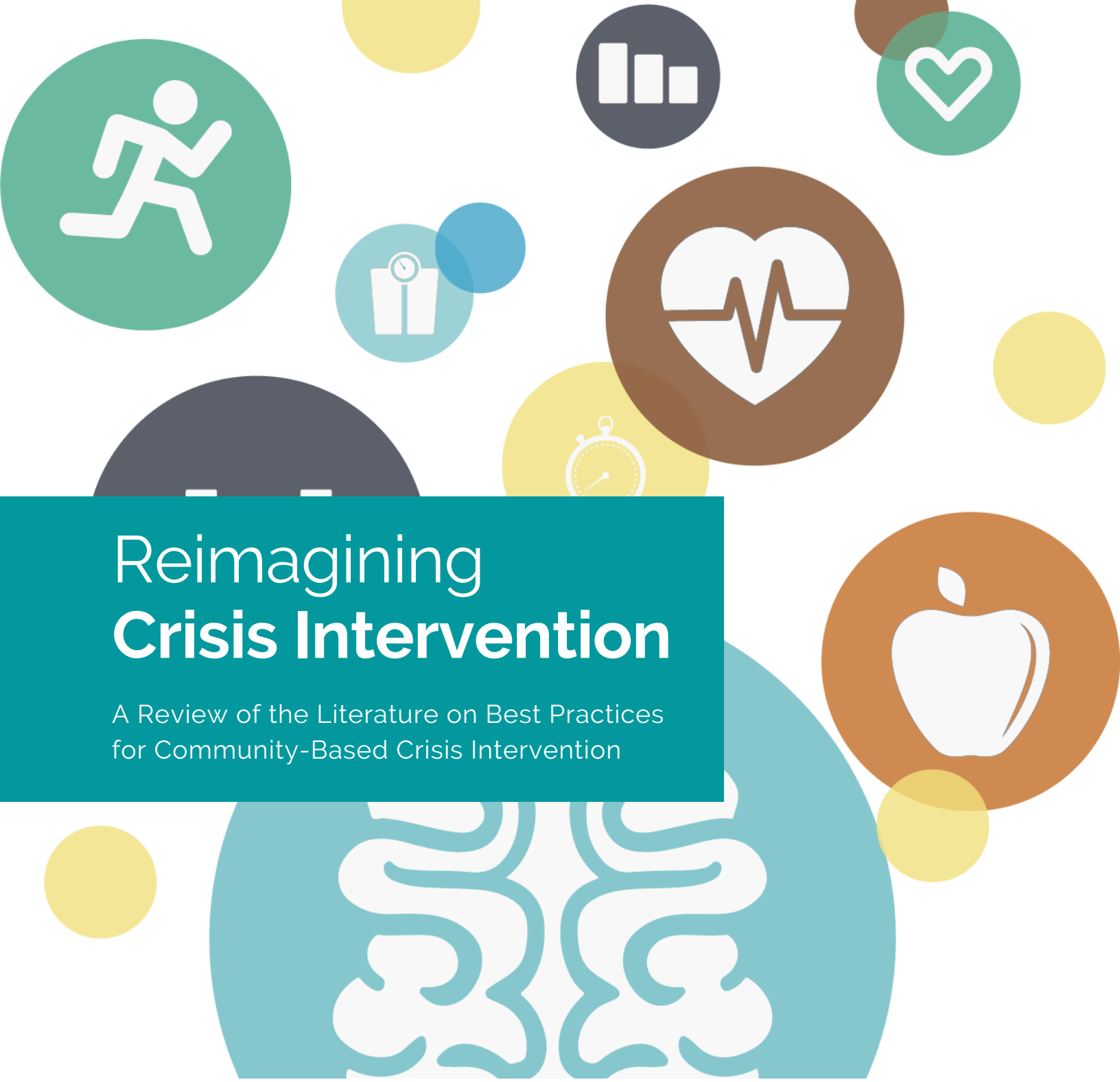


Reimagining **Crisis Intervention**

A Review of the Literature on Best Practices for Community-Based Crisis Intervention

Author: Nasra Hussein | April 2021

SOCIAL PLANNING COUNCIL of Ottawa
Le CONSEIL de PLANIFICATION SOCIALE d'Ottawa

SPECIAL THANKS TO

- Heather Hunter, Program Manager, SPC (Editor)
- Parastu Mirabzadeh, Effective Measures Manager, SPC (Editor)
- Dianne Urquhart, Executive Director, SPC
- SPC Board of Directors 2020-2021
- The rest of the SPC Staff

Reimagining
Crisis Intervention

Social Planning Council of Ottawa
815 St Laurent Blvd, Suite 235
Ottawa, ON, Canada K1K 3A7

(613) 236-9300
office@spcottawa.on.ca
https://www.spcottawa.on.ca
https://ocphe.ca/shared-minds/

SOCIAL PLANNING COUNCIL of Ottawa
Le CONSEIL de PLANIFICATION SOCIALE d'Ottawa

Executive Summary

A mental health crisis is a terrifying and traumatic experience to go through; it can be made even worse if the intervention used is prolonged or handled poorly. Crisis interventions are the methods used to help distressed individuals cope with their crisis from its critical moment towards recovery and follow-up. Literature about crisis intervention indicates that racialized persons with mental illness (PMIs) are disproportionately more likely to be injured or die after police encounters in the US, UK, Australia and Canada.

Aside from police who have been assigned as first responders to crises, the other most common crisis intervention model is the co-responding police-mental health program. Such programs reflect a partnership between mental health agencies and law enforcement agencies to build more efficient ways to handle PMIs. However, there has been limited evidence regarding whether co-responding police-mental health programs avert crisis escalation, improve officers' perceptions of individuals who have a mental illness or are cost-effective. Moreover, the evaluation of co-responding models has not produced clear findings that could identify it as 'best practice' at diverting PMIs from the judicial system or reducing the likelihood of police brutality.

Evidence shows that investment in community-based crisis intervention programs involving interagency collaboration between service providers can foster collective impact in reducing the exposure of PMIs to the criminal justice system. A community-based approach effectively supports PMIs with diversion, treatment, and recovery while connecting them to community resources such as health care, stable and affordable housing, mentoring, conflict resolution, trauma-informed care, and employment services. Such initiatives are structured to address the root causes of mental illness by providing a supportive environment to help people overcome their challenges and tackle their socio-economic and health issues.

This report provides information on:

1) the impacts of the social determinants of health on mental health crisis intervention,
2) barriers to effective crisis intervention based on the current system,
3) facilitators for effective crisis intervention that support persons with mental illness, especially those who are racialized and disproportionately affected by traditional policing, and
4) existing non-police and community-based crisis intervention models.

Section 1 Summary: Mental Health Crisis Intervention

Crisis interventions are most effective when they not only address mental health symptoms, but incorporate an intersectional approach that addresses the social determinants of health. The social determinants are personal, socio-economic and environmental factors that influence individual and population health. Crisis intervention is best achieved when it addresses the intersections of mental health and the social determinants such as homelessness, poverty, and social supports.

Section 2 Summary: Barriers to Effective Crisis Intervention

1. Police Not Equipped to Handle Mental Health Crises

- Insufficient training results in incomplete evaluations, using inappropriate practices on PMIs and using physical force as a means for a quick solution to 'solve the problem'
- Black and Indigenous people have historically been prone to this type of treatment by law enforcement. Black and Indigenous people are also disproportionately represented amongst police fatalities compared to their fragment of the total population

2. Insufficient Funds Towards Social Services

- Community-based mental health services and programs continue to be insufficiently supported by government funding
- Advocators call for implementing restorative practices and prioritizing supportive community services that would significantly decrease the need for police intervention

---

Section 3 Summary: Facilitators for Effective Crisis Intervention

1. Screening Triage and Acuity Scale

- A screening triage and acuity scale assists 911 dispatchers or designated crisis hotlines in determining if an incoming call requires a police response, medical response or a community-based response
- A cost-effective method for saving on police and/or medical time and resources, allowing police officers to focus on dangerous crimes that impact public safety

2. Mobility of Crisis Teams

- Crisis programs require the capacity of mobility, particularly in rural areas or areas where social or emergency services are hard to access
- The mobility of crisis intervention makes it easier to reach any person in crisis in his or her home, workplace or anywhere in the community promptly, to provide immediate relief in an environment that they're most comfortable

3. Trauma-Informed De-escalation

- A trauma-informed framework considers how prior trauma can affect someone and avoids re-traumatizing someone during crisis interaction, which is often not practiced by first-responding law enforcement
- Incorporating trauma into de-escalation is crucial in becoming emotionally attuned to someone's needs and building rapport in a crisis situation

4. Collaborative System of Care

- Social service providers who can help identify which needs could be met by existing community resources and which might require supplemental strategies
- Family members who participate in their loved ones' care experience less burden and stigma
- Peers support PMIs by providing a sense of hope and model that things get better

5. Anti-Racist and Culturally Responsive Praxis

- Anti-racist and culturally responsive praxis is an action-oriented approach to address racism and underlying basic needs such as education, employment, etc.
- The progression towards anti-racist and culturally responsive praxis aims to empower racialized groups in family-centred services, self-help groups, neighbourhood-friendly access to information, collateral services, and large-scale integrative systems

6.Long-Term Crisis Safety Plan

- Safety planning is a crisis prevention tool that people who have a history of mental health crisis have been using to prevent police interaction
- A crisis safety plan is a written plan developed by the person with the mental health condition and their support team to address symptoms and behaviours and to help plan ahead before a crisis occurs

Section 4 Summary: Community-Based & Non-Police Crisis Intervention Models

CAHOOTS (Eugene, Oregon, USA)	• CAHOOTS provides first response for crises involving mental illness by mobilizing a 2-person team consisting of a medic and a crisis worker with substantial training and experience in mental health • CAHOOTS aims to resolve crises where a social service response is more appropriate than a police response
REACH Edmonton (Edmonton, Alberta, Canada)	• Operate a 24/7 crisis diversion program with interagency collaboration • A crisis diversion team adequately trained in mental health is dispatched responding to people in distress on the streets of Edmonton with the intention "to reduce the need for expensive medical, judicial and polices interventions"
Gerstein Crisis Centre (Toronto, Ontario, Canada)	• The Gerstein centre provides 24-hour community-based crisis services for adults 16+ who are dealing with mental health or substance use issues and are currently experiencing crisis • Four main services: (1) mobile crisis teams, (2) telephone crisis line, (3) crisis and recovery services, and (4) referrals to health and social services
NYC Well (New York City, New York, USA)	• NYC Well provides a multitude of different services and programs including (1) mobile crisis team, (2) telephone line, (3) in-person crisis interventions (i.e., crisis respite, safety planning and PADs), (4) home-based crisis intervention services for children
Anne Arundel County Crisis Response System (Annapolis, Maryland, USA)	• The Anne Arundel County Crisis Response System offers a multitude of services including (1) mobile crisis teams, (2) care coordination and follow-up, (3) mobile assertive community treatment, (4) hospital diversion program, (5) jail diversion program, and (6) in-home interventions for children and adults
Albuquerque Community Safety (Albuquerque, New Mexico, USA)	• The Albuquerque Community Safety is a new department of first-responders, along with the police and fire departments • The new department will include trained professionals such as social workers, housing and homelessness specialists, violence prevention and diversion program experts.
Mental Health Ambulance (Stockholm, Sweden)	• In Stockholm, Sweden, a mental health ambulance is operated by two psychiatric registered nurses and one emergency medical technician • The team responds to emergency mental health issues and patients are taken care of by trained nurses, in the same way, if an individual was experiencing a somatic problem
Mental Health Acute Assessment Team (MHAAT) (Western Sydney, Australia)	• MHAAT consists of a paramedic and mental health nurse, and are tasked by the Ambulance Control Centre • After the team conducts a clinical assessment to determine the best course of care for the individual, they are able to refer patients to general practitioners or mental health facilities instead of an emergency department

Table of Contents

List of Figures & Tables

Abbreviations

BIPOC – Black, Indigenous and People of Colour

ED – Emergency Department

MCTs – Mobile Crisis Teams

PMIs – Persons with Mental Illness

SDoH – Social Determinants of Health

Introduction

In the wake of the murder of George Floyd, a Black man murdered in broad daylight by Derek Chauvin, a white police officer, more cities in North America are exploring community-based, non-police crisis response alternatives that not only protect racialized[1] groups but all individuals experiencing mental health challenges. Police misconduct and fatal use of force against racialized people have long led the civil rights movement and protests against the legal system and lack of police accountability.

Over the past year in Canada, police have made headlines with their involvement in the murder of five **Black, Indigenous and People of Colour (BIPOC)** – D'Andre Campbell, Rodney Levi, Regis Korchinski-Paquet, Chantel Moore and Ejaz Chaudry – during mental health wellness checks (Donato, 2020). These are just five of many deaths caused by police on racialized individuals who were experiencing a mental health crisis and just needed proper support. Currently, in Canada, there is no publicly available government database that lists the number of deaths at the hands of police; however, CBC created their own database with detailed information about fatal encounters where police used force on persons with mental illness or substance abuse issues (Singh, 2020). According to its latest update, 157 racialized people have died in Canada from January 2000 to June 2020, with Black and Indigenous people disproportionately represented amongst the fatalities compared to their fragment of the total population (Singh, 2020). These Canadian statistics coincide with international literature indicating that racialized persons with mental illness are disproportionately more likely to be injured or die after police encounters in the US, UK and Australia (Baker & Pillinger, 2019).

In the last decade or so, social service agencies have had their funding significantly reduced, which has forced the brunt of front-line work related to crisis placed upon the police (Bergen, 2020). In Canada, we have created a system where there is no other option but to call the police when someone is in distress. As a result, there has been a push towards 'defunding the police' and investing in more community-based supports that are better suited at dealing with mental health and its contributing factors such as poverty, unstable housing, unemployment, mental health, addiction, etc. (Bergen, 2020).

[1] "The term "racialized person" or "racialized group" is preferred over "racial minority," "visible minority," "person of colour" or "non-White" as it expresses race as a social construct rather than as a description based on perceived biological traits. Furthermore, these other terms treat "White" as the norm to which racialized persons are to be compared and have a tendency to group all racialized persons in one category, as if they are all the same."(Ontario Human Rights Commission, 2009)

This report focuses on crisis intervention models designed to manage potentially dangerous mental health crises on-site and mediate their impacts after the fact. The documents reviewed include academic journal articles, literature reviews, government reports, third-party evaluations on existing programs, reports about existing crisis models in different communities, and grey literature. For more information on Methodology, refer to Appendix A.

This review has **four main objectives**:

1) To highlight the impact of the social determinants of health on mental health crisis intervention.
2) To identify barriers to effective crisis intervention based on the current system.
3) To explore facilitators for effective crisis intervention that support persons with mental illness, especially those who are racialized and disproportionately affected by traditional policing.
4) To identify existing non-police and community-based crisis intervention models.

Section 1: Mental Health Crisis Intervention

A *mental health crisis* is defined as "a response to daily life events that overwhelm an individual's coping capacities and adaptive behaviours and is experienced as a distressing mental and emotional disequilibrium" (Central East Local Health Integration Network, 2015). Depending on the intervention used to resolve a mental health crisis, the outcome can be life-altering in that it can lead the individual to sustainable recovery or a downward spiral of distress. In this report, **mental health crisis intervention** refers to *methods that help an individual cope with a stressful event, beginning from the initial crisis moment towards recovery and follow-up* (Williamson, 2012). Community-based crisis interventions should provide immediate relief for crisis symptoms by resolving the crisis as soon as possible and preventing the crisis from worsening.

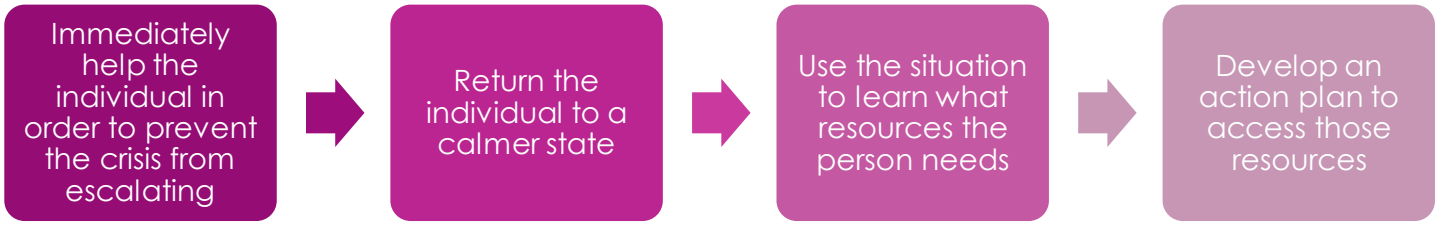


Figure 1: *Four primary purposes of mental health crisis intervention* (Williamson, 2012)

1.1. Crisis Intervention & The Social Determinants of Health

Understanding the ***social determinants of health (SDoH)*** is essential, especially when dealing with individuals who have experienced trauma and crisis. The social determinants are personal, social, economic, and environmental factors that influence individual and population health (Public Health Agency of Canada, 2019). In Canada, there are 12 SDoH that have been identified to influence the long-term health and life outcomes of Canadians (see **Figure 2**).

Figure 2: *The 12 Social Determinants of Health (SDoH) that exist in Canada (Public Health Agency of Canada, 2019)*

The SDoH impact an individual's place or social location in society (Public Health Agency of Canada, 2019). Racism and traumatic experiences are important social determinants that significantly impact BIPOC communities. When analyzing the SDoH, three themes emerge that significantly affect an individual's mental health outcomes: (1) freedom from discrimination, (2) social inclusion, and (3) access to economic resources (Central East Local Health Integration Network, 2015).

The combination of unaffordable housing, racism in employment and housing, underfunding of community mental health services and the over-policing of racialized neighbourhoods has negatively affected the mental health of many racialized groups (Frederick, O'Connor, & Koziarski, 2018). Discussions about mental health have to go beyond law enforcement and corrections strategies; the solution needs to be inclusive of the SDoH. Intertwining the SDoH into mental health care requires multi-sector collaboration between service providers to meet critical and underfunded community needs; "such as health care, stable and affordable housing, mentoring, conflict resolution, restorative justice, trauma-informed care, education, and employment services" (Donato, 2020; Frederick et al., 2018; Hasford, Amponsah, & Hylton, 2018; Sakala, Harvell, & Thomson, 2018).

1.2. The Connection Between Racism and Mental Health Crisis

Racism is one of the social determinants of health listed by the Public Health Agency of Canada. Only recently have institutions finally recognized that racism is a public health issue that needs to be addressed. For example, in the field of social and community services, there is an absence of people of colour in positions of authority or leadership (Ferguson, 1996). People of colour are both underserved by the present system and underrepresented in its workforce. This racial divide between service providers and clients suggests a need for close attention to issues of diversity.

Racism amplifies stressors such as poverty, familial adversity, and homelessness. African Canadians especially experience discrimination and systemic racism in employment, housing, education, the child welfare system and the criminal justice system (Hasford et al., 2018). It is likely that African Canadians fray away from mental health services due to cultural stigma related to mental illness and mistrust of mainstream health services. Hasford et al. (2018) indicates that "lack of access to culturally relevant services further increases the criminalization and marginalization of African Canadian youth" and "untreated mental health issues end up being addressed through the criminal justice system."

McKenzie & Waldron (2009) conducted a study to observe the life events, stress, and discrimination on mental health for four main groups: (1) asylum seekers; (2) refugees; (3) recent or long-term immigrants; and (4) Canadian-born racialized individuals.

Their findings include:

- All four groups, including Canadian-born racialized groups, suffer from "emotional, psychological, spiritual and physical distress" due to "social exclusion, social inequality and discrimination" (K. McKenzie & Waldron, 2009).
- The impact of discrimination and its interaction with the SDoH signifies "that it is experienced as trauma and could be usefully considered as such by mental health professionals" (K. McKenzie & Waldron, 2009).

What these findings indicate is that the current social service and mental health systems are not working. These services operate out of little understanding of how race issues should be addressed as part of program design and development. The above results amplify the need for more ethnocultural and racialized service providers who understand not only the culture of their local community members but also their current social realities.

Section 2: Barriers to Effective Crisis Intervention

2.1. Police Not Equipped to Handle Mental Health Crises

"When an incident does end badly, there has typically been a coronial inquest/fatality inquiry, which results in recommendations intended to improve the outcome of similar situations in the future. The most common recommendation is to increase the 'training' of police officers in order that they are better prepared."

(Coleman & Cotton, 2010)

But is this really a viable solution?

In the absence of community-based crisis services, police services have become the central component of mental health crisis-response systems in many countries and jurisdictions. This raises concerns about potential unnecessary arrests, use of force resulting in injury or death, and involuntary escorts to the **emergency department (ED)** (Lamanna et al., 2018). **Persons with mental illness (PMIs)** have reported poor treatment by police officers, creating a negative crisis-response experience and generating mistrust in subsequent police interactions. Furthermore, police officers often perceive themselves to be inadequately prepared to provide crisis support (Lamanna et al., 2018; Lindström, Sturesson, & Carlborg, 2020).

It is estimated that 1/3rd of those with serious mental illness first attempt at accessing mental health support involves police interaction (Bumby, 2016). Crises involving PMIs are often poorly handled by police resulting in incarceration or physical and psychological harm instead of receiving the appropriate treatment (Parker et al., 2018).

Research shows that police have about the same level of knowledge regarding mental illness, including similar negative understandings as the general public (Bumby, 2016; Lord, Bjerregaard, Blevins, & Whisman, 2011). Despite this, first-responding police officers are tasked with triaging at the crisis scene and quickly determining if the cause of an individual's behaviour is psychiatric or criminal (Bumby, 2016).

PMIs are particularly prone to systemic criminalization. Those with mental issues or addictions are not criminals; they are ill. Encounters with PMIs present officers with many unique challenges, and frequently PMIs do not respond well to law enforcement officers. Despite their lack of knowledge on mental health, police are still expected to procure a split-second solution about how best to respond to a crisis. Too often, their choice may lead PMI to become caught up in a revolving door between living in the community and a criminal justice system unable to adequately meet their needs (Baker & Pillinger, 2019; Lord et al., 2011). The consequences that result from insufficient training of police officers include (1) incomplete evaluations and use of inappropriate practices on PMIs, (2) officers' stereotypical views on PMIs, tending to view them as 'unpredictable' and 'inherently violent,' (3) using physical force as a means for a quick solution to 'solve the problem' (Baker & Pillinger, 2019).

When approaching a PMI, officers with a more aggressive approach than a care-based approach may adversely confront the PMI rather than de-escalate the situation, thereby inflaming the situation to potentially lead to police force as a quick resolution (Baker & Pillinger, 2019). Additionally, despite police interactions with PMIs being mostly about minor, often nuisance types of offences, many PMIs end up in jail without charge (Lord et al., 2011). There is an inability of the criminal justice system to adequately provide services to PMIs, which may worsen their condition. Jails are not equipped to manage serious mental illness, and most incarcerated PMIs will receive no treatment (Lord et al., 2011).

Those with serious mental illness are more prone to poverty and homelessness due to circumstances related to a lack of affordable housing and low social assistance rates, which may exacerbate their pre-existing mental illness. This type of vulnerability can increase the likelihood of PMIs entering into the criminal justice system through increased police interaction brought on by a mental health crisis. The Mental Health Commission of Canada investigated police interactions with PMIs and found that "persons with mental illness were overrepresented in both lethal and non-lethal interactions involving police weapons" (Stanyon, Goodman, & Whitehouse, 2014).

There are many cases where individuals experiencing a mental health crisis had reported how terrifying it was when police showed up at their door yelling, tackling and handcuffing them. Some even have nightmares or have developed post-traumatic stress disorder to the point where they start shaking and crying when they see police (Donato, 2020). Black and Indigenous people have historically been prone to this type of treatment by law enforcement and have reported unjust treatment in in-patient care and involuntary institutionalization. Moreover, as crime rates decline, over-policing in low-income Black and brown neighbourhoods increases the risk of the police force

and violence in those neighbourhoods (Rodenberg, 2020). According to CBC's Deadly Report, Black and Indigenous people are disproportionately represented among fatalities involving police compared to their fragment of the total population (Singh, 2020). As shown in **Figure 3**, Black people form 8.63% of deaths and only make up 2.92% of the population, and Indigenous people form 16% of deaths but only make up 4.21% of the population (Singh, 2020).

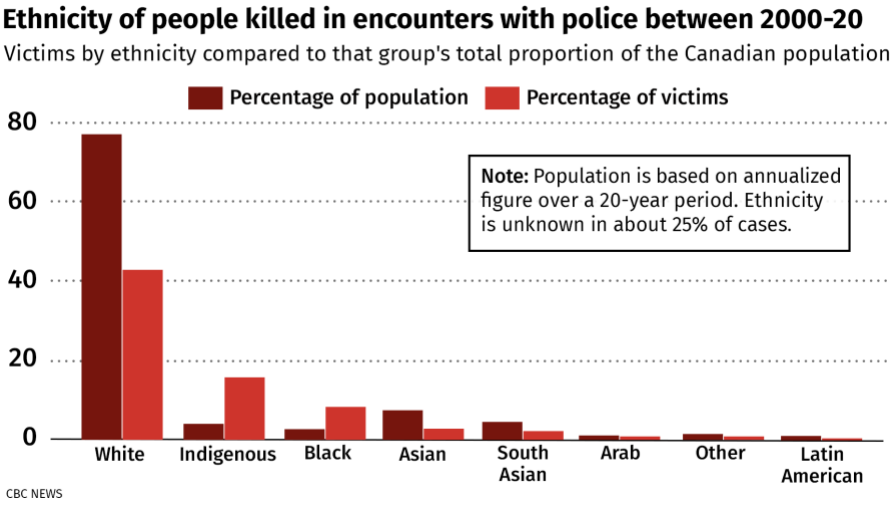


Figure 3: *Number of people killed by police in Canada between 2000 to 2020, by race/ethnicity* (Singh, 2020)

Through media misrepresentation, police interactions with PMIs reinforce the belief that persons with mental illness are inherently dangerous, affecting both the public's perception and police response. The concept of police responding to mental health crises in the first place reflects the government's failure to prioritize and invest in viable community-based solutions for mental health care.

2.1.1. Co-Responding Police and Mental Health Models

A common crisis intervention model identified in the literature is the co-responding police and mental health model. This model is a partnership between mental health agencies and law enforcement agencies to build more efficient ways to handle PMIs (Lord et al., 2011). The most widely accepted of these models is the Crisis Intervention Team (CIT) program developed in Memphis, Tennessee, in 1988. Since then, CIT has been adopted worldwide, in places like Canada (e.g., MCITs, Car 67, COAST, IMPACT, etc.), Australia (e.g., PACER) and the United Kingdom (e.g., Street Triage) (Baker & Pillinger, 2019; Lord et al., 2011; Shapiro et al., 2015; Watson, Compton, & Pope, 2019). As part of the CIT program, police officers receive 40 hours of mental health training to perform as front-line responders

to support PMIs and direct them away from the judicial system and towards appropriate mental health services (Baker & Pillinger, 2019).

Table 1: *Step-by-step process on how the Crisis Intervention Team (CIT) Model operates* (Baker & Pillinger, 2019)

How does it work?
1. 911 dispatchers receive training to triage mental health calls and assign these calls to CIT-trained police officers. 2. CIT officers apply de-escalation techniques to get the individual in a calmer state. 3. If de-escalation is successful, the CIT officer will provide the individual with information to mental health services; however, if further help is needed, the CIT officer will transport the individual to a centralized psychiatric emergency drop-off-site with a 'no closed door' policy.

2.1.2. Issues with the Co-Responding Police-Mental Health Model

The major problem with models such as CIT is the involvement of police who have historically harmed and caused trauma to racialized communities and PMIs. There has been limited evidence about whether the model averts crisis escalations and injuries, improves officers' perceptions of individuals who have a mental illness or is cost-effective (Shapiro et al., 2015; Watson & Fulambarker, 2012). The model also only responds to a relatively small proportion of mental health emergency calls due to lack of capacity and lack of clarity about the programs' role among community partners – for example, in Toronto, CIT only responded to 11% of mental disturbance calls (Shapiro et al., 2015). Other problems related to this model include difficulty establishing partnerships between two very different organizational cultures (police vs. mental health services); the scarcity of psychiatric emergency drop-off centres; and forming an organizational structure that supports joint police mental health program operations (Bailey et al., 2018; Lord et al., 2011; Munetz, Morrison, Krake, Young, & Woody, 2006).

Finally, evaluations of these models have not produced clear findings that could lead it to be considered an 'evidence-based best practice' at reducing lethality during police encounters and

diverting PMIs from the judicial system (Coleman & Cotton, 2010; Rogers, McNiel, & Binder, 2019; Shapiro et al., 2015).

2.2. Underfunding of Social and Health Services

The second barrier to effective crisis intervention is the underfunding of social and health services. The de-institutionalization of PMIs from hospitals was meant to shift mental health care to the community. Unfortunately, mental health care has been placed in the wrong hands, and police have been assigned as first responding "street corner psychiatrists" while lacking the skills and resources to help those in mental health crises (Baker & Pillinger, 2019; Bergen, 2020; Central East Local Health Integration Network, 2015). Advocators call for implementing restorative practices and prioritizing supportive community services that would significantly decrease the need for police intervention (Bergen, 2020; Sharkey, Torrats-Espinosa, & Takyar, 2017). However, community-based mental health services and programs continue to be insufficiently supported by government funding (mostly provincial) (Baker & Pillinger, 2019; Bergen, 2020).

The literature has identified return visits and involuntary admissions to emergency services as indicators of failure to provide appropriate services to PMIs (Central East Local Health Integration Network, 2015). Many social service agencies also do not operate 24 hours a day (Bergen, 2020). A multi-faceted approach that includes various community partners is essential to alleviate these issues; however, that cannot happen if community services continue to be underfunded, discriminatory practices are present in employment and education, and continued over-policing of racialized communities (Frederick et al., 2018).

Table 2: *The negative effects of insufficient funds to social and health services on PMIs (Central East Local Health Integration Network, 2015)*

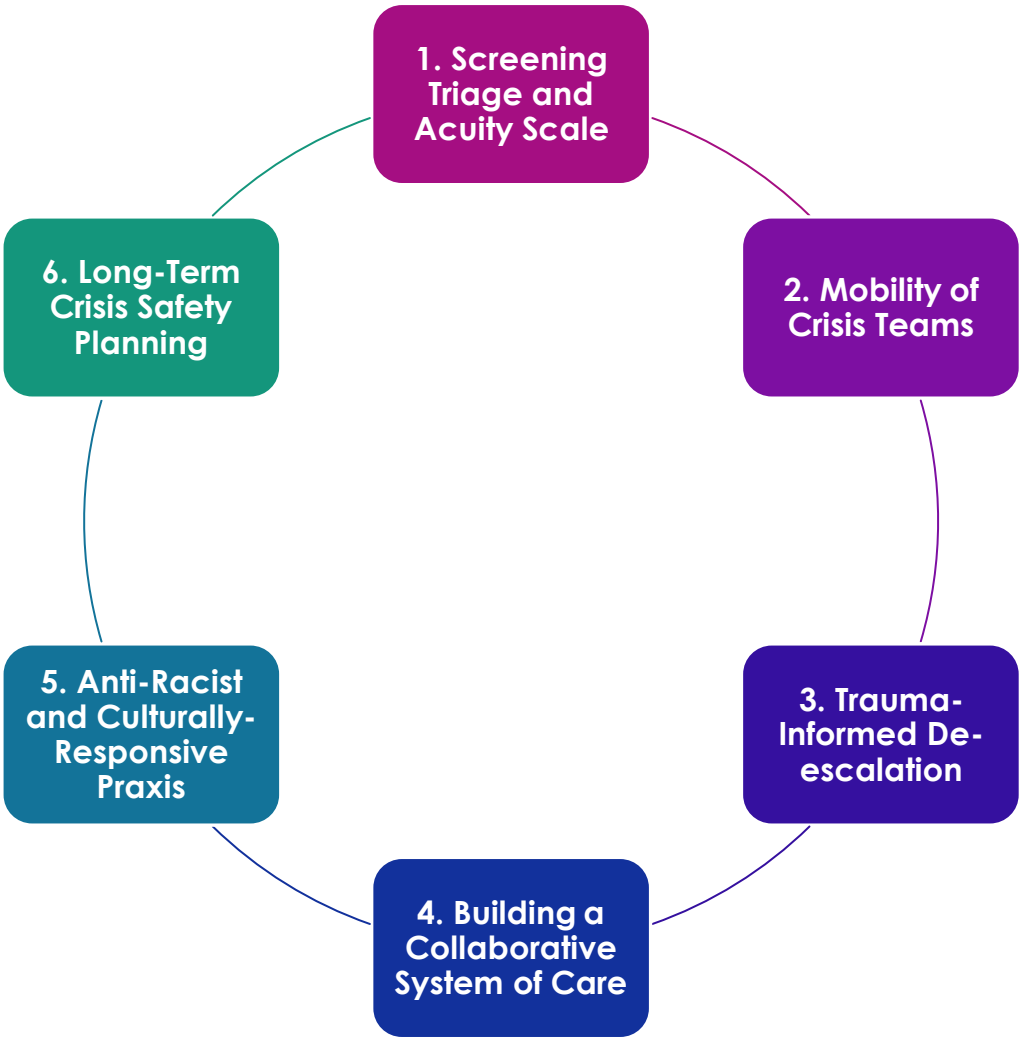
The implications of insufficient funds to social and health services negatively affects PMIs and leads to:

1. Lack of communication of client information between service providers leading to a lack of continuity of care or inappropriate care/treatments
2. Lack of specialized service for concurrent disorders
3. Lack of crisis beds or crisis bed sites throughout communities
4. Lack of options to support individuals in crisis who are noncompliant with treatment
5. Lack of recovery-based follow-up programming
6. Dissatisfaction on the part of the client with mental health services, leading them to disengage from treatment and being prone to experiencing the 'cycle of crisis'
7. Prolonged emergency department wait times for mental health patients or being placed on long waiting lists leading to departure before service is provided

Section 3: Facilitators for Effective Crisis Intervention

A mental health crisis is a scary experience. Contingent on the intervention used to help the individual cope, the outcome can either lead to a healing journey towards recovery or, on the opposite spectrum, cause irreversible harm (i.e., involuntary hospitalization, or brutality resulting in injury or death). The following facilitators aim to effectively manage mental health crises on-site and mediate impacts following the crisis. The facilitators outlined represent evidence-based best practices that aim to resolve the crisis as soon as possible while preventing the crisis from worsening.

Community developers and decision-makers may consider implementing any of the following facilitator measures as a starting point to develop a community-based, non-police mental health crisis model:



3.1. Screening Triage and Acuity Scale

Most successful crisis intervention models include a screening triage and acuity scale to assess the risk of incoming crisis calls. A **screening triage** helps 911 dispatchers or designated crisis hotlines to determine if an incoming call requires a police response, medical response, or a community-based response (SAMHSA, 2020). Screening is a cost-effective method for reducing police time and resources, allowing police officers to focus on dangerous crimes that occur in the community and disrupt public safety.

3.1.1. Georgia Crisis & Access Line Triage Acuity Scale

The Georgia Crisis & Access Line in the United States is a community-based crisis intervention developed by the State of Georgia Department of Behavioural Health & Developmental Disabilities (Berry, n.d.). The Georgia Crisis and Access Line is a crisis centre that includes a crisis line, mobile crisis team and crisis stabilization and recovery services. As part of their crisis line, dispatchers use a comprehensive Triage Acuity Scale to assess the risk of incoming calls.

The Georgia Crisis and Access Line's Acuity Scale has five different levels (with details in **Figure 4**):

(1) **Level 1:** Law Enforcement Leads with Accompanying Mobile Crisis Team
(2) **Level 2:** Mobile Crisis Team Leads with Accompanying Law Enforcement
(3) **Level 3:** Mobile Crisis Team Lifeline with Law Enforcement on Standby by Phone
(4) **Level 4:** Mobile Crisis Team Arrives Alone
(5) **Level 5:** Secure Location

Level 1	**Law Enforcement Leads** (with Mobile Crisis Team Accompanying or Following Behind) The team must heed police instructions and respond as the scene is deemed safe for entry.	This level indicates situations that are too dangerous to deploy without the environment first being secured by law enforcement. It is also key in these situations to have a response within the shortest time possible. The Georgia Crisis & Access Line initiates Rescue Protocol and does not dispatch the Mobile Crisis Team as sole responder if the caller is in imminent danger to self and/or others (as evidenced by any of the following): • "Likely" or "Very Likely" intent for suicide attempt (more than desire/ideations and capability alone) • "Likely" or "Very Likely" intent for homicide attempt • Threat to staff • Possession of weapon
Level 2	**Mobile Crisis Team Leads** (with Law Enforcement in the Background or Following Behind but on the Scene)	Caller reports any of one of the following: • History of aggression • Recent acts of aggression • Self-Injury This level indicates situations where BHL staff enters into the environment first but law enforcement is immediately available if needed.
Level 3	**Mobile Crisis Team Lifeline** (Law Enforcement on Standby by Phone)	All "Emergent" cases and certain "Urgent" cases (where clinical judgment suggests that a call to apprise law enforcement of the situation is prudent)
Level 4	**Mobile Crisis Team A lone** (With no Law Enforcement)	"Urgent" cases in which the absence of clinical intervention suggests the advancement to greater risk or other cases where children or adolescents are being referred to the state hospital or LOC
Level 5	**Secure Location (Hospital, Jail, Social Service Agency Etc...)**	These cases are in a safe location so a clinician may respond alone without a Field Care Consultant. Calls to residences, (apartments, homes etc.) are not "safe sites." With supervisory permission, a Clinician may be sent alone if another mental health or social services professional is already on site (i.e. DFCS, CSB employee).

Figure 4: *The Georgia Crisis and Access Line's Triage Acuity Scale* (Berry, n.d.)

3.1.2. Broome County Risk Assessment Tool

Broome County, New York, has implemented a 911 Distressed Caller Diversion Program, which aims "to identify and refer qualifying non-emergency mental health-related calls for immediate connection to a counselor" (Haight, 2019). By enhancing the communication skills of dispatchers and reducing misunderstandings related to mental illness, the diversion program seeks to provide the best possible care for individuals in crisis, connecting them to mental health professionals (Haight, 2019). This allows law enforcement to remain available for priority assignments and saves on police/fire department resources. The program utilizes a risk assessment flowchart tool to improve mobile response to crisis calls and transport persons with mental crises to appropriate crisis centres and services. **Figure 5** is an adapted flowchart from the original Broome County risk assessment tool (Haight, 2019).

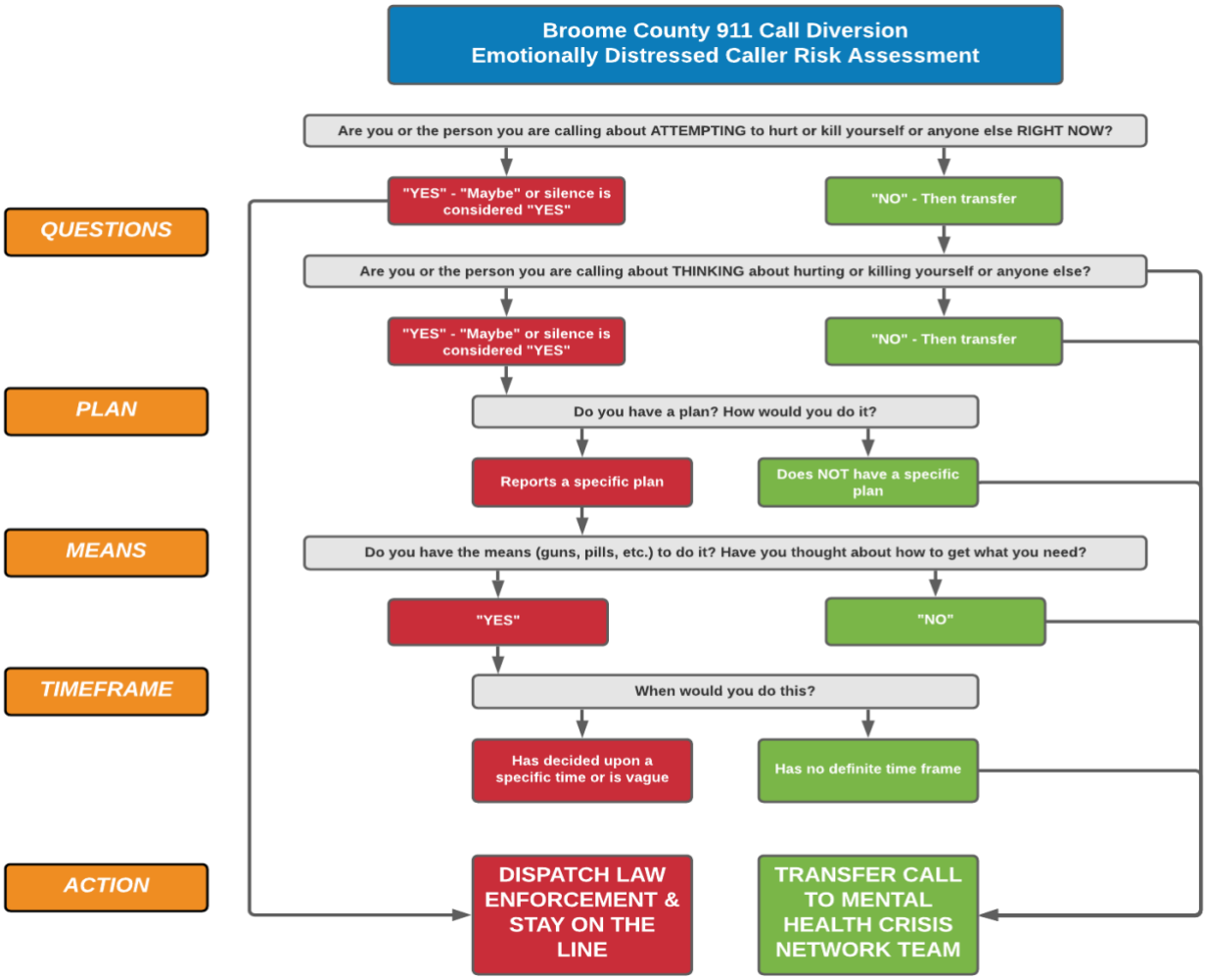


Figure 5: *An adapted flowchart from the Broome County Risk Assessment Tool* (Haight, 2019)

3.1.3. Digital Screening Software

Police services have received much criticism over how they respond to PMIs during a crisis. While the hope is to replace a police response with a community-based response in the foreseeable future, a way to minimize harm during an emergency mental health crisis call is by teaching police officers about screening tools and significant indicators of serious mental health disorders. Digital screeners help police officers identify persons with serious mental disorders and send the information to appropriate social and mental health services in real-time.

HealthIM

HealthIM is a "digital public safety system" mobile app designed to increase safety for both the person in crisis and responding personnel, improve mental health crisis outcomes and provides

effective oversight (HealthIM, 2021). The app is easily accessible through police officers' mobile devices and has been shown to de-escalate situations and connect people to the best available care.

Table 3: *Step-by-step process on how the HealthIM system operates*

How does it work?
The system has four main components: 1. **Pre-Response Safety Briefing** • Before contact with the person in crisis, first responders look through a brief synopsis of critical factors such as "de-escalation techniques, any known triggers and contextual information compiled from previous contact" (HealthIM, 2021). 2. **Mental Health Risk Screener** • Responders use the interRAI Brief Mental Health Screener (interRAI BMHS) to evaluate risk or harm on-scene and to determine appropriate next steps for the individual (HealthIM, 2021). 3. **Inter-Agency Communication** • Wireless transmission of on-scene observations is sent to the hospital, community mental health providers and other partner agencies (HealthIM, 2021). • Advance notice before transportation to the hospital facilitates a warm hand-off approach between community partners. 4. **Reporting and Analytics** • Real-time access to response data "via secure analytics portal and automated reporting" for community agencies and policymakers (HealthIM, 2021).

In December 2020, the Guelph Police Service became the first in Canada to use an improved version of HealthIM. HealthIM was first implemented in Guelph in January 2018 in collaboration with the CMHA Waterloo Wellington and the Guelph General Hospital "as part of broader efforts to promote safer and more compassionate emergency response to individuals in acute crisis situations" (GuelphToday.com, 2021). The app sends a pre-alert to **emergency department (ED)** staff to better prepare them for the arrival of a patient experiencing a mental health crisis. ED staff receive digital information obtained by police officers that will aid in the care and safety planning of individuals who arrive. Since its implementation three years ago, HealthIM has reduced both officers' wait times in the

ED, and the number of individuals involuntarily admitted for ED assessment (GuelphToday.com, 2021). CMHA Waterloo Wellington has also benefited from HealthIM, indicating that the system allows them to receive the referral in real-time, enabling staff to safely and effectively support and follow up with individuals and their families promptly (GuelphToday.com, 2021).

3.2. Mobility of Crisis Teams

Crisis programs require the ability to be mobile, particularly in rural areas or areas where social or emergency services are hard to access (Forchuk, Jenson, Martin, & Csiernik, 2008). Based on current crisis intervention models, a centrally deployed **mobile crisis team (MCT)** is vital in responding to mental health emergencies. The mobility of crisis intervention makes it easier to promptly reach any person in crisis in their home, workplace, or anywhere in the community, to provide immediate relief in an environment that they're most comfortable in (Central East Local Health Integration Network, 2015; SAMHSA, 2020).

Table 4: *Best Practices for a Mobile Crisis Response Team* (SAMHSA, 2020)

Best Practices for a Mobile Crisis Team
[Adapted from SAMHSA (2020)]

- include a medical professional capable of assessing the needs of the individual, the causes of the crisis (e.g., psychiatric, substance abuse) and their medical history
- include a two-person team to support emergency department and justice system diversion as well as for safety; both team members should be well-trained on trauma-informed de-escalation
- incorporate peers within the MCT
- respond without law enforcement unless special circumstances warrant inclusion; even well-intentioned police officer may escalate the situation solely based on their appearance (i.e., police vehicle, uniform, weapons)
- implementation of real-time GPS technology in partnership with a crisis line to support efficient connection to needed resources and tracking of engagement
- connect individuals to facility-based care and schedule outpatient follow-up appointments with a warm hand-off (i.e., transferring care between two healthcare or service providers in front of patient and/or family

3.3. Trauma-Informed De-escalation

A mental health crisis is often rooted in trauma, and care received during and after a crisis can be made worse when an individual feels a loss of freedom, is in a noisy environment or if force is used to restrain them (SAMHSA, 2020). These scenarios can lead to re-traumatizing individuals, leading to exacerbated symptoms and a reluctance to seek help in the future (SAMHSA, 2020). A **trauma-informed framework** considers how prior trauma can affect someone and avoids re-traumatizing someone during crisis interaction, something often not practised by first-responding law enforcement (Donato, 2020). Trauma-informed care is essential in crisis settings because of the relationship between crisis and trauma, and people's vulnerability during a crisis.

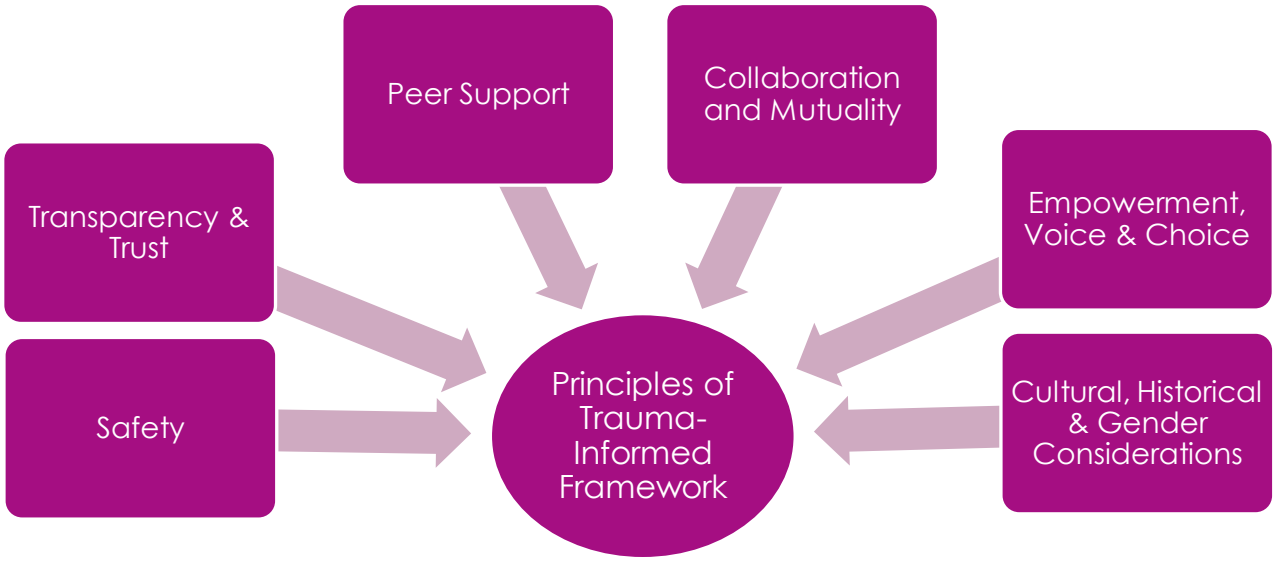


Figure 6: *The Principles of a Trauma-Informed Framework* (SAMHSA, 2020)

Incorporating a trauma-informed framework into **de-escalation** is crucial in becoming emotionally attuned to someone's needs and building rapport in a crisis situation (Donato, 2020). A crisis can be made worse when first-responders start reacting with fear, control and anger instead of care, openness, patience and a relaxed/unhurried attitude (Icarus Project, n.d.). It is easy to overreact during an interaction with a person in crisis; their point of view might be 'off' according to you, but they have real feelings and need to be listened to (Icarus Project, n.d.). Responders' use of effective communication and empathy creates a less hostile environment for the PMI (Bumby, 2016; Lamanna et al., 2015). An interaction that involves respect for dignity and listening without judgement has led to a positive exchange between PMI and responder (Bumby, 2016; Lamanna et al., 2015).

Table 5: *Recommended De-Escalation Techniques* (Icarus Project, n.d.; SAMHSA, 2020)

De-Escalation Techniques

- Keep the tone of your voice calm
- Actively listen to the person
- Express support and concern
- Avoid continuous and threatening eye contact
- Ask them how you can help
- Move slowly and don't make any sudden movements
- Offer options instead of trying to take control
- Avoid touching the person unless you ask for permission and they agree
- Be patient
- Gently announce actions before initiating them
- Give them space, avoid making them feel trapped
- Avoid making judgemental comments
- Do not argue with the person
- Unfold arms

3.4. Building a Collaborative System of Care

Over the last few decades, the Canadian mental health care system has undergone fundamental reform by establishing community-based services and supports for people with severe mental illness to receive appropriate care and live comfortably in the community, rather than in institutional settings (Canadian Mental Health Association, 2004). These reforms are a part of Canada's vision for a high-quality mental health system. Still, in order to maintain this vision, **a collaborative system of care** requires coordination between community service providers, family and peers to support struggling community members.

3.4.1. Community Service Providers

Those with serious mental illness rate their quality of life as poor due to marginalization, living in disadvantaged low-income neighbourhoods and enduring the dual stigma of mental illness and poverty (Canadian Mental Health Association, 2004). Their lives are often made worse by substance use, physical health problems and criminal justice involvements. As denoted in **Section 1,** a SDoH approach is required to target the deep-rooted issues related to mental health. This includes creating employment and educational attainment opportunities, increasing accessibility of affordable housing and offering other avenues for PMIs to thrive. People with severe mental illness who have access to these things report benefits such as "income, freedom, increased self-esteem and a sense of contributing to and being a part of a community" (Canadian Mental Health Association, 2004).

Engaging with a wide range of partners can "help identify which needs could be met by existing community resources and which might require supplemental strategies, such as incubating new service providers, creating new coalitions or networks" (Sakala et al., 2018). For immigrants and racialized groups, connecting with culturally focused service providers and organizers is also crucial in mental health service delivery.

In a Canadian restorative justice project involving young people in conflict with the law, researchers found that the relationship with leaders of ethnic communities was significant to prevent convicted youth from recidivism (Kelly, Caputo, & Totten, 2006). Ethnic leaders are concerned about their young people coming into conflict with the law, and schools were also considered a significant community for young people as they spend most of their time there (Kelly et al., 2006; Ontario.ca, 2020).

To understand the needs of the community, decision-makers should consider using community engagement strategies such as "community-based participatory research, grassroots surveys, analysis and community engagement of administrative data (e.g. data walks) and town halls and focus groups" (Sakala et al., 2018). The solution for a community-based crisis model starts on the ground with directly affected community members and grassroots organizations who know first-hand what goes on in their community and can specifically identify gaps, needs and changes to cultivate safer communities for PMIs.

3.4.2. Family Support

The families of Ejaz Choudry and Regis Korchinski-Paquet have heavily criticized police officers in the media for preventing them from entering into their loved one's place of residence to help de-escalate the situation (Donato, 2020). Family members have a wealth of knowledge about their loved one's mental health and are frequently involved in their health care needs. With the support of first responders, family members can share the responsibility of de-escalating a crisis (Baker & Pillinger, 2019; Icarus Project, n.d.)

Family involvement has been shown to effectively improve the quality of family life and individual functioning of family members (Kelly et al., 2006). At the Canadian Mental Health Association in Middlesex-London and at CAHOOTS in Eugene, Oregon, caregivers and family members are directly involved in their distressed loved ones' care and can even talk to a crisis centre worker about their own experiences with secondary trauma or stress (CAHOOTS, 2020b; CMHA Middlesex, n.d.).

Family members can contribute to mental health care through education, community planning, research, and advocacy. Family members who participate in self-help programs with their loved ones experience less burden and stigma (Canadian Mental Health Association, 2004). With all this in consideration, the mental health system should acknowledge families' valuable contributions and adequately support their needs as well.

3.4.3. Peers

Many individuals who have experienced mental health struggles and violence due to police intervention have found solidarity in peer-led groups (Donato, 2020). Many PMIs value the availability of peer support during the crisis. Peers with a lived experience similar to those of the population they serve can provide comfort to the distressed individual because they have someone to relate to while they receive care. Peers offer personal experiences with mental illness and past mental health crises, allowing them to convey a sense of hopefulness and model that recovery is possible (Forchuk et al., 2008; SAMHSA, 2020). Peer-led groups also provide a plethora of knowledge about helpful resources available in the community, such as a supportive circle of people who have shared experiences, thus alleviating feelings of isolation and fear, accompanying a mental health crisis (SAMHSA, 2020). Peers may also engage with the family members of those in crisis to educate them about self-care and ways to provide support (SAMHSA, 2020).

3.5. Anti-Racist and Culturally Responsive Praxis

Anti-racist praxis is "an action-oriented strategy for institutional systemic change that addresses racism and other interlocking systems of social oppression" (Hasford et al., 2018). It differs from conventional cross-cultural or critical theory models through targeting underlying basic needs such as education, employment, and other fields. Anti-racist praxis also addresses the everyday impacts of racism and trauma that BIPOC communities often face.

Anti-Racist Praxis with Street-Involved African-Canadian Youth, by Hasford et al. (2018), outlines four main concepts that make up anti-racist praxis. The first and most central concept of anti-racist praxis is addressing **anti-black racism**, which "acknowledges that Black Canadians face a unique type of racism that differs in kind and extent from that faced by many other groups and that merits distinct forms of intervention" (Hasford et al., 2018). The second key concept of the anti-racist praxis – which also stems from the critical race theory – emphasizes the **distinction between 'colour-blindness' and anti-racism**. Colour-blindness refers to the "ideological belief that society consists of a multicultural utopia where race does not matter and merit determines life chances" (Hasford et al., 2018). Anti-racism is the belief that racism is permanent and embedded into Western capitalist democracies (Hasford et al., 2018). To effectively practice anti-racism means to take a critical examination of how race impacts the development of programs and policies within your organization. The third important concept of anti-racist praxis is **intersectionality**, which involves "understanding how multiple forms of

identity, such as race, class, gender and ability intersect to create unique experiences of oppression (and privilege)" (Hasford et al., 2018). It is important to avoid using a 'one size fits all' approach when developing programs and policies. For example, when planning an intervention for Black youth, practitioners can integrate an intersectional lens by engaging youth in frequent discussions about various aspects of their identity. The fourth and final concept of anti-racist praxis is **microaggressions**, which are everyday verbal, nonverbal and environmental insults (either intentional or unintentional) that communicate derogatory or harmful messages based on a person's racial identity.

Frequently white social service practitioners go into their practice intending to help all people; however, their **social location** may present problems with marginalized groups. Social location refers to a "person's affiliation or categorization within intersecting webs of oppression and privilege, which include, but are not limited to, race, age, gender, sexual orientation, class, and religion" (Hasford et al., 2018). These affiliations determine an individual's societal roles and expectations and where they fit on the spectrum from privilege to oppressed (Hasford et al., 2018). Differing social locations can result in "oppressive societal power relations" (Hasford et al., 2018). That is where the importance of **allyship** comes in at advancing anti-racist praxis. An ally refers to "a person who works from an awareness of their social location in relationship to others, who recognizes the privilege they receive from society's patterns of injustice, and who takes responsibility for changing these patterns" (Hasford et al., 2018). Creating change and challenging racism and discrimination is emotionally draining work that racialized people are expected to fulfil; however, allyship reduces racialized peoples' brunt of the work, creating a shared responsibility for taking on the labour involved in challenging racism (M. McKenzie, 2014). Allyship goes beyond work as a social service provider; it is an identity grounded in challenging social inequities and the status quo by standing side by side with marginalized groups (Hasford et al., 2018).

An example of an anti-racist service delivery model is **Across Boundaries**, an organization in Toronto, which provides "equitable, inclusive and holistic mental health and addiction services for racialized people across the Greater Toronto Area" (Across Boundaries, n.d.). Their organization recognizes that racism is a social determinant of mental health and a root cause of other social determinants such as low-income and homelessness. Their anti-racist approach is intersectional, aiming to fight injustice and oppression in the mental health system, and considers diversity among racialized people such as religion, language, culture/ethnicity, gender, citizenship status, and/or disability (Sarang et al., 2009). The Across Boundaries model for anti-racism acknowledges how individual and systemic racism present barriers to accessing mental health services; highlighting common barriers such as inappropriate use of interpreters, culturally irrelevant treatment methods, and social service providers

who impose their values on populations they know very little about (Sarang et al., 2009). These barriers may prevent racialized people from seeking help and receiving further mental health support until it's too late (i.e., a crisis occurs).

Appendix B further outlines anti-racist and culturally responsive practices such as providing services in different languages and alternatives to traditional western therapy, practices to better serve ethnocultural and racialized individuals in their mental health care. The social and health sectors' progression toward anti-racist and culturally responsive praxis empowers racialized groups to access community resources such as family-centred services, self-help groups, neighbourhood-friendly information, collateral services, and large-scale integrative systems (Ferguson, 1996).

3.6. Long-Term Crisis Safety Plan

A **crisis safety plan** is a written plan developed by the person with the mental health condition and their support team (i.e. family members, close friends) and potentially a mental health or social service provider (Brister, 2018a; Williamson, 2012). It is designed to address symptoms and behaviours and to help plan ahead before a crisis occurs. This plan should be updated whenever there is a change in diagnosis, medication, treatment or service provider (Brister, 2018). Every plan is individualized and may include information such as the distressed person's name, contact information of social supports, current diagnosis and medications, and other valuable information that could prevent a crisis from re-occurring (Brister, 2018; Williamson, 2012). For templates on Long-Term Crisis and Safety Plans, refer to Appendix C and Appendix D.

A long-term crisis safety plan should be in place for people who experience repeated distress or crises. Based on results from the co-response police mental health model, police officers are often tasked to respond to numerous calls about the same person in distress. Typically in this scenario, the individual is admitted into emergency services or extended hospital care, discharged, and the process repeats itself, thereby becoming a continuous 'cycle of crisis' (Lamanna et al., 2018). Safety planning is a crisis prevention tool that people who have a history of mental health crisis have been using to prevent police interaction or force enacted on them during a crisis (Donato, 2020; Williamson, 2012).

3.6.1. Wraparound Process

In 1999, the Alternative Responses in Communities (ARC) project was launched as a community-based restorative justice alternative for young individuals in conflict with the law in a large Canadian city (Kelly et al., 2006). A component of this project called the **'Wraparound Process (WP)**,' is based on a specific set of policies and practices used to develop individualized services and supports for youth and families experiencing ongoing emotional and behavioural difficulties (Kelly et al., 2006). WP has been shown to effectively improve the quality of family life and individual functioning of family members. It is used to create individualized care plans that are "based on the unique strengths, values, norms and preferences of the child, family and community" (Kelly et al., 2006). WP is based on the **Integrated Systems of Care (ISOCs)** model. ISOCs are cooperative arrangements in which various human service organizations such as schools, mental health providers and child welfare agencies join together to establish a process enabling the system to respond using a wide range of flexible, highly individualized services for an individual and their family (Kelly et al., 2006). WP is a long-term process and requires a robust network of service providers.

3.6.2. Psychiatric Advance Directives

Psychiatric Advance Directives (PAD) can be used alongside a crisis safety plan, especially when a person loses their capacity to give informed consent to crisis treatment. PADs are legal documents that share a person's specific instructions or preferences regarding future mental health treatment (Brister, 2018; SAMHSA, 2020). It can include specific consent to communicate with family members, caregivers or friends during crises (Brister, 2018; SAMHSA, 2020). Currently, PADs are commonly used in the US but not in Canada.

Section 4: Community-Based and Non-Police Crisis Intervention Models

The models in this report have been selected based on the criteria that they include most, if not all of the mentioned facilitators for effective crisis intervention;

i. **screening triage and acuity scale,**
ii. **mobility of crisis teams,**
iii. **trauma-informed de-escalation,**
iv. **collaborative system of care,**
v. **anti-racist and culturally responsive praxis, and/or**
vi. **long-term safety planning.**

More importantly, the selected models that are cited are all non-police and community-based. They are fully designed to manage potentially dangerous mental health crises on-site and include factors to mediate impacts after the crisis. The existing models have been implemented in Canada, the US, Sweden and Australia – countries with similar infrastructure and jurisdiction.

The following community-based and non-police mental health crisis intervention models are highlighted:

1. CAHOOTS (USA)

2. REACH Edmonton (Canada)

3. Gerstein Crisis Centre (Canada)

4. NYC Well (USA)

5. Anne Arundel County Crisis Response System (USA)

6. Albuquerque Community Safety (USA)

7. Mental Health Ambulance (Sweden)

8. Mental Health Acute Assessment Team (Australia)

4.1. CAHOOTS Model (Eugene, Oregon, USA)

The **Crisis Assistance Helping Out on the Streets, or CAHOOTS** for short, is one of the most popular crisis intervention models in North America. CAHOOTS is a community-based public safety system that was first developed in Eugene, Oregon and has now been picked up in other cities in North America (Bergen, 2020; CAHOOTS, 2020b). The model provides first response for crises involving mental illness, homelessness and addiction (CAHOOTS, 2020b). It mobilizes a two-person team consisting of a medic (i.e., nurse or paramedic) and a crisis worker who has extensive training and experience in the mental health field (CAHOOTS, 2020b). All team members receive over 500 hours of training, including trauma-informed de-escalation, non-violent conflict resolution, substance abuse and harm reduction, suicide prevention and intervention, and conducting welfare checks (CAHOOTS, 2020b).

CAHOOTS aims to resolve crises where a social service response is more appropriate than a police response. The CAHOOTS team may sometimes be sent out with law enforcement; however, in only 0.6% of their calls did they require police backup (Bergen, 2020). The CAHOOTS team are not law enforcement; therefore, they do not carry weapons, and they are plain-clothed in an effort to make people in crisis feel safer. CAHOOTS services are voluntary, confidential and free of charge reducing accessibility barriers (CAHOOTS, 2020c).

Table 6: *Step-by-step process on how the CAHOOTS model operates (CAHOOTS, 2020b)*

How does it work?
1. CAHOOTS calls come from dialling 911 or from the police non-emergency number. 2. Dispatchers receive training to recognize mental health crises using a behavioural health assessment and route calls to CAHOOTS. 3. The team responds, evaluates the situation, and provides immediate stabilization for urgent medical needs or psychological crises. 4. Based on their assessment, the team either provides information and referrals to individuals requiring additional support from social services, or they may transport the individual directly to treatment/services.

The success of CAHOOTS is attributed to three main factors: (1) a robust human services network, (2) trust of the population they serve, and (3) a community culture of care and compassion supporting urgent (non-police) response to struggling community members (CAHOOTS, 2020b, 2020a). According to their recent Media Guide, the CAHOOTS Model is also cost-saving and has reportedly saved Eugene, Oregon, an estimated $8.5 million in public safety spending annually by answering 17% of Eugene Police Department's overall call volume (CAHOOTS, 2020b).

Since its launch, the CAHOOTS model has been adopted all over the US. In Denver, Colorado, they recently launched a similar model called **Support Team Assisted Response** or **STAR**. This program provides mobile crisis intervention to individuals requiring free medical care, first aid, or mental health support for a broad range of emergencies such as drug overdoses, suicide, intoxication and more (Denver Justice Project, 2020). Following in the CAHOOTS model, the STAR van carrying a paramedic and mental health clinician is dispatched using Denver's 911 communications center diverting calls away from police and toward mental health professionals (Denver Justice Project, 2020).

4.2. REACH Edmonton (Edmonton, Alberta, Canada)

REACH Edmonton is a backbone agency that "conducts its work through community involvement, stakeholders engagement, and interagency collaboration" (REACH Edmonton, 2020b). They have a 24/7 Crisis Diversion program that operates 365 days a year, involving a collaboration with the Canadian Mental Health Association, Edmonton Police Service and other community partners (REACH Edmonton, 2020a). Similar to CAHOOTS, a crisis diversion team is dispatched responding to people in distress and vulnerable on the streets of Edmonton with the intention "to reduce the need for expensive medical, judicial and polices interventions" (REACH Edmonton, 2020a). They ensure that all front-line crisis diversion workers are adequately trained and provide a warm hand-off approach for frequent clients (REACH Edmonton, 2020a).

4.3. Gerstein Crisis Centre (Toronto, Ontario, Canada)

Gerstein Crisis Centre in Toronto is a great example of an alternative to non-police mobile crisis intervention. The centre provides 24-hour community-based crisis services for adults 16 and older who are dealing with mental health or substance use issues and are currently experiencing crisis (Gerstein Crisis Centre, 2020a). Their team comprises mental health experts; however, they are currently limited in resources and cannot always respond to crises immediately. The Gerstein Crisis Centre has four main services: (1) **mobile crisis teams (MCTs)**, (2) telephone crisis line, (3) crisis and recovery services, and (4) referrals to health and social services (see **Table 7**).

Table 7: *Services Provided at Gerstein Crisis Centre (Gerstein Crisis Centre, 2020b, 2020a)*

Services	How does it work?
1. MCTs	• MCTs consist of skilled and experienced crisis workers trained in suicide prevention and intervention, harm reduction and trauma • Many of the crisis workers also have lived experience
2. Telephone Crisis Line	• A 24/7 telephone crisis line

3. Crisis and Recovery Services	• Gerstein provides 24/7 crisis services and support with short-term follow up to individuals 16 years and older
	• Safe crisis beds available in 3 different locations
	• Other available recovery services include:
	  o Wellness Recovery Action Plan (WRAP) in different languages
	  o Finding Recovery Through Exercise Skills and Hope (FRESH)

4. Referrals	• Provides referrals to various health and social services for adults 16 years and older

4.4. NYC Well (New York City, New York, USA)

New York City Well, or NYC Well for short, defines a crisis as a "time of intense difficulty, distress or trouble," whether personal, such as a family crisis, or related to some other life event (NYC Well, 2020c). They advise calling 911 for emergencies, which involve immediate risk of an individual hurting themselves or someone else. They provide a multitude of different services and programs including, (1) MCT, (2) telephone line, (3) in-person crisis interventions (i.e., crisis respite, safety planning and PADs), (4) home-based crisis intervention services for children (see **Table 8**).

Table 8: *Services Provided at NYC Well* (NYC Well, 2020b, 2020a, 2020d, 2020c)

Services	How does it work?
1. MCTs	• MCTs are composed of health professionals (i.e., nurses, social workers, psychiatrists) who provide mental health services, primarily in people's homes • Operates 24/7/365 throughout New York City
2. Telephone Line	• Requests come in from NYC Well's own telephone line • Calls can be made for family members, friends, and acquaintances who are experiencing or at risk of crisis
3. In-Person Crisis Intervention	• **Crisis Respite:** temporary residential stay in a safe and supportive home-like environment where individuals in crisis can come and go as they please, replacing a traditional in-patient hospital room. The program provides 24/7 support by mental health professionals and peers who have experience with mental health issues. • **Safety and Crisis Planning:** these plans recognize individual triggers, who to call for help and how to best care for an individual and keep them safe if a crisis were to occur. The plan can include information such as referrals to community-based mental health services. • **Psychiatric Advance Directives (PADs):** these are written documents outlining instructions for an individual's mental health if they lose the ability to explain their treatment or care (more on PADs here).
4. Home-Based Crisis Intervention	• Intensive in-home crisis care for 4-6 weeks for children ages 5-18 • An alternative to hospitalization for youth experiencing emotional distress • Services include problem-solving skills, individual and family counselling, connection to community-based resources, case management, medication evaluation and management

4.5. Anne Arundel County Crisis Response System (Annapolis, Maryland, USA)

The **Anne Arundel County Crisis Response System** in Maryland, USA, is a comprehensive crisis system that provides a wide range of behavioural health options and support for distressed individuals. They offer a multitude of services including, (1) MCTs, (2) care coordination and follow-up, (3) mobile assertive community treatment, (4) hospital diversion program, (5) jail diversion program, and (6) in-home interventions for children and adults (see **Table 9**).

Table 9: *Services Provided at Anne Arundel County's Crisis Response System* (Anne Arundel County Mental Health Agency Inc, n.d.)

Services	How does it work?
1. MCTs	• 911 dispatchers refer crisis calls to one of the county's MCTs • MCTs are dispatched and are responsible for stabilizing the distressed individual and connecting them to appropriate resources • Operates 24/6/365
2. Care Coordination	• Care coordination is vital to the success of Anne Arundel County's CRS as it ensures that individuals can remain stable and mitigate additional crises from occurring • This is a follow-up service that is conducted with individuals after their immediate crisis is resolved • The operators also contact service providers to coordinate further care for the individual
3. Mobile Assertive Community Treatment (ACT)	• **Assertive Community Treatment** is "an evidence-based practice that improves outcomes for people with severe mental illness who are most at risk of psychiatric crisis and hospitalization and involvement in the criminal justice system." • Research shows that ACT decreases hospitalization, increases housing stability and enhances the quality of life for individuals with a severe mental illness
4. Hospital Diversion Program	• This program aims to divert distressed individuals who arrive at the emergency department from entering into in-patient hospital care • A clinician located at Anne Arundel's medical center consults with hospital staff to determine if there is an alternative to in-patient stay for an individual • When it is determined that the individual can be better cared for by community services, they are safely discharged using a warm hand-off approach

	• One of the services they provide individuals is access to crisis beds; individuals are discharged from restrictive in-patient hospital care to short-term crisis beds where they receive crisis stabilization support for up to 10 days
5. Jail Diversion Program	• The program is for individuals who are: in pre-trial status, charged with a misdemeanour and have screened positive for a behavioural health disorder • Those that participate in the program agree to receive community-based services upon release • Once individuals are accepted into the program, a 90-day post-release plan of care is developed, which "includes strategies to address housing needs, mental health and substance use disorder treatment, physical health and attainment of benefits."
6. In-Home Intervention Teams	**For children** • A "family-focused, community-based, in-home intervention program" that provides services for children and adolescents with behavioural health disorders and at risk of out-of-home placement • The program offers individualized, coordinated treatment and skill-building to the child and their family • The approach engages the child, their family and critical members influential in the child's well-being, such as school staff, mental health professionals or extended family (similar to the ***Wraparound Process***) • In this program, youth remain in their homes, thereby significantly reducing the need for institutional care or out of home placement **For adults** • An "intensive community-based treatment approach for individuals with chronic and severe mental illnesses" • This program is meant for individuals for whom less intensive outpatient treatment has been ineffective • 24-hour crisis availability support allowing individuals to be stabilized within their current living situation, thereby reducing the need for emergency visits or in-patient institutional hospital care

4.6. Albuquerque Community Safety (Albuquerque, New Mexico, USA)

The mayor of Albuquerque, New Mexico, recently announced creating a third department of first responders called **Albuquerque Community Safety**. This department will serve alongside the Albuquerque Police department and Albuquerque Fire department "to deliver a civilian-staffed, public health approach to safety" (The City of Albuquerque, 2020). The Albuquerque Community Safety department took two years of planning in an effort to change the way Albuquerque handles public safety and comes amid calls to move resources away from armed police response (The City of Albuquerque, 2020). Albuquerque is well into its police reform process compared to many other cities worldwide. The Community Safety department will help the city focus police resources on tackling dangerous crimes, and firefighters and paramedics can focus on fire and medical emergencies. The new department will include trained professionals such as social workers, housing and homelessness specialists, violence prevention and diversion program experts (The City of Albuquerque, 2020).

Table 10: *Step-by-step process on how the Community Safety model will operate* (The City of Albuquerque, 2020)

How does it work?
1. 911 dispatchers will have the option to refer calls to the Community Safety department when a community response is "more appropriate than a paramedic, firefighter or armed police officer" response. Thereby greatly reducing response times to respond to crises. 2. The Community Safety department will respond to calls on "homelessness, addiction, mental health and other issues that do not present an immediate threat to public safety." 3. Moreover, the department will "more efficiently connect those in need with service providers that address underlying issues including housing or treatment for addiction and behavioural health." Responders will call for police assistance if there is a threat to their own safety or the safety of others.

4.7. Mental Health Ambulance (Stockholm, Sweden)

In Stockholm, Sweden, a **mental health ambulance** is operated by an acute mobility team comprised of two psychiatric registered nurses and one emergency medical technician (Bergen, 2020; Lindström et al., 2020). They respond to emergency mental health issues with suicide prevention as the main priority. Patients are taken care of by trained nurses in the same way as if an individual was experiencing a physical problem (Bergen, 2020; Lindström et al., 2020). Unfortunately, like many community mental health programs, the mental health ambulance is under-resourced and underfunded, with 15-20 calls/day and one operating vehicle. In this regard, it is difficult for the mobility team to attend to all emergency mental health crises promptly, so staff can only attend to the most serious patients (Bergen, 2020).

Based on a study evaluating patients' perceptions about the mental health ambulance program, they expressed how staff provided them with a safe environment where they could receive care by nurses without fear of being ignored or judged (Lindström et al., 2020). In comparison to police intervention, patients noted that the act of caring they received from the psychiatric acute team was mostly absent when they received help from police (Lindström et al., 2020). Overall, the program has reportedly contributed to better outcomes for patients, their families and the psychiatric team.

Table 11: *Step-by-step process on how the Mental Health Ambulance Model operates* (Lindström et al., 2020)

How does it work?
1. The emergency medical community centre (EMCC) dispatches the mental health ambulance after assessing the emergency call as a psychiatric emergency. If required, police are dispatched by the EMCC. 2. Two options for patients: a) A patient in need of further assessment or in-patient care is transported by the psychiatric team and admitted to the appropriate emergency division (psychiatric, somatic or substance use) b) Patients who are not transported to care are provided with advice for self-care, and necessary mental health supports with family/caregivers as involved as possible

4.8. Mental Health Acute Assessment Team (Sydney, Australia)

The most common model for crisis intervention throughout Australia is the Crisis Assessment and Treatment Team (CATT) (health direct Australia, 2019). CATTs are referred to by many different names across Australia, but they all perform similar roles.

An example of a CATT is the **Mental Health Acute Assessment Team (MHAAT)**, a partnership between New South Wales Ambulance and Sydney Local Health District Mental Health Services (Faddy, McLaughlin, Cox, & Muthuswamy, 2017). MHAAT consists of a paramedic and a mental health nurse (Watson et al., 2019). Like the mental health ambulance model in Sweden, MHAAT uses an ambulance vehicle that is not stretcher-capable but can transport a seated patient.

***Table 12**: The different operational roles of the MHAAT team (Faddy et al., 2017)*

How does it work?
Each member of the MHAAT team plays a different role. **Paramedic** • As part of the team, they provide thorough physical assessment and determine whether the patient is suitable for referral to a destination other than an emergency department • Undergo extensive training in patient assessment, risk mitigation and clinical decision making **Nurse** • Responsible for conducting a complete mental health assessment in accordance with the mental health outcome assessment tool **Dispatcher** • Uses the medical priority dispatch system where potential cases are categorized as an acute mental health crisis and tasked to the MHAAT team

After the team conducts a clinical assessment to determine the best course of care for the individual, they then refer patients to general practitioners or mental health facilities instead of an ED (Faddy et al., 2017). Patients also have a role in determining which care option works best for them. Options available to them include transport to the ED for psychiatric care, transport directly to a mental health facility, transport to an alternative mental health provider, or leave the patient at home to be cared for (Faddy et al., 2017). Initial evaluation of this model has indicated that 70% of patients had bypassed ED care for more appropriate care settings, with 2/3rd directly being transported to a mental health facility (Faddy et al., 2017; Watson et al., 2019).

Conclusion

Police officers are often called on to respond to and handle mental health crises that they are not well-trained or well-positioned to address. The literature reveals focused attention towards developing community resources that target the social determinants of health and the intersectional factors that may lead someone toward mental health crises (e.g., experiencing both racism and unemployment). In practice, community-led initiatives prioritize community needs to enhance everyone's quality of life in the community. Such enterprises are structured to address the root causes of mental illness by providing a supportive environment to help people tackle their challenges. Additionally, a community-based approach will provide PMIs with options within reach for treatment and recovery, and connections to community resources such as health care, stable and affordable housing, mentoring, conflict resolution, trauma-informed care and employment services.

Transforming the mental health system to respond to mental health crises more effectively is not an easy process. It involves the coordination and collaboration of healthcare providers, social services, community members and law enforcement agencies. Facilitating a robust network of healthcare and social service providers across multiple sectors is pivotal in developing an alternative model for crisis intervention. When we work together, we can develop solutions that are better suited to support PMIs and racialized communities in accessing community-based resources and diverting them from entering into the judicial system or involuntary in-patient hospital care.

We hope that the findings in this report will facilitate conversation and ultimately lead to investment in non-police crisis interventions that not only protect marginalized communities from harm but uplift and empower them. As a starting point, community developers and decision-makers can consider implementing any of the following facilitator measures: screening triage and acuity scale; trauma-informed de-escalation; collaborative system of care; anti-racist and culturally responsive praxis; long-term crisis safety planning; and mobility of crisis teams, so that they may gradually transform their mental health crisis intervention into a model that is non-police and community-based.

References

1. Across Boundaries. (n.d.). What We Do — Across Boundaries. Retrieved March 30, 2021, from https://www.acrossboundaries.ca/about-Us
2. Anne Arundel County Mental Health Agency Inc. (n.d.). Crisis Response System. Retrieved January 19, 2021, from http://www.aamentalhealth.org/crisisresponsesystem.cfm
3. Bailey, K., Paquet, S. R., Ray, B. R., Grommon, E., Lowder, E. M., & Sightes, E. (2018). Barriers and facilitators to implementing an urban co-responding police-mental health team. *Health & Justice*, 6(21). https://doi.org/10.1186/s40352-018-0079-0
4. Baker, D., & Pillinger, C. (2019). 'If You call 911 they are going to kill me': families' experiences of mental health and deaths after police contact in the United States. *Policing and Society*, 1–14. https://doi.org/10.1080/10439463.2019.1581193
5. Bergen, R. (2020, June 14). Approach mental health crises with care, not policing: crisis worker. Retrieved August 7, 2020, from https://www.cbc.ca/news/canada/manitoba/defund-police-mental-health-crisis-intervention-1.5608627
6. Berry, F. W. (n.d.). *Guide: Using mobile crisis services in lieu of an order to apprehend*. Georgia, Atlanta. Retrieved from https://dbhdd.georgia.gov/mobile-crisis-services#:~:text=For access to services and,4225%2C available 24%2F7.
7. Brister, T. (2018). *Navigating a mental health crisis: A NAMI resource guide for those experiencing a mental health emergency*. Retrieved from www.nami.org
8. Bumby, K. (2016). *Crisis response to persons with mental illness: Understanding responder capacity*. *University of Northern British Columbia*.
9. CAHOOTS. (2020a). About Us | White Bird Clinic. Retrieved July 24, 2020, from https://whitebirdclinic.org/about/
10. CAHOOTS. (2020b). *Media guide 2020*. Retrieved from https://whitebirdclinic.org/wp-content/uploads/2020/07/CAHOOTS-Media.pdf
11. CAHOOTS. (2020c). Services. Retrieved July 24, 2020, from https://whitebirdclinic.org/wp-content/uploads/2020/06/11x8.5_trifold_brochure_CAHOOTS.pdf
12. Canadian Mental Health Association. (2004). Making a difference: Ontario's community mental health evaluation initiative, 52. Retrieved from http://www.ontario.cmha.ca/cmhei/images/report/Making_a_Difference.pdf
13. Central East Local Health Integration Network. (2015). *Community crisis service review priority project - March 2015*. Retrieved from http://www.centraleastlhin.on.ca/page.aspx?id=71CC9FF4139B4FED9D6EABB3C2077953
14. CMHA Middlesex. (n.d.). *Family Support Guide*. Retrieved from https://cmhamiddlesex.ca/wp-content/uploads/2017/02/Family-Support-Guide-Web-Version.pdf
15. Coleman, T., & Cotton, D. (2010). *Police interactions with persons with a mental illness: Police learning in the environment of contemporary policing*. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/Law_Police_Interactions_Mental_Illness_Report_ENG_0_1.pdf
16. Denver Justice Project. (2020, June 8). Press Release: DJP Helps Launch Alternative Public Health Emergency Response Pilot In Denver. Retrieved January 19, 2021, from http://www.denverjusticeproject.org/2020/06/08/press-release-alternative-public-health-emergency-response-pilot-launches-in-denver/
17. Donato, A. (2020, June 29). How To De-Escalate A Mental Health Emergency Without Calling The Police. Retrieved August 7, 2020, from https://www.huffingtonpost.ca/entry/deescalate-mental-health-crisis-tips_ca_5ef67d60c5b6ca97090fa2b1
18. Faddy, S. C., McLaughlin, K. J., Cox, P. T., & Muthuswamy, S. S. (2017). The mental health acute assessment team: A collaborative approach to treating mental health patients in the community. *Australasian Psychiatry*, *25*(3), 262–265. https://doi.org/10.1177/1039856216689655
19. Ferguson, S. A. (1996). Towards an anti-racist social service organization. *Journal of Multicultural Social Work*, *4*(1), 35–48. https://doi.org/10.1300/J285v04n01_03
20. Forchuk, C., Jenson, E., Martin, M.-L., & Csiernik, R. (2008). *Crisis services: A comparative approach to evaluation (SEEI phase ii report)*. Retrieved from https://www.eenet.ca/sites/default/files/wp-content/uploads/2013/10/crisis-services-final-report.pdf
21. Frederick, T., O'Connor, C., & Koziarski, J. (2018). Police interactions with people perceived to have a

mental health problem: A critical review of frames, terminology, and definitions. *Victims and Offenders*, *13*(8), 1037–1054. https://doi.org/10.1080/15564886.2018.1512024
22. Gerstein Crisis Centre. (2020a). Our Crisis Services - Gerstein Crisis Centre. Retrieved August 10, 2020, from https://gersteincentre.org/our-crisis-services/
23. Gerstein Crisis Centre. (2020b). Philosophy - Gerstein Crisis Centre. Retrieved August 10, 2020, from https://gersteincentre.org/about-us/philosophy/
24. GuelphToday.com. (2021, December 18). Guelph police first in the country to use new safety system for emergency crisis response. Retrieved January 21, 2021, from https://www.guelphtoday.com/police/guelph-police-first-in-the-country-to-use-new-safety-system-for-emergency-crisis-response-3193548?fbclid=IwAR2s7FBTN-lmP638SIjM7VPMPiJpVtcA30_-UIeoewsKm-nyZSYDnBHwzQQ
25. Haight, N. (2019). Broome County 911 distressed caller diversion program. In *NYS911 coordinators conference - October 30, 2019* (p. 23). Retrieved from https://nys911.com/wp-content/uploads/2019/12/OMH-Diversion-Webinar-short.pdf
26. Hasford, J., Amponsah, P., & Hylton, T. (2018). Anti-racist praxis with street-involved African Canadian youth. In *Mental Health & Addiction Interventions for Youth Experiencing Homelessness* (pp. 125–137). Retrieved from https://www.homelesshub.ca/sites/default/files/attachments/Ch2-4-MentalHealthBook.pdf
27. health direct Australia. (2019, October). CATT – the crisis assessment and treatment team | healthdirect. Retrieved January 19, 2021, from https://www.healthdirect.gov.au/crisis-management
28. HealthIM. (2021). HealthIM. Retrieved January 21, 2021, from https://www.healthim.com/
29. Icarus Project. (n.d.). Navigating crisis. *Icarus Project*. Retrieved from https://fireweedcollective.org/publication/navigating-crisis/
30. Kelly, K., Caputo, T., & Totten, M. (2006). Community-based alternatives? Lessons from a restorative justice project for youth. *Canadian Review of Social Policy*, (57), 85–103.
31. Lamanna, D., Kirst, M., Shapiro, G., Matheson, F., Nakhost, A., & Stergiopoulos, V. (2015). *Toronto mobile crisis intervention team (MCIT): Outcome evaluation report*. Toronto, Ontario. Retrieved from http://stmichaelshospitalresearch.ca/wp-content/uploads/2016/12/MCIT-outcomeevaluation-%0AFinal-report.pdf%0A
32. Lamanna, D., Shapiro, G. K., Kirst, M., Matheson, F. I., Nakhost, A., & Stergiopoulos, V. (2018). Co-responding police–mental health programmes: Service user experiences and outcomes in a large urban centre. *International Journal of Mental Health Nursing*, *27*(2), 891–900. https://doi.org/10.1111/inm.12384
33. Lindström, V., Sturesson, L., & Carlborg, A. (2020). Patients' experiences of the caring encounter with the psychiatric emergency response team in the emergency medical service—A qualitative interview study. *Health Expectations*, *23*(2), 442–449. https://doi.org/10.1111/hex.13024
34. Lord, V. B., Bjerregaard, B., Blevins, K. R., & Whisman, H. (2011). Factors influencing the responses of crisis intervention team-certified law enforcement officers. *Police Quarterly*, *14*(4), 388–406. https://doi.org/10.1177/1098611111423743
35. McKenzie, K., & Waldron, I. R. (2009). *Re-conceptualizing "trauma": Examining the mental health impact of discrimination, torture & migration for racialized groups in Toronto*. Retrieved from http://yourexperiencesmatter.com/wp-content/uploads/2016/01/R_341.pdf
36. McKenzie, M. (2014). *Black girl dangerous: On race, queerness, class and gender*. Oakland, CA, USA: BGD Press.
37. Munetz, M. R., Morrison, A., Krake, J., Young, B., & Woody, M. (2006). Statewide implementation of the crisis intervention team program: The Ohio model. *Psychiatric Services*, *57*(11), 1569–1571. https://doi.org/10.1176/appi.ps.57.11.1569
38. NYC Well. (2020a). Crisis Services – NYC Well. Retrieved January 19, 2021, from https://nycwell.cityofnewyork.us/en/crisis-services/
39. NYC Well. (2020b). Home Based Crisis Intervention – NYC Well. Retrieved January 19, 2021, from https://nycwell.cityofnewyork.us/en/crisis-services/home-based-crisis-intervention/
40. NYC Well. (2020c). Know Who to Call – NYC Well. Retrieved January 19, 2021, from https://nycwell.cityofnewyork.us/en/crisis-services/know-who-to-call/
41. NYC Well. (2020d). Mobile Crisis Teams – NYC Well. Retrieved January 19, 2021, from https://nycwell.cityofnewyork.us/en/crisis-services/mobile-crisis-teams/
42. Ontario.ca. (2020, March 20). Ontario's anti-racism strategic plan. Retrieved August 10, 2020, from https://www.ontario.ca/page/ontarios-anti-racism-strategic-plan
43. Ontario Human Rights Commission. (2009). *Policy and guidelines on racism and racial discrimination*

(Vol. 2005). Retrieved from http://www3.ohrc.on.ca/sites/default/files/attachments/Policy_and_guidelines_on_racism_and_racial_discrimination.pdf
44. Parker, A., Scantlebury, A., Booth, A., MacBryde, J. C., Scott, W. J., Wright, K., & McDaid, C. (2018). Interagency collaboration models for people with mental ill health in contact with the police: A systematic scoping review. *BMJ Open*, *8*(3). https://doi.org/10.1136/bmjopen-2017-019312
45. Public Health Agency of Canada. (2019). Social determinants of health and health inequalities. Retrieved August 19, 2020, from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html
46. REACH Edmonton. (2020a). 24/7 Crisis Diversion – REACH Edmonton. Retrieved September 23, 2020, from https://reachedmonton.ca/initiatives/24-7-crisis-diversion/
47. REACH Edmonton. (2020b). About REACH – REACH Edmonton. Retrieved September 24, 2020, from https://reachedmonton.ca/about-reach/
48. Rodenberg, H. (2020). Understanding police violence as a mutual problem. *American Journal of Public Health*, *110*(4), 456–457. https://doi.org/10.2105/AJPH.2020.305585
49. Rogers, M. S., McNiel, D. E., & Binder, R. L. (2019). Effectiveness of police crisis intervention training programs. *Journal of the American Academy of Psychiatry and the Law*, *47*(4), 414–421. https://doi.org/10.29158/JAAPL.003863-19
50. Sakala, L., Harvell, S., & Thomson, C. (2018). *Public investment in community-driven safety initiatives: Landscape study and key considerations*. Retrieved from https://www.urban.org/sites/default/files/publication/99262/public_investment_in_community-driven_safety_initiatives_1.pdf
51. SAMHSA. (2020). *National guidelines for behavioral health crisis care: A best practice toolkit*. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
52. Sarang, A., Ocampo, M., Durbin, J., Strike, C., Chandler, C., Connelly, J., … Hanson, E. (2009). *How we do it: Across Boundaries' anti-racist, holistic service delivery model*. Retrieved from https://static1.squarespace.com/static/535010aee4b02e8e0e0eb13b/t/5d711255cb38ee0001d3d8eb/1567691354015/How+We+Do+It+Manual.pdf
53. Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: A review. *Adm Policy Ment Health*, *42*, 606–620. https://doi.org/10.1007/s10488-014-0594-9
54. Sharkey, P., Torrats-Espinosa, G., & Takyar, D. (2017). Community and the crime decline: The causal effect of local nonprofits on violent crime. *American Sociological Review*, *82*(6), 1214–1240. https://doi.org/10.1177/0003122417736289
55. Singh, I. (2020). CBC News: Deadly Force. Retrieved March 30, 2021, from https://newsinteractives.cbc.ca/fatalpoliceencounters/
56. Stanyon, W., Goodman, B., & Whitehouse, M. (2014). Using simulation to educate police about mental illness: A collaborative initiative. *Gateways: International Journal of Community Research and Engagement*, *7*(1). https://doi.org/10.5130/ijcre.v7i1.3394
57. The City of Albuquerque. (2020, June 15). Mayor Tim Keller to Refocus Millions in Public Safety Resources with First-of-Its-Kind Civilian Response Department — City of Albuquerque. Retrieved January 19, 2021, from https://www.cabq.gov/mayor/news/mayor-tim-keller-to-refocus-millions-in-public-safety-resources-with-first-of-its-kind-civilian-response-department
58. Watson, A. C., Compton, M. T., & Pope, L. G. (2019). *Crisis response services for people with mental Illnesses or intellectual and developmental disabilities: A review of the literature on police-based and other first response models*. Retrieved from https://www.vera.org/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf
59. Watson, A. C., & Fulambarker, A. (2012). The crisis intervention team model of police response to mental health crises: A prime for mental health practitioners. *Best Pract Ment Health*, *8*(2), 71. https://doi.org/10.2140/pjm.1965.15.347
60. Williamson, B. (2012). *Crisis intervention - ACDS*. Alberta. Retrieved from https://acds.ca/files/ACDS_Products/Crisis_Intervention_printable_format.pdf

Appendices

Appendix A – Methodology

Literature was retrieved from July 20, 2020, to September 23, 2020. The research question and literature search strategy explicitly focused on crisis intervention models designed to manage potentially dangerous mental health crises on-site and factors to mediate impacts after the crisis. All literature identified by the search was initially screened for relevance by title, followed by abstract and/or introduction. Literature included crisis services, supports and models specific to Canada, the USA, Europe and Australia. The date of publication for the literature ranges from 1996 to 2020. The review only includes literature written in the English language; literature written in languages other than English were excluded. Articles that did not meet the scope of the research question were also excluded.

The documents reviewed include academic journal articles, literature reviews, government reports, third party evaluations on existing programs, various reports for particular police services, reports concerning crisis models provided in different communities and the grey literature. The literature was chosen from multiple subject areas ranging from law, psychiatry, nursing and social work, and research specific to mental health, police practice and community development. In referring to individuals who encounter police during a crisis, various terms appeared in the literature: consumers, persons with mental illness, individuals in crisis, people with behavioural health challenges and people with mental health problems. For consistency and the term being the most common in the literature, the term persons with mental illness (PMIs) is used throughout the report. Methods of analysis include content analysis and thematic analysis using software such as NVivo, Excel and Mendeley (used mainly for references and citations).

Appendix B – Anti-Racist and Culturally Responsive Staff Practices

Key Concept	Staff Practices
Break the Silence About Racism But, Respectfully	• Working with racialized people requires acknowledging your own social location as a service provider[2] • Service providers must first address power issues within helping relationships or when they have failed to integrate culture into their intervention approaches. [1] • Those from dominant groups have become accustomed to having their voices heard and speaking up before marginalized groups; in doing so, they perpetuate an already visible power imbalance.[3] Therefore, staff should become self-aware of their position and actively listen to their clients' feelings with compassion and empathy.[2,4] • Addressing racism is exhausting and traumatic so allow the client to speak about racism at their own pace; let that guide their recovery process.[3] • Make it clear that breaking their silence will not result in punishment, humiliation or being dismissed.[3]
Addressing Racism & Mental Health Together	• Acknowledge and recognize that racism can have a broad impact on mental health and access to other services such as employment, housing, medical treatment, etc.[3] • Recognize that what a social service practitioner may label as delusion can be considered a microaggression against the racialized person.[1,3] These expressions may not be symptoms of illness but rather a sign of racist treatment that the racialized person has experienced. • Incorporate anti-racist practices into recovery (i.e., treatment, case management, planning, outreach and community interactions).
Move from Awareness of Racism to Anti-Racist Action	• Advocate for clients to receive culturally specific and acceptable services they need from professionals who share their characteristics such as culture, ethnicity, race, gender, etc.[1,3] • A funded staff position to provide anti-racism education for the community to inform programming and professional development to meet clients' needs better.[3]

[2] Hasford, J., Amponsah, P., & Hylton, T. (2018). Anti-racist praxis with street-involved African Canadian youth. In *Mental Health & Addiction Interventions for Youth Experiencing Homelessness* (pp. 125–137). Retrieved from https://www.homelesshub.ca/sites/default/files/attachments/Ch2-4-MentalHealthBook.pdf

[3] McKenzie, M. (2014). *Black girl dangerous: On race, queerness, class and gender*. Oakland, CA, USA: BGD Press.

[4] Sarang, A., Ocampo, M., Durbin, J., Strike, C., Chandler, C., Connelly, J., … Hanson, E. (2009). *How we do it: Across Boundaries' anti-racist, holistic service delivery model*. Retrieved from https://static1.squarespace.com/static/535010aee4b02e8e0e0eb13b/t/5d711255cb38ee0001d3d8eb/1567691354015/How+We+Do+It+Manual.pdf

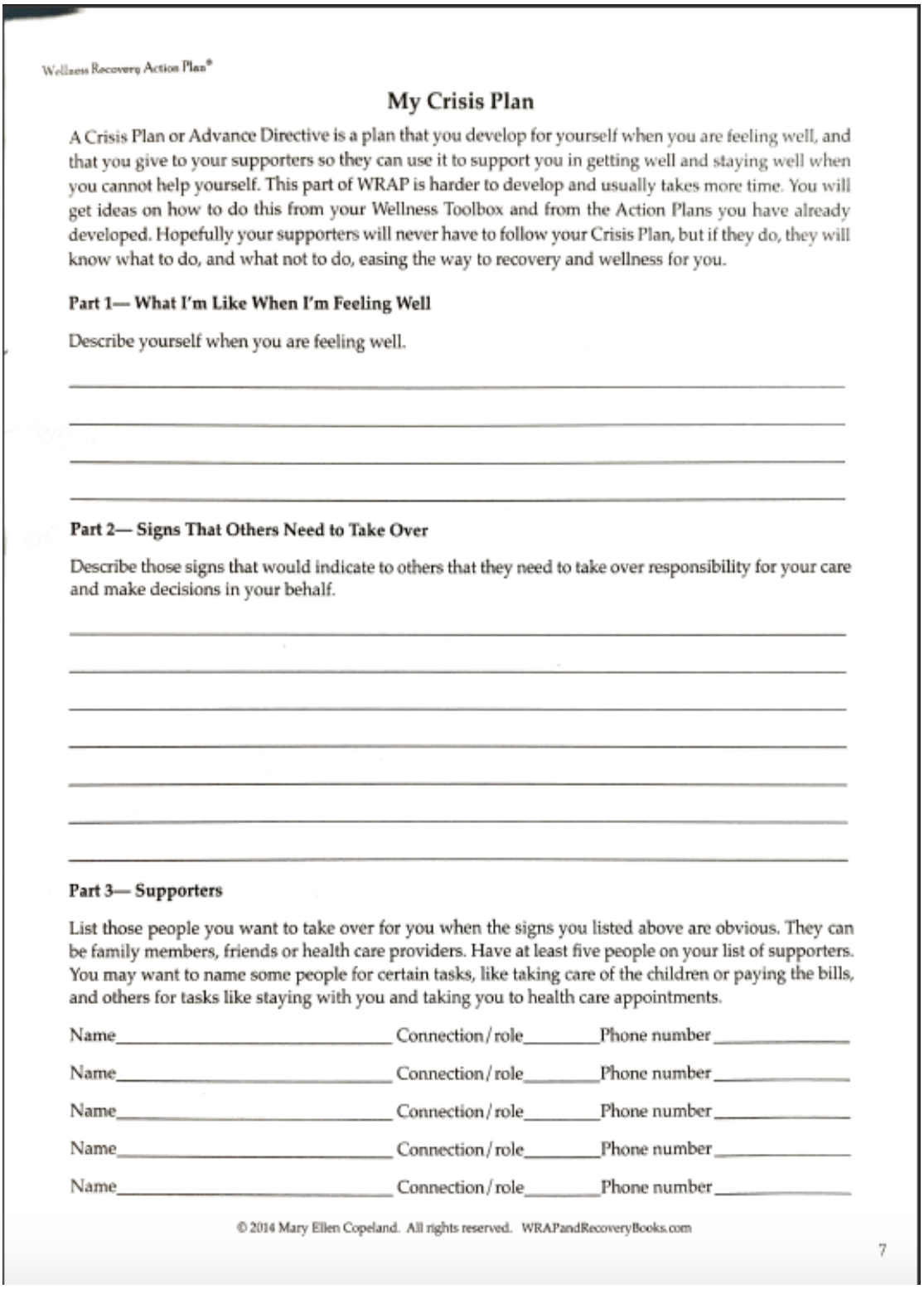
	• Racism may be covert and not explicitly known to service providers; allow a space for racialized people to address discrimination, concerns and needs safely, but when they are ready.[3]
Holistic Delivery Model	• Examine the client beyond their diagnosis and look at other experiences in their life such as unemployment, culture shock, poverty, food issues, racism, lack of housing, etc.[1,3] These factors can significantly impact one's mental health, so consider this when referring clients to services. • Take an intersectional approach and examine the client's life to address their needs - religion, culture and family.
Alternatives to Traditional Western Treatments	• Consider using untraditional/non-medical healing & recovery approaches such as religion/spirituality, traditional herbal medicine, art therapy, creative expressions, yoga, or other forms of complementary medicine.[3,4,5] • Services should be free of charge to eliminate financial barriers.[3] • Understand how each client you serve views health.[3] • De-stigmatize cultural misrepresentations about mental illness.[3] • Empower clients to choose the appropriate treatment for them.[2,3]
Community Engagement	• Go beyond your scope of work to engage in anti-racist policy development via joining community consultations or community advisory committees/boards.[1] • Support and empower groups, projects, and organizations run by and for marginalized people, so their voices are the loudest on issues that affect them.[2,6] • More linkages with ethnic and racialized community services to connect people to culturally relevant and responsive resources.[4,5] • Create a community of best practice group via social media or in-person where you share resources related to racism, white supremacy, hate crimes and mental health and discuss what actions could improve these situations.[3] • Participate in social activism – the Black Lives Matter movement is one of the most successful anti-racist social activist movements worldwide, which has created some systemic change.[1] There are many forms of activism, ranging from direct action through protests or artistic forms such as music and graffiti to indirect forms such as fundraising, sharing information and signing petitions.[1,2]

[5] McKenzie, K., & Waldron, I. R. (2009). *Re-conceptualizing "trauma": Examining the mental health impact of discrimination, torture & migration for racialized groups in Toronto*. Retrieved from http://yourexperiencesmatter.com/wp-content/uploads/2016/01/R_341.pdf

[6] Kelly, K., Caputo, T., & Totten, M. (2006). Community-based alternatives? Lessons from a restorative justice project for youth. *Canadian Review of Social Policy*, (57), 85–103.

Appendix C – Example of a Crisis Prevention Plan

Figures retrieved directly from: Copeland, M. E. (2014). *WRAP (Wellness Recovery Action Plan) Workbook*. Vermont, USA: Peach Press Dummerston. Retrieved from https://www.mentalhealthsf.org/wp-content/uploads/2020/01/WRAP-Workbook-10.16.17.pdf



Wellness Recovery Action Plan®

My Crisis Plan

A Crisis Plan or Advance Directive is a plan that you develop for yourself when you are feeling well, and that you give to your supporters so they can use it to support you in getting well and staying well when you cannot help yourself. This part of WRAP is harder to develop and usually takes more time. You will get ideas on how to do this from your Wellness Toolbox and from the Action Plans you have already developed. Hopefully your supporters will never have to follow your Crisis Plan, but if they do, they will know what to do, and what not to do, easing the way to recovery and wellness for you.

Part 1— What I'm Like When I'm Feeling Well

Describe yourself when you are feeling well.

Part 2— Signs That Others Need to Take Over

Describe those signs that would indicate to others that they need to take over responsibility for your care and make decisions in your behalf.

Part 3— Supporters

List those people you want to take over for you when the signs you listed above are obvious. They can be family members, friends or health care providers. Have at least five people on your list of supporters. You may want to name some people for certain tasks, like taking care of the children or paying the bills, and others for tasks like staying with you and taking you to health care appointments.

Name_____ Connection/role_____ Phone number _____

Name_____ Connection/role_____ Phone number _____

Name_____ Connection/role_____ Phone number _____

Name_____ Connection/role_____ Phone number _____

Name_____ Connection/role_____ Phone number _____

© 2014 Mary Ellen Copeland. All rights reserved. WRAPandRecoveryBooks.com

7

There may be health care providers, family members, or friends who have made decisions that were not according to your wishes in the past. They could inadvertently get involved if you don't include the following:

I **DO NOT** want the following people involved in any way in my care or treatment:

Name _____

Why you do not want them involved (optional)

_____

_____

Name _____

Why you do not want them involved (optional)

_____

_____

Name _____

Why you do not want them involved (optional)

_____

_____

Settling Disputes Between Supporters

Describe how you want possible disputes between supporters settled. For instance, you may want to say that a majority need to agree, or that a particular person or two people make the determination.

_____

_____

_____

Part 4— Medication and Health Care

Physician _____ Phone Number _____

Physician _____ Phone Number _____

Physician _____ Phone Number _____

List the medications you are currently using and why you are using them. Include the name of your doctor and your pharmacy.

_____

_____

_____

_____

_____

© 2014 Mary Ellen Copeland. All rights reserved. WRAPandRecoveryBooks.com

List those medications you would prefer to take if medications or additional medications became necessary, and why you would choose those.

List those medications that would be acceptable to you if medications became necessary and why you would choose those.

List those medications that must be avoided and give the reasons.

Part 5— Treatments

List treatments that help you feel better and when they should be used.

List treatments you would want to avoid.

© 2014 Mary Ellen Copeland. All rights reserved. WRAPandRecoveryBooks.com

Part 6— Home/Community Care/Respite Center

Set up a plan so that you can stay at home or in the community and still get the care and support you need.

Part 7— Treatment Facilities

List treatment facilities where you prefer to be treated or hospitalized if that becomes necessary.

List treatment facilities you want to avoid.

Part 8— Help From Others

List those things that others can do for you that would help you feel better or make you more comfortable.

List those things you need others to do for you and who you want to do what.

© 2014 Mary Ellen Copeland. All rights reserved. WRAPandRecoveryBooks.com

List those things that others might do, or have done in the past, that would not help or might make you feel worse.

Part 9— Inactivating the Crisis Plan

Describe signs, lack of signs or actions that indicate supporters no longer need to use this plan.

You can help assure that your Crisis Plan will be followed by signing it in the presence of two witnesses. It will further increase its potential for use if you appoint a durable power of attorney.

I developed this plan on (date) _____ with the help of _____.

Any plan with a more recent date supersedes this one.

Signed _____ Date _____

Witness _____ Date _____

Witness _____ Date _____

Attorney _____ Date _____

Durable Power of Attorney (If you have one)

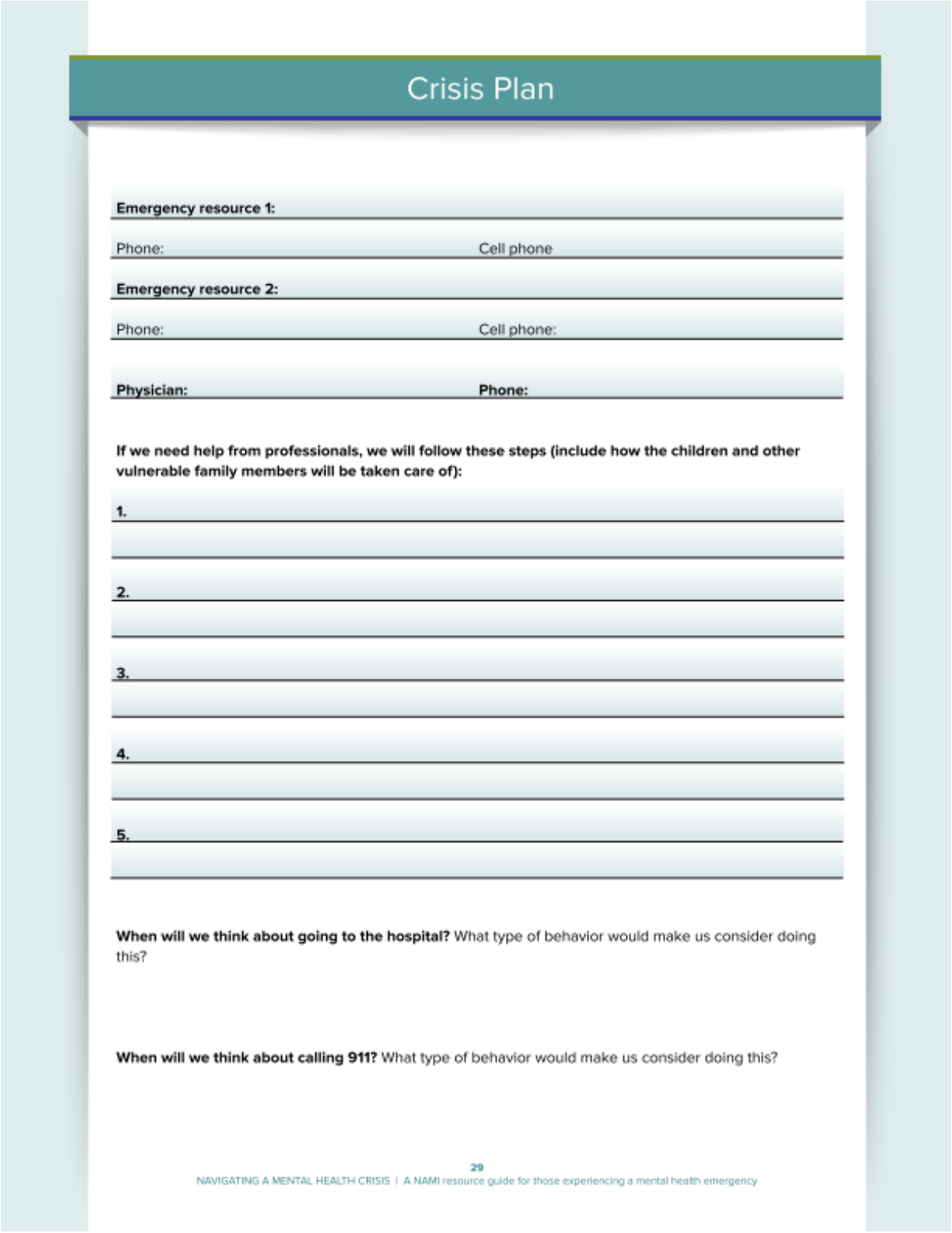
_____

Phone number _____

© 2014 Mary Ellen Copeland. All rights reserved. WRAPandRecoveryBooks.com

Appendix D – Example of a Crisis Plan

Figure retrieved directly from: Brister, T. (2018a). *Navigating a mental health crisis: A NAMI resource guide for those experiencing a mental health emergency*. Retrieved from www.nami.org



Crisis Plan

Emergency resource 1:

Phone: Cell phone

Emergency resource 2:

Phone: Cell phone:

Physician: **Phone:**

If we need help from professionals, we will follow these steps (include how the children and other vulnerable family members will be taken care of):

1.

2.

3.

4.

5.

When will we think about going to the hospital? What type of behavior would make us consider doing this?

When will we think about calling 911? What type of behavior would make us consider doing this?

29

NAVIGATING A MENTAL HEALTH CRISIS | A NAMI resource guide for those experiencing a mental health emergency