 16 and 24
Constraints	Call centre capacity, availability of volunteers
Outcome	Call is transferred or referral is made
Gaps	Lack of awareness in the public and other mental health agencies on the Distress Centre's role and services
Performance metrics	Number of calls, service outcomes
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	Calls are recorded so they can be referred to. Responders can also make notes for follow-ups or refer to previous calls for context.
Misdirected call tracking	No

Youth Services Bureau

The Youth Service Bureau (YSB) is the main service provider for youth in crisis. YSB operates a crisis line for youth that is the first point of contact for many youths in crisis, as well as parents or caregivers of youth in crisis. The crisis line also served as an access point for the YSB mobile crisis team to be dispatched when it was operating prior to the pandemic, or for referrals to other YSB services such as counselling. The crisis line and mobile crisis team worked collaboratively with police and the mobile crisis team would come and take over for police when available

and where there was no risk. Police may also be called by the crisis line or mobile crisis team in situations where there is imminent danger. The mobile crisis team stopped operating at the start of the pandemic and has yet to resume operations. Previously, the mobile crisis team consisted of a single team working from 2:00pm to 10:00pm and responded to calls when available.

Table 12: Youth Services Bureau Data Collection Summary

Information Request	Response Detail
Script	No script used
Service Languages	English and French
Specialized response for youth and children mental health and substance use calls	Services are directed specifically to children and youth
Training	Staff receive suicide prevention training and regularly attend sessions on specific topics
24/7 service provision	Yes
Referral for follow-up process and alternatives	Referrals are made to the mobile crisis team and other YSB services such as counseling. The police are engaged in cases of emergency.
Classification of call types related to mental health and substance use	Suicide screening questions are used with all callers to determine suicide risk. Presenting issues are also tracked.
Call flow	
Definition used to determine levels of acuity of mental health and substance use calls	Call acuity is not tracked.
Call Tracing Technology	The crisis line tracks postal codes for calls and can show locations.
Collection of race, ethnicity, age, geolocation	Demographics and identity-based data are tracked. A data base is used to collect names and basic self-identifying info.
Constraints	Challenges recruiting and retaining staff

	Demand levels and the complexity of cases are increasing The social determinants of health (e.g., proper housing, poverty, etc.) influence youth in crisis but are largely outside of YSB control
Outcome	Referral is made, crisis counseling provided, or mobile crisis team dispatched
Gaps	Long wait times for services such as counseling YSB mobile crisis team not currently operating since the pandemic and only operating 2:00pm to 10:00pm prior to the pandemic Lack of capacity leading to an inability to address root problems
Performance metrics	Collect length of call, presenting issue, ASQ (suicide screener)
Differences in processes for diverse Indigenous, ethno-racial and ethno-cultural communities re: mental health and substance use calls	None
Quality Assurance Program	Information not available.
Misdirected call tracking	No

AccessMHA

AccessMHA is a coordinated access point for mental health and substance use services in the Ottawa region. AccessMHA partners with a range of hospital-based and community services including mental health, substance use and addiction treatment. Services are provided in English and French to individuals aged 16 and older.

AccessMHA functions using two pathways including a self-referral online to book an initial appointment and a primary care referral pathway. Individuals seeking help are scheduled for a 30-minute initial appointment to determine which services are best for them. After the first call, individuals are connected to the appropriate services for their needs.

AccessMHA is not a crisis service and directs persons in crisis to contact the Distress Centre or 911 for immediate assistance. Initial appointments with AccessMHA can take two weeks or longer to schedule depending on the current demand. As it is not a crisis service, this report includes AccessMHA for context but does not describe its operations in full detail.

Intake Summary

As described in earlier sections, the 911 response system including the police and paramedic services is currently the only system able to respond to mental health crises 24 hours per day. Further, the police are relied on in situations where safety is a concern including where weapons are present, an individual is suicidal, or in cases where a person

is highly distressed or acutely psychotic. The table below provides a summary of the availability of phone and in-person responses to mental health crises in Ottawa, listed by intake agency.

Table 13: Ottawa Intake Agency Summary

	PSAP (911)	Police	Paramedics	211	311	Distress Centre	YSB
Phone Access Hours	24/7	24/7	24/7	24/7 (7:00am to 7:00pm based in Ottawa, answered from out-of-region overnight)	24/7	24/7	24/7
Can agency initiate in-person response to crisis?	Yes	Yes	Yes	No	No	Yes (through transfer to Ottawa Hospital Mobile Crisis Team)	No
In-Person response hours	N/A	24/7	24/7	N/A	N/A	9:00am to 9:00pm (OH Mobile Crisis Team)	N/A (formerly 2:00pm to 10:00pm)
Can call taker provide community referrals?	No	No	No	Yes (limited information on referral agencies)	Yes (limited in scope)	Yes	Yes
Specialized response for children and youth	No	No	No	No	No	No	Yes
Collection of age, race, or ethnicity data	No	No	No	No	No	Yes	Yes

Callers seeking to access a mental health crisis response primarily contacted the Distress Centre and 911. The table below outlines the annual calls identified as mental health related. While this table can provide an order of magnitude estimate of the demand for mental health crisis response, there are several caveats to the data. First, this data only captures the police and paramedic occurrences where a mental health-related issue was the primary issue reported. This likely leads to the numbers significantly underrepresenting the true demand for service. Second, the

Card 16 "Behavioural" classification used by the paramedics does not capture overdoses and the Card 25 overdose data is not useful as it combines overdoses with other incidents such as accidental poisonings from any cause. Further, none of the data indicates the urgency or acuity of these calls to demonstrate whether the calls were appropriately directed. Mental health-related calls to 311 are not tracked and MNP did not receive statistics on the volume of calls to YSB.

Table 14: Summary of In-bound Demand for Mental Health Crisis Response

Agency	Annual Calls Identified as Mental Health Related	Notes
Ottawa Distress Centre	60,366	Includes text and chat interactions; 2020 – 2021 Fiscal Year; anecdotal reports indicate approximately 10% of calls are then transferred to Ottawa Hospital Mobile Crisis Team
Ottawa Police Service	3,918	Calls originated through 911 system; 2021 calendar year
Ottawa Paramedic Service	2,835	Card 16 "Behavioural" incidents; annual average over three years 2019 – 2021. A recent internal review of paramedic call documentation over a limited time revealed 25 calls per day have a mental health component. This could indicate closer to 9,000 calls annually are mental health related.
211 Eastern Ontario	1,050	April 1, 2021, to March 31, 2022

Response

The sections below outline the current response options available to respond to mental health crises in Ottawa. These include both physical responses, as well as virtual or phone service responses.

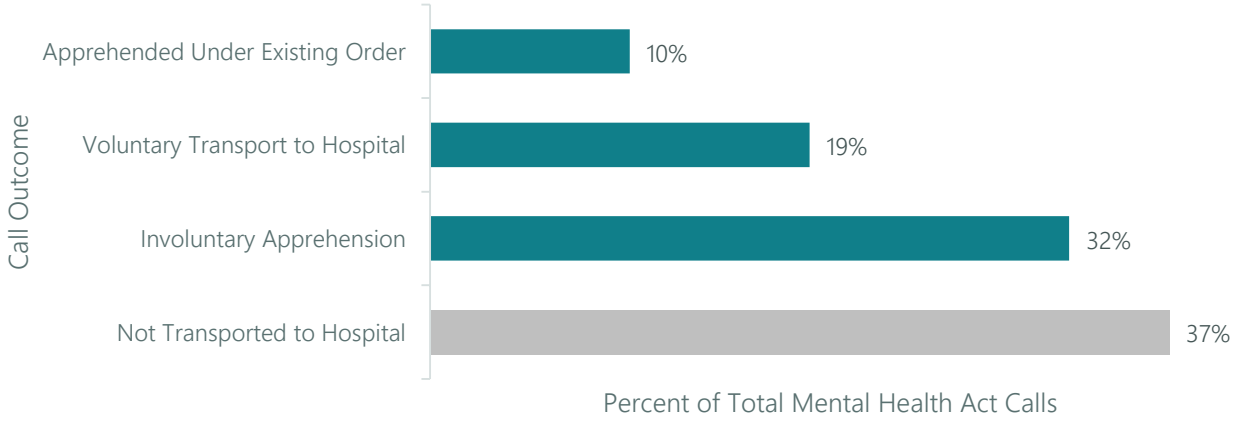
Ottawa Police Service

The Ottawa Police Service (OPS) is currently the only agency in Ottawa with authority under the Ontario Mental Health Act to involuntarily transport individuals for examination by a physician. Under the Ontario Mental Health Act, police are compelled to apprehend and bring a person for examination by a physician when they have threatened or attempted to harm self or others, show a lack of competence to care for themselves, or have behaved violently towards another person. The transportation can be done via ambulance or by police depending on the person's behaviour with their personal safety and the safety of the first responders as a priority.

Currently, the OPS deploys general patrol officers when police dispatch determines that an in-person response is needed. The OPS maintains a Mental Health Unit (MHU) whose officers have additional mental health training and experience. The MHU provides follow-up services and may advise dispatch on whether an officer response is required but does not typically provide an initial response to mental health crisis calls. If there is a risk of harm, the OPS may also request the presence of paramedics at the scene to assist once the officers have deemed the area safe.

The figure below outlines the outcomes of OPS mental health calls (as recorded in police Health IM software) in 2021. As shown below, 61% of mental health calls responded to by the OPS resulted in transportation to hospital, either voluntarily or through apprehension.

Figure 11: 2021 OPS Mental Health Call Outcomes (Health IM)



Ottawa Police Service Mental Health Crisis Demand

The OPS recorded a total of 337,364 occurrences in 2021 of which 8,528 (2.5%) were Mental Health Act occurrences. These Mental Health Act occurrences are detailed in the table below. An additional 203 occurrences in 2021 were cited as overdoses and 99 as suicide or attempted suicide. Numerous other call types can often involve individuals struggling with mental health and substance use, but this is not captured in the primary occurrence type and is frequently only noted in the qualitative supplementary officer notes or not captured at all.

Table 15: OPS Occurrences Labeled with Connection to Mental Health Act

Occurrence	2019	2020	2021
Mental Health Act (In Progress)	5,387	5,245	5,594
Mental Health Act (Mobile Response)	1,395	1,352	1,613
Mental Health Act (Form to be executed)	814	781	894
Mental Health Act	383	312	349
Mental Health Act - Imminent Danger (In Progress)	89	56	43
Mental Health Act (Report)	34	17	10
MHA - Other	19	8	10
MHA Form 2	11	13	9
MHA SEC. 17 Apprehension	2	4	4
MHA Hospital Voluntary	4	2	1
MHA Form 1	4	2	1

Occurrence	2019	2020	2021
Total Mental Health Act Occurrences (% of all occurrences)	**8,142 (2.4%)**	**7,792 (2.5%)**	**8,528 (2.5%)**
Total OPS Occurrences – All Types	**345,763**	**314,322**	**337,364**

Determining the actual number of calls involving mental health factors would require extensive call and occurrence data analysis including reviewing individual reporting from calls and conducting keyword searches on the qualitative reporting. Because this was outside the scope of this project, the MNP team decided to apply the findings from the University of Western Ontario to the OPS occurrences and provide the Guiding Council with a rough, preliminary estimate of the number of calls for OPS involving mental health and/or substance use factors.

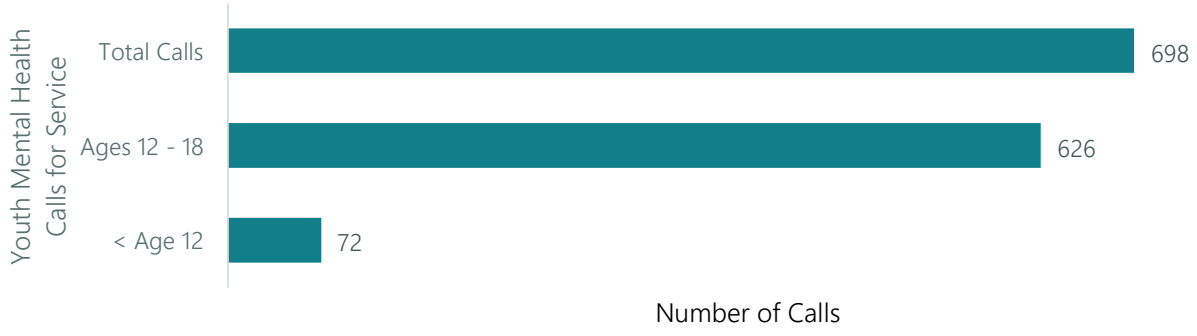
In the University of Western Ontario study cited earlier, 0.9% of total calls for service received a mental health or suicide classification. Using a keyword search methodology which included manual review and analysis of all calls for service (not only those labelled with mental health as a primary occurrence type), that study identified mental health and substance use factors in 10.8% of total calls for service. While the University of Western Ontario study breaks down the rates of mental health and substance use factors further by occurrence type, these are not directly comparable to Ottawa due to differences in classification and occurrence types.

While differences between cities can be expected, MNP believes the University of Western Ontario study could provide an order-of-magnitude estimate that can be applied to Ottawa. Using a 10.8% rate for the presence of mental health and substance use factors as in the study could reasonably provide a sense of the magnitude of the current demand in Ottawa for mental health and substance use responses. Following this application, potentially more than 36,000 occurrences in 2021 involved mental health or substance use as primary or contributing factors.

Youth Mental Health Demand

In 2021, the OPS received 698 calls for service that were identified as youth mental health related. Of the 698 calls for service, 388 (56%) were from first-time callers and the remaining were from repeat callers. Depression and anxiety are the most common issues recorded; however, many youths face multiple issues. The Mental Health Unit follows up with youth experiencing mental health crises and attempts to work with their families to connect them with resources. The figure below outlines the breakdown in youth calls for service and whether the youth are under 12 or over 12 years of age.

Figure 12: 2021 OPS Youth Mental Health Calls for Service



Ottawa Paramedic Service

The Ottawa Paramedic Service responds to both mental health-related calls and overdose calls. As noted earlier, most mental health-related calls are categorized as "Behavioural" unless there is a physical injury or overdose in progress. The paramedic service reported 8,504 incidents classified as behavioural between 2019 and 2021 for an annual average of 2,834. A recent internal review of paramedic call documentation over a limited time revealed 25 calls per day have a mental health component. This could indicate closer to 9,000 calls annually are mental health related. Across all call types, the paramedic service recorded approximately 132,000 responses in 2020 and 145,000 responses in 2021 (each vehicle dispatched counts as a 'response').

The paramedic service typically sends frontline paramedics to attend all types of mental health calls. In some cases, the Mental Wellbeing Response Team may self-assign to incoming 911 calls or may respond after a frontline paramedic response.

The Ottawa Paramedic Service has several partnerships which impact the delivery of mental health services and the range of response options to mental health crisis. The first partnership is a joint pilot project with The Ottawa Hospital Mobile Crisis Team where a paramedic and crisis worker travel together and respond to a person in mental health crisis. This pilot is described in the earlier intake section and applies to non-violent and non-criminal calls.

The paramedic service also partners with Ottawa Inner City Health, Shepherds of Good Hope and the OPS on the Targeted Engagement and Diversion (TED) program. This program provides care for individuals who routinely utilize hospital emergency services for mental health and substance use reasons. The TED program offers a safe environment for monitoring while individuals are under the influence, and provides easy access to care for substance use, physical health problems, and mental illness. The TED program targets harm reduction as well as diversion from hospitals.[8]

Distress Centre of Ottawa and Region

The Distress Centre of Ottawa and Region serves as both an intake point for calls and a response to mental health crisis. The Distress Centre can both handle calls relating to mental health distress and crisis and make referrals to external agencies and providers. Additional details on the Distress Centre are included in the Distress Centre intake section earlier in this report.

The following response services are provided within Ottawa and the Champlain region:

- 24/7 Crisis Line (English and French)
- 24/7 Distress Line (English and French)
- Chat and Text Services (10:00am-11:00pm, 7 days a week, 365 days a year, English only)
- Wellness Checks are offered at Ottawa hospitals following a hospitalization or a visit to an emergency department for a mental health-related issue. The goal of this program is to reduce emergency room visits. When released from a medical health environment for mental health reasons, patients receive a voluntary offer for a distress centre responder to provide them with a follow-up call. The Distress Centre responders will call the person up to three times over a period of days to check in on them. The Distress Centre tracks the number of requests and calls to the patients along with the outcomes of the wellness checks.
- OC Transpo: Phones are located on transit buses and trains that go directly to the Distress Centre. This

8 https://www.ottawainnercityhealth.ca/programs/

initiative followed a similar initiative implemented in Toronto between their transit provider and distress centre.

- Educational programs: The Distress Centre provides training to government and community agencies including Distress Centre workshops, suicide intervention training, and safeTALK training.

The Ottawa Hospital Mobile Crisis Team

The Ottawa Hospital Mobile Crisis Team (MCT) is a community-based outreach team that is designed to provide a rapid assessment of and stabilization for individuals in the community who are in crisis. The MCT currently operates from 9:00am to 9:00pm, 365 days per year. The team operates with eight staff per shift including three registered nurses, and five crisis counsellors. The Distress Centre serves as the primary intake point for the MCT with rough estimates indicating approximately 10% of Distress Centre calls are being directed to the MCT. The MCT also receives referrals from other sources including family physicians, schools, and organizations such as Ottawa Community Housing. While based out of The Ottawa Hospital, the MCT works with all other Ottawa hospitals as well.

The MCT has a working partnership with the Ottawa Police Service's Mental Health Unit (MHU) which has existed for twenty years. There is a Memorandum of Understanding (MOU) in place that allows for information sharing between both agencies with access to health data limited to officers in the MHU. Although this partnership has been described as a 'reactive', this partnership can also be proactive in the sense that they also keep people from becoming ill to the point where they must go to the hospital. The MCT and the MHU meet virtually for 'rounds' at the start of every day and decisions are made as to whether either team should respond on their own or if it is appropriate for them to respond together. Members of the MCT feel the relationship and support from the MHU is vital as there are calls where they as civilians do not feel comfortable or safe going without the support of a police office. Anecdotal reports suggest that the MHU responds jointly to approximately 20% of MCT visits but data was not available to confirm this estimate.

The MCT recently began a pilot project with the Ottawa Paramedic Service that involves pairing a MCT crisis counsellor with a paramedic. Their role is to look at and respond when appropriate, to calls for service involving persons experiencing a mental health crisis. MCT also operates 11 Crisis Stabilization Beds located at 5 different locations in Ottawa.

The table below highlights the number of individuals served through fiscal year 2021 – 22. Historical data was not available for earlier years, however, the MCT reported an increase in demand during COVID and as a result, identified staffing resource limitations as a constraint.

Table 16: Ottawa Hospital Mobile Crisis Team FY 2021-22 Statistics

	FY 2021-2022
Non-Face-to-Face Visits	17,986
Total Individuals Served	3,746
Referrals from Ottawa Police	213
Repeat Referrals	20

Youth Services Bureau

The Youth Service Bureau (YSB) is the main service provider for youth in crisis. Additional information on YSB's crisis line is included in the earlier intake section of this report. YSB offers the following response services for youth in the Ottawa region:

- Crisis line: Crisis team operates a 24/7 bilingual crisis line and crisis chat service
- Mobile crisis team: Previously available 2:00pm to 10:00pm, 7days a week, but not currently operating since the pandemic. In the past, the mobile crisis team consisted of a single team who would respond in person as available to referrals from the crisis line.
- Mental health walk-in clinic: Access to a registered psychotherapist two days per week for youth ages 12 to 20. The clinic serves as a transition point to counselling for youth.
- Counselling services: Provided on an ongoing basis
- Bridges program: Partnership working with youth ages 12 to 17. This program is run by a multi-disciplinary team for high-risk youth and those with complex mental health issues
- Community services including a drop-in centre, male shelter, female shelter, and transitional housing.
- Youth justice department: Work with youth in the mental health court system.
- Employment services

YSB employs staff who specialize in areas of mental health including eating disorders and trauma. While crisis line services are available throughout the Ottawa region, in-person services are limited to YSB's central Ottawa location.

Response Summary

Across Ottawa, the police, paramedics, and mobile crisis team are the primary providers of an in-person response to mental health crises. The table below summarizes key response information across the agencies described above.

Table 17: Ottawa Crisis Response Agency Summary

	Police	Paramedics	Distress Centre	Mobile Crisis Team	YSB
In-Person Crisis Response	Yes	Yes	No	Yes	No
In-Person Response Hours	24/7	24/7	N/A	9:00am to 9:00pm Daily	N/A
In-Person Response Capacity	All frontline officers	All frontline paramedics	N/A	3 RN's 5 Crisis Counsellors	N/A
Phone-based Crisis Counseling	No	No	Yes	Yes	Yes

	Police	Paramedics	Distress Centre	Mobile Crisis Team	YSB
Follow-Up Provided	OPS Mental Health (MHU) Unit follows-up	Distress Centre or Mobile Crisis Team (post-hospital wellness checks or visits)	Transfer to mobile crisis team or referral to community providers; wellness checks	Team follows-up directly, refers to MHU, and/or provides community referrals	YSB services such as ongoing counseling
Areas Served	Entire Ottawa region	Entire Ottawa region	Entire Ottawa region	Entire Ottawa region	Crisis line serves the Ottawa region; in-person services only provided at YSB locations
In-Person Response Time	Ranges from minutes to over an hour based on priority level assigned and unit availability.	Ranges from minutes to over an hour based on priority level assigned and unit availability.	N/A	Response time varies based on the priority of calls. High priority calls may be seen the same day while others are prioritized and scheduled at morning rounds.	N/A

Outcomes

Following a response to a mental health or substance use crisis, several outcomes are possible including the person being taken into custody under the Mental Health Act (MHA) and involuntarily transported to hospital, voluntary transport or self-admission to hospital, or referral to another agency or follow-up services. The sections below describe these outcomes in more detail. A crisis call may also result in an individual declining further services or referrals, or in the crisis call being cancelled with no further actions taken.

Hospital

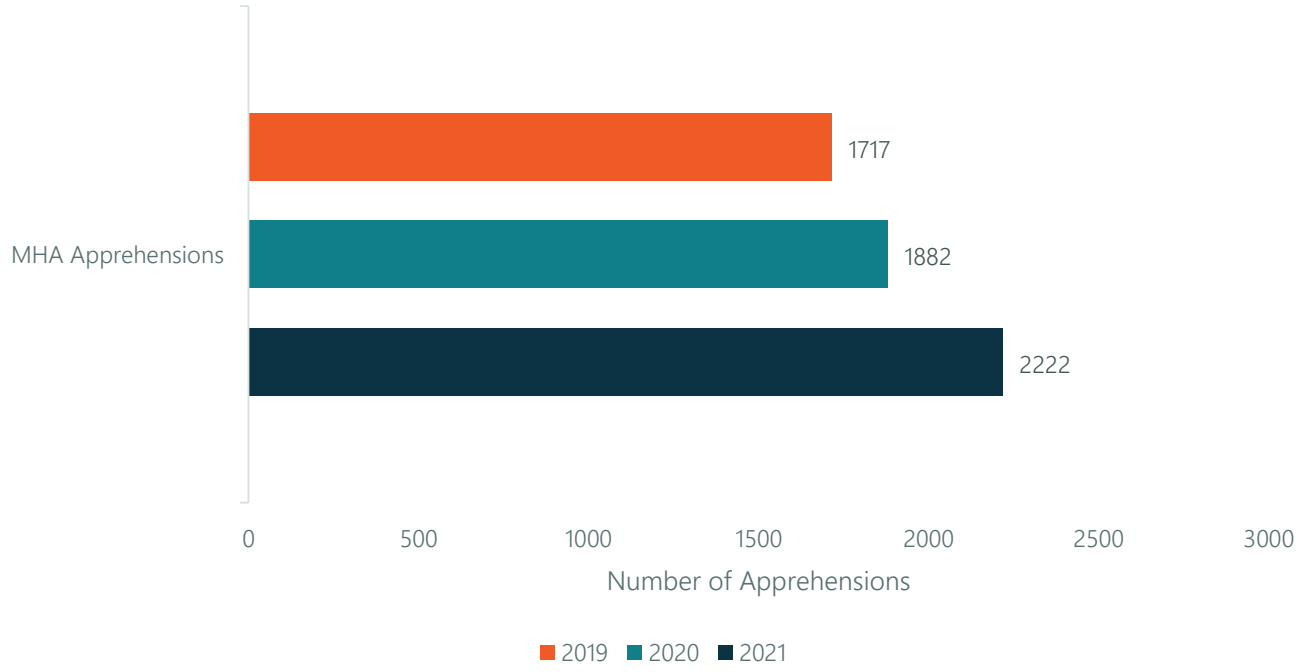
Following the initial mental health crisis response, individuals may be transported to hospital by either police or paramedics, or self-report to a hospital for care. Upon being seen by a physician, patients may receive one or more of the following outcomes or services:

- Admitted to hospital for care
- Provided community referrals or information on resources
- Discharge or release from hospital
- Offered a follow-up call from the Distress Centre

Transport to the hospital by police may be either on a voluntary or in-voluntary basis. The Ottawa Police Service (OPS) is the only agency with authority to involuntarily transport individuals to hospital. Under the Ontario Mental Health Act, OPS officers may take a person into custody and transport them for examination by a physician when the person has threatened or attempted harm to self or others, shown a lack of competence to care for themselves, or has behaved violently towards another person. When a person is taken into custody under the Mental Health Act, police transport the person to hospital and must then wait with the individual until they can be seen by a physician, often resulting in lengthy wait times for the police officers at the hospital as they accompany the patient.

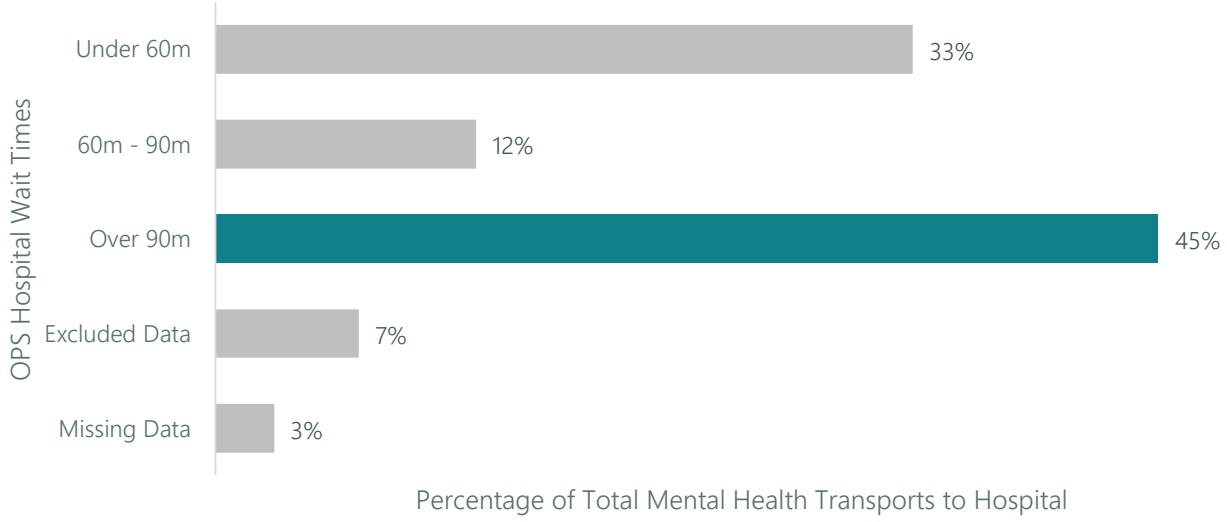
The use of the Mental Health Act to involuntarily transport a person for medical examination may be initiated by a police officer responding to a mental health crisis call. Alternately, a health care provider may submit a mental health form which compels the police to take the individual into custody and transport them for a medical examination. The outcome for both pathways is the same and results in an examination by a physician. The medical exam may then lead to a longer-term hospitalization, immediate discharge from hospital, or a range of other treatment options. The figure below outlines the number of Mental Health Act apprehensions in Ottawa between 2019 and 2021.

Figure 13: Ottawa Municipal Mental Health Act (MHA) Apprehensions (Statistics Canada)



Wait times have been reported to be a significant barrier facing police or paramedics when transporting patients to hospital. Both services are required to stay with the patient until they can turn the patient over to the care of a physician. The figure below outlines the 2021 hospital wait times recorded by the OPS. Of note, 45% of hospital transports by police resulted in police waiting 90 minutes or more at hospital.

Figure 14: 2021 Ottawa Police Service Hospital Wait Times - Mental Health Transport to Hospital (Health IM)



Referral

When mental health and crisis calls do not result in arrest or hospitalization, they typically result in a referral to follow-up services or community resources. This could include any of the follow-up services or prevention services described in the sections below, or other community organizations or government agencies. A portion of calls also end in the cancellation of the call or visit with no services provided.

Follow-up Services

Mental Health Unit

The Mental Health Unit (MHU) is a dedicated unit of the OPS which follows-up on mental health related calls and incidents. The unit is comprised of four officers and one sergeant who operate on 8am to 8pm, 365 days per year, mirroring the schedule of The Ottawa Hospital Mobile Crisis Team. In addition to its regular complement of officers, the MHU utilizes accommodated officers with four accommodated officers currently assisting the MHU in either full- or part-time capacities. The MHU does not typically respond to 911 calls or real-time crisis calls and rather performs a follow-up function based on referrals and calls with identified mental health components. MHU officers respond in plainclothes and unmarked vehicles.

The MHU works very closely with The Ottawa Hospital Mobile Crisis Team and conducts joint rounds meetings with them every morning via Teams. The MHU has a memorandum of understanding (MOU) with the team through The Ottawa Hospital and maintains tight restrictions around personal health information. As part of the MOU, health information cannot be shared with the wider members of the OPS and is kept between members of the MHU. Depending on the situation and client needs, members of the MHU and Mobile Crisis Team may deploy jointly or separately.

MHU officers have access to Health IM reports, and typically review 15 to 20 Health IM reports daily. The Health IM software assists officers across the OPS in articulating why someone needs to go to hospital and is used for every

police hospital transport including Form 1 and Form 2 pickups. The Health IM software also provides officers with statistics and baseline data including factors from past interactions such as suicide risk or aggression.

The MHU comprises a relatively small portion of the OPS mental health crisis response due to the size of the team relative to the police service and population served. The unit was formed at its current complement size of four officers and one sergeant approximately 20 years ago and maintained this size since then. At the time, it was recommended that the unit include ten officers and two sergeants.

CMHA Ottawa

CMHA Ottawa operates the Mental Health Community Support Services (MHCSS) program for individuals with severe and persistent mental illness. The program is designed to provide case management for individuals who lack supports and needs assistance using resources appropriately. This could include frequent users of services who are over-using emergency services and not gaining access to the appropriate long-term supports. CMHA services are primarily provided during business hours with limited availability of some services on weekends.

CMHA Ottawa provides outreach services including court outreach, hospital outreach, and housing outreach:[9]

- Court outreach offers support and works to divert individuals from the justice system toward mental health court and services in the community. Police can provide referrals and information to CMHA but do not receive information back. The program has defined criteria for the program and has limited capacity which cannot always meet demand.
- Hospital outreach helps people integrate back into the community following discharge from psychiatric hospitalization and connects them to appropriate services
- Housing outreach works with individuals living in shelters to find and maintain housing. A dedicated Housing Impact Team also works specifically with the chronically homeless.

Ottawa Paramedic Service

The Ottawa Paramedic Service is primarily a response-oriented agency with paramedics providing the medical response to a crisis. Follow-up care to mental health calls will typically be provided by mental health professionals, not paramedics. Follow-up services could include the Mobile Crisis Team and Distress Centre through the partnerships and referral processes described earlier.

Other follow-up services provided by the paramedic service include the community paramedicine program. Specific to mental health, this program can provide health education, assistance with health care system navigation, and referrals to community resources.

The Ottawa Paramedic Service partners with Ottawa Inner-City Health and other agencies on the Targeted Engagement Diversion (TED) program. This program was meant for individuals prone to substance use but also serves those suffering from mental health crisis. The TED program includes 60 beds total of which 6 are observation beds under the care of a nurse. The TED program also operates a safe consumption site for substance use under observation.

[9] *https://ottawa.cmha.ca/programs-services/community-support-services/*

Ottawa Inner City Health

Ottawa Inner City Health (OICH) was created by a partnership of organizations that serve the homeless with the aim of improving health and access to healthcare for people who are chronically homeless in Ottawa. OICH serves individuals with complex needs including severe mental illness and chronic substance use. OICH operates a range of programs including the following:

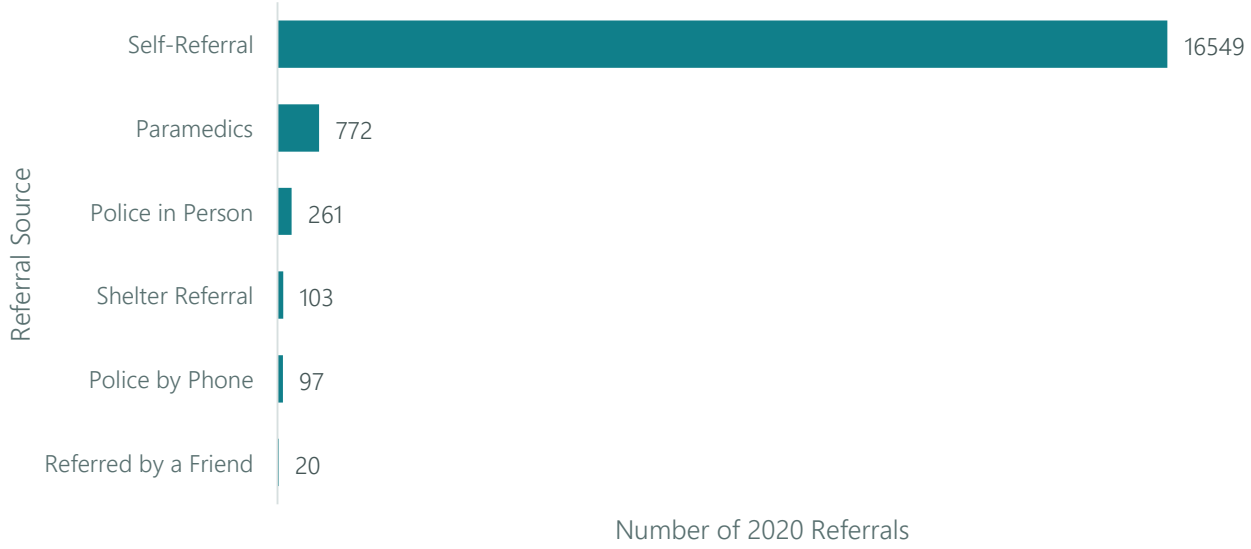
- Safe consumption
- Targeted Engagement and Diversion Program
- Transitional housing
- Supportive housing
- Primary care clinic
- Outreach van
- Access to psychiatry, mental health nurses, and nurse practitioner

Targeted Engagement and Diversion Program

OICH has been operating the Targeted Engagement and Diversion (TED) program since January 2013 in partnership with the Ottawa Paramedic Service, Shepherds of Good Hope, and OPS. The program's primary mandate is to respond to clients in crisis and engage in proactive diversion of emergency room visits by the program's clients. The intended service population is homeless men and women under the influence of drugs or alcohol who would otherwise present frequently to emergency services. The TED program includes 60 beds, six of which are under the observation of a nurse. Clients must be cleared by a nurse to use one of the beds not under observation. The program is located next to the OICH safe consumption site, enabling close access for clients using the site.

Most of the TED program's clients self-refer to the program but police and paramedics regularly use the program to divert clients from police cells for sobering, or hospital for either mental health crises or substance use. The figure below outlines the referral sources for clients in 2020.

Figure 15: 2020 TED Program Use by Referral Source



TED program clients are often frequent service users who regularly rely on the supports provided. The figure below outlines the number of admissions per individual client, including 85 different clients who used TED services at least 50 times per year.

Figure 16: Number of TED Admissions per Client in 2020

Prevention Services

Mental health crisis prevention services are provided by a wide range of agencies ranging from health centres to community resource centres, counselling resources and other non-profit organizations. The prevention services are characterized by a focus on lower acuity mental health issues and are largely fragmented across a broad range of providers. The availability of services is also dependent to some extent on the physical geography and locations of services relative to the persons seeking care with some services only located in limited central sites.

The following list of prevention services is not comprehensive but provides a view of the scope and types of service providers serving the community:

- Wrap-around services include:
    - 35 Safe beds; this compares to an estimated need for 50 safe beds
    - 5 Assertive Community Treatment (ACT) teams; these teams typically have long waitlists because of high demand and their clients require long periods of service for very acute mental health and substance use issues
    - Intensive case management services coordinate the necessary supports for individuals with severe mental health and substance use issues but individuals face an approximately 3-year wait list
    - System navigators based out of Pinecrest Queensway Community Health Centre and Southeast Ottawa Community Health Centre
    - Substance use services: Sandy Hill Community Health Centre provides harm reduction services, a drop-in, safe consumption site; Ottawa Inner City Health team provides harm reduction, patient care, and outreach in partnerships with other Ottawa service providers
- Community-based approaches to mental health crisis including prevention and early intervention programs

and efforts such as community houses
- Targeted efforts toward more culturally appropriate mental health service access: Ottawa Newcomer Health Centre and Somerset West CHC's multicultural health care navigator program has expanded access
- Counselling services including Counselling Connect

Service Gaps and Limitations

While MNP's findings relating to service gaps are not comprehensive, numerous service gaps and limitations became clear through MNP's interviews with stakeholders and background research including documents such as the Coalition of Community Health and Resource Centres of Ottawa's publication entitled *Rethinking Community Safety in Ottawa*.[10] Mental health and substance use services in Ottawa are delivered by a large system of service providers. Within this system, MNP has identified the following gaps or service limitations:

- The police currently have no alternative response options outside of a general patrol response for mid- to high-acuity mental health crisis calls. Community crisis response options are currently focused on low acuity crisis response or as a secondary response following police intervention.
- The OPS Mental Health Unit is under-resourced relative to comparable cities and is not a crisis response service.
- No mobile crisis response currently operating for children and youth.
- The delivery of mental health services is fragmented and there is a lack of coordination of services and information sharing between service providers.
- Mobile crisis and street outreach teams do not provide 24/7 services, with some limited in their response geography.
- There is a lack of community health centres east of the Rideau River.
- Eastern Ottawa lacks a safe injection site.

[10] *Coalition of Community Health and Resource Centres of Ottawa. (2021, October). Rethinking Community Safety in Ottawa. Retrieved June 15, 2022, from http://www.coalitionottawa.ca/media/114568/final-rethinking-community_saftey_in_ottawa.pdf*

Comparator Alternatives

Within the scope of this project, MNP was asked to examine four comparator jurisdictions including details of the alternative response models to mental health crisis outside of a general patrol police response. The four comparator cities include the Niagara Region, City of Toronto, City of Vancouver, and Eugene and Springfield Oregon.

Niagara Region

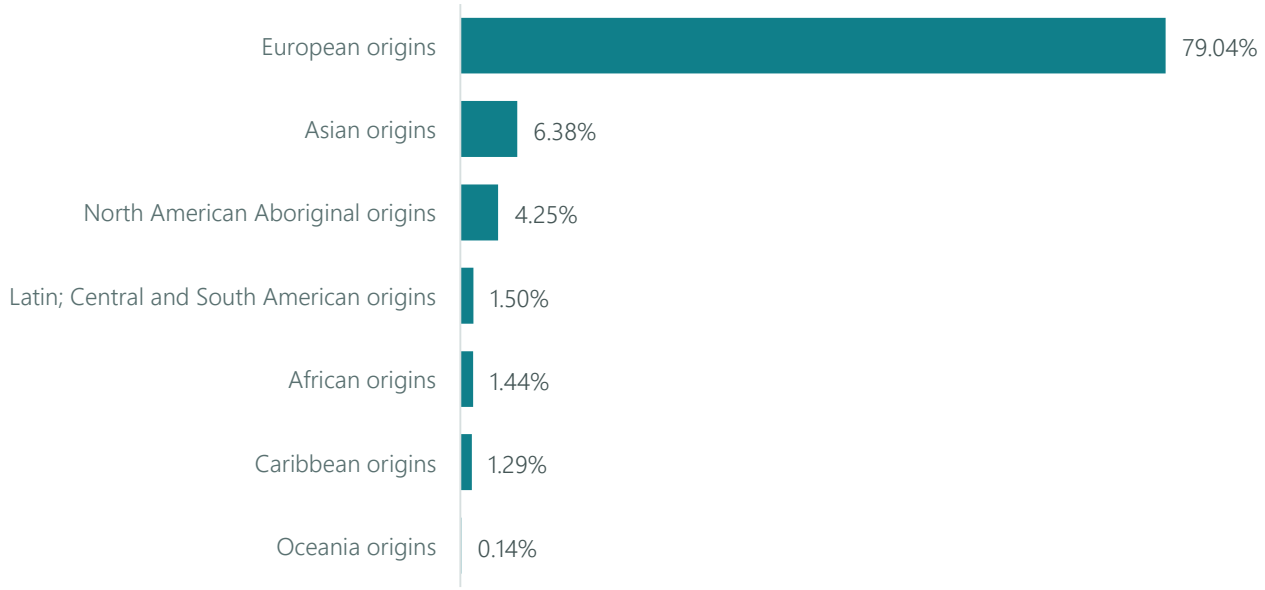
Profile

The Niagara Region has a population of 447,888. The land area of the rural municipality is approximately 1,853 square kilometres[11]. The regional municipality is composed of 12 municipalities with St. Catharines comprising almost 31% of the regional municipality's total population.

Figure 17 shows that the Niagara Region is not as ethnically diverse as the other Canadian comparative cities. 79% of the population identify as European. The Asian population is mostly represented by Chinese, East Indian, and Filipino people which collectively make up approximately 60% of the total Asian demographic.

Approximately 82% of the total Niagara Region indicated English as their first language. 14% of the region reported to have a non-official language as their mother tongue with Italian being the most noted in this category at 2.4%.

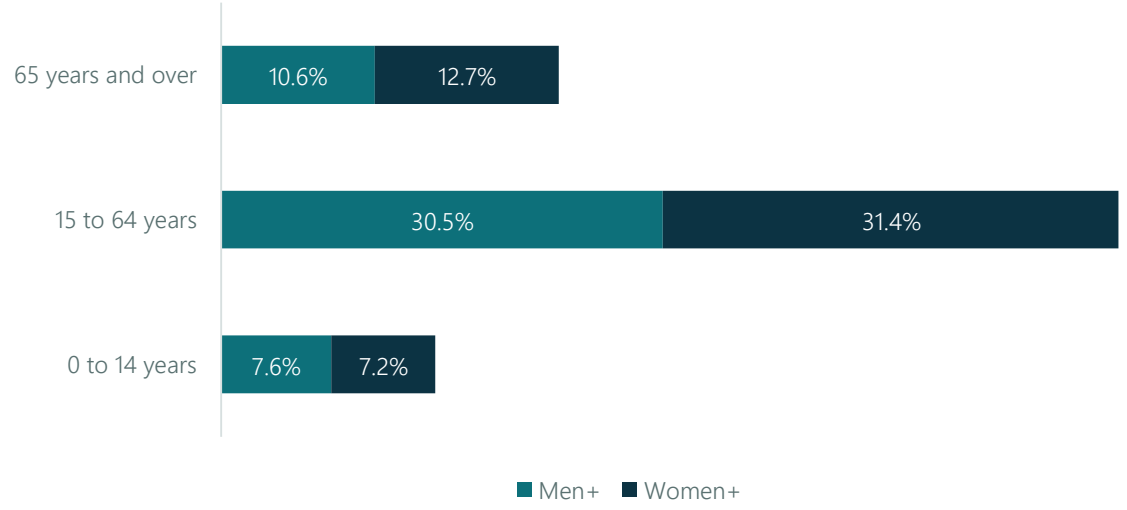
Figure 17: 2016 Census Profile, Ethnic Origin - Niagara Region



[11] *Statistics Canada. 2022. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released April 27, 2022.*
https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

Figure 18 depicts the Niagara Region's population by age group per 2021 census. The median age of the total population is 46.0. The highest proportion of individuals in this age group are in the range of 55 to 59 years old, contributing to 12.4% of the total 15-to-64-year age group.

*Figure 18: 2021 Census, Population by Age Group - Niagara Region**



**(+) indicates inclusion of some non-binary respondents*

Figure 19 depicts the urban and rural areas of the Niagara Region. Urban areas are mostly concentrated in the major population centres of St. Catharines, Niagara Falls, and Welland. It is estimated about 15% of the Niagara Region is urban and the remaining 85% is rural[12]. Figure 20 is the Niagara Regional Police Service district map to provide insight into the scope of service the police provide for the region[13].

[12] https://www.livinginniagarareport.com/living-in-niagara-2017/environment-2017/land-2/
[13] https://www.niagarapolice.ca/en/what-we-do/districtoperationspolicestationsmap.aspx

Figure 19: Niagara Region - Urban and Rural Area Map

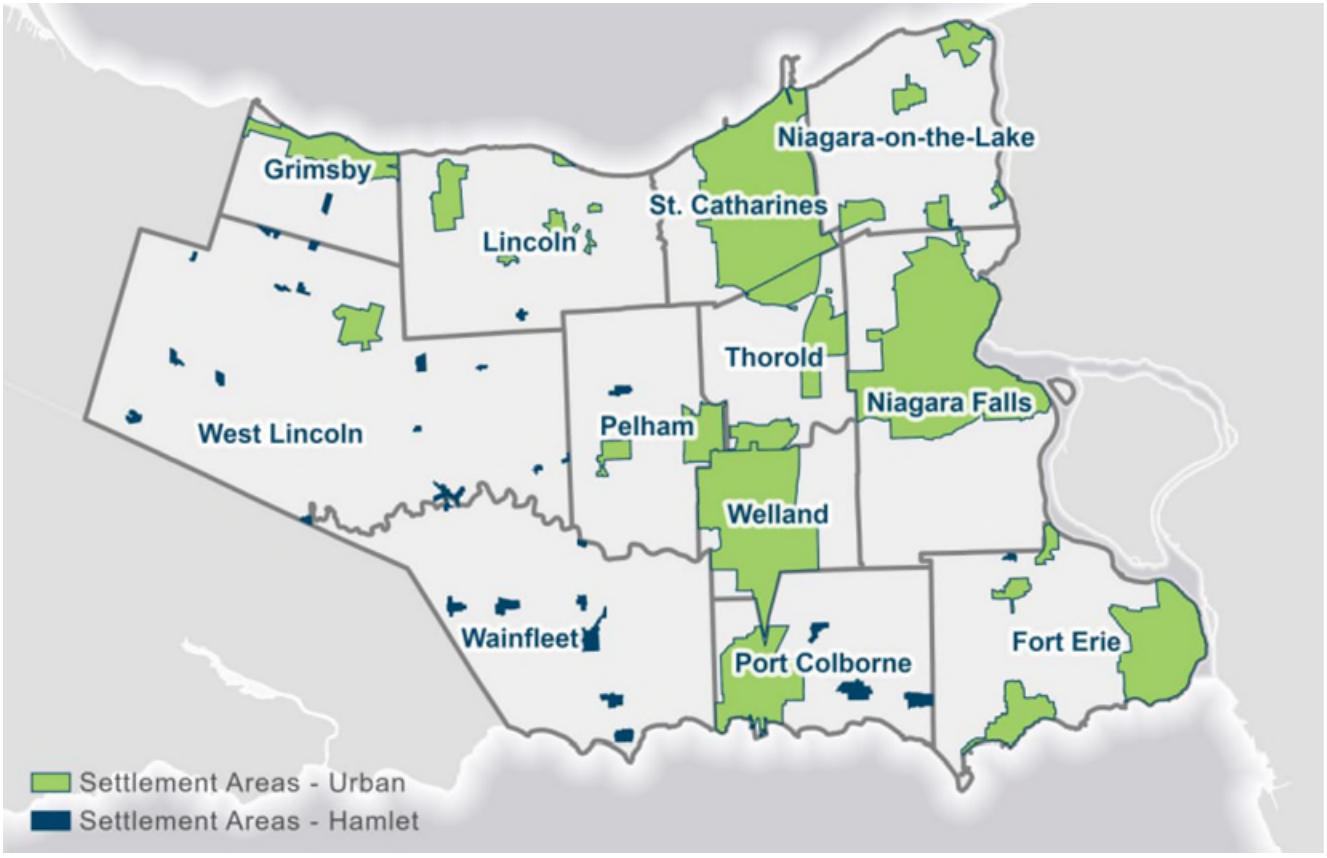
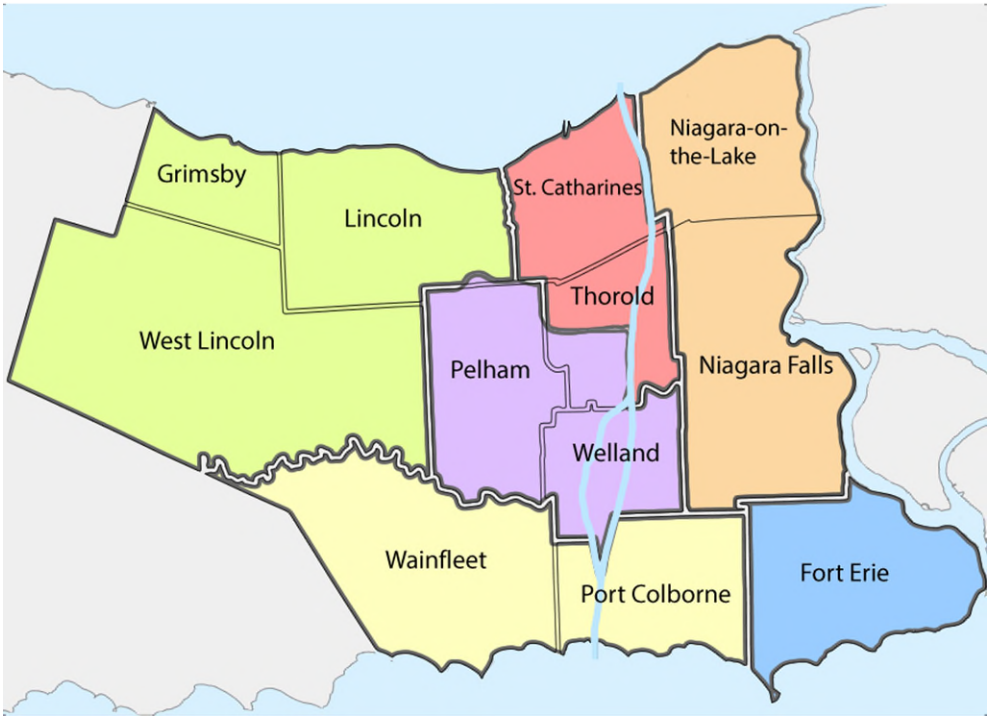


Figure 20: Niagara Region - Niagara Regional Police Service District Map



Intake

The public can access help for mental health crisis through several intake lines including the Public Safety Answering Point (PSAP) at 911, through 211 Central South Region Ontario services, or through the COAST crisis line.

Public Safety Answering Point (911)

The Niagara Police are contracted to run the Public Safety Answering Point (PSAP) in the Niagara Region. Like most other jurisdictions, the PSAP asks callers if they need police, fire, or ambulance and directs their call to the appropriate service. Call takers do not ask additional questions before transferring callers to the requested service provided. As with other jurisdictions, calls are not identified as mental health related at this stage. All PSAP call takers are trained in crisis management.

Police Communications Centre

The Niagara Regional Police communications centre utilizes a priority dispatch system where call-takers are provided with specific questions to ask based on a proprietary algorithm and the callers' response to the previous questions. Due to the proprietary nature of the system, the communications centre is unable to share a copy of questions or decision trees. As an output, the priority dispatch system categorizes calls into call types, each with a specified response for the dispatcher to follow. The priority dispatch system limits the ability of call takers to probe for mental health factors when not disclosed in response to the questions provided by the system. The priority dispatch system does provide the communications centre with a layer of risk mitigation as all callers receive consistent service that is backed by research and the provider of the priority dispatch software will support the police service in court if the recommendations of the priority dispatch system are in question.

All communications centre call takers and dispatchers are trained in crisis management. Service is provided in English with access to a translation service for other languages. Through a local partnership involving the YMCA and CMHA, police also have access to translation services on-scene through an iPad for audio and face-to-face translation. The communications centre employs data analysts who perform quality assurance work using a quality improvement framework that completes theming on incidents, reviews call types, conducts investigations, and performs root cause analysis. The communications centre performs complete critical incident and stress management reviews on major incidents and does community follow-up on incidents.

As described in later sections, the police communications centre has two main dispatch options for mental health crisis calls including a general patrol response, or the Mobile Crisis Rapid Response Team (MCRRT) which operates two teams in the region.

Niagara EMS Dispatch Centre

The Niagara EMS dispatch centre provides standard dispatch services for paramedic and ambulance services, in addition to several alternate service options. When a call is determined to not be life-threatening and not time-critical, the emergency medical dispatcher may transfer a call to an emergency communication nurse (ECN). ECNs are employed by and located in the dispatch centre and are certified emergency registered nurses. They can provide medical advice or instructions over the phone and will direct callers to where their needs can be best met. If needed, a paramedic may be sent for further assessment at the scene. ECNs do not have additional training for mental health crisis and are reported to struggle to handle callers experiencing a mental health crisis. They do have a good understanding, however, of the community mental health resources available for referral. In addition to

ECNs, EMS dispatchers can refer mental health and substance use calls to the Mental Health and Addiction Response Team (MHART) which is described in more detail in the response section of this report. In cases of overdose, an in-person response is required so MHART can respond while an ECN cannot.

The EMS dispatch centre uses a five-priority system for identifying the urgency of a response with Priority 1 being the most urgent. Each priority level has a target time allotted in which dispatchers are instructed to determine the appropriate response. In the case of Priority 1 calls, these are to be dispatched as soon as possible. For the other lower priority levels, the dispatch centre has found it helpful to give their dispatchers more time to get to a determinant to learn more about the actual issue, root causes, and optimal response to the situation. The dispatch centre targets the following call lengths for the associated priorities:

- Priority 2 – 2 minutes 30 seconds
- Priority 3 – 10 minutes
- Priority 4 – 30 minutes
- Priority 5 – 1 hour

Similarly, the dispatch centre trains dispatchers to think of a Priority 1 dispatch and the use of lights and sirens as a medical tool that is to be used appropriately but not overused.

211 Central South Region – Niagara

211 Central South Region Ontario provides a similar set of services to 211 Eastern Ontario in Ottawa. 211 operates as an intake and referral point that connects callers with resources to meet their needs. For callers in mental health crisis, some of the organizations that 211 refers to include:

- Distress Centre of Niagara
- CMHA
- Youth Resources Niagara

Crisis Outreach and Support Team (COAST) Crisis Line

The Crisis Outreach and Support Team (COAST) crisis line is operated by CMHA Niagara. COAST has a mandate to serve youth and adults ages 16 and up. The COAST crisis line provides immediate telephone counselling and in-person crisis outreach services as needed and available. COAST operates 24/7 and can be reached through a dedicated toll-free crisis phone line. Upon calling, the crisis line provides ongoing telephone support and/or referrals to appropriate follow-up services. When needed, the COAST mobile crisis team will respond directly to the person in crisis. The mobile crisis team is not a rapid response service and response times may vary.

Response

Mental health and substance use calls are frequently responded to by general patrol police officers and paramedics. The following sections outline the EMS Mobile Integrated Health (MIH) teams and Niagara Regional Police Service's Mobile Crisis Rapid Response Team (MCRRT) which serve as alternative response models to mental health and substance use calls. As outlined in the following sections, these programs have succeeded in diverting a portion of mental health and substance use calls from the general response streams and increased diversions from hospital.

EMS Mobile Integrated Health Teams

After identifying growing needs in certain demographics and call types, the Niagara EMS introduced three Mobile Integrated Health (MIH) teams to address specific needs. The MIH teams are based on an interdisciplinary partnership approach that seeks to reduce the number of repeat users of emergency services and address more root causes. All MIH teams can be assigned by dispatch or can assign themselves to a call and cancel the ambulance response. All three MIH teams combined typically respond to between 350 and 500 incidents per month. Approximately 74% of the combined calls are dispatched and 26% are self-assigned. Assignments are highest from October through January, and weekdays are busier than weekends. Two of the three MIH teams can respond to calls related to mental health and substance use and are described in more detail below. The third team, called the Falls Intervention Team (FIT), is not a mental health or substance use response. FIT pairs a paramedic and occupational therapist who seek to reduce the risk of falls by seniors in the community.

Community Assessment & Referral Team

The Community Assessment & Referral (CARE) team is a team of paramedics that provides education and referrals to individuals with underlying conditions, complex needs, or who are frequent users of the emergency system. The team performs home visits, conducts medical assessments and routine monitoring, and helps with medicine or chronic disease management. The CARE team may also participate in a patient's coordinated care plan with allied health or social agencies.

Mental Health and Addictions Response Team

The Mental Health and Addictions Response Team (MHART) responds to 911 calls to address the real-time need for a response to non-life-threatening mental health and substance use calls. MHART consists of a single team where a paramedic is paired with a mental health nurse. The Niagara Region currently has one MHART team which covers the entire region and operates from 9:30am to 9:30pm, 7 days a week. MHART works to assess patients experiencing acute mental health or substance use related crises and find the best resource. MHART can begin preparing individuals for transport to hospital when appropriate or assist in accessing in-person referrals or follow-ups with Niagara Region or other community programs. The mental health nurse on the team is seconded from a Niagara hospital which provides the team smoother access when admitting patients. Transports to hospital assisted by MHART can be significantly faster than through other channels because MHART can bypass the triage process and directly communicate with the hospital unit.

Objectives of the MHART program include:

- Responding to low acuity patients in psychological distress and attempting to align them with community resources that best meet their needs, rather than transporting them to an emergency department
- Responding to active overdose calls as well as following-up with post-overdose patients, encouraging addiction treatment and referral to community resources, and providing harm reduction guidance and materials
- Helping reduce the stigma associated with mental illness and substance use by providing an enhanced medical response to 9-1-1 calls and creating an opportunity to work closely with police services to ensure mental health is treated as a health and medical issue.

The MHART initiative has delivered measurable improvements in outcomes since its inception which have benefited the entire service. For example, in 2019 Niagara EMS saw a 6.9% decrease in transports of mental health patients to the emergency departments despite an 8.1% increase in the number of mental health-related calls. This means that more patients are accessing real-time alternatives to hospitalization and more appropriate health care.

A 2021 study entitled an *Economic Analysis of Mobile Integrated Health Care Delivered by EMS Paramedic Teams* examined the results of Niagara EMSs MIH teams and further demonstrated the positive benefits of specialized paramedic teams.[14] The study matched 1,740 calls serviced by MIH in 2018 and 2019, with an ambulance cohort of calls having the same profile in the two years prior. On average, the MIH teams spent less time on task as compared to the ambulance responses. In total, 28.6% of the calls attended by MIH required transport to hospital as compared to over 74% of the calls attended by ambulance. Further, the mean cost-per-1000 calls was $122,760 for MIH teams as compared to over $290,000 for ambulance response.

Mobile Crisis Rapid Response Team

The Mobile Crisis Rapid Response Team (MCRRT) was started in 2015 and is an integrated team that pairs a Niagara Regional Police Service (NRPS) officer with a CMHA mental health and substance use clinical specialist (occupational therapy, social work, or nursing). When a call comes into the police communications centre and it is determined there may be a mental health need, a secondary interview is completed to determine if a specialized team such as MCRRT should be dispatched.

NRPS officers rotate through MCRRT, with different officers assigned to the team daily. NRPS has taken a broad approach to mental health response and has put approximately 75% of its frontline officers through CMHA crisis intervention training. Officers with this training are eligible to rotate through MCRRT based on their daily assignments. In partnership with the clinical specialist on the team, MCRRT aims to respond to the trauma involved, not simply the crisis that is presenting.

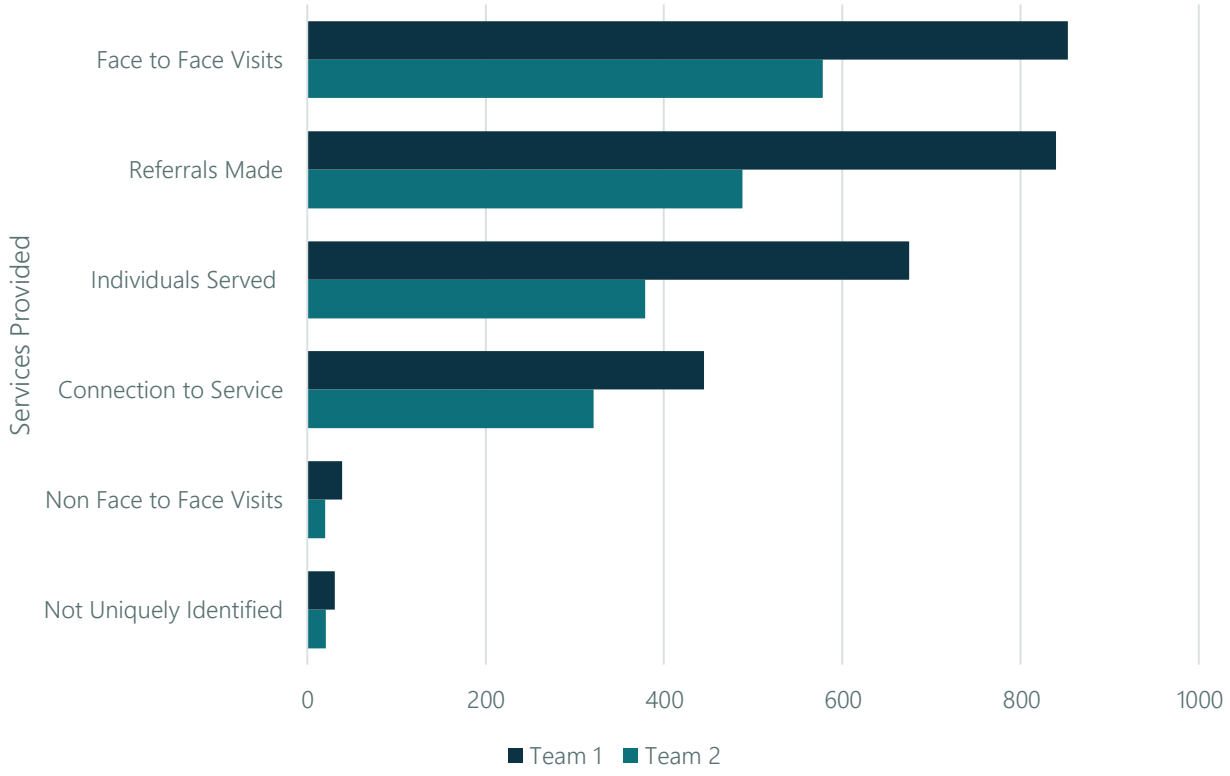
The goals of MCRRT include the following:

- Decrease wait times for individuals in crisis to connect with a mental health worker.
- Decrease the number of Mental Health Act apprehensions and divert from hospital.
- Increase community connections to service for individuals in crisis.
- Develop police capacity to respond to mental health calls.

MCRRT began operating with a single team and added a second team in April 2021. The figure below provides an overview of the annual numbers for both teams in 2021. The numbers for Team 2 diverge from Team 1 since Team 2 did not operate for the full year.

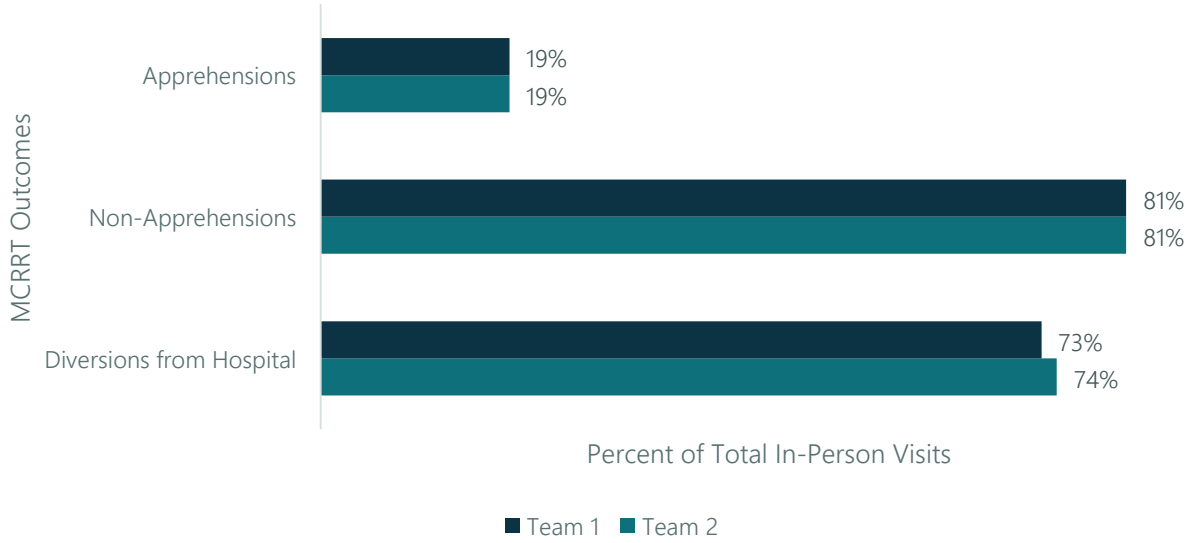
[14] *Xie, F., Yan, J., Agarwal, G., & Ferron, R. (2021, February 24). Economic Analysis of Mobile Integrated Health Care Delivered by EMS Paramedic Teams. JAMA Network Open. Retrieved April 20, 2022, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776751?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2021.0055*

Figure 21: MCCRT 2021 Annual Numbers for Team 1 and Team 2



The figure below provides a summary of MCRRT outcomes for both teams in 2021 as a percentage of in-person visits. As indicated below, the team has shown measurable success in diverting a large portion of calls from hospital.

Figure 22: 2021 MCRRT Outcomes by Team



The following table provides a more detailed breakdown of MCRRT statistics for 2021 including the average team response times, and subsequent referrals to COAST.

Table 18: MCRRT Statistics - Jan. 1, 2021, to Dec. 31, 2021

2021 MCRRT Statistics	
Team 1 (1D) calls for service	853
Team 2 (2D) calls for service (April to December)	578
Non-apprehension	1009
% Diverted from hospital	71%
MCRRT (1D) referrals to COAST	244
MCRRT (2D) referrals to COAST	168
MCRRT (1D) response time	9:39
MCRRT (2D) response time	10:15

The table below provides a summary of NRPS mental health response activity with a breakdown of total mental health act (MHA) apprehensions and MCRRT responses. The years shown below reflect the presence of one MCRRT team as a second team was added in April 2021.

Table 19: NRPS and MCRRT Mental Health Response Statistics, 2017 to 2020

	2017	2018	2019	2020
NRPS Total MHA – Apprehensions	2,034	2,225	2,064	2,111
NRPS Total MHA non- Apprehension	2,718	3,084	2,537	2,674
MCRRT Individuals served	727	644	612	473
MCRRT Face to Face Visits	1019	947	868	581
MCRRT Non-Face to Face Visits	132	81	75	75
MCRRT Average Response Time	9:43	10:09	9:59	10:51

Follow-up Services

The Niagara Region offers a range of follow-up services which are detailed below including the Crisis Outreach and Support Team (COAST), CMHA Niagara, Mobile Integrated Health (MIH) teams, and the Niagara Distress Centre.

Crisis Outreach and Support Team

The Crisis Outreach and Support Team (COAST) is a secondary response model that pairs a plainclothes officer trained in crisis intervention with a CMHA Niagara mental health worker. The COAST unit has been operational since November 2011. Unlike MCRRT, COAST has two officers dedicated to the unit who work with CMHA Niagara consistently. Referrals can be made to COAST by MCRRT or hospitals for COAST to follow up with individuals a

couple days after the initial crisis response incident. All 911 calls identified as mental health related are also referred to COAST for follow-up.

The COAST mobile response team provides service seven days a week and operates during the hours of noon to midnight, Monday to Saturday, and noon to 8pm on Sundays. Service is available to youth and adults ages 16 years and up. The table below provides a summary of 2021 COAST unit statistics including the number of referrals received from police and other agencies, and the number of individuals served.

Table 20: 2021 Statistics for Joint Police - COAST Teams

2021 COAST Unit Statistics	
Police - COAST unit referrals	573
Other agencies - COAST unit referral	992
Individuals served	1407
Phone calls fielded	12563
Number of mobile outreaches	463

CMHA Niagara

CMHA Niagara offers a wide range of mental health and substance use services including counselling, safe beds, system navigation, housing support, transitional housing, court support, and case management. CMHA Niagara also operates the COAST crisis line as outlined in the intake section of this report.

Mobile Integrated Health Teams

The Mobile Integrated Health (MIH) teams described in the response section above provide a key follow-up service for users of the EMS system. In particular, the Mental Health and Addictions Response Team (MHART) and Community Assessment and Referral (CARE) team work with high users of EMS and emergency departments to provide appropriate community supports, identify root causes, and reduce reliance on EMS and hospital services.

Niagara Distress Centre

The Niagara Distress Centre operates a 24/7 crisis line for the Niagara Region. Chat and text crisis services are available in partnership with ONTX Ontario Online & Text Crisis Services (ONTX) during the hours of 2:00pm to 2:00am.

The Distress Centre also provides a mental health and substance use access line which operates 24/7 and provides resources and referrals for individuals struggling with mental health or substance use. The access line is not a crisis line and is targeted at individuals requiring non-urgent assistance.

Model Summary

The Niagara Region response model to mental health crises is rooted in partnerships between traditional service providers such as the police and EMS, and community or hospital-based mental health clinicians. Rather than dispatching general patrol officers or non-specialized paramedics, the Niagara model seeks to bring mental health clinical expertise into the crisis response while maintaining the presence of police or EMS on the scene. In the case

of MCRRT, the police officer on scene makes the final decision on whether a person is apprehended under the Mental Health Act, however, any disagreement or conflict between the officer and clinician would typically be escalated to the officer's supervisor for a final decision. The police also conduct background checks for the COAST program and influence the hiring process. The Niagara partnership model began with MOUs in place for information sharing between the partnered services and work is ongoing to extend the governance structures to standard operating procedures for the units through additional MOUs.

Strengths

- Police presence on MCRRT provides the mental health specialist with security while providing service
- MCRRT model allows a mental health specialist to provide service and attend calls that would be assessed as too high a risk for a community-based response
- Police co-response teams have access to both police and health information to better serve the client
- Mental health specialist can provide on-the-job training to police officers while working on co-response teams, enabling officers to better respond to mental health crises when on general patrol duties
- MHART teams can bypass hospital triage with established hospital relationships, reducing wait times for the patient and EMS teams
- Follow-up services are provided to connect with clients after mental health crises to confirm they accessed the services they needed or to provide follow-up service

Weaknesses

- Police presence on MCCRT may be seen as a barrier by persons in crisis and could lead to lower engagement with clinicians or a higher risk of escalation
- 911 Priority dispatch system limits questioning that could identify the presence of mental health elements
- Programs with separate funders can create challenges with designing programs and aligning co-response team members
- The limited hours of availability and limited number of co-response teams is a barrier because if a service is requested and not available it deters people from reaching out again
- There is a mismatch in the priority system between police and EMS where police prioritize suicide higher than EMS which results in police consistently arriving first on the scene
- Assessing calls for mental health factors can be time-consuming and challenges the current service standards and performance metrics for emergency call taking
- There is the potential for overlap between integrated teams depending on how the call is received and triaged
- Calls that are directed to the police may not be directed back to EMS and MHART even when this is a better response as each service (police or EMS) defaults to the responses available within its service response options

Service Gaps

- Limited hours and number of co-response teams result in many calls still receiving a general patrol police or non-specialized EMS response
- The Niagara model offers several co-response services including MCRRT and MHART but there is a lack of coordination and information sharing between the co-response services (and police and EMS in general) leading to a fragmented approach

- Long wait times for hospital admissions when not being admitted through the MHART channel

City of Toronto

Community Profile

The City of Toronto has a population of approximately 2.8 million. The land area of the city is 631 square kilometres and has a population density of about 4,428 people per square kilometre[15].

Figure 23 depicts the ethnic composition of the City of Toronto's population. Census data from 2016 indicate that most individuals identify as European or Asian at 48% and 40%, respectively. Chinese, East Indian, and Filipino people contribute to about 65% of the total Asian demographic.

Approximately 51% of the population indicated English as their first language. 44% indicated a non-official language as their native language, with similar proportions of Cantonese and Mandarin identified as the primary language.

Figure 23: 2016 Census Profile, Ethnic Origin - Toronto

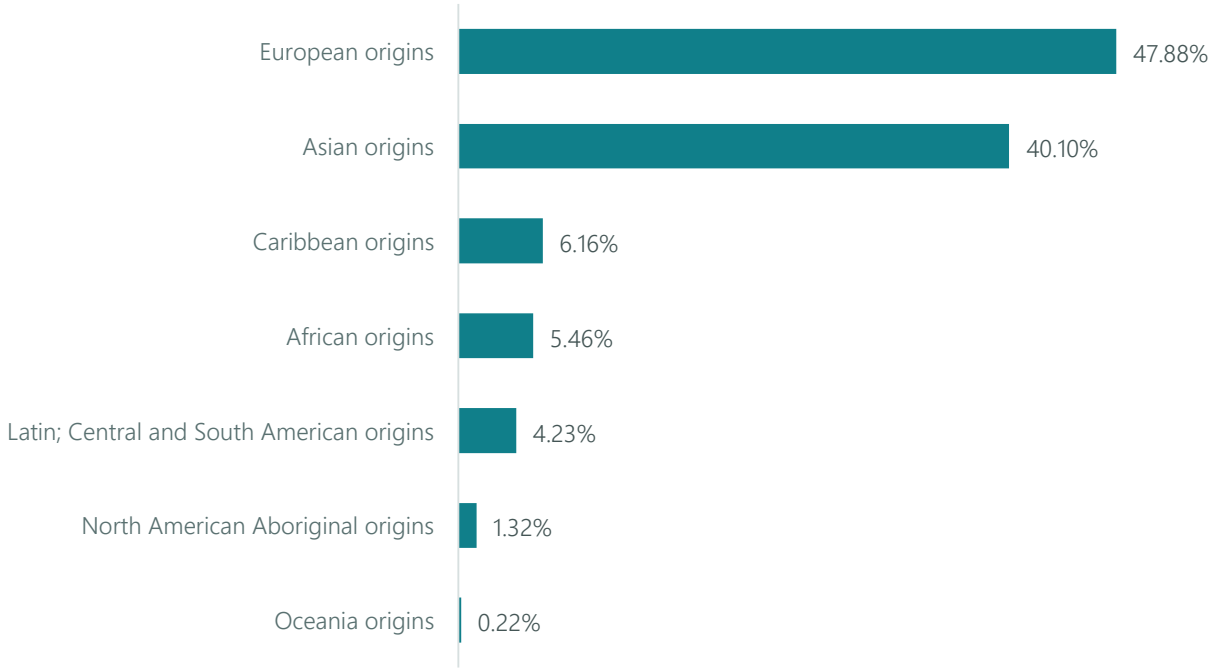
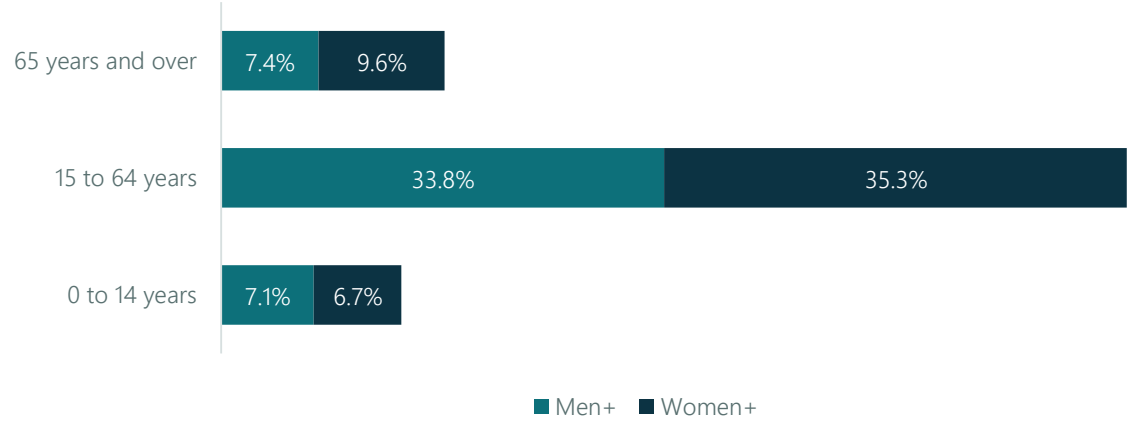


Figure 24 shows the City of Toronto's population by age group per the 2021 Census. The median age of the total population is approximately 39.6 years. Most individuals fall in the range of 30 to 34 years old, contributing to approximately 12.8% of the total 15-to-64-year age group.

[15] *Statistics Canada. 2022. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released April 27, 2022.*
https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

*Figure 24: 2021 Census, Population by Age Group - City of Toronto**



**(+) indicates inclusion of some non-binary respondents*

The City of Toronto has a complex structure. The City of Toronto increased its neighbourhood count from 140 to 158 neighbourhoods as of April 2022 with the intent to help the city collect and analyze data for city planning activities and for improved census data integrity[16]. These neighbourhoods can be grouped into 25 wards and further consolidated into four council areas (

[16] https://www.toronto.ca/city-government/data-research-maps/neighbourhoods-communities/neighbourhood-profiles/about-toronto-neighbourhoods/

Figure 25)[17]. Etobicoke York, North York, Scarborough, and East York are suburban in nature, while the former Toronto proper is considered urban[18]. The Toronto Police Service's district map outlines 16 divisions which are relatively comparable to the 25 wards in terms of borders (Figure 27)[19]. Table 21 provides a comparison summary of the components of each council area.

[17] https://www.toronto.ca/city-government/data-research-maps/neighbourhoods-communities/community-council-area-profiles/
[18] http://3cities.neighbourhoodchange.ca/wp-content/themes/3-Cities/pdfs/Toronto-CMA-Inner-Outer-suburbs-location-map.pdf
[19] https://torontopolice.on.ca/divisions/map.php

Figure 25: City of Toronto Community Council Area Map

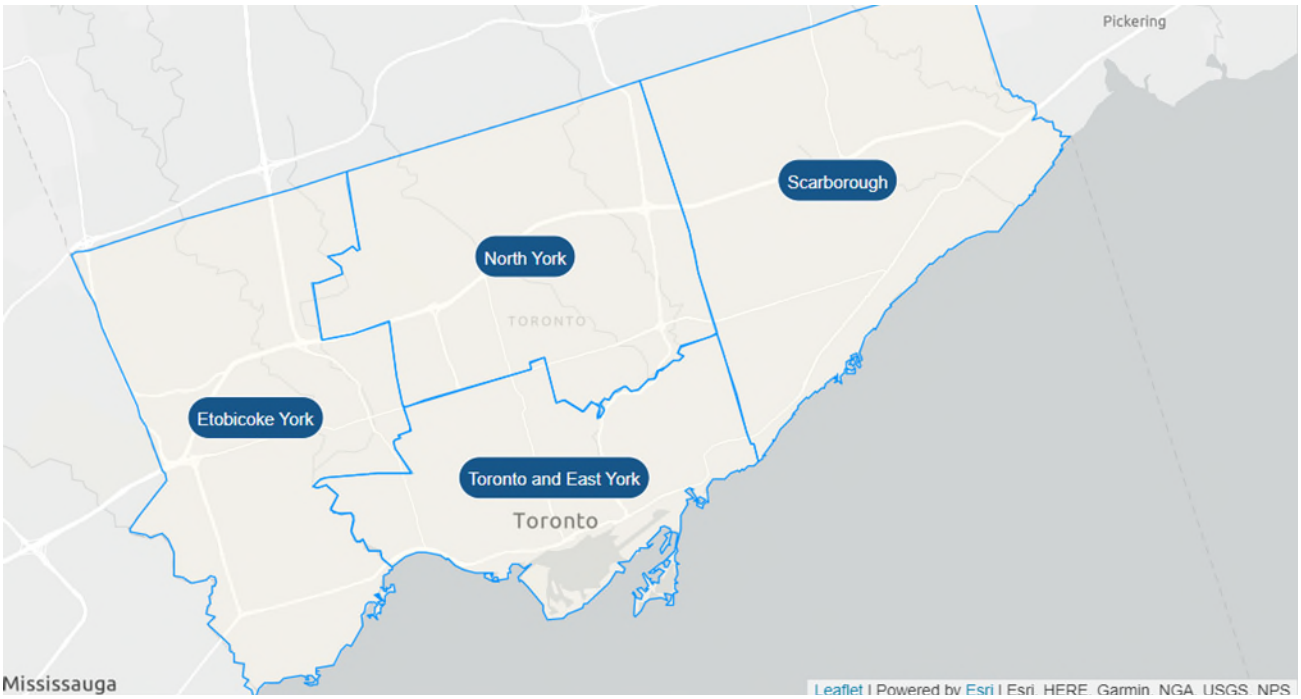


Figure 26: City of Toronto - Suburb Map

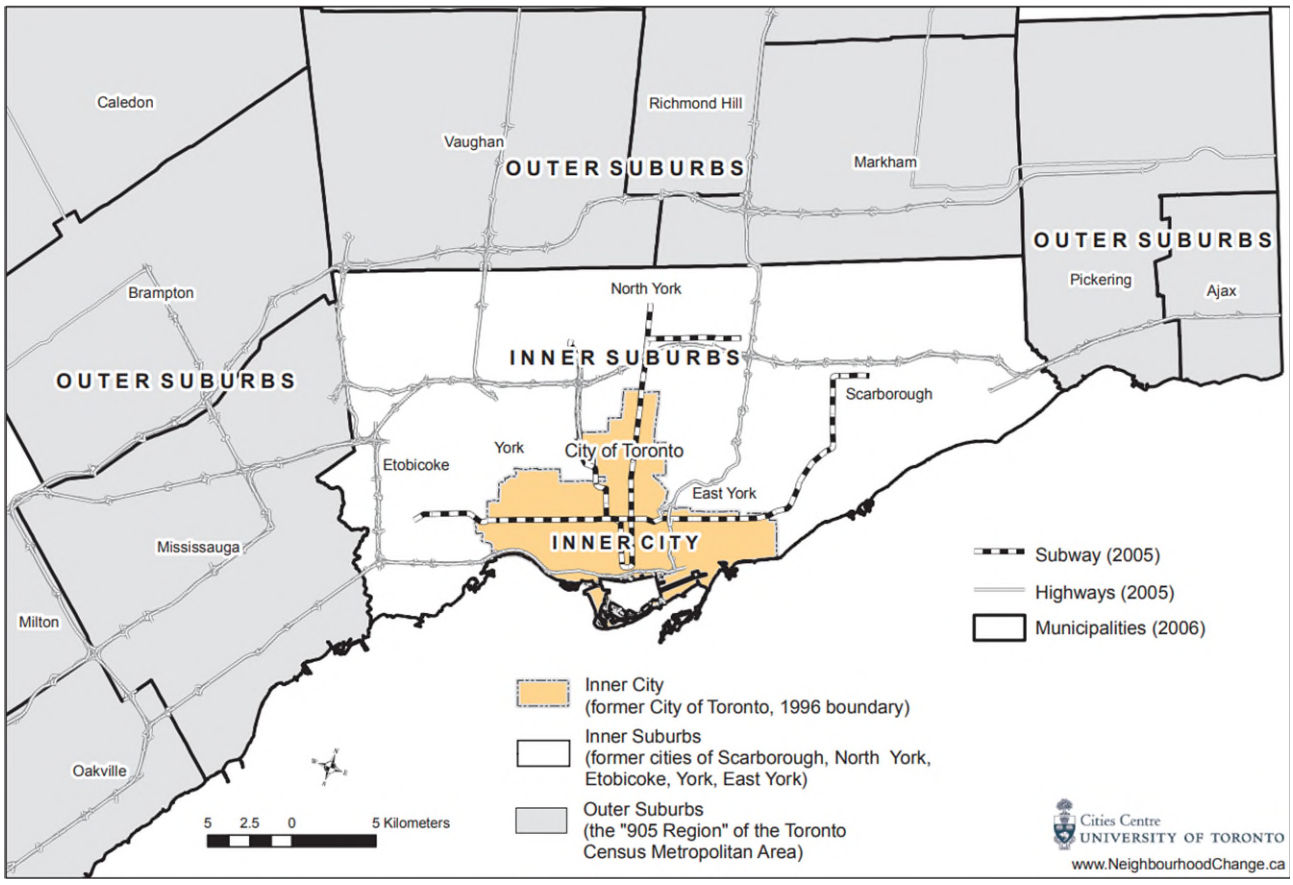
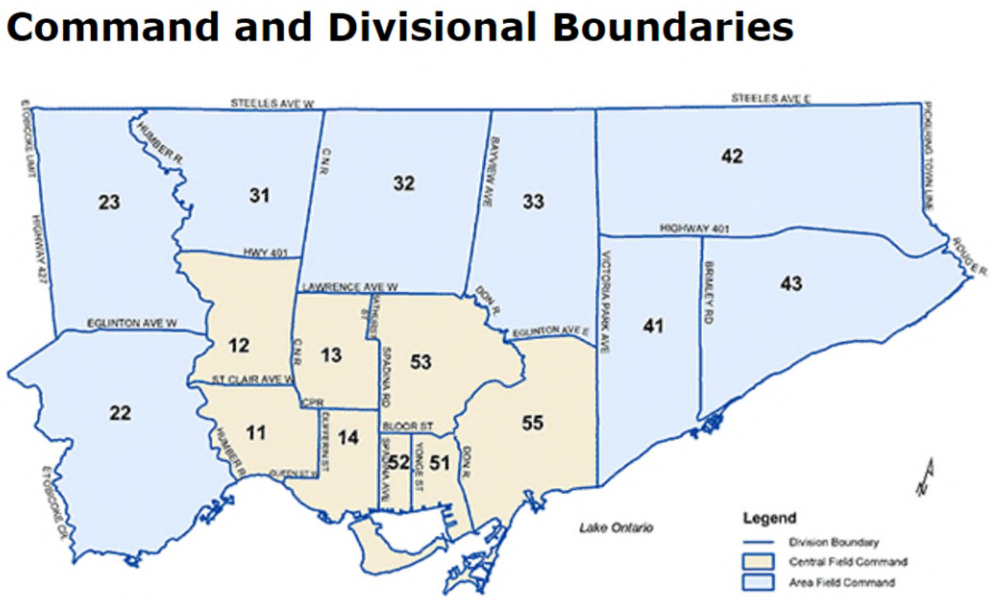


Figure 27: City of Toronto - Toronto Police Service District Map



Central Field, 75 Eglinton Av. W.
11 Division, 2054 Davenport Rd.
12 Division, 200 Trethewey Dr.
13 Division, 1435 Eglinton Av. W.
14 Division, 350 Dovercourt Rd.
51 Division, 51 Parliament St.
52 Division, 255 Dundas St. W.
53 Division, 75 Eglinton Av. W.
55 Division, 101 Coxwell Av.

Area Field, 30 Ellerslie Av.
22 Division, 3699 Bloor St. W.
23 Division, 5230 Finch Av. W
31 Division, 40 Norfinch Dr.
32 Division, 30 Ellerslie Av.
33 Division, 50 Upjohn Rd.
41 Division, 2222 Eglinton Av. E.
42 Division, 242 Milner Av. E.
43 Division, 4331 Lawrence Av. E

Table 21: City of Toronto Council Area Organization Summary

Council Area	City Wards in Council Area	Police Division in Council Area (Approximation)
Etobicoke York	• Etobicoke North • Etobicoke Centre • Etobicoke-Lakeshore • Humber River-Black Creek • York South-Weston	• 22 • 23 • 31
North York	• York Centre • Eglinton-Lawrence • Willowdale • Don Valley North • Don Valley West • Don Valley East	• 12 • 13 • 32 • 33 • 53
Toronto and East York	• Parkdale-High Park • Davenport	• 11 • 14

Council Area	City Wards in Council Area	Police Division in Council Area (Approximation)
	• Toronto-St. Paul's • University-Rosedale • Toronto Centre • Spadina-Fort York • Toronto-Danforth • Beaches-East York	• 51 • 52 • 55
Scarborough	• Scarborough-Agincourt • Scarborough Centre • Scarborough Southwest • Scarborough North • Scarborough-Guildwood • Scarborough-Rouge Park	• 41 • 42 • 43

Intake

Intake for mental health crisis calls in Toronto is primarily conducted through either 911 or 211 Central. The following sections outline these access points in more detail.

Public Safety Answering Point (911)

The Public Safety Answering Point (PSAP) is run by the Toronto Police. As with other jurisdictions, the primary purpose of the PSAP is to ask if callers require police, fire, or ambulance assistance and then transfer the call to the appropriate service as quickly as possible.

Police Communications Centre

The Police Communications Centre has access to both traditional and alternative response options in response to mental health crises. Dispatchers have the option to dispatch a general patrol response or the Mobile Crisis Intervention Team (MCIT) for a police response. For a civilian response, the communications centre can transfer calls to a co-located community crisis worker to provide on-the-phone support or transfer the call to a specialized mental health team at 211 who can dispatch an in-person community mobile crisis team response. Further details on the MCIT and 211 are provided in later sections.

The co-located crisis worker consists of a mental health professional employed by the Gerstein Crisis Centre, a community non-profit agency, working in the police communications centre who can take calls that are mental health related. Calls must meet specific criteria before they can be transferred to the co-located crisis worker including the requirement that the caller not be in imminent danger. Call takers must also obtain consent from the callers to transfer them and their information to someone who is not a police employee. The co-located crisis worker operates separately from the police to maintain a higher level of trust with the community.

Before call takers can send an in-person community mobile crisis team, they first conduct an assessment to determine that there is no danger to the public or the individual. The call taker then does a warm transfer to a specialized 211 mental health team. 911 provides 211 with the police event number and a basic call description including information on their situation and where they live. If the situation escalates at any point, 211 or the crisis

team can call 911 with the event number to reactivate the earlier event file and prevent the need to repeat information. After the transfer, 211 does a short environmental risk assessment. The 211 team then dispatches one of its four partner agencies through a portal. Once 211 gets confirmation that the crisis team has the request, they confirm with the caller that the response is on the way. The community mobile crisis teams are currently only available in four police districts with a different partner agency responsible for each district.

211 Central

211 Central operates as an information and referral service like the 211-service available in Ottawa. In addition, 211 operates a specialized mental health team which handles mental health crisis calls and conducts the intake and dispatch for the community mobile crisis team pilot project. 211 Central serves the Toronto, Durham, Peel, and York regions. Call operators are bi-lingual with access to a language line. All operators are given training to understand trauma-informed approaches. The contact centre employs approximately 30 full-time-equivalent positions.

The community mobile crisis team pilot project involves four partner agencies who are contracted to provide mobile crisis response services. Each partner agency operates in one separate police district. Mobile crisis teams are dispatched under 6 call types:

- Advised
- Dispute
- Distressing and disorderly behaviour
- Person in crisis
- Suicidal
- Well-being checks

There are three call flows or paths through 211 Central for mental health crisis calls:

Path #1

In the first path, a call is transferred from 911 after they conduct an initial assessment and determine there is no danger to the public or the individual. In this path, 911 conducts a warm transfer directly to the specialized 211 mental health team. 211 receives the associated event number from 911 and a basic call description including information on the situation and where the person in crisis lives. Caller information received provided by the caller is held at 211 and not shared back with police. If the situation escalates at any point, 211 or the crisis team can call 911 with the event number to reactivate the earlier event file and prevent repeating information. The 211 mental health team conducts a short environmental risk assessment as outlined in the table below. The 211 team then dispatches one of the four partner agencies through a portal. Once 211 gets confirmation that the crisis team has the request, they confirm with the caller that the response is on the way.

Table 22: Environmental Risk Assessment Prior to Dispatching In-Person Crisis Team

Environmental Risk Assessment Questions
Do you feel safe in your environment?
Make the caller aware of the response to their request for help (Example: a team will come out to see you)
Does the caller have any disabilities?
What language do they need service in? (Identify if an interpreter is required)

What type of housing is the caller in? (Depending on the location, additional precautions may be taken such as requesting the presence of building security to meet the crisis team on arrival)
Are any pets present and what kind?
Are there people present in addition to the caller? Who? Are there minors?
Are there any weapons present?
Do the crisis team have easy access to you? (Example: can they knock on the door to gain access?)

Path #2

In path #2, incoming 211 calls can be identified by the initial call takers as mental health crises and transferred to the specialized 211 mental heath team. The specialized mental health team will then follow a similar call flow as described above for Path #1.

Path #3

In Path #3, the community crisis teams themselves can self-refer when they see a person in crisis. These responses are known as "in-communities". When the crisis team self-refer and initiate the crisis response themselves, they will advise 211 of the self-referrals to record the interaction and related data.

211 Central tracks if calls are dropped or if service is declined, along with cases where the crisis team arrives, and service is declined. If the client declines a mobile crisis response, the 211 call takers become the support and look at referrals that are available. 211 documents their referrals and conducts a follow-up a couple of days later to see how the referrals worked out. If the caller has not been able to connect to the referral or needs additional support, 211 can offer the crisis team again.

Response

The mental health and substance use response options in Toronto can be categorized into police-led and civilian-led responses. The sections below describe both types in more detail.

Police-Led Response

Police-led responses to mental health and substance use crises can take the form of either a general patrol officer response or a response by the Mobile Crisis Intervention Team (MCIT). The section below describes the MCIT in more detail.

Mobile Crisis Intervention Teams

The Mobile Crisis Intervention Team (MCIT) consists of an emergency department mental health nurse paired with a police officer. MCIT can be dispatched by the police communications centre in response to 911 calls or calls to the police non-emergency line. MCIT operation 7 days a week from 11:00am to 11:00pm. The services provided by MCIT include:

- Make an immediate on-site clinical assessment of the person in crisis
- Attempt to stabilize and defuse the crisis
- Assist in removing the individual from serious harm to themselves or others
- Provide supportive counselling as needed

- Arrange appropriate mental health treatment through referrals to an appropriate agency or apprehension under the Mental Health Act
- Coordinate and facilitate transportation to the hospital emergency department if further psychiatric and medical assessment is required

Community-Led Response

Two primary community-led responses are available to mental health crises including the co-located crisis worker based in the police communications centre, and the pilot project partnering with four community agencies to deploy civilian mobile crisis teams in four police districts. The sections below describe both programs in more detail.

Co-Located Crisis Worker

In the co-located crisis worker response model, a crisis worker employed by the Gerstein Crisis Centre, a community agency, is co-located in the police communications centre. When a person in crisis calls 911, they may be transferred to the co-located crisis worker when the call meets the program's scope. The program scope includes no criminality, no plan and means for suicide, and no information on current violence. The Toronto Police Service (TPS) counts approximately 32,000 events annually as persons-in-crisis under six call types. Of those 32,000, there is a small percentage that meets the defined scope, and of those calls that meet the scope, approximately half can be dealt with by the crisis worker over the phone. Further, if disclosure of domestic assault occurs at any point, this automatically triggers a police response.

Before transferring a call to the crisis worker, a police dispatcher must receive consent from the caller for the crisis worker to help them, and consent to their information being provided to the crisis worker. The communications centre stops recording the call once the warm transfer is made from the police call taker to the co-located crisis worker because the communications centre is not a health information recorder. Police officers can also redirect calls to the co-located crisis worker if they arrive at a call and believe they should not be involved and the person consents.

Crisis workers are employed by the Gerstein Crisis Centre and the City of Toronto has a contract with the centre for the program. The program model deliberately uses the language that the crisis workers are co-located, not embedded with the police. This stems from some of the crisis workers not wanting to be directly associated with or perceived to be employed by the police, and the term 'embedded' does not communicate the clear separation of roles and jurisdictions that exists in the relationship.

Civilian Mobile Crisis Teams

The City of Toronto is conducting four pilot projects for non-police physical response to individuals in mental health crisis. Each project serves a separate police district and is run by a different community anchor agency. The City of Toronto is funding 100% of the pilot projects and is responsible for monitoring the pilot project operations, oversight over the programs and quality assurance and any complaints. They will also be responsible for collecting data to evaluate the success of the programs based on a defined evaluation framework. The city refined the pilot model, built the governance and evaluation framework, and selected the anchor partners. The city is also responsible for public education and building awareness for the new pilots. The evaluation of the pilots will focus on outcomes including:

- Reduced repeat calls (this is a major focus)
- Improved community experience
- Diverted calls

- Referrals
- Use of Force

The first pilot launched in March 2022 with the remaining three pilots coming onboard after and all expected to launch by the end of Summer 2022. The pilots operate as mobile crisis support teams made up of a multidisciplinary team of crisis workers with crisis intervention and de-escalation training. The mobile crisis teams are dispatched to non-emergency, non-violent crisis calls involving persons-in-crisis, wellness checks, and other mental health and substance use calls to be determined. The mobile crisis support teams serve youth and adults ages 16 and up. Follow-up is provided by the teams within 48 hours after the initial call-out.

The pilots were launched with a $12 Million budget and initially provided 24-hour coverage Sunday through Friday (6 days a week) with Saturdays off until the end of May. This was expected to increase to 24/7 coverage as hiring and training activities could take place. Crisis workers are provided with a 5-week training program prior to beginning work in their roles.

Due to the recent launch of the pilots, comprehensive and long-term data on outcomes was not available for this report. During the short period (2-3 weeks) that the program had been operating at the time of our conversations, the mobile crisis team response averaged 28 minutes from when the call came in to when the crisis team arrived on scene. This was acknowledged by the TPS to be a quicker response than they would normally provide for these types of calls. In the first 3 weeks of operation, the mobile crisis teams responded to 65 calls with only 2 of 4 regions operational and operations still ramping up. 53 of the 65 calls were considered diversions where 911 would have normally responded to them. As these are preliminary results from a short time during the program ramp-up period, outcomes cannot be extrapolated until more data is reported.

Follow-up Services

Follow-up services are provided by both 211 Central and the Civilian Mobile Crisis Teams. Additional follow-up services are available in the form of referrals to health and community agencies but typically require the active engagement of the person in crisis.

211 Central

As described in the response section above, 211 documents their referrals and conducts a follow-up a couple of days after a mental health crisis event to check how the person is doing and whether they have been able to connect with the referrals provided. If the caller has not been able to connect to the referral or needs additional support, 211 can offer the crisis team again or provide additional referrals at this time.

Civilian Mobile Crisis Teams

The pilot project civilian mobile crisis teams have a follow-up model built into their system of operations. The crisis teams provide follow-up within 48 hours after they are initially called out. This ensures that fewer people fall into a support gap and re-enter the crisis response system.

Model Summary

The Toronto mental health crisis response model is the only Canadian model examined in this report which incorporates a civilian-led mental health crisis response that can be accessed through 911. Like the Niagara Region, Toronto also has access to a police co-response model that pairs an officer with a mental health clinician. The

sections below outline the current strengths, weaknesses, and gaps present in the current Toronto model.

Strengths

- Access to civilian mobile crisis teams through both 911 and 211 ensures a no-wrong-door approach and facilitates access for people who are hesitant to contact police
- Multiple response options that are appropriate for a range of acuity levels including a civilian-only response for lower acuity calls and joint police and mental health clinician response to higher acuity calls
- Caller information is held by 211 and/or the co-located crisis worker and not shared back with police. 211 and/or the crisis worker retain the event number and can re-engage the police if the situation escalates
- The police communications centre stops recording once transferred to the crisis worker because they are not a health information recorder, facilitating improved sharing of health information
- The City of Toronto has selected pilot project service providers that are known and trusted in their communities and have existing mental health service provision
- Civilian-led, community-based crisis response options avoid medicalizing mental health crises and reduce the likelihood of interactions escalating or resulting in apprehension

Weaknesses

- Police operation of 911 creates the conditions for a police-oriented response
- The current interpretation and application of privacy legislation limits mutual information sharing between partner agencies
- Police background checks can be a deterrent for mental health staff wanting or being able to work and co-locate in the police communications centre
- Asking for too much background information upfront can be a barrier or risk when individuals are seeking help
- Police organizational cultural can be a barrier to acceptance and buy-in of new service models and external partner agencies
- Emergency call response has traditionally been focused on speed but with mental health there is a need to slow it down and ask more questions, gather information, and build trust with the caller. This has not yet been addressed in the Toronto 911 and dispatch channels.

Service Gaps

- Pilot programs are limited to 4 of 16 police districts and initial hours of operation are not 24/7. Further data is also required to determine whether the pilots are staffed appropriately to fully meet the potential demand.
- More crisis beds are needed for individuals after the initial crisis outreach
- Paramedic capacity was identified as a limitation when exploring co-response options involving EMS

City of Vancouver

Community Profile

The City of Vancouver has a population of 662,250. Approximate land area of the city is 115 square kilometres and has the highest population density of all the comparison areas at about 5,750 people per square kilometre[20].

Figure 28 shows the City of Vancouver's mix of ethnic diversity. 2016 Census data shows people with Asian and European origins represent most of the population, representing over 49% and 48% of the total population, respectively. About 82% of the total Asian population identify as East and Southeast Asian. This is mostly attributed to a high Chinese population that contributes about 57% of the total Asian demographic. The other ethnic groups only represent 8% of the total population when combined.

About 51% of the city's population indicated English as the mother tongue while 44% reported a non-official language as their native language, Cantonese was identified as the most prevalent at about 13.7%.

Figure 28: 2016 Census Profile, Ethnic Origin – City of Vancouver

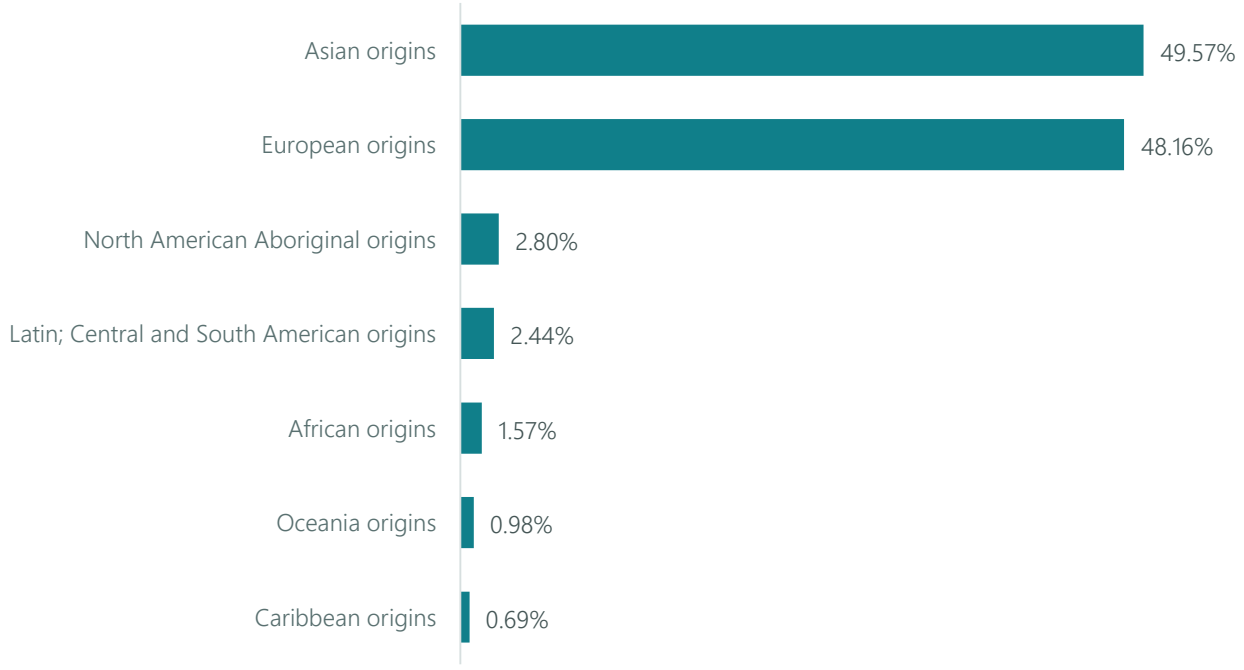
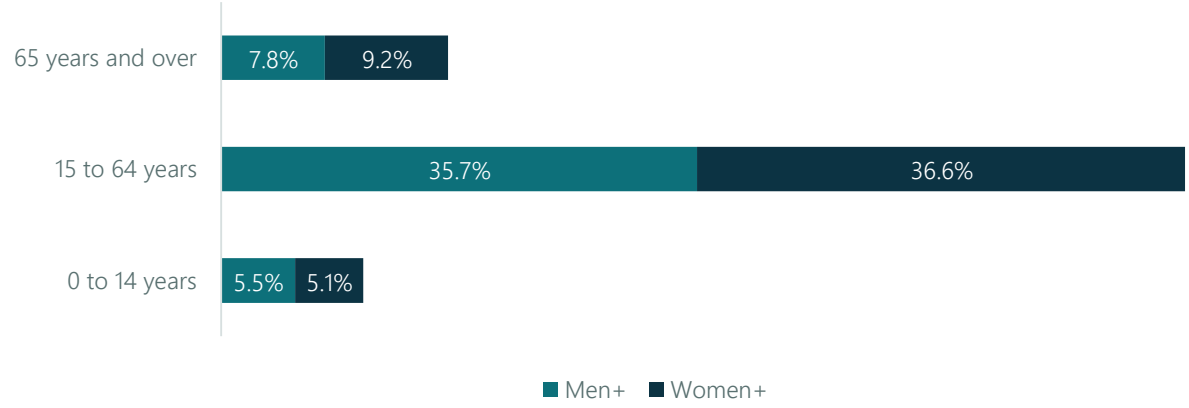


Figure 29 shows the City of Vancouver's population by age group per 2021 Census. The median age of the total population is 39.6 years. The highest proportion of individuals falls in the range of 30 to 34 years old, contributing to about 14.5% of the total 15-to-64-year age group.

[20] *Statistics Canada. 2022. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released April 27, 2022.*
https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

*Figure 29: 2021 Census, Population by Age Group - City of Vancouver**



**(+) indicates inclusion of some non-binary respondents*

Figure 30 shows the neighbourhood distribution for the City of Vancouver. There are 22 main neighbourhoods that the city recognizes, outlined by the beige-shaded areas[21] [22]. Figure 31 is the Vancouver Police Department district map for the City of Vancouver[23]. Table 23 shows a summary of Vancouver Police Department's district organization with the city's recognized neighbourhoods.

Figure 30: City of Vancouver Neighbourhood Map

[21] https://vancouver.ca/news-calendar/areas-of-the-city.aspx
[22] http://www.vancouveruserguide.com/neighborhood.html
[23] https://vpd.ca/about-the-vpd/organizations-divisions/

Figure 31: City of Vancouver - VPD District Map

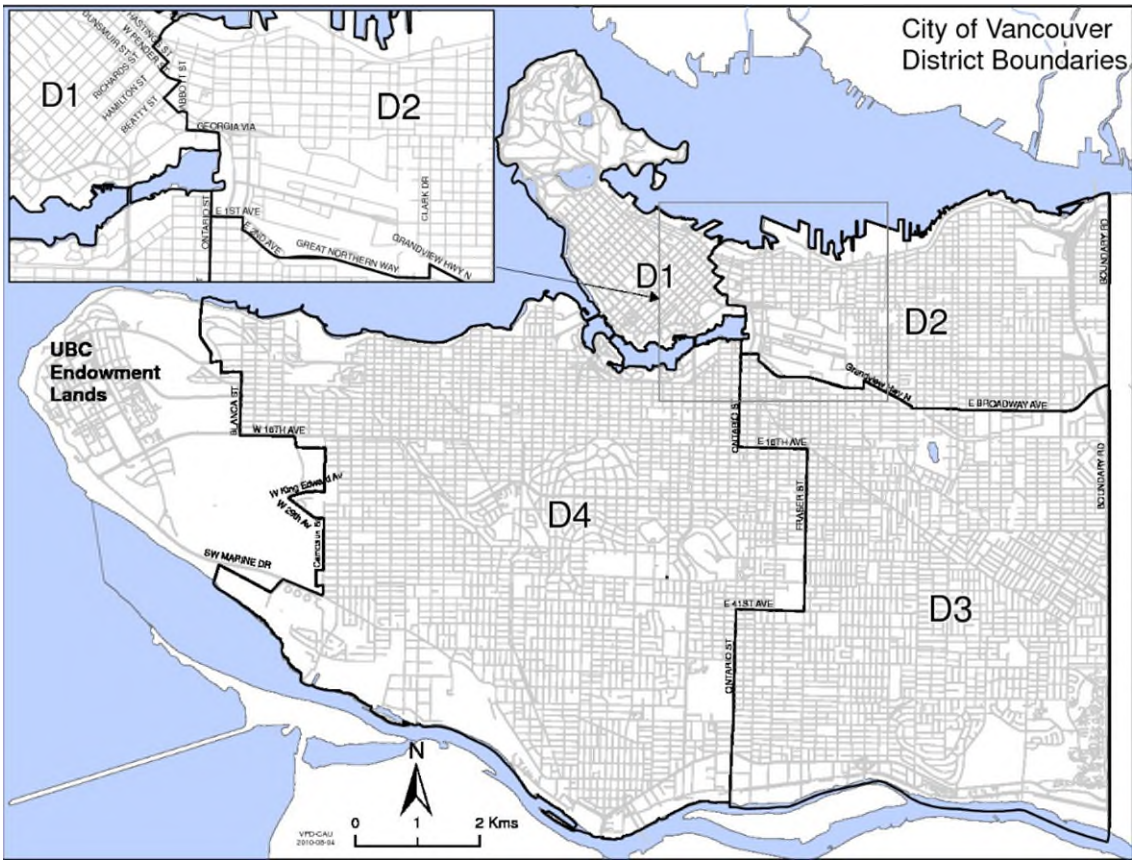


Table 23: Vancouver Police Department District-Neighbourhood Summary

D1	D2	D3	D4
• West End • Downtown	• Strathcona • Grandview-Woodland • Hastings-Sunrise	• Mount Pleasant • Kensington-Cedar Cottage • Sunset • Victoria-Fraserview • Renfrew-Collingwood • Killarney	• West Point Grey • Dunbar-Southlands • Kitsilano • Arbutus Ridge • Kerrisdale • Fairview • Shaughnessy • South Cambie • Oakridge • Marpole • Riley Park

Intake

E-Comm

E-Comm provides 911 services for 25 regional districts in British Columbia, handling over 99% of the province's call volume. E-Comm also provides police and fire dispatch services for many of these same districts. E-Comm was established in 1997 under the provincial Emergency Communications Corporations Act and is owned by the municipalities and agencies it serves. In Vancouver, E-Comm provides both 911 call-taking and police dispatch services. While E-Comm operates with a shared pool of dispatchers for multiple districts, Vancouver has a dedicated team of dispatchers due to its relatively high call volumes. Neither call-takers nor dispatchers have specific training for mental health-related calls or crises.

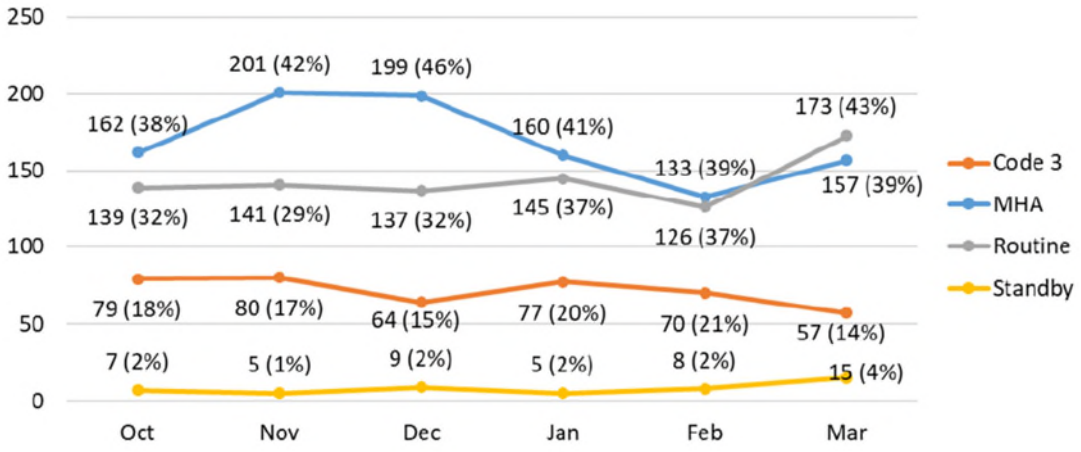
In the E-Comm model, the call-taker and dispatcher roles are separate. Call-takers enter the call into the Computer Aided Dispatch (CAD) software and police dispatch get the file. 911 call-takers are not allowed to triage the initial call and simply ask callers whether they need police, fire, or ambulance. In most mental health crises, callers ask for the police. There is currently no process in British Columbia for handing calls off to any agency other than police, fire, or ambulance.

For mental health crises, dispatchers can send either a general patrol police response or the Car 87 / Car 88 if available. The Car 87 / Car 88 program is a co-response model that pairs a plainclothes officer with a mental health clinician and is described further in the response section below. The Car 87 / Car 88 program has limited capacity with only one car operating for the entire city, resulting in many calls being dispatched to a general patrol officer response. The Vancouver Police Department has a policy in place where they will have an ambulance also dispatched to mental health calls to stand-by.

Response

Mental health and substance use crises are typically directed by 911 call takers and dispatchers toward a response by the Vancouver Police Department (VPD). Most of these calls result in the dispatch of a general patrol police response but several VPD programs also operate as an alternative response. As noted earlier, ambulances are often dispatched along with a police unit in response to mental health crises. The figure below outlines the number of ambulance requests issued by the VPD by call type.

Figure 32: VPD Ambulance Requests by Call Type, October 2021 to March 2022



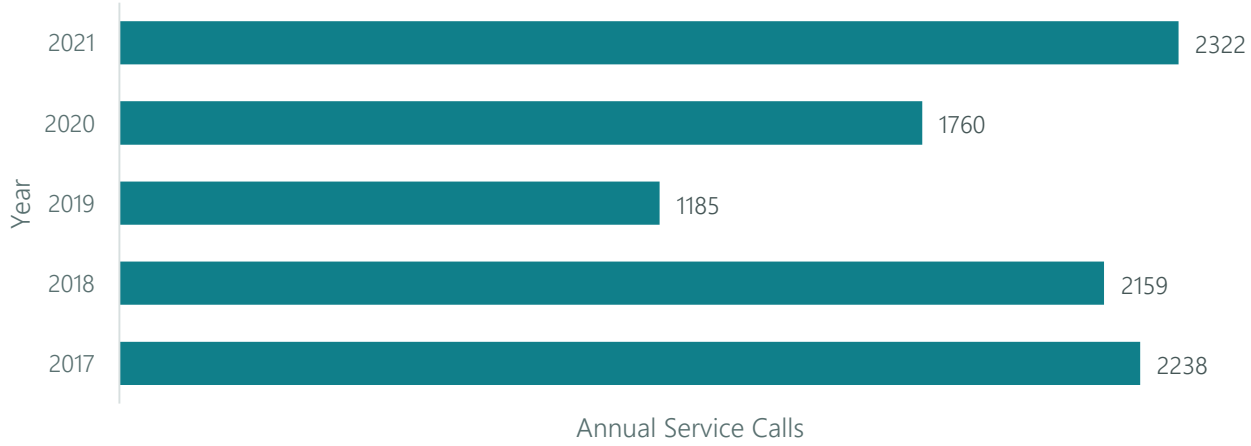
VPD Mental Health Unit Responses

The Vancouver Police Department (VPD) operates three alternative response programs as part of its Mental Health Unit (MHU). All three programs are structured as partnerships with external providers and are described below.

Car 87 and Car 88

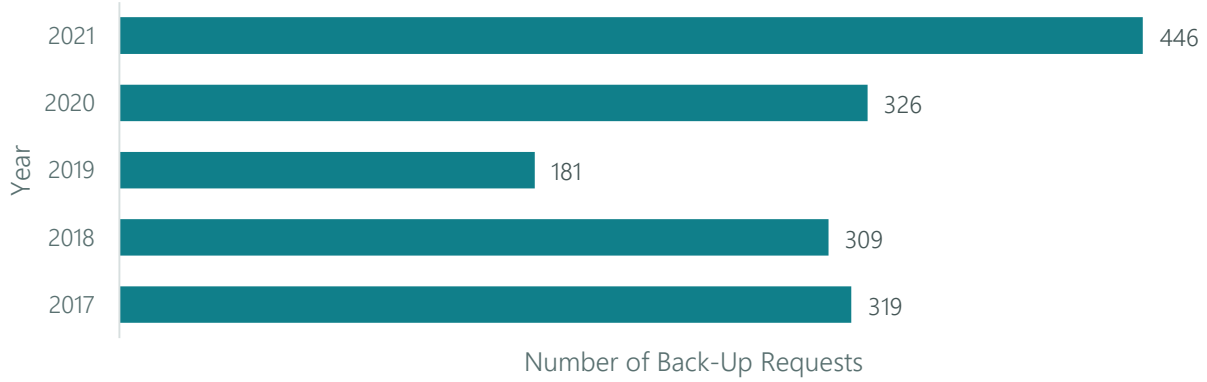
The Car 87 and Car 88 program is a partnership between the Vancouver Police Department and Vancouver Coastal Health's Access & Assessment Centre's Crisis Response Team. Car 87 / 88 is comprised of a plainclothes officer paired with a mental health clinician from Vancouver Coastal Health. They are considered a crisis response and see referrals from the public, patrols, and partner agencies. Intake can take place through 911 or the Access & Assessment Centre's 24-hour crisis line. The program began on a trial basis in 1978 and was formalized as a permanent program in 1981. The program operates 7 days a week from 7:00am to 11:30pm. Outside of these hours, general patrol officers respond to all mental health crisis calls. The program is split into two shifts with Car 87 referring to the day shift, and Car 88 referring to the evening shift. The figure below outlines the number of service calls involving Car 87 / 88 over the past five years.

Figure 33: Number of Service Calls involving Car 87 / 88



The Car 87 / 88 program operates primarily on an appointment basis and is typically not dispatched in real time to most of their calls. If available, they can respond to incoming 911 calls or attend calls in progress. In practice, the program is very busy, so they do not have the capacity to respond to 911 calls often. The clinician on the team takes the lead on mental health assessments and sets the appointments for the team. As part of their activities, the team is often called on to see clients who need to be apprehended and picked up on mental health forms for medical assessment. As an additional resource, the program has access to a doctor every Tuesday that can complete mental health certifications in the field. Based on the situation described and that unfolds upon arrival, Car 87 / 88 has the option to call for a general patrol unit to attend as backup. The following figure outlines the number of requests for backup by Car 87 (excluding Car 88) over the past five years.

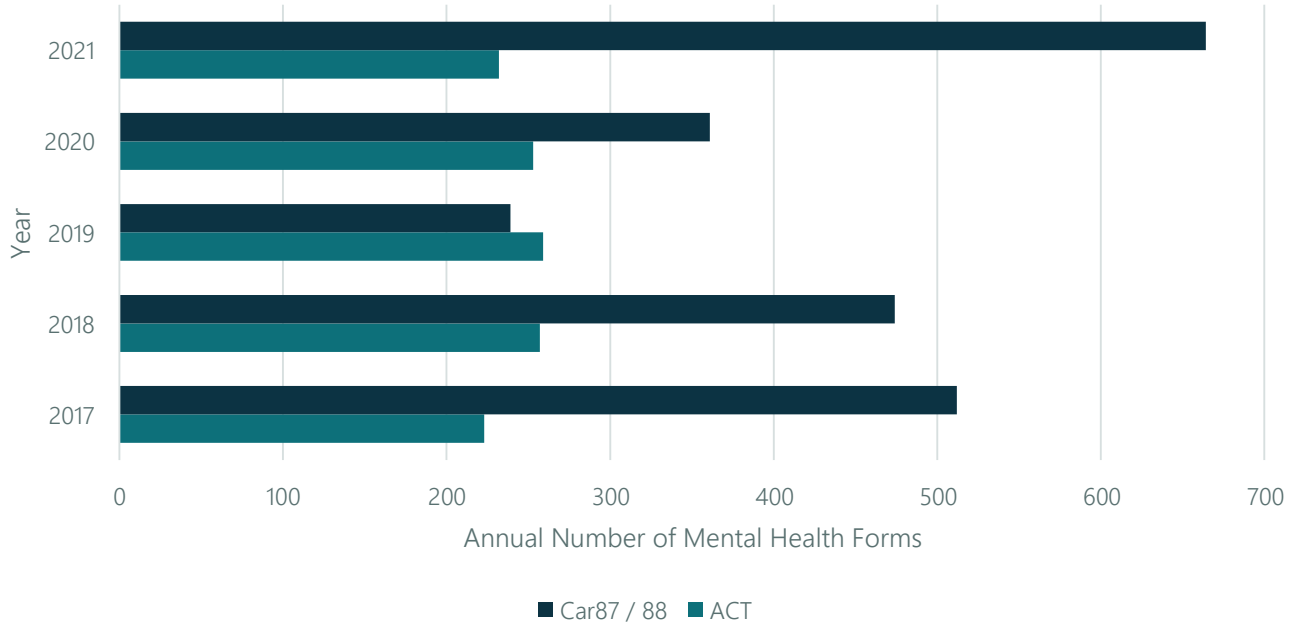
Figure 34: Car 87 (Primary Unit) Requests for Patrol Back-Up (Secondary Unit)



Assertive Community Treatment Team

Vancouver Coastal Health (VCH) operates six Assertive Community Treatment (ACT) teams which are multidisciplinary and comprised of five to six professionals including occupational therapy, social work, and psychiatry. These teams provide tertiary care, and each carries a caseload of approximately 70 clients. The VPD has one police officer attached to the ACT program who works collaboratively with all six teams. The officer provides safety and security for ACT teams when the clinicians feel it is needed on client visits. The officer assigned to ACT only attends when there is a level of risk for safety and does not attend other visits where they are not safety concerns. The officer is assigned to the ACT program by themselves, so they regularly call on general patrol officers to provide backup. The officer assigned to the ACT program is also called on to execute mental health warrants when mental health forms are completed by the teams. The figure below outlines the number of mental health forms involving Car 87 / 88 and the ACT officer.

Figure 35: Number of Mental Health Forms (4, 10, 21) Involving Car 87 / 88 or ACT



Assertive Outreach Team (AOT)

The Assertive Outreach Team (AOT) is a bridging team that works with people about to be discharged form institutions including mental health facilities and prison. They work to ensure there is a discharge plan in place and the client gets their prescriptions filled and takes their medications when prescribed. The team consists of one plainclothes officer paired with a mental health clinician and carries a caseload of 20 to 30 clients. The AOT provides short-term care, typically ranging from 30 to 60 days where they see the client daily. If needed and capacity is available, AOT clients can be transitioned and become ACT clients.

Child and Adolescent Response Team

The Child and Adolescent Response Team (CART) is run by the BC Crisis Centre and the Youth in BC crisis service. The team provides an urgent, community-based response to mental health crises. Children and youth up to the age of 18 can receive service from CART. Services range from phone consultations to on-site assessments, short-term counselling, and psychiatric assessments.

North Shore Peer Assisted Care Team

The North Shore Peer Assisted Care Team (PACT) is a mobile civilian-led team operated in partnership with CMHA BC that responds to mental health and substance use crisis calls on the North Shore. The program was launched in November 2021 in partnership with CMHA BC and pairs a mental health professional with a peer support worker to provide a trauma-informed, culturally safe support to youth and adults ages 13 and up. PACT offers support via phone and text or in-person. Individuals seeking care can access PACT services by reaching out directly to PACT by phone or text. The team provides crisis counselling and de-escalation and can accompany callers to hospital or community resources. PACT also provides referrals to appropriate resources and conducts short-term follow-up care.

Follow-up Services

The Car 87 / 88 program takes on the role of both crisis response and follow-up service. Due to the appointment-based approach taken for most calls, the program often functions as a secondary crisis response or follow-up service. Mental health crisis calls that are responded to by general patrol officers may be referred to the VPD Mental Health Unit (MHU) and/or Car 87 / 88 for follow-up after the initial incident. Aside from the MHU, most follow-up services take the form of a referral to subsequent providers and services instead of a proactive follow-up model except for the North Shore PACT program which is limited to the North Shore region.

Model Summary

The Vancouver mental health crisis response model is the only model evaluated where the 911 and police dispatch roles are conducted by a civilian agency. Vancouver was an early leader in developing alternative response models with its Car 87 program starting in 1978 but faces a lack of capacity with only one mobile team for the entire city. Further partnerships between police and health personnel through the ACT and AOT programs maintain an enforcement role for the police with their role often defaulting to keeping other staff safe and executing mental health from apprehensions. While this provides a smoother path for case managers, there is less emphasis on diversion from hospitals in the Vancouver model as compared to other comparator cities.

Strengths

- Strong police relationships with the health system across multiple programs
- Car 87 / 88 is a long-standing service in the City of Vancouver with established partnerships where police members understand the service and how to use it to serve the community
- North Shore PACT provides a civilian-led crisis response option for some residents
- Civilian-led 911 and dispatch services may reduce the chance of bias towards service provision by a given provider

Weaknesses

- The ability to add an additional "fourth" dispatch option through 9-1-1 is the responsibility of B.C.'s 25 regional districts, creating a more complex environment in which to change call-flows
- Strong focus on use of mental health act forms followed by hospitalization for mental health crisis response with less emphasis on hospital diversion as a goal of alternate response options

Service Gaps

- Lack of capacity for Car 87/88 to respond to all eligible calls and there is only one unit to serve the entire city with no staffing overnight
- No community-based mental health crisis response option through 911
- Peer Assisted Care Team is limited to North and West Vancouver
- More follow-up options are needed in addition to AOT and ACT teams

Eugene and Springfield, Oregon

Community Profile

The City of Eugene has a population of 176,654 and a land area of 43.72 square miles (113 square kilometres). Eugene's population density is approximately 1,560 people per square kilometre per 2020 US Census data. The City of Springfield has a population of 61,851 and a land area of 15.74 square miles (41 square kilometres). Springfield's population density is about 1,517 people per square kilometre per 2020 US Census data[24].

Figure 36 indicates that Eugene and Springfield do not exhibit much ethnic diversity. The populations of both cities are predominantly White, representing over 80% of their respective populations. Visible minorities in both cities are mostly represented by people of Hispanic or Latin origin. Eugene estimates about 10.4% of its population is Hispanic while Springfield estimates approximately 11.3%.

[24] https://www.census.gov/quickfacts/fact/table/springfieldcityoregon,eugenecityoregon/POP060210

Figure 36: 2020 US Census, Race - Eugene and Springfield

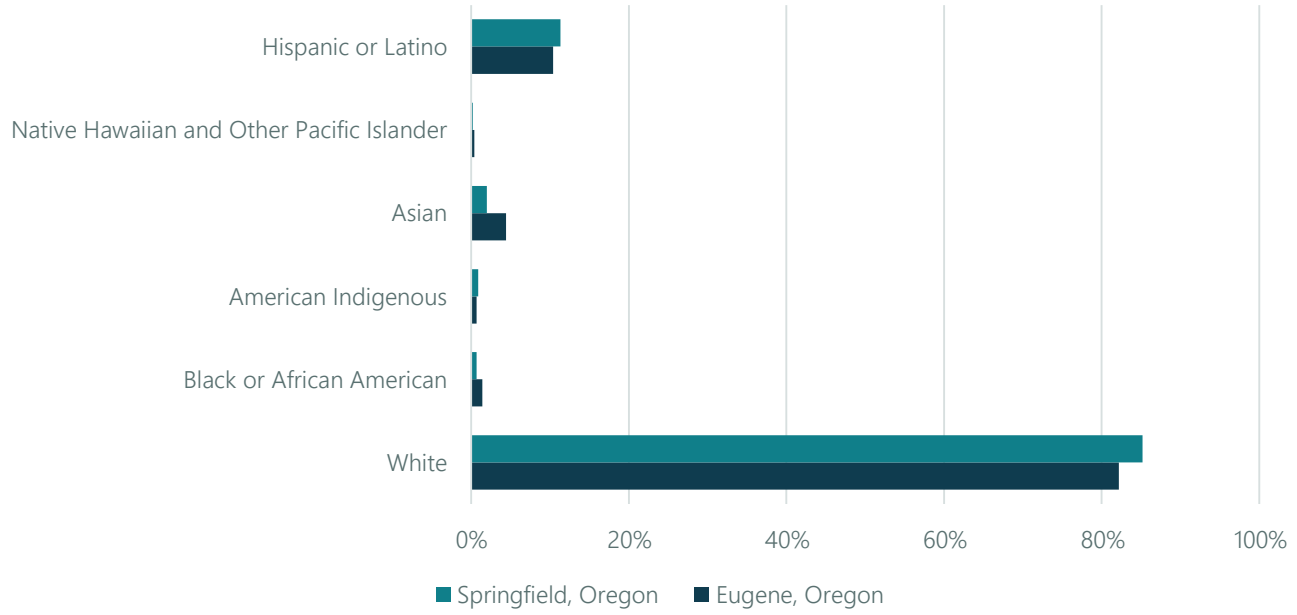


Figure 37 outlines the city borders of Eugene and Springfield[25] and Figure 38 indicates the district map for the Eugene Police Department. The Eugene Police Department's Central Lane Communications acts as dispatch for fire, EMS, and select police departments for the County, providing coverage that extends beyond Eugene's borders[26].

Figure 37: Map of City of Eugene and City of Springfield

[25] https://www.aaroads.com/oregon/eugene/
[26] https://www.eugene-or.gov/579/Area-Served

Figure 38: Eugene Police Department District Map

CAHOOTS (Crisis Assistance Helping Out On The Streets)

CAHOOTS is a program established in 1989 and run through the White Bird Clinic in partnership with the City of Eugene. CAHOOTS is available 24/7/365 (as of 2020) with dispatch via the same 911 system as the Eugene Police Department (EPD) and Eugene Springfield Fire (ESF). CAHOOTS responds to a variety of calls, diverting some from EPD and other emergency services, as well as a unique subset of calls that would not normally be responded to by law enforcement. CAHOOTS personnel provide crisis counselling and often provide initial contact and transport for individuals using substances, or who are mentally ill, or disoriented. CAHOOTS also provides transport for necessary non-emergency medical care.

CAHOOTS is a valued partner within the city of Eugene and provide a needed service within the community. They operate as a partner organization where they meet specific and unique needs. Additionally, CAHOOTS and EPD often respond together to calls for service (CFS) to meet those needs.

CAHOOTS diverts calls from EPD, however not all its calls are diversions. When comparing the total number of CAHOOTS calls to EPD calls, CAHOOTS appears to divert 17-20% of calls from the EPD. Since the type of calls responded to by CAHOOTS include call types different than those responded to by police, the actual diversion rate falls between 5% - 8%.

Additionally, EPD provides backup for some Calls for Service where CAHOOTS was the primary unit initially assigned. EPD rates of CAHOOTS requesting backup are higher than what has previously been reported. Nonetheless, the backup rates for more "traditional" CAHOOTS-centric calls including Check Welfare, Assist Public and Transport are low. When CAHOOTS responds to calls that are traditionally police-centric like Criminal Trespass, the instances of CAHOOTS requiring backup from the police jump significantly.

Intake

Calls for CAHOOTS come in through either the emergency 911 system or the non-emergency line. Additionally, calls may be self-initiated, such as instances where members of the community flag down the CAHOOTS vans. CAHOOTS personnel are viewed as valuable resources by EPD front-line officers, often being called upon to assist them when attending Calls for Service that are not criminal in nature where there are mental health or substance use factors present.

Response

911 calls related to substance use, disorientation, mental health crises, and homelessness but which do not pose a danger to others are routed to CAHOOTS. Staff members respond in pairs; usually one has training as a medic and the other has experience in street outreach or mental health support. Responders attend to immediate health issues, de-escalate, and help formulate a plan which may include finding a bed in a homeless shelter or transportation to a healthcare facility. CAHOOTS is dependent upon the availability of other services. For example, a team may be able to talk a person in crisis into going to a hospital or a homeless shelter, but there must be a hospital or homeless shelter available to accept the person.

CAHOOTS do not handle requests that involve violence, weapons, crimes, medical emergencies, or similarly dangerous situations. Some calls require both CAHOOTS and law enforcement to be called out initially, and sometimes CAHOOTS calls in law enforcement or law enforcement calls in CAHOOTS. About 60% of all calls to CAHOOTS are for persons experiencing homelessness.

In 2019, CAHOOTS responded to 13% of all emergency calls for service made to the EPD. Since the public is aware of the program, many of the calls made are requests for CAHOOTS service and not diversions from calls where police would normally respond. In 2019, 83% of the calls to which CAHOOTS responded were for "Welfare Check", "Transportation", or public assistance, none of which are traditionally handled by EPD. Thus, the true proportion of calls to which police would have responded was it not for CAHOOTS is estimated to be between 5-8%.

Calls handled by CAHOOTS alone required police backup only about 2% of the time, however this rate increases substantially when responding to calls police would traditionally handle. For example, in 2019 when CAHOOTS responded to calls for "Criminal Trespass" and located the individual, they needed police backup 33% of the time.

The table below provides a summary of CAD association types responded to by CAHOOTS in 2019. Of these calls, 17,995 (87%) were CAHOOTS-only associations. The available data did not demonstrate which emergency service provider co-responded with CAHOOTS in the 2,751 calls that had at least dual association.

Table 24: 2019 CAHOOTS Total CAD Associations[27]

Rank	Nature	Count	Percent
1	Check Welfare	5,806	28%
2	Assist Public - Police	5,555	26.8%
3	Transport	4,583	22.1%
4	Suicidal Subject	1,442	6.95%
5	Disorderly Subject	529	2.55%
6	Intoxicated Subject	421	2.03%
7	Found Syringe	347	1.67%
8	Traffic Hazard	307	1.48%
9	Criminal Trespass	288	1.39%
10	Dispute	225	1.08%
11	Other (106 Categories)	1,243	5.99%
	TOTAL	**20,746**	

Inbound calls may not result in dispatch due to several reasons including a call not requiring a response, caller cancelling the call, or the caller not giving sufficient information for a response. The table below outlines the 2019 CAHOOTS dispatched calls for service.

[27] *Eugene Police Department Crime Analysis Unit. (n.d.). Cahoots Program Analysis - Eugene, Oregon. Retrieved June 17, 2022, from https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis*

Table 25: Total 2019 CAHOOTS Dispatched Calls for Service[28]

Rank	Nature	Count	Percent
1	Check Welfare	5,083	28.7%
2	Assist Public - Police	5,555	25.7%
3	Transport	4,547	21.2%
4	Suicidal Subject	1,389	7.85%
5	Disorderly Subject	457	2.58%
6	Intoxicated Subject	356	2.01%
7	Found Syringe	310	1.75%
8	Traffic Hazard	298	1.68%
9	Criminal Trespass	215	1.21%
10	Dispute	214	1.21%
11	Other (106 Categories)	1,075	6.07%
	TOTAL	**17,700**	

Of these calls, 13,854 (78%) were CAHOOTS-only associations. The available data did not demonstrate which emergency service provider co-responded with CAHOOTS in the 3,846 calls that had at least dual association.

The table below outlines the total calls CAHOOTS attended in 2019. The number of attended calls is less than dispatched due to calls being cancelled prior to arrival (e.g., subject may no longer be on scene) and these numbers do not include calls where CAHOOTS was called in as a secondary response after another emergency response attended and called for back-up.

Table 26: Total CAHOOTS Response (Arrived)[28]

Rank	Nature	Count	Percent
1	Check Welfare	4,689	29.0%
2	Assist Public - Police	4,085	25.7%
3	Transport	3,341	21.0%
4	Suicidal Subject	1,294	8.15%
5	Disorderly Subject	402	2.53%
6	Intoxicated Subject	320	2.02%
7	Traffic Hazard	257	1.62%

[28] *IBID*

Rank	Nature	Count	Percent
8	Found Syringe	255	1.60%
9	Criminal Trespass	190	1.20%
10	Dispute	190	1.20%
11	Other (106 Categories)	937	5.90%
	TOTAL	**15,879**	

Of these calls, 13,854 (87%) were CAHOOTS-only associations. The available data did not demonstrate which emergency service provider co-responded with CAHOOTS in the 2,025 calls that had at least dual association.

In 2019, 2,018 joint calls were attended by CAHOOTS and EPD. CAHOOTS called EPD for backup on 311 (2%) calls for service. In these cases, CAHOOTS was the only response initially dispatched, arrived first, and EPD was subsequently dispatched and arrived on scene after CAHOOTS.

Follow-up Services

The following follow-up services are offered through White Bird Clinic:

- Crisis Counseling
- Suicide Prevention, Assessment, and Intervention
- Conflict Resolution and Mediation
- Grief and loss
- Substance Abuse
- Housing Crisis
- First Aid and Non-Emergency Medical Care
- Resource Connection and Referrals
- Transportation to Services

Model Summary

The CAHOOTS model has been widely examined as it has operated as a civilian response to mental health crises for decades while many other jurisdictions are only considering a similar approach in recent years. The model has demonstrated positive results over the years and is structured to provide trauma-informed care for low acuity mental health crisis and substance use calls.

Strengths

- Access to civilian crisis response through 911 service
- Civilian-led community response to low acuity mental health and substance use crisis
- Close working relationship with police to address potential safety concerns

Weaknesses

- Police-led dispatch could lead to favouring a police response in some circumstances

Service Gaps

- Limited response capacity with two teams available for 12 hours per day and one team available the other 12 hours
- Lack of integrated police and clinician co-response for higher acuity or higher risk calls
- Lack of mental health specific EMS response options
- Lack of downstream service capacity limits CAHOOTS ability to meet long-term needs

Comparison Jurisdiction Summary

The table below provides a summary of key model elements across the comparison jurisdictions examined in this report. The table does not reflect the level of service delivery provided such as area served, hours of availability, or capacity to meet demand.

Table 27: Model Summary of Comparison Jurisdictions

	Ottawa	Niagara Region	Toronto	Vancouver	Eugene & Springfield
Agency that runs the PSAP	Police	Police	Police	E-Comm	Police
Process in place for handing 911 calls off to alternative response?	No	No	Yes	No	Yes
Option for on-phone crisis support accessed through 911	Yes	No	Yes	No	No
Co-Located Crisis Worker in Comm Centre	No	No	Yes	No	No
Police and Mental Health Professional Co-Response	No	Yes	Yes	Yes	No
Paramedic and Mental Health Professional Co-Response	Yes	Yes	No	No	No
Community-led all Civilian Response Team	No	No	Yes	No	Yes
Police-Only Specialized Mental Health Response	Yes	Yes	Yes	Yes	No
Community Crisis Line(s)	Yes	Yes	Yes	Yes	Yes
Community Navigation Phone Line	Yes	Yes	Yes	Yes	No

Systemic Gaps

While there are innovative elements in each of the models and jurisdictions reviewed, there are common themes and systemic gaps shared among the programs we examined. We found a common lack of capacity in the alternative response approaches currently implemented including limited hours of availability, limited geographical availability of services, and limited capacity to meet the true demands for service. As a result, the data which comes out of many alternative response models is likely a significant underrepresentation of the true demand for service. Further, some of the most innovative programs are currently pilots with limited data still available.

Across jurisdictions, we found relatively siloed operations and mental health responses between emergency service providers such as police and EMS. This lack of coordination extended to community agencies where the fragmentation of service delivery can lead to additional gaps. There is a lack of information sharing across all systems, and no city had an effective shared access database or cross-agency information sharing protocol outside of one-to-one MOUs and individual client information requests. Additionally, service providers operate under diverging KPIs and performance measures, and mental health and substance use factors are not adequately captured in the current data collection processes.

Finally, we found a consistent shortage of downstream resources to treat the root causes behind mental health crisis and substance use calls including transitional beds, detox and treatment facilities, and case management services.

Evaluation Options for Consideration

The evaluation criteria section provides a suggested framework for consideration when evaluating alternative response models to mental health crises. The decision on how to select a model of service delivery and what elements should be included is ultimately that of the community and this report does not provide a recommendation for or against the specific models compared. However, the approach described here provides a potential framework for the community to determine which outcomes could be prioritized, and for evaluating whether the models considered meet the community's priorities.

Potential Factors for Model Selection

Prior to evaluating any potential models, it is critical for the community to agree on how the models will be measured and what factors will be used in the selection of a model. The table below provides a list of potential factors that can be utilized when comparing response models. The table also includes associated Key Performance Indicators (KPIs) which could be selected to provide an objective basis of comparison or measurement either between models or when comparing alternative response models to the status quo. We saw several of these factors used in the model development and selection processes in the comparison cities and have augmented the list with additional factors identified in our conversations across jurisdictions.

Table 28: Potential Factors for Model Selection and Associated Key Performance Indicators

Factors for Model Selection and Development	Associated Key Performance Indicators
Ability and capacity to divert calls from the police and/or hospital	Number of calls transferred from 911 and dispatch to alternative providers
Ability and capacity to respond to crisis calls in a timely way	Response time from call to arrival; alternative model response time compared to police response time for similar call types
Ability to reduce apprehension rates by police	OPS mental health call outcomes
Ability to reduce repeat calls to police and emergency services	Number of calls for service per user, ratio of first-time callers to total calls for service
Ability to reduce use of force by police on calls involving mental health	Calls diverted from police; OPS mental health call outcomes; mental health and substance use training received by officers; ratio of calls responded to by general patrol versus specialized mental health unit(s)
Ability to provide follow-up, refer and connect people in crisis with community and health supports	Number of referrals provided; number of follow-up calls provided post-crisis; effectiveness of referral (as measured during follow-up)
Financial sustainability	Cost per call benchmarked against police and paramedic costs per call
Ability to provide comprehensive coverage including areas of service and hours of operations	Hours of operation, Ottawa neighborhoods serviced

Factors for Model Selection and Development	Associated Key Performance Indicators
Availability and capacity to deliver trauma-informed, culturally appropriate services	Number of peer support workers; crisis response team composition relative to callers served; availability and wait time to receive service from cultural providers; access to and use of cultural elements in response
Ability to integrate and form a comprehensive service delivery model	Number of call transfers between service providers; continuum of responses available by call acuity level
Improved community experience	OPS mental health call outcomes; post-interaction client survey; community perception survey

To keep the evaluation focused yet comprehensive, MNP suggests identifying five or six key factors which best reflect the community's priorities and desired outcomes from implementing an alternative response model. The table below provides a suggested list of model selection factors based on MNP's preliminary understanding of the community's needs. These factors can be modified or interchanged with any of the above factors or entirely different factors based on community consultation efforts or other decision processes.

Figure 39: Suggested Factors for Model Selection

Factors for Model Selection	Key Performance Indicators
Ability and capacity to divert calls from the police and/or hospital	Number of calls transferred from 911 and dispatch to alternative providers
Ability to reduce apprehension rates by police	OPS mental health call outcomes
Ability to provide follow-up, refer and connect people in crisis with community and health supports	Referrals provided; number of follow-up calls provided post-crisis; effectiveness of referral (as measured during follow-up)
Ability to provide comprehensive coverage including areas of service and hours of operations	Number of referrals provided; number of follow-up calls provided post-crisis; effectiveness of referral (as measured during follow-up)
Availability and capacity to deliver culturally appropriate services	Number of peer support workers; crisis response team composition relative to callers served; availability and wait time to receive service from cultural providers; access to and use of cultural elements in response;

Evaluation Framework

Once the model selection factors and KPIs are selected, MNP recommends applying the evaluation criteria outlined by the Organization for Economic Cooperation and Development (OECD) in their publication entitled *Applying Evaluation Criteria Thoughtfully* to develop a comprehensive view of the models under consideration[29] These criteria include relevance, coherence, effectiveness, efficiency, impact, and sustainability. The OECD established these six criteria to support the design and delivery of policies and programmes that lead to fairer and more

[29] *OECD (2021), Applying Evaluation Criteria Thoughtfully, OECD Publishing, Paris, https://doi.org/10.1787/543e84ed-en*

sustainable outcomes. The OECD evaluation criteria were informed by the 2030 Agenda for Sustainable Development including the Sustainable Development Goals (SDGs).

Under the OECD framework, the criteria should be applied in the context of two key principles. The first principle states that the criteria should be applied thoughtfully to support high-quality, useful evaluation. The second principle holds that the criteria should not be applied mechanistically and that the use of the criteria depends on the purpose of the evaluation. The table below provides guiding questions for applying the OECD criteria within the context of the suggested factors for model selection. These questions are intended to serve as a framework for analysis and can be revised to fit the agreed-upon goals and decision-making process.

Table 29: Guiding Questions for Evaluating Model Options

Criteria	Guiding Questions
Relevance	• Is the model designed in ways that respond to the needs and priorities of all Ottawa residents, including underrepresented and marginalized groups? • Does the model provide an appropriate response for each level of acuity? • Does the model provide a trauma-informed response to mental health crises? • Are the community's priorities addressed in the model? • Are the model's goals and objectives clearly defined with unambiguous metrics?
Coherence	• Can the model be effectively integrated with existing systems and processes? • To what extent does the model enable effective care through information sharing while maintaining client privacy? • How are new services in the model distinct and differentiated from existing services? • How will new services in the model be aligned with existing and continuing services?
Effectiveness	• Does the model have well-defined, measurable outcomes? • Does the model collect sufficient data to measure its outcomes? • Does the model reduce the need for a general patrol police response or ambulance response in either a primary or backup role? • Does the model reduce the number of hospital visits for mental health crisis? • What trade-offs or negative effects on other systems or agencies may result when implementing the model?
Efficiency	• What are model response times compared to status quo response times? • Do the model response times meet the needs of those served? • Is sufficient data collected to measure cost efficiency and response times? • What is the model's cost per call in comparison to a police or ambulance response?
Impact	• How significant are the positive outcomes? • How common and severe are any unintended negative effects? • If a pilot project, is the model sufficiently scalable? • Is there a clear agreement among stakeholders on the desired impact? • Are baseline indicators available to measure outcome data against?
Sustainability	• Do model system users receive adequate follow-up care? • Are root causes of mental health crisis and substance use adequately addressed? • Is there sufficient community, political, and financial support to sustain the model?

Criteria	Guiding Questions
	• When will the model be evaluated? • What risks are present and what risk mitigation plans have been made? • Are there sufficient community resources to meet client needs after interacting with the model and reduce the recurrence of crises?

Thank you

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