Hamilton Police Services Board

Thursday, June 13, 2019, 1:00 P.M.
Council Chambers, Hamilton City Hall
71 Main Street West

Pages

1. Call to Order

1.1 Moment of Silence

1.2 Changes to the Agenda

2. Public Presentations & Deputations

2.1 Members of the Month

3. General

3.1 Declarations of Interest

4. Consent Items

4.1 Approval of Consent Items

That the Board approve and receive the consent items as distributed.

4.2 Adoption of Minutes - May 9, 2019 4

The minutes of the meeting held Thursday, May 9, 2019, be adopted as printed.

5. Discussion Items

5.1 Presentation: Year End Report: Use of Force - 2018 (PSB 19-045) 93

That the Hamilton Police Services Board receive the presentation with respect to the Year End Report: Use of Force - 2018, as provided.

5.2 Hamilton Police Services Board: Complaints Process for Board Member Conduct (PSB 19-054) 117

That the Board approve the *amended* Police Services Board Complaint Process for Board Member Conduct, attached hereto as Appendix “A”

6. New Business

6.1 Verbal Update on the Enforcement of Illegal Dispensaries & Court Actions

6.2 Verbal update with respect to Outstanding Issue #4 – The Board requested a report on services / relationships with respect to the indigenous community and the Hamilton Police Service

7. Adjournment

THE POLICE SERVICES BOARD WILL ADJOURN THE PUBLIC PORTION OF THE MEETING AND RECONVENE IN CAMERA FOR CONSIDERATION OF PRIVATE AND CONFIDENTIAL MATTERS.

MINUTES OF THE HAMILTON POLICE SERVICES BOARD

Thursday, May 9, 2019
1:00pm
Hamilton City Hall
Council Chambers

The Police Services Board met.

There were present:	Fred Eisenberger, Chair Donald MacVicar, Vice Chair Fred Bennink Chad Collins Geordie Elms Tom Jackson Patricia Mandy
Absent:	Deputy Chief Dan Kinsella
Also Present:	Chief Eric Girt Deputy Chief Frank Bergen Chief Administrative Officer Anna Filice Superintendent Jamie Anderson Superintendent Nancy Goodes Ritchie Acting Superintendent Paul Hamilton Superintendent Will Mason Inspector Robin Abbott Inspector Shawn Blaj Inspector Treena MacSween Staff Sergeant Frank Miscione Marco Visentini, Legal Counsel Jackie Penman, Corporate Communicator John Randazzo, Manager, Finance Leanne Sneddon, Director, Human Resources Lois Morin, Administrator

Call to Order

Chair Eisenberger called the meeting to order.

1.1 Additions/Changes to Agenda

None

After discussion, the Board approved the following:

Moved by: Vice Chair MacVicar
Seconded by: Member Mandy

That the Agenda for the Hamilton Police Services Board Public meeting be adopted, as printed.

Carried.

Presentations

2.1 Member of the Month

Chair Eisenberger and Chief Girt presented the Member of the Month Award for March 2019 to Constable Jennyfer Carranza-Mejia and Constable Ryan King. Constable Carranza-Mejia and Constable King were commended for the arrest and search authorities. Their actions exceeded the experience level and they were able to get a drunk driver and wanted party off the street.

2.2 Mothers Against Drunk Driving (MADD) Award

Constable Watler Johnson was presented the first Mothers Against Drunk Driving (MADD) Award. The award was presented by Ms. Alison Merideth of the Hamilton MADD Chapter and Constable Franklin Loppie.

General

3.1 Declarations of Interest

None

Consent Agenda

4.1 Approval of Consent Items

Moved by: Member Collins
Seconded by: Member Elms

That the Board approve and receive the consent items as distributed.

Carried

4.2 Adoption of Minutes – April 11, 2019

The minutes of the meeting held Thursday, April 11, 2019, be adopted as printed.

4.3 Auction Account Fund

Support / Upcoming Events

RECOMMENDATION(S)

- That the Board provide support to the 27th Annual Wesley Open Golf Tournament, in the amount of $200, to be paid from the auction account.

4.4 For the Information of the Board:

a) City of Hamilton Police Services Board Policies (PSB 19-036)

b) Memorandum from Stephen Beckett, Assistant Deputy Minister, Public Safety Division and Public Safety Training Division, Ministry of Community Safety and Correctional Services with respect to Update on Transformation of Policing Grants for 2019 – 20 and On-going.

c) Correspondence from Gena Dureault, Senior Development, Mohawk Foundation with respect to the Hamilton Police Services Board Bursary Program.

d) Correspondence from Amy Leaming Cote, Development Officer, Hamilton Foundation for Student Success thanking the Hamilton Police Services Board for support to the Rainbow Prom.

e) Outstanding Issues as of May 9, 2019

Discussion Agenda

5.1 Presentation: Year-End Report: Youth Crime - 2018 (PSB 19-034)

After discussion, the Board approved the following:

Moved by: Member Mandy
Seconded by: Member Bennink

That the Board receive the presentation with respect to the Year-End Report: Youth Crime, as provided.

Carried.

New Business

6.1 Update on the Enforcement of Illegal Dispensaries

Chief Girt and Deputy Chief Kinsella provided an update with respect to the enforcement on Illegal Dispensaries.

The Board requested that future updates would include information regarding court cases and charges as it relates to the Enforcement of Illegal Dispensaries.

Next Meeting of the Board

Chair Eisenberger announced that the next meeting of the Board is scheduled for Thursday, June 13, 2019, 1:00pm, at Hamilton City Hall, Council Chambers.

Adjournment

Moved by: Member Bennink
Seconded by: Member Collins

There being no further business, the public portion of the meeting then adjourned at pm 2:25pm.

Carried.

* * * * * * * * * * * *

The Board then met in camera to discuss matters of a private and confidential nature.

Taken as read and approved

Lois Morin
Administrator

Fred Eisenberger, Chair
Police Services Board

May 9, 2019
lem:

4.3

Morin, Lois

From: Canadian Association of Police Governance <communications@capg.ca>
Sent: May-08-19 5:31 PM
To: Morin, Lois
Subject: 2019 Conference Program Attached | August 9 - 11, Calgary

View this email in your browser

We're pleased to invite you to join us for the **Canadian Association of Police Governance 30th Annual Conference** *on August 9th-11th*, 2019.

We are also pleased to be hosting our **FIRST NATIONS Police Governance Council CONFERENCE** on *August 8th*, 2019

Register Now

Don't miss out: Earlybird pricing for members ends May 31st.

CAPG's 30th Annual Conference

The 2019 Conference will explore this theme through a lens of **'representation'** and try to answer the overarching question: How do **police boards and police commissions,** collectively and as individuals, effectively **represent the diverse community members** on

whose behalf we are tasked with providing oversight?

Highlighted sessions:

- KEYNOTE: Update by the Minister of Public Safety (invited)
- Police Governance at a Crossroad: Lessons Learned
- Gold Standard Strategic Plans for Police Services
- Innovations in Community Engagement: Quality of Life Measurements
- Building Community Health, Safety & Well-being
- The Police Governance Dashboard

Now Available: **Download the 2019 CAPG Conference Program**

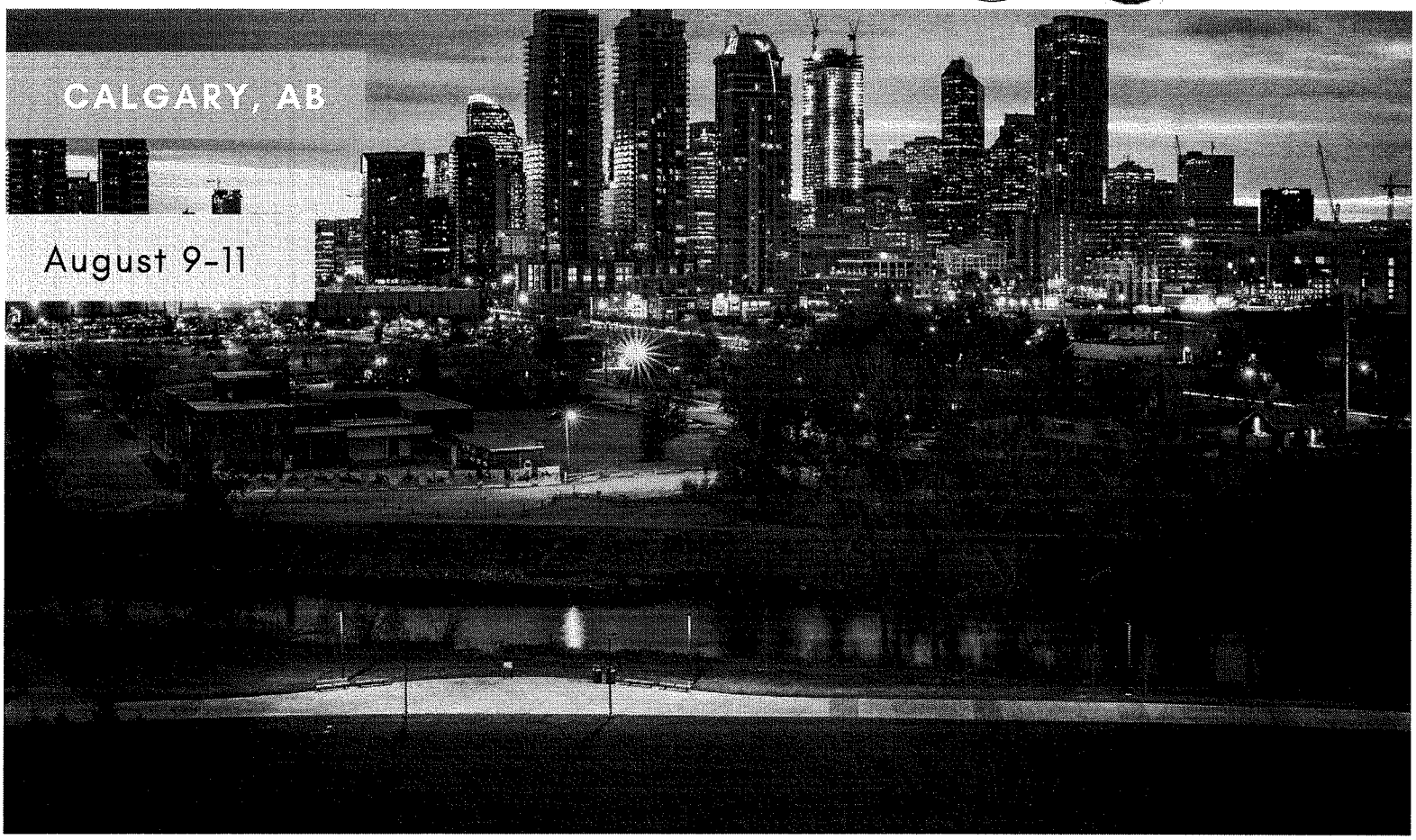
Register Today

Daily rates and companion programs available.

Our mailing address is:
Canadian Association of Police Governance
78 George Street
Suite 204
Ottawa, ON K1N 5W1
Canada

COMMUNITY SAFETY, COMMUNITY SERVICE, COMMUNITY STRENGTH

CAPG 2019 CONFERENCE PROGRAM



THE WESTIN CALGARY

320 4 AVE SW

The 2019 CAPG Conference will explore this theme through a lens of 'representation' and try to answer the overarching question: How do police boards and police commissions, collectively and as individuals, effectively represent the diverse community members on whose behalf we are tasked with providing oversight?

CAPG 2019 CONFERENCE PROGRAM

Thursday, August 8

12:00 - 8:00pm
Conference Registration | CENTRAL FOYER

7:00am - 4:30pm
First Nations Police Governance Session
NOTE: This sessions requires a separate registration.

Friday, August 9

7:00am - 8:00am
Breakfast | GRAND FOYER

8:00 - 8:30am
Opening Ceremonies
Master of Ceremonies: **CAPG President Mary Anne Silverthorn**
Speakers: *Premier of Alberta; Minister of Justice and Solicitor General;* **Hon. Naheed Nenshi**, *Mayor of Calgary;* **Brian Thiessen**, *Chair of Calgary Police Commission;* Mark Newfeld, *Chief of Police, Calgary Police Service*

8:30 - 9:00am
Plenary Session: Opening Keynote
Keynote Speaker: **Hon. Ralph Goodale (invited)**, *Minister of Public Safety*
Minister Goodale will update CAPG delegates on Cannabis Legalization, Opioid Crisis, RCMP Civilian Oversight Board and the Government's response to CAPG Resolutions

9:00 - 10:00am
Plenary Session: ***Human Rights Issues for Police Governance***
Speaker: **Chief Commissioner Renu Mandhane (invited)**, *Ontario Human Rights Commission*
Commissioner Mandhane will speak to the gender diversity issues reviewed for the Ottawa Police Service, the study of racial profiling/carding by the Toronto Police Service and how bringing the results of these studies back to the police governance bodies encourages the setting up of appropriate policies, ensuring they are complied with and reporting back to and following up with the community to gauge their satisfaction.

10:00 - 10:15am
Refreshment & Stretch Break | GRAND FOYER

10:15 - 11:15am
Plenary Session: ***Police Governance at a Crossroads***
Panel Speakers: **Andrew Graham**, *Queen's University;* **Fred Kaustinen**, *Governedge;* **Celina Reitberger**, *Chair Thunder Bay Police Services Board*
This panel will not dwell on what went wrong with the Thunder Bay Police Services Board as identified in Senator Murray Sinclair's report issued by the Ontario Civilian Police Commission in December 2018 and resulting in the suspension of the board. It will look at the recommendations made; how a board and service can become disconnected from parts of the community they serve; understanding oversight of the chief and deputy chief; acknowledging power and privilege and unconscious bias; and board and police training around inclusivity and diversity. The actions of any board have a direct impact on their ability to carry out their legislated function of setting policy. We will get an update on the steps needed to build that bridge of trust with community.

11:15am - 12:30pm
Plenary Session: ***Gold Standard Strategic Plans for Police Services***
Speakers: **Dr. Tullio Caputo, Dr, Mike McIntyre, Tarah Hodgkinson**
In a survey of CAPG membership conducted by the CAPG in 2018, strategic planning was identified as the research area most significant to the membership, and as the topic that most needed immediate research attention. CAPG conducted a new survey in 2019 to drill down on how strategic plans are built, what is included in them and what is done with the final product. The survey developed and analyzed by Dr. Caputo & Dr. McIntyre provides an initial overview of existing strategic planning practices. Objectives of the study will be to identify areas where existing practices can be improved so that CAPG members can gain the maximum benefit from the time and resources currently devoted to strategic planning in their organizations. Phase II of the project will take a deeper dive and this session will bring you up to speed on the project, what we've learned so far and where we can take this forward to ensure 'Gold Standard Strategic Plans'.

12:30 - 1:15pm
Lunch | GRAND FOYER

1:15 - 2:45pm
CAPG Annual General Meeting
This session is restricted to voting delegates who are full members of the CAPG and their Board staff.

2:45 - 3:00pm
Refreshment & Stretch Break | GRAND FOYER

3:00 - 4:30pm
Roundtable Discussions: Discussion topics will be set in advance. Facilitators for each group will be CAPG Directors.

- **Small Police Boards**
- **Medium Police Boards**
- **Large Police Boards**
- **First Nations Police Boards**

7:00 - 9:30pm
CAPG 30th Anniversary Dinner and Cultural Event | GREY OWL RESORT, TSUUT'INA
Join your fellow delegates in Tsuut'ina for dinner and a cultural evening. Tsuut'ina Elders will have a smudge ceremony and opening prayer, traditional dancing and a drum circle. We will celebrate 30 years of CAPG working towards the pursuit of excellence in police governance in Canada.

CAPG 2019 CONFERENCE PROGRAM

Saturday, August 10

7:00am - 8:30am
Kick-off Breakfast for Victoria 2020 | GRAND FOYER

8:30 - 9:30am
Plenary Session: ***Innovations in Community Engagement***

Speaker: **Chief Neil Dubord,** *Delta Police Department*

Quality of Life Measurements: Engaging the Community in Public Safety
Chief Neil Dubord will cover how Delta Police Department worked with the Delta Police Board and the City to develop a multi-stakeholder public safety committee and develop quality of life indicators. The BC Chiefs of Police are also working on a 5-dimension score card.

9:30 - 10:45am
Plenary Session: **Police Governance Dashboard**

Speaker: **Dr. Gordon McIntosh,** *Banff Executive Leadership*

Dr. Gordon McIntosh will reveal the final product that was developed through the three CAPG Governance Summits. The Police Governance Dashboard includes the core functions framework depicts the Boards/Commissions ream as revolving around the service's strategic direction and policy choices. It also portrays service delivery and system coordination as the primary functions in the Chief's realm.

This will be a practical tool that delegates can bring back and apply to their own governance structure. Dr. McIntosh will host two afternoon workshops where attendees can work through their own questions on applying the tool.

10:45 - 11:00am
Refreshment & Stretch Break | GRAND FOYER

11:00am - 12:15pm
Plenary Session: **Building Community Health, Safety, and Well-Being**

Panel Speakers: **Frank Cattoni,** *Executive Director, SORCe;* **Jan Fox,** *Executive Director, REACH;* **Felix Munger**, *Executive Director, Canadian Municipal Network on Crime Prevention*

This panel will explore how various groups and organizations are assisting communities in developing the tools, resources and guides to build a community's capacity for health, safety and well-being.

12:15 - 1:00pm
Lunch | GRAND FOYER

1:00 - 2:30pm - CONCURRENT SESSIONS
Police Governance Dashboard – Practical applications to your own board/commission | BONAVISTA

Led by: **Dr. Gordon McIntosh,** *Banff Executive Leadership*

Community Engagement Through Social Media | BOW VALLEY

Led by: **Michael Nunn (invited),** *CPS Communications Manager*

Addressing Inequity & Creating Change | EAU CLAIRE NORTH/SOUTH

Led by: **Dr. Rebecca Sullivan (invited),** *University of Calgary*

Indigenous Awareness Training | LAKEVIEW ENDROOMS

Led by: **Holly Fortier (invited),** *Nitso Consulting*

2:30 - 2:45PM
Refreshment & Stretch Break | GRAND FOYER

2:45 - 4:15PM - CONCURRENT SESSIONS
- **Police Governance Dashboard**
- **Community Engagement Through Social Media**
- **Addressing Inequality & Creating Change**
- **Indigenous Awareness Training**

6:00 - 9:30pm
Calgary Host Evening & Dinner: Fundraiser for Youthlink

Sunday, August 11

7:30am - 8:30am
Breakfast | GRAND FOYER

8:30 - 9:30am
Plenary Session - Community Special Needs: Pacific Autism Family Network

Speakers: Wendy Lisogar-Cocchia, Jack McGee, CPKN

1 in 66 Canadian children are diagnosed with ASD. People with ASD are 7 times more likely to come in contact with police and these calls are 3 times more likely to end in an emergency.

Panelists will discuss why Autism Awareness and Technique Training is important to Canada's citizens and police, some of the indicators that a first responder can recognize as indicative to an individual with autism, as well as some strategies and recommendations that may help first responders adapt or modify their approach to better support the individual with ASD in an emergency situation.

9:30 - 10:00am
Networking Break | GRAND FOYER

10:00 - 11:30am
Plenary Session: **CACP/CPA/CAPG Town Hall**

Join leadership from the Canadian Association of Chiefs of Police (CACP), the Canadian Police Association (CPA) and the Canadian Association of Police Governance (CAPG) for a facilitated discussion on **'Defining the Role of Community in Shaping Future Leaders in Policing'**. With a large number of police chiefs retiring the pressure is on police governance bodies to get the right person hired. *What do they look for in a Chief? What is the best process for hiring? How do you engage the community? How do you evaluate you've made the right choice?*

11:30 - 11:45am
Wrap up remarks and brief overview of conference by CAPG President

FIRST NATIONS POLICE GOVERNANCE COUNCIL

2019 CONFERENCE PROGRAM

The Westin Hotel
Calgary, AB

THURSDAY, AUGUST 8

7:00- 7:30am
Opening Ceremonies

7:30am - 8:30am
Hot Breakfast

8:30 - 9:00am
Welcome and Opening Remarks
Speakers: **Chief Lee Crowchild**, *Tsuut'ina Nation;* **Violet Meguinis**, *Governance Advisor/Analyst, Tsuut'ina Nation;* **Keith Blake**, Chief of Police, Tsuut'ina Nation Police Service; **Dan Bellegarde**, *Executive Director, Treaty Governance Office of The Federation of Saskatchewan Indian Nations & Board Chair of File Hills Board of Police Commissioners*

9:00 - 10:00am
Keynote Presentation: **Community Safety and Security as a Human Right, an Inherent Right and a Treaty Right**
Speaker: **Dr. Wilton Littlechild (invited)** *founder, International Organization of Indigenous Resource Development*

10:00 - 10:15am
Refreshment & Stretch Break

10:15 - 11:15am
Boards Challenges: **Lessons from Thunder Bay and File Hills Boards of Police Commissioners**
Speaker: **Andrew Graham (invited)**, *Queen's University*

- Understanding role, power, responsibility and authority
- Relationships with the Chief of Police, the public and leadership
- Internal discipline and Board effectiveness
- Board self-evaluation

11:15am - 12:15pm
Learning from Various Jurisdictions
This panel session will showcase examples of good practices that incorporate governance and culture to create safer communities. Topics include Guns & Gangs, Peacemaker programs and innovations in Justice from the Blood Tribal Police, Onion Lake Cree Nation & Lethbridge

12:15 - 1:00pm
Lunch

1:00 - 2:30pm
The Police Board Dashboard

- Training and professional development for Board members
- Groups will work together to flesh out a Police Governance Dashboard for their First Nations Police Governance Authority

2:30 - 2:45pm
Refreshment & Stretch Break

2:45 - 3:45pm
Report: **Policing in Indigenous Communities**
Speakers: **Council of Canadian Academies**
Challenges in Board governance recommendations

3:45 - 4:30pm
Recap, Open Mike, Q&A, Undertakings and Wrap-up
With **Dan Bellegarde**, *Facilitator*

5:00
Tour of Tsuut'ina Police Service headquarters and presentation by Chief of Police and Officers.
Optional dinner at the Grey Eagle Resort and Casino. Travel by cab.

CANADIAN ASSOCIATION OF POLICE GOVERNANCE
ASSOCIATION CANADIENNE DE GOVERNANCE DE POLICE

CALL FOR NOMINATIONS

To: **CAPG Members**

From: **CAPG Executive Director**

Date: **March 31, 2019**

On behalf of the CAPG Nominations Committee, we are pleased to invite nominations to the Canadian Association of Police Governance (CAPG)'s Board of Directors for the term 2019 - 2021.

The following chart lists the positions that are currently vacant on the CAPG Board of Directors and those terms that will expire on August 9, 2019 at the Annual General Meeting.

All directors whose terms expire in 2019 are eligible to run for election for an additional two-year term BUT this provision **does not preclude any other eligible and interested candidates from submitting their own nomination for the vacancy**.

There are 9 vacancies listed below:

British Columbia (2 vacancies)	1. John Rizzuti, Central Saanich Police Board (Interim appointment to 2019) 2. Vacancy
Saskatchewan (1 Vacancy)	• Marcel Roy, Weyburn Board of Police Commissioners (term expires August 2019)
Manitoba (1 Vacancy)	• Vacancy

Ontario (3 Vacancies)	1. Mary Anne Silverthorn, Woodstock Police Services Board (term expires August 2019) 2. Sandy Smallwood, Ottawa Police Services Board (term expires August 2019) 3. Michael Vagnini, Greater Sudbury Police Services Board (term expires August 2019)
Nova Scotia (1 Vacancy)	• Wayne Talbot, Truro Police Board (term expires August 2019)
First Nations (1 Vacancy)	• Ron Skye, Kahnawake Peacekeepers Board (retired in December 2018)

Nominations are an important responsibility of our members. The effectiveness and success of our Association depends on the strength and quality of our volunteer Board. It is up to you to propose nominees who will bring the necessary competencies and commitment.

CAPG By-Laws state:

5.2 Composition of the Board

The Board shall be comprised of representatives of the geographic regions of Canada represented by its Members. The Nominations Committee shall be responsible for preparing a slate of directors for election by the Members which complies with these By- laws and the operating policies of the Corporation.

5.3 Qualifications

In addition to the qualifications for Directors set out in the Act,

a) Only those individuals who are appointees of a Police Board who is a Member of the Corporation, are eligible to be elected as Directors of the Corporation; and

b) Candidates nominated for election to the Board must reside in the province or territory in which the Police Board is located.

5.4 Election and Term of Directors

The Directors shall be elected by the Members at each annual meeting of Members for which an election of Directors is required. Each Director shall be elected to hold office for two years, at which time each such Director shall retire as a Director, but, if qualified, shall be eligible for re-election.

When more than one qualified nomination is received for the same vacancy the Nominations Committee will advise that this will require an election to be held by ballot at the Annual General Meeting. Each candidate will be given time to address the members to support their election.

Following the receipt of nominations and identification of eligible candidates, the Nominations

Committee will present a slate for election at the Annual General Meeting on Friday, August 9, 2019 in Calgary, Alberta.

Attached to this document are the following:

- Schedule A is the form to be used by nominees who are not currently on the CAPG Board of Directors.

- Schedule B is the form to be used by current directors who meet all the same requirements and are looking to be nominated for another two-year term.

- Schedule C is the form to indicate areas of interest or expertise of the Nominee.

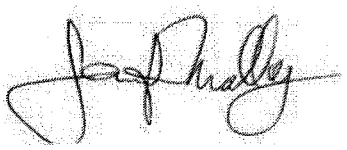
Please submit your nomination forms electronically to the attention of, Chair, Nominations Committee at the following address: nominations@capg.ca before June 28, 2019.

The deadline for receipt of nomination papers is FRIDAY, JUNE 28, 2019. The members of the Nominations Committee are:

- Mary Collins, Victoria, British Columbia
- Jonathan Franklin, Saint John, New Brunswick
- Ron Skye, Kahnawake, Quebec.

If you have any questions, please feel free to send them to me via jmalloy@capg.ca or via the nominations@capg.ca email.

Sincerely



Jennifer Malloy
Sent on behalf of the Nominations Committee

Schedule A: Nomination Form

TO BE SIGNED BY BOARD/COMMISSION CHAIR/VICE CHAIR AND NOMINEE:

We _____, being members in good standing of CAPG,

nominate _____ for the position above.

We also confirm that:

- We are members in good standing of the Association
- The nominee resides in the province where our Police Board/Commission is located
- The nominee is willing to commit to the Association for at least a two-year term
- The nominee has the time to attend the annual board retreat, lobby day & joint meeting to be held the last weekend of September each year (3-4 days)
- The nominee has the time to attend the annual conference of CAPG
- The nominee has the financial support of our Police Board/Commission to cover the cost of his/her attendance at the these two meetings a year including airfare and accommodation (estimated financial commitment is $4,000 - $5,000)
- The nominee is able to participate in a two-hour bi-monthly teleconference board meeting; and
- The nominee is willing to sit on at least one working committee and actively participate in the work of that committee.

Signature: Name: (please print)

Chair of Board/Commission

NOMINEE:

I _____ being a member of, _____ consent to this nomination. I am currently a _____ (provincial, municipal, citizen appointment) representative on my police board/commission and I have _____ years left to serve. I am eligible for another reappointment for_____years.

Address: _____

Telephone: _____

Fax: _____

Email: _____Date_____

Signature: Name: (please print)

Return this form by email to nominations@capg.ca
by June 28, 2019

Schedule B: RE-CONFIRMATION FORM FOR DIRECTORS WHO WOULD LIKE TO BE RE-NOMINATED

TO BE SIGNED BY BOARD/COMMISSION CHAIR/VICE CHAIR & NOMINEE

We confirm that we are members in good standing of the CAPG and that all of the conditions set out in the original Nominations document are confirmed including the financial support and time commitment of the nominee and board/commission and that the Nominee is able to serve the two-year term from August 2019 to August 2021.

Board Chair/Vice Chair

Signature:

Name: (please print)

Chair of Board/Commission

Nominee:

Signature:

Name: (please print)

Nominee

Return this form by email to nominations@capg.ca
by June 28, 2019

SCHEDULE C – Areas of Interest or Expertise

Experience	Interest	
		Governance – research on police governance
		Policy development for police governance authorities
		Advocacy on legislation effecting police governance authorities
		First Nations Police Governance
		Governance – emerging issues on board composition and appointments
		Conference and educational program development
		Innovations in crime prevention
		Victims services
		Team building and leadership development
		Risk management
		Labour Relations
		Human resources
		Strategic planning
		Knowledge of federal, provincial, municipal governments
		Contacts, networking, especially on a national level
		Community engagement
		Proposal and grant writing
		Information Technology
		Marketing & public relations
		Fundraising & special events
		Business administration, especially non-profit
		Accounting & Finance in non-profit
		Legal, especially non-profit & tax-law

4.5

Auction Account Fund

Support / Upcoming Events

RECOMMENDATION(S)

- That the Board provide support to the Freedom & Hope Women's Golf Tournament in support of Jared's Place at Interval House of Hamilton in the amount of a $100 hole sponsorship, to be paid from the auction account.

HAMILTON POLICE SERVICES BOARD

- INFORMATION -

DATE:	June 13, 2019
REPORT TO:	Chair and Members Hamilton Police Services Board
FROM:	Eric J. Girt Chief of Police
SUBJECT:	***Budget Variance Report as at April 30, 2019*** ***PSB 19-046***

BACKGROUND:

As at April 30, 2019, net expenditures are 51,247,805 or 31.04% of the 2019 Operating budget of $165,096,070. The budget variance summary is provided in the attached Appendix "A". Overall, the net expenditures are anticipated to be within budget at year-end.

Eric Girt
Chief of Police

EG/J. Randazzo

cc: Anna Filice, Chief Administrative Officer
John Randazzo – Director of Finance/Chief Financial Officer

Attachment: *Appendix A*

Hamilton Police Service **Appendix A**

Budget Variance Report

Period Ended April 30, 2019

YTD Budget % : 33.33%

	Annual Budget	YTD Budget	YTD Actual	Available Balance	% Spent	Comments
Revenues						
Grants and subsidies	$ 9,483,120	$ 3,159,776	$ 3,178,062	$ 6,305,058	33.51%	In line with budget.
Fees and general revenues	2,707,210	902,044	725,043	1,982,167	26.78%	Revenue is less than anticipated due to cyclical demand, as well as timing of collection, in Special Duty, False Alarm Fees, Tow Fees and Gen Occur/Photo ID Sales. This is offset by increase in Police Fees revenue.
Reserves/Capital recoveries	610,380	203,384	203,384	406,996	33.32%	In line with budget.
Total revenues	12,800,710	4,265,204	4,106,489	8,694,221	32.08%	
Expenses						
Employee Related Costs	159,352,440	53,096,216	50,075,542	109,276,898	31.42%	The YTD Budget includes an estimated Collective Agreement % increase as the current Collective Agreement has expired.
Materials and supplies	6,536,670	2,178,040	1,264,881	5,271,789	19.35%	Some expenditures are less than YTD Budget. Though they are expected to be incurred over remaining months, they are anticipated to be within Budget.
Vehicle expenses	2,075,000	691,392	552,964	1,522,036	26.65%	
Buildings and grounds	2,287,600	762,232	571,557	1,716,043	24.99%	
Consulting expenses	42,600	14,196	-	42,600	0.00%	
Contractual expenses	775,950	258,548	205,856	570,094	26.53%	
Agencies and support payments	42,300	14,096	14,096	28,204	33.32%	
Reserves/Recoveries	4,638,800	1,542,656	1,542,656	3,096,144	33.26%	
Cost allocation	660,250	219,996	219,996	440,254	33.32%	
Capital Financing	1,116,130	371,896	371,896	744,234	33.32%	
Financial/Legal Charges	369,040	122,964	133,070	235,970	36.06%	
Total expenses	177,896,780	59,272,232	54,952,514	122,944,266	30.89%	**Overall, expenditures are within Budget.**
Total Net Expenditure	$ 165,096,070	$ 55,007,028	$ 50,846,025	$ 114,250,045	30.80%	**Net Budget is on target for the year.**

Ministry of Health and Long-Term Care

Office of the Deputy Premier and Minister of Health and Long-Term Care

777 Bay Street, 5th Floor Toronto ON M7A 1N3
Telephone: 416 327-4300 Facsimile: 416 326-1571
https://www.ontario.ca/health

Ministère de la Santé et des Soins de longue durée

Bureau du vice-premier ministre et du ministre de la Santé et des Soins de longue durée

777, rue Bay, 5e étage
Toronto ON M7A 1N3
Téléphone : 416 327-300
Télécopieur : 416 326-1571
https://www.ontario.ca/sante

Solicitor General

Office of the Solicitor General

25 Grosvenor Street, 18th Floor
Toronto ON M7A 1Y6
Tel: 416 325-0408
MCSCS.Feedback@Ontario.ca

Solliciteur général

Bureau de la solliciteure générale

25, rue Grosvenor, 18e étage
Toronto ON M7A 1Y6
Tél.: 416 325-0408
MCSCS.Feedback@Ontario.ca

Ontario

HLTC2972IT-2019-33

MEMORANDUM TO: Hospital Chief Executive Officers
All Chiefs of Police and Commissioner OPP
Chairs, Police Services Boards
Chiefs, Paramedic Services

FROM: Hon. Sylvia Jones
Solicitor General
Hon. Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care

SUBJECT: POLICE-HOSPITAL TRANSITIONS FRAMEWORK

We are pleased to share with all hospitals and police services in Ontario the newly released *Improving Police-Hospital Transitions: A Framework for Ontario* as well as the supporting toolkit, *Tools for Developing Police-Hospital Transition Protocols in Ontario*.

The Ministry of the Solicitor General and the Ministry of Health and Long-Term Care recognize the need for guidance and support in implementing local transition protocols between police services and hospitals, and have been pleased to work in partnership with the Provincial Human Services and Justice Coordinating Committee (PHSJCC) and the Canadian Mental Health Association, Ontario, in the development of this framework. Both ministries support its consideration for use in emergency departments across the province.

The purpose of the framework is to assist police services and hospitals with developing joint emergency department transition protocols, which are responsive to unique local needs, in order to ensure the seamless transfer of care for persons in a mental health or addictions crisis brought to a hospital by police officers. The key objectives of the framework are to:

- Improve health outcomes for individuals apprehended by police under the *Mental Health Act*;

- Improve transition of clients between police officers and hospital workers; and
- Improve coordination and collaboration among partners involved in the transition.

The framework was developed through a collaborative process, working with a range of policing and health care partners, including the Ontario Association of Chiefs of Police and the Ontario Hospital Association. This process has allowed for the development of a framework which is adaptable to operational realities and considerations, such as staff safety, while ensuring flexibility for application to a range of local circumstances. Moreover, the framework reflects evidence and successful practices in various communities across Ontario.

Both the Ministry of the Solicitor General and the Ministry of Health and Long-Term Care endorse and recommend that all Ontario police services and hospitals consider using the Framework and establish a written local emergency department transition protocol for individuals who are brought to the hospital emergency department by police officers under the *Mental Health Act*.

The framework is also supported by a toolkit that police services and hospitals may use and adapt to reflect their local circumstances.

As partners in ensuring community safety and well-being in Ontario's communities, we thank you in advance for working together on this important initiative.

If you have any questions about the Framework, please contact Joseph Szamuhel, Project Manager, PHSJCC Secretariat by phone at 1-800-875-6213 ext. 4127, or by email at jszamuhel@ontario.cmha.ca.

Sincerely,

Sylvia Jones
Solicitor General

Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care

Attachments

c: Chief Executive Officers, Local Health Integration Networks
Mr. Mario Di Tommaso, Deputy Solicitor General, Community Safety
Ms. Helen Angus, Deputy Minister, MOHLTC
Ms. Melanie Fraser, Associate Deputy Minister, Health Services, MOHLTC
Mr. Stephen Beckett, Assistant Deputy Minister, Public Safety Division, Solicitor General
Mr. Phil Graham, Acting Assistant Deputy Minister, Community, Mental Health and Addictions and French Language Services Division, MOHLTC

Ministry of the Solicitor General

Public Safety Division
Public Safety Training Division

25 Grosvenor St.
12th Floor
Toronto ON M7A 2H3

Telephone: (416) 314-3377
Facsimile: (416) 314-4037

Ministère du Solliciteur général

Division de la sécurité publique
Division de la formation en matière de sécurité publique

25 rue Grosvenor
12e étage
Toronto ON M7A 2H3

Téléphone: (416) 314-3377
Télécopieur: (416) 314-4037

Ontario

MEMORANDUM TO: All Chiefs of Police and
Commissioner Thomas Carrique
Chairs, Police Services Boards

FROM: Stephen Beckett
Assistant Deputy Minister
Public Safety Division and Public Safety Training Division

SUBJECT: **Police-Hospital Transitions Framework**

DATE OF ISSUE:	**June 3, 2019**
CLASSIFICATION:	**General Information**
RETENTION:	**Indefinite**
INDEX NO.:	**19-0042**
PRIORITY:	**Normal**

Please review the attached joint memorandum and attachments sent on behalf of the Honourable Sylvia Jones, Solicitor General and the Honourable Christine Elliott, Minister of Health and Long-Term Care.

Sincerely,

Stephen Beckett
Assistant Deputy Minister
Public Safety Division and Public Safety Training Division

Attachments

Tools for Developing Police-Hospital Transition Protocols in Ontario May 2019

A COMPLEMENTARY GUIDELINE TO SUPPORT THE IMPLEMENTATION OF *IMPROVING POLICE-HOSPITAL TRANSITIONS: A FRAMEWORK FOR ONTARIO*

Canadian Mental Health Association Ontario | Association canadienne pour la santé mentale Ontario
HSJCC Human Services & Justice Coordinating Committee
OHA Ontario Hospital Association
Ontario Association of Chiefs of Police OACP

Acknowledgements

This toolkit was developed in partnership with:

- Ministry of Health and Long-Term Care
- Ministry of the Solicitor General
- Provincial Human Services and Justice Coordinating Committee
- Canadian Mental Health Association (Ontario)

Legal Disclaimer

Police-Hospital Transition Task Force

We would like to express our gratitude to all of the members of the Police-Hospital Transition Task Force for their advice and guidance in the development of these tools and resources.

Katie Almond and Michael Dunn, Provincial Human Services and Justice Coordinating Committee
Fuad Abdi, Ministry of the Solicitor General
Nina Acco Weston and Alexia Jaouich, Centre for Addiction and Mental Health
Kashfia Alam, Human Services and Justice Coordinating Committee Secretariat
Jeffrey Bagg, Ontario Hospital Association
Alison Bevington, Waterloo Regional Police Service
Amanda Baine, Ministry of Health and Long-Term Care
Lisa Beck, Thunder Bay Regional Health Sciences Centre
Dena Bonnet, Ministry of the Attorney General
Brian Callanan, Toronto Police Association
Uppala Chandrasekera, Canadian Mental Health Association, Ontario
Raymond Cheng, Ontario Peer Development Initiative
Vanessa Aspri, Ministry of the Solicitor General
Theresa Claxton-Wali, Ontario Association of Patient Councils
Marg Connor, Ministry of Health and Long-Term Care
Sean Court, Ministry of Health and Long-Term Care
Sandra Cunning, Centre for Addiction and Mental Health
Alison DeMuy and Rebecca Webb, Waterloo-Wellington Local Health Integration Network
Ryan Fritsch, Legal Aid Ontario
Francine Gravelle, Youth Services Bureau
Paul Greenwood, St. Michael's Hospital
Lori Hassall, Canadian Mental Health Association, Middlesex Branch
Jenna Hitchcox, Human Services and Justice Coordinating Committee Secretariat
Ashley Hogue, Central Local Health Integration Network
Doug Lewis, Ontario Provincial Police Association
Phil Lillie, Provincial Human Services and Justice Coordinating Committee
Robyn MacEachern, Ontario Provincial Police
Diana McDonnell, Lanark County Mental Health
Terry McGurk, St. Joseph's Health Care Hamilton
John Pare, London Police Services and Ontario Association of Chiefs of Police
Stephen Waldie, Ministry of the Solicitor General
Margo Warren, Ministry of Health and Long-Term Care
Jeremy Watts, Alex Lam and Bryan Laviolette, York Region, Paramedic and Seniors Services Branch
Mike Worster, Hamilton Police Service
Jodi Younger, St. Joseph's Health Care Hamilton

Overview

The following tools and resources have been developed as a complementary guideline to support the implementation of *Improving Police-Hospital Transitions: A Framework for Ontario*.

These tools and resources were developed based on existing promising practices in Ontario. Their use is not a mandatory requirement, rather they are designed to help police, hospitals and others comply with legal requirements (e.g. as found in Ontario's mental health, human rights, policing and privacy legislation) and best practices. These tools may be tailored to the specific needs of local communities (except for Tool 4: interRAI Brief Mental Health Screener which is a trademarked product).

The use of the term "hospital" throughout these documents refers to public hospitals under the *Public Hospitals Act*, and the term "Schedule 1 Psychiatric Facilities" refers to psychiatric hospitals which provide inpatient services and are designated under the *Mental Health Act*.

- **Tool 1:** Stages of Transition for an Individual in Crisis (pp.3-14)
  This diagram provides a general overview of an individual's pathway from the moment of the onset of a mental health or addictions-related crisis, to police officers arriving on the scene for support, to their arrival at the hospital, through to their release back into the community
- **Tool 2:** Police-Hospital Committee Terms of Reference (pp.15-19)
  This is a recommended template that may be adapted as needed
- **Tool 3:** Police-Hospital Transition Protocol (pp.20-30)
  This is a recommended template that may be adapted as needed
- **Tool 4:** interRAI Brief Mental Health Screener (pp.31-34)
  This is a recommended tool to support police officers when responding to a mental health or addictions-related crisis situation
- **Tool 5:** Transfer of Custody Form (pp.35-36)
  This is a recommended template that may be adapted as needed

Tool 1: Stages of Transition for an Individual in Crisis

This diagram provides a general overview of an individual's pathway from the moment of the onset of a mental health or addictions-related crisis, to police officers arriving on the scene for support, to their arrival at the hospital, through to their release back into the community. This tool represents a simplified map of the pathway of an individual that has been apprehended under the *Mental Health Act*. Each person's pathway is very different, and some journeys will not be reflected here. This map is meant only as a general overview.

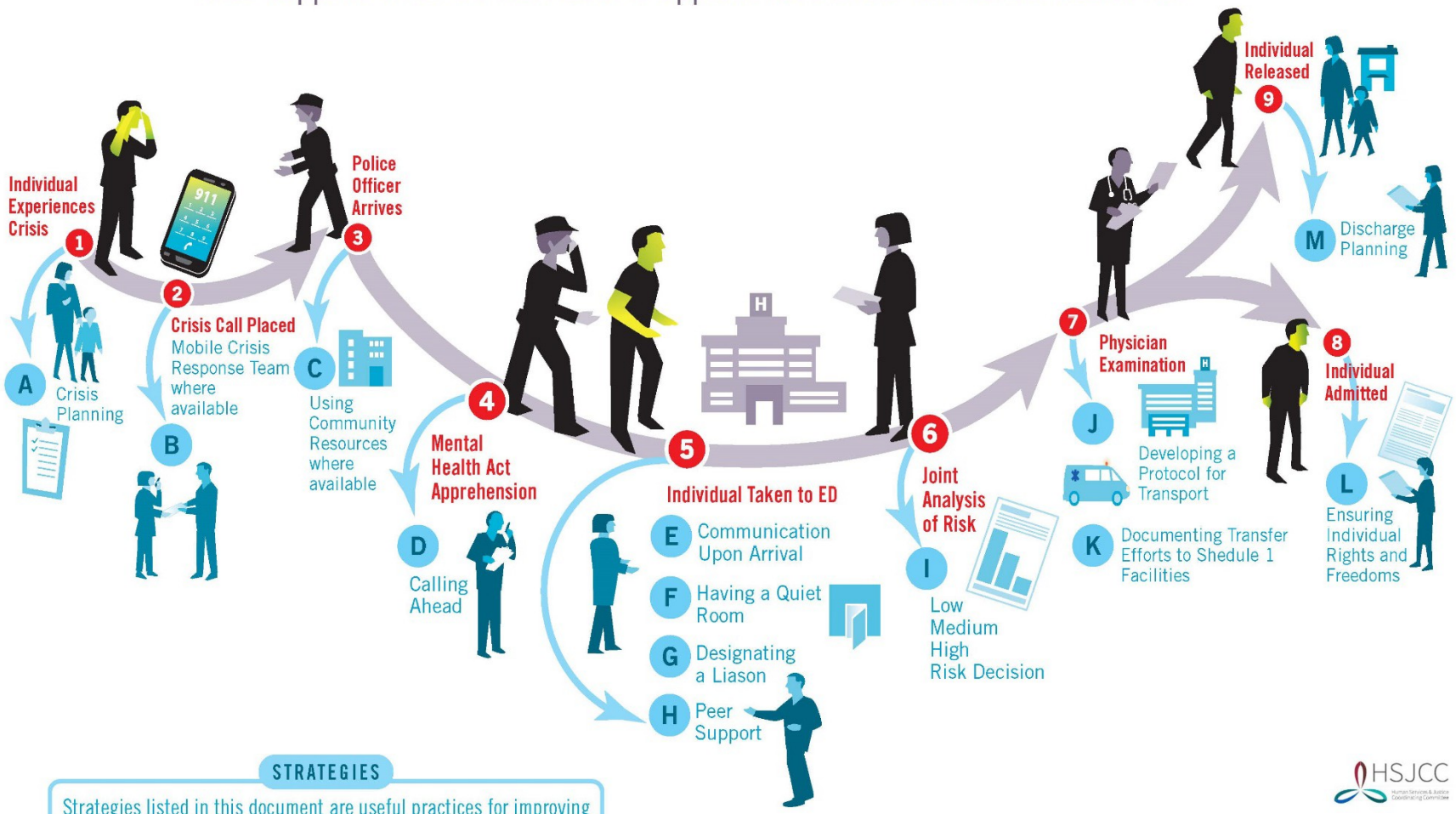
The Stages of a Police-Hospital Transition map can be used for two purposes:

- To inform users of the health care system about the general pathway to care that an individual may experience if they are apprehended under the *Mental Health Act* (map can be printed as a single page hand out for use with the general public with shortened descriptions of each step and strategies).

- To educate hospital staff, police officers and other community service providers involved with *Mental Health Act* apprehensions about the typical stages of transition for the individual experiencing a mental health or addictions-related crisis.

Stages of a Police-Hospital Transition

What happens when an individual is apprehended under the *Mental Health Act*



STRATEGIES

Strategies listed in this document are useful practices for improving client experiences and reducing police-hospital wait times.

HSJCC

Canadian Mental Health Association Ontario — Mental health for all

Association canadienne pour la santé mentale Ontario — La santé mentale pour tous

Rose Zgodzinski

For more information please visit **www.hsjcc.on.ca**

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Available 24/7: 1-866-531-2600
www.connexontario.ca

1. Individual Experiences Crisis: When an individual is experiencing a mental health or addiction-related crisis, the person requires care and attention to address their physical and mental health needs while ensuring that they and others are kept safe in a difficult and often unfamiliar situation. A mental health or addictions-related crisis can include: a serious, immediate mental health or addictions problem, a situational crisis, psychosis, risk of self-harm or harm to others, emotional trauma, agitation or inability to sleep as a result, severe depression or anxiety, symptoms of moderate withdrawal and needing support, or suicidal thoughts.

There are many individuals that may be involved to provide support during a crisis situation, such as an individual's family and friends, crisis centres, dispatch staff, police officers, paramedics and emergency medical services, hospital staff, emergency nurses and doctors, community mental health and addictions organizations and peer support workers. In many communities, there are crisis services available that may be called before 911. ConnexOntario hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions-related concerns. For more information, visit:
www.connexontario.ca

2. Crisis Call is Placed: When someone is experiencing a mental health or addictions-related crisis, additional help for the person may be required and the individual or their family may not know where to go for help. In these cases, friends, family members, or the individual themselves may call a crisis line to seek assistance, such as ConnexOntario which operates a free, 24-hour crisis response line: 1-866-531-2600. If crisis lines are not available within a community, then 911 may be called for help.

3. Police Officer Arrives: When the police are called or they come into contact with an individual experiencing a crisis, they have a large role in determining the best course of action to help the individual and ensure public safety. If the police officer determines that the individual requires care for mental health or additions-related concerns, they may apprehend the individual under the *Mental Health Act*.

4. *Mental Health Act* Apprehension: Under the *Mental Health Act,* police officers have the responsibility to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. Upon making the apprehension, the police officer remains with the individual until transfer of custody to the hospital occurs. At this point, police officers can use a mental health and addictions screening form (such as the interRAI Brief Mental Health Screener) to document their observations of the individual apprehended under the *Mental Health Act*. The individual may also be subject to a safety search by a police officer at this time.

5. Individual Taken to Emergency Department: An officer that has made an apprehension under the *Mental Health Act* is required to transport the individual to a psychiatric or health care facility. Often, the best option for immediate care for the individual is the hospital emergency department. When arriving at the hospital, as part of the intake process, the individual in crisis may be subject to a safety search.

6. Joint Analysis of Risk: After arriving at the hospital, the police officer(s) and hospital staff should jointly conduct an analysis of the level of risk the individual poses to themselves and others within the hospital. Depending on the outcome of this risk assessment, the police officers will either remain in the hospital or leave the individual in the care of the hospital. If the police officers are no longer required, the individual has the option of remaining in the hospital for an assessment by a physician to determine their mental health care needs, or the individual may leave.

7. Physician Examination: After an examination, the physician makes a decision about whether a Form 1 is required. If the individual is issued a Form 1, there is the authority to take the individual in custody to a psychiatric facility forthwith and detain the individual for up to 72 hours for psychiatric assessment. If a Form 1 is not issued, the individual can either stay voluntarily at the hospital for additional care, or they can leave. Following this assessment, the physician or a hospital staff person may ask the individual if the outcomes of this assessment can be communicated back to the police officer(s) that apprehended the individual under the *Mental Health Act*.

8. Individual Admitted: An individual can be voluntarily or involuntarily admitted to a psychiatric facility once they have been assessed by a physician. If a Form 1 is issued and an involuntary admission is made, the hospital then has the authority to hold custody of the individual for up to 72 hours. Persons assessed on a Form 1 have a right to know the outcomes of their assessment and potential detention, and to know of their right to counsel.

9. Individual Released: Leaving an acute care setting for individuals that have experienced a mental health or addictions-related crisis requires good quality discharge planning for a successful transition back into the community. Recovery from a crisis is experienced differently by everyone. For many, it is important that the proper community supports are put in place and connections or referrals to community programs are provided. To keep an individual well within their community, it is important for hospital staff to identify unique needs of individuals when released from the hospital.

A. Planning for a Crisis: Crisis Planning helps to ensure client-centred care and offers a way for individuals to establish a plan of action in preparation for periods of illness. Crisis plans provide time-tested strategies for de-escalating crisis situations, provides the tools for reducing triggers, and outlines specific treatments and medications that have either mitigated or aggravated such experiences in the past. Individuals maintain the ability to control the care they receive when they may be unable to effectively communicate. For more information about crisis planning, see the Provincial Human Services and Justice Coordinating Committee Information Guide: *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario* (pg. 13-15) available at www.hsjcc.on.ca

B. Mobile Crisis Response Teams: Mobile crisis response services may involve health care professionals responding to a crisis or may involve a joint response between police services and health care organizations. The joint response teams typically include a police officer working alongside a mental health professional. Where available, these response teams may be dispatched to assist the individual in crisis and they generally arrive on the scene after the area has been made secure. The mobile crisis response team assesses the individual in crisis and refers them to the appropriate place in the community for care, whether it is a hospital or a community-based mental health and addictions service provider.

C. Using Community Resources: If a mental health apprehension is not made, police officers can connect individuals to community resources in their area. ConnexOntario can connect individuals in crisis (youth and adults), family and friends, and professionals with information on types of services/programs and estimated wait times for support within their community. The crisis response lines are staffed by Information and Referral Specialists that are trained in suicide intervention skills and most have worked within frontline mental health and/or addictions services. They engage in supportive listening with callers to help ensure that individuals requiring support are linked to the most appropriate services in their community. For more information, visit: www.connexontario.ca

D. Calling Ahead: When police officers are en route to the hospital, it is best that the police officers or the Police Service Communication Centre (dispatch) call ahead to inform the emergency department staff that a mental health apprehension has taken place and police officers will be arriving at their facility with the individual. This information allows emergency department staff some additional time to adequately prepare for the incoming individual.

E. Communication Upon Arrival: Establishing communication between the police officers and hospital staff upon arrival in the emergency department, and having the officers provide all relevant information to hospital staff, can expedite the process and can assist hospital staff in providing the best possible care to the person in crisis. Furthermore, establishing strong communication upon arrival can help determine the length of time that police officers will be required to remain at the hospital.

F. Having a Quiet Room: Having a quiet space for individuals experiencing a crisis can reduce the stigma associated with mental health and/or addictions conditions. The quiet space provides privacy for the individual and offers shelter from the watchful eyes of others waiting in the emergency room. A quiet space can also provide safety and security for the individual in crisis.

G. Designating a Liaison: A designated crisis coordinator in the emergency department can be an asset to hospital staff as well as police officers in terms of establishing clear communication. The designated crisis coordinator can also provide services and supports to the individual experiencing a mental health or addictions-related crisis, including conducting an initial mental health assessment, providing counselling services, and connecting the individual to appropriate mental health and addictions resources in the community.

H. Peer Support: Some hospitals have peer support workers available within their facility that can play a key role in supporting an individual in crisis. Having peer support available for individuals experiencing a mental health or addictions-related crisis can help the individual, family or other support people have conversations with a person that is familiar with their situation and can assist with planning for any potential future crisis situations that may arise.

I. Low/Medium/High Risk Decision: An individual experiencing a mental health or addictions-related crisis can be low, medium or high risk in harming themselves or others, or fleeing from the hospital. The police officers and hospital staff should engage in a conversation to collaboratively determine the risk level of the individual in crisis.

J. Developing a Protocol for Transport: Non-Schedule 1 Facilities with emergency departments should develop a protocol for transporting individuals who require a psychiatric assessment to Schedule 1 Psychiatric Facilities. It is best practice that the physician completing the Form 1 also provide a clinical assessment of how the individual can be safely transferred to the new facility. The determination of transfer method and rationale should be recorded by the physician. If paramedic services are needed for the transport of the individual between facilities, the Provincial Transfer Authorization Centre will need to be consulted during the development of the protocol.

K. Documenting Transfer Efforts to Schedule 1 Facility: The *Mental Health Act* states that the transfer of an individual to a Schedule 1 Psychiatric Facility for an assessment needs to be completed "forthwith" which is generally interpreted in case law as "as soon as reasonably possible." It is recommended that the hospital staff document the efforts made to transfer to the individual to the new facility, the care provided while waiting for the transfer, and the ongoing monitoring and assessment of the individual to ensure that the criteria for an individual to require a psychiatric assessment under Form 1 are still present.

L. Ensuring Individual Rights and Freedoms: The hospital and police officers responding to a crisis should take necessary steps to ensure that the individual's right and freedoms are protected at all times.

- To learn more about individual rights when a Form 1 has been issued, please see the Community Legal Education Ontario resource *Are you in hospital for a psychiatric assessment?* available at: http://www.cleo.on.ca/sites/default/files/book_pdfs/form1.pdf
- For individuals seeking additional information on their rights while in the care of an Ontario hospital for a mental health or addictions-related concern, contact the Psychiatric Patient Advocate Office at 1-800-578-2343
- To learn more about the legal authorities of hospitals to detain individuals that may be at risk to harming themselves or others, please see the Ontario Hospital Association *Practical Guide to Mental Health and the Law in Ontario* available at www.oha.com

M. Discharge Planning: Support from family, the community, and having access to the social determinants of health (for example: housing and food) are key to increasing wellness and preventing individuals from coming into contact with police or experiencing additional, unanticipated visits to the emergency department. It is recommended that discharge planning for individuals that have been frequently apprehended under the *Mental Health Act* be reviewed by hospital staff to identify any gaps or issues that need to be addressed to better connect individuals to community services while respecting the individual's right to treatment, choice and privacy.

Stages of Transition for an Individual in Crisis

The stages of transition for individuals that have experienced a mental health or addictions-related crisis and have been apprehended under the *Mental Health Act* are described below. The strategies listed below are based on promising practices that have been implemented in communities across Ontario. Please note that the strategies are intended to support the development and implementation of a successful police-hospital emergency department transition protocol and should be considered as recommendations only, and are not mandatory requirements. Some strategies require resources which may not be available in all communities.

1) Individual experiences a mental health or addictions-related crisis

When an individual is experiencing a mental health or addictions-related crisis, the person requires care and attention to address their physical and mental health needs while ensuring that the person and others are kept safe in a difficult and often unfamiliar situation. A crisis may require the assistance of professionals to help reduce risks and provide care for the individual and others, especially if the circumstance is new or unmanageable for the individual and those around them.

A mental health or addictions-related crisis can include: a serious, immediate mental health or addictions problem, a situational crisis, psychosis, risk of self-harm or harm to others, emotional trauma, agitation or inability to sleep and, as a result, severe depression or anxiety, symptoms of moderate withdrawal and needing support, or suicidal thoughts.

There are many individuals that may be involved to provide support during a crisis situation, such as an individual's family and friends, crisis centre dispatch staff, police officers, paramedics and emergency medical services, hospital staff, emergency nurses and doctors, community mental health and addictions organizations and peer support workers.

In many communities, there are crisis services available for individuals experiencing a mental health or addictions-related crisis that may be called before 911. ConnexOntario

Addiction, Mental Health, and Problem Gambling Treatment Services:

1-866-531-2600 | **Available 24-hours every day**
ConnexOntario: www.connexontario.ca

hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns.

STRATEGY A: Planning for a crisis

Individuals and families can develop a plan to prepare for a crisis situation. Crisis Planning helps to ensure client-centred care and offers a way for individuals to establish a plan of action in preparation for periods of illness. Crisis plans provide time-tested strategies for de-escalating crisis situations, provide the tools for reducing triggers, and outline specific treatments and medications that have either mitigated or aggravated such experiences in the past. Individuals maintain the ability to control the care they receive when they may be unable to effectively communicate.

For more information about crisis planning, see the Provincial Human Services and Justice Coordinating Committee Information Guide: *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario* (pp.13-15). www.hsjcc.on.ca

2) Crisis call is placed

When someone is experiencing a mental health or addictions-related crisis, additional help for the person may be required and the individual or their family may not know where to go for help. In these cases, friends, family members, or the individual themselves may call a crisis line to seek assistance. If crisis lines are not available within a community, a 911 emergency call may be placed.

The role of the Police Service Communication Centre (dispatch) is important in the response to individuals in crisis when a 911 call is placed. Particularly in communities where there may be mobile crisis response teams that can be dispatched to a location to assist police officers in their response, these teams can potentially divert individuals away from emergency departments and the justice system, and offer care where the individual is located. Crisis bed programs in the community may also be available to support individuals in crisis.

ConnexOntario hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns.

STRATEGY B: Utilizing mobile crisis response teams or other community mental health and addictions agencies for support, where available

Mobile crisis response services may involve health care professionals responding to a crisis or may involve a joint response between police services and health care organizations. The joint response teams typically include a police officer working alongside a mental health and addictions professional. Where available, these response teams may be dispatched to assist the individual in crisis and they generally arrive on the scene after the area has been made secure. The mobile crisis response team assesses the individual in crisis and refers them to the appropriate place in the community for care, whether it is a hospital or a community-based mental health and addictions service provider.

3) Police officer(s) arrive to assist the individual in crisis

When the police are called or they come into contact with an individual experiencing a mental health or addictions-related crisis, they have a large role in determining the best course of action to help the individual and ensure public safety. In some cases, there may be a criminal incident that has also occurred at the same time as the mental health or addictions-related crisis. In those situations, there may be times when a police officer has to decide whether it is appropriate to make a mental health apprehension or to lay a criminal charge. In appropriate circumstances, police officers should be encouraged to make all efforts to divert a person away from the criminal justice system. Police officers should give primary consideration to whether the *Mental Health Act* can appropriately address the factors of concern in any particular case.

Police officers can connect individuals to community resources at any point. For instance, where a criminal charge is not laid and a mental health apprehension is not made, a police officer may connect the individual to community resources in their area. ConnexOntario hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns.

Addiction, Mental Health, and Problem Gambling Treatment Services:

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ConnexOntario: www.connexontario.ca

ConnexOntario can connect individuals in crisis (youth and adults), family and friends, and professionals such as police officers with information on types of services/programs and estimated wait times for support within their community. The crisis response lines are staffed by Information and Referral Specialists that are trained in suicide intervention skills, most have worked within frontline mental health and/or addictions services, and engage in supportive listening with callers to help ensure that individuals requiring support are linked to appropriate services in their community.

STRATEGY C: Using community resources, where available

If a criminal charge is not laid and a mental health apprehension is not made, then police officers can connect the individual to community resources in their area. For more information about community resources contact ConnexOntario, which hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns: www.connexontario.ca

4) Apprehension under the *Mental Health Act*

Under the *Mental Health Act*, when the required circumstances are met, police officers have the authority to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. Upon making the apprehension, the police officer remains with the individual until transfer of custody to the hospital occurs.

At this time, police officers can use the interRAI Brief Mental Health Screener form to document their observations of the person apprehended under the *Mental Health Act*. See Tool 4: interRAI Brief Mental Health Screener for more information.

During this process, the individual may also be subject to a safety search by a police officer.

STRATEGY D: Calling ahead

When police officers are en route to the hospital, it is best that the police officer(s) or the Police Service Communication Centre (dispatch) call ahead to inform the emergency department staff that a mental health apprehension has taken place and the police officer(s) will be arriving at their facility with the individual. This information allows emergency department staff some additional time to adequately prepare for the incoming individual.

5) Individual taken to the hospital emergency department

When the police officer(s) arrive at the hospital emergency department with the individual experiencing a mental health or addictions-related crisis, a number of service dynamics can occur during this transition process resulting in issues that impact on police services, hospital staff and the individual in crisis. At this point, as part of the intake process of the hospital, the individual in crisis may be subject to a safety search.

Establishing a Police-Hospital Transition Protocol is recommended to support everyone involved in the transition. See Tool 3: Police-Hospital Transition Protocol for a general template that may be adapted as needed.

STRATEGY E: Communicating upon arrival

Establishing communication between the police officer(s) and hospital staff upon arrival in the emergency department, and having the officer(s) provide all relevant information to hospital staff, can expedite the process and can assist hospital staff to provide the most appropriate care to the individual in crisis. Furthermore, establishing strong communication upon arrival can help determine the length of time that police officers will be required to remain at the hospital.

STRATEGY F: Having a quiet room

Having a quiet space for individuals experiencing a crisis can reduce the stigma associated with mental health and/or addictions conditions. The quiet space provides privacy for the individual and offers shelter from the watchful eyes of others waiting in the emergency room. A quiet space can also provide safety and security for the individual in crisis.

STRATEGY G: Designating a liaison

A designated crisis coordinator in the emergency department can be an asset to hospital staff as well as police officers in terms of establishing clear communication. The designated crisis coordinator can also provide services and supports to the individual experiencing a mental health or addictions-related crisis, including conducting an initial mental health and addictions assessment, providing counselling services, and connecting the individual to appropriate mental health and addictions resources in the community.

STRATEGY H: Peer support

Some hospitals within Ontario have peer support workers available within their facility that can play a key role in supporting an individual in crisis. Having peer support available for individuals experiencing a mental health or addictions-related crisis can help the individual, family or other caregivers have conversations with peers that are familiar with their situation and can assist with planning for any potential future crisis situations that may arise.

6) Joint analysis of risk

After arriving at the hospital, the police officer(s) and hospital staff should jointly conduct an analysis of the level of risk the individual poses. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer.

The purpose of the joint analysis of risk is to determine whether the individual poses a risk in harming themselves or others at the hospital, and whether the individual poses a risk of fleeing from the hospital. In view of these particular risks, the designated hospital staff person and the police officer should determine whether the hospital is ready to take immediate custody of the individual such that the police officer(s) may leave the hospital premises.

This risk analysis is distinct from the assessment associated with the decision about whether to issue a Form 1. When required, the decision regarding issuing a Form 1 under the *Mental Health Act* rests solely with a physician.

At this point, a transfer of custody form can be used by hospital staff to document decisions pertaining to the joint analysis of risk conducted by the hospital staff and the police officer. See Tool 5: Transfer of Custody Form for a general template that may be adapted as needed.

Strategy I: Low, Medium, High Risk Decision

An individual experiencing a mental health or addictions-related crisis can be low, medium or high risk with respect to harming themselves or others, or fleeing from the hospital. The criteria for high, medium and low risk should be defined clearly and should appear on the transfer of custody form keeping in mind the overarching goals of the protocol, specifically, to improve and formalize the transition process.

If the individual is **low-risk**, the police officer(s) can transfer custody to the hospital staff immediately.

Medium-risk individuals may or may not require the police officer(s) to stay. To determine if the police officer(s) need to remain in the hospital, the hospital staff and police officer(s) should engage in a conversation to collaboratively determine the decision.

If the individual is **high-risk**, the police officer(s) must remain with the individual until the individual has been assessed by a physician for the purpose of determining whether to issue a Form 1.

An individual's level of risk may fluctuate from low-to-high or high-to-low at any time during or after the transition of custody. If the individual's observable behaviour indicates that they present a noticeable increased risk of harm after the police officers have left, the hospital may call the police to return – police services should prioritize these return calls.

It is best practice that if there is any dispute on the decision of the joint analysis of risk, the police officer(s) should stay in the hospital at the request of the hospital staff. If disagreement is persistent and systematic, police services and the hospital may trigger their dispute resolution mechanism through their Police-Hospital Transition Protocol to address the ongoing issues.

7) Physician's Form 1 related examination

After an examination, the physician makes a decision about whether a Form 1 is required (whether the test in Section 15 of the *Mental Health Act* is met). If the individual is issued a Form 1, there is the authority to take the individual in custody to a psychiatric facility forthwith and detain the individual for up to 72 hours for psychiatric assessment. If a Form 1 is not issued, the individual can either stay voluntarily at the hospital for additional care, or they can leave.

Following this assessment, the physician or a hospital staff person may ask the individual if the outcomes of this assessment can be communicated back to the police officer(s) that apprehended the individual under the *Mental Health Act*. The individual's consent to share or not to share information with the police officers should be documented.

(7a) Transport to Schedule 1[1] Psychiatric Facility may be required

In some situations, the hospital where the person had been accompanied to by a police officer does not have the legal authority to detain a patient on an involuntary basis. Where this is the case, the person should be transported to a Schedule 1 Psychiatric Facility,[1] that provides in-patient services, under the *Mental Health Act* for further assessment and care.

A Form 1 is effective for seven days and provides authority to take the individual in custody to a psychiatric facility where they may be detained, restrained, observed and examined for no more than 72 hours.

STRATEGY J: Developing a protocol for transport

Non-Schedule 1 Facilities with emergency departments should develop a protocol for transporting individuals who require a psychiatric assessment at Schedule 1 Psychiatric Facilities. It is best practice that the physician completing the Form 1 may also provide a clinical assessment of how the individual can be safely transferred to the new facility. The determination of transfer method and rationale should be recorded by the physician. Should it be determined that paramedic services are needed for the transport of the individual between facilities, the Provincial Transfer Authorization Centre will need to be consulted when developing the protocol as this is the body responsible for coordinating and approving all transfers conducted by paramedic services in Ontario.

[1] A full list of designated Schedule 1 Psychiatric Facilities that provide in-patient psychiatric services in Ontario can be found here: http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx

Currently, within Ontario communities, the transport of the individual to a Schedule 1 Psychiatric Facility may be done by a family member, friend, paramedic services or other patient transport service, or police officer(s). It is recommended that hospitals, paramedic services, police services, and other appropriate transport entities ensure that a process has been established for transporting clients to Schedule 1 Psychiatric Facilities. This process can be embedded into the Police-Hospital Transition Protocol.

STRATEGY K: Documenting transfer efforts to Schedule 1 Psychiatric Facility

The *Mental Health Act* states that the transfer of an individual to a Schedule 1 Psychiatric Facility for an assessment needs to be completed "forthwith" which is generally interpreted in case law as "as soon as reasonably possible." It is recommended that the hospital staff document the efforts made to transfer the individual to the new facility, the care provided while waiting for the transfer, and the ongoing monitoring and assessment of the individual to ensure that the criteria for an individual to require a psychiatric assessment under Form 1 are still present.

8) Individual is admitted to hospital

An individual can be voluntarily or involuntarily admitted to a Schedule 1 Psychiatric Facility once they have been assessed by a physician. If a Form 1 is issued, the hospital then has the authority to hold custody of the individual for up to 72 hours.

It should be considered best practice for hospitals to inform individuals assessed on a Form 1 of their right to learn the reasons for their assessment and potential detention, and be informed of their right to counsel, upon admission at the psychiatric facility. Psychiatric facilities have certain obligations under the *Mental Health Act*, including obligations to advise individuals of their rights (usually through delivery of a Form 42).

STRATEGY L: Ensuring individual rights and freedoms

The following actions can be taken by hospital staff and police officers to ensure that an individual's rights and freedoms are protected in a crisis situation:

- ✓ As much as possible, it is recommended that hospital staff review internal processes to ensure that individuals apprehended under the *Mental Health Act* are quickly assessed, and that a decision for the hospital to assume custody is made as early as possible (and so in compliance with legislation). Hospitals can ensure that Canadian Triage Acuity Scale (CTAS) levels being assigned to individuals presenting with mental health or addictions-related crises are accurately reflecting acuity by internally reviewing CTAS guidelines and how they are being applied within the emergency department setting. Where all acuity is equal, the hospital can put a process in place that prioritizes individuals accompanied by police officers to be seen first in an effort to expedite the transition process for individuals in crisis.

- ✓ Provide supervised or monitored quiet rooms without locks.

- ✓ Train hospital staff on the limits of their detention, search and restraint powers, and alternative measures that may be used.

- ✓ Train hospital and security staff on the legal rights framework, de-escalation techniques, and human rights accommodations and privacy requirements, with an emphasis on appropriate and effective communication.

- ✓ Train hospital staff on how to assess and triage apprehended persons who are unable or unwilling to communicate.

- ✓ Identify clear procedures around the provision of Form 42 and the availability of peer support and advocacy services.

Additional resource for hospitals: To learn more about the legal authorities of hospitals to detain individuals that may be at risk of harming themselves or others, please see the Ontario Hospital Association *Practical Guide to Mental Health and the Law in Ontario* available at www.oha.com

9) Individual is released from hospital

Leaving an acute care setting for individuals that have experienced a mental health or addictions-related crisis requires good quality discharge planning for a successful transition back into the community. Recovery from a crisis is experienced differently by everyone. For many, it is important that the proper community supports are put in place and connections or referrals to community programs are provided. To keep an individual well once back in their community, it is important for hospital staff to work with the individual to identify their unique needs when released from the hospital.

STRATEGY M: Discharge planning

The "revolving door" can occur in the emergency department. Police officers may accompany an individual apprehended under the *Mental Health Act* to the emergency department; yet once the individual is examined by the physician, the individual may be released back into the community because they did not meet the criteria for involuntary admission to a psychiatric facility.

Support from family, the community, and having access to the social determinants of health (for example: housing and food) are key to increasing wellness and preventing individuals from coming into contact with police or experiencing additional, unanticipated visits to the emergency department.

It is recommended that discharge planning for individuals that have been frequently apprehended under the *Mental Health Act* be reviewed by hospital staff to identify any gaps or issues that need to be addressed to better connect individuals to community services while respecting the individual's right to treatment, choice and privacy.

Tool 2: Police-Hospital Committee Terms of Reference

This tool is a template for Ontario communities to use to assist with establishing a joint police-hospital committee to support the development of a police-hospital transition protocol. Communities can adapt and change this template to their local needs using available resources. The purpose of this Terms of Reference document is to clearly outline the role and scope of the Police-Hospital Committee, including the committee's objectives, membership, frequency of meetings and key contact information for matters relating to police-hospital transitions and the corresponding protocol.

Police-Hospital Committee Terms of Reference

(Insert date when Terms of Reference was created or revised)

Purpose of Police-Hospital Committee

The purpose of the committee is to bring together representatives from police services, hospitals, paramedic services and community mental health and addictions organizations in (*insert name of your city/town*) to develop and implement a police-hospital transition protocol that complies with legal requirements and best practices associated with Ontario's mental health, human rights, policing and privacy legislation.

To support the work of this committee, members are encouraged to use *Improving Police-Hospital Transitions: A Framework for Ontario.* The information, templates and tools in this framework will provide guidance to members of this committee to establish effective police-hospital transition protocols for individuals that have been apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care.

Objectives of Police-Hospital Committee

- To improve outcomes for people experiencing a mental health or addictions-related crisis that are accompanied to an emergency department by a police officer while respecting individual rights, including the right to privacy;
- To enhance collaboration and coordination between hospitals and police services in Ontario communities;
- To decrease police officer wait times to transfer custody of apprehended individual to hospital emergency department;
- To protect health care worker safety and security through system improvements
- To promote public safety
- To identify strategies and solutions to any issues that may arise during the implementation of the police-hospital transition protocol
- To develop strategies for ongoing monitoring and evaluation of the effectiveness of the police-hospital transition protocol
- To annually review the work of this police-hospital committee and update the terms of reference as necessary

Reporting Relationships

The *(insert name of your committee)* shall report to the Chief Executive Officer (CEO) of *(insert name of your hospital)*, and the Chief of Police of (*insert name of your police service)* or Ontario Provincial Police (OPP) Detachment Commander. Paramedic services and community mental health and addictions organizations are responsible for reporting to their own respective organizations' CEOs or their managers.

Responsibilities of Members

All members are responsible for attending Police-Hospital Committee meetings on a regular basis and working to achieve committee objectives noted above. The responsibilities outlined below indicate specific responsibilities of committee members.

Police Chief/OPP Detachment Commander and Hospital CEO will:

- Be the executive sponsors of the protocol

Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.) will:

- Provide guidance to staff on the successful implementation of the protocol and resolve any disputes that may arise between the organizations
- Ensure all frontline staff complete the necessary training needed to implement the police-hospital transition protocol
- Provide guidance to frontline staff throughout the implementation phase
- Ensure the ongoing monitoring and evaluation of the police-hospital transition protocol
- Manage relationships and resolve issues between representatives of police service(s), hospital and other members

Frontline police officers and hospital emergency department and privacy office staff will:

- Deliver on the expectations associated with the written agreement between the hospital and police service(s)
- Participate in all necessary training related to the police-hospital transition protocol
- Work with other frontline police and hospital staff to implement the protocol
- Communicate progress and report any issues to their respective superiors

Other Service Provider Roles and Responsibilities:

- Deliver on the expectations associated with the protocol
- *(Insert additional details)*

Police-Hospital Committee Membership

Hospital representatives

Police representatives (can include multiple municipal police services and the OPP)

Paramedic Service representatives

Community Mental Health and Addictions Organization(s) representative(s)

Individual(s) with lived experience of police-hospital transitions

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Police-Hospital Committee Meetings

Meetings will be held at least annually at *(insert name of meeting location)*.

Meetings will be chaired by the Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.).

Secretarial support for this Committee for minute-taking and other activities will be provided by (*insert name of organization*).

Contact Information

For information about the Police-Hospital Committee, contact:

Hospital representative:
Title:
Telephone Number:
Email:

Police representative:
Title:
Telephone Number:
Email:

Tool 3: Police-Hospital Transition Protocol Template

This tool is a template for Ontario communities to use to assist with the development of a police-hospital transition protocol. Communities can adapt and change this template to their local needs using available resources. The purpose of this tool is to determine the processes involved with police-hospital transitions when an individual has been apprehended under the *Mental Health Act*.

Police-Hospital Transition Protocol

(insert names/logos of partner organizations)

1. Introduction

This protocol is designed to enhance collaboration between hospitals and police services with the purpose of improving outcomes for individuals that have been apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care.

The intent of this protocol is to 1) Improve outcomes for individuals apprehended by police under the *Mental Health Act*, while respecting individual rights, including the right to privacy; 2) Improve transitions between police officers and hospital workers; and 3) Improve coordination and collaboration among partners involved in the transition.

The protocol may be extended to include partnerships with other stakeholders in the community, such as paramedic services, community-based mental health and addictions agencies, peer and family support organizations, child and youth mental health and addictions agencies and others.

2. Purpose

This protocol was developed in collaboration with key stakeholders who are the first responders to individuals experiencing a mental health or addictions-related crisis. This document reflects the commitment of all participants to provide an effective and integrated response to such crisis situations in (*insert name of your town/city*).

The purpose of this agreement is to:

- To improve outcomes for people experiencing a mental health or addictions-related crisis that are accompanied to an emergency department by a police officer while respecting individual rights, including the right to privacy;
- To enhance collaboration and coordination between hospitals and police services in Ontario communities;
- To decrease police officer wait times to transfer custody of apprehended individual to hospital emergency department;
- To protect health care worker safety and security through system improvements; and
- To promote public safety.

This agreement outlines:

- The roles of the signatories in responding to the individual that has been apprehended by police officers under the *Mental Health Act*; and
- The respective responsibilities of each signatory to ensure seamless transition between frontline police officers and hospital staff.

3. Key Definitions

Mental Health: is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.[2]

Mental Illnesses: mental illnesses are health problems that affect the way we think about ourselves, relate to others, and interact with the world around us. They affect our thoughts, feelings, and behaviours. Mental illnesses can disrupt a person's life or create challenges, but with the right supports, a person can get back on a path to recovery and wellness. It is important to understand that there are many different types of mental illnesses that affect people in different ways.[3]

Addiction: The term addiction is generally applied to patterns of heavy use of psychoactive drugs that are taken primarily for their effects on consciousness, mood and perception. In general, addiction has been replaced by the more specifically defined term substance (or drug) dependence. However, "addiction" continues to be used widely and is generally thought of as compulsive use leading to physical symptoms of withdrawal when use is discontinued. For that reason, it is often equated with physical dependence.[4]

Form 1: This is the Application for Psychiatric Assessment and can be used to bring someone to a psychiatric facility for an assessment that lasts up to 72 hours (three days). To order a Form 1, a physician must have personally examined the person within the previous seven days and have reason to believe that the person meets certain criteria under the *Mental Health Act*. During the assessment, other mental health professionals (e.g., nurses, psychologists and social workers) may meet with the person and their family members, friends or caregivers to get additional information.[5]

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[2] Public Health Agency of Canada's definition of mental health, taken from: http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/index-eng.php

[3] Canadian Mental Health Association's definition of a mental illness, taken from: https://www.cmha.ca/mental_health/mental-illness/

[4] Canadian Centre for Substance Abuse's definition of addiction, taken from: http://www.ccsa.ca/Resource%20Library/ccsa-011811-2010.pdf

[5] Centre for Addiction and Mental Health's definition of Form 1, taken from: http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Pages/challenges_choices_appclegalform.aspx

Hospital and Schedule 1 Psychiatric Facility: Hospital refers to public hospitals under the *Public Hospitals Act*, and Schedule 1 Psychiatric Facility refers to psychiatric hospitals which provide inpatient services and are designated under the *Mental Health Act*. Schedule 1 Psychiatric Facilities have the legal authority to detain involuntary patients under the *Mental Health Act*, and they provide inpatient mental health programs, including acute and short-term care and treatment, to individuals experiencing mental health and addictions related issues.[6]

4. This protocol is between:

(List all organizations involved with the protocol)

Hospital

Police Service (can include multiple municipal police services and the OPP)

Paramedic Services

Community Mental Health and Addictions Organization(s)

(List any other partners)

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5. Team Response

As soon as a *Mental Health Act* apprehension has been made and the police officer(s) take the individual experiencing a mental health or addictions-related crisis to the hospital emergency department, the following procedure will be followed:

5.1) The police officer(s)/Police Service Communications Centre will advise the hospital emergency department of the estimated time of arrival and that an individual experiencing a mental health or addictions-related crisis will be brought in for assessment.

[6] A full list of designated Schedule 1 Psychiatric Facilities that provide in-patient psychiatric services in Ontario can be found here: http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx

5.2) The police officer(s)/Police Service Communications Centre will share the following information with the emergency department:

- Estimated time of arrival; and
- Whether the individual is being transported in a police vehicle or by ambulance.

5.3) The responding police officer(s) will complete the interRAI Brief Mental Health Screener *(see Appendix for sample form)*. A copy of the completed Form may be provided to *(insert appropriate emergency department staff position)*.

5.4) If the individual experiencing a mental health or addictions-related crisis is being transported by police and their state as observed is such that routine triage may not be appropriate or safe, the transporting officer(s) will use the ambulance entrance of the hospital emergency department.

5.5) When an individual experiencing a mental health or addictions-related crisis is brought to the hospital emergency department pursuant to the *Mental Health Act*, the triage assessment will be completed by *(insert appropriate emergency department staff position)*.

6. Joint Analysis of Risk

After arriving at the hospital, the police officer(s) and hospital staff should jointly conduct an analysis of the level of risk the individual poses. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer.

The purpose of the joint analysis of risk is to determine whether the individual poses a risk in harming themselves or others at the hospital, and whether the individual poses a risk of fleeing from the hospital. In view of these particular risks, the designated hospital staff person and the police officer should determine whether the hospital is ready to take immediate custody of the individual such that the police officer(s) may leave the hospital premises.

This risk analysis is distinct from the assessment associated with the decision as to whether to issue a Form 1. When required, the decision regarding issuing a Form 1 under the *Mental Health Act* rests solely with a physician. Following the assessment to determine if a Form 1 will be issued, the physician may ask the individual if the outcomes of this assessment can be communicated back to the police officer(s) that apprehended the individual under the *Mental Health Act*. The individual's consent to share or not to share information with the police officers should be documented.

The police officer shall remain with the individual until the transfer of custody responsibility is complete. The transfer of custody is considered complete when the responsible hospital staff member and police officer have reviewed the Transfer of Custody Form and both have signed off in the designated areas *(see Appendix for sample form)*.

(In the following section, the criteria for high risk, medium risk and low risk should be defined clearly and should appear on the transfer of custody form keeping in mind the overarching goals of the protocol, specifically, to improve and formalize the transition process.)

An individual experiencing a mental health or addictions-related crisis can be low, medium or high risk:

- If the individual is **low-risk**, the police officer(s) can transfer custody to the hospital staff immediately (*add additional information as appropriate*).

- **Medium-risk** individuals may or may not require the police officer(s) to stay. To determine if the police officer(s) need to remain in the hospital, the hospital staff person and police officer(s) should engage in a conversation to collaboratively determine the decision (*add additional information as appropriate*).

- If the individual is **high-risk**, the police officer(s) must remain with the individual until the individual has been assessed by a physician for the purpose of determining whether to issue a Form 1 (*add additional information as appropriate*).

An individual's level of risk may fluctuate from low-to-high or high-to-low at any time during or after the transition of custody. If the individual's observable behaviour indicates that they present a noticeable increased risk of harm after the police officers have left, the hospital may call the police to return – police services should prioritize these return calls.

It is best practice that if there is any dispute on the decision of the joint analysis of risk, the police officer(s) should stay in the hospital at the request of the hospital staff. If disagreement is persistent and systematic, police services and the hospital may trigger their dispute resolution mechanism through their Police-Hospital Transition Protocol to address the ongoing issues.

7. Dispute Resolution

In the event of a dispute between the hospital and the police service concerning any matter arising under this protocol, the Police Designate with decision-making authority and the Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.), shall meet, by telephone, or in person, to engage in conversation to resolve the dispute.

In the event that any matter referred to the representatives set out above remains unresolved after a period of 20 business days from its referral, then resolution will fall to the Police Chief/OPP Detachment Commander and the Hospital CEO.

8. Forms to Complete

- interRAI Brief Mental Health Screener for use by frontline police officers to document observations regarding the individual apprehended under the *Mental Health Act* *(see Appendix for sample form)*.

- A Transfer of Custody Form for use by hospital staff to document decisions pertaining to a joint analysis of risk conducted by the hospital staff and the police officer. The joint analysis of risk can be completed by a designated hospital staff person (not necessarily a physician) and the police officer. However, when required, the decision regarding issuing a Form 1 under the *Mental Health Act* rests solely with a physician *(see Appendix for sample form)*.

9. Depending on the needs and resources available in your community, insert the following:

Connecting Individual to Supports in the Community

(If community based agencies are involved with the police-hospital transition protocol, then include the instructions for connecting the individual to supports in the community here, including those related to respect for the individual's right to treatment, choice and privacy).

10. Information sharing associated with a *Mental Health Act* apprehension

Information sharing between police and hospital personnel concerning an individual apprehended under the *Mental Health Act* will typically involve both the individual's personal information and their personal health information. For example, a police officer's observations about the individual will be the individual's personal information. When the hospital collects and uses information for the purpose of providing health care to the individual, the information is the individual's personal health information.

In sharing information, police, hospital and other emergency service partners must be cognizant of their privacy-related obligations under relevant statutes such as the *Freedom of Information and Protection of Privacy Act*, *Health Care Consent Act*, *Mental Health Act*, *Municipal Freedom of Information and Protection of Privacy Act* and *Personal Health Information and Protection Act*. This means that the disclosing organization must have the authority to disclose and the recipient organization must have the authority to collect and use the personal information and/or personal health information at issue.

In this context, it is noteworthy that hospital staff must generally comply with the limiting principles set out in Section 30 of the *Personal Health Information and Protection Act*. Section 30 generally requires that no personal health information be collected, used or disclosed if other information will serve the purpose and that no more personal health information be collected, used or disclosed than is reasonably necessary to meet the purpose. Similar limiting principles also apply to the collection, use and disclosure of personal information by police under *Municipal Freedom of Information and Protection of Privacy Act*.

10.1) Disclosures and collections related to apprehension and transport

Under the *Mental Health Act*, police officers have the authority to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. In the course of apprehending an individual under Section 17 of the *Mental Health Act,* police officers may collect relevant information about an individual's demeanor, behavior and circumstances, and use that information to safely apprehend and transport that individual to hospital.

While in transit, police officers may call ahead to inform the emergency department staff that a mental health apprehension has taken place and police officers will be arriving at their facility with the individual. In addition, upon arrival in the emergency department, police officers may disclose further personal information to hospital staff where that information is reasonably likely to be relevant to the hospital's safe assessment, treatment, detention and release of the individual, including information describing the officers' observations about the individual's demeanor, behavior and circumstances.

As health information custodians, hospitals can only collect, use and disclose personal health information in accordance with the rules set out in the *Personal Health Information Protection Act* including the limiting principles set out in section 30.

Reasonable care should be taken by both police officers and hospital staff to ensure that information sharing be restricted to information that is as accurate, complete and up-to-date as possible.

10.2) Disclosures and collections related to transfer of custody

Upon making the apprehension, police remain with the individual until transfer of custody to the hospital occurs. The *Mental Health Act* regulations require that: a decision about the transfer of custody be made as soon as is reasonably possible; the hospital decision maker consult with the police officer(s); and hospital staff promptly inform the police of the decision.

Under this protocol, the transfer of custody generally occurs under one of the following two circumstances:

1. Custody of an individual may pass from police to the hospital where the responsible hospital staff member and police officer have reviewed the Transfer of Custody Form; agreed that the hospital is ready to take immediate custody of the individual; and signed the designated areas of the Transfer of Custody Form.

   In informing the police of this transfer decision, the hospital should restrict its disclosure of personal health information to the police to the information on the Transfer of Custody Form.

2. Where the responsible hospital staff member and police officer have determined that the police officer should remain at the hospital until a physician has decided whether to issue a Form 1, custody of an individual may pass from police to the hospital after the physician has made the Form 1 decision.

   Following an initial examination, hospital staff can inform the police officers of their decision to issue or not issue a Form 1 for the individual if the police officer has remained in the hospital. But if this assessment has occurred after the police officers have passed custody to the hospital and left the hospital premises, the hospital staff may ask the individual if they consent to sharing this information (whether the individual is admitted or not).

   If the police ask the hospital to disclose whether the individual is ultimately detained under a Form 1, the hospital may inform the police officer as to whether or not a Form 1 was issued with the express consent of the individual.

As a general rule, the hospital should only ask the individual to consent to this disclosure of their personal health information after the Form 1 decision has been made. Moreover, in order to ensure that the consent is knowledgeable and freely given, the individual must be informed of the specific personal health information that will be disclosed to the police (i.e. that a Form 1 has been issued or that no Form 1 has been issued), the specific purpose(s) for the disclosure, and the individual has the right to give or withhold consent to the hospital's disclosure of this personal health information. In addition, the individual should be informed that this disclosure of personal health information could lead to further mental health-related disclosures by the police (e.g. about the issuance of a Form 1 to other police services through the Canadian Police Information Centre).

In addition, the individual must be capable of consenting to any disclosure of their personal health information, which includes information regarding the issuance of a Form 1. The test for consent to the collection, use and disclosure of personal health information is set out in s. 21 of the *Personal Health Information Protection Act* (PHIPA).

10.3) Other disclosures and collections

An individual's level of risk may fluctuate during or after the transition of custody phase. If an individual's observable behavior indicates that they present a noticeably increased risk of harm after the officers have left (e.g. to another person or to themselves), the hospital may call the police and ask them to return to the hospital or assist in the re-location of the individual.

Authority for such a disclosure is found in Section 40(1) of the *Personal Health Information and Protection Act* which permits a hospital to disclose personal health information if the hospital believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. "Significant risk of serious bodily harm" includes a significant risk of both serious physical as well as serious psychological harm. Like all collection, use and disclosure provisions of the *Personal Health Information and Protection Act*, Section 40(1) is subject to the limiting principles in Section 30.

It is understood and agreed that the parties in this protocol shall hold all information, materials and client information gained through participation in this agreement in confidence in accordance with each organization's policies.

11. Joint Training

Training will be an important component of our ability to better serve the individual experiencing a mental health or addictions-related crisis. Our partners are committed to assisting each other in their training needs. Training will be constantly modified to enhance our ability to serve the individual experiencing a mental health of addictions-related crisis.
(Insert training details)

12. Contact Information

For more information about this protocol, contact:

Hospital representative:
Title:
Telephone Number:
Email:

Police representative:
Title:
Telephone Number:
Email:

13. Signatories

(Signatures from all organizations involved with the protocol)

Hospital

_____

Police Service (can include multiple municipal police services and the OPP)

_____

Paramedic Services

_____

Community Mental Health and Addictions Organization(s)

_____

(List other partners here)

Tool 4: interRAI Brief Mental Health Screener

The interRAI Brief Mental Health Screener provides police officers with a tool to assist in identifying persons experiencing a mental health or addictions-related crisis. This tool enables police officers to record their observations about the individual in crisis and articulate their observations to appropriate health care professionals. The use of the interRAI Brief Mental Health Screener is recommended for police services across Ontario.

About the interRAI Brief Mental Health Screener

The interRAI Brief Mental Health Screener (BMHS) provides police officers with a tool to assist in identifying persons experiencing a mental health or addictions-related crisis. It enables police officers to record their observations about the individual in crisis and articulate their observations to appropriate health care professionals. The purpose of BMHS is to develop an effective way of documenting the observations made by the police officers at the time of the crisis/incident so as to better inform and support decision-making by staff in the emergency department. The ultimate goal underlying the development and use of the BMHS is to ensure that people experiencing a mental health or addictions-related crisis who come into contact with police officers receive prompt access to appropriate health care services, reducing the risk of criminalization.

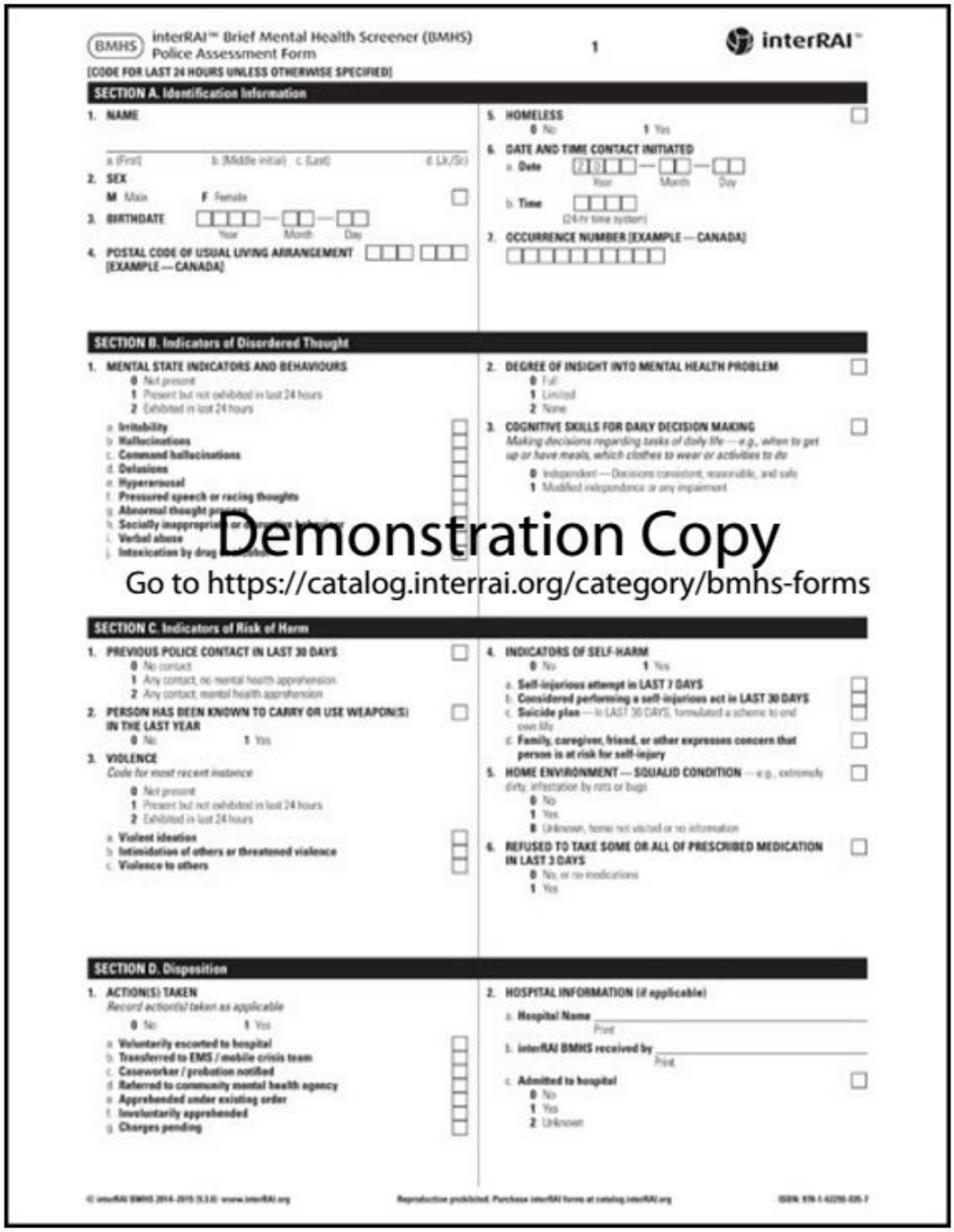
Core items on the BMHS were extracted from a sample of 40,000 cases in the Ontario Mental Health Reporting System database for the Resident Assessment Instrument for Mental Health (RAI-MH) version 2.0, which is the psychiatric assessment tool used with all patients admitted to psychiatric hospital beds in the province of Ontario. Additional items were identified through collaboration with police officers, hospital staff, and mental health and addictions professionals. A pilot study was conducted over an eight-month period with the participation of two police services, four general hospitals and one psychiatric facility in southern Ontario. The effectiveness of the BMHS was demonstrated by testing the association between police officers' ratings on the form and clinicians' assessments conducted in the emergency department of the general hospitals.

There are two major benefits to using the BMHS. First, when police officers learn to use the BMHS, they are receiving enhanced evidence-informed training on the key indicators of mental health and addictions conditions. Second, because the core items on the BMHS mirror that of the RAI-MH tool, police officers are using a form that is not only based on health system data but also written in health system language. Using common language acts as a bridge between the two sectors, thus laying the foundation for a more collaborative approach between hospitals, police services and community mental health and addictions service providers.

The BMHS does not replace a police officer's authority under the *Mental Health Act*. Police officers complete the BMHS for all persons presenting with a mental health or addictions-related crisis regardless of the officer's intended course of action (i.e. release, referral, diversion, *Mental Health Act* apprehension, arrest for criminal offence, etc.). A copy of the BMHS is provided to emergency department staff or to community mental health and addictions service providers, as the BMHS may be used by emergency department staff to assist in their assessment, and community mental health and addictions service providers may use the form to determine whether follow-up care is necessary with the individual.

interRAI Brief Mental Health Screener Demonstration Copy

Copies of this form are available at minimal cost. For more information, visit: https://catalog.interrai.org/category/bmhs-forms



BMHS interRAI™ Brief Mental Health Screener (BMHS) Police Assessment Form 1 interRAI™

[CODE FOR LAST 24 HOURS UNLESS OTHERWISE SPECIFIED]

SECTION A. Identification Information

1. NAME
   a. (First) b. (Middle initial) c. (Last) d. (Jr./Sr.)
2. SEX
   M Male F Female
3. BIRTHDATE Year Month Day
4. POSTAL CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE — CANADA]
5. HOMELESS
   0 No 1 Yes
6. DATE AND TIME CONTACT INITIATED
   a. Date Year Month Day
   b. Time (24-hr time system)
7. OCCURRENCE NUMBER [EXAMPLE — CANADA]

SECTION B. Indicators of Disordered Thought

1. MENTAL STATE INDICATORS AND BEHAVIOURS
   0 Not present
   1 Present but not exhibited in last 24 hours
   2 Exhibited in last 24 hours
   a. Irritability
   b. Hallucinations
   c. Command hallucinations
   d. Delusions
   e. Hyperarousal
   f. Pressured speech or racing thoughts
   g. Abnormal thought process
   h. Socially inappropriate or disinhibited behaviour
   i. Verbal abuse
   j. Intoxication by drug or alcohol
2. DEGREE OF INSIGHT INTO MENTAL HEALTH PROBLEM
   0 Full
   1 Limited
   2 None
3. COGNITIVE SKILLS FOR DAILY DECISION MAKING
   Making decisions regarding tasks of daily life — e.g., when to get up or have meals, which clothes to wear or activities to do
   0 Independent — Decisions consistent, reasonable, and safe
   1 Modified independence or any impairment

SECTION C. Indicators of Risk of Harm

1. PREVIOUS POLICE CONTACT IN LAST 30 DAYS
   0 No contact
   1 Any contact, no mental health apprehension
   2 Any contact, mental health apprehension
2. PERSON HAS BEEN KNOWN TO CARRY OR USE WEAPON(S) IN THE LAST YEAR
   0 No 1 Yes
3. VIOLENCE
   Code for most recent instance
   0 Not present
   1 Present but not exhibited in last 24 hours
   2 Exhibited in last 24 hours
   a. Violent ideation
   b. Intimidation of others or threatened violence
   c. Violence to others
4. INDICATORS OF SELF-HARM
   0 No 1 Yes
   a. Self-injurious attempt in LAST 7 DAYS
   b. Considered performing a self-injurious act in LAST 30 DAYS
   c. Suicide plan — in LAST 30 DAYS, formulated a scheme to end own life
   d. Family, caregiver, friend, or other expresses concern that person is at risk for self-injury
5. HOME ENVIRONMENT — SQUALID CONDITION — e.g., extremely dirty, infestation by rats or bugs
   0 No
   1 Yes
   8 Unknown, home not visited or no information
6. REFUSED TO TAKE SOME OR ALL OF PRESCRIBED MEDICATION IN LAST 3 DAYS
   0 No, or no medications
   1 Yes

SECTION D. Disposition

1. ACTION(S) TAKEN
   Record action(s) taken as applicable
   0 No 1 Yes
   a. Voluntarily escorted to hospital
   b. Transferred to EMS / mobile crisis team
   c. Caseworker / probation notified
   d. Referred to community mental health agency
   e. Apprehended under existing order
   f. Involuntarily apprehended
   g. Charges pending
2. HOSPITAL INFORMATION (if applicable)
   a. Hospital Name (Print)
   b. interRAI BMHS received by (Print)
   c. Admitted to hospital
      0 No
      1 Yes
      2 Unknown

Accessing the interRAI BMHS

To use the BMHS, a police service must sign a User Agreement with interRAI and agree to purchase BMHS manuals for training purposes (manuals are available online at a minimal cost: https://catalog.interrai.org/category/bmhs-manuals). There are various ways that police officers can convey the information on the BMHS to health care professionals, from hand delivery to electronic transmission. To determine which method is most appropriate for your police service and to obtain a copy of the BMHS User Agreement please contact:

Dr. Ron Hoffman
School of Criminology and Criminal Justice
Nipissing University, 100 College Drive, Box 5002
North Bay, Ontario, P1B 8L7
Tel: (705) 474-3450 ext. 4565
Email: ronhoffman@nipissingu.ca

Development of the interRAI BMHS

There were several stages to the development of the interRAI BMHS including a focused literature review, an analysis of the RAI-MH database, the creation of a research team and advisory committee.[7] Input was also solicited from interRAI researchers and in particular the interRAI Network of Mental Health (iNMH) which was established in 2005 to support research and implementation of the interRAI mental health instruments. The iNMH is comprised of about 30 researchers and clinicians from nine countries (Canada, United States, Finland, Iceland, Netherlands, Australia, Brazil, Chile, Peru, Russia) with a broad range of expertise in mental health services.

About interRAI

interRAI is an international collaborative network of researchers in over thirty countries committed to improving the quality of life of vulnerable persons through a seamless comprehensive assessment system. As a not-for-profit consortium, interRAI strives to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings. For more information about interRAI, visit: www.interrai.org

[7] For more information about the interRAI BMHS, see: Hoffman, R. et al. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry*, 47, 28-35. Retrieved from http://www.sciencedirect.com/science/article/pii/S0160252716300449

Tool 5: Transfer of Custody From

This tool is a template for Ontario communities to use to assist with the development of a police-hospital transition protocol. Communities can adapt and change this template to their local needs using available resources.

This form is used to document the joint analysis of risk conducted by the police officer(s) and hospital staff. The purpose of the joint analysis of risk is to determine whether the individual poses a risk with respect to harming themselves or others, and whether the individual poses a risk of fleeing from the hospital. The outcome of this analysis is to determine if the police officer(s) can transfer custody of the individual to the hospital staff or remain in the hospital. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer(s).

Transfer of Custody Form

This form is used to document the joint analysis of risk conducted by the police officer(s) and hospital staff. The purpose of the joint analysis of risk is to determine whether the individual poses a risk with respect to harming themselves or others at the hospital, and whether the individual poses a risk of fleeing from the hospital. The outcome of this analysis is to determine if the police officer(s) can transfer custody of the individual to the hospital staff or remain in the hospital. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer(s).

Personal Information

Name	
Address	
Telephone	
Date of Birth	

interRAI Brief Mental Health Screener Completed by Officer(s):

☐ No ☐ Yes ☐ BMHS form attached

Behaviour(s) Observed:

Disposition

Disposition of the individual. Descriptors are guidelines only.

High Risk ☐	Many verbal and physical indicators are demonstrated in the past 30-minutes. Individual is not cooperative. Has a history of violence or of absconding from institutions. Recent substance abuse. If the individual is **high-risk**, the police officer(s) must remain with the individual until the individual has been assessed by a physician for the purpose of determining whether to issue a Form 1.
Medium Risk ☐	Some verbal and physical indicators are demonstrated in the past 30-minutes. Individual is cooperative some of the time. May have a history of violence or absconding from institutions. May have had recent substance abuse. **Medium-risk** individuals may or may not require the police officer(s) to stay. To determine if the police officer(s) need to remain in the hospital, the hospital staff and police officer(s) should engage in a conversation to collaboratively determine the decision.
Low Risk ☐	Individual is docile and cooperative during the past 30-minutes. No history of violence or absconding from institutions. No recent substance abuse. If the individual is **low-risk**, the police officer(s) can transfer custody to the hospital staff immediately.

Action

Did the Police Officer leave the individual at the hospital?

Yes ☐	Time Officer left:
No ☐	Officer remained for the following reasons:

Additional Comments or Observations:

The signatures below indicate agreement with the behaviour(s) observed and the disposition checked:

Hospital Staff:		Time:
Police Officer:	Badge Number:	Time:

Police Officer returned to the facility:	Time:
Reason:	

Additional Resources

Hoffman, R. et al. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry*, 47, 28-35. http://www.sciencedirect.com/science/article/pii/S0160252716300449

Ontario Hospital Association. (2012). *Practical Guide to Mental Health and Law in Ontario*. http://www.oha.com/CURRENTISSUES/KEYINITIATIVES/MENTALHEALTH/Pages/MentalHealthandtheLaw.aspx

Provincial Human Services and Justice Coordinating Committee. (2013). *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario.* http://www.hsjcc.on.ca/Provincial/Planning%20and%20Priorities/Strategies%20for%20Implementing%20Effective%20Police-Emergency%20Department%20Protocols%20in%20Ontario.pdf

Public Services Health & Safety Association. (2013). *Completing the Violence/Aggression Assessment Checklist (VAAC) for Emergency Departments (ED) or Emergency Medical Services (EMS)*. https://www.pshsa.ca/wp-content/uploads/2013/02/VAACEtoo_-instruction.pdf.pdf

Relevant Legislation can be accessed at: https://www.ontario.ca/laws

- *Freedom of Information and Protection of Privacy Act, 1990*
- *Mental Health Act, 1990*
- *Municipal Freedom of Information and Protection of Privacy Act, 1990*
- *Personal Health Information Protection Act, 2004*

Improving Police-Hospital Transitions:

A Framework for Ontario

Canadian Mental Health Association Ontario
Association canadienne pour la santé mentale Ontario
HSJCC Human Services & Justice Coordinating Committee
OHA Ontario Hospital Association
Ontario Association of Chiefs of Police OACP

Acknowledgements

This framework was developed in partnership with:

- Ministry of Health and Long-Term Care
- Ministry of the Solicitor General
- Provincial Human Services and Justice Coordinating Committee
- Canadian Mental Health Association (Ontario)

Legal Disclaimer

Police-Hospital Transition Task Force

We would like to express our gratitude to all of the members of the Police-Hospital Transition Task Force for their advice and guidance in the development of this framework.

Katie Almond and Michael Dunn, Provincial Human Services and Justice Coordinating Committee
Fuad Abdi, Ministry of the Solicitor General
Nina Acco Weston and Alexia Jaouich, Centre for Addiction and Mental Health
Kashfia Alam, Human Services and Justice Coordinating Committee Secretariat
Jeffrey Bagg, Ontario Hospital Association
Alison Bevington, Waterloo Regional Police Service
Amanda Baine, Ministry of Health and Long-Term Care
Lisa Beck, Thunder Bay Regional Health Sciences Centre
Dena Bonnet, Ministry of the Attorney General
Brian Callanan, Toronto Police Association
Uppala Chandrasekera, Canadian Mental Health Association, Ontario
Raymond Cheng, Ontario Peer Development Initiative
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Marg Connor, Ministry of Health and Long-Term Care
Sean Court, Ministry of Health and Long-Term Care
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Francine Gravelle, Youth Services Bureau
Paul Greenwood, St. Michael's Hospital
Lori Hassall, Canadian Mental Health Association, Middlesex Branch
Jenna Hitchcox, Human Services and Justice Coordinating Committee Secretariat
Ashley Hogue, Central Local Health Integration Network
Doug Lewis, Ontario Provincial Police Association
Phil Lillie, Provincial Human Services and Justice Coordinating Committee
Robyn MacEachern, Ontario Provincial Police
Diana McDonnell, Lanark County Mental Health
Terry McGurk, St. Joseph's Health Care Hamilton
John Pare, London Police Services and Ontario Association of Chiefs of Police
Stephen Waldie, Ministry of the Solicitor General
Margo Warren, Ministry of Health and Long-Term Care
Jeremy Watts, Alex Lam and Bryan Laviolette, York Region, Paramedic and Seniors Services Branch
Mike Worster, Hamilton Police Service
Jodi Younger, St. Joseph's Health Care Hamilton

Executive Summary

This framework has been designed to provide police services and hospitals in communities across Ontario with the tools necessary to establish effective police-hospital transition protocols for individuals that have been apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care. This framework outlines best practices and recommendations for the development of effective protocols that can be tailored to meet the needs of the local community.

The essential first step to developing an effective police-hospital emergency department transition protocol is to establish a strong relationship between the hospital and police service(s), including municipal police services and Ontario Provincial Police (OPP) Detachments. Building a strong relationship opens the door for clear and consistent communication between police officers and emergency department staff.

This framework identifies key drivers of effective police-hospital relationship building:

1. **Obtain endorsement from Police Chief(s)/OPP Detachment Commander(s) and Hospital CEO,** as strong commitment, support and endorsement from the most senior leaders of the organizations has a cascading effect and encourages all levels of staff across the organizations to establish positive working relationships.

2. **Establish Police-Hospital Committee** to provide the leadership and coordination necessary to assess current practices and develop, implement, routinely monitor and evaluate the effectiveness of the protocol.

3. **Develop Protocol** and a written agreement that outlines each step in the police-hospital emergency department transition (i.e. beginning when a police officer apprehends a person under the *Mental Health Act* and ending when the person is transferred from police officer's custody to the hospital emergency department).

4. **Provide Training** on the implementation of the protocol, including the provision of training to all staff who have a role in the protocol.

5. **Implement Protocol** beginning with an initial testing phase where issues arising from the protocol are identified and necessary corrections are made immediately.

6. **Monitor Protocol** routinely to ensure that, as issues arise from the implementation of the protocol, adjustments are made as needed.

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Purpose

This framework has been designed to provide police services and hospitals in communities across Ontario with the tools necessary to establish effective police-hospital transition protocols for individuals that have been apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care.

The intent of this framework is to support communities to:

1) Improve outcomes for individuals apprehended by police under the *Mental Health Act* while respecting individual rights, including the right to privacy;
2) Improve transitions between police officers and hospital workers; and
3) Improve coordination and collaboration among partners involved in the transition.

Intended Audiences

This framework has been specifically developed to assist police services, hospital staff and providers of community mental health, addictions and other human services across Ontario to deliver more effective and coordinated care for persons experiencing a mental health or addictions-related crisis who may be apprehended by police and may require hospital emergency department services.

Increasing need for effective police-hospital transition protocols in Ontario

Research evidence indicates the complex challenges associated with police-hospital transitions and the increasing need for effective transition protocols in Ontario. As emergency responders, police officers often provide assistance to individuals experiencing a mental health or addictions-related crisis. Under the *Mental Health Act*, police officers also have the authority to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. Upon making the apprehension, the police officer remains with the individual until transfer of custody to the hospital occurs. A number of service dynamics occur during this transition process resulting in issues that impact on police services, hospital staff and the individual in crisis.

Research conducted by the Provincial Human Services and Justice Coordinating Committee[1] further highlights the importance of improving transitions between police services and hospitals:

Impact on individuals in crisis. Police accompanied visits to emergency departments increase the stigma associated with mental health and addictions conditions. Being accompanied by a police officer for an extended period of time in a crowded emergency department, particularly while handcuffed or restrained, can worsen the situation and can serve to reinforce the misperceptions about people with mental health and addictions issues, and can also result in the further distress of the individual. In these situations, privacy is often compromised as the individual may feel uncomfortable communicating with hospital staff in the company of police officers, thus hindering their care and treatment.

Impact on emergency departments. Police accompanied visitors often pose additional challenges for hospitals that must balance emergency care with meeting the needs of individuals experiencing a mental health or addictions-related crisis. Limited quarters inside emergency departments mean these individuals may have to remain in a general waiting area under police custody, creating uncomfortable experiences for them and other individuals awaiting care. Hospitals that do not have quiet safe rooms or security guards often rely on police officers to maintain security and safety for everyone in the emergency department. Where hospital security guards may be available, their role with respect to police accompanied visitors is often unclear.

Impact on police services. Police officers often remain in the emergency department with the individual in crisis for extended periods of time until transfer of custody to the hospital occurs. Police presence may also be requested to ensure security and safety of hospital staff. Public safety may be impacted when police officers are required at emergency departments rather than providing services out in the community.

Increasing wait times. Emergency rooms typically face a high volume of clients. Without effective protocols in place to ease transitions, police officers may wait in hospital emergency departments several hours before the individual in crisis may be seen by a physician. These delays may result as individuals experiencing a mental health or addictions-related crisis may be given a lower triage priority compared to those experiencing a physical trauma. Across Ontario, limited number of beds in mental health inpatient units at hospitals and limited 24-hour community-based crisis intervention supports may further contribute to these increasing wait times.

This framework is a strategy for addressing these multiple, intersecting issues associated with police accompanied visits to hospital emergency departments. This framework outlines best practices and recommendations for the development of effective police-hospital transition protocols.

Developing an effective police-hospital transition protocol

Building a strong relationship between the hospital and police service(s) is the most important component of an effective police-hospital emergency department transition protocol.

Research evidence indicates that the essential first step to developing an effective police-hospital emergency department transition protocol is to establish a strong relationship between the hospital and police service(s), including municipal police services and Ontario Provincial Police (OPP) Detachments.[1]

Building a strong relationship opens the door for clear and consistent communication between police officers and emergency department staff. It is important that the relationship building occurs at many levels across the organizations, from the frontline staff level to the most senior levels of management.

Establishing a joint police-hospital committee is recommended to provide the leadership and coordination necessary to assess current practices and develop, implement, routinely monitor and evaluate the effectiveness of the protocol.

Detailed below are key drivers of effective police-hospital relationship building.

[1] Provincial Human Services and Justice Coordinating Committee. (2013). *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario.* www.hsjcc.on.ca

Key drivers of effective police-hospital relationship building

1) Obtain endorsement from Police Chief(s)/OPP Detachment Commander(s) and Hospital CEO

To develop an effective police-hospital emergency department transition protocol, commitment, support and endorsement is necessary from the Chief of Police/OPP Detachment Commander and the Chief Executive Officer (CEO) of the hospital.

Strong commitment, support and endorsement from the most senior leaders of the organizations has a cascading effect and encourages all levels of staff across the organizations to establish positive working relationships.

Communication at all levels of the organization will facilitate a seamless transition for individuals apprehended under the *Mental Health Act*.

The following relationships are crucial to the success of the police-hospital emergency department transition protocol:

a. Police Chief/OPP Detachment Commander and Hospital CEO to be the executive sponsors of the protocol;

b. Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.) to provide guidance to staff on the successful implementation of the protocol and resolve any disputes that may arise between the organizations; and

c. Frontline police officers and hospital emergency department staff to deliver on the expectations associated with the written agreement between the hospital and police service(s).

Key drivers of effective police-hospital relationship building

2) Establish Police-Hospital Committee

It is recommended that the organizations jointly establish a police-hospital committee, which meets regularly, for the purpose of assessing current practices and developing, implementing, routinely monitoring and evaluating the effectiveness of the police-hospital emergency department transition protocol.

The composition of the committee should include representation from frontline staff as well as management from:

- Hospital emergency department (including physicians and nurses) and privacy office;
- All police services within the hospital's catchment area. Where appropriate, local protocols may consider a different catchment area that is reasonable for the local circumstances (e.g. based on the police services' catchment area that captures multiple hospitals);
- Local paramedic services;
- Individuals and families with lived experience of police-hospital transitions; and
- Other important stakeholders in the community as needed, such as community-based mental health and addictions agencies, peer and family support organizations, child and youth mental health and addictions agencies, legal representation, Local Health Integration Network representation and others.

It is recommended that the Police-Hospital Committee develop a terms of reference document which outlines the purpose of the committee, the objectives to be achieved and the frequency of meetings.

Key drivers of effective police-hospital relationship building

3) Develop Protocol

It is recommended that a written agreement be established that outlines each step in the police-hospital emergency department transition protocol (i.e. beginning when a police officer apprehends a person under the *Mental Health Act* and ending when the person is transferred from the police officer's custody to the hospital emergency department).

The written agreement should be developed under the leadership of the Police-Hospital Committee, with executive signatories from each organization involved with the implementation of the protocol.

Where possible, people with lived experience of police-hospital transitions should be engaged in the development of the protocol.

The written agreement should include:

a. Procedures for transferring the individual from the police officer's custody to the hospital emergency department when an apprehension has occurred under the *Mental Health Act*;

b. A Mental Health and Addictions Screening Form for use by frontline police officers to document observations regarding the individual apprehended under the *Mental Health Act*;

c. A Transfer of Custody Form for use by hospital staff to document decisions pertaining to a joint analysis of risk conducted by the hospital staff and the police officer. The joint analysis of risk can be completed by designated hospital staff (not necessarily a physician) and the police officer. However, when required, the decision regarding issuing a Form 1 (Application by Physician for Psychiatric Assessment) under the *Mental Health Act* must be made by a physician;

d. Roles and responsibilities of each organization and respective staff members at each step of the transition; and

e. Signatures from the senior leaders of each organization involved in the protocol.

Key questions to consider when developing a police-hospital emergency department transition protocol:

- What are the existing processes, policies and procedures for police-hospital transitions? How will existing practices be impacted by developing a protocol? Is there an opportunity to improve upon existing protocols?
- What key goals and targets are to be achieved through the protocol?
- What are the roles and responsibilities of each partner organization and respective staff members involved with the protocol?
- How will individuals and families with lived experience of police-hospital transitions be included in the committee and involved in the development of the protocol?
- Is a legal opinion needed to clarify the transfer of custody of individuals who have been apprehended under the *Mental Health Act*?
- Is a legal opinion needed to clarify the requirements under various legislation? (e.g. *Mental Health Act, Police Services Act, Freedom of Information and Protection of Privacy Act, Municipal Freedom of Information and Protection of Privacy Act, Personal Health Information Protection Act*, etc.)

Recommended goals for a police-hospital transition protocol include:

- ✓ Improve outcomes for people experiencing a mental health or addictions-related crisis that are accompanied to an emergency department by a police officer while respecting individual rights, including the right to privacy;
- ✓ Decrease police officer wait times to transfer custody of apprehended person to hospital emergency department;
- ✓ Enhance collaboration and coordination between hospitals and police services in Ontario communities;
- ✓ Protect health care worker safety and security through system improvements; and
- ✓ Promote public safety.

Key questions to consider when developing a police-hospital emergency department transition protocol (continued):

- Are there any other implementation barriers that need to be considered? Are there any existing supports that can be leveraged to assist with the development and implementation of the protocol?
- How will the decision to transfer custody from the police to the hospital be determined?
- What are the procedures for conducting an analysis of risk in order to determine when a police officer should remain at the hospital to maintain security and safety for everyone in the emergency department?
- How will disputes between frontline police officers and hospital staff be addressed? (i.e. what will be the dispute resolution process if a police officer and hospital staff disagree about the level of risk an individual in crisis may pose to themselves or others in the emergency department)?
- If the hospital is not a Schedule 1 Psychiatric Facility, which organization will be responsible for transporting the individual to the nearest Schedule 1 facility?
- Under what circumstances and how will transition-related personal health information about a patient be collected, used, disclosed, stored and secured? Who will be responsible for information-sharing decisions and how will those decisions be documented?
- What special considerations are needed for children and youth, and seniors?
- What special considerations are needed for Indigenous communities?
- What special considerations are needed for racialized communities?
- What special considerations are needed for other marginalized populations in the community?
- How will language barriers be addressed, especially French language requirements?
- What other elements should the protocol contain in order to be inclusive of consideration for special and vulnerable populations (e.g. children and youth, seniors, those with developmental disabilities, etc.)?

Key drivers of effective police-hospital relationship building

4) Provide Training

Each organization must locally determine how to provide training on the implementation of the police-hospital emergency department transition protocol, including the provision of training to all staff who have a role in the protocol.

Wherever possible, it is recommended that joint training sessions be held to encourage relationship building across the organizations involved with the protocol and support a collaborative educational experience.

The training on the protocol should include:

- Roles and responsibilities of each organization and respective staff members;
- Training on the Mental Health and Addictions Screening Form;
- Training on the Transfer of Custody Form; and
- Instructions for carrying out each stage of the protocol.

Additional content to support the training needs of staff may include: background information about the legal requirements of police-hospital transitions in Ontario (i.e. *Mental Health Act*, *Police Services Act*, *Freedom of Information and Protection of Privacy Act*, *Municipal Freedom of Information and Protection of Privacy Act*, *Personal Health Information Protection Act*, etc.); background information about mental health, addictions and the circumstances that may lead an individual to experience a mental health or addictions-related crisis; information sharing and privacy obligations; and information about the mental health and addictions services and supports available in the local community.

Where possible, individuals and families may be engaged to share their lived experiences about mental health or addictions-related crisis situations and the impact of police-hospital transitions.

Key drivers of effective police-hospital relationship building

5) Implement Protocol

Frontline police officers and hospital emergency department staff should be responsible for managing the day-to-day implementation of the protocol, with guidance from the Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.).

The implementation phase should include an initial implementation or testing phase followed by a full implementation phase:

a. During the initial implementation phase, issues arising from the protocol should be identified and necessary corrections should be made immediately;

b. During the initial implementation phase, a designated staff person should be available from the police service(s) and the hospital to answer any questions related to or address any issues arising from the protocol in real time; this responsibility can rest with the shift commander of the police service(s) and a designated on-call staff member of the hospital;

c. When the testing period is over and the full implementation phase begins, the Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.) should continue to provide guidance to staff on the successful implementation of the protocol and resolve any disputes that may arise between the organizations; and

d. As the executive sponsors, the Police Chief/OPP Detachment Commander and Hospital CEO should continue to hold ultimate accountability for the protocol during all stages of implementation.

Key drivers of effective police-hospital relationship building

6) Monitor Protocol

Under the leadership of the Police-Hospital Committee, the police-hospital emergency department transition protocol should be routinely monitored and evaluated. Over time as issues arise from the implementation of the protocol, the Police-Hospital Committee should update the protocol and make adjustments as needed.

The monitoring and evaluation process should include:

- Key indicators of success to be achieved;
- Pre- and post-test to gauge the progression of the key indicators of success;
- Timed intervals for when the data should be gathered;
- Routine report back to the Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.); and
- An annual review of the protocol and updates as required.

Additional resources and sample tools to aid in the development of the protocol, including a sample written protocol, will be made available through a complementary guideline, *Tools for Developing Police-Hospital Transition Protocols in Ontario.*

4.6(c)

Morin, Lois

From: Kerry Jarvi <kerry@downtownhamilton.org>
Sent: May-21-19 11:12 AM
To: egirt@hamiltonpolice.on.ca; JAnderson@hamiltonpolice.on.ca; MWFletcher@hamiltonpolice.on.ca; Farr, Jason; Morin, Lois
Subject: Downtown Hamilton BIA Request
Attachments: ACTION Request.pdf

Dear Chief,

Please see attached a letter from our Board of Management with regards to policing in the downtown core. We ask that you share this with the Hamilton Police Services Board for support and consideration.

If we can offer any further information, please let me know.

Thank you,

Kerry Jarvi, Executive Director
Downtown Hamilton Business Improvement Area
20 Hughson Street South, Suite 104
Hamilton, Ontario L8N 2A1
(905) 523-1646
www.downtownhamilton.org

DOWNTOWN HAMILTON

Chief Eric Girt
Hamilton Police Services Board
155 King William Street
P.O. Box 1060, LCD 1
Hamilton, Ontario, L8N 4C1

May 17, 2019

Dear Chief Girt,

On behalf of the Downtown Hamilton BIA Board of Management, we would like to share our thoughts on changes that have transpired in the downtown core with regards to diminished community policing efforts.

The Downtown Hamilton BIA has worked closely with the ACTION Team, the Crime Managers, the Mounted Unit and many other departments of the HPS to reduce crime in our area which has translated into lower crime statistics over the past few years. In the past few years, we have increased the residential mix downtown, welcomed many new businesses and benefitted from a decreased vacancy rate in both retail and office vacancies. These improvements have been a result of community policing efforts and targeted economic development strategies.

We are aware that the ACTION Team is responsible for the entire city; we have noticed a large decrease in their visibility in the downtown core on a day to day basis as well as for special events. The presence of these officers significantly contributes to the sense of safety and security downtown.

One strategic focus for the Downtown Hamilton BIA Board of Management over the next two years is New Employer Attraction. A task force has been established to create new initiatives and programs to attract new employers that will reduce our office and commercial vacancy. The sidewalk experience of those that are coming downtown for the first time is impactful on their decision to locate here. The graffiti, loitering, excessive panhandling and repeated break-ins, especially of properties under construction diminish the sidewalk experience. These instances are on the rise.

We strongly recommend the return of a dedicated ACTION team to downtown Hamilton. Safety and security of our businesses, our visitors and our residents is a high priority for all of us.

Sincerely,

Una Gibbons
Chair, Downtown Hamilton BIA

Downtown Hamilton Task Force Participants: Dave Thompson – WALTERFEDY, Mark Poce – Dan Lawrie Insurance Brokers, Paul Demarco – Simpson Wigle Law LLP, Beth Molnar – Aragon Properties, Stefanie Bonazza – Alectra Utilities, Evan Apostol – Wilson Blanchard Management, Steve Kulakowsky – Core Urban

DOWNTOWN HAMILTON

Cc:
Mayor Fred Eisenberger
Councillor Chad Collins
Councillor Jason Farr
Councillor Tom Jackson
Mr. Fred Bennink
Mr. Donald MacVicar
Mrs. Pat Mandy
Lois Morin, Administrator
Superintendent Jamie Anderson
Sergeant Matt Fletcher

4.6(d)

Hi ! I wanted to write an e-mail to let you know I really appreciate the changes you have made on the Redhill. I drive on that road 4 times a day, and have now for 11 years. I myself have received a speeding ticket on that road (I am not perfect).

I feel as though the reduced speed has made a positive impact on traffic, and traffic safety. I do not have access to accident statistics, but I would assume they are lower. I really feel like the road is a lot safer to travel on with less accidents, and less traffic jams.
I also appreciate the police presence on the Redhill, and hope you will keep a police car monitoring speeding there on a daily basis. It really helps to slow people down.

I am very happy that this Police initiative is working! Thank you for ensuring the safety of the community (and my family).

One thing I would suggest to increase the road safety is put guard rails up in the middle of the road between Mud St. and King St. At certain times of the day due to the sun, it looks like a continuation of the road, instead of a median. I drive the road, and know it well. Someone who was not familiar could be at risk. I know it sounds unbelievable but it can be deceiving and metal guard rails with reflectors would alleviate accidents where they cross the Redhill on to oncoming highway traffic (this happens often).

Thank you for all of your hard work. Hamilton Police are the best !!!!

[redacted]

Copy to PSB.

HAMILTON POLICE SERVICES BOARD

OUTSTANDING ISSUES as of June 13, 2019

ITEM	ORIGINAL DATE	ACTION REQUIRED	STATUS	EXPECTED COMPLETION DATE
1. Other Business	May 26, 2016	That Chair Eisenberger work with the Board Administrator to implement the use of Electronic devices for monthly agendas.	PSB 16-001 – Ongoing	2nd Quarter of 2019
2. Body-Worn Camera Steering Committee Second Year Report (PSB 16-127)	November 16, 2017	That the Board approve that continued investigation occur prior to accepting, rejecting or engaging in a Body Worn Camera pilot deployment program.	Ongoing – Board is waiting for further information with respect to the use of Body Worn Camera use in other Police Services	Ongoing
3. Sex Assault Review - PSB 18-103	November 22, 2018	That the a report be brought back to the Board on the progress of the recommendations presented within the Sexual Assault Review Report (PSB 18-103)		4th Quarter of 2019
4. New Business – Thunder Bay Police Services Board and the recent report from the OIPRD	December 20, 2018	Member Mandy requested a report on the services / relationships with respect to the indigenous community and the Hamilton Police Service.		2nd Quarter of 2019
5. New Business - Current Vacancy of Community Relations Coordinator	December 20, 2018	Member Jackson requested information with respect to the community relations coordinator position which has been vacant for quite some time. Chief Girt stated he would inform the Board when an applicant has been hired.		Ongoing

4.6(e)

5.1

HAMILTON POLICE SERVICES BOARD

- INFORMATION -

DATE:	June 13, 2019
REPORT TO:	Chair and Members Hamilton Police Services Board
FROM:	Eric Girt Chief of Police
SUBJECT:	***Year End Report: Use of Force 2018*** ***PSB 19-045***

BACKGROUND:

Attached is the annual Use of Force Report for 2018. This report is completed to capture information forwarded to the Service Armourer/Use of Force Training Sergeant by members who have completed a Use of Force Report.

As per the *Police Services Act* Regulation 926 Sec. 14.5(1) Reports on Use of Force: A member shall submit a report to the Chief of Police or Commissioner whenever the member,

(a) draws a handgun in the presence of a member of the public, excluding a member of the police force while on duty, or points a firearm, or discharges a firearm;

(b) uses a weapon other than a firearm on another person; or

(c) uses physical force on another person that results in an injury requiring medical attention.

Hamilton Police Service Policy & Procedure 1.02 *Use of Force* addresses the member requirements for submitting Use of Force Reports at the Hamilton Police Service.

Eric Girt
Chief of Police

EG/N. Goodes-Ritchie
Attachment: *2018 Use of Force Statistical Report*

cc: Frank Bergen, Deputy Chief – Support

2018 Use of Force Statistical Report

Prepared by Sergeants
Gino Ciarmoli and Scott Galbraith

A statistical summary of reported Use of Force Incidents by the Hamilton Police Service

Hamilton Police Service
Training Branch
Use of Force Section

Table of Contents

2018 Use of Force Statistical Report

Introduction

This report will provide a statistical summary of reports of Use of Force incidents that occurred in 2018; where a particular Use of Force option was utilized by a member of the Hamilton Police Service. The report will also compare the number of 2018 Use of Force incidents with the number of incidents from the years 2009 to 2017. The report will also compare the total number of force options used in 2018 to the total force options used in the years 2009-2017. In addition this report will focus on Use of Force incidents by Service Branch (i.e. Patrol, Support or other) and by officer's years of service. Lastly, there will be a breakdown of the 2018 incidents into the following categories: incidents per month, incidents per day of the week and incidents per time of day. The source material for the data is Use of Force Reports and/or Hamilton Police Service Conducted Energy Weapon (CEW) Reports submitted by the involved officer(s). All data prior to 2005 was provided by the Professional Standards Branch.

As per the Ontario Police Services Act Regulation 926 Sec. 14.5(1) Reports on Use of Force and Hamilton Police Service Policy and Procedure 1.02, Use of Force Reporting, Hamilton Police Service members shall complete and submit Hamilton Police Service Use of Force Reports to the Chief of Police, through their Command Officer, prior to the completion of their shift, as follows:

Parts A and B of the Use of Force Report are required whenever the Member:

a. Draws a handgun in the presence of a member of the public, excluding a Member of the Police Service while on duty, points a firearm at a person, or discharges a firearm other than on a Police Range; in the course of a training exercise, target practice or ordinary firearm maintenance, in accordance with Service Policies and Procedures;

b. Uses a weapon other than a firearm on another person, with the exception of a weapon other than a firearm used on another Member of a Police Service in the course of a training exercise in accordance with Service Policies and Procedures;

c. Uses physical force on another person that results in an injury requiring medical attention, with the exception of physical force used on another Member of a Police Service in the course of a training exercise in accordance with Service Policies and Procedures; or

d. Handles a Police Service Dog where the dog bites a suspect or any member of the public as the result of the involvement of the Canine Branch.

e. While operational as a Mounted Unit Officer, uses the equine to apply force to a member of the public that results in an injury requiring medical attention.

Parts A, B of the Use of Force Report and parts C, D of the CEW Report are required whenever the Member deploys a Conducted Energy Weapon (CEW) in the cartridge deployment mode.

Parts C and D are required whenever the Member draws, points or displays a Conducted Energy Weapon in the presence of a member of the public, excluding a Member of the Police Service while on duty, other than on a Police Range; in the course of a training exercise or ordinary CEW maintenance in accordance with Service Policies and Procedures.

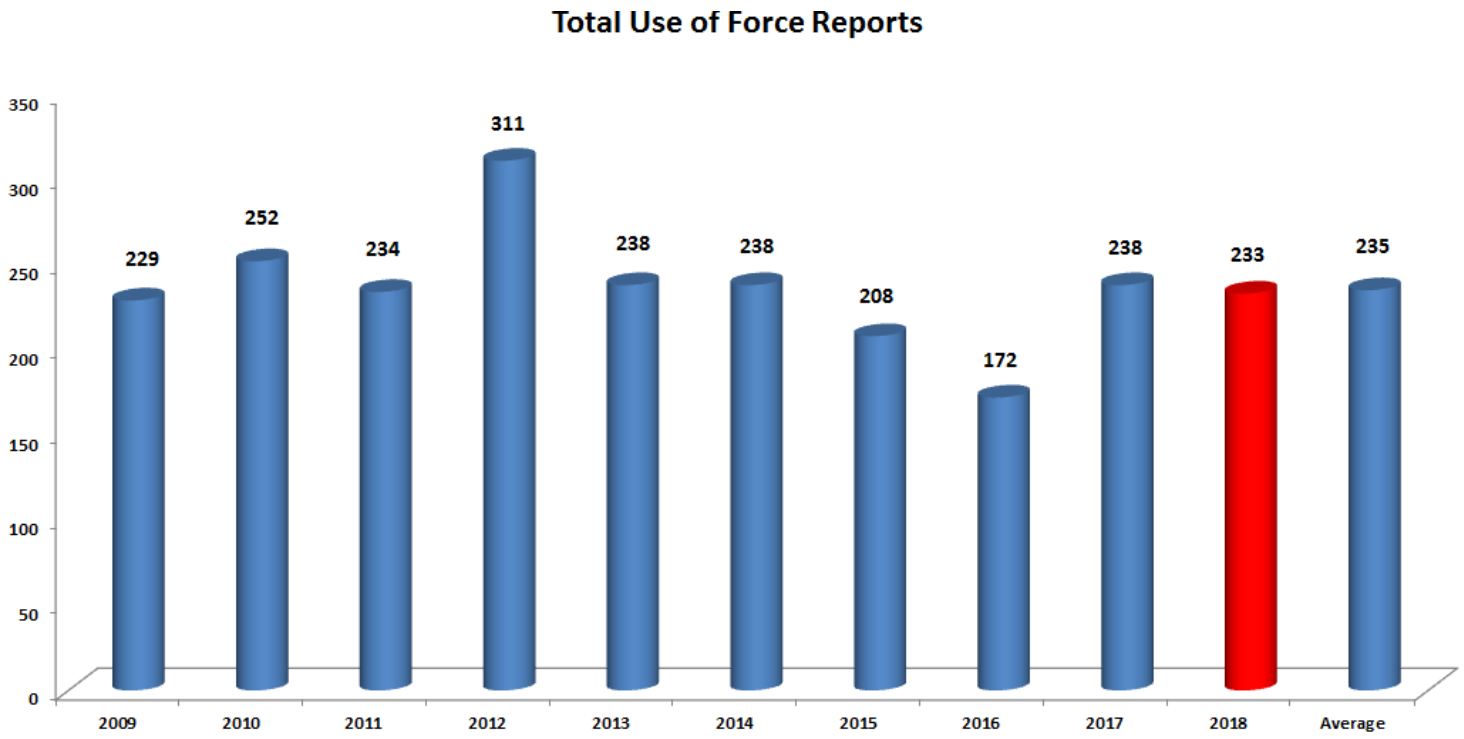
This report only summarizes those incidents in which a Use of Force Report was submitted and does not totally reflect all instances in which a Use of Force option was used upon a member of the public. For example, handcuffing a person is considered a Use of Force application; however if no injury is incurred a Use of Force Report is not required.

The Use of Force options that are tracked by Use of Force Reports are:

- Firearm Discharged
- Firearm Pointed
- Handgun Drawn
- Aerosol Weapon (Oleo capsicum (OC) spray or foam)
- Impact Weapon Hard (ASP Baton)
- Impact Weapon Soft (ASP Baton)
- Empty Hands Hard
- Empty Hands Soft
- Other (K9 bites, Mounted Patrol Unit, weapons of opportunity)
- Conducted Energy Weapon (CEW) in the cartridge deployed mode.

Statistical Summary of Use of Force Incidents

During the ten year period from 2009 – 2018 the average number of incidents reported was 235 incidents per year, with a low of 172 incidents in 2016 and a high of 311 incidents in 2012. The total number of Use of Force incidents in 2018, 233, is lower than the 10 year average of 235 incidents per year.



In 2018, our officers reported 233 Use of Force incidents. There were 83 incidents where more than one Use of Force option was used. This number increased from 75 incidents in 2017. For example, an officer(s) may use more than one option to resolve an encounter, such as initially attempting empty hands soft and then deploying an aerosol weapon. Of note, there were an additional 107 CEW display mode reports (this number includes 27 multi option incidents). These reports do not factor into the statistics captured on the standardized Use of Force Report submitted to the Ministry of Community Safety and Correctional Services for statistical purposes.

Total Use of Force Options

	Firearm Discharge	Firearm Pointed	Handgun Drawn	Aerosol Weapon	Impact Hard	Impact Soft	Empty Hands Hard	Empty Hands Soft	K9 Bite / Misc	CEW	Total Incidents
2009	45	91	18	28	10	1	17	8	2	27	229
2010	42	112	17	28	5	2	22	26	3	45	252
2011	43	110	13	21	6	1	19	31	4	22	234
2012	46	145	52	22	7	2	35	39	5	49	311
2013	62	99	22	13	7	4	32	21	0	41	238
2014	47	100	23	14	3	1	15	18	2	64	238
2015	30	145	59	9	4	0	13	12	0	47	208
2016	18	98	40	7	1	1	26	25	4	38	172
2017	24	125	19	3	3	0	22	44	1	58	238
2018	28	125	39	2	3	1	23	36	2	57	233
Avg	39	115	30	15	5	1	22	26	2	45	235

NOTE Adding the cells from any given year will not result in the sum calculated in the “Total Incidents” cell. This is due to the fact that some incidents involve multiple options therefore producing a number of a lower value when totalled.

2017 vs 2018 Options Used / Total Incidents

	2017	2018	Percentage increase or decrease
Firearm Discharge	24	28	17
Firearm Pointed	125	125	0
Handgun Drawn	19	39	105
Aerosol Weapon	3	2	-33
Impact Hard	3	3	0
Impact Soft	0	1	100
Empty Hand Hard	22	23	5
Empty Hand Soft	44	36	-18
K9 Bite/Other	1	2	100
CEW (Both Modes)	169	164	-3
Total Options	410	423	3

Firearm Discharged

The discharging of a service pistol, shotgun, or one of the tactical firearms is a very serious occurrence. Officers are taught as per the Ontario Use of Force Model and Police Services Act Regulation 926, Sections 9 and 10: "that they shall not draw a handgun, point a firearm or discharge a firearm unless he or she believes, on reasonable grounds, that to do so is necessary to protect against loss of life or serious bodily harm," or "to call for assistance in a critical situation, if there is no reasonable alternative; or to destroy an animal that is potentially dangerous or is so badly injured that humanity dictates that its suffering be ended."

There were 28 incidents in 2018 where Hamilton officers discharged a firearm. The ten year average for Firearm Discharged is 39 incidents per year. The most common use of service firearms is to euthanize injured animals. In 2018, 26 firearms discharged incidents were for this purpose. The two other incidents fell under the mandate of the SIU. One of those investigations has been concluded and the other is still ongoing. For tracking purposes, each firearm was counted as a statistic. This is a 16.7% increase compared to the 24 incidents in 2017.

Firearm Pointed

Again, officers are taught as per the Ontario Use of Force Model and Police Services Act Regulation 926, Section 9; "that they shall not draw a handgun, point a firearm or discharge a firearm unless he or she believes, on reasonable grounds, that to do so is necessary to protect against loss of life or serious bodily harm." The types of incidents where a service pistol is removed from its holster (or rifle, shotgun, etc.) and pointed at a member of the public, range from officers making high risk arrests where weapons are believed to be involved, to the Emergency Response Unit (ERU) making dynamic entries; i.e.: barricaded individuals, warrant execution involving weapons, etc.

The ten year average for Firearm Pointed is 115 incidents per year. In 2018 there were 125 firearm pointed incidents. This is a zero % change compared to 2017.

Handgun Drawn

The drawing of a member's handgun from its holster is something different than the pointing of a firearm, in that as per Regulation 926 s. 14.5(1)(a) a Use of Force Report is only submitted when a handgun is drawn in the presence of a member of the public. Again, officers are taught they can only draw their handgun if "he or she believes, on reasonable grounds, that to do so is necessary to protect against loss of life or serious bodily harm." The numbers reflected in this category are much lower than the pointing of a firearm. This can be attributed to the fact that an Officer will respond to a serious call that warrants the pistol being drawn, but at the time of deployment is not directly pointed at a member of the public; i.e.: pistols are drawn prior to a dynamic entry or building search and this is witnessed by members of the public; therefore a Use of Force Report is required to be submitted. Should an incident progress from Handgun Drawn to Firearm Pointed, the latter would ultimately be used to capture the occurrence as it is the more significant of the two. There were 39 incidents in 2018 where an officer drew their handgun in front of a member of the public. This is above the ten year average of 30 incidents per year and 105% increase from 2017's 19 incidents.

Aerosol Weapon (Oleo Capsicum – (O/C)

O/C is classified as an "intermediate weapon" and a subject/threat must exhibit at minimum, "actively resistant" behaviour before its use can be considered. There were 2 O/C incidents in 2018 which is below the ten year average of 15 incidents per year and 40% less than 2017's 3 incidents.

The use of O/C significantly decreased with the introduction of the CEW in 2005. In 2004, O/C was deployed 68 times but its' use plummeted to 39 incidents in 2005 when CEWs were introduced. It was anticipated that O/C use would continue to decline or plateau as CEW use became more widespread; and overall, O/C use has generally declined since 2005.

Impact Weapon Hard

Impact weapons "hard" refers to using the ASP Baton to strike an "assaultive" subject. The ASP Baton was used 3 times in 2018 to strike a subject displaying assaultive behaviour, which is lower than the ten year average of 5 incidents per year and no change from the 3 incidents in 2017.

Impact Weapon Soft

Impact weapons "soft" refers to using the ASP Baton as a point of leverage while depressing a pressure point on a subject. This option would generally be applied to suspects displaying passive resistant to active resistant behaviour and historically this option is very rarely utilized. There was 1 reported incident of Impact Weapon Soft in 2018, 100% more than 2017's zero incidents and on par with the ten year average of 1 incident per year.

Empty Hands Hard

The use of empty hands "hard" refers to the striking of a generally assaultive person. This would include punches, kicks, elbow strikes, knee strikes and grounding techniques. As per Reg. 926 s.14(c) an officer is only required to submit a report for Empty Hands Hard if they "use physical force on another person that results in an injury requiring medical attention." However, an officer is also required to submit a report if they use another force option that requires a report in conjunction with Empty Hands Hard even though medical attention was not required; i.e.: Empty Hands Hard in conjunction with O/C.

There were 23 reported incidents in 2018 of Empty Hands Hard. This is slightly above the ten year average of 22 incidents per year and an increase of 5% when compared to 2017's 22 incidents.

Empty Hands Soft

The use of empty hands "soft" refers to the application of joint locks, some grounding techniques and/or pressure points to a person. Again, as per Reg. 926 s.14(c) an officer is only required to submit a report for Empty Hands Soft if they "use physical force on another person that results in an injury requiring medical attention."; or if they use this option in conjunction with another option that requires mandatory reporting i.e.: Empty Hands Soft in conjunction with OC or CEW. In 2018, there were 36 reported incidents of Empty Hands Soft. This is above the ten year average of 26 incidents per year and a decrease of 20% compared to 2017's 44 incidents.

Conducted Energy Weapon (CEW)

Conducted Energy Weapons, also known as TASERs were authorized for limited police use in Ontario in late 2004. Their use was originally limited to Tactical Teams, Containment Teams and Front Line Patrol Supervisors and designates when acting in a supervisory capacity. The HPS definition of Front Line Supervisor was expanded in 2007, 2008, 2009 to include Crime Managers, Vice and Drug Officers, Gangs and Weapons Enforcement Officers, Break, Enter, Auto Theft and Robbery Unit (B.E.A.R.) Officers, Fugitive Apprehension Unit Officers, Mounted Patrol Unit and Addressing Crime Trends In Our Neighbourhoods (A.C.T.I.O.N) Supervisors.

In August 2013, the Ministry of Community Safety and Correctional Services announced that they would be moving forward to eliminate restrictions on which police officers would be authorized to carry a CEW. The Hamilton Police Service implemented a training plan in September, 2013 in which all active officers would be trained in the use of a CEW. In November, 2013 the Ministry announced that each Police Chief in partnership with their Police Service's Board could designate which classes of officers within their organization would be authorized to carry a CEW. Effective August 11, 2014 any Hamilton officer trained to carry a CEW would be authorized to do so. The Hamilton Police Service currently has over 700 qualified CEW officers.

In 2005, a Hamilton Police Service TASER Report was implemented to track CEW use and deployment mode(s) that were not being captured by a Use of Force report. Officers are only required to submit a Use of Force report with respect to CEW use when a cartridge is fired at a subject or when directly applied in the contact mode.

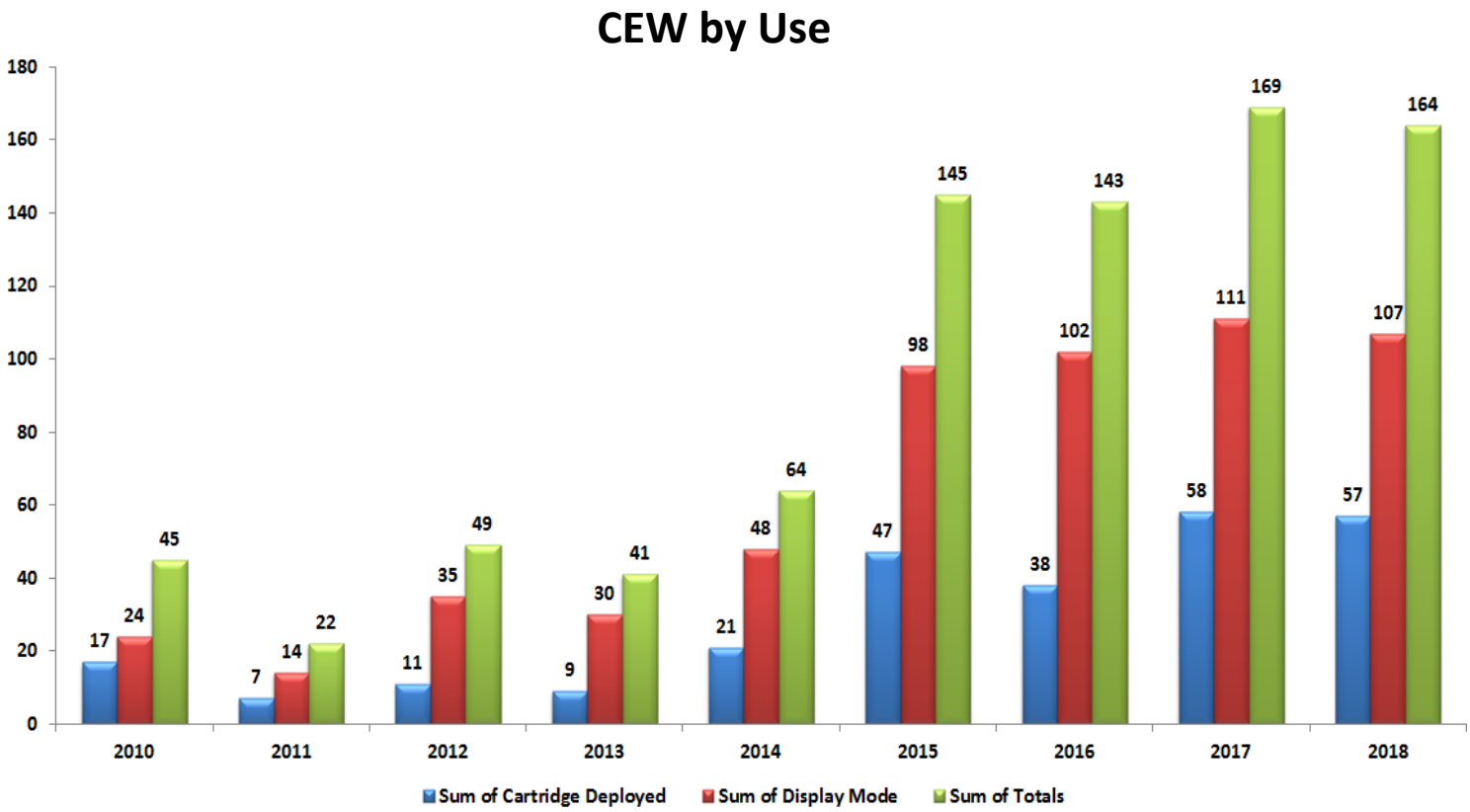
The TASER report captures the following deployment modes: a) CEW used in the "cartridge deployed" mode where a cartridge is fired at a subject; b) CEW used in the "contact" mode where the CEW is applied directly to a subject otherwise referred to as "touch tase, drive stun or push stun" and c) Force Presence/Display mode; in any instance in which the CEW is removed/drawn from its holster in front of a member of the public; or where the CEW's laser sight is applied to a subject; or when the CEW is "spark tested" in front of a subject in the effort to gain subject cooperation without having to actually apply the CEW. The use of the Hamilton Police Service TASER Report was discontinued in early 2006; but was re-designed and re-implemented in November, 2007. The report was further re-designed and is now Parts C and D of the H.P.S. Use of Force Report.

As per the Ontario Use of Force Model, the CEW is an "intermediate weapon", which police can consider to use when a subject exhibits "actively resistant" behaviour. However, in June 2009, the Hamilton Police Service

changed its CEW policy to; a subject must exhibit at minimum "assaultive and/or serious bodily harm or death behaviours to themselves or another person" before CEW use can be considered. This is a reflection of current National and Provincial best practices.

CEW Use

The CEW was used 164 times in 2018; a decrease of 3% from the 169 incidents in 2017. There were a total of 233 Use of Force incidents reported in 2018. In 83 incidents there were multiple Use of Force options used. In 27 of these incidents the CEW was included as one of the multiple options used. In 57 incidents the CEW was used in deployment mode meaning probes were fired from the cartridge. In 107 incidents the CEW was used in display mode meaning it was a show of force / de-escalation tool and no probes were fired from the cartridge. As per the below chart, since 2010, the majority of CEW use is in the display mode.

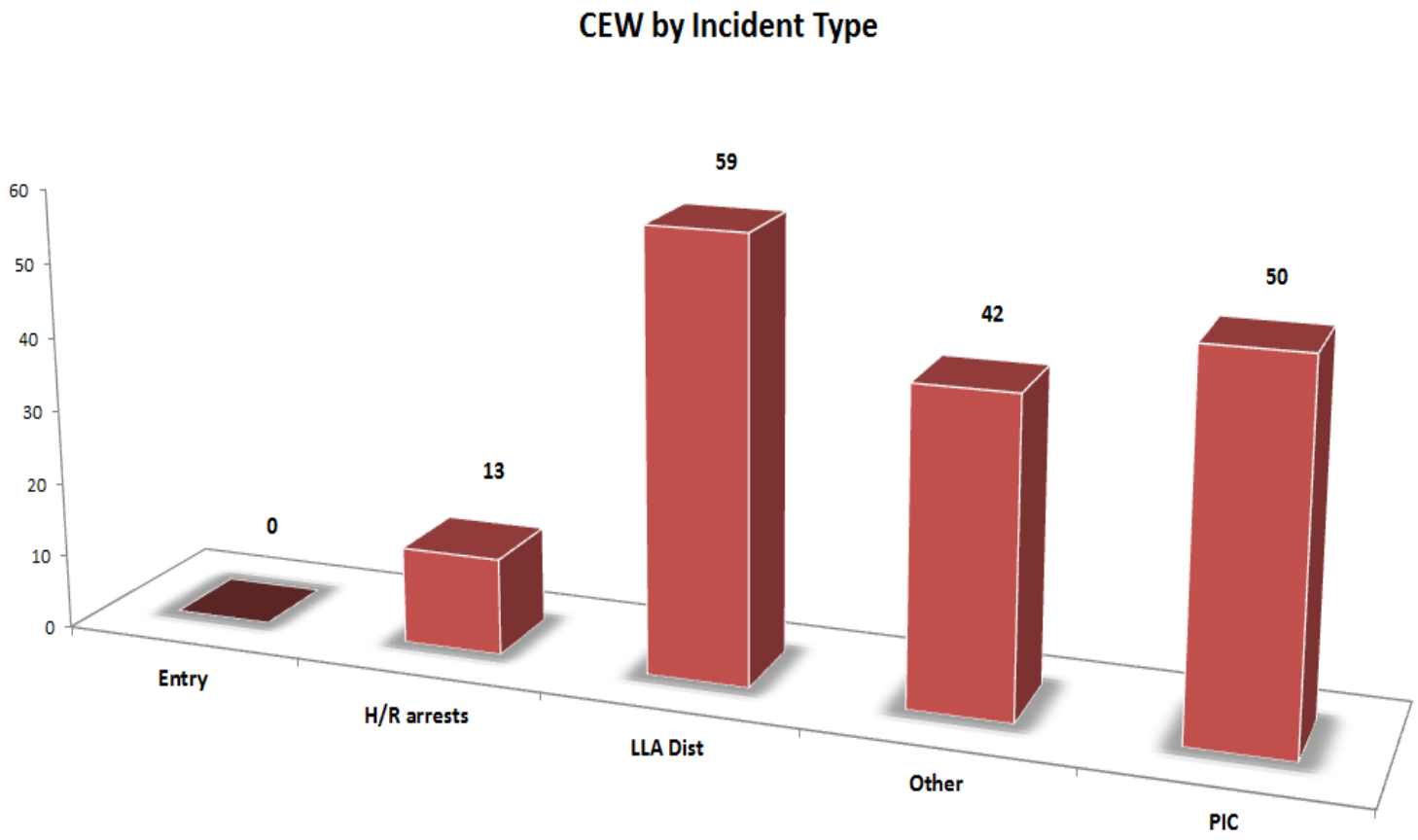


NOTE * 2015 represents the first year that contact mode has been discouraged in training as it cannot achieve neuromuscular incapacitation. As a result, the contact mode statistics from the previous years were not included as to give a proper comparison. When adding the totals (Deployment + Display) a lower number is explained by those missing contact mode incidents. A higher number is explained by multiple modes used in a single incident.

CEW by Incident Type

The CEW was deployed to apprehend/control persons in crisis or PIC's (50 incidents), High Risk Arrests where an individual was armed or thought to be armed with a weapon (13 incidents - **This is a 65% decrease from the 37 incidents in 2017),** Disturbances, usually involving Liquor License Act violations, Other Incidents, which are general arrests involving assaultive suspects and Dynamic Entry.

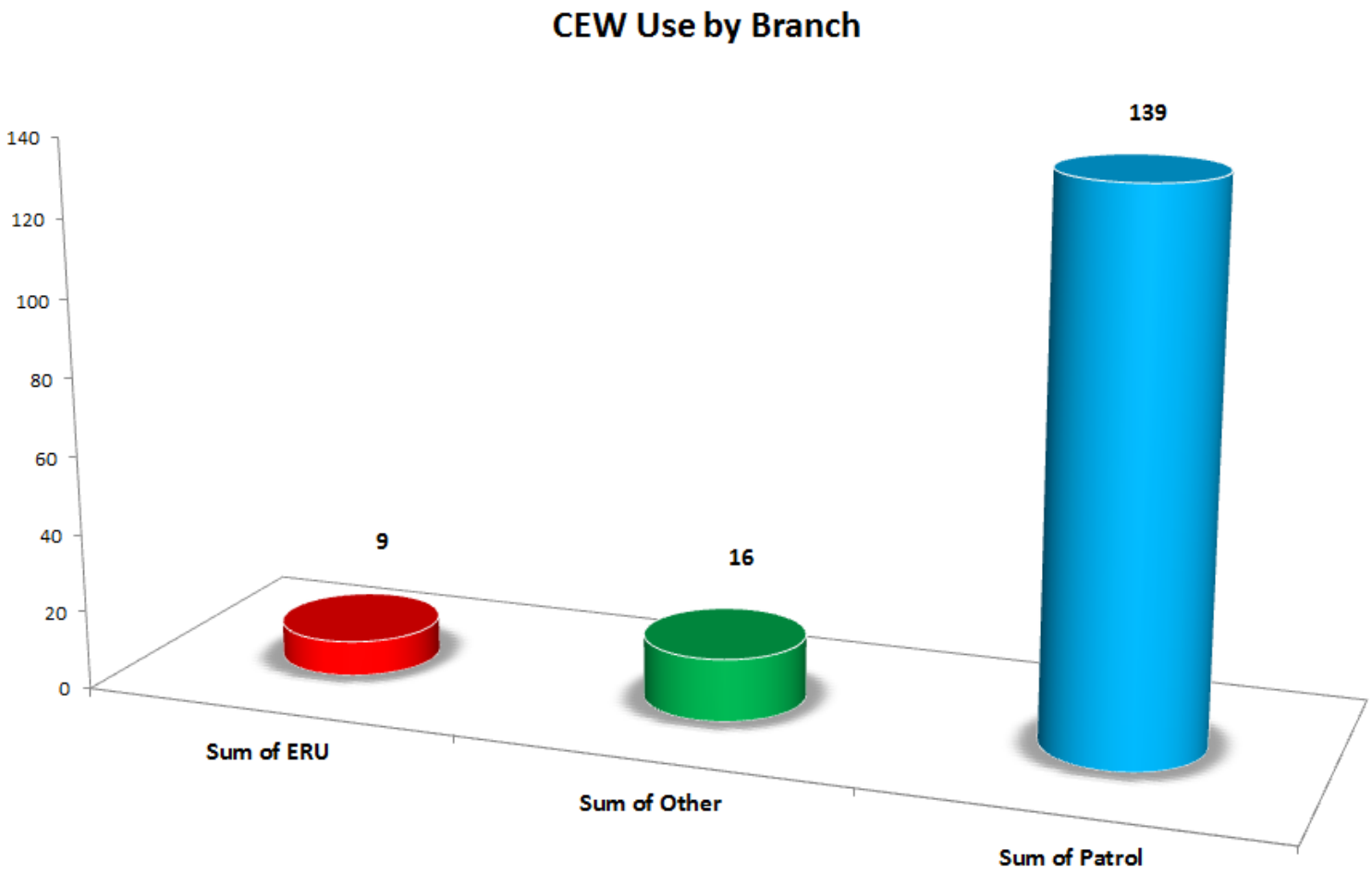
In 68 of the 2018 CEW incidents the subjects were displaying or had immediate access to a weapon. 37 involved a knife of some type, 6 involved a firearm or replica and 25 involved an "other" implement (axe, sword, hammer, razor blades, screwdriver, bat, metal pipe and glass).



CEW Use by Service Branch

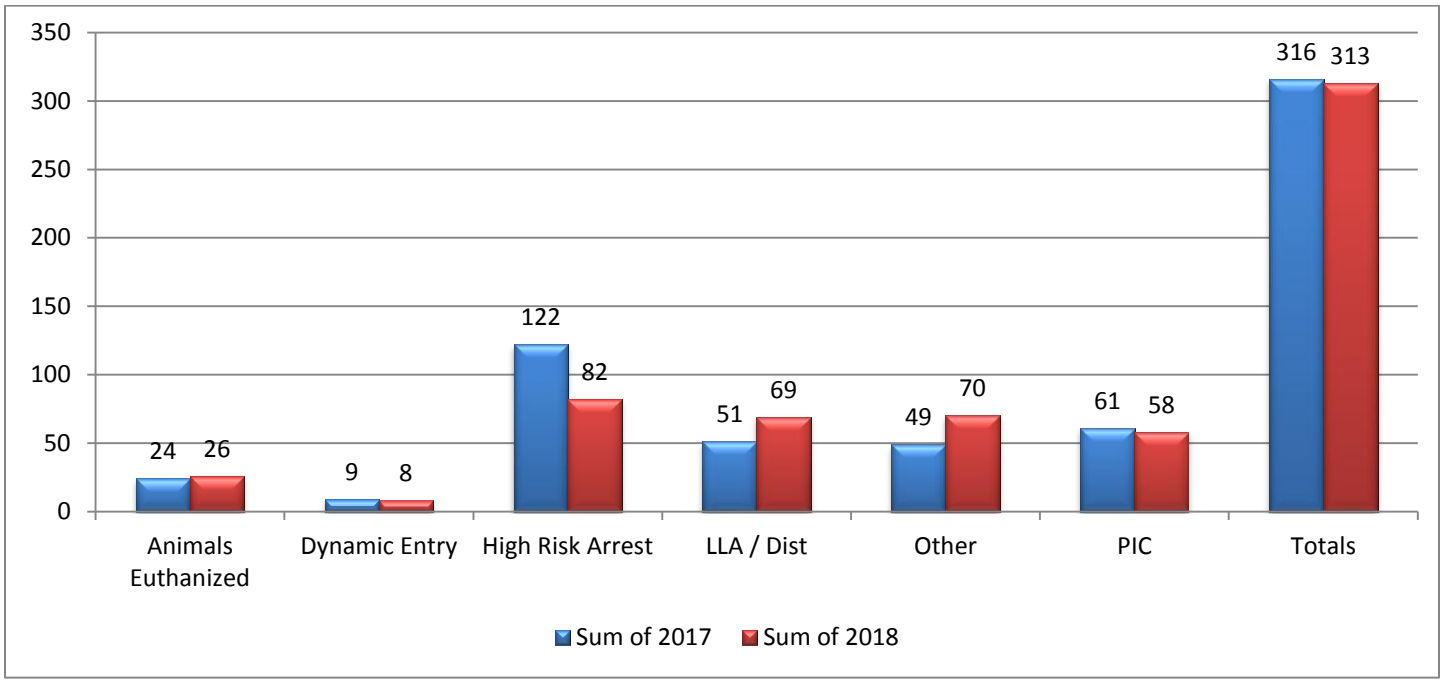
With respect to Use of Force by Branch, the Service is divided for statistical purposes into five groups or Branches; 1. Uniform Patrol 2. Emergency Response Unit (ERU) 3. Other (Vice and Drugs Intelligence, BEAR, HEAT, A.C.T.I.O.N., etc.) 4. Courts/Custody 5. Paid Duties. CEW use in 2018 by Branch is as follows; Emergency Response Unit - 9 incidents, Other -16 incidents and all other incidents were identified as Uniform Patrol (139). In 2 incidents the CEW was used in both display and deployment modes.

CEW use remained consistent in 2018 when compared to 2017 and was predominantly deployed in the Force Presence/Display Mode. The increase of the CEW in the Force Presence/Display in recent years would suggest that the presence of a CEW at an incident appears to act as a general deterrent and de-escalation tool.



Use of Force by Incident Type

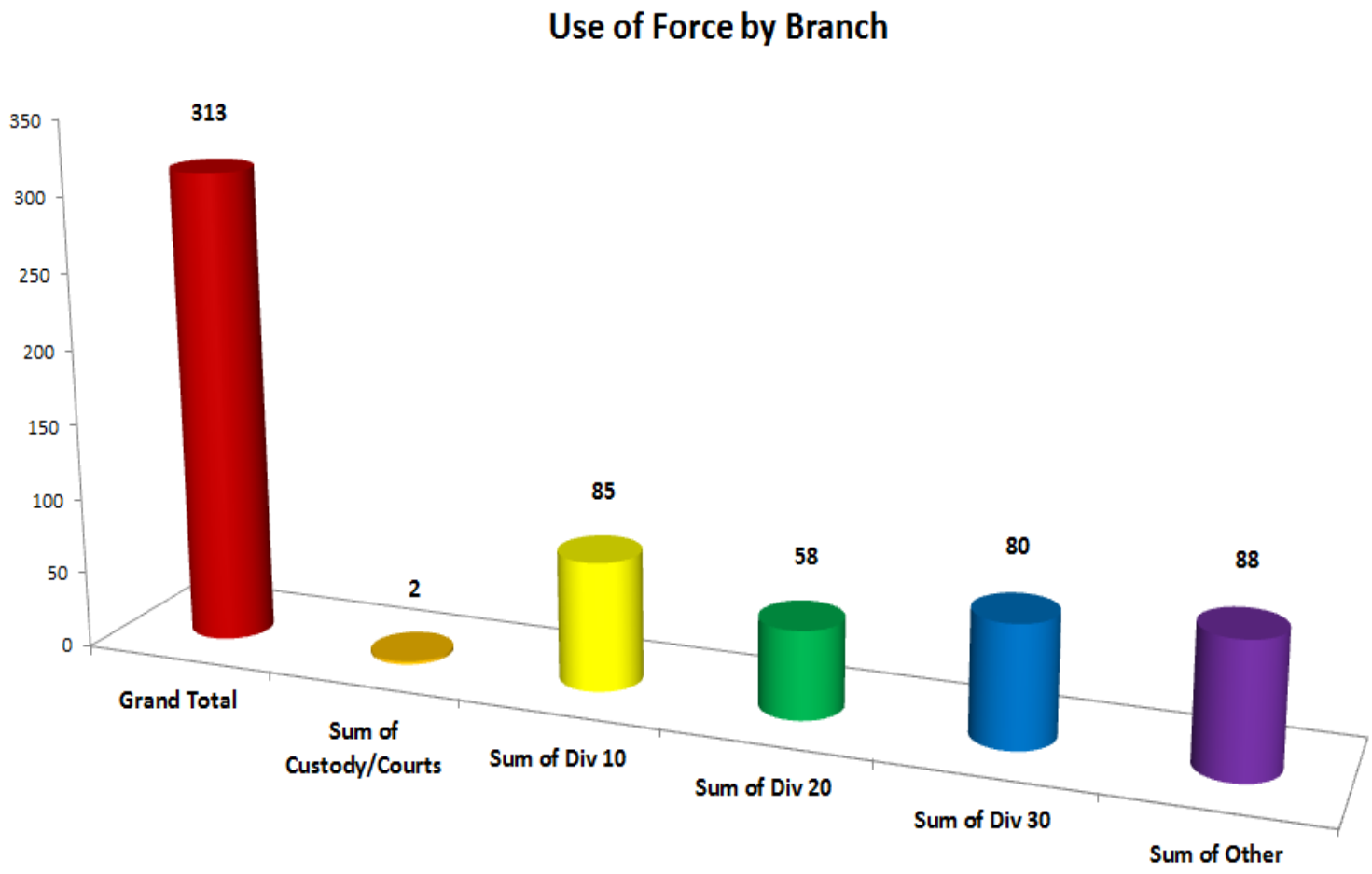
Use of Force incidents were grouped into the following categories: 1. High Risk Arrests where a subject was/believed to be armed with a weapon, 2. Persons In Crisis (PIC), 3. Liquor Licence Act/Disturbances, 4. Dynamic Entry Warrant Execution generally upon a premise, 5. Other; which includes subjects who were assaultive, as well as Court and Custody incidents and 6. Animals euthanized.



NOTE * this chart distinguishes between **incidents** and **Use of Force incidents**. 287 represent the total number of incidents reported by Hamilton Police on a member of the public (313-26 animal euthanizations). 233 represents the total from that 313 that are Ministry identified Use of Force incidents. Therefore, 107 incidents were CEW display, 27 of those transitioned to a Use of Force incident which would require a Use of Force report. This would leave 80 CEW incidents which were strictly Display Mode only and are not required to be reported to the Ministry therefore are not included in the 233 reported Use of Force reports.

Use of Force by Branch

As previously mentioned the Service is divided for statistical purposes into five groups or Branches; 1. Uniform Patrol, 2. Emergency Response Unit (ERU), 3. Other (Vice and Drugs, Intelligence, BEAR, HEAT, etc.), 4. Courts/Custody, 5. Paid Duties. Although there were 233 reported Use of Force incidents in 2018, in some incidents more than one Branch responded and used force; i.e.: Patrol plus B.E.A.R., Patrol plus E.R.U., etc. Note, CEW reported data as well as Use of Force reported data has been included in the following chart. Uniform Patrol Officers accounted for 223 (71%) of reported incidents and ERU / specialized "Other" Units accounted for 90 (29%). ERU incidents are primarily dynamic entries. There were 2 incidents reported by Custody/Courts and no incidents reported by Paid Duty.

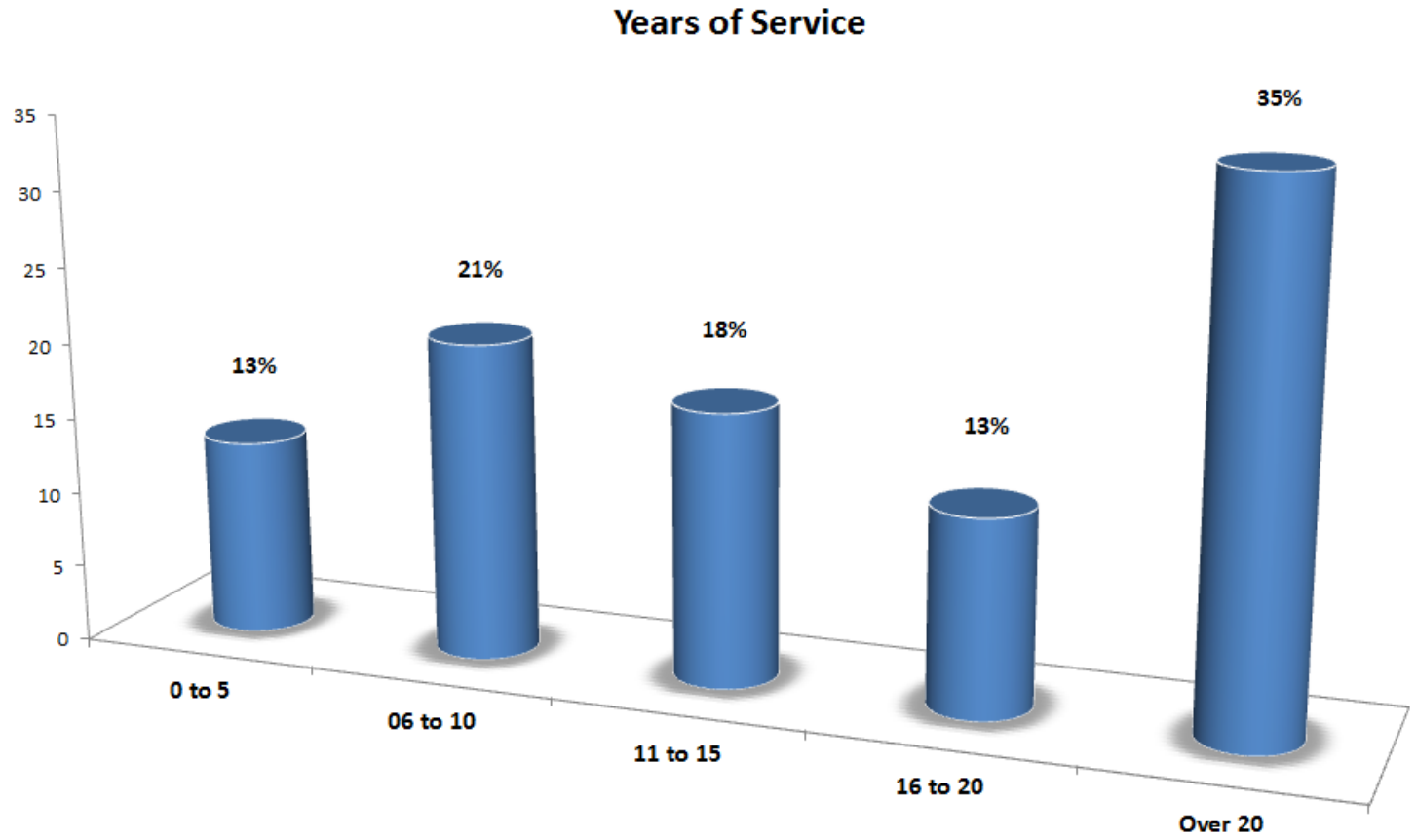


Use of Force by Years of Service

The Use of Force Report has a Length of Service section to be completed by the submitting officer. In certain circumstances this section is not completed. The most common reason for this area not being completed is when the Emergency Response Unit files a "team" report and the Years of Service area is not completed and/or a CEW is used in the display mode only. Currently as per HPS Policy and Procedure 1.02, only parts C and D of the Use of Force Report must be completed if the CEW is used in the display mode only and these sections don't have a Years of Service area.

A risk reduction strategy has been developed in relation to the Use of Force Reporting Policy (1.02) revised in 2012. If a Use of Force Report is required as a result of the actions of several officers in a common incident, each officer shall submit their own Use of Force Report. The ERU shall be the only unit permitted to submit a 'team' report.

For statistical purposes officers were grouped into the following Years of Service categories: 0-5 years, 6-10 years, 11-15 years, 16-20 years, >20 years.

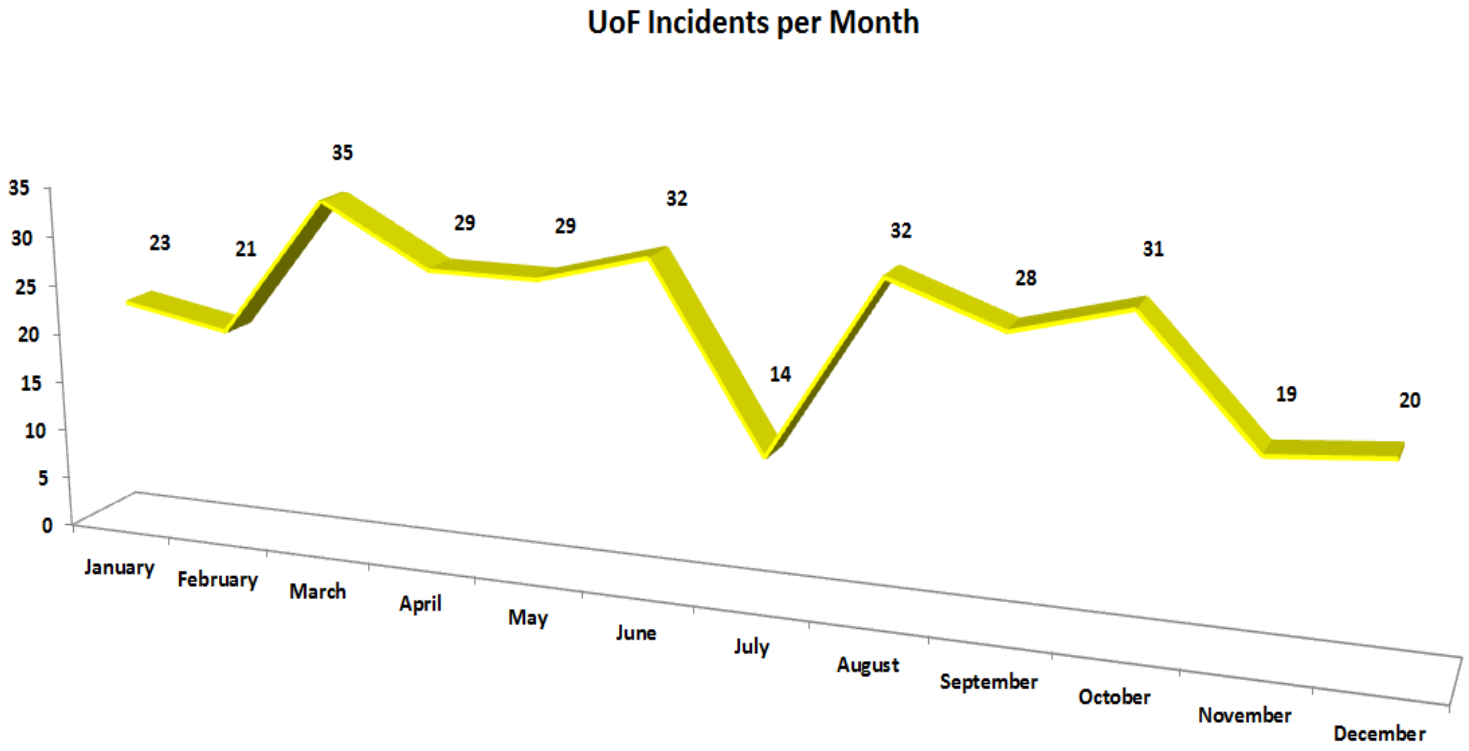


As per the Incidents by Branch and Incidents by Years of Service charts, Uniform Patrol is involved in the majority of 2018's Use of Force Incidents as would be expected. The 0-10 Years of Service group accounts for approximately 34% of the officers who completed the years of service section. This is easily explained as approximately 37%* of officers assigned to Uniform Patrol have less than 10 years of service so their involvement in Use of Force incidents is proportional to their numbers.

*Uniform Patrol and Years of Service data supplied by Human Resources.

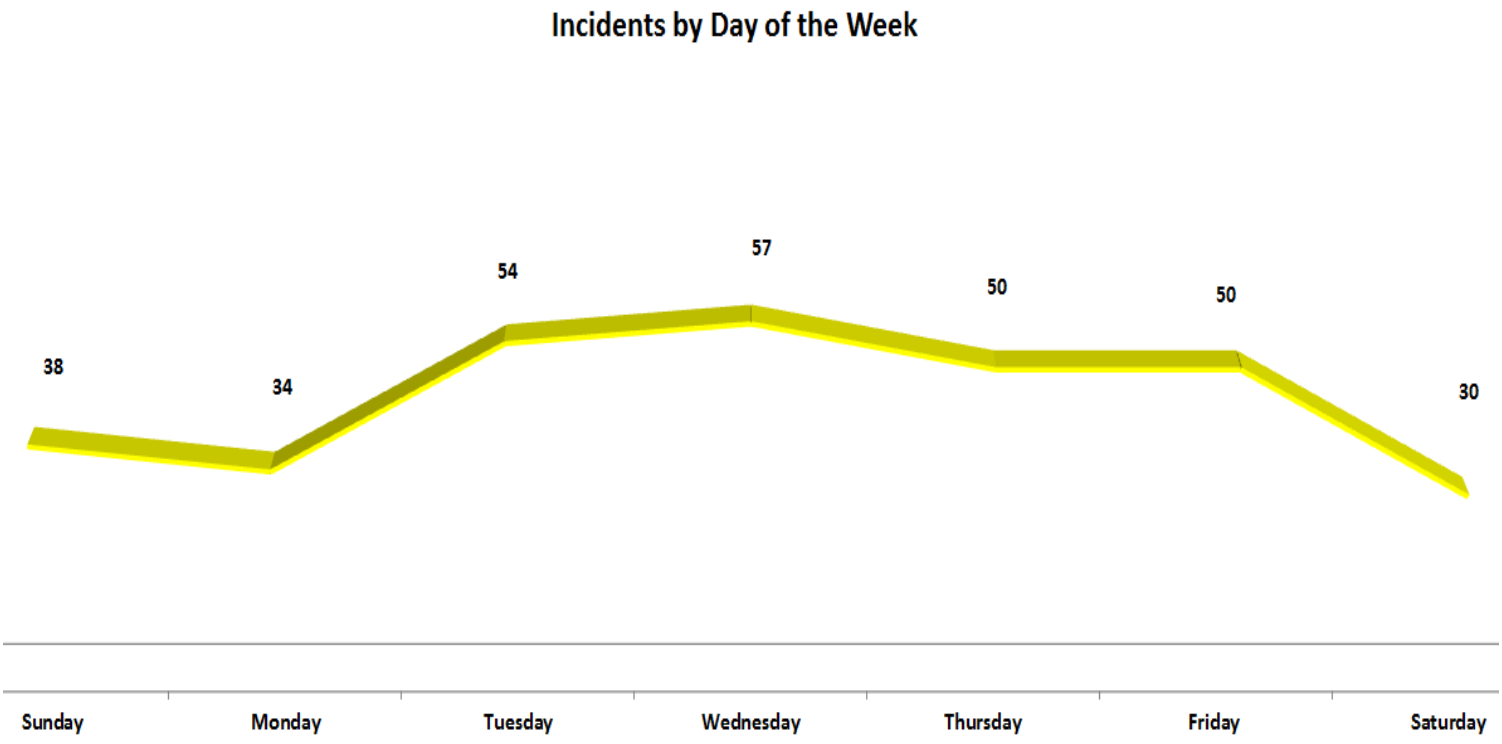
Use of Force by Incidents per Month

There were 313 reported incidents in 2018 for an average 26.1 incidents per month; with a high of 35 incidents in March and a low of 14 in July. The number of Use of Force incidents appears to rise slightly during the first part of the year before reaching its' lowest point in July and then rise again and plateau for the remainder of the year.



Use of Force Incidents per Day of the Week

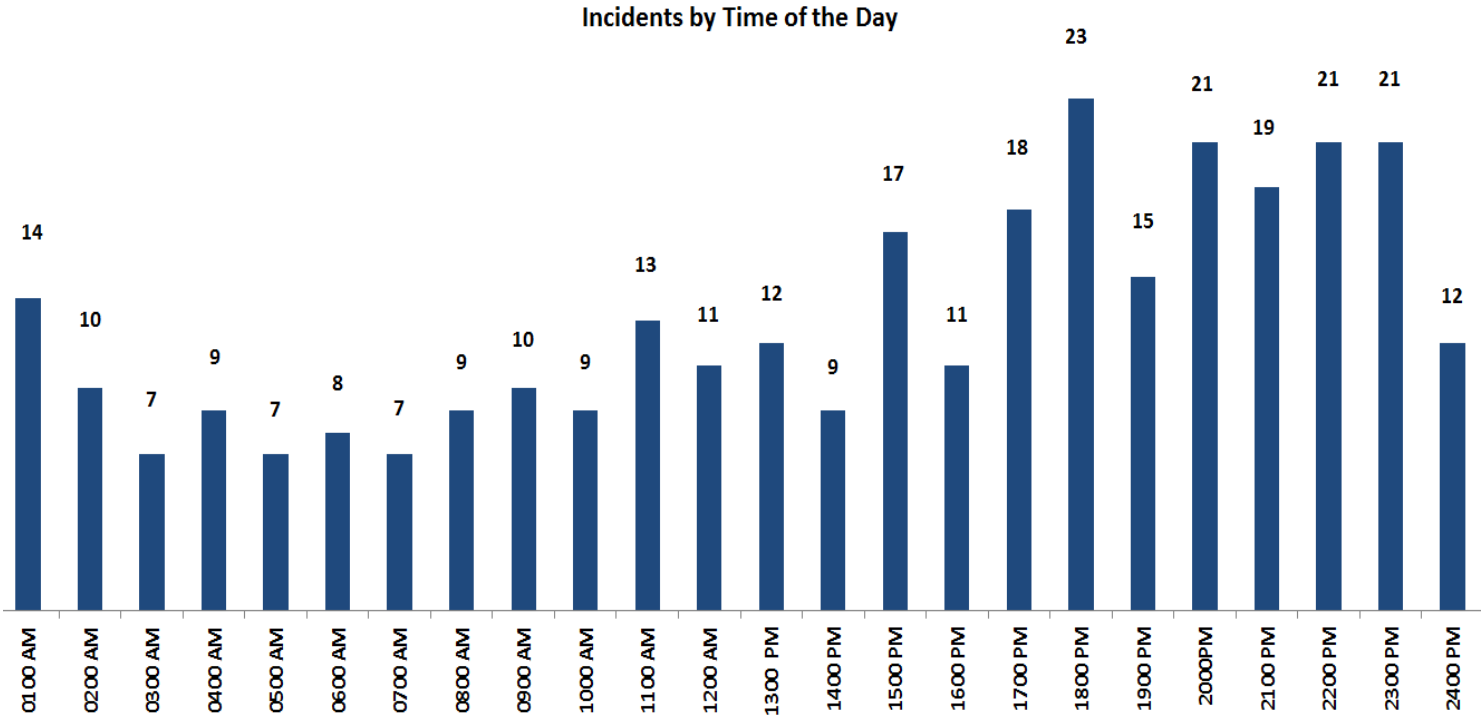
This is the tenth year that Use of Force incidents have been tracked by number of incidents per day of the week. In 2018, the day with the highest number of Use of Force incidents was Wednesday with 57 incidents and the lowest was Saturday with 30 incidents. When 2018 data is compared to the recent average (2008-2018) it is clear that the incident rate goes slightly down on Mondays, begins to rise and peaks during the mid-week, and then lowers once again over the weekend. There is no obvious explanation for this pattern.



Use of Force Incidents by Time of Day

This is the tenth year that Use of Force incidents have been tracked by the time in which they occur. Historically the time was separated into 6 time periods: 0801–1200, 1201-1600, 1601-2000, 2001-2400, 0001-0400 and 0401-0800. In 2015 each hour was tracked.

A review of the 10 year average data (2009-2018) indicates that the bulk of Use of Force incidents occur in the twelve hour period between 1600 to 0400 hours. The least number of incidents occur in the eight hour period between 0401 to 1200 hrs. The number of incidents begins to rise steadily beginning at noon hour and peaks between 2001 and 0400 hrs. The below data from 2018 indicates the majority of incidents occurred between the hours of 1500 to 0100hrs. There was a steady decline between 0300 and 0800 hours. The hours between 0800 hours and 1500 hours remain relatively consistent.



Suspects/Police Officers Injured/Require Medical Attention

In 2018, there were 66 incidents in which a subject, a Police Officer, or both, were reportedly injured. 66 subjects injured required medical treatment of a varying nature. 1 Officer was injured and required medical attention. In the majority of incidents the injuries to both Officers and subjects were reportedly minor in nature.

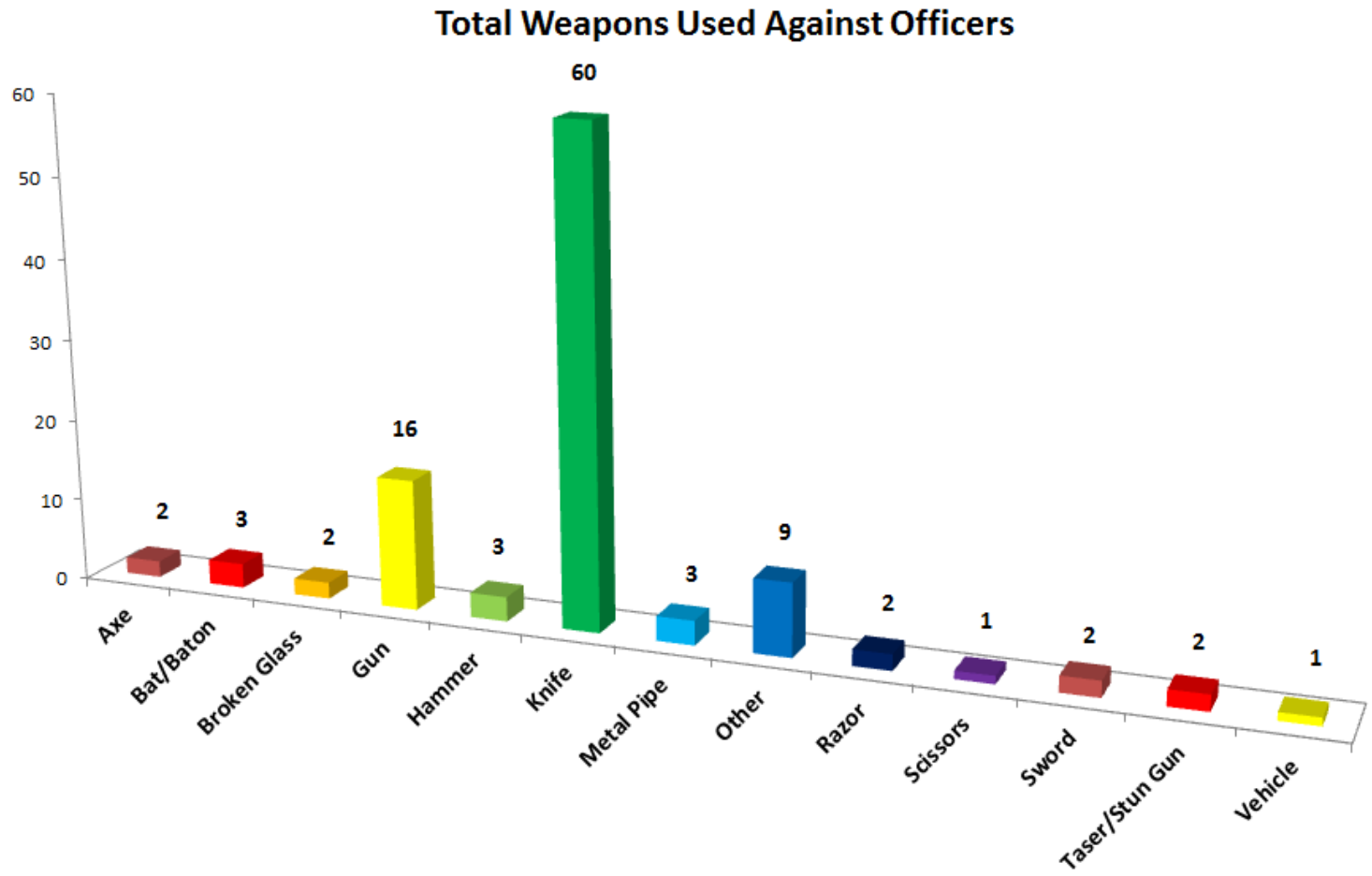
The reasons/causes for medical attention are as follows and may contain multiple causes for one incident: Grounding (2), Mental Health Assessment (44), Self-Inflicted/Occurred prior to Police Arrival (10), and CEW Probe Removal (23). The suspect can receive medical attention for several reasons; i.e.: MHA assessment, plus probe removal (23 incidents in 2018).

With respect to injuries by incident type, the majority of subjects were injured/required medical attention as the result of a Person In Crisis incident/call for service. In 44 of the PIC incidents the subject was taken to the hospital for a mandatory mental health assessment. **These apprehensions account for 14.1% of the 313 total Use of Force encounters.**

Use of Force Incidents and Suspect's Weapons

In 2018, there were 102 incidents reported where the suspect was actually carrying or had access to a weapon close-by. In 4 of the incidents the suspect(s) had access to more than one weapon type. An edged weapon of some type was the most frequently reported involving 60 knife incidents. There were 16 incidents where a firearm/replica/toy gun was used and in 2 incidents a sword was identified as the weapon, along with other edged weapons. An axe, hammer and a Taser/stun guns were also identified weapons.

In 2017, there were a total of 94 incidents involving weapons. Knives were the dominant weapon (45) carried by subjects followed by firearm/replica/toy gun (18).

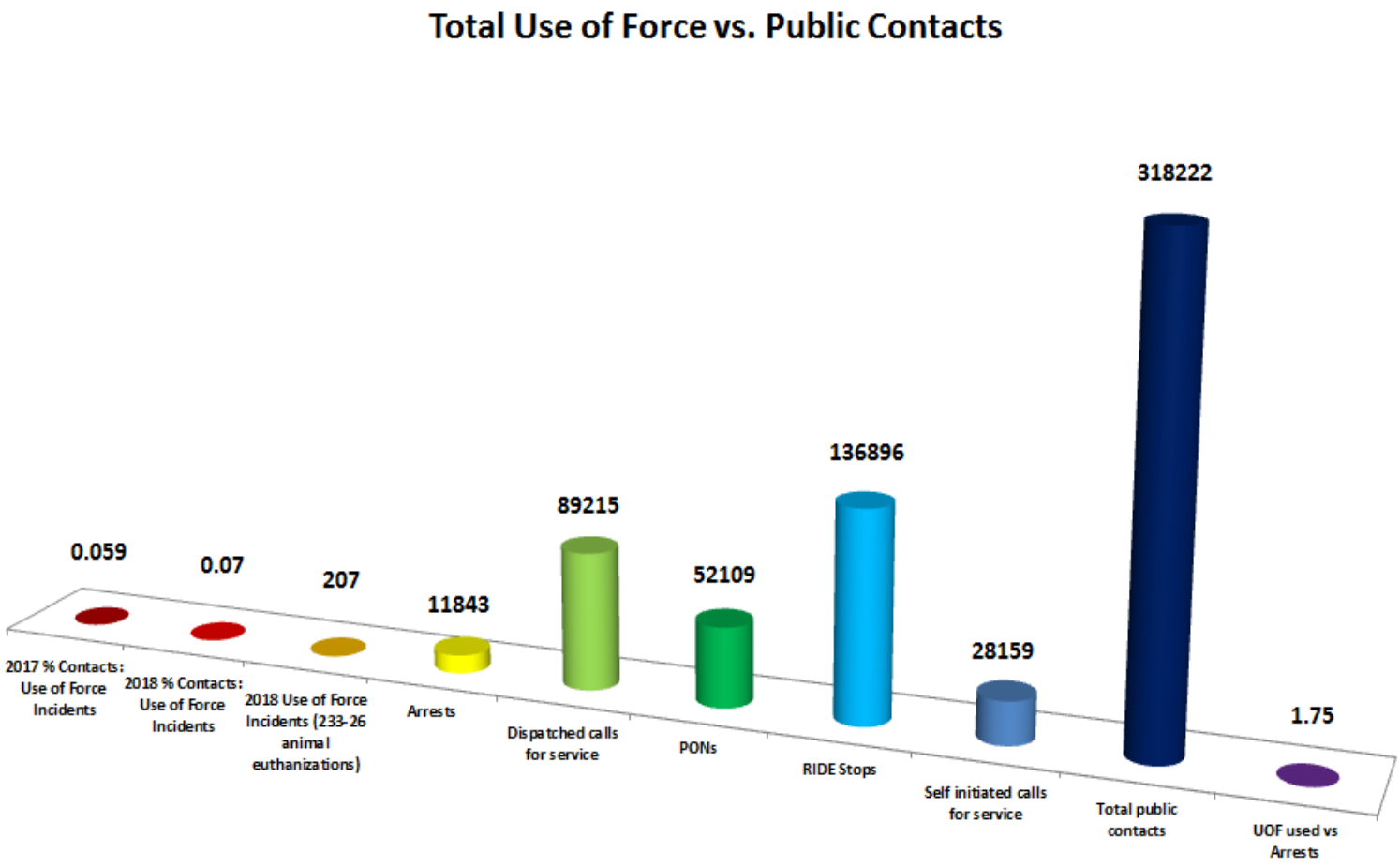


Use of Force in Relation to Public Contacts

In 2018, members of the Hamilton Police Service were involved in 233 incidents where a Use of Force Report was submitted. Included in that number are 26 animal euthanizations. This ultimately means that there were 207 incidents involving a member of the public where a Use of Force Report was submitted. Compared to the total number of contacts (318,222)* the police had with the public, only .070% of contacts resulted in a Use of Force incident.

In comparison, Use of Force incidents vs. public contacts rose slightly in 2018 (.070%) compared to 2017 (.059%) and 2016 (.037%).

*Public Contact data supplied by the Crime Information Analysis Unit and the Traffic Branch.



Conclusions / Trends

During the 10 year period from 2009-2018 the average number of reported Use of Force incidents is 235 per year. A low of 172 incidents were reported in 2016 and a high of 311 incidents in 2012. 2018 showed a decrease in Use of Force Reports over the previous year and remains below the 10 year average.

1. The number of times an Officer discharged a firearm increased to 28 incidents in 2018. The average since 2009 is 39 discharges per year. The 2018 statistics are greatly attributed to the number of times in which Officers are being called upon to euthanize injured animals. Hamilton officers euthanized 26 animals in 2018. 2 other incidents fell under the mandate of the SIU. One of those investigations has been concluded and the other is still ongoing.

2. There was a slight increase in the use of Empty Hands-Hard (5%) and a decrease in Empty Hands-Soft (18%) in 2018 compared to 2017. The use of these options in 2018 is slightly higher than the 10 year average of 22 for Empty Hands-Hard and a significant increase in Empty Hands-Soft which has a 10 year average of 26.

3. The use of Aerosol Weapons reached a plateau in the last several years with an average of 15 incidents per year since 2009. 2018 had only 2 incidents, well below the average and the lowest since records have been kept.

4. The introduction of the CEW in late 2004, early 2005 had an immediate impact on how Police Officers use force. In 2014/2015 the Hamilton Police Service began a gradual roll out of CEWs to frontline personnel. In 2014 there were 64 CEW incidents which rose to 145 incidents in 2015 and remained consistent at 143 incidents in 2016 and increased to 169 incidents in 2017 with a slight drop to 164 in 2018. Those incidents that are statistically captured in the Ministry Use of Force report (CEW Deployed) totaled 21 in 2014, 47 in 2015, 38 in 2016, 58 in 2017 and a slight decrease to 57 in 2018. The ten year average is 45 incidents per year. It was anticipated that CEW use would increase with full frontline deployment; however the CEW is utilized most often in the display mode.

5. Uniform Patrol is the Branch of the Service most likely to encounter incidents requiring an application of Force and therefore submits the most Use of Force Reports.

6. This is the 10th year that Use of Force incidents have been tracked by number of incidents per month. There does not appear to be a significant relationship between number of Use of Force incidents and the month of the year other than they appear to rise in March, June, August and October for an unknown reason and fall in July for an unknown reason and remain relatively consistent for the remaining months. Data from future years could solidify/confirm any trends.

7. This is the 10th year that Use of Force incidents have been tracked by number of incidents per day of the week. Comparative data shows it is clear that the incident rate goes down on Saturdays for an unknown reason. 2018 statistics illustrate a spike on Wednesdays with other weekdays remaining consistent. There is no obvious explanation for this pattern. Again, data from future years could solidify/confirm any trends.

8. This is the 10th year that Use of Force incidents have been tracked by the time in which they occurred. A review of historical data indicates that the bulk of Use of Force incidents occur in the twelve hour period between 1600 to 0400 hours. The least number of incidents occur in the eight hour period between 0400 to

12 noon. The number of incidents begins to rise steadily beginning at noon hour and peaks between 2001 and 0500 hours.

9. This is the 8th year where Suspects' Weapons has been tracked. It is clear that an edged weapon of some type is the weapon of choice. In 2018, 60 incidents involved a knife or some type of edged weapon, 16 incidents involved a gun or replica and 9 incidents involved an "other" item. Weapon use against officers in Hamilton has risen since 2014 and increased from 93 incidents in 2016, 94 in 2017 and 102 in 2018.

10. This is the 8th year in which Officer and Subject injuries have been tracked. The injury rate for both Officers and Subjects is relatively low (1 Officers and 66 Subjects). The majority of the injuries that were reported in 2018 were minor in nature. The most common causes for injuries to officers and subjects are the use of grounding techniques and/or a general struggle between the officer and subject while trying to affect an arrest. Use of Force should continue to train officers in proper grounding and self-defense techniques.

11. The Use of Force incident rate is extremely low when put into the context of total public contacts (318,222) compared to Use of Force incidents (207 incidents; 233 incidents minus 26 animal euthanizations), resulting in a Use of Force reporting incident rate of .070%.

12. Persons In Crisis or "PIC" incidents account for 14.1% of all Use of Force encounters by Hamilton Police in 2018.

5.2

HAMILTON POLICE SERVICES BOARD

- RECOMMENDATION -

DATE:	2019 June 13
REPORT TO:	Chair and Members Hamilton Police Services Board
FROM:	Lois Morin Administrator
SUBJECT:	***Hamilton Police Services Board*** ***Complaints Process for Board Member Conduct*** ***(PSB 19-054)***

RECOMMENDATIONS:

That the Board approve the *amendment* to the Police Services Board Complaints Process for Board Member Conduct Policy, attached hereto as Appendix "A".

Lois Morin
Administrator

FINANCIAL / STAFFING / LEGAL IMPLICATIONS:

FINANCIAL – n\a

STAFFING – n\a

LEGAL – n\a

BACKGROUND

Section 37 of the *Police Services Act* provides that a Board shall establish its own rules and procedures in performing its duties under the Act.

At its meeting of December 20, 2018, the Board approved a Governance Subcommittee to review and recommend amendments and or new policy for approval by the Board.

The Hamilton Police Services Board approved a policy with respect to Complaints Process for Board Member Conduct at its meeting of October 22, 2015. Section 8 of the policy has been reviewed and has been amended to provide for a public report of the review and the actions taken with respect to any complaint. Further, section 6 of the policy has been amended to reflect that the Board will deal with the complaints as a personal matter and hold its review in camera. Amendments in the policy have been **bolded** and <u>underlined</u>.

The above recommendations have been incorporated in the *policy* which is attached for Board approval.

/lem

Attachment (1): *Appendix "A": Draft Policy: Complaints Process for Board Member Conduct*

Complaints Process for Board Member Conduct

It is the policy of the Hamilton Police Services Board (the Board) that:

1. The Chair, or any member of the Board, will be required to bring forward all complaints about the conduct of the Chair or any other member of the Board to the entire Board, at a Board meeting, for review;

2. All complaints will be received in writing with the complainant's name and return address identified;

3. The Chair (or the Vice Chair in the Chair's absence or if the Chair is the subject of the complaint) will make a recommendation as to how the Board should review the complaint;

4. In reviewing the complaint, the Board will consider the following options:

    a. the complaint is of a minor nature and the affected Board Member should be asked to provide a written response to the complaint;

    b. the complaint is of such a significant nature that external legal counsel should be retained; or

    c. the complaint is of a serious nature and the Board should request that the Ministry of Community Safety and Correctional Services ("the Ministry") conduct an investigation into the member's conduct; or request that the Ontario Civilian Police Commission ("OCPC") conduct an investigation into the member's conduct under s. 25 of the *Police Services Act.*

5. The affected Board Member will be permitted to provide a written response to the Board regarding the allegations contained in the complaint;

6. The Board shall **treat the complaint as a personal matter about an identifiable individual** and will hold its review *in camera* ~~in accordance with the *Act*~~ and determine whether the affected Board Member should be present during the review;

7. Upon Board review of the complaint, the Board will, follow one of the following courses of action:

   a. receive the complaint and take no action;

   b. require the member to appear before the Board and be reprimanded (as per s.15 of the *Code of Conduct*); or
   c. request the Ministry to conduct an investigation into the member's conduct or request that OCPC conduct an investigation into the member's conduct under s. 25 of the *Act.*

8. The Board will be aware of its duty of public accountability and **provide** ~~may consider providing~~ a public reporting of its review and any actions taken; and

9. That upon completion of a review of a complaint, the Chair (or Vice Chair if the Chair is the subject of the complaint) will be authorized to communicate the Board's decision to the complainant and affected Board Member. Furthermore, if required, the OCPC will be copied on this correspondence.

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Chair Fred Eisenberger