Reach Out
Response Network

Final Report on Alternative Crisis Response Models for Toronto

NOVEMBER 2020

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EXECUTIVE SUMMARY

Toronto residents have long advocated for reform of the City's response to mental health emergencies. The rash of recent deaths of racialized people who died during their interactions with police while experiencing a crisis have amplified this call, and in June 2020, Toronto City Council voted to begin exploring crisis response alternatives.

The Reach Out Response Network is a group of community stakeholders who believe that a mental health crisis is not a crime, and therefore that mental health crises should be responded to by mental health experts, not police. Between July and November 2020, our network has engaged over 800 residents, service providers, service users, and key informants through a series of town halls and interviews. This report summarizes the key findings of these events and sets out a detailed proposal for a new crisis response service for the City of Toronto.

Toronto residents told us that they have had negative experiences with police; many find the police response to mental health crises to be frightening, criminalizing, harmful, inexpert, excessive and stigmatizing. While their experiences with Toronto's police-partnered Mobile Crisis Intervention Teams (MCIT) were more positive, many found this service to be rushed, unhelpful, and intimidating. Communities stressed the lack of adequate services for those experiencing mental health concerns more generally, including lack of coordination, resource gaps, long wait times, insufficient crisis beds and respite care, and lack of follow up care.

Our proposed service responds to this community call for a more effective crisis response model. Our proposed mental health emergency service is what we call a "hybrid-style" service, meaning that it is neither police-partnered like the MCIT nor entirely community-based like the Gerstein Centre. Instead, it is a hybrid, in that it integrates a team made up entirely of mental health clinicians and peer workers into 911 dispatch and other existing public safety infrastructure. In addition to being accessible through 911, our proposed service will be accessible through its own separate three-digit number, and it will be available across Toronto 24/7, with immediate response times. Modelled on Eugene, Oregon's CAHOOTS service, the proposed service will be grounded in anti-oppressive practice principles and trauma-informed approaches to care, reducing stigma and supporting more positive outcomes.

Worries that the service would be risky or ineffective are allayed by the promising data gathered from CAHOOTS and other similar services. Staff are safe, the service is effective, and cases are successfully diverted away from more expensive EMS and police services. Our proposed crisis service would replace police response to non-violent mental health crises with response from mental health experts. We propose a non-police crisis response service that is effective, economical, accountable, professional, and safe.

INTRODUCTION

BACKGROUND

Our network believes that a mental health crisis is a health crisis, not a crime. Police are trained to respond to crime. Mental health workers are trained to respond to mental health crises and should be empowered to do so on a larger scale.

Between April 6, 2020 and June 20, 2020, five Canadians experiencing mental health crisis died or were killed during interactions with law enforcement. Their names are D'Andre Campbell, Regis Korchinski-Paquet, Chantel Moore, Rodney Levi, and Ejaz Choudry. All were people of colour, and all needed and deserved compassion, support, treatment, and care. Instead, the crisis system ostensibly set up to help them in fact contributed to their deaths.

Their tragic deaths amplified the urgent call to do what many Toronto residents have been advocating for decades – the reformation of crisis response for mental health and other non-crime related emergencies in Toronto. Finally, on June 30, 2020, Toronto City Council voted affirmatively on a motion that would begin the journey to exploring what changes in Toronto's crisis response might look like. Our current police-led response model is inadequate in that it does not allow sufficient time for de-escalation, does not include meaningful service referral, and leaves transport to a hospital emergency room under the Mental Health Act as the only option for care. Toronto residents have been advocating for additional options and services for decades. Drawing upon crisis response models such as CAHOOTS in Eugene, Oregon, the City of Toronto has aimed its focus toward non-police crisis response for emergencies that do not involve criminal activity. The Reach Out Response Network, a group of community stakeholders advocating for change in Toronto's community crisis response model, has stepped forward to support and drive this change. The City has contracted with us to do extensive community engagement and research, and to summarize our findings in this report.

Our network believes that a mental health crisis is a health crisis, not a crime. Police are trained to respond to crime. Mental health workers are trained to respond to mental health crises and should be empowered to do so on a larger scale. We believe that our proposed hybrid-style mental health emergency service will:

- reduce the stigma of mental health crisis;
- promote the best possible outcomes for service users in crisis;
- save money; and
- free up police resources so that time and money previously devoted to intervening in mental health crises can now be re-allocated towards preventing and solving crime.

As subject-matter experts on non-police crisis response models, the Reach Out Response Network has been engaging with community members, emergency response agencies, social service organizations and other key stakeholders to explore what a new community-led crisis response model in Toronto might look like. Between July and November 2020, our network has engaged over 800 Toronto residents in town halls, surveys, focus groups, and key informant interviews to hear their thoughts on the model outlined below. We have also developed a list of thirty-three core mobile crisis teams we are using as models and points of reference for our proposal to integrate a new mental health emergency team into municipal services in Toronto. This document will explore key findings from our town halls and other community engagement and will set out our proposal in the context of the research we conducted, with reference to the structure, implementation, and experiences of our thirty-three core teams, as well as the stated needs and wishes of Toronto residents.

Between July and November 2020, our network has engaged over 800 Toronto residents.

The Reach Out Response Network's town halls were conducted with members of Black communities, members of Indigenous communities, peer workers, service providers, service providers who work with homeless populations, service users, family members of people with mental health or addictions concerns, and lawyers and legal advocates. An additional town hall was open to all Toronto residents. The Reach Out Response Network also conducted a survey with individuals experiencing homelessness, which was distributed by a number of partner agencies (including drop-in spaces and street outreach teams), and a survey of Deaf communities, which was distributed by several partner agencies that work with the Deaf. The Reach Out Response Network also conducted two focus groups, one with Deaf communities and one with individuals with developmental disabilities. We further conducted individual interviews with high school students and Autistic individuals. A list of these engagement efforts and attendance at each event is included in an appendix. These consultation groups were chosen because they were identified as groups likely to be most impacted by current and future crisis services. Additionally, six consultations were conducted with service providers as part of the Reach Out Response Network's contract with the City of Toronto. Additional town halls with members of Indigenous communities, Black communities, LGBTQ+ communities, and others were not conducted once the City of Toronto partnered with other organizations better positioned to lead these consultations, as the Reach Out Response Network did not want to detract from the consultations being conducted by Indigenous-led, Black-led, and LGBTQ+ led organizations.

In each town hall, focus group, interview, and survey, participants were asked for their knowledge of and experiences with existing crisis services, where they see gaps in existing services, and what they think a new crisis service should look like. They were further asked which professionals should staff a new crisis service and how the new service should be accessible (ex. through 911 or a separate number).

Data from town halls, interviews, and surveys were analyzed for key themes by volunteers with expertise in qualitative research and data analysis.

COMMUNITY ENGAGEMENT KEY THEMES

PARTICIPANTS' EXPERIENCE WITH POLICE

"When [my clients] are in crisis, the last thing they want is to see a police officer." This comment accurately summarizes our participants' feelings about and experiences with police.

In both our town halls and our surveys, participants predominantly described negative experiences with police responses to mental health crisis. While some participants, particularly family members, described positive experiences with individual officers, many of those same participants discussed structural and procedural aspects of police response, such as handcuffs and uniforms, that they perceived as harmful, unnecessary, or both. One service provider participant stated, "When [my clients] are in crisis, the last thing they want is to see a police officer." This comment accurately summarizes our participants' feelings about and experiences with police. It is also important to note that many police officers themselves agree that mental health crisis calls should be handled by mental health professionals, rather than by police.

Negative experiences with handcuffs, physical restraints, and violence from police

Many participants said that they, their loved ones, or their clients had been handcuffed when in mental health crisis and that this experience had been frightening, triggering, and/or traumatizing for them. Several participants stated that the handcuffs had caused

bruising. A number of participants described being tackled or physically restrained by police officers and stated that these experiences had been scary and traumatic. One service provider participant said, "The work I do is with people who have already had contact with the police. [The clients] show us their bruises and how they've been hurt [by police]." A service user participant further stated,

"When I cycled in and out of mental health crisis over fifteen years, I never went voluntarily, and police were always called, and to this day, I can still feel their hands on me, the cold steel of the handcuffs. It was so traumatizing. I work in a hospital now, and I would get re-traumatized all over again seeing police in the hospital. I had to go back into therapy last year to work through all of that trauma from police."

A mother commented, "Being handcuffed [was] traumatic [for my daughter]. My daughter was beaten by police, handcuffed, [and] thrown in the van to be brought to hospital."

Excessive number of police officers arriving on scene

Many participants commented that the number of police officers arriving to respond to a mental health crisis is "overwhelming" and "excessive." One mother described calling the police for her son, who was in "active drug-induced psychosis," but "had never been violent," and said that "nine police officers" had arrived to respond to the call and that it was "overwhelming." A service user participant stated, ""A large group of police showed up at my place with armored officers that were holding bean bag shotguns. All they knew was that there was a single knife. [It] seemed shockingly excessive." Another participant described six police officers showing up in response to her experiencing non-violent suicidal ideation. She stated, "There were six white male police officers, for me, a Muslim brown female. I think that is way too many for someone that did not commit a crime and who did not resist." Another participant described a similar situation, saying,

"I live in Toronto Housing, and there was a woman here who was having a mental health breakdown and [police] ended up kicking down her door and assaulting her. I think a lot of that could have been avoided. She was clearly in distress and she has children...there were nine police officers in different vehicles and a firefighter [who arrived]. There was no reason for [that many] people to be there...that's a real waste of resources, in my opinion."

Discomfort or fear related to police uniforms, police cars, and other markers of police presence

A number of participants commented that police uniforms and bulletproof vests can be triggering, particularly for women who have experienced trauma. Several service providers noted that the bulletproof vests worn by MCIT staff were particularly triggering and distressing for their clients. One service provider participant stated, "The uniform automatically sets up a power dynamic, which can be very triggering, particularly for people who have been in and out of institutions. It can escalate a crisis and escalate emotions and lead to a greater sense of discomfort." A school social worker said, "I've had police officers come into the school wearing orange vests and carrying what look like rifles for a kid in a mental health crisis, and this creates a lot of stigma and scares the other kids who have to watch this."

A number of participants commented that police uniforms and bulletproof vests can be triggering, particularly for women who have experienced trauma.

A number of family member participants stated that they had called 911 in the hopes of having their loved ones taken to the hospital, but their loved ones were taken to jail instead.

A service user participant commented, “It feels traumatic when police come – if you’re having a hard time with your mental health, you’re not in a good frame of mind to see armed people with uniforms and sirens. It causes fear in a person to see all this drama. It doesn’t help.” Another service user participant stated, “The uniform and the guns are scary as hell.” Homeless participants in particular frequently commented on police uniforms and police use of sirens as being distressing and unhelpful.

Concerns about criminalization and criminal justice system involvement and impacts

A number of participants noted concerns about a mental health crisis leading to criminal justice system involvement. For example, a service provider participant stated, “I work at an opioid injection site for women and for us calling the police is just not an option. What we’re often doing is protecting people from police.” This service provider was concerned that if she called police when one of her clients was in crisis, this could lead to either that client or other clients in the space being arrested. Several other service provider participants noted that they would not call police when their clients were in crisis in case their client had an open warrant, in which case calling the police would lead to the client’s arrest. Several service users and service providers noted that police interactions with clients experiencing mental health crisis may show up on vulnerable sector checks and impact a service user’s future employment opportunities. While we are aware that the Toronto Police Service allows people to apply to have mental health-related records expunged so they will not show up on vulnerable sector checks, service users may not be aware of this option, which may make service users less likely to reach out for help.

A number of family member participants further stated that they had called 911 in the hopes of having their loved ones taken to the hospital, but their loved ones were taken to jail instead. One family member described her experience with her son:

“When he was an adolescent, he displayed a lot of violent behaviours and we had to call the police. First we called a children’s mental health centre and they said that they wouldn’t be able to admit him unless we had him charged for assaulting us. So we called the police because he was brandishing a knife at me. The police sent the mental health care team and they spent some time talking to him, trying to de-escalate the situation, but then they didn’t take him to the children’s mental health centre. They took him to jail and he spent the night in jail when he was thirteen years old. It was very frightening for all of us.”

Family member participants also shared their perception that police were focussed on punishment and criminalization of their loved ones. For example, one participant said, “Police get fed up responding after a while and they start saying things like, ‘The next time we come to your home, we’ll have to remove someone.’” This participant’s partner was in fact criminally charged after the police had attended several times to their home to respond to his partner’s substance-induced crisis.

Service provider participants further noted that their clients’ experiences of trauma may impact the way they react to police officers, leading to criminalization. For example, one service provider stated,

"People with disabilities may become fearful of police and react in ways that may be seen as aggressive because their defence mechanisms are kicking in because they don't understand." Another service provider participant noted that for domestic violence survivors, having a police officer physically touch them may act as a trigger and provoke resistance and lead to charges of "resisting arrest." Another service provider participant added, "I cannot tell you how many clients we get for release planning and mental health diversion with [only] charges of Resist Arrest and Assault Peace Officer. It's depressing." This service provider participant felt that her clients were being criminalized for trauma-related responses they had to police interactions.

Service providers' perception that they or their clients are put at risk by police intervention

Some service provider participants stated that their organizations had explicit policies against calling police, since they felt that doing so would harm their clients. Other service providers described their distrust of the police and the actions they take to protect their clients from police intervention. One service provider participant said, "We have an understanding with police that they cannot breach our front door without making themselves known." Another service provider participant stated, "We don't trust that the police will come in a non-aggressive manner. If police show up at our door, we don't let them in. We have to go get a supervisor to ask, and if we're having a drop-in or a group, we go into the space and tell [the participants] the police might be coming so leave now." Another service provider participant said, "We've identified observers who will watch what police are doing while another person talks to police. For us, it's about protecting our community members from the police, to be honest." These comments demonstrate an extreme distrust of police by service providers and the way policing systems challenge service providers' ability to support their clients effectively.

Service providers also expressed concern about the way they themselves were treated by police. One service provider participant said, "The way the police treat us as service providers, they're often aggressive and belittling. They don't support the work we do." Another service provider participant described being regularly harassed by a particular police officer who patrolled the area where she used to work. One service provider participant described a time that someone at her agency had called 911 because a client was self-harming with a knife. Police officers arrived and yelled at the client to drop the knife, and when the client did not drop the knife, the officers took out their firearms and pointed them at the client. This service provider said of herself and her colleagues, "We were afraid they were going to kill her. We ended up putting our bodies in front of her to shield her and they did not back down. It was evident to us that we were risking our lives because their guns were out."

Negative impact of police response in drop-in or community care settings

A number of service provider participants noted the negative impact of police response to one client's crisis on other clients in the space. Service providers described police presence as being frightening, triggering, and overwhelming for other clients, and they further stated that police presence could damage other clients' trust with their agency or service.

Feeling disrespected, judged, humiliated, or stigmatized

Many participants felt disrespected, judged, humiliated, and stigmatized by police response to their mental health crisis. Some participants noted that individual officers made disrespectful comments towards them, their loved ones, or their clients. For example, one service provider who works with HIV-positive individuals stated that she often hears police make disparaging comments about her clients and that she has heard officers publicly comment on a client's HIV-positive status. For example, this service provider had seen a police officer announce to a journalist that the person he had arrested was HIV-positive and had spat at him.

More often, participants stated that the experience of police response to mental health crisis was stigmatizing in itself. One participant stated, "The way they treat you when you call 911 is not effective when you have mental health issues, because they come with the police which makes you [feel] judged already." Another participant said, "When the police officers come, you're painted with a certain brush already, and it heightens the person's crisis when the officer comes, because the person feels embarrassed and ashamed and everyone seeing it is assuming that the person did something wrong. It really does a disservice to the person in crisis."

Participants described being accompanied by police in hospital emergency rooms as embarrassing and stigmatizing. Several participants told stories of being led by police out of their homes and put into the back of a police car, in front of their families and neighbours. Numerous participants described these experiences as making them look or feel "like a criminal." One participant noted "the damage [this experience did to her] reputation."

Feeling coerced or fearing coercion

Many participants described police response as coercive and explained that fear of coercion by police acts as a barrier to individuals reaching out for help. One participant stated that organizations' "duty to report" policies can feel like a threat,

"Because your personal decision-making is taken away and you don't have control over that, and there's the threat of the police being called on you, which is extremely unsafe for a lot of people, and also means that you're going to be 'outed' to your neighbours and the people at the hospital who see you with the police sitting next to you."

Racialized communities' distrust and negative experiences with police

A number of racialized participants commented that police response does not feel safe to them. One Black participant said, "Police don't feel like they're 'for me,'" and that this is a common experience for Black people. Another Black participant stated that police "completely disregard the needs and reality of Black folks." An Indigenous participant noted that many Indigenous communities' associations with police are that police are "the people who took them away from their parents when they were children." Another participant commented, "Many newcomer communities have a distrust of police." These comments suggest that racialized individuals are disproportionately harmed by police response to mental health crisis and that these individuals are less likely to seek out help as a result.

Fear of police response can make people less likely to reach out for help

Many participants noted that they are hesitant to reach out for help during a crisis because of duty to report and because they fear police response to their crisis. This is particularly heightened for undocumented immigrants, individuals engaged in sex work, or individuals who use substances, due to fears of deportation or criminalization if police respond to their crisis. One service provider participant said, "The limits to confidentiality…create a real barrier to being able to genuinely help someone who's struggling, because it creates a list of things we can't talk about…because of the legitimate fear people have [of police]." Another participant commented, "People are afraid of being tasered or shot" and "of being apprehended under the Mental Health Act," and as a result are less likely to reach out. In particular, Black, Indigenous, and other people of colour are at a greater risk of harm when engaging with police officers and are therefore less comfortable calling for help during a crisis because of fears that police will respond and institutionalize or incarcerate them.

Lack of adequate police training

Nearly all participants were in agreement that police officers lack the skills, training, and/or background to respond effectively to mental health crises. One service provider participant analogized police response to mental health crisis by saying, "If you have a leak in your roof and ten plumbers show up, they're not going to be able to fix the problem. It has to be someone with the right training to solve the problem." Another service provider participant noted that police's first instinct is "aggression and hostility." A paramedic participant stated, "I find that police on scene often antagonize the clients." A service provider participant noted that police lack an understanding of neurobiological trauma responses. She stated,

"The police are…thinking they're responding to someone who's rational in the moment, which they aren't because their nervous system [fight or flight response] has taken over. The police are also being activated into an autonomic response and they're then unable to make a rational, deliberate choice."

Another service provider similarly stated, "I have clients with complex trauma histories and the police's first response is to tackle them to the ground, which will only cause more trauma. These are people who are reacting because of their life circumstances and this perspective is missing in crisis response. It's often about how we can get this person subdued as quickly as possible so we can go onto the next person."

Another service provider participant commented, "What I see most often is that the first thing that happens is the police arrive and [the officer] yells STOP. The individual in crisis reacts. Then it gets worse."

Many service provider participants noted that they were often afraid to call 911 in response to their clients. One service provider participant stated,

"Sometimes I've had to use the police to call for a wellness check. I find it really scary to use the police because I worry about causing more harm to them, because I've had clients be intimidated by the police or beaten up by the police. It leaves me really anxious about

Participants noted that they are hesitant to reach out for help during a crisis because of duty to report and because they fear police response to their crisis.

Homeless participants in particular stated that police often directed them toward hospitals, which they perceived as unhelpful.

what to suggest. It's not so easy to call 911 when you're at risk, especially if someone is Indigenous or a person of colour."

Another service provider participant similarly stated, "I work with adults with longstanding mental health issues who don't typically have great relationships with the police. I had a client tell me that his partner called the police when he spoke of having suicidal concerns and wanted to take a kitchen knife, and because he had mentioned a kitchen knife, the police came and handcuffed him and dragged him away, and he spoke about what a horrible experience that was. Especially lately with racialized clients, if I hear of any racialized clients in our agency in crisis, I'm praying, 'Don't call the police, don't call the police.' I fear for them."

Additionally, service provider participants consistently noted that police officers are not mental health professionals and therefore lack the training necessary to de-escalate and effectively intervene in mental health crises. One service provider participant said, "It is not just police culture. There are REAL SKILLS that one needs to acquire, which take years to learn through courses, lived experience, practicum, mentoring in mental health." Service provider participants consistently stated that expecting police to do a mental health professional's job, when police are not mental health professionals, is setting police up for failure.

Lack of options available to police to provide support

A number of participants commented that police have limited options to support people. Police can either arrest a person, apprehend the person under the Mental Health Act and transport them to a hospital, or they can leave the scene. Participants noted that "a hospital is not always needed," and what people sometimes need is simply a "supportive conversation" or connection to resources. One service provider participant said, "[When a client is in crisis], she's looking for a place, a moment, to heal, and that's the last thing that happens when you involve institutions, both police institutions and hospital institutions." Homeless participants in particular stated that police often directed them towards hospitals, which they perceived as unhelpful. Participants agreed that often clients do not require incarceration or hospitalization, but they do need some form of care and intervention, and police are unable to provide care or intervention beyond incarceration or hospitalization.

One service provider participant summed up this problem by saying, "When you call 911, they say, 'Police, fire, ambulance.' That's only three things. Those are very limited services." He explained that there are many other services that Toronto residents might require, such as disposal of needles on the street or mental health crisis de-escalation, that police, fire, or ambulance cannot provide. He stated that community organizations have the flexibility needed to support people and can provide options to meet people's individual needs, whereas police are limited in what they can offer – incarceration, hospitalization, and not much else.

SUMMARY

Participants' experiences with police

Participants reported the following key themes in their interactions with police while in crisis:

- Negative experiences with handcuffs, physical restraints, and violence from police
- Excessive number of police officers arriving on scene
- Discomfort or fear related to police uniforms, police cars, and other markers of police presence
- Concerns about criminalization and criminal justice system involvement and impacts
- Service providers' perception that they or their clients are put at risk by police intervention
- Negative impact of police response in drop-in or community care settings
- Feeling disrespected, judged, humiliated, or stigmatized
- Feeling coerced or fearing coercion
- Racialized communities' distrust and negative experiences with police
- Fear of police response can make people less likely to reach out for help
- Lack of adequate police training
- Lack of options available to police to provide support
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KEY THEMES

PARTICIPANTS' EXPERIENCE WITH THE MOBILE CRISIS INTERVENTION TEAM (MCIT)

Participants consistently stated that structural and procedural aspects of the MCIT service, such as wearing uniforms and lacking enough time to adequately respond to mental health calls, limited the efficacy of the MCIT service.

Toronto's Mobile Crisis Intervention Team (MCIT) is a partnership between the Toronto Police Service and several hospitals. The MCIT pairs a mental health nurse and a police officer with specialized training to respond to mental health-related calls. A small number of service user participants had had experiences with the MCIT and shared those experiences. A much larger number of service providers had directly or indirectly experienced MCIT response or had requested the MCIT for their clients. Individual experiences with the MCIT were mixed, with some participants reporting positive experiences and others reporting negative and unhelpful experiences. Participants consistently stated that structural and procedural aspects of the MCIT service, such as wearing uniforms and lacking enough time to adequately respond to mental health calls, limited the efficacy of MCIT service.

Negative experiences with MCIT uniforms

Participants consistently stated that the bulletproof vests worn by MCIT nurses can be "triggering" and "intimidating." One service user participant noted that "it can be difficult to tell who the police officer is." A paramedic service provider participant stated, "A lot of peo-

ple are afraid of police and MCIT nurses look like police." A service user participant further commented, "I found the MCIT intimidating because the person who was there as a mental health person had a police jacket on."

Negative experiences with capacity and resourcing of MCIT response

Both service provider and service user participants commented that they felt rushed throughout the MCIT's response. Participants noted that the MCIT did not have enough time to adequately listen and respond to their concerns. One service provider participant stated, "The time they are willing to take with clients is just not enough." Another service provider participant said, "You can hear the amount of calls the MCIT team continue to get as they are attending to your call." Service provider participants further commented that there are too few MCIT units available, leading to unnecessarily long response times or an inability to get an MCIT dispatched. One service provider participant said, "It is near impossible to get an MCIT team to respond." Another service provider participant commented, "You're better off playing the lottery than thinking you're going to get a hold of [the MCIT]." Participants also stated that the MCIT could not respond quickly enough, since they are secondary responders and are generally dispatched only after a Primary Response Unit has arrived and assessed the scene.

Negative experiences with MCIT nurses

A number of participants noted negative experiences with MCIT nurses. One service provider participant stated, "I've seen a nurse being as authoritarian as the police officer." A service user participant described an experience with MCIT nurses by saying, "I felt that they had more of a police-type approach to the situation. I didn't feel a lot of caring or compassion coming from them." These sentiments were echoed by many participants. One service provider participant stated that her clients do not feel supported by psychiatric interventions and have had negative experiences with MCIT nurses as a result. She said, "I've never had one client prefer a psychiatric nurse over an officer. My clients always have a history of hospitalizations, so my clients are never happy to see frontline mental health professionals."

Several service user participants also raised concerns that the MCIT nurse would not support them if police officers became aggressive or violent. One service user participant said,

"I have watched the police 'crisis teams' brutalize my friends, with the cops behaving in disgusting and violent ways and a mental health nurse wringing their hands behind them while completely powerless to really do anything helpful."

Limitations of the MCIT service

Participants consistently noted that the MCIT's efficacy is limited because the MCIT will not respond to high-acuity situations. For example, one paramedic service provider stated, "I've personally had bad experiences with the MCIT in Toronto, because when people are having psychosis or are otherwise difficult to speak with, they will just tap out. I've had many MCIT teams back out of calls saying they can't assess my patients because the patients aren't acting appropriately."

"I've seen a nurse being as authoritarian as the police officer."
- Participant

Mental health advocates such as peer workers should accompany police officers in the MCIT model.

Additional service provider participants described situations in which they had specifically requested the MCIT, but the MCIT had not attended, either because an MCIT unit was unavailable or because the call was not deemed to fall under the MCIT's purview. These experiences resulted in significant frustration for service providers and led to a lack of trust in the MCIT service.

Several service providers also noted that the MCIT will rarely attend alone (without a Primary Response Unit accompanying them). One service provider participant said, "I had a client who...called [the] MCIT for her twelve-year-old and ten cops showed up. [It] was so traumatizing." Other participants further commented on the perceived excessive number of other officers accompanying the MCIT.

Participants' view of the ideal MCIT role

Many participants expressed that they think the MCIT has an important role to play, but that it currently is not optimized to provide maximum benefits. Participants expressed frustration that the MCIT will not respond to high-acuity situations involving weapons or a risk of violence, and they described their view of an ideal MCIT as a team that would respond to these types of high-acuity situations where a civilian-only response would not be appropriate. One service provider participant said that police may need to be involved if a service user has a weapon, "but they should hang back and let the other experts lead the intervention," where possible.

Our participants further recommended that an MCIT involve plainclothes, rather than uniformed, officers, and that the MCIT become a primary rather than a secondary responder to ensure rapid response times. Service user participants suggested that mental health advocates such as peer workers should accompany police officers in the MCIT model and that MCIT staff should have broader experiences than of the medical model currently promoted. Service provider participants suggested that the MCIT should evolve towards a partnership with police and community agencies, rather than a partnership between police and hospitals.

Several lawyer participants stated that an MCIT should respond to situations where criminal behaviour occurs during a behavioural health crisis, so that a person can be taken to get medical or mental health help rather than to jail. One lawyer participant said,

"Some clients genuinely need medical help, and the perspective from the defense lawyers is that when people need medical help, police are often filling that gap. So having a medical professional there can be helpful for that piece. There are many cases I deal with where the person should have been apprehended under the Mental Health Act rather than being taken to jail. It's not the client making the choice in this situation – the police are choosing to take someone to jail instead of to the hospital. If medical professionals aren't involved, the jail system will continue to be overly populated. Both perspectives [medical and non-medical] are needed."

SUMMARY

Participants' experiences with the Mobile Crisis Intervention Team (MCIT)

Participants reported the following key themes in their interactions with the MCIT while in crisis:

- Negative experiences with MCIT uniforms
- Negative experiences with capacity and re-sourcing of MCIT response
- Negative experiences with MCIT nurses
- Limitations of the MCIT service
- Participants' view of the ideal MCIT role
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KEY THEMES

PARTICIPANTS' EXPERIENCE WITH OTHER SERVICES

Participants consistently identified a lack of knowledge of services beyond 911 that could support them or their loved ones in crisis.

Many service user and service provider participants described their experiences with other services, such as the Gerstein Centre, crisis lines, hospitals, and culturally-specific services. A number of key themes emerged regarding these experiences. The most salient of these themes was that existing services are often under-staffed, under-resourced, under-funded, and poorly integrated (ex. "silos" within the mental health system), leading to negative outcomes for service users.

Difficulty in knowing who to reach out to

Participants consistently identified a lack of knowledge of services beyond 911 that could support them or their loved ones in crisis. Participants frequently stated that they had called 911 simply because they did not know who else to call. This was particularly pronounced for family member participants, as exemplified by one family member who stated, "Many times we defer to 911/ police because there aren't a lot of options." Another family member participant explained that during a first crisis, it is particularly difficult to know who to call other than 911. She said, "Initially, since you come into this very suddenly, the first time around you're always going to call 911 because you don't know what else is out

there. You're in total fear, you're panicking, you call 911." Another family member participant said, "We have generations of training that if we're feeling unsafe, we should call 911, but the situation might actually not be unsafe, just uncertain."

When additional resources such as the Gerstein Centre were raised by other participants in our sessions, often other participants expressed surprise and said that they had never heard of these other services before. A number of participants also expressed misconceptions or misunderstandings of what services like the Gerstein Centre can provide. For example, family member participants often believed that only the person in crisis themselves could call Gerstein and that they could not call on behalf of their loved ones.

Even service providers were often unaware of resources or felt like resources were insufficiently accessible. One service provider participant said, "I'm really at a loss where to send people." Another service provider participant said, "There's a lot of anxiety for [service providers] about where to refer people to."

Long wait times, insufficient hours of operation, and limited resourcing

Participants frequently reported difficulty accessing other services due to limited resourcing. This was particularly true of the Gerstein Centre and the Distress Centre. These two services were mentioned in nearly all of our town halls as being valuable and supportive, but insufficiently resourced to provide the services needed, leading to long periods of time waiting on hold or needing to call multiple times to get through. One service user participant commented, "It's a problem when we call crisis lines and get put on hold, [because] it makes people consider whether they're 'in crisis enough' and therefore deserving of that support." Another service user participant said about crisis lines, "The chiming of a hold beeping on a phone can be dysregulating when I'm in crisis. The whole beeping for forty minutes can send me over the edge." A service provider participant stated, "Gerstein has never actually sent a mobile crisis team when I've called and I'm talking about dozens of phone calls. They never have a team available and just tell me to call 911."

Participants also expressed frustration with long wait times for ongoing services. One service user participant said, "Counselling [waiting lists] can take 3-4 months, or up to a year, and when someone is in crisis, they can't wait that long." Participants commented that many services are also not available 24/7, leading to periods of time where only police are available to respond to crises, since services like the Gerstein Centre are even more overwhelmed late at night when other services are closed. One service provider participant summed up this dilemma by saying,

"What we have now in terms of crisis management is completely insufficient to the number of crises we have in the city. Literally all we can do is send someone to a hospital or refer them to the Gerstein Centre. We don't have enough crisis management services. Even the MCIT isn't able to handle the amount of calls and the need that's out there."

Not enough crisis beds/ respite care

Service provider participants and homeless participants in particular noted the need for additional crisis

Even service providers were often unaware of resources or felt like resources were insufficiently accessible.

Participants noted the need for more crisis beds and for those crisis beds to be more accessible.

beds and for these crisis beds to be more accessible. Many participants commented that Gerstein's beds are nearly always full and that there are limited options elsewhere. Participants also commented on the need for spaces for service users to detox or come down from drugs or alcohol, without necessarily needing to be hospitalized. Participants further raised the need for respite care and safe places people can go when they simply "need a break from each other." For example, one service provider participant said that many 911 calls stem from interpersonal conflicts where incarceration or a forceful response is not needed, but the individuals involved need some space or some support in mediating their conflict. Finally, service provider participants commented on restrictions in accessing safe beds. For example, one service provider participant said, "I have had situations where I have tried to refer clients to some mental health beds in Toronto, and the clients have been denied due to the current criminal charges that the client is facing." Participants complained of a lack of available safe beds and respite spaces, leading to unnecessary hospitalizations and incarceration.

Limited catchment areas and resource gaps

A number of service provider participants commented that many areas of the city are under-resourced. For example, one service provider participant said, "Gerstein is the few places I am comfortable referring people to. Unfortunately, it's a crap shoot in terms of whether people can actually access the services there because of a lack of resources...there's a huge gap in services in certain areas of the city." Another service provider said, "We have Gerstein in the core, but in Rexdale, Scarborough, there's zero." Participants stated they were much more likely to call 911 and receive police response in areas of the city with fewer available alternatives. Notably, the areas of the city in which the greatest proportion of newcomers and racialized individuals live are the areas most poorly resourced by non-police crisis services, increasing the likelihood of these individuals interacting with police when in crisis.

Denial of needed services/ services being inadequate to support needs

Participants stated that many crisis services have a narrow mandate and are not able to serve people whose needs or demographics extend beyond their mandate. For example, services may be restricted to people in the downtown core, people with a given diagnosis, or people of a particular age group. Additionally, participants identified that service users are often turned away from needed services because their behaviour is considered "disruptive" or because their needs are greater than the service can accommodate. Service user participants and service provider participants alike described this process as akin to a game of "hot potato." Service provider participants in particular noted that community services are often not adequately equipped/resourced to respond to high-acuity situations such as suicidal behaviours or self-harm, so they deny service or tell people to call 911.

Participants also identified concerns with the limitations of the services that agencies can provide. For example, one service user participant said, "Most [existing] crisis supports are not intensive enough to allow someone to really heal from

and understand their crisis." Another service user participant said, "So many crisis services are eager to push folks out of services. If your crisis isn't solved within a fifty-minute hour (which they very rarely are), you're pushed out without the support you needed in the first place." Similarly, a service user participant stated, "There are lots of places to call, but they don't always have very good resources when you do call. A lot of times people end up with a list of phone numbers and a list of places you can call next, and that's often not helpful."

Feeling unsupported by the dominant medical model

A number of participants also commented that the dominant medical model feels unsupportive to them or is insufficient to respond to their needs. One service user participant said, "The biggest gap is that most people are not trauma-informed when they go to give help. When I was trying to get help through the medical system, it was just medical, not trauma-informed." Another service user participant stated, "[So many service providers] assume everything is med-related, like 'Oh, you're off your meds,' but we don't all have access to those in the first place." Similarly, a service user participant said, "A lot of the current services have a very medical focus, and even when they're trying to move away from that model, they keep a lot of that language, ex. Asking about your medications and your diagnosis." A service provider participant said, "People want non-coercive, non-medical model teams, and instead what they got was police/hospital combo, which are the two most coercive services. Instead of looking at services connected to police, there are other [non-medical, non-coercive] services that don't have enough resources."

Negative experiences with hospitals

Nearly all of our participants expressed dissatisfaction with both their experiences with hospitals and the fact that they and/or their clients are most frequently directed to hospital emergency rooms when in crisis. In particular, homeless participants described being regularly directed to hospital emergency rooms, but that going to hospital was rarely helpful. These participants described hospitals as "triggering," "unsafe," "confined," and "uncomfortable." They further noted that space was limited in hospital emergency rooms and that they often simply needed a place to sleep, which they were not permitted to do in the emergency room.

In general, participants described negative experiences and perceptions of hospitals. One participant said, "Hospitals for physical emergencies aren't very mental health friendly at all." Another participant added, "Hospitals are really traumatizing for a lot of people." A service provider participant commented, "My feeling is that we need to scrap the whole hospital experience. It's just not working. The hospital experience just adds more trauma." Another service provider participant noted, "Psychiatric services are often just as frightening if not more frightening than police." A service provider participant further said, "Most of my clients from Black communities have not had good outcomes when going to hospital ERs." Another service provider participant said, "I've had suicidal clients who felt even more suicidal after leaving [the hospital]."

Participants specifically commented on restraint use and seclusion as reasons for discomfort with hospitals. One service provider partici-

pant said, “I generally get quite negative feedback [from clients] who go to [hospital] emergency [rooms, due to] negative experiences of restraint use.” Another service provider added, “I have yet to see hospitals have sufficient experience on how to de-escalate and manage people safely, [without using] seclusion and restraint.”

Participants described feeling dehumanized, isolated, and ignored in hospitals. One service user participant described her hospital stay by saying, “I had no voice. I was treated like less of a human.” Another service user participant said,

“I was fortunate enough to have a family member and then-partner come to meet me at the hospital. Having them there to talk with me made the safer location beneficial. However, if they had been unavailable to stay with me, I would have been left alone, handcuffed to a hospital bed, alone, for nearly 16 hours. That would not have helped. It left me fearful for if I ever had to be brought to a hospital but didn’t have someone to meet me there.”

Additionally, participants commented that actual care was often not provided during their hospital stays. Participants noted that “supportive conversations” or one-to-one counselling were rarely offered during hospital stays, and homeless participants in particular said that staff would sometimes refuse to provide medications. Other participants said that staff were too quick to medicate and would turn to medication rather than simply speaking with and providing support to the clients. One client described a lack of care, support, and programming received during her hospital stay as follows,

“I had no call bell and was told to stay in my room due to COVID-19 precautions. The nurses [came] around rarely. In a twelve-hour period, there were three nurses and they each came at the beginning of their shift and to drop off food. [There were] no more additional visits.”

This service user was clearly not receiving any kind of treatment for her suicidal ideation while hospitalized, and her hospital stay only intensified her suicidal ideation.

Participants also commented that hospitals are often “full” and simply will not admit service users who are seeking support. One service provider participant said, “Even if clients are taken to the hospital, they’re often let out after eight hours with the same problem.” Another service provider participant agreed and said, “Some clients do want to go to hospital and they’re kicked out of hospital because there aren’t enough resources.” Another service provider participant added, “Often people are turned away [from hospital] as not in a ‘bad enough’ situation. It lessens the likelihood that people will try again.”

Lack of follow up from crisis services or hospitals

Participants frequently commented on the lack of follow up care from crisis services, including the MCIT and most acutely from hospital stays. One family member participant said,

“Calling 911 and getting police response and getting our loved one taken to hospital and then finding out that they’re discharged immediately after or not connected with resources, it becomes a really disenchanting process. A lot of family members believe that calling 911 will lead to answers, but a lot of the time it just leads to more questions and more confusion.”

Another family member participant said, "At times, our family has decided not to call the police because we don't want our family member taken to hospital, because he often leaves a day or two later in an even more agitated state than he was in before. In our experience, in our family, the hospital has done more harm than good."

Similarly, another family member participant described her daughter's experience being hospitalized as follows,

"She stayed willingly at the hospital for almost two weeks, but it was a very traumatic experience and it didn't seem to actually help. It seemed to cause even more trauma. They recommended day programs but then they just handed off care to her GP. They didn't seem to want to personalize the care they were providing. They just gave her the list of resources and then said to see her GP. There was no follow up. If we'd had access to a follow up service, maybe our daughter wouldn't have had a second episode. The hospitalization process isn't a way to get recovery. It often impedes recovery."

Participants noted that hospitals either fail to make aftercare plans for service users or these aftercare plans are inadequate. One service user participant said, "There is a shocking lack of follow up for clients discharged from [hospitals]." A family member participant said, "When someone is taken to a hospital, there often isn't an aftercare plan for when they're discharged." A service provider participant further noted,

"Even when people have supports in the community, those supports are often not brought into the care plan/discharge plan when someone is in hospital. There's no connection between these services, which is a problem, and when people are discharged, there's no follow up. People who work in hospitals often don't know about existing community-based crisis services."

Duty to report acts as a deterrent to seeking care

Participants often stated that professionals' legal duty to report risk of harm to self, others, or a child was a deterrent to either themselves, their clients, or their communities accessing mental health care. Participants were concerned about service providers' obligation to call 911 in certain circumstances, and this led participants to be less honest with service providers about suicidal ideation or actions in order to avoid triggering duty to report. One school social worker commented, "[My clients] know what to say [and what not to say] so we don't have the conversations about going to hospital or calling someone."

Indigenous participants in particular were concerned about duty to report child abuse acting as a deterrent to Indigenous individuals reaching out for help. One Indigenous participant commented, "[With mainstream services], there's been a trajectory towards [calling] CAS [on Indigenous clients]." Another Indigenous participant added, "In [our] community, people call it in [to CAS] without even knowing what's going on. This is really prevalent in our community [and there's] not a lot of sensitivity around this issue [from mainstream services and non-Indigenous service providers]." One Indigenous service provider noted that women in particular are less likely to seek help for their mental health because they worry about "where are the kids going to go," and whether their kids will be apprehended.

Indigenous participants in particular were concerned about duty to report child abuse acting as a deterrent to reaching out for help.

They felt supported and de-escalated when service providers simply listened to them and were present with them.

Positive experiences with peer support and peer-led services

Participants reported positive experiences with peer-led services such as Progress Place and Sound Times. One service user participant said, “One of the most helpful things for me has been peer support groups. I’ve always found that the most helpful in times of crisis, because they understand what I’m going through.” Service user participants reported positive perceptions of and experiences with safe beds and peer-led respites and advocated for these services to be built in Toronto as well. The Soteria House peer-led respite model was raised by multiple participants as a successful example of a peer-led service that should be replicated here.

Positive experiences of being listened to

Participants commented that they felt supported and de-escalated when service providers simply listened to them and were present with them. In particular, the Distress Centre and the Gerstein Centre were mentioned as services that effectively provided this kind of support. One service user participant said, “The Gerstein mobile team was amazing because it provided a sense of safety and also a sense of anonymity. When you’re in crisis, it’s so overwhelming, and when you’re filled with so many different emotions, it can be so hard to even think. When you have someone there with you who can listen, it really helps, as opposed to feeling isolated.” Another service user participant stated, “Crisis line wait times are too long, but when someone picks up, your mood can change almost immediately and you can calm down five minutes later. It makes a huge difference.”

SUMMARY

Participants' experiences with other services

Participants reported the following key themes in their interactions with other crisis services:

- Difficulty in knowing who to reach out to
- Long wait times, insufficient hours of operation, and limited resourcing
- Not enough crisis beds/respite care
- Limited catchment areas and resource gaps
- Denial of needed services/services being inadequate to support needs
- Feeling unsupported by the dominant medical model
- Negative experiences with hospitals
- Lack of follow up from crisis services or hospitals
- Duty to report acts as a deterrent to seeking care
- Positive experiences with peer support and peer-led services
- Positive experiences of being listened to
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KEY THEMES

KEY INGREDIENTS FOR THE NEW SERVICE

New crisis teams must be comprised of individuals from the communities they serve and that these teams must prioritize the representation of Black, Indigenous and other people of colour.

Participants identified a large number of key ingredients that will be essential to the success of a new service. These themes are described below.

Crisis teams must be culturally competent, anti-oppressive, anti-racist, and diverse

Participants consistently stated that the new crisis teams must be comprised of individuals from the communities they serve and that these teams must prioritize the representation of Black, Indigenous, and other people of colour. Participants underscored the importance of being responded to by someone who "looks like you" and who shares similar life experiences and cultural backgrounds. One service provider participant suggested that the new service consist of "neighbourhood teams" that can be "part of the community rather than [responding] to the community." Another service provider participant concurred and stated that the teams "need to rise out of the community."

Many participants also raised the need for linguistic diversity among the team's staff. They suggested that staff members should be able to speak the native language of the person they are responding to, rather than needing to rely on interpreters. Participants identified phone-based interpretation services as problematic and ineffective. Participants further commented that even when a person does speak some English, when in crisis, it may be much easier for that person to com-

municate in their first language, and that the new crisis service should be set up to accommodate this.

In addition, participants identified linguistic and cultural barriers, which may impact the accessibility of the service for communities of colour or newcomers to Canada. For example, one service provider participant said, "Mental health has a lot of stigma in some parts of the world, so some people might not think of that word as something they're needing." Participants suggested that the service should not be branded as a "mental health-only" service, as this could create a barrier for communities for whom the term "mental health" is not culturally appropriate. Participants instead said that the service should be branded in an open, broad, flexible manner. Participants suggested terms such as "wellness," "distress," "urgent support/care teams," "personal distress," and "harm reduction support response" to use instead of "mental health." Participants further stated that service staff should "reflect the language the client is using" as much as possible. For example, a service provider explained that terms like "depression" or "anxiety" may be accessible to younger Canadian-born people but stigmatized for elderly individuals or newcomers to Canada. She suggested that frontline staff should take their cues from the service user and not apply their own labels to the service user's experience.

Participants further identified that staff on the new teams will need to receive rigorous training in anti-oppressive, anti-racist practice, as well as training and knowledge related to cultural safety. In particular, participants stated that staff will need to be informed about cultural traditions and traditional knowledge and support practices of the communities they are serving. Furthermore, in keeping with the concept of cultural safety, service providers should be encouraged to continually reflect on power differentials, as well as how different identity groups experience social services and society as a whole in order to increase their empathy and understanding of their service users. Similarly, participants suggested that culturally-specific services and traditional healing practices should be incorporated into the new teams. In particular, Indigenous Elders could work alongside clinical and peer staff, and traditional Indigenous medicines such as sage could be provided to Indigenous service users. Participants further suggested that the new service build strong connections with existing culturally-specific agencies, particularly those that serve newcomers and racialized communities. The new service should also connect with cultural institutions such as churches and mosques that are well-trusted by racialized individuals.

Finally, participants raised the importance of collecting race-based data to measure service outcomes and ensure that people of colour are not being disproportionately directed towards policing and other carceral systems. One service user participant noted,

"Risk assessment is a very racialized issue. Depending on how someone presents, racially or gender-based, then their risk of violence to self or staff members is overestimated and leads to restraints or other harm. When we're looking at developing these services, we need to be looking at how racialized experiences of trauma are often criminalized or looked as an expression of violence, when really it's 99.99999% of the time an expression of trauma and deep pain."

Staff on new teams will need to receive rigorous training in anti-oppressive, anti-racist practice, as well as training and knowledge related to cultural safety.

The new crisis service must commit to not stigmatizing people who use substances.

Crisis teams must operate from a trauma-informed lens

Participants consistently raised the importance of service staff providing trauma-informed care. Trauma-informed care means that service providers approach each client with the assumption that the client has experienced trauma and adapt their approach so as not to exacerbate, trigger, or re-traumatize clients. Some examples of trauma-informed care might include taking time to establish safety, trust, and rapport with a client; giving a client physical space and not approaching or touching a client without permission; and empowering clients by providing choices and seeking consent in all aspects of care. Service provider participants frequently noted the importance of service staff understanding the neurobiology of trauma and how trauma survivors' nervous systems can be dysregulated by elements common to current crisis response systems, such as police uniforms or handcuffs.

Crisis teams must take a harm reduction approach

Participants noted that the new crisis service must commit to not stigmatizing people who use substances and must take a harm reduction approach. A harm reduction approach is one aimed at de-stigmatizing substance use and reducing the negative consequences associated with substance use while respecting the rights, autonomy, and dignity of those who use substances. Participants' suggestions for how to incorporate a harm reduction approach included ensuring that people using substances "are not arrested on drug charges when they're seeking out help," providing harm reduction supplies such as naloxone kits, and treating clients and their choices to use substances with respect and dignity.

Teams must be client-centered, non-coercive, and respect clients' dignity and autonomy

Participants noted that the new service will need to be client-centred and flexible enough to adapt to clients' unique experiences and needs. One service user participant said,

"The response can't and shouldn't be 'one-size-fits-all.' People have different needs and different wants. My hope for the response team is that responders would be sensitive to the particular person they are meeting and know different techniques and approaches for communicating and helping in the moment."

A service provider participant commented, "The thing that's most important to me is about flexibility, being able to really listen to people and see what they actually need, because often they have the answers within themselves and they just need some help teasing that out, rather than a one-size-fits-all approach."

Other participants commented on the importance of treating clients with respect and recognizing their humanity. A family member participant noted that current crisis systems such as police and hospitals can often feel punitive to clients and suggested that "the [new] team shouldn't feel like a punishment." Another service provider noted that often when people are in crisis, systems such as police and hospitals tend to separate them from the things that give them comfort, like their pets, their home, their own clothing, and their friends and family. This service provider suggested that the new service prioritize keeping people connected with the comforts and supports they find helpful.

Participants further raised the importance of the new service being consent-based and non-coercive. One lawyer participant commented, "Any possibility of coercion during the interaction will escalate rather than de-escalate." Another lawyer participant added, "I think we should take out of the situation any player that has the legal power to take control of the person, who can genuinely say, 'I'm only here to help you. I cannot hurt you. I don't have the legal power to hurt you and I'm not here to force you to do anything.'" This participant suggested that teams should not include psychiatrists, police officers, or anyone else with the legal power to hold someone involuntarily under the Mental Health Act in order to ensure this non-coercive outcome. A service user participant further stated that it's important for staff of the new service to consistently remind service users that they are in control of the interactions they have. She said the team should "ask what people need rather than saying, 'We're going to do this.'" Another service user participant said that it's important for the new service not to "treat people like they're fragile and helpless and about to break." This participant noted that the idea that people are helpless is what often leads to coercion.

Participants in our town halls consistently commented on the importance of respecting service users' agency and self-determination. They further stated that frontline staff need to view service users as the expert of their own experiences. A service provider participant noted, "People are often very good at identifying what kind of help they need, but can't access it, either because of capacity limits in the system, or because they aren't taken seriously as experts on their own situation." Another service provider participant added, "I think self-determination is huge and often missed in crisis intervention. What does the client want, what do they think is best for them? Clients need to be engaged with during this process." A service user participant further reflected, "Asking 'what would be helpful for you right now?' has been really good for me."

Crisis teams must focus on active listening and being present with the person in crisis

Participants consistently raised the importance of simply listening to and being present with a person in crisis. One service provider participant said,

"[What a person in crisis needs is] an active listener, just a calm presence giving space to the person and trusting that you're not adding to the agitation and anxiety, you're just there for listening to what is needed, and asking them what is needed. The attitude must be very calm, without judgment, just, 'How can I support you and help you from now on?' So many times someone shows up and wants to explain what the person did before to lead the person here, like, 'You were punching walls and that's why I'm here.' That closes the conversation. But you should start with where the person is right now and what they need now."

Another service provider participant added, "Crisis situations require hope, belief, love, [and] softness." Participants further noted that validation, empathy, grounding skills, helping service users identify their strengths and resilience, a calm and gentle presence, and feeling like someone is "on their side" can help people get through a crisis. One service user participant said, "The

best supporters are the best listeners." Another service user participant suggested that the team's staff operate by the "platinum rule – treat people as they want to be treated." A service user participant further commented,

"When you're in crisis, it's so overwhelming, and when you're filled with so many different emotions, it can be so hard to even think. When you have someone there with you who can listen, it really helps, as opposed to feeling isolated…having someone to…just be there in the moment helps."

Crisis teams must have adequate time available to de-escalate a crisis
A number of participants brought up the importance of the new teams having enough time to adequately support a person in crisis. One service provider participant commented, "It takes a lot of time and patience to speak to someone in crisis." Another service provider participant added, "[People] could use access to a supportive, non-violent team that has many hours to de-escalate someone, because sometimes it takes that amount of time." A service provider participant further stated,

"Nothing is more nerve-wracking for a person in crisis than feeling like the person supporting them just wants to move them along. When you sit with the person and give them the attention they need, in the majority of cases, it takes time to establish that rapport and have that conversation and show your interest and care. It's not a process that happens in the next ten minutes and then we move onto the next case. The metrics for this program should be based on the quality of care rather than the number of people we serve in a given amount of time."

Service user participants concurred that adequate time is essential to support them during a crisis. One service user participant said,

"It's important for me to be asked if I feel satisfied and at a point of completion before being released from the attention of a responder. Despite the reality that it may be a busy and high demand service, it's really important to me to not feel like a number or just another client. I have felt rushed and unwelcome when moving through these situations, like I'm an inconvenience. It can plant more seeds for further issues to arise."

Teams must provide support to families, not only to the identified client
Participants consistently noted the importance of supporting family members and loved ones of individuals in crisis. They further suggested that "family members and loved ones" should be defined broadly, including biological family but also housemates and friends, where relevant. One family member participant said, "Any civilian-led crisis response team needs to be able to support the families, not just the individuals. The family perspective needs to be present." Another family member participant added, "Family members need a tremendous amount of support to cope with these extremely challenging situations." Family member participants also commented on the need for teams to provide education and resources to families of individuals, such as by sharing information to de-stigmatize mental illness or to direct family members to their own support groups. One family member participant suggested, "'Mental Health Act 101' would be helpful for any crisis response team to provide to families." Family member participants emphasized that service staff providing information both

about mental illness generally and about their loved one's condition specifically, within the limitations of relevant privacy laws, could be extremely helpful for families.

Several other participants noted that when police officers respond to a mental health crisis, they typically tell family members and others in the area to leave so they can speak only with the client. Participants said that a new service should not isolate people in crisis from loved ones and other sources of support, and that staff members should instead speak with the family members in order to gather information that might be helpful, such as whether the person has been in crisis before and if so, what has been helpful for them in the past. One service provider participant suggested that staff members could even connect with the service user's support network prior to arriving on site, particularly if the person in crisis is known to the service, so that when staff arrive on site, they already "have context and background information."

Crisis teams need to be available across the city 24/7 with immediate response times

Participants stated unanimously that the new service would need to be available around the clock with rapid response times. Participants identified inadequate response times and limited operating hours as reasons for utilizing the police rather than other crisis services and uniformly stated that a new service would need to have the same availability and rapid response times as police in order to overcome this challenge. For example, one service provider participant explained why she had called police when a client was in crisis even though she believed police would likely make the situation worse, "I felt that there was no one else to call. There was no one else I could call who would come now. Every other service was next week, three months from now." Additionally, participants noted that the service will need to be available uniformly across the city with no geographic "blind spots" and with staffing levels adequate to support the needs of each area.

Crisis teams must also play an advocacy role

Participants suggested that the new crisis teams will need to play an advocacy role in addition to crisis and outreach services. Participants stated that this advocacy role is particularly important in hospital emergency rooms if a service user agrees to attend the hospital. One service provider participant said that staff members should stay in the emergency room with service users when requested to ensure that service users are not left alone in their moment of need and that their human rights are being respected by hospital staff. A service user participant further stated, "People might feel less alone and demonized [in the hospital] if a supportive person could be with them and hold space for them when police and medical staff are present." Another service user participant said, "When I'm overwhelmed, I go mostly mute, so having someone else accompany and help me communicate [to hospital staff] would be really helpful."

Participants suggested that the new crisis service could also play an advocacy role after the termination of the crisis. For example, one family member participant said, "Having someone who will act as an advocate for the person and their family through the time following the crisis" would be helpful. A service provider participant further noted that it might be helpful for service

Participants stated unanimously that the new service would need to be available around the clock with rapid response times.

Participants identified the need for the new service to connect service users to housing, food, and employment supports.

staff to accompany service users to other services (such as safe beds or community-based mental health services) rather than simply providing the name or phone number of the service.

Referral pathways and crisis beds must be integrated into the new crisis service

Participants frequently underscored the importance of referral pathways being integrated into the new crisis service to ensure that people are expeditiously connected with needed services. In particular, participants identified the need for the new service to be able to provide or connect service users to housing, food, and employment supports. One lawyer participant said,

"Many of our clients who are in crisis are very vulnerable to being evicted. When you're dealing with mental health issues and eviction and the tribunal system, in most of these cases people are eventually evicted, and they need resources to help keep them in their homes."

Additionally, many participants raised the need for crisis beds, detox spaces, and other respite services. One service provider participant said, "We need safe spaces to bring people to be in...not hospitals that may medicalize or criminalize or worse." Another service provider participant concurred and said, "It's important to have a safe place for someone to go to, and home is not always a safe place. A safe place is absolutely essential to help someone come out of their reactive mode and settle." Participants agreed that often people in crisis do not need to be in a hospital or a jail, but they do need somewhere safe to stay. A number of participants suggested peer-run respites such as Soteria House as effective models that could be replicated in Toronto. A service user participant recommended that the City of Toronto invest in "safe houses, somewhere [people] can go to be safe." This service user made some suggestions for what the safe houses could look like,

"[It could be] a crisis centre with mental health support inside the centre, maybe a coffee/TV room, a lounge area where people can talk, some plants, with some life to it. We could get the person into one of these safe houses for a bit and figure out what's going on with them and how to help them, listen to them, see if you can help them with what they want and what they need."

Finally, many participants identified that crisis beds, detox spaces, and other respite services that service users may be referred to should also operate from an anti-oppressive, trauma-informed, culturally competent framework, including options that cater to specific identity groups. Noting this, many culturally-specific services exist throughout the city and some participants suggested that service users have the option to be transferred to one of these services rather than the hospital. In addition, participants suggested that service users should have the option of being transferred to a safe location of their choice.

Crisis teams must be made up exclusively of unarmed, plainclothes civilians

Participants agreed that crisis teams should not carry weapons or wear uniforms, since identifiable uniforms can create stigma or fear for clients. Participants suggested that rather than wearing uniforms, staff could have sweaters, jackets, or hats with the team's name written on them, an ID badge or lanyard, or

vests similar to those worn by the Red Cross. Participants further stated that the teams should not be police-partnered co-responder models but should be entirely civilian teams unless there is a serious risk of violence involved.

Peer workers and people with lived experience should be integrated into the design and operations of the team

Participants identified people with lived experience as integral to both designing and staffing the new service. One service provider participant stated, "People with lived experience need to have a big part in [designing] the model. You learn from the people who have been through it, from their experiences of what did and didn't work." Other participants commented on the need for peer workers to be on the front lines supporting service users, and many participants commented on the benefits of peer support. One service user participant said, "Peer supporters are a beacon of hope for people. [They demonstrate that] people can and do recover!"

Teams should be built specifically for youth and specifically for seniors

Participants suggested that teams be created specifically for youth and specifically for seniors. One participant noted, "Kids in crisis and adults in crisis are very different." Service provider participants noted that laws and regulations for children are different than those related to adults and suggested that teams responding to youth should have specific expertise in these areas. Additionally, service provider participants commented that youth are more likely to be living with parents or other adults and that teams responding to youth would likely need additional training and experience in managing these family dynamics and providing resources to other family members while protecting the young person's privacy. Several service provider participants also noted the unique needs of senior citizens and the importance of having teams with expertise in geriatric populations, particularly in relation to differentiating between medical issues, neurological or cognitive issues, and mental health issues, to ensure that the team is providing the appropriate type of care.

Crisis team staff must receive extensive training

Participants stated that crisis team staff must receive extensive training and made a number of suggestions for what kinds of training are essential. One lawyer participant noted the importance of understanding the impacts of different types of substances and the relevant symptoms and needs service users might have in relation to substances. A number of participants mentioned knowledge of the impacts of crystal meth use as particularly important. Participants also frequently raised the importance of naloxone/overdose prevention training.

Service provider participants noted that staff must receive advanced training in working with people experiencing psychosis, particularly substance-induced psychosis, as this is a specialized but essential skillset. Participants also suggested that teams will need to be trained in working with neurodiverse populations, particularly with Autistic individuals and individuals with developmental disabilities. More generally, participants said that teams will need to be trained in de-escalation, active listening, anti-oppressive practice, and physical self-protection skills.

Service users should be permitted to remain anonymous, rather than needing to provide a health card or full name.

Other participants noted the necessity of staff to be trained in understanding culturally-specific expressions of distress. Participants also noted that they would have more confidence using a service that clearly considers the ways in which their identities impact how they move through the world in everyday life, any stigmas and barriers to access they face, and accommodations they might need. Furthermore, staff should be trained in culturally-specific de-escalation techniques, taking into account the sorts of actions that may unintentionally escalate situations involving particular cultural identity groups as a result of being ignorant to that group's needs and customs.

Privacy and confidentiality must be maintained

Participants stated that in order to preserve the confidentiality and privacy of service users, frontline staff of the new crisis teams should not wear uniforms or have any overtly visible markers. For example, staff should not wear clothing with the words "mental health crisis team" or something similar on them. Participants further raised concerns regarding information about individuals in mental health crisis being shared with police, even if the new team is civilian-led. In many of our town halls, participants emphatically and unanimously said that the new crisis team must never run people's names for open warrants or allow police officers to do so. Participants said that if people are afraid that there could be legal consequences to accessing the new service (such as if a service user has an open warrant), this will drastically reduce the efficacy of the service and act as a substantial barrier to access. Participants further suggested that the database storing information for the new service's calls should be separate from the police database, because having a mental health-related record in a police database can be stigmatizing for service users and also show up on vulnerable sector checks and therefore impact a person's future employment opportunities.

Participants also suggested that service users should be permitted to remain anonymous, rather than needing to provide a health card or full name. Service user participants in particular expressed concerns about integrated electronic health records and the possibility that a record of the crisis call might impact future medical care, due to stigma surrounding mental health. Participants stated that they would feel much more comfortable using the service if they could choose which personal information to provide, rather than being compelled to share a full name or health card number.

Crisis teams must engage in outreach and relationship-building with vulnerable communities

Participants commented that in additional to responding to crisis calls, the new crisis service must also do substantial outreach and relationship-building with vulnerable communities. For example, participants suggested that staff could provide outreach to schools, through religious organizations, and in encampments. Participants also suggested that teams could do "patrols," such that they would be visible in community spaces like parks where people tend to congregate, and that service users could then approach them if they were having a difficult day and needed support. One service provider participant suggested that an additional benefit to this kind of outreach would be that people may be able to get support with circumstances that might not be extreme

enough to warrant a call to 911 but are still challenging. This service provider said that through this relationship-building process and visibility, staff could provide a direct phone number to service users that they could then contact again if they are in crisis. Another service provider added that having staff members visible in parks or other public spaces would be particularly beneficial for service users who might not have access to phones or transportation to travel to other services. One service user participant elaborated on the benefits of this kind of outreach as follows,

"Maybe [the team could] have events where you let people know who you are and where you will be in the community and eat together and connect and build the relationship with people who might also feel a lot of anxiety about reaching out, so the focus isn't just you're in trouble, it's more, 'Hi, we're here, let's get to know you'...finding ways to connect with people and building those relationships is important, because communities are very fractured right now. We need to create partnerships so people can identify the crisis response network and know that people are there and feel like they have a support, and it's not just a number, it's a face."

Participants further suggested that teams should be dedicated to specific geographic regions so they can build relationships with individuals that might be frequent users of the service, rather than one team serving the entire city. Participants said that structures must be built into the new service to reduce staff turnover (such as providing generous benefits and structured "community of practice" peer supervision for staff), in order to maintain the relationships staff members will build with service users. Participants also suggested that one aspect of community outreach and relationship-building could be creating safety plans with individuals prior to them entering a crisis, such as by making a list in advance of what would be helpful should the person go into crisis and how the person would like to be supported.

Community consultations must be ongoing throughout the service's tenure to promote accountability

Participants made a number of suggestions for promoting accountability of the new service. One frequent suggestion was that community consultations be ongoing throughout the service's tenure rather than simply happening at the beginning. Other suggestions included a paid community advisory board, an outside agency to investigate "any reports of wrongdoing," and feedback forms that clients can fill out in a private space.

Development of new crisis service must include a substantial public education campaign

Participants stated that a substantial public education campaign must accompany the creation of the new service to ensure that Toronto residents are aware of its existence and understands what kinds of services it can provide. Participants highlighted the importance of building mental health literacy and suggested that this could be a task taken on by the new service as it is publicized. One service provider participant suggested that the service could put out "a one-pager of what [people can] do [when a loved one is in crisis] instead of calling police, so the average person, a family or friend, knows what to do. An education component is important." Participants also said that if a new number is created to access the new service, this number will have to be advertised broadly to ensure that people use it instead of calling 911.

SUMMARY

Key ingredients for the new service

Participants noted the following key ingredients for the new crisis service:

- Crisis teams must be culturally competent, anti-oppressive, anti-racist, and diverse
- Crisis teams must operate from a trauma-informed lens
- Crisis teams must take a harm reduction approach
- Teams must be client-centered, non-coercive, and respect clients' dignity and autonomy
- Crisis teams must focus on active listening and being present with the person in crisis
- Crisis teams must have adequate time available to de-escalate a crisis
- Teams must provide support to families, not only to the identified client
- Crisis teams need to be available across the city 24/7 with immediate response times
- Crisis teams must also play an advocacy role
- Referral pathways and crisis beds must be integrated into the new crisis service
- Crisis teams must be made up exclusively of unarmed, plainclothes civilians
- Peer workers and people with lived experience should be integrated into the design and operations of the team
- Teams should be built specifically for youth and specifically for seniors
- Crisis team staff must receive extensive training
- Privacy and confidentiality must be maintained
- Crisis teams must engage in outreach and relationship-building with vulnerable communities
- Community consultations must be ongoing throughout the service's tenure to promote accountability
- Development of new crisis service must include a substantial public education campaign

KEY THEMES

WHAT ADDITIONAL SERVICES SHOULD THE NEW TEAMS PROVIDE?

Participants suggested a number of additional services that the new teams should provide. One service provider participant said, "Being able to provide a wide variety of options would be great so that [people in crisis] can decide what would be most helpful to them." The most frequently suggested additional supports were referrals/warm transfers to other services, connections to case management services, transportation (particularly to shelters and safe beds), follow up visits, support with housing and getting on housing waiting lists, food, blankets, tents, and harm reduction kits for people who use substances. Additionally, one service user participant suggested that teams should provide grounding/comfort items such as mesh or puffer balls for service users to hold. Another service user participant suggested that service staff should carry cigarettes to offer to service users, as allowing service users to smoke is often an effective de-escalation tool and demonstrates respect for a service user's autonomy. Several participants suggested that teams should bring traditional medicines like sage when responding to Indigenous service users. One service provider participant also suggested that it might be helpful for the team to be able to support service users with medication prescriptions or urgent medical care. For example, staff members could be able to prescribe or provide a single dose of medication such as Ativan or Methadone. Another service provider participant suggested that the team should be able to provide or connect service users with legal assistance, particularly for service users who are vulnerable to eviction or criminalization.

Finally, a service provider participant suggested that the team ought to be able to provide response to the person making the crisis call, particularly when the person making the call is not in the same location as the person in crisis.

SUMMARY

Participants suggested that the new teams could provide the following additional services:

- Referrals and warm transfers
- Connection to case management
- Transportation
- Follow-up visits
- Support with housing
- Food
- Blankets
- Tents
- Harm reduction kits
- Grounding/comfort items
- Cigarettes
- Traditional medicines
- Medication prescriptions
- Connection to legal assistance
- Response to the person making the crisis call
-

KEY THEMES

WHICH CALLS SHOULD THE NEW TEAMS RESPOND TO?

Participants suggested that in addition to responding to suicide-related and mental health-related calls, the new teams might also be able to respond to some domestic dispute calls, calls related to conflict with children or teens, conflicts in encampments, and calls related to substance use. Participants further suggested that teams could replace police in doing general welfare/wellness checks.

SUMMARY

Participants suggested that the new teams should respond to the following calls:

- Suicide-related calls
- Mental health-related calls
- Substance-use related calls
- Domestic disputes
- Conflicts with children and teens
- Conflicts in encampments
- Welfare/wellness checks

KEY THEMES

WHO SHOULD STAFF THE NEW SERVICE?

Nearly all participants identified peer workers as being essential to the success of the team.

Participants identified a preference for a multi-disciplinary team with a strong peer worker element. In addition to peer workers, social workers, caseworkers, counsellors, therapists, mental health nurses, paramedics, social service workers, harm reduction workers, and Indigenous Elders were suggested as possible team members. Family member participants also suggested that "family peer support workers" could be incorporated into the response team to support loved ones of people in crisis.

Nearly all participants identified peer workers as being essential to the success of the team. Peer workers are individuals with lived experience of mental health challenges or substance use who have received extensive training in providing mental health support and crisis intervention. Several programs, such as Peer Support Canada, offer training and certification for peer workers. Peer workers are often able to quickly build rapport with service users due to their own lived experiences, and their presence often reduces stigma and engenders hope for service users in crisis. Our participants consistently expressed enthusiasm about peer workers being incorporated into the new team.

Participants were more split on the topic of mental health nurses. Some participants indicated discomfort with dominant medical models of care and worried that mental health nurses might replicate the harms of these models. Conversely, other participants identified mental health nurses as important because of their ability to respond to medical emergencies and support service

users around medications and prescriptions, when desired. One service user participant described this tension by stating, “I don’t have the best feeling about a mental health nurse because of the association with the medical model. However, when there are other medical issues at play, a nurse does have more training in these areas.” Another service user participant stated that mental health nurses would be beneficial for the team because they are able to “consider both physical and psychological well-being.”

Additionally, a small minority of participants believed that the service should be led entirely by peers, without any mental health or medical professionals involved. These participants generally stated that systems like social work have histories of harm to Black and Indigenous communities and that many clients have experienced trauma at the hands of mental health professionals, and therefore teams should be made up entirely of peers to promote safety and eliminate the potential for coercion.

A number of participants raised concerns about “credentialism,” or the excessive valuation of professional degrees. These participants stated that regardless of the degree someone has, what matters most is their individual ability to connect with and support a person in crisis. For example, one service user participant said, “Each situation is different. It comes down to who is able to serve that person best without harm, and sometimes who that person is might change depending on the circumstances. Another service user participant said,

“People want to see a multi-professional team that includes peer support workers and peer navigators. Regardless of the title, it’s about your ability to develop rapport and trust. I don’t care as long as the person who is coming to help me can connect with me, can listen to me, can validate me, can do something to help. Social workers, for the most part, they’re trauma-informed, they’re resourceful, but they’re not all great. It’s about people.”

Regardless of the title, it’s about your ability to develop rapport and trust.

Another service user participant added, “It’s important to have people who have the human element and compassion, even if they don’t have the letters beside their name. If you insist on graduate degrees, you’re eliminating a huge group of people. You need to look at the whole of the person.”

Participants further commented that peer workers and clinicians on the teams must be given equal respect and equal compensation for their work. This was a point raised emphatically in nearly every town hall. A number of participants specifically identified the benefits that peer workers can bring to a crisis team. For example, one service pro-

vider participant said that someone who has been through "the system" themselves is likely to know a lot about various resources and which ones will be most helpful for a given service user. A service user participant said, "For me, in my recovery journey, I needed a peer. I needed someone who understood what I'd been through, so I didn't need to tell my story over and over." Participants identified peer workers as being particularly skillful at advocacy on behalf of service users and stated that incorporating peers "creates accountability" for the service.

However, participants said that peer workers need to be compensated equitably for the skills they provide. One service provider participant said, "I support a team of a peer worker and a clinician. I think the most important thing is that the value of someone's expertise needs to be equitable, whether your expertise is in lived experience or in educational background." A service user participant concurred and said, "Any peer workers you employ have to be paid well and honoured for their skills and experience rather than being involved in token ways and having all real decision-making done by clinicians."

Participants identified the value of having one staff member responding from a "peer perspective" and one person responding from a "more clinical perspective," but raised concerns about "creating a power dynamic between the mental health clinician and the peer worker," as one service provider participant described it. Participants suggested that both roles will need to have a "similar culture," and one service user participant said,

"I think it's healthy to bring multiple perspectives to inform...what you're doing...[but] you need to be selective about which clinicians you bring on. There are [clinicians] who are open-minded about the peer perspective, so you select those, because you don't have to time to waste if the clinician isn't open to peer support or if they aren't open-minded."

Another service user participant said, "Simply being a peer isn't enough. People need to have abilities and values like valuing emotions and not feeling like the response is to medicate it away. When peers are required to fit clinical value systems, then they lose the distinction between peers and everybody else. Peers that have to fit themselves into an institutional model lose their freedom to advocate and provide support the way they should."

A service provider participant suggested, "As you're building the model, think about anti-oppressive practices around class, ability, and substance use, because the one thing we don't want to do in building the model [is] end up having the model parallel the same hierarchical oppressive structures we're trying to replace."

Participants also expressed their views on how peer work and clinical work should be integrated into the new service. Most participants thought that the clinician and peer should be equal partners, while others thought that peers should take the lead and clinicians should be available only when requested. For example, one service user participant said, "I don't think everybody has to be a peer for them to be empowering and rights-oriented, but I think it should be run by peers, so peers can select the people who will be rights-based and respectful." A service provider participant agreed and said, "I believe that peer

"People need to have abilities and values like valuing emotions and not feeling like the response is to medicate it away." - Participant

supporters are in the best position to be the 'first on the scene' with other providers, such as clinicians, available to people should they prefer/choose these options." Another service user participant said, "I think having a frontline of mainly peer supporters would be really great, and having a multidisciplinary team that offers different perspectives in a supportive role where the person is given a choice about who they want to interact with."

Additionally, participants suggested that two people should attend each call, in order to support each other but not overwhelm the person in crisis. Participants said that if necessary, such as if a crisis is unfolding in a public place with a large number of bystanders, additional team members could be called in to provide additional support. They also suggested building flexibility into the dispatch system to ensure that the best possible person responds to the person in crisis. For example, a number of participants suggested that a woman who has experienced domestic violence will likely be more comfortable with a female crisis responder, while a teenage boy might be more comfortable with a male crisis responder.

Participants also suggested offering flexibility and options as a way to build comfort and ensure that the teams dispatched resemble the clients and the clients' communities as much as possible. For example, one service provider participant said that if a client is Indigenous, the crisis responder should also be Indigenous, where possible. Additionally, some crises may require a response by a medical professional like a nurse or paramedic, while others will not. Several service user participants suggested that when service users call the service, they should be asked which staff members they would like to have attend (ex. a peer worker, a social worker, a nurse). One service user participant suggested that service users could be asked whether they want the first-available or closest team to respond to them or whether they wish to have a specialized team respond, such as a team with fluency in a particular language or a team comprised only of peer workers. Participants also highlighted the importance of having a diverse group of peer workers with varied lived experiences, particularly experiences of being racialized, of experiencing homelessness, or of using substances.

SUMMARY

Who should staff the new service?

Participants advocated for multi-disciplinary teams including the following workers:

- Peer workers with extensive training in de-escalation
- Family peer workers, who support families of those experiencing mental health challenges
- Mental health clinicians such as therapists and social workers
- Indigenous Elders
- Participants were split on whether mental health nurses should be involved
- Participants noted the importance of equity, and pay equity in particular, amongst all service staff
- Participants commented that everyone on the team should share similar values, such as a recovery-oriented and trauma-informed approach
- Participants suggested that two staff members should attend each call
- Flexibility should be built into dispatch so that the best staff member for each situation can be dispatched (ex. a team that speaks a particular language)
-

KEY THEMES

HOW SHOULD THE SERVICE BE ACCESSIBLE?

The service should be accessible both through 911 dispatch and its own separate three-digit number such as 811.

Our participants suggested that the service be accessible both via phone and via various non-phone-based options. In particular, they suggested that the service be accessible via text or via an app service users can download. One service provider participant suggested that an app with pictures or symbols in addition to words would be helpful, particularly for those with developmental disabilities or low literacy skills, or for whom English is not their first language. Participants also suggested that outreach teams be available in key locations such as encampments so that service users who might not have access to phones can still get assistance when needed. In addition, one service provider participant suggested that the new service could ask business owners to put up stickers in their windows to let people who may not have access to a phone know that if they are in crisis, they can enter that business and staff at that business will contact the service for them.

Our participants generally expressed consensus that the service should be accessible both through 911 dispatch and its own separate three-digit number such as 811. The discussion of whether the service should be integrated into 911 was lively in each of our town halls, with a number of advantages and concerns being raised. The most common view was that 911 is the number most people know to call, so it may not be realistic to expect people to call another number. This service provider participant's comment is the best example of the sentiment that was raised in all of our town halls, "I think the 911 piece will be critical because people are going to call that. They're so familiar with it

and used to it, so that's where people will call." Another service provider participant added,

"If the guy at the corner store has to call for support, they're more likely to call 911 than look for another phone number during a crisis. 911 is accessible. People are aware of it. It would just be on the operator to filter it through a mental health crisis lens if that's what's happening."

Another service provider participant agreed and said, "Personally, if I were in distress and a stranger was going to make a call for me and chose to call 911 because that's all they know, I would want the 911 operator to be able to direct them to the proper response team."

"We want to make sure that not only police attend when people do call 911."
- Participant

Participants consistently stated that "911 is a universal number," and, "Everyone knows 911 is the number to call in an emergency." One service provider participant said, "I'd be worried in a crisis of people not thinking that there's another number we can call." A lawyer participant said, "People are always still going to be calling 911, and we want to make sure that not only police attend when people do call 911." Participants also commented that 911 integration could be beneficial because if the team needs police backup, they will be able to access it much more expeditiously, and that integration would allow dispatch to know if a team has already been dispatched to a given scene rather than dispatching another team. For example, a service provider participant explained that often when crises occur in public places, multiple people are making 911 calls, so even if some bystanders had called the alternative service, 911 dispatchers would not know this without integration and would still send out police to respond. A service provider participant further stated,

"I think it will be very difficult for civilians to distinguish between a medical crisis and a mental health crisis, so 911 makes sense. Hypoglycemia for example can often seem like psychosis, and someone without medical knowledge won't be able to distinguish these things. So you're going to need paramedics on scene anyway for most of these calls if they're high acuity. The other benefit is that all the infrastructure is already set up for 911."

However, participants also raised concerns about 911 integration. The primary concern raised was that police might still be sent to respond to calls that should go to the non-police team. Participants were also concerned about racial bias in risk assessments that might lead dispatchers to unreasonably assess racialized individuals as higher risk than white individuals, leading to disproportionate police response to racialized individuals. Some participants also expressed fear or

discomfort with 911 because of its association with police and the fact that 911 dispatchers are civilian employees of the Toronto Police Service. One service provider participant said, "I think if there is a chance that police will be sent, people will not feel safe using this service, especially people who use drugs, especially people who are marginalized, especially people who have a previous negative history with police." A service user participant said, "911 will need to have a policy that they won't send the police unless the person asks for police."

Participants generally agreed that having the service accessible both through 911 and its own three-digit number would be an ideal compromise that would address many of their concerns. A three-digit number would be simple enough to be memorable in a crisis and would be well-publicized; however, for those who do not know the new number, they will still have access to the service via 911. One family member participant's conclusion was representative of this viewpoint, "It might take time for a new service to be readily known by the community. A lot of promotion and marketing would be needed. It would be better to have the services connected so the calls from 911 could be triaged and redirected to 811." A service user participant said, "If people feel intimidated by calling 911, they can call the other number and know they're getting an alternative to police, so both would be good if possible." Another service user participant added that the best solution would be a "combination of both [911 and another three-digit number]. 911 because everyone calls and because if 911 can't pass them along, too many calls will go to the police. 811 so if you don't want to deal with 911, you can do a shortcut." Another service provider participant said,

"All routes that lead to this kind of team are good routes. There will be some people who pick up the phone [and] 911 is the first thing that comes to mind. For a couple of years, I sat at a table of children's mental health service providers where we were tasked by the province to come up with a central point of access for youth mental health. We were tasked to make sure that all pathways, no matter which door the family walked in, led to the same place. There's already a precedent for having multiple doors that lead [to the same place]. If you have a central point of intake for the service that's fed by 911, 811, community mental health agencies, police radio room operators, that's the best way."

SUMMARY

Our participants suggested that the new service should be accessible via the following methods:

- 911 dispatch, since 911 is the number people are most familiar with
- A separate three-digit number such as 811 or 988
- Text, online chat, and an app

KEY THEMES

AUTISTIC COMMUNITIES

The Reach Out Response Network consulted with Autistics for Autistics Ontario, an Autistic self-advocacy group, and conducted fifteen individual interviews with Autistic service users to hear about their experiences with existing crisis services and what they think a new crisis service should look like. The following are our findings from this engagement work.

Participants' experiences with police

Those of our participants who had had experiences with police while experiencing a crisis described those experiences as "negative," "harmful," "atrocious," and "traumatic." These participants expressed distrust of police due to their perception that police lack knowledge or understanding of how to interact with Autistic individuals. For example, one participant said, "[Police] want to help, [but] they don't understand what it is to have autism. They'd be like, 'Calm down!' You're being ordered [to do] things [when you are] not very coherent or in a very distressed place." Another participant said, "[Police] don't understand your behaviour and think that you are a threat." Other participants described physical or verbal aggression from police, which only escalated their distress. For example, one participant described having a non-violent argument with her ex-partner and being "screamed at," "restrained," and "beaten" by police responders. She further stated that police are "not equipped to deal with" non-violent interpersonal disputes.

Clinical approaches often "don't accommodate for sensory needs" of Autistic service users.

Participants' experiences with hospitals and hospital-adjacent services

Our participants described experiences with hospitals and hospital-adjacent services, particularly when they have been in mental health crisis, as "unhelpful," "invasive," "very rough," "cold and clinical," and "emotionally traumatic." Participants stated that medical staff often lack training in interacting with Autistic service users and may treat Autistic service users unjustly or make incorrect assumptions about their needs and capacity, particularly where Autistic individuals are non-verbal. Participants described experiences of being talked down to and patronized by clinical staff. One participant described experiencing physical restraints in a hospital emergency room, and several others commented that medical staff expected them "to behave" like a neurotypical (non-Autistic) person. Other participants stated that clinical approaches often "don't accommodate for sensory needs" of Autistic service users. One participant said, "For people who are suicidal, apprehending them and throwing them into psych wards or isolation is the absolute worst thing you can do. The objective should be to show someone that life is worth living, not the complete and total opposite."

Fear of police and hospitals makes participants less likely to seek help

Participants frequently commented that the threat of being involuntarily admitted to a hospital or being responded to by police led them not to reach out for help when they were in distress. One participant said, "I was actively suicidal and never told anyone because [of fear of] police and [the] ER." Another participant stated, "One of the things that I've found very anxiety-inducing when having episodes is threats of psychiatric holds. [Psychiatric holds] are just unhelpful in the long run and [don't] actually solve anything, and [it] just makes you less likely to want to seek help." Another participant commented, "The threat of coerced treatment is big...especially as an Autistic person who sometimes says things that get a little bit misinterpreted by people around me, especially when it comes to things like suicide, [that makes me afraid to reach out for help]." Another participant said, "I've had times where I would have really wanted some services and support, but I'm so worried that if I call I'm going to say something that's going to set something off that will make someone say, 'You have to go here and get this treatment.'"

Recommendation: Ensure the service is able to accommodate the needs of Autistic service users

Participants made a number of suggestions to ensure the service is accessible to Autistic service users. Some of these suggestions and comments were:

- Have an Autistic-specific resources list handy, such as a list of organizations or service providers who can provide client-centred and respectful care to Autistic service users
- When making referrals, support Autistic service users with "scripts" that they can use to contact and follow up with the service
- Provide support with executive functioning tasks, for example by providing clear step-by-step instructions and explanations
- Provide written instructions or information where possible

- Do not make assumptions about Autistic service users' capacity; do not assume incompetence, but also recognize the challenges Autistic service users can face when they are in distress
- Provide food and personal care supplies, since a crisis may be escalated when someone is hungry or not having basic needs met
- Recognize that many Autistic individuals are transgender or non-binary; ask Autistic service users for their correct gender pronouns in order to avoid misgendering them

Recommendation: Accommodate non-verbal communication methods

Many Autistic individuals are non-verbal, while others may become non-verbal or find it more difficult to process or use spoken language while in distress or meltdown. As such, our participants recommended that the new crisis service be able to accommodate a number of non-verbal communication methods. In particular, the team should be trained to communicate with augmentative and alternative communication (AAC) users, which are individuals who use non-verbal communication methods such as text or text-to-speech apps on their phones. Participants suggested that the team could provide physical cards with words or pictures to help Autistic service users communicate their needs. They further suggested that the team be able to communicate in writing with service users, such as by supporting an AAC user in accessing their communication tool (such as a phone or iPad) or by providing an iPad, notebook, or other way for service users to type or write out their needs. Participants also recommended that service staff use clear, unambiguous language while communicating with Autistic service users and allow additional time for processing or answering questions.

Recommendation: Reduce sensory overstimulation

Autistic individuals are typically very sensitive to sensory stimulation. Sensory overstimulation can both cause distress and exacerbate existing distress. Therefore the new service will have to take care to reduce sensory stimulation when responding to Autistic service users. For example, our participants stated that the new service will have to avoid using loud or bright sirens when arriving on scene. For some Autistic individuals, bright colours can be a sensory trigger, so the service will need to ensure that its staff are dressed in neutral colours. Physical touch can be triggering and distressing for Autistic service users, so service staff must not restrain service users or touch them without consent. Loud noises and shouting can also be distressing, so staff will need to ensure they are speaking in a quiet, gentle, calm voice at all times. Additionally, our participants commented that crowds can be distressing for Autistic individuals, so service staff will need to remove bystanders from the area where possible or take Autistic service users to a private, low-sensory environment. Several participants further suggested that the service should provide support for Autistic service users in grounding themselves, such as by providing soft objects like pillows. Finally, one participant noted that the new service will have to ensure that its website is accessible to Autistic individuals, such as by limiting bright colours and creating accessible formatting, particularly to accommodate the use of screen readers.

Recommendation: Provide calmness, stability, and predictability

Many Autistic individuals experience distress with unpredictable situations or abrupt changes to routines. Our participants recommended that the new service provide as much information to Autistic service users as possible to reduce this anxiety and distress. For example, one participant suggested that service staff should "[in a] calm voice, explain what's going to happen and what the options are, and stick to that." Participants also recommended that service staff take their time with Autistic service users and make sure they are explaining everything clearly, rather than rushing the process. Several participants suggested that it could be valuable for Autistic service users to know at the time of calling the service who will be dispatched; for example, the dispatcher could provide the name of the person/people being sent to help, or if the dispatcher could describe what the person/people look like and what they are wearing so the service user knows who to expect. Another participant recommended that clear, detailed, step-by-step information be available on the service's website, explaining exactly what happens when a person calls the service and what service users can expect.

Participants also suggested that staff not wear uniforms, particularly uniforms that might look similar to police or hospital staff, as these uniforms might be triggering and escalating. Participants stated that the team should focus on "creating and holding physical and emotional space" for the person in crisis and should not engage in physical interventions without consent. Additionally, participants commented that the team should support service users in remaining calm and grounded, such as by providing comfort items or doing breathing exercises.
Recommendation: Provide respectful, flexible, individualized, and client-centered care

Our participants noted that the service will need to be flexible to be able to meet the varied needs of Autistic service users. Participants commented on the importance of active listening, empathy, clear and patient communication, giving service users time to respond to questions rather than making service users feel "interrogated," offering options, being able to sit with service users' strong emotions, having a sense of humour, and treating service users "as individuals" rather than "as numbers." Participants also suggested that service users should be able to request the gender of the crisis responder.

Recommendation: Protect service users' privacy

Participants emphasized the importance of protecting service users' privacy. They made a number of recommendations for how this could be ensured:

- Service users should not have to provide an OHIP card or other identification to receive service
- Identifying information should only be collected with consent
- Service users should have an option to use a pseudonym if they wish
- Crisis responders should be in plain clothes, rather than in uniforms or wearing obvious markers such as neon vests
- Crisis responders should move service users away from others and find a quiet, private place to speak
- Crisis responders should only contact or speak to a service

user's family members with consent

Recommendation: Ensure informed consent is given by service users in every interaction

Participants noted the importance of informed consent. They recommended that information should never be shared with others without a service user's consent and that service staff should provide detailed information about each step of the process and ensure a service user's consent is given for each step. Participants further emphasized the importance of providing non-verbal methods of communicating consent, such as using physical cards or written communication. Additionally, participants stated that service users' wishes not to have police involved must be respected, unless a crime is being committed or danger is posed to others. One participant commented, "From what I understand of 911, even if you call for non-police, police are still sent. [You will need to make] sure that if this [team] is accessible through 911, that [police will not be dispatched without a service user's consent]."

Recommendation: Ensure staff are knowledgeable about autism

Our participants emphasized that staff must be knowledgeable about autism and how to provide support to Autistic service users. Specifically, they identified that staff must be knowledgeable about "meltdowns," which are "extreme stress responses that cause the person experiencing a meltdown to lose control of their mental and physical faculties." Meltdowns may involve verbal or physical signs of distress, such as repeating the same words over and over, screaming, shaking, heavy breathing, jerky movements, rocking, or self-harm. Meltdowns may also include a loss of speech or ability to communicate verbally or efforts to reduce stimulation like covering eyes or ears. When a person is experiencing a meltdown, staff will need to be calm and patient in responding to the person and may need to provide non-verbal communication methods and assist the person in reducing sensory stimulation. Staff must also recognize that meltdowns are not a service user's "fault" and that a service user is not in control of their behaviour.

Additionally, our participants identified "stimming" as another aspect of Autistic experience staff will need to be familiar with. "Stimming" refers to "self-stimulating behaviours" such as repetitive movements or sounds. Stimming might involve arm flapping, rocking back and forth, pacing, or repeating words or phrases. Service staff will need to be able to recognize stimming and that stimming is not harmful, dangerous, scary, or a sign of escalation. In fact, stimming is an Autistic person's way of self-soothing and managing distress. Therefore insisting that an Autistic person stop stimming behaviours will likely escalate the situation. Service staff must be familiar with Autistic service users' body language and not try to punish or control these differences in body language.

Participants further noted that training about Autistic service users and common behaviours should come from Autistic people themselves, rather than from autism service providers, since many autism service providers use outdated methods that Autistic individuals have found harmful. Participants suggested that Autistic-led self-advocacy groups, such as Autistics for Autistics On-

Staff must be knowledgeable about autism and how to provide support to Autistic service users.

tario, can provide training to teams in communicating with non-speaking people and those who have unreliable speech, including the basics of AAC.

Recommendation: Incorporate Autistic peers onto the team

Participants suggested that well-trained Autistic peer workers should be incorporated onto the team. Participants identified the importance of staff understanding "Autistic realities" through their own lived experience. For example, one participant said, "No one can understand Autistics like Autistics. Especially in those types of crisis situations, it's easier to have someone who understands the difference between a meltdown and a psychiatric breakdown."

Recommendation: Partner and build credibility with Autistic self-advocacy groups

Participants suggested that the new service should partner and build credibility with Autistic self-advocacy groups in order to ensure knowledge and trust of the service among Autistic communities. Participants emphasized the importance of partnering with groups run by and for Autistic people rather than partnering with groups like Autism Speaks that mainly represent traditional service providers and are focussed on "treating" or "curing" autism. Participants specifically identified the Autistic Self Advocacy Network, the Autistic Non-Binary Network, and Autistics for Autistics as organizations to partner with in order to build trust and credibility. Participants also mentioned that word-of-mouth reputation of the service being Autistic-friendly and neurodiverse in its staffing would be helpful.

Which calls should the service respond to?

Participants suggested that the new crisis service could respond to mental health crises, suicidality, flashbacks, panic attacks, and homeless people experiencing a crisis. Participants also suggested the team could carry out death notifications. Participants emphasized that the team could be particularly helpful for Autistic individuals experiencing "meltdowns" due to overstimulation or anxiety. Typical police responses such as giving verbal instructions or using physical interventions will often exacerbate a meltdown and make it much worse. Having the new service respond to meltdowns will be much more effective and supportive.

Who should staff the service?

Participants stated that the team should be staffed by a combination of peer workers, mental health workers such as counsellors and social workers, and medical professionals such as nurses and paramedics. One participant also mentioned that service dogs can be particularly helpful for Autistic individuals, and that at least some staff on the team should have training in handling service dogs. Participants noted that staff should be representative of the racial, ethnic, sexual orientation, and gender diversity of Toronto. Participants further noted that staff should be trained in mental health, de-escalation, understanding autism, and trauma therapy. Finally, participants commented that any staff members who have provided Applied Behavioural Analysis (ABA) to Autistic service users should be "automatically excluded" from the team, because many Autistic service users have experienced harm from ABA therapy or methods.

How should the service be accessible?

Participants suggested that the service be accessible both through 911 and its own separate number, as well as through non-verbal methods such as text or online chat, since many Autistic individuals have auditory processing issues or other difficulties in using the telephone to communicate.

SUMMARY

Autistic communities

The following recommendations emerged from our engagement with Autistic communities:

- Ensure the service is able to accommodate the needs of Autistic service users
- Accommodate non-verbal communication methods
- Reduce sensory overstimulation
- Provide calmness, stability, and predictability
- Provide respectful, flexible, individualized, and client-centered care
- Protect service users' privacy
- Ensure informed consent is given by service users in every interaction
- Ensure staff are knowledgeable about autism
- Incorporate Autistic peers onto the team
- Partner and build credibility with Autistic self-advocacy groups
- The service should respond to Autistic individuals experiencing meltdowns, mental health crises, suicidality, flashbacks, panic attacks, and homeless people experiencing a crisis
- The service should be staffed by peer workers, mental health workers such as counsellors and social workers, and medical professionals such as nurses and paramedics
- The service should be accessible via both 911 and its own separate number, as well as through non-verbal methods such as text or online chat
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KEY THEMES

DEAF COMMUNITIES

Participants frequently commented that they struggled to communicate with police officers while in crisis.

The Reach Out Response Network conducted a survey and a focus group with Deaf Toronto residents, in partnership with the Bob Rumball Centre of Excellence for the Deaf. The following are our findings from this engagement work.

Participants' experiences with police

We asked participants whether they had ever been in crisis and received a response from police. For those who said yes, we asked them how police response had made them feel. Participants said they felt "powerless," "nervous," "very sick," "helpless," "uncomfortable," "scared," "sad," "panic," "degraded," "blamed," "embarrassed," and "bad about myself."

Participants frequently commented that they struggled to communicate with police officers while in crisis. The following comments are representative of this theme:

- "I didn't know how to make them understand."
- "We had some difficulty in communicating and they had a hard time understanding me."
- "The police couldn't understand my tone."
- "I was misunderstood. The officers arrived, but [there was] no sign of using ASL [American Sign Language]."
- "Because [the police officer] could not use sign language, we had some difficulties in communication. We could only communicate through some body language and handwritten words."
- "There is no communication. The whole process is just guessing."

Participants further expressed frustration with the response they had received from police. For example, one participant said, "Police don't understand the needs of Deaf people." Another participant stated that the police officers who responded to her crisis had had "no patience." Participants commented that police sometimes chose "to listen to and side with the hearing person," rather than taking them as Deaf people seriously. Participants' comments also suggested stigma and stereotypes getting in the way of effective police response to their crises. For example, one participant said, "[Police] think I'm dumb, so they don't respect me." Another participant said of police response to her crisis, "I had no clue what was going on. [I was] treated like I was a leper."

Recommendation: Incorporate Deaf staff into all aspects of the new service

Participants emphatically stated that Deaf communities ought to be heavily involved in the design process as well as the internal and frontline operations of the new service. One participant said that such involvement was essential in order for her to feel "confident that [the service has] appropriate cultural knowledge/background, which only happens when dealing with Deaf staff and never happens with hearing staff." Another participant said, "You [should] have Deaf people on your Board and in positions with power of decision-making. Have Deaf frontline staff. Don't assign [supporting Deaf service users] to hearing people. Adhere to the idea of 'nothing about us without us.'" Another participant cautioned us against "letting hearing people decide what's best for Deaf people" and advocated for involving Deaf people in leadership and frontline service provision.

Recommendation: Frontline staff responding to Deaf service users should be able to sign fluently

Participants told us that even if frontline staff are not Deaf themselves, they must be able to sign fluently. Participants expressed frustration with relay interpreting services, both because of the time delay to reach the relay service and because of poor-quality service. For example, one participant said, "As a Deaf person, we often have to reach out through a relay service. They put you on hold, before you finally get the right person. That adds a delay. It would be better to be able to get direct service [from staff members] who are fluent in ASL." While having an ASL interpreter accompany non-signing staff could also be effective, participants said that this option was not ideal due to potential role confusion between interpreters and counselling staff when responding to mental health crisis. One participant noted, "Interpreters are interpreters [and] staff are staff. It can get messy when interpreters are involved with a mental health crisis." Another participant agreed and said, "Interpreters are not helpers. That's not what they do. If a person is in a mental health crisis, the interpreter wouldn't know what to do around providing support." If the only person communicating directly with the person via sign language (the interpreter) is not able to provide mental health support and the person who is able to provide mental health support is not able to communicate directly with the person in crisis, this can become challenging and complex. Having mental health workers fluent in ASL responding to Deaf service users will avoid this difficulty. The service may wish to create a dedicated unit of staff to respond to crisis calls from Deaf service users, to ensure that signing staff members are available to respond to these calls.

Participants expressed frustration with relay interpreting services because of the time delay and because of poor-quality service.

Recommendation: If interpreters are used, ensure the availability of both an ASL interpreter and a Deaf interpreter

Participants suggested that if interpreters must be used, Deaf individuals should be able to request that both an ASL interpreter and a Deaf interpreter be present at calls for service. An ASL interpreter is an interpreter who can translate spoken English into ASL, while a Deaf interpreter is a Deaf person with extensive training and understanding of the nuances of Deaf culture and communication. When ASL interpreters work with Deaf interpreters, ASL interpreters translate spoken English into sign language to the Deaf interpreter, who then further translates the message to be linguistically and culturally accessible to the Deaf service user. Deaf interpreters may be particularly helpful for Deaf service users with mental health or cognitive challenges or when the information being conveyed is particularly sensitive or complex. Participants stated that Deaf interpreters are necessary to promote optimal communication in crisis situations, particularly where emotions may be heightened and communication may be fragmented as a result.

However, as Deaf communities are small and often Deaf community members know one another, the service must protect the privacy of Deaf service users by ensuring to the best of its ability that Deaf interpreters do not respond to service users they know personally. This concern may be somewhat mitigated by providing Deaf service users with the option of whether or not to have a Deaf interpreter respond.

Recommendation: All frontline staff should be trained in basic sign language

Participants suggested that even if not all frontline staff are fluent in sign language, all staff should be trained in basic signs so that they can reassure a Deaf person and let them know that interpreters will be attending soon. One participant said, “Having a crisis worker who can sign even a little bit can make a huge difference. Just being able to say, ‘Hello, I don’t sign very much, but I’m here for you,’ can be so helpful.”

Recommendation: Staff must be knowledgeable about Deaf mental health and culture

Participants noted that mental health challenges can impact Deaf individuals differently than hearing individuals and can also look different in Deaf individuals. One participant said, “At least someone on the team has to know what mental health looks like for Deaf people. It’s not the same as for the general population. You have to think in the specific community, what does mental health present as?” Deaf individuals also have unique needs and face unique barriers in accessing mental health care, and teams must be familiar with these experiences and how to support Deaf service users. Finally, participants commented that if interpreters are used, they must be particularly familiar with Deaf mental health in order to understand the nuances in communication for a Deaf person in crisis.

Participants also noted the importance of hearing staff, particularly those who might be first on scene responding to a Deaf person in crisis, understanding cultural differences in communication with Deaf communities. For example, one

participant commented that hearing people sometimes can misinterpret Deaf individuals' expressiveness as "anger" or "threat," because they are unfamiliar with the nuances of ASL communication and the expressiveness that is part of ASL. Participants raised concerns that these kinds of misunderstandings could lead to police being inappropriately dispatched to respond to Deaf people who are mis-perceived as angry or threatening.

Recommendation: Ensure that service users are able to communicate in their native sign language

Participants noted that not all Deaf individuals are fluent in ASL and may communicate in other sign languages such as Quebec Sign Language (LSQ). Service users must have access to staff who are fluent in other sign languages when ASL is not their first language.

Recommendation: Service staff must respect and accommodate Deaf service users' communication preferences

Participants commented that service staff will need to be flexible to accommodate Deaf service users' communication preferences. For example, even when Deaf individuals are able to speak, they may prefer to communicate using sign language, particularly during times of crisis. The new service must accommodate this preference rather than insisting that Deaf individuals communicate via spoken English. Service staff must understand the heightened risk of misunderstandings and resulting escalation when Deaf individuals are forced to use uncomfortable or inaccessible communication methods, particularly in crisis situations.

Additionally, participants noted that service staff will need to be mindful of not obstructing communication with Deaf service users. For example, one participant stated, "I'm Deaf and read lips. [Service staff] should find out if I have my hearing aids on and working. [They should] speak so I can see [their mouths], allow processing time, and check in to confirm my comprehension." Other participants suggested that staff should not cover their mouths, mumble, or speak while standing behind a Deaf person, as these actions may prevent Deaf individuals who lip-read from understanding. Staff should also not yell or speak at an excessively loud volume with a Deaf service user.

Recommendation: The service must provide accessible referrals to Deaf service users

Participants noted that many mental health or substance use agencies are insufficiently accessible for Deaf service users. As such, service staff will need to be knowledgeable about which organizations are able to effectively support Deaf service users in order to ensure they are providing useful referrals. Additionally, participants suggested that the new crisis service could provide outreach and information to existing mental health and substance use organizations about how to effectively serve Deaf service users. Participants also suggested that interpreters or service staff who use sign language should accompany Deaf service users to hospitals, shelters, or crisis beds to provide a warm handoff to another interpreter or signing staff member, rather than simply leaving a Deaf person alone in a hospital emergency room or other setting.

Signing staff members or interpreters from the crisis service should stay with the Deaf service user until another signing staff member or interpreter arrives and may need to provide advocacy and education to staff members at the receiving service on how to accommodate Deaf service users' needs. For example, staff at the receiving service may not know how to contact an ASL interpreter and may need information on how to do this. They may also need education on why ASL interpretation is necessary and why they cannot simply communicate in writing with a Deaf service user. Staff members of the new crisis service must be knowledgeable about the Accessibility for Ontarians with Disabilities Act and be able to effectively advocate for service users' rights while coordinating services and referrals.

Recommendation: The service should partner with Deaf-specific organizations to provide care to Deaf service users

Participants suggested that the new service form partnership with agencies such as the Canadian Hearing Society, Silent Voice Canada, the Bob Rumball Centre of Excellence for the Deaf, PAH, and other organizations that serve Deaf communities. They suggested that with service users' consent, it could be valuable to share information between these agencies and the new crisis service to determine in advance of a crisis how to best support a given service user. One participant said, "I would feel better if staff knew of my mental health history," and that this could be accomplished via consensual information-sharing. Participants also commented that the new service could build trust with Deaf service users by doing community outreach at Deaf-specific services. They further suggested that the new service be able to refer Deaf service users to local Deaf clubs, associations, or seniors groups in order to combat social isolation, since many Deaf individuals experience social isolation and loneliness that heightens the likelihood of crisis.

Recommendation: The service should provide support with navigating employment and social benefit systems

Participants noted that many Deaf individuals struggle with employment and may also struggle with navigating social benefit systems such as the Ontario Disability Support Program (ODSP). They suggested that the new service either be able to provide support in these areas or be able to provide referrals to agencies that can support Deaf service users in these areas.

Recommendation: The service should provide client-centered, respectful, and non-coercive care

Participants emphatically stated that the new service must be client-centered, respectful, and non-coercive. Participants noted that service staff must communicate directly with the Deaf service user rather than looking to hearing people "in hopes that they would answer for" the Deaf service user. Participants stated that service staff must not be "forceful" or "pushy," or "shout at" or "try to control" the Deaf service user. Participants also stated that service staff should not "tell [them] what to do" or force them "into something [they are] not comfortable with." Participants said that staff must be "compassionate," "empathetic," "supportive," "reassuring," "calm," and "caring," and that "respect for the person who needs help is key!"

The new service must be client-centered, respectful, and non-coercive.

Additional suggestions and comments

- "[I would like a team that can] take me somewhere else for 1-2 days to adjust and return home in a better state of mind, and function properly."
- "[I would like to] have someone to talk to and help."
- "[I would feel comfortable] if the [staff member] was a woman."
- "Having a friend or family member with me [would be helpful]."
- "Honestly, just a talk, a few days off from school and a calm meal [would be helpful]."
- "[There should be] one other person in the room only. Too many people makes it hard to breathe."
- "[It isn't helpful to have] a bunch of people trying to make me talk about what I'm feeling. I don't want to just say how I'm feeling. Maybe chat a little first, let me tell you what's wrong and how my day went. I'd want the person helping me to be able to identify how I'm feeling through my actions. I wouldn't want to say how I was feeling because I don't know how I'm feeling."
- "Sometimes when people see police, things escalate very quickly and people get angry"

Which calls should the service respond to?

Participants suggested that the new service could respond to family conflicts, domestic violence, roommate conflicts, teenagers or youth in crisis, suicide calls, self-harm, and mental health calls.

How should the service be accessible?

Participants stated that the new service should be accessible via multiple avenues. They suggested that the new service should be accessible via text, although one participant noted that some Deaf service users are not fluent in English and may only be fluent in ASL or another sign language, which can make texting a barrier. Participants commented that the new service could have its own number to text, or it could be accessible via T-911, which is a service Deaf individuals can pre-register for that allows them to text 911. Participants also suggested that the service could be accessible via video relay or via an app. One participant suggested that an app could allow participants to store personal information, such as what would be helpful for them during a crisis or what their triggers are. Then when the person is in crisis and reaches out for help, the service would already have information via the app about how to help the person. This participant commented that such an app would be beneficial because it can be hard for people to explain exactly what's going on and what they need during a moment of crisis.

SUMMARY

Deaf communities

The following recommendations emerged from our engagement with Deaf communities:

- Incorporate Deaf staff into all aspects of the new service
- Frontline staff responding to Deaf service users should be able to sign fluently
- If interpreters are used, ensure the availability of both an ASL interpreter and a Deaf interpreter
- All frontline staff should be trained in basic sign language
- Staff must be knowledgeable about Deaf mental health and culture
- Ensure that service users are able to communicate in their native sign language
- Service staff must respect and accommodate Deaf service users' communication preferences
- The service must provide accessible referrals to Deaf service users
- The service should partner with Deaf-specific organizations to provide care to Deaf service users
- The service should provide support with navigating employment and social benefit systems
- The service should provide client-centered, respectful, and non-coercive care
- The service should respond to family conflicts, domestic violence, roommate conflicts, teenagers or youth in crisis, suicide calls, self-harm, and mental health calls
- The service should be accessible via text, T-911, and an app

KEY THEMES

DEVELOPMENTALLY DISABLED COMMUNITIES

The Reach Out Response Network conducted a focus group with individuals with developmental disabilities to hear about their experiences with existing crisis services and what they think a new crisis service should look like. Seventeen individuals attended the focus group. The following are our findings from this engagement work.

Participants' experiences with police and emergency services

Those of our participants who had had experiences with police and/or traditional emergency services such as paramedics and hospitals described communication challenges with these emergency responders, due primarily to the responders' lack of understanding of neurodivergent behaviours and modes of communication. For example, one Autistic participant noted that her literal and blunt responses to questions have caused challenges with hospital and other medical staff. Another participant said, "Neurodivergent people understand each other, but we aren't always understood by people in authority, so we get accused of being obstinate or not deferent enough. Almost anything we do gets misinterpreted on a regular basis." Another participant added, "There isn't enough awareness or training on how neurodivergent people in crisis might react differently than expected." Participants described incidents in which "disabled people were subjected to violence [by authorities] just because we weren't acting the way people in authority expected us to act." Participants also noted that because police and emergency responders often lack awareness of behaviours typical of those with developmental or cognitive disabilities, these behaviours can be misinterpreted as potential indicators of violence or risk. Stimming (described above in the "Autistic communities" section), pacing, and flat affect were noted as behaviours that may lead police or emergency responders to assume risk where none exists, since these behaviours are typical

for individuals with disabilities. One participant added, “There’s often an assumption that someone is going to become violent because they’re becoming emotional.” The assumption that someone might become violent may lead to restraint use or other pre-emptive physical interventions, thereby further escalating the person in crisis.

Several participants described experiences in which police or emergency responders misinterpreted their behaviours and assumed that behaviours indicative of a disability were in fact indicative of substance use. One participant explained that police officers had mischaracterized an anxiety attack as substance use and said, “Even now, when I talk to police, they still reference that and think I used to do drugs, which is not true.” Another participant described paramedics assuming she was “on drugs” due to her flat affect. She explained that the paramedics were unable to support her “because they weren’t asking questions beyond which drugs I had taken, and I wasn’t taking any drugs.” This participant was not provided with the medical care she needed due to the assumptions made by the paramedics.

These experiences with emergency services make individuals with developmental disabilities less likely to reach out for help in a crisis. One participant said, “You call an ambulance and you get the cops. It’s scary. You can’t reach out for help because you don’t know if you’re going to get help.” Another participant said, “I’m scared that the police will come and treat me [badly]. When I was in a domestic situation last year, I was afraid to call the police because I didn’t know what I was going to get when they came.”

Recommendation: Train service staff to understand differences in communication that may stem from cognitive or developmental disabilities

Participants highlighted that service staff will need to be extensively trained in recognizing signs of cognitive or developmental disabilities and communicating with individuals with these disabilities. Such training will reduce the risks associated with misinterpretation. Additionally, participants underscored the importance of listening non-judgmentally and without making assumptions to what service users are saying. For example, one participant said it would be important for staff to “listen to the things I [am] saying rather than the way I [am] delivering [them].” Another participant suggested staff should “take things a little bit slower and [make] sure the responder confirms their understanding of the situation with the person,” and give the person a chance to correct any misconceptions.

Recommendation: The new service should provide flexible, client-centred, and individualized care

Participants emphasized the need for flexible, client-centred care. They described the importance of understanding and accommodating service user’s unique needs and their particular disabilities. For example, one participant suggested that the team might offer food to some service users but should not offer food to a person with Prader-Willi Syndrome, as Prader-Willi Syndrome is a condition characterized by insatiable hunger and continually feeding a person with Prader-Willi Syndrome is detrimental. This comment highlighted the importance of service staff being knowledgeable

about various conditions and adjusting their approach accordingly. Participants also suggested that the service should accommodate varied communication needs, including written communication, sign language, and AAC (described above in the "Autistic communities" section). Additionally, participants noted that the service should be able to provide a variety of referrals to meet individuals' needs.

One participant said, "Support needs to be offered in a way that feels good to the person it's being offered to." Similarly, another participant said it's important to "make sure the person feels comfortable with the [responder]. It's like building a bridge, one step at a time." Participants noted the importance of responders taking time to understand and empathize with service users, as well as the importance of offering concrete tools such as grounding techniques and distress tolerance skills. Finally, participants highlighted the importance of service staff respecting service users' independence. Rather than making decisions for individuals with disabilities or doing tasks for them, participants suggested that service staff should demonstrate how to do these tasks and support people with disabilities in carrying out these tasks themselves.

Recommendation: The new service should provide support and psychoeducation to families

Participants noted that families of individuals with disabilities often require support and education to help them effectively support their loved one. Participants suggested that teams provide written resources to help families better understand their loved one's challenging behaviours and how to best support them. They further suggested that teams could help families navigate and understand the landscape of services available for individuals with disabilities. For example, one participant explained that parents with Autistic children are often directed towards Applied Behavioural Analysis as the only option for their children; however, ABA can be harmful to Autistic children and may not effectively meet their needs. This participant suggested that teams might be able to provide information to parents about what other resources and therapies exist and how they can access those services for their children.

Recommendation: The new service should build trust through community outreach

Participants indicated that they would feel safer accessing the new service if it was connected to or recommended by a service or agency they already trusted. They further stated that they would feel more comfortable contacting the service if they knew what to expect. Participants therefore suggested that the new service should partner with existing community agencies to provide outreach and information and build trust with community members.

Which calls should the service respond to?

Participants suggested that the new service should respond to wellness checks, mental health calls, domestic calls, and calls related to children or individuals with disabilities wandering or eloping. Wandering and eloping are very common amongst individuals with disabilities, and police are often called to respond to these behaviours and locate the individual. These calls are generally not dangerous or risky, but simply involve finding a person who has wandered off and communicating effectively with them to return them to a safe location.

Who should staff the service?

Participants most frequently identified peer support workers and social workers as the most appropriate professionals to staff the new service. One participant noted the importance of "neurodivergent peer responders [being] involved in calls. Nothing about us without us." Many participants described having positive experiences with social workers and noted that some programming can only be accessed by referral from social workers. Additionally, participants stated that staff on the team must be "good with people," "patient," "empathetic," and "understanding [of] intersectional issues like race, religion, gender identity, and sexuality."

SUMMARY

Developmentally disabled communities

The following recommendations emerged from our engagement with developmentally disabled communities:

- Train service staff to understand differences in communication that may stem from cognitive or developmental disabilities
- The new service should provide flexible, client-centred, and individualized care
- The new service should provide support and psychoeducation to families
- The new service should build trust through community outreach
- The new service should respond to wellness checks, mental health calls, domestic calls, and calls related to children or individuals with disabilities wandering or eloping
- The new service should be staffed by peer workers, including neurodivergent peer workers, and social worker

KEY THEMES

HIGH SCHOOL STUDENTS

The Reach Out Response Network conducted twenty individual interviews with high school students to hear about their experiences with existing crisis services and what they think a new crisis service should look like. The following are our findings from this engagement work.

Participants' experiences with police

A small number of our participants had experienced or witnessed police response to a mental health crisis. These participants described feeling "unsafe," "uncomfortable," and a "lack of control" with police response to the crisis. They further commented on their perception that police lack training in responding to mental health crisis. One participant stated, "Police provide more muscle than support." Another participant described a situation in which his supervisor at work had called 911 to support a client who had attempted suicide and said, "When the police got there it was like the whole vibe changed from, 'I'm trying to support you,' to 'You're in trouble.'"

Participants' experiences with other services

The primary service our participants knew about and reached out to when in crisis was Kids Help Phone, which is a telephone-based counselling service for youth. However, participants noted that Kids Help Phone frequently has long wait times, which has sometimes led them to hang up while waiting on hold. Approximately half of our participants mentioned reaching out to therapists, social workers, or

guidance counsellors when in crisis or distress, and the majority had had positive experiences with these professionals, primarily because those professionals had built trust with them and listened supportively to them. However, several participants commented that they had had negative experiences with hospitals or ambulances. For example, one participant had attended a hospital emergency room while in crisis and described this experience as "traumatic and scary." Several participants also stated that they had not reached out for help when in crisis, due to stigma around accessing services, a lack of knowledge of what services were available, concerns about their parents being notified, or fear of police or hospital involvement.

Recommendation: The new service should engage in outreach and trust-building with youth

Our participants frequently commented that they would feel more comfortable with familiar and trusted staff members than with strangers. Therefore, the new service ought to engage in outreach to build trust with students. Participants stated that they have learned about mental health services primarily from school, so it would be beneficial for the new service to do this trust-building outreach in partnership with schools. Participants said that awareness-building should start at a young age and therefore that outreach should occur in elementary and middle schools in particular. Participants also suggested that the new service engage in a campaign to challenge mental health stigma, since stigma is a primary reason why many young people do not reach out for help. They noted the importance of advertising and public education campaigns depicting diverse communities to ensure that individuals see themselves represented in the service and feel comfortable accessing it.

Recommendation: The new service should strongly protect service users' privacy

Participants stated that they would feel most comfortable using the new service if they had the option to remain anonymous or use a pseudonym. They further commented on the importance of confidentiality, informed consent, and collecting only information that is necessary to provide the service. Participants also said that their interactions with the service should not be audio-recorded or video-recorded.

Recommendation: Parents or families should only be involved with the service user's consent

Some of our participants indicated that they would like support and involvement of their parents when in crisis, while others indicated that they would not want their parents to be involved. Several participants said that they had hesitated to reach out for help in the past because of fear of their parents being notified. Most participants agreed that information should only be shared with parents with the service user's consent, similarly to other counselling or health care services for teenagers. Sharing information with parents without the service user's consent will likely deter teenagers from accessing the service.

Who should staff the service?

Our participants suggested that the service be staffed by a mixture of peer workers and clinicians such as social workers, nurses, paramedics, and therapists. Participants were particularly positive about the inclusion of peer workers on the team and underscored the depth of understanding that peers have of a service user's experience. One participant said, "It would be pretty helpful and comforting to have someone who's been through it talk to you. I'd feel way more safe." Participants also noted the importance of peer workers being demographically similar to the individuals they serve. Two participants noted that they would feel more comfortable with younger peer support workers rather than older ones.

Social workers and therapists were the most frequently mentioned preferred clinical staff members. Participants indicated a high degree of trust in these professionals, while participants were more divided in their opinions on nurses and paramedics. One participant described nurses and paramedics as scary, while several others emphasized the importance of having medically trained staff on the team.

Participants also stated that team members must be diverse and representative of the communities they serve. They suggested that the response team should not be in full uniforms, but should be in plainclothes or subtle uniforms. They further suggested that teams should not be too large, and that two staff members on a team is likely an ideal number.

Social workers and therapists were the most frequently mentioned preferred clinical staff members.

SUMMARY

High school students

The following recommendations emerged from our engagement with high school students:

- The new service should engage in outreach and trust-building with youth
- The new service should strongly protect service users' privacy
- Parents or families should only be involved with the service user's consent
- The service should be staffed by a combination of peer workers and clinicians
-

PROPOSED MODEL

RECOMMENDATIONS AND PROPOSED MODEL

Based on our community consultations and the feedback received, we have developed a service model that will best serve the needs of Torontonians experiencing a mental health crisis. Where relevant, we also draw upon practices of thirty-three existing mobile crisis teams that we have identified from our research. The details of our proposed model are described below.

Our proposal

We propose creating crisis teams staffed jointly by peer support workers (mental health experts with lived experience of their own mental health challenges and extensive training in crisis support), mental health clinicians such as social workers and psychotherapists, and medical professionals such as EMTs and nurses. These teams will be integrated into municipal services and accessible both through the 911 dispatch system and through their own independent three-digit number, such as 811. The teams will be operated either directly by the city of Toronto or by a partnership between the city of Toronto and a number of non-profit agencies across the city who could be contracted to run the service in their respective areas. The teams will operate 24/7 across the city and will be staffed by individuals

The new crisis teams will be the first responders to the majority of mental health crises throughout Toronto.

from the communities they serve. Teams will be demographically and linguistically representative of the parts of the city they work in. Teams will not independently attend calls involving violence or imminent risk of bodily harm to others, such as calls involving guns or other dangerous weapons.

The new crisis teams will be first responders to the majority of mental health crises throughout Toronto. Toronto's current police-partnered MCITs are only able to respond to between 20-25% of all non-violent mental health calls across the city, due to lack of capacity and the prohibitive costs associated with expanding that capacity. Toronto MCITs are primarily secondary responders to mental health crises, meaning that they are not dispatched directly by 911 dispatchers and cannot be requested by individual callers. Instead, Primary Response Unit officers must arrive on the scene first to ensure that the scene is safe for the MCIT to attend. The secondary response model makes Toronto MCITs more expensive than MCITs that use a co-response police-partnered model, such as Hamilton's MCRRT teams, or hybrid-style teams such as Eugene, Oregon's CAHOOTS service. Using a secondary response model also reduces the benefits of having mental health workers as the initial contact with a person in crisis.

We propose that our new crisis response teams, at least initially, will operate as a complement to Toronto's MCITs, such that 911 dispatchers will send the MCITs to respond to the 25% highest-acuity mental health crises, while the 75% lowest-acuity mental health crises will be routed to the new crisis teams. The City of Toronto will receive a strong cost benefit from instituting this model. Due to the hybrid-style response model, these teams will be less expensive for Toronto than extensive MCIT expansion would be, and both teams operating in tandem could successfully respond to the 30,000 mental health calls received by 911 each year, while maintaining public safety and allocating the most appropriate resource to match the needs of individuals in crisis. 911 operators will receive extensive training in identifying which calls should be routed to the new teams and which calls should go to the MCITs. Eugene, Oregon's CAHOOTS team has developed detailed protocols and training for Eugene's 911 dispatchers, and we will use this training as a base for training our own 911 staff. Toronto may also consider an embedded clinician model, discussed below, in which mental health clinicians are embedded into the 911 dispatch centre and empowered to directly dispatch the new crisis teams.

PROPOSED MODEL

WHAT SERVICES WILL THE NEW CRISIS TEAMS PROVIDE?

The new crisis teams will provide de-escalation, risk assessments, safety planning, and on-the-spot mental health support to clients experiencing suicidal ideation or mental health challenges.

The new crisis teams will provide de-escalation, risk assessments, safety planning, and on-the-spot mental health support to clients experiencing suicidal ideation or mental health challenges. The teams will also do street outreach to the homeless population and will provide referrals and service navigation assistance to clients. The teams may also provide medication management and basic medical care. These services will effectively divert clients from unnecessary use of hospital emergency rooms and interactions with the criminal justice system.

All of the mobile crisis teams in our sample provide mental health support, with some teams such as Stockholm's Mental Health Ambulance focussing specifically on suicide calls. Some teams, such as those in Eugene, Denver, Portland, Oakland, and Olympia, also do street outreach, while other teams, such as those in New York City, Stockholm, Atlanta, and Waterloo-Wellington focus exclusively on providing mental health support. Additionally, teams that include nurses as frontline staff often provide medication support and basic medical care, while other teams that include only social workers, counsellors, or peer support workers do not offer medication support.

Eugene's CAHOOTS team does a number of other tasks beyond mental health support and street outreach. For example, CAHOOTS has replaced the police department in doing death notifications, and CAHOOTS responds to all welfare checks and intoxicated person calls across the city. Similarly, Albuquerque's new Community Safety Department responds to mental health calls as well as other non-criminal city issues such as abandoned cars or malfunctioning traffic lights. Toronto residents consistently noted in our town halls, surveys, and focus groups their desire for these teams to have a broad scope and to respond to a greater number of emergency calls. We hope that over time as the new crisis service demonstrates its effectiveness, its scope may be modified to include a broader range of tasks that may be suited to their skillsets.

PROPOSED MODEL

WHO WILL STAFF THE NEW CRISIS TEAMS?

Throughout out consultations, Toronto residents consistently communicated a desire for a multi-disciplinary team.

Various models exist for staffing hybrid-style mobile crisis teams. Many of these teams, including Eugene's CAHOOTS teams, Oakland's MACRO teams, Portland's Street Response teams, Denver's STAR teams, and Houston's CIRT+ teams staff their teams with Emergency Medical Technicians or paramedics along with mental health workers. For the mental health component, some teams, such as Stockholm's Mental Health Ambulance, Toronto's MCITs, Vancouver's Car 87, and Hamilton's COAST and MCRRT teams staff their teams with mental health nurses. Other teams, such as NYC Well, Olympia's Crisis Response Unit, Denver's STAR teams, the Bay Area's youth mobile crisis teams, Atlanta's hospital-based Upstream Crisis Intervention teams, Sacramento's Office of Community Response, Albuquerque's Community Safety Department, and Austin's EMCOT teams, staff their teams with licensed counsellors or social workers, the majority of whom have a master's degree in a mental health-related field.

However, Eugene's CAHOOTS teams, Oakland's MACRO teams, Portland's Street Response teams, Waterloo-Wellington's IMPACT teams and Here 24/7 service, and Toronto's Gerstein Centre use unlicensed mental health experts. While some of these staff members may

have master's degrees in a mental-health related field and some may be registered with regulatory bodies, all staff have substantial experience doing mental health crisis work. These teams find that hiring unlicensed "crisis workers" rather than licensed social workers or counsellors allows greater flexibility in hiring and promotes the integration of individuals with lived experience of mental health challenges into their staff. Individuals with lived experience bring incredibly valuable skills and knowledge to any crisis service.

The Reach Out Response Network proposes to hire both peer supporters and licensed mental health professionals; however, we have not taken a position on whether it is more appropriate to create two different jobs for peer supporters and licensed mental health workers or whether both can be folded into the category of "crisis worker" or "mental health worker." During our community consultations, we asked service users, service providers, and other Toronto residents what they thought about this issue. Our participants identified a number of benefits and drawbacks to each model and did not reach consensus on which model might be preferable. However, our participants consistently stated that principles of equity require that peer support staff and licensed clinical staff, regardless of their titles, will need to be paid the same salary. We strongly agree with this recommendation. We do not want to create a hierarchy within the organization in which peer support workers would be valued less than licensed clinical staff, or where peer support is stigmatized. We also do not want to make peer support workers feel that sharing their own lived experience is a condition of their employment or set up the expectation that peer supporters must share these experiences either with clients or with colleagues. Participants in our town halls stated that peer support workers and licensed clinical staff may play two different, but equally important, roles on the team, and that some service users may feel safer knowing explicitly that someone with lived experience is on the team. This can be signalled easily with the title of "peer support worker." Calling all mental health workers on the team "crisis workers" may lead to ambiguity or confusion, such that service users might not realize that crisis staff have lived experience and may be mistrustful of crisis staff as a result. Additionally, numerous studies have found that peer support in moments of crisis can provide hope for service users, because service users can see someone else who has been through something similar and come out the other side of it. Ambiguity or confusion about crisis workers' lived experiences may lessen this benefit.
While most teams that hire peer supporters fold them into the category of "crisis worker" rather than identifying them formally as peer supporters, as noted above, New York City's proposed Mental Health Team is one exception, in which peer supporters will work alongside medical staff on the mobile crisis team, without licensed clinicians. Similarly, New York City's LEAD teams and Utah's MCOT teams pair social workers with peer support workers to provide mobile response to mental health crises.

Throughout our consultations, Toronto residents consistently communicated a desire for a multi-disciplinary team. While we initially asked participants which two roles they would like to see represented on the teams, it quickly became apparent that Torontonians wish to see more than two different staff roles on the teams. Participants told us they would like peer supporters, mental health nurses, social workers, psychotherapists, harm reduction workers, and perhaps even paramedics represented on the team. While only two staff members would attend most calls, in order to efficiently allocate resources and avoid overwhelming a person in crisis, the diversity of backgrounds could allow for the best possible skillset to be dispatched to each call. For example, an elderly individual in crisis may be best served by a mental health nurse, while a younger person experiencing suicidal ideation but no immediate medical needs may be better served by a psychotherapist and a peer worker. A multi-disciplinary team could provide versatility and flexibility that would enhance service user outcomes.

PROPOSED MODEL

HOW WILL THE NEW CRISIS TEAMS BE ACCESSED?

Our proposal to make the teams available via both 911 and an independent three-digit number like 811 aims to address the challenges with choosing either model on its own.

We propose that the new crisis teams will be reachable both via 911 and through their own independent three-digit number, such as 811. The majority of teams in our sample, such as those in Albuquerque, Atlanta, Austin, Chattanooga, Denver, Eugene, Hamilton, Houston, Los Angeles, New Haven, New York, Oakland, Olympia, Portland, Sacramento, San Francisco, Stockholm, Vancouver, and Waterloo-Wellington are integrated into 911 dispatch. Sacramento's Office of Community Response is accessible both through 911 dispatch and through its own separate number. Similar, New York City's proposed Mental Health Team will be accessible both through 911 and its own independent three-digit number, such as 988. Teams in Houston, Chattanooga, and Portland will additionally be accessible through either 211 or 311. Several other services are accessible through their own ten-digit number or through another agency's referral process. For example, Atlanta's mobile crisis team can be dispatched directly through the Georgia Crisis and Access Line and Austin's EMCOT teams can be dispatched directly through the Integral Care crisis line; in Austin, Integral Care operates the mobile crisis teams in partnership with the city.

In most cities, teams may be dispatched via 911 or may self-initiate interactions; for example, teams in Olympia and Eugene carry police radios and can choose to go to any call that appears to have a behavioural health component. These teams also spend a significant amount of time doing community outreach in the downtown areas of their cities, and they may self-initiate crisis interactions if they witness a person in distress and choose to approach the person to offer help. We propose that the new crisis teams' staff will also carry police radios and will therefore be able to choose to attend calls that sound like they may include a behavioural health component. We also expect that the team will spend a significant amount of time doing community outreach and will self-initiate interactions within the community during this outreach work.

Our proposal to make the teams available via both 911 and an independent three-digit number like 811 aims to address the challenges with choosing either model on its own. 911 is operated by police in most cities, including Toronto, and many residents, particularly Black and Indigenous Torontonians, other Torontonians of colour, and newcomers to Canada, have told us that they do not trust 911. They may have had negative experiences with police in the past, either in Toronto or in their countries of origin, and as a result they may hesitate to call 911 if they are experiencing a mental health crisis. Additionally, integrating the team into 911 will require us to provide a substantial amount of training to our 911 operators on how and when to dispatch the team. However, this logistical barrier is not insurmountable; teams in Olympia, Denver, and Eugene have managed to provide the extensive training required to effectively integrate the service into 911.

We believe that it is important to provide service users with the choice to bypass the 911 police dispatch system if they wish and to call a separate number such as 811. We believe this will promote autonomy and self-determination for service users, while also providing a layer of security, since service users will know exactly who they are calling and the service they will be receiving. Additionally, operating a number like 811 would likely be less expensive than 911 since its staff would not be employed by the police department. Having a separate number could thereby reduce costs and take pressure off the 911 system, with the benefit that emergency calls could be answered more quickly.

However, a number like 811 cannot succeed on its own, without additional 911 integration. 911 is the number people are trained since childhood to call during an emergency, and a mental health emergency is still an emergency. It would be very difficult and not of significant benefit to try to convince people not to call 911 in a mental health emergency. Additionally, no matter how well-publicized a number like 811 is, it will likely never be as well-known or accessible as 911, and therefore people may not call the number simply because they don't know it exists. Service users and family members attending our town halls consistently stated that 911 was the only number they were aware of, particularly during their or their loved one's first crisis. Family members in particular stated that during their loved one's first crisis, they were not thinking clearly enough to remember or do a Google search for a ten-digit number, and 911 was all they could think of in that moment. They therefore indicated strong support for 911 integration of the new team. Additionally,

participants in our town halls reminded us that 911 is a more accessible number than any other. When a person's phone is out of minutes, or if a person is at a payphone but does not have money to pay, they are not able to dial any other number but 911. Additionally, if the new service is not integrated into 911, 911 may still receive calls from people witnessing the situation unfolding, and 911 dispatch will not know that a crisis team has already been sent out. For example, when a crisis occurs in a public area, often multiple 911 calls will be made regarding the same incident. If the new service is integrated into 911, when 911 receives an additional call about the same crisis, dispatch will know that a team has already been sent out. However, if the new service is not integrated into 911, police will end up continuing to respond to many situations where a non-police team could have effectively responded alone, simply because 911 dispatch will not know if a team is already responding.

If our service is accessible through both 911 and 811, protocols will need to be developed to allow these agencies to communicate with one another and quickly transfer calls from one service to the other if necessary. Some callers may call 911 believing they require a police response, such as if a bystander witnesses a person walking around on the street and yelling at invisible people. That bystander may believe a police response is required; however, a well-trained 911 operator would likely realize that this call is more likely to involve a behavioural health crisis, rather than violence or crime, and that a mobile crisis team ought to be dispatched rather than police. Similarly, a person may call 811 believing a mobile crisis response is required, but it may become clear during the call that the situation has escalated and the person in crisis is behaving in an assaultive way or is armed with a dangerous weapon, and therefore 811 will need to transfer the call to police dispatch for a police response. 811 will also need the capacity to transfer calls to other agencies such as 211 or 311, such as if someone mistakenly calls 811 believing that 811 is the number to reach city services.
Setting up a number like 811 may be logistically challenging due to the complexity of establishing a new three-digit number with telecommunications companies. It may be more efficient to route Reach Out Response Team calls to be dispatched by 211, rather than setting up a new number, and then publicize 211 as the number to call either for mental health and addictions resources or to access the new crisis teams.

PROPOSED MODEL

HOW WILL THE NEW CRISIS TEAMS BE DISPATCHED?

Eugene, Denver, and Olympia have provided substantial training to their 911 dispatch staff to enable dispatch staff to directly dispatch their hybrid-style teams. This model has the advantage of being efficient and streamlined, but it may be challenging to implement for 911 call centres with a high volume of calls. Conversely, a number of cities like Houston and Austin have trained clinical staff such as social workers to work in 911 dispatch centres. The NHS in England has a similar service that embeds mental health nurses into 911 dispatch, and York Region began a similar pilot in March 2020, which was halted in the summer due to COVID-19. In this model, as calls are received by 911 call dispatchers, the dispatchers are able to flag situations that might be appropriate for a non-police team and transfer these calls to the embedded clinicians. The embedded clinicians are also able to continuously monitor the calls in police and fire dispatch queues and take on calls where a clinical response may be more beneficial. Clinicians are also able to reach back out to callers to gather more information where necessary.

When a clinician answers a 911 call, the clinician is able to effectively screen the situation, do a risk assessment, and determine the best course of action. If the clinician screens the call and determines that a medical emergency or a risk of imminent violence is present, the clinician can return the call to the police queue. Otherwise, the

clinician assumes responsibility for the call. If the clinician determines that a mental health concern may be present, the clinician might be able to resolve the incident directly over the phone by connecting the caller with additional resources, or the clinician may dispatch a non-police mobile team via radio to support the caller. The mobile team could then contact the caller directly to gather additional information on their way to the scene.

The Reach Out Response Network would support either a direct dispatch model or an embedded clinician model. A direct dispatch model has the benefit of having many more call-takers who could directly dispatch a non-police mobile team. However, it may be difficult to train 911 dispatchers to effectively use discretion to determine when a call may be appropriate for a non-police team. 911 dispatchers are generally trained to dispatch as many services as may be needed to respond to a crisis, so they may err on the side of dispatching police even where police may not be needed. Conversely, clinicians are generally trained to use “least restraint” as a first resort and scale up only when needed. This training may be more appropriate for diverting calls away from police response where possible, so that an embedded clinician model may dispatch a non-police team more often than 911 dispatchers themselves would. Additionally, cities that use embedded clinician models find that a high proportion of mental health 911 calls can be resolved directly over the phone, without needing to send a mobile team. Therefore the embedded clinician model may be more efficient and cost-effective.

However, an embedded clinician model must be staffed appropriately to effectively divert calls. For example, if the City of Toronto estimates that a non-police crisis team could respond to 10% of 911 calls, there must be 10% the number of embedded clinicians as there are 911 dispatchers, or else the non-police crisis team will be underutilized and face many of the same problems faced by the MCIT, as outlined above.

PROPOSED MODEL

HOW WILL THE NEW CRISIS TEAMS' STAFF BE TRAINED?

All teams in our sample provide extensive training to their frontline staff. For example, CAHOOTS provides 40 hours of classroom training and 500 hours of field training before their staff can take calls independently. Similarly, Reach Out Response Team staff will receive, among other things, advanced training in de-escalation, suicide risk assessment, safety planning, suicide intervention, and domestic violence safety planning and assessment. Teams will further receive training in working with individuals experiencing psychosis or alternative realities, including drug-induced psychosis. Teams will receive training in working with homeless populations and individuals using substances. Teams also will receive extensive trauma-focussed training to ensure they are well-equipped to support trauma survivors. Additionally, teams will receive training in anti-oppressive and anti-racist practice, and in providing recovery-oriented, client-centered care. Teams will receive specific training in working with Black, Indigenous, and LGBTQ+ communities, as well as newcomers, seniors, and youth. Teams will also be trained in using police radios and in other 911 dispatch protocols to ensure they are able to effectively navigate the existing infrastructure.

PROPOSED MODEL

WHO WILL OPERATE THE NEW CRISIS TEAMS?

Small cities such as Eugene and Olympia have contracted with one non-profit organization in their respective communities to operate their mobile crisis teams. Large cities such as Denver and New York City have proposed to contract with a number of different organizations across their respective cities to operate their service, such that each distinct community would have its own team, operated by a credible organization that is well-trusted within that community. Conversely, Albuquerque and Chattanooga have created new city departments to operate their hybrid-style mobile crisis teams. Sacramento has developed a hybrid model in which a new city department has been created to operate the teams, and teams are staffed by social workers employed by the city. However, each team will have a community worker from a well-trusted agency within its catchment area embedded with the social workers, such that three staff members would respond to each call, two being social workers employed by the City of Sacramento and one being a community worker employed by an independent agency. The Reach Out Response Network proposes that Toronto should either contract with well-trusted agencies to operate the teams or create a new city department to operate the teams. Both models seem effective in the cities where they have been tried.

In a city the size of Toronto, it may be impractical to have one agency run the service across the entire city. Likely either the new crisis teams will need to be run centrally through the city with separate geographic "precincts" to ensure rapid response to crisis calls, or Toronto will need to contract with a number of different non-profits to run the service. Olympia, Denver, and other cities contracting with non-profits to run their teams have put out requests for proposals so that interested agencies can demonstrate why they would be most effective at running the team in their community. This is a more effective and expeditious model than designating an agency to operate the teams at the beginning of the planning process. At this point it is too early to predict who the successful candidates would be in various parts of the city. However, if Toronto does choose to contract with a number of organizations to run the teams, organizations like the Gerstein Centre should be front and centre in the design process, as they have expertise in the mobile crisis model.

A significant benefit to operating the service through multiple agencies would be that each organization will have a better sense of the community it serves than what a centralized model could provide. Additionally, the successful agencies are likely to be demographically diverse and to have credibility in the communities they serve. However, contracting with multiple agencies raises problems with service coordination and standardization, and it may be logistically challenging to integrate multiple agencies into one centralized phone number. It may also be difficult to find the right agency partners with sufficient expertise in some areas of the city, and individual agencies' internal challenges (such as high staff turnover) might negatively impact program delivery. Creating a new city department may solve these coordination problems, but it might be more challenging to ensure demographically representative teams are built across the city if the teams are centralized. Additionally, creating a new department to run the service poses logistical problems such as acquiring appropriate premises for staff to work from across the city to ensure rapid response times, whereas if the teams were run through an existing organization they could in many cases work out of existing infrastructure. A new department will also likely be more vulnerable to funding cuts in a new political administration. If a new department is created to run the program, it will be necessary to heavily involve subject matter experts such as the Gerstein Centre in the design of the new department.

Operating the program through either a police station or a hospital would be impractical and likely too expensive for Toronto. Among other challenges, operating the program through a police station would raise too many logistical challenges related to data security and the Personal Health Information Protection Act (PHIPA). Operating the program through a hospital or through a partnership between several hospitals would likely not spread teams sufficiently throughout the city. Additionally, many service users would not feel safe accessing a team run either through a hospital or through the police department. Participants in our town halls frequently noted that the new teams should not be under the purview of either the police service or the hospital system. The new crisis teams will need to be independent from, although coordinated with, both police and hospitals.

A significant benefit to operating the service through multiple agencies would be that each organization will have a better sense of the community it serves.

PROPOSED MODEL

HOW WILL THE NEW CRISIS TEAMS BE FUNDED?

Initially, Toronto ought to fund the service to operate in three diverse areas of the city, with a gradual expansion built into the plan.

Approximately half of the mobile crisis teams in our sample are funded partially or exclusively by the health budget, including teams in Atlanta, Austin, Hamilton, New York City, the Bay Area, Waterloo-Wellington, and Toronto's MCIT. The majority of police-partnered mobile crisis teams are partially or exclusively funded by the police budget; however, Eugene, Oregon's CAHOOTS program and proposed CAHOOTS-style teams in Oakland and Portland are both funded by the police budget, even though they are not police-partnered teams. Additionally, Denver's team is funded by a grant from a taxpayer-funded non-profit organization, and teams in Albuquerque, Chattanooga, Houston, New York City, Sacramento, San Francisco, and Stockholm are funded by their respective cities or counties. In Albuquerque, funding for their new city department to run their mobile crisis team will come from re-allocating money from five other city departments, including the police department, the fire department, and the transit department. In Stockholm, funding for their Mental Health Ambulance is allocated by the Stockholm County Council. In New York City, their proposed Mental Health Team will be funded as a line item in next year's city budget. In Olympia, their Crisis Response Unit is funded by a public safety levy that Olympia taxpayers voted to enact in 2017. This public safety levy amounts to a 0.1% sales tax.

In Toronto, it is unclear at this time what the best source of funding for the new crisis teams will be. The Reach Out Response Network does not take a position at this time on which level of government should provide primary funding for the teams, or where that money should come from. However, whichever source of funding is chosen will need to have a fairly broad mandate and sufficient flexibility to allow the teams to serve a broad range of community members and provide services that are responsive to their individual needs. The source of funding will also need to be stable enough to provide for program consistency and expansion over time.

If the new crisis teams were to respond to approximately 20% of Toronto's 911 calls, the direct cost for these teams would likely be around $30 million CAD annually. Houston, with a population of 2.4 million in the city proper, has projected that their teams will be able to respond to 20% of all 911 calls in Houston on a budget of $18 million USD. Toronto's budget would likely be slightly higher due to our greater population (2.9 million in the city proper). Additional funding may also be required to increase the capacity of relevant referral pathways, such as crisis beds and intensive case management. However, cities that have integrated hybrid-style mobile crisis services to divert mental health calls from police response report significant cost-savings from instituting such programs. For example, Eugene's CAHOOTS program saved an estimated $8.5 million USD in public safety funding in 2019 and an estimated $14 million USD in health budget funding due to hospital diversion. CAHOOTS cost only $2.1 million USD in 2019 to operate, therefore providing savings of eleven times its cost. The cost savings in Toronto would likely be of a similar ratio.

Initially, Toronto ought to fund the service to operate in three diverse areas of the city, with a gradual expansion built into the plan. In New York City, the proposed budget for a similar pilot is $3.3 million USD. In Portland, the proposed budget for such a pilot is approximately $2 million USD, and in Oakland, the proposed budget for a pilot is approximately $1.5 million USD. Toronto's budget for a pilot would likely be similar to New York City's budget.

PROPOSED MODEL

HOW QUICKLY WILL THE NEW CRISIS TEAMS RESPOND TO CRISIS CALLS?

The new crisis teams will be first responders to mental health crises, with response times equivalent to other emergency responders such as fire, police, and ambulance. Teams in Albuquerque, Atlanta, Aurora, Austin, Berkeley, Denver, Eugene, Houston, Los Angeles, New Haven, New York City, Oakland, Olympia, Portland, Sacramento, San Francisco, and Stockholm are similarly hybrid-style first responders to mental health crises.

To ensure rapid response times, these teams must be spread throughout the city. This may involve purchasing or leasing premises across Toronto for the teams to work out of. Additionally, the vehicles the teams operate may need to be equipped with lights and sirens that can be turned on when there is heavy traffic. Teams in Eugene, Olympia, and elsewhere do not use lights or sirens because the geographic area of those cities is much smaller; however, Toronto is a large enough city that, depending on how many teams are built and how far away each team is positioned from the others, lights and sirens may be necessary to ensure rapid response times. Whether or not vehicles are equipped with lights and sirens, they will still need to maintain the appearance of being civilian vehicles rather than police vehicles or ambulances in order to minimize stigma.

PROPOSED MODEL

WHAT RELATIONSHIP WILL THE NEW CRISIS TEAMS HAVE WITH OTHER EMERGENCY SERVICES?

The new crisis teams will not be part of the police department or part of EMS; however, they will be closely linked with both agencies. The teams will be integrated into the 911 dispatch system, and we anticipate that like teams in Eugene, Olympia, Oakland, Portland, Sacramento, and Denver, the teams will carry police radios so that they can be dispatched to calls or self-dispatch to calls that involve a behavioural health component. Additionally, carrying police radios will allow the team to easily call for police or ambulance backup if needed. The teams may co-respond with police or ambulance services when necessary to ensure safety; however, the goal of the teams will be to divert service users as much as possible from using more expensive emergency services such as police and EMS. In this way, police and EMS will only be brought in when essential to ensure safety.

It will be essential for strong working relationships and trust to be built between the teams and other emergency services, particularly police. The teams and police should see themselves as partners in supporting Torontonians in crisis and will recognize and respect the unique roles that each entity plays. Trust will likely take time to build, and we will look to the Eugene Police Service's strong relationship with CAHOOTS as a positive model for how to build this partnership. We will consistently communicate that the teams are not intended to usurp police responsibilities; our goal is instead to allocate resources most effectively to fit the needs of individuals in crisis. Some circumstances may require a police response, others may require a Reach Out Response Team response, and still others may require co-response of both teams or response by the police-partnered MCIT.

PROPOSED MODEL

HOW WILL FRONTLINE WORKERS BE PROTECTED FROM VIOLENCE?

In our sample of thirty-three teams, no staff member has at any time been seriously injured or killed during a crisis call.

In our sample of thirty-three teams, no staff member has at any time been seriously injured or killed during a crisis call. Minor injuries, such as a team's car being rear-ended in traffic on their way to a call or a staff member being spat at by a client, occurred approximately 1 in every 25 958 calls. The new crisis teams will not respond independently to highly dangerous situations, such as those involving guns or assaultive behaviour, and team members will be trained to trust their judgment and training and exit a scene if it feels unsafe. Crisis team staff will carry police radios and will be able to call police for backup if necessary. This is similar to the approach taken by CAHOOTS staff. In 2019, CAHOOTS responded to 24 000 calls and requested police backup on 311 of those calls – approximately 1% of calls. The majority of these requests for backup were made due to the need for Mental Health Act apprehensions, rather than for violence. Statistics are similar for other teams; for example, in 2019 Olympia's Crisis Response Unit responded to approximately 2100 calls and requested police backup only three times. We expect that injuries and calls for police backup would be similarly low for the new crisis service.

PROPOSED MODEL

HOW WILL SERVICE OUTCOMES BE MEASURED?

The Reach Out Response Network proposes a combination of qualitative and quantitative evaluation methods for the new service. A program logic model will be used as a framework for evaluating key service activities and key service outcomes. A program logic model describes a service's resources (such as staff, time, and money), service activities engaged in, outputs yielded from those service activities, and outcomes that a service is intended to achieve. Key service activities could include but are not limited to the number of calls received, location of calls, nature or purpose of calls and service response time, and would be primarily assessed quantitatively. These key activities would need to be routinely measured and would serve as indicators on how well the service is operating and whether desired outputs are being achieved. Key service outcomes could be measured both quantitatively and qualitatively.

Quantitative measures could include collecting administrative data and indicators from mental health service associations, the Toronto Police Service, hospitals, and the justice system. This data will examine both short-term and long-term outcomes and efficacy. This could include data on those who initiated mental health-related 911 calls and outcomes of calls (such as hospital visit, referral to other services, arrest, etc.). Data collection to assess longer-term outcomes could include hospital diversion rates, cost savings to municipal services, and rates of requests for police backup. Qualitative evaluation methods could include using methods such as focus groups, interviews, and/or town halls to assess the development and implementation of the new service. This could include interviews with service providers, 911 dispatchers, and MCIT teams to determine conditions before and after implementation of the service. Service users should have many opportunities to give qualitative feedback to share whether they felt supported, listened to, and respected, and whether they felt that they were connected with useful services. Additional qualitative measures could assess service provider perspectives of service delivery and impact of service. A data collection plan must be developed with specific partners, timelines, data sources, costs, and analysis to facilitate evaluation.

CONCLUSION

CONCLUSION AND AREAS FOR FURTHER RESEARCH AND CONSIDERATION

While our research and our town halls have crystallized some aspects of our proposed model, additional research and consideration will be required on a number of elements. For example, in preparing this report our network has not had access to detailed Toronto-specific data on mental health-related calls, beyond the general statistics shared on the Toronto Police Service's open data portal. However, this data portal does not include information on who initiated mental health-related 911 calls (for example, service users themselves, family members, service providers, or bystanders) or what the outcomes were of these calls (for example, how many resulted in incarceration or hospitalization and how many led to service users being connected with resources). The data portal also does not include information about whether service users in crisis were handcuffed or otherwise restrained. This information will be integral to the design of a new service. As one of our town hall participants said, "We need to look at why people are calling police and ask people what they were looking for when they called 911 to figure out how to meet that need."

Additionally, the City will need to consider how to ensure the new service is entirely separate from policing and that information will not be shared with police. The City will also need to consider what the scope of the new service should be. For example, participants at our town halls and the international models we examined are in general agreement that hybrid-style teams should respond only to non-violent crises; however, teams have varied ways of defining "non-violent." Some hybrid-style teams will respond either alone or with police to people with edged instruments, particularly if those instruments are being used for self-harm rather than threatening others, while other teams will not attend at all. People with knives or other edged instruments are in fact the ones most likely to be harmed or killed by police responders, as was the case for Chantel Moore, D'Andre Campbell, Ejaz Choudry, Rodney Levi, and (allegedly) Regis Korchinski-Paquet, so excluding these individuals from response by a hybrid-style team may mean that the team will be inadequate at preventing the deaths of people in mental health crisis. It may be useful to collect data related to 911 calls that implied or expressed the presence of a weapon to determine based on the responding officers' notes how many of these calls actually did involve weapons or progressed to violence, in order to enhance risk assessment and related training and dispatching. The City will need to design the new service's scope to ensure both the safety of frontline staff members and the safety of service users they are called to protect.

In summary, our research into mobile crisis service models combined with our consultations with service users, service providers, and other community stakeholders points to an urgent need for a new type of crisis response service. The key elements of this service are:

- These new mobile crisis teams should be first responders for the majority of mental health-related emergency calls
- Police should only be first responders if a weapon or imminent risk of violence to others is present
- Police should be called in as secondary responders only when required
- The service should be available 24/7/365
- Peer workers must staff the front lines of the service
- The staff must be multidisciplinary
- Staff should reflect the diversity of the community members they serve
- The service should integrate traditional healing practices and social life frameworks of the communities being served
- Service referral pathways must be included and available at point of contact with service users
- The service should be integrated into 911 dispatch and accessible via 911, another three-digit number such as 811, and other means such as text services and apps
- Service users should have autonomy over their care
- The service should employ a harm-reduction approach
- Crisis beds, detox centres, culturally-specific healing spaces, and other service organizations should be added as other options for service user transport

Given these recommendations and others fully elucidated in previous sections of this document, the time is now for a new service delivery model. It is imperative that our standard of care match our values as Canadians – to be inclusive, compassionate, and robust. Our recommendation to replace police-led crisis response with integrated hybrid-style crisis response teams will lead to substantial cost savings and improved healthcare outcomes which will trickle down to improved life outcomes for all. The City of Toronto is known as a leader in science, technology and healthcare. As such, we should continue to prioritize innovation both by adopting pre-existing alternative frameworks utilized in other communities and building on these models through continuous improvement and research. The City of Toronto has the opportunity to emerge as a leader in eradicating the stigma associated with mental health crisis and providing effective, compassionate responses. The time to act is now.

APPENDIX A

ENGAGEMENT SESSIONS

Engagement efforts included two surveys, sixteen town halls, two focus groups, and about 120 key informant interviews.

# OF PEOPLE	PARTICIPANTS
122	Mental health service providers
35	Substance use service providers
11	Justice-adjacent service providers
17	Service providers who work with people with disabilities
14	Hospital staff and first responders
38	Service providers who work with the homeless and precariously housed
114	Survey of people who are homeless/precariously housed
24	People who are Deaf
15	People who are Autistic
17	People with developmental disabilities
17	Indigenous people
20	High school students
21	Family members
26	Black community
20	Lawyers
41	Peer workers
30	Service users
32	Open to all Toronto residents
18	Service provider advisory panel
17	Black community advisory panel
16	Peer worker advisory panel
7	Service users advisory panel
11	Family members advisory panel
9	Indigenous community advisory panel
~120	additional individual interviews and key informant interviews

APPENDIX B

MOBILE CRISIS TEAMS REFERENCED

NAME OF SERVICE	LOCATION
Community Safety Department	Albuquerque, New Mexico
Mobile Crisis Intervention	Atlanta, Georgia
	Aurora, Colorado
EMCOT	Austin, Texas
Specialized Care Unit	Berkeley, California
Department of Community Resilience	Chattanooga, Tennessee
	Chicago, Illinois
STAR	Denver, Colorado
CAHOOTS	Eugene, Oregon
MCRRT	Hamilton, Ontario
COAST	Hamilton, Ontario
CIRT+	Houston, Texas
	Los Angeles, California
	Madison, Wisconsin
	Milwaukee, Wisconsin
Community Crisis Response Team	New Haven, Connecticut
NYC Well	New York City, New York
Mental Health Team	New York City, New York
LEAD	New York City, New York
MACRO	Oakland, California
Crisis Response Unit	Olympia, Washington
Portland Street Response	Portland, Oregon
Crisis Intervention Services Unit	Rochester, New York
Office of Community Response	Sacramento, California
MCOT	Salt Lake City, Utah
Street Crisis Response Team	San Francisco, California
Uplift Family Services	Santa Clara County, California
Mental Health Ambulance	Stockholm, Sweden
MCIT	Toronto, Ontario
Gerstein Centre	Toronto, Ontario
Youthdale	Toronto, Ontario
Car 87	Vancouver, British Columbia
Here 24/7	Waterloo-Wellington, Ontario
IMPACT teams	Waterloo-Wellington, Ontario

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