FROM BLUE TO GREEN

A Case Study of a Non-Police Crisis Intervention Program in Toronto

Nicole Khuc

York University, School of Public Policy and Administration
GS/PPAL 6230 B – Professor Thomas Klassen
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Introduction

The current state of mental health services in Canada often seems bleak for those suffering from mental illnesses. For many years, the police have become the default first responder to mental health crisis calls in Canada and many other jurisdictions around the world. Mental health-related crises take up a substantial proportion of emergency calls to police departments. According to a study by Statistics Canada in 2012, approximately one in five contacts with police involved someone with a mental or substance use disorder (Boyce et al., 2012). The increasing interactions between police and person with mental illnesses ("PMIs") and the nature of these interactions in recent years have called into question the appropriateness of the role of police in responding to mental health-related service calls.

In 2019, the Toronto Police Service ("TPS") responded to 30,689 calls involving PMIs, which is approximately 7% of the total service calls attended that year (Toronto Police Service, 2020a). Of the 30,689 calls, 25% led to an apprehension under the Mental Health Act (Toronto Police Service, 2020b). In 2020, a string of deaths[1] involving PMIs in crisis during their interactions with the police resulted in mounting calls from the health care professionals, advocates and the public to remove police officers from the front-line response to mental health-related calls. There is an urgency for policymakers to design and implement a comprehensive and appropriate crisis mental health care approaches to address the unique needs of PMIs while alleviating the burden on other first responders.

In 2021, the City of Toronto (the "City") introduced a non-police, community-led crisis intervention program called the Toronto Community Crisis Service ("TCCS"). The program is currently being piloted in four geographical regions, covering 60% of the City (City of Toronto, 2022). This crisis intervention model is a recent effort to decrease police involvement in mental health crises. It aims to provide a trauma-informed and client-centred response to non-emergency crisis calls and wellness checks. There is growing evidence that non-police crisis intervention models are effective in addressing the needs of PMIs while diverting them from the criminal justice system, reducing the rate of involuntary hospitalization, and increasing the rate of referrals to community resources (Shapiro et al., 2015; Kisely et al., 2010; McKenna et al., 2015; & Lamanna et al., 2018). However, there is a significant lack of research on non-police crisis response models in the Canadian context.

The purpose of this paper is to inform policymakers and practitioners with a better understanding of effective crisis intervention programs by answering the question: "What are the key characteristics of a crisis intervention program to ensure effective responses to people in mental health crises?"

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[1] For example: Chantel Moore was shot by Edmundston Police in June 2020, Regis Korchinski-Paquet fell from a high-rise building after interaction with Toronto Police in 2020, D'Andre Campbell was shot by Peel Regional Police in April 2020, Ejaz Ahmed Choudry was shot by Mississauga Police (Cooke, A. 2020).

This exploratory qualitative study will capture the perspectives of policy and frontline staff who are involved in the planning and implementation of the TCCS program to understand the following:

(1) What are the characteristics of an effective crisis intervention service?
(2) How is a non-police crisis intervention service different from other crisis response services?
(3) What are some difficulties the TCCS is facing?
(4) Recommendations for future improvement of an effective crisis intervention service.

Background

A. What is a mental health 'crisis'?

Before diving into the discussion, it is important to set a foundation by understanding what is considered a crisis. According to Dixon (1982, pg. 27), a crisis is "a time-limited break in a person's capacity to cope with stimuli that have temporarily exhausted all of a person's problem-solving strategies…". As such, a crisis is the temporary inability of a person to cope with a stressful event or situation. Similarly, Brimblecome (1993) defined 'crisis' as "an internal disturbance" caused by a stressful event that arises when an individual's coping mechanism becomes ineffective. The term 'crisis' is usually used to refer to a range of problems that are often caused by a stressful event which affects a person's ability to cope and solve the issues. According to Roberts (2005), a crisis is mainly caused by the combination of an extremely stressful and traumatic event along with two other factors:

(1) The individual's perception of the event as the cause of disruption
(2) The individual's inability to resolve the disruption by using existing coping mechanisms.

The relationship between mental illness and crisis is not necessarily linear. Most crisis theories assume that crises are episodes that are expected to occur during the lives of most people; they are not directly a reflection of pathology or mental illness (Tomlinson & Allen, 1999). Therefore, most intervention models examine the response of 'normal' individuals to traumatic events. Although, the experience of developing or relapsing a mental illness can be a crisis on its own. In addition, it's important to recognize that each person has a different coping mechanism and capability to deal with a stressful situation. What is considered a crisis to one individual may not be the same as another individual under the same circumstances. Therefore, a crisis is a highly individualized response to a set of circumstances, which will require individualized approaches to support persons in crises. From Dixon's definition, a crisis can also be interpreted as a temporary event that a person can overcome and become stabilized once provided with the appropriate support. Therefore, it is important to develop an effective crisis response plan that not only helps an individual overcome their current crisis but also builds resilience to deal with any future crises that may arise.

B. The intersections between police and person with mental illnesses (PMIs)

In Western countries, prior to the 1920s, many diagnosed PMIs were confined within institutions for the mentally ill. Police interaction with PMIs was not very common and kept to a minimum. From the 1960s to the 1980s, PMIs were transitioned from institutions to different facilities or back into their communities in a process called deinstitutionalization (Koziarski, 2018; Tucker, 2008). As such, many Western countries experienced an influx of demand for community-based mental health services for PMIs. However, inadequate investment and planning in community resources post-institutionalization has resulted in a lack of facilities and appropriate services for PMIs (Cotton & Coleman, 2010). Due to the uncertainty surrounding situations involving PMIs and the lack of suitable alternatives to address their distinctive needs, responsibility for responding to mental health crisis calls has fallen on the police. In addition, legal reforms coupled with policies created to assist law enforcement when responding to PMIs; and the relative lack of collaboration between police, social services, and health care system; have contributed to the increase in contact between police and PMIs. Phrases such as “street-corner psychiatrist” or “the gatekeeper of the mental health care system” are often used to describe the overreliance on police in responding to mental health crises.

The resources available to police and the protocol for responding to a mental health crisis depends on the legislation governing that police service and the supports available in the community. For example, when police in Toronto respond to a mental health crisis call, they have three options: (1) transport the person to a psychiatric facility for assessment (often to the emergency department of a local hospital); (2) use informal verbal skills to de-escalate the situation and the individual to remain in their environment; and (3) arrest the person under the Mental Health Act (“MHA”) (Teplin, 2000). When the situation cannot be de-escalated and given limited options, police often find themselves having no other choice but to either transfer the person to the emergency department (“ED”) or practice involuntarily apprehension. Teplin (2000) found that police are not arresting PMIs at an increased rate when all variables (including the dangerousness of the scene and those involved) are taken into account, but rather when they feel that there are no other alternatives to control the situation. The police mandate is, first and foremost, to protect the safety of the public. Although, during mental health crisis circumstances, this is often at the expense of the welfare of PMIs (Marcus & Stergiopoulos, 2022). Police officers often feel service calls involving PMIs are complex, and they are not fully equipped to go into these calls. Meanwhile, for people in crisis, the presence of police or those in uniform is often traumatizing and stigmatizing, which can result in an escalation of the situation (Lamanna et al., 2018; Puntis et al., 2018). Alternative approaches to respond to mental health crisis calls have been developed for quite some time. However, those methods are often grassroots-led and are not standardized across jurisdictions.

C. The emergence of crisis intervention services

Crisis intervention has evolved over the years into a specialty mental health field based on a solid theoretical foundation that dates back more than fifty years. In the 1990s, the

most common approach when dealing with a person in crisis was hospitalization (Tomlinson & Allen, 1999). However, there were growing criticisms of established psychiatric services, and the demand grew for alternatives to hospitals for people in crisis (Tomlinson & Allen, 1999). The roots of crisis intervention in Canada stemmed from the work of two community psychiatrists – Erich Lindemann and Gerald Caplan. Tracing back early works in crisis intervention, Lindenmann in 1944 proposed that the person providing the intervention has a dual role. The first role is to reduce the impact of the stressful event where possible. The second role is to help those affected to solve their present problems so that they can build their capacity and resiliency to respond to future crises (Lindenmann, 1944). The emergence of crisis services was grounded in the idea that mental health care in the community was a more desirable approach to hospitalization (Tomlinson & Allen, 1999). Gerald Caplan expanded Lindemann's 1944 pioneering work, introducing the theoretical framework for the community care approach. Caplan introduced an alternative approach that focused on preventative measures rather than the treatment of the symptoms. In his work in 1970, Caplan developed a style of consultation whereby the expertise of the specialists is transferred to the person in crisis. As such, the goal of consultations is not only to help a person overcome the immediate crisis but, more importantly, to teach them the necessary skills to help them deal effectively with similar future crises (Mendoza, 1993).

With the emergence of community crisis care, there are now opportunities to delve into the details of what constitutes an effective form of crisis provision. MIND, a health charity founded in 1946 in England and Wales, conducted consultation with its local association and its user network to determine what is needed and the form of crisis provision that should be established (Tomlinson & Allen, 1999). The following characteristics were determined for what constitutes 'effective' crisis services: offer flexibility, do no harm, offer anonymity, autonomy, including choice of treatment, opportunities to talk through the underlying causes of distress, take a holistic approach, safeguard resources from psychiatric hospitals for mental health services, offer safety when needed. In addition, provision should be established in a familiar and emotionally safe environment, as well as allow people to withdraw from the service gradually and be linked to longer-term support if needed (Tomlinson & Allen, 1999).

D. Literature Review

Efforts to improve mental health crisis response in Canada have resulted in the adoption of three mobile crisis intervention models: the Crisis Intervention Team (CIT) model, the Co-Responder Team (CRT) model, and the civilian-led mobile crisis model. This section below will explore the strengths and limitations of each model.

Crisis Intervention Team (CIT)

The crisis intervention team (CIT) model originated more than 30 years ago in Memphis, Tennessee, USA (Huey et al., 2021). It is also widely known as the Memphis model. This model consists of providing a 40-hour comprehensive training package on crisis intervention and mental health to police officers (Blais et al., 2020). The training

curriculum often includes classroom-delivered content and simulation-based experiential learning scenarios (Huey et al., 2021). The goal of CIT is to improve an officer's general knowledge about mental health-related issues, symptoms associated with mental illnesses, effective intervention and communication strategies, including de-escalation and situational assessment practices (Blais et al., 2020; Huey et al., 2021). In addition, CIT also provides training components for dispatch operators to identify calls involving PMIs to deploy appropriate services to the scene (Huey et al., 2021). The officers, after having gone through CIT training, will then serve as specialized front-line responders to service calls involving PMIs.

Although most research highlights the effectiveness of CIT in increasing awareness among officers about mental illness, there are mixed results regarding how training leads to attitudinal change (if any), which eventually results in behavioural outcomes (that is, how frontline officers interact with PMIs). A systemic review of 64 evaluations on the CIT model conducted by Engel et al. (2020) highlighted the overall success of de-escalation training in generating greater self-reported knowledge and confidence among trained officers. With similar results, Compton et al. (2006) deployed a pre-and post-survey to 159 officers in Georgia immediately before and after a 40-hour CIT training program. Officers reported improved attitudes regarding aggressiveness towards individuals with schizophrenia after gaining knowledge of the illness. The study concluded that an educational program such as the CIT might reduce the stigma of officers towards persons with schizophrenia (Compton et al., 2006). However, Engel et al. (2020) pointed out that behavioural outcomes are less consistent than those reported for survey-based outcomes. Specifically, although the number of violent incidents decreased after training in approximately half (52%) of the studies from Engel et al.'s systemic review (n=64), the findings from Ore (2002) and Whittington & Wykes (1996) showed that the rates of assault were higher among CIT-trained officers compared with their untrained counterparts (Engel et al., 2020). Similarly, results regarding the arrest rate concerning interactions between PMIs and officers who have received CIT training are also inconsistent. Some research suggested that PMIs are less likely to be arrested and more likely to be referred to mental health services by police departments with CIT initiatives (Compton et al., 2008). However, more recent data suggested that CIT training did not significantly influence the probability of arrest among PMIs (Watson et al., 2021). In addition, CIT teams also report a moderate effect on diversion from the criminal justice system and emergency department (Seo et al., 2021).

Co-responder Team (CRT)

The co-responder model of crisis intervention mostly consists of a police officer and a mental health practitioner, who work in collaboration to respond jointly to mental health-related service calls. According to Lamanna et al. (2018), there are variants of this model operating in the United States, Canada, Austria, England and Wales. According to a systemic review by Shapiro et al. (2015), the CRT model is now the most common approach to mental health-related incidents in Canada. Most of the CRT models operate as a secondary response. This means that oftentimes, a police team will arrive on the scene first to provide an initial assessment of the situation. If the police team deems that

the scene is safe and there is no imminent risk of threat or harm, the CRT will respond if the person needs assessment and/or support by a mental health practitioner. The police officers who work on CRT do not generally have specialized mental health training. However, there has been a shift in recent years to have co-responder police officers receive specialist training (for example, with Toronto's Mobile Crisis Intervention Teams - MCIT).

Most of the evaluations on the CRT model highlight its effectiveness in responding to PMIs in crisis compared to a police-only model. First, the consensus about CRT from the literature is that CRT interactions result in a lower rate of injury and arrest as well as create a smoothness in the handover process at ED (Lamanna et al., 2018; McKenna et al., 2015). Second, the pairing of psychiatric personnel and a police officer can bridge the informational gap between the mental health and criminal justice system (Iacobucci, 2014; Lamanna et al., 2018). The police officers from CRT also report a better understanding and improved perception of mental illness. Third, service users reported having positive encounters with CRT compared with the police-only response (Lamanna et al., 2018; Boscarato et al., 2014). Other advantages of CRT include releasing police officers to attend to other non-mental health-related tasks; allowing direct access to inpatient mental health services (McKenna et al., 2015); increasing PMIs referrals to other mental health services and encouraging greater engagement with outpatient services (Kisely et al., 2010).

Kisely et al. (2010) was one of the first studies that used controlled before-and-after evaluation of CRT. It used quantitative data comparing an area using CRT in Nova Scotia with a control area without access to such a service one year before and two years after program implementation. The quantitative data was combined with qualitative data from interviews and focus groups with service users and other stakeholders. Results showed an increase in the use of the CRT service in the first two years of the program implementation. In year 2 of the program implementation, the study found that police spent significantly less time on the scene due to the help of CRT compared to the control area without the CRT program. According to the study, people who used the CRT model found it useful because it gave them the opportunity to talk to someone, get advice, and receive referrals. The CRT model also helped reduce police officers' time spent on-scene, enabling them to dedicate more time to other non-mental health-related calls (Kisely et al., 2010).

However, there is mixed evidence regarding the relationship between CRT outcomes and ED referrals (Shapiro et al., 2015). Although some studies indicated that CRT interactions resulted in a higher rate of escorts to hospitals compared to the police-only model (Lamanna et al., 2018). Other studies showed that the CRT model diverts service users from the ED to more appropriate mental health care (McKenna et al., 2015). For example, Lamanna et al. (2018) conducted a study on the Mobile Crisis Intervention Teams ("MCIT"), a CRT model consisting of a police officer and a mental health nurse in Toronto, and found that MCIT were 2.3 times more likely to escort service users to hospitals than police-only teams. The study offered two explanations for the higher rates of ED referrals. First, it is possible that MCIT interacted with service users who had more serious mental

health symptoms compared to police-only teams, which warranted a higher need for ED referrals. Second, first-responding police-only teams might be inclined to request CRT support if they suspected the interaction might require ED escort to avoid time consumed in ED waiting rooms. Another possible explanation was that police-only teams were unable to identify those who require a full psychiatric assessment which resulted in ED under-referral (Lamanna et al., 2018).

Limitations of CITs and CRTs

Although many studies suggest that CITs and CRTs have positive effects, there is also evidence indicating their limitations. Most prominently, for a CIT or CRT program to function effectively, most literature stresses the importance of having a central and identifiable drop-off location or available psychiatric beds for PMIs with a “no-refusal” policy and rapid streamlined intakes (Koziarski et al., 2021; Kisely et al., 2010). This is because many CITs and CRTs end up getting held up in the ED, only to find that the individual will not be admitted or may be admitted and discharged only a few hours later (Canada et al., 2010). For example, in Toronto, MCIT officers reportedly wait for an average of 2 hours for an ED transfer (Iacobucci, 2014). Long wait times for hospital transfer may result in low response rates from CITs or CRTs because the teams are constantly being held up at ED and are unable to respond to other individuals who are in crisis. Although Koziarski et al. (2021) pointed out that there is no empirical research exploring the linkage between ED transfer wait times and CIT/CRT response rates, drastically low response rates in various Canadian and United States jurisdictions (for example in Iabocci, 2014 and Durbin et al., 2010) implied that the lengthy transfer process in ED might be a contributing factor to the low response rates, alongside other limitations such as low staffing (Forchuk et al., 2015). Specifically, Durbin et al. (2010) found that of the 49% of Ontario police services that employ a CRT, the teams were utilized in less than 25% of crisis incidents. Similarly, MCIT in Toronto only responded to 11% of all crisis calls (Iacobucci, 2014).

Forchuk et al. (2015) examined three CRT models in the communities of Haldimand-Norfolk, Chatham-Kent, and Hamilton to identify key issues in the development of crisis service programs across Ontario. Overall, the qualitative data collected from focus groups of consumers, family members and other stakeholders (n=143) indicated that all three groups were satisfied with the service. However, concerns were expressed by consumers and family members regarding the barrier to accessing the service. Specifically, transportation for consumers living in rural communities and busy phone lines were identified as being impediments to access (Forchuk et al., 2015). As such, consumers indicated their preference for a “warm-line” service which includes peer support services as part of their crisis care as opposed to a professional intervention (as in “hotline” services). Another challenge identified in this study is the lack of psychiatric beds in hospitals. The lack of suitable hospital beds can be very time consuming and inconvenient as it creates a bottleneck in the ED and deters CRTs from responding to other service calls. This sentiment is also echoed in other studies (such as in Koziarski et al., 2021), as mentioned above. These barriers to crisis service raise the need for a crisis response model that is accessible to service users 24/7, available to rural communities, and utilizes

peer support and community services so that PMIs are averted from being hospitalized. A mobile crisis intervention that is community-based and led by crisis workers could potentially address some of the limitations that the current CIT/CRT models are experiencing.

Community-based crisis intervention models

While research on both CITs and CRTs shows positive benefits compared to traditional policing (Shapiro et al., 2015; Kisely et al., 2010; McKenna et al., 2015; & Lamanna et al., 2018); barriers to providing mental health care to PMIs still exist. As such, alternatives to non-police crisis intervention models are being widely explored in different jurisdictions to divert PMIs from the criminal justice system or the ED and alleviate the burden from the police force. These services are often grassroots-led, community-based, and varied in their operational structure. Examples of non-police models with civilian-led mobile crisis units include the Crisis Assistance Helping Out On The Streets (CAHOOTS) model in Oregon, United States (Beck et al., 2020), the Psychiatric Emergency Response Team (PAM) in Sweden (Bouveng et al., 2017), and recently the Toronto Community Crisis Service (TCCS) in Canada (City of Toronto, 2020). Most of these models are still quite new, except for CAHOOTS, which was created in 1989. As such, there have not been a lot of resources to evaluate outcomes or to compare these non-police models with other existing models (Marcus & Stergiopoulos, 2022).

Marcus & Stergiopoulos (2022) was one of a few studies comparing the three crisis intervention models to answer the question:" How do police, co-responder and non-police crisis response models compare in terms of effectiveness?". The study used a rapid review framework to compare the three models (n=62 articles). The study found that while some studies indicated minimal to no backup call for police assistance required for non-police models, others found that team collaboration with other sectors was common. Specifically, a report on the STAR mobile crisis service in Denver, United States, conducted by Enos (2020), indicated that in over 400 calls, no interactions required a follow-up or backup call for police assistance. On the contrary, Bouveng et al. (2017) conducted an evaluation of the PAM model (a model consisting of two psychiatry nurses and a paramedic) in Sweden and found that ambulance attendance was required in 55% of calls (n=1254) and police in 49% of calls. Only 24% of cases were handled without other services involved. The difference in result could be due to how the calls for services were triaged for each model. While the STAR model in Denver responded to only calls that were deemed non-emergency (Enos, 2020), the PAM model from Sweden specifically responded to emergency calls involving persons in severe mental health, with suicide prevention as the main priority (Bouveng et al., 2017). Other results from non-police models include improved response time and more positive experiences reported by service users compared to police-only models (Marcus & Stergiopoulos, 2022). However, similarly to evaluations on CRT, evidence is mixed regarding hospital referral rates for non-police models. It was suggested from the systemic reviews that legislation changes to enable crisis workers to detain service users are necessary to decrease over-reliance on police in some situations (Marcus & Stergiopoulos, 2022). In addition, echoing the sentiment from Forchuk et al. (2015) for a preference for a "warm-service" line, many

non-police models reported the importance of a treatment or a follow-up component for a holistic crisis care and ED diversion approach.

Evaluation approaches of crisis intervention models

While evaluations on the effectiveness of CIT and CRT models are in abundance, quality evaluations on community-based crisis intervention models are lacking. Although it is not the intended purpose of this paper to evaluate the effectiveness of such a model, it is important to understand how these models have been evaluated and what is lacking in terms of quality evaluation for an effective crisis intervention model.

The evaluation of crisis intervention models often involves either process outcomes or stakeholder-focused outcomes. Process outcomes involved examining the effectiveness of such a model in diverting PMIs away from the criminal justice system by looking at administrative data regarding arrest rates, referral rates, the use of force, response time, escort to ED rates or ED handover times. On the other hand, stakeholder-focused outcomes often reflect service users' experience, police officers' subjective perceptions of their own knowledge and attitudes change (in the case of CIT), or other stakeholders' (including mental health nurses, professionals, or staff) perceptions of the effectiveness of said model(s). In addition, most of the evaluations from the literature search use pre-post evaluation designs (for example in Forchuk et al., 2015) or comparison sites to compare the impact of different crisis intervention approaches (Marcus & Stergiopoulos, 2022).

Studies to date have adopted various methodologies in evaluating crisis intervention models. However, most studies have failed to include control groups. For those that included control groups (for example in Kisely et al., 2010), they failed to establish a direct causal relationship between the result and the intervention. As such, most studies are of descriptive nature only and lack pretrial data or a control group to compare results. There is also a lack of generalizability in most of the studies since there is diversity in the operational structure, mandate, and response type (first or secondary response) of each crisis intervention program.

Since there is little evidence to support police involvement in many mental health crisis interventions, there is a consensus that models that decrease police interactions with PMIs should be prioritized. Good quality research on non-police models was lacking, especially those with control or comparison data. Results were mostly observational and descriptive in nature. Most evaluations for non-police models focus on the following components: the need for police backup, hospital admission rate, response time, and overall service user experiences.

E. The Toronto Community Crisis Service (TCCS)

While there is growing evidence that a non-police crisis intervention model is desirable, there aren't many services available and operated on a large scale. Most non-police crisis services are grassroots-led, have limited capacity, and are operated siloed with one

another. To gain a better understanding of how a centralized non-police crisis intervention program is operated, the Toronto Community Crisis Service ("TCCS") was chosen as a case study for this paper.

From 2016 to 2021, the Toronto Police Service saw a 32.4 percent increase in calls involving "persons in crisis" (City of Toronto, 2021). "Person in crisis" in this context is defined as "a person experiencing a temporary breakdown of coping skills reaching out for help" (City of Toronto, 2021). Through extensive community engagement and stakeholder consultation process between October to December 2020, the City of Toronto (the "City") proposed piloting a non-police mobile crisis service for non-emergency mental health calls. In February 2021, Toronto City Council unanimously approved the proposal. The TCCS program was launched on March 31st, 2022 through partnerships between the City, Toronto Police Service, Findhelp 211, and four community-based anchor partners – Gerstein Crisis Centre, TAIBU Community Health Centre, Canadian Mental Health Association-Toronto, and 2-Spirited People of the 1st Nation.

The pilot is currently being implemented in four different geographical regions in the city, covering 60 percent of the whole city, with a plan for city-wide implementation in 2026 (City of Toronto, 2021). According to the City's website, the program has five key principles which were identified through community engagement:

1. *Enable multiple coordinated pathways for clients to access crisis services;*
2. *Ensure a transparent and consent-based service of care;*
3. *Incorporate a harm-reduction and trauma-informed approach in all aspects of the service;*
4. *Ground the service in the needs of the service-user, while providing adaptive and culturally relevant individual support needs;*
5. *Guarantee accountability to service users' voices and outcomes by establishing clear pathways for complaints, issues and data transparency.*

The City partners with four anchor organizations, who oversee the implementation of the pilot in four regions in the city. The map below highlights the geographical areas covered by the pilot, as well as the partnered organizations overseeing each pilot.

Figure 1: Toronto Community Crisis Service pilot map

Credit: Provincial System Support Program & Shkaabe Makwa, 2023 (pg. 11).

Members of the public can access the service through 911, 211 (a helpline that connects people to social services, programs and community supports), or one of the community anchor partners. The crisis teams are available 24/7, and consist of nurses, mental health clinicians, addictions specialists, crisis workers, or people with lived experience who are trained in de-escalation practices and harm reduction. The services provided by the team range from assessing and responding to immediate crisis needs to connecting clients to longer-term support through other partnering organizations in the area if needed. Calls received through 911 will be assessed if it meets the criteria for the TCCS program (Provincial System Support Program & Shkaabe Makwa, 2023).

The primary intake source for the program at the moment is 911. Calls received by 911 operators are assessed for TCCS eligibility. The eligible criteria for the TCCS program include:

- Individuals over 16 years of age;
- requires support within the four geographical service areas;
- falls within one of the six call categories:
  - thoughts of suicide/self-harm,
  - person in crisis,
  - wellbeing check,
  - distressing/disorderly behavior, dispute, advised,
  - others.

Upon assessment and if provided consent by the person in crisis, the calls are then transferred to 211 for a secondary assessment. After 211 operators conduct a secondary safety assessment, depending on the nature of the call, the call will be routed to one of three general pathways: (1) deploy a Mobile Crisis Team when there is an identified and urgent need for the mobile team to respond to a person in crisis on site; (2) provide information and referral over the phone; (3) transfer the call back to 911 if there is an imminent safety risk and there is a need for emergency services (e.g., police, fire, paramedic).

In January 2023, a six-month implementation evaluation report was produced. The evaluation was conducted by a third-party evaluator from the Provincial System Support Program and Shkaabe Makwa at the Centre for Addiction and Mental Health. The report highlighted some initial successes of the program, as well as identified a range of implementation difficulties faced by partners and provided recommendations for future improvements. The key findings of the report were that the TCCS had initial successes in (1) diverting calls from 911, (2) reducing reliance on the police and emergency services when responding to calls involving PMIs, and (3) referring PMIs to case management and longer-term supports. Specifically, between March 31st, 2022, to September 30th, 2022, 1,197 calls (78%) transferred from 911 resulted in a successful diversion that did not require police involvement (with 41 calls receiving information and referral over the phone and 1,156 calls being handled by the mobile crisis teams). Dispatch teams were sent to 2,092 calls out of a total of 2,489 calls received (approximately 84%). Out of all calls dispatched, only 2.5% of calls required police assistance. Similarly, only 1.7% of those calls required an ambulance (Provincial System Support Program & Shkaabe Makwa, 2023). Some key difficulties identified through the evaluation report include system-level capacity gaps in support services such as housing, shelter and safe beds; process improvements such as collaboration between the TCCS and other first responders on-site; and data collection and management. In addition, the lack of race and disability data also affects the evaluation of health equity and utilization of services amongst equity-deserving groups. Another area of improvement suggested by the evaluation team is to increase public awareness and community engagement activities to reduce staff time spent explaining the intervention. A second evaluation which focuses on the experiences of service users, program staff, and stakeholders, will be conducted in the summer of 2023, with the plan to publish by the end of 2023.

The qualitative data from this research intends to shed more light on some of the aspects covered in the evaluation report. From the perspectives of program staff and those who are involved with the planning and implementation of the TCCS in various capacities, the goal of this paper is to provide insights into some of the lessons learned from the implementation of a non-police crisis intervention program in a large urban centre. This research will further add to the body of literature on crisis intervention approaches, especially addressing the research gap on non-police crisis intervention while informing policymakers of effective responses to mental health crises.

Original research

In addition to reviewing the existing literature (in the earlier part of the paper), this paper also includes interviews with experts in the mental health field and those familiar with the TCCS program. An invitation was sent to the selected participants inviting them to participate in a semi-structured interview (see Appendix A for the email invitation). The interviews were conducted virtually via Microsoft Teams between February and March of 2023. There were six participants (n=6) consisting of City staff, staff from one of the anchor partner organizations, front-line crisis workers, staff from mental health care providers, and an advocate (see table below for participant information). Each participant was asked to sign a consent form prior to the interview (see Appendix B for Informed Consent Form).

Participant ID	Employer	Year(s) of experience in the field	Position held	Date of interview	Length of interview
P1	Advocacy focused organization	9 years	Co-founder	February 6th	1 hour
P2	Centre for Addiction and Mental Health (CAMH)	9 years	Mobile crisis intervention team nurse	February 8th	37 mins
P3	Centre for Addiction and Mental Health (CAMH)	10+ years	Manager	February 16th	30 mins
P4	Anchor partnered organization	10+ years	Manager	February 24th	40 mins
P5	Jane & Finch Community Centre	3+ years	Peer mentor	March 2nd	30 mins
P6	City of Toronto	10+ years	Manager	March 10th	30 mins

Table 1. Participant information.

The data were transcribed verbatim and grouped for similar themes and subthemes. The table below presents the grouping of initial codes to form the themes and subthemes in this paper. In the table, the final column displays the total count of interviewees who discussed the various themes.

Questions	Themes	n of participants contributing (N=6)
Q1. Key characteristics of effective crisis intervention services	**Theme 1:** Having a multi-disciplinary team with team members from diverse backgrounds	5
	Theme 2: A flexible, individualized, and accessible program • Meet PMIs where they are at • Provide culturally appropriate services • Individualized, trauma-informed, person-centred • Provide consistent continuum of care	6
	Theme 3: A range of response options, ensure multiple doors of access	5
	Theme 4: Empower individuals by using a voluntary, consent-based approach	4
	Theme 5: Integrated into the central emergency framework	3
	Theme 6: Provide public education and reducing stigma	5
Q2. Distinctions between TCCS vs. MCIT and TPS	**Theme 1:** Different in mandate/types of calls responded	3
	Theme 2: Different in scope and resources	2
Q3. Barriers and opportunities	**Program level:** • Role clarification between TCCS and other crisis response services • Strengthen the dispatch system through process streamlines and improvement • Standardized and centralized data collection and management • Build staff capacity and resiliency	4
	System level: • Increase public awareness • Improve upstream supports	6

Table 2. Grouping of initial codes to form themes and subthemes.

Thematic analysis was used for this research because it is a flexible approach and does not require a detailed theoretical or technological approach as seen in quantitative methods or other qualitative methods (such as ethnography or phenomenology). In addition, Braun & Clarke (2006) and King (2004) asserted that thematic analysis allows researchers to examine the similarities and differences in the perspectives of participants while generating unanticipated insights. Since the TCCS is a new program, little data is available at the time of the research (other than the City Council reports and the six-month evaluation report). Therefore, the interviews with staff who are involved with the planning and implementation of the TCCS provide useful informational data about the program. As well, the qualitative data from the interviews converge with quantitative data from the evaluation report providing a holistic picture of the implementation and lessons learned from the TCCS program.

Findings from the interviews

A. Key characteristics of an effective crisis intervention program

When asked to describe what characteristics an effective crisis intervention program has, most participants echoed the need for a program that provides culturally appropriate services, available whenever and wherever PMIs need, has a trauma-informed and person-centred lens, and empowers PMIs to make their own decisions.

A.1. A multi-disciplinary crisis team that provides culturally appropriate services

All participants mentioned the importance of multi-disciplinary mobile crisis teams consisting of members with diverse backgrounds and experiences in order for the PMIs to feel relatable and safe when receiving support.

> *It's important to have a multi-disciplinary team and so somebody who may have harm reduction, somebody who might be a training community nurse. Somebody who might be a peer, so sort of having all types of backgrounds and experiences is critical to ensuring that the person in crisis may see themselves in somebody who is there to help them and work with them and to support them. (P6)*

The diversity within the response team that reflects the demography of the areas they serve is a critical element, especially when serving PMIs from racialized or equity-deserving communities.

> *I feel like, you know, with myself being from Jane and Finch, I am well aware of a lot of the issues in the community. So when I'm talking to a client or participant or a community member, I have that experience, and I'm able to bring that with me, which is very important because when you're talking to someone, you want them to relate to you. You want them to feel safe in your presence. (P5)*

Servicing a diverse population in the City of Toronto requires an emphasis on the cultural appropriateness of service. The TCCS prided itself in having a pilot planned by and dedicated towards Indigenous communities (the Downtown West pilot, led by 2-Spirited People of the First Nation), as well as a pilot specifically tailored to serve Black Canadians (the Scarborough pilot, led by Taibu Community Health Centre). Participants have also praised the program for focusing on the unique needs of PMIs from racialized groups while acknowledging the importance of understanding mental health from various cultural perspectives.

> *[Most of the mental health services] are all rooted in a Eurocentric medical model approach to how we do mental health support [where] hearing voices is bad.*
>
> *Hearing voices is something that we want to give folks medication in order to stop. If you look from a non-Eurocentric [view], in a lot of cultures and a lot of communities here, and globally, folks who can hear voices are shamans in communities, they're spiritual leaders, they're healers... And I think it's important for us to [respond to crisis and] not think about what someone's diagnosis is, but what are the symptoms that are causing someone's stress because maybe actually hearing voices isn't causing someone's stress. (P4)*

A.2. A flexible, individualized and accessible program

To make PMIs feel safe, crisis intervention needs to be available 24/7 and administered in familiar settings where PMIs feel comfortable, often in the comfort of their own homes or the community. It is also essential for the responders to dedicate the time to listen to understand the unique needs of each individual without judgment.

> *I think they need someone to listen, someone to meet them where they're at, someone to be non-judgmental. Someone who has adequate time and resources to just be with them for as long as they need. Listen to what they need and figure out how to meet those needs, which could require transportation somewhere. (P1)*

Most participants emphasized that it is important for a crisis intervention program to be individualized, trauma-informed, and person-centred.

> *There's no cookie-cutter approach to this. It's really about being creative at the moment, trying to figure out how we can work alongside someone to support them. And crisis looks different to absolutely everyone. What's going to be a crisis for me? What's going to be a crisis for you? What's going to be a crisis for somebody else? It's all going to look very different... The people in crisis are the experts in their own lives. And it's integral to the program that they [PMIs] lead the crisis planning. (P4)*

Each individual who is experiencing a crisis might require other types of social support. The crisis intervention team needs to be flexible to respond to those diverse needs.

Often, what a lot of these teams do is distribute food or socks, or bottled water, or warm blankets, or things like that, because a lot of the clients that they're responding to are people experiencing homelessness and being able to offer those things can really build trust with that population. (P1)

Individuals with chronic mental illnesses or those in need of social support require a continuum of care. This ensures that their immediate needs are met during a crisis and that they have access to resources to handle future crises.

I think that even a simple phone call after and say like, "Hey, we just wanted to check up on you. We're thinking about you, and we wanted to know how you're feeling now". It's not hard at all to follow up. And I feel like a lot of people when they're experiencing a crisis, it's just like they're crying out for help. (P5)

A.3. Ensure multiple doors of access

A non-police crisis response team is an added alternative to the existing crisis response services (along with co-responder teams - MCIT and police-only response teams). It is important to match the right kind of teams to the right situations depending on the assessed risks on the scene. In an ideal situation, calls received from 911 and 211 will be assessed for imminent risks and appropriateness to send in the TCCS. If the safety of anyone involved is at risk or if someone needs to be apprehended under the Mental Health Act, the MCIT or police will be called to respond.

So, I see a continuum of care where you have low-risk, nonviolent calls [mental health calls] where you send the community responder model, the non-police crisis team. The higher risk calls where there may be a weapon involved, there may be some violence, there may be some risk... this is when you send a specially trained officer who is there, who is able to maintain the safety of everyone on the scene. And it might be that you need several officers, all of whom have this training as well as potentially a social worker, a peer worker, or whoever would be appropriate for that scene... And then you have other calls where there isn't a mental health component, these are just criminal calls, violent, and that's when you need the police. (P1)

A.4. Empowers individuals in crisis

One of the defining features of the TCCS program is a voluntary, consent-based approach. This is a critical element for a crisis intervention program, as mentioned by the participants, to ensure that the service users are empowered to make their own decisions when it comes to receiving support.

It is important for a program to center [around] the person in crisis and people who care for them, the family and others; but most importantly, the person in crisis. They have to be given agency to determine what they actually need to be empowered to make those decisions. And I think

we're only going to be able to make this [program] successful if we ensure that we keep that voluntary consent-based ethos in the work. Because far too often, responding to mental health crises and other types of challenges, there is an element of stripping the person away from their choice. I think we have to at the micro level really empower the person with the choice and be there to support them. (P6)

A.5. Integrated into the central emergency services framework

Most community-based crisis intervention programs are grassroots-led and often operate silos with one another. To improve response time, collaborate with other emergency services, and provide accessible service to PMIs whenever and wherever they need, a mobile crisis intervention program needs to be centrally deployed and integrated with other emergency services. Through the interviews, participants from the City and partnered organizations expressed that the intended goal for the TCCS program is to become integrated into the central emergency service system.

The vision is for the TCCS to be a standalone, fourth pillar of the emergency response system. We have police, fire, and paramedics. The goal is to make this [the TCCS] the fourth option, mental health crisis. By building it out as the fourth pillar, we make sure that it is as reliable as the other three pillars are, as available as the other three pillars are, and as responsive as the other three pillars are. (P6)

A.6. Provide public education and combat stigmatization towards mental illness

Besides providing timely support to people in crisis, one of the main purposes of having a non-police team responding to mental health service calls is to reduce the stigma associated with PMIs. The presence of law enforcement at a mental health crisis call implies the level of danger and risks of the situation. This perception subsequently stigmatized people with mental illness as “dangerous”. It is important to note that most people experiencing a mental health crisis are not violent. If supported appropriately, most service calls involving PMIs can be handled without the assistance of the police. Most participants in this study have emphasized the importance of having a non-police crisis intervention service to change the way in which people associate PMIs with danger and criminalization.

I think that one of the reasons people have this incorrect perception that these calls are violent is because people associate the police with violence. So, when they see police responding to a mental health crisis call, they sort of bootstrap that onto, well, the police must be responding because this person is violent.

And then they carry that idea forward that that must mean people with mental health challenges are violent, and then that makes them think that police are the only ones [who can respond]. So it's very circular. I think once you get police out of that equation and you have the majority of mental health crisis calls being responded to by people who aren't police,

that is going to break the association that people have in their minds between mental health and violence or mental health and crime. And it won't happen right away. But I'm thinking, you know, 20 or 30 or 40 years from now, like my generation and my younger sister's generation, who is 9, who will grow up with these programs just being the norm. They're not going to have the same knee-jerk stigma that a lot of other people have towards mental illness. (P1)

As part of the program features, the TCCS can also become an effective tool to mend the gap in mental health literacy while building community capacity to respond to mental health crises.

I always say that we're really good at health promotion action campaigns. You know, every few years, Toronto Public Health has those posters where there's a bunch of lemons, and one of them is red. And if your urine is red, you've got to get it checked out. I don't think we do mental health action campaigns at all, although we do a lot of mental health awareness campaigns. For example, the Bell: Let's talk! talks about mental health awareness. It doesn't talk about mental health action. TCCS is not only able to provide an alternative to folks who are in crisis but also be able to help build capacity within our communities to be able to support one another. So if we see someone having a crisis on the TTC, maybe we reach a point where we don't actually need to call anyone. But the community is able to rally around folks and help support folks in a crisis. (P4)

The TCCS program is able to leverage its community connections to provide psychoeducation activities due to its unique positioning of being led by community-based and grassroots organizations that have several years of building trust with the communities that they serve.

Overall, from the perspectives of the participants, an effective crisis intervention service is one that is accessible, trauma-informed, person-centred, culturally sensitive, flexible in terms of support provided, empowers PMIs, centrally deployed, and provides public education efforts to create awareness while reducing stigma towards people with mental illness.

B. Distinctions between a non-police crisis intervention team and other crisis response services

To better understand the role of a non-police crisis intervention program such as the TCCS, it is essential to understand its scope and the distinction when being compared to other types of crisis response services. In particular, this section looks to explore the differences between the TCCS with the co-responder and police-only response. Most participants agreed that the TCCS is designed to respond to mental health-related calls that have the lowest level of risk involved. With the rise in the number of crisis calls and the nuances each call can bring, there is a need to have all three types of responses

available to address the volume of calls, as well as the level of acuity involved in these calls. However, it is essential that all crisis response services share the same values and approaches when it comes to serving PMIs.

> *There's room for everybody because there are a lot of people in need, and there are limited resources across our system. I think that the police play an important role in crisis response. Currently, they've been the status quo to date, and there's always room for improvement in terms of the way that we respond to people in crises. I think that different response types can work for different types of people. But overall, I think they need to share the values of having that trauma-informed approach, being adequately trained, and approaching people appropriately and in the right context. And so sometimes that should involve the police, and sometimes that should not involve. I think it's really context-dependent. (P2)*

In addition, a non-police crisis intervention program such as the TCCS can fill in the gap in services that the co-responder teams or the police-only teams might lack, and vice versa. In particular, the MCIT program doesn't run 24/7, whereases the TCCS provides around-the-clock services. On the contrary, the TCCS does not have the mandate and capacity to apprehend individuals under the *Mental Health Act* like the MCIT or police.

> *In terms of their [MCIT] availability is quite limiting. The MCIT doesn't run 24/7 the way TCCS does. But the types of calls are [also] quite different. Like the types of calls that [the MCIT] are supposed to be responding to [are] higher acuity calls where there may be an element of public safety risks and/ or where there may need to be a mental health apprehension. Don't forget that the TCCS is voluntary consent based, so we don't have the capacity, nor do we intend to have the capacity to detain anybody or form (i.e., apprehend someone under the Mental Health Act) anybody. So, there's room, and there's a need for MCIT to provide that type of response. (P6)*

When compared to the police-only response, most participants highlight the police's role in ensuring the safety of everyone involved. As such, police presence is critical in situations where there are imminent risks to PMIs and those on the scene. Although statistics from non-police crisis intervention models showed that the majority of mental health calls do not require law enforcement assistance[2]. In certain situations where physical intervention is required, the police's response is still needed. In addition, as explained earlier in the paper, the police often have limited scope and options when it comes to responding to mental health calls, which limits their abilities to provide the appropriate care that PMIs need.

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[2] For example, according to the TCCS six-month evaluation report, only 2.5% of calls responded required police assistance. Similarly, in 2019, out of 24,000 CAHOOTS calls (a non-police response program in Oregon, U.S.), only 150 times required police backup. (Source: Building mental health into emergency responses (apa.org))

We know that there are alternatives [resources], but those alternatives are for mental health workers. Police, their hands are tied. When they show up on the scene, they can do one of three things: If someone's committed a crime, they can arrest them. If someone meets the criteria for apprehension under the Mental Health Act, they can apprehend and take them to an emergency room to be checked out by a psychiatrist. Or they could do nothing... since there's no crime here, there's no statutory power, they cannot do anything. They could be the nicest guys in the world, but those are the tools in their toolkit. Whereas for mental health workers and peer workers, they have other tools in their toolkits, and they can get people connected with services. (P1)

Certain limitations in scope and resources from the MCIT and police-only response warrant the need for a community-led crisis intervention service such as the TCCS to provide flexibility and dedicated care towards PMIs.

C. Barriers and opportunities

As the first non-police crisis intervention program being implemented on a large scale, there is a lot of potential for the TCCS to become more effective. There are several program-level improvements which the participants have identified throughout the interviews. These improvements include the need for role clarification between TCCS and other crisis response services to improve collaboration; strengthen the dispatch system through process streamlining; standardization and centralization of data collection and management between different anchor organizations; and build staff capacity and resiliency. All of those are covered in greater detail in the six-month evaluation report. Hence, it won’t be elaborated further in this paper.

In addition to the program-level improvements, two system-level lessons that were emphasized throughout all interviews are (1) increasing public awareness and engagement; and (2) improving upstream supports and eliminating system-level barriers through funding and intergovernmental partnerships.

We found that it [public awareness] was a huge barrier and actually one of those unanticipated ones we weren't expecting to see. The fact that the program is consent-based is really a defining feature of the program, and that's what helps it to align with all of its guiding principles. But at the same time, that presents challenges. Particularly when you have a new service that not many people know about. We found that 911, in particular, was spending a really long time having to explain the service to people; and people who aren't familiar with it don't necessarily trust the service, so they're not willing to engage with it. I think that public awareness will play a really big role both in reducing the time spent by 911, but also in redirecting calls from 911 to let people know that you can call 211 directly instead, and so that will also help to increase diversion. (P3)

The lack of housing support and community resources to support PMIs (such as counselling or crisis beds) is one of the main concerns that will limit the TCCS from achieving its full potential.

> *The biggest problem that I hear about whenever I do any focus groups in Toronto is housing. A 10-year-long wait list for housing. No support for housing. Shelter beds are full. Also, shelters are not really supportive places for people with mental illnesses to begin with. We don't have the resources for that. We don't have enough free counselling therapy, [it's] just not there. (P1)*

And the thing is, a crisis team is only as good as the resources around it. If you have a house, you can build a really beautiful front door. But if there is nothing behind the front door, you can't really live in it. (P1)

> *I think it's a huge barrier to being able to enact the service. I think you have a premise that you're going to be able to connect people to community-based resources, but no additional resources were invested in those community resources. So, they don't necessarily have the capacity to take on new clients. We're finding that that's a significant and anticipated barrier, particularly in terms of access to things like crisis beds and supportive housing; those have been big, big needs for people experiencing mental health and addictions challenges across the sector. (P3)*

We need greater access to detox beds, crisis beds, and counselling support. Those upstream pieces are critical, and they're part of the broader crisis infrastructure. And without those, the TCCS will not be able to make substantive changes in the overall health and well-being of people in crisis. We have to do more work in that field, and that work requires intergovernmental conversations, intergovernmental lobbying, as well as collaborations to be able to fund the upstream needs that we have. (P6)

System-level deficiencies pose major obstacles for individuals in crisis seeking services, especially those with mental illness compounded by social issues like homelessness and poverty. The lack of investment in mental health community resources, primary health care, and other social services further exacerbates the disparities among people with mental illness while adding pressure on an already frail healthcare system. Several participants mentioned how this pressure affects front-line staff who often experience

burnout. Increasing funding to support front-line staff while addressing the shortage in health human resources is recommended.

> *Frontline workers, especially within emergency departments, feel a lot of pressure from both the receiving ends of a lot of frustration and anger. From people requiring access to care, and also from other professionals who are going into that space, trying to support folks. I definitely think we need to see a commitment to an increase in funding for all of our frontline workers to ensure that we're able to provide the best support to folks. (P4)*

> *One of the recommendations is probably for long-term funding for staff. Again, for staff, burnout is a real issue with a lot of the frontline workers. Trying to realize that a lot of social workers and individuals that are doing community work are starting to get the effects of burnout. We are working very long hours. We're working a very intense role. We work with people often. Sometimes people are in different positions in their mood and stuff like that, and sometimes maybe they could project that onto others. (P5)*

Community workers and social workers are people at the end of the day, so there's only so much we can take as people. (P5)

Although there are several areas of improvements the TCCS can make before launching on a larger scale, all participants felt rewarded and proud to be a part of a transformative program. The TCCS program is a long-overdue alternative to mental health crisis care, and it has the potential to help change the way in which people in mental health crises receive appropriate support while reducing the stigma associated with mental illness.

Analysis

For many years, the police have become the default first responder to mental health crises. However, lack of adequate education about mental illness, gaps in community mental health services, and other barriers have limited the police capacity to respond effectively to the unique needs of PMIs. The current state of affairs when police are the gatekeeper of both the health care system and the criminal justice system, are increasing criminalization and potential injury or death as a result of PMIs contact with police (Adelman, 2003). Other alternatives to the police response to mental health crises have been explored largely. Most commonly, special-trained police teams and co-responder models are part of the attempts to address this gap in crisis response. However, the presence of law enforcement during a mental health crisis often implies that the situation is dangerous or a criminal matter. People with mental illness often feel stigmatized and traumatized when police are involved during their moments of crisis (CIT International, 2021). Furthermore, for racialized communities that hold traumatic histories with the police, the negative impact of police involvement is even more exacerbated. As such,

alternatives to law enforcement when responding to mental health crises are much needed.

Four factors that play an important role in the successful intervention and resolution of crisis are (1) immediacy of response, (2) location of service delivery, (3) prior knowledge of service, and (4) flexibility of service (Sawicki, 1988). These four factors align with the guiding principles of the TCCS that the participants have identified from the interviews.

Immediacy of response

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States published the National Guidelines for Behavioral Health Crisis Care in 2020. The report provided the following core elements of a crisis system:

(1) regional crisis call centers that accept all calls and dispatch support based on the assessed need of the caller;
(2) centrally-deployed, 24/7 mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments);
(3) 23-hour crisis receiving and stabilization programs; and
(4) essential crisis care principles and practices.

First, to ensure the immediacy of response, the toolkit recommended having a regional, 24/7, clinically staffed crisis call center to provide PMIs with someone to talk to during their moments of crisis. According to the toolkit, this behavioral health crisis line should be analogous to a 911 call for emergencies, where all calls are accepted and assessed for risk before triaging to mobile team services or connecting clients to facility-based care through warm hand-offs (SAMHSA, 2020). As such, it is recommended that this call center must incorporate GPS-based technology to enable collaboration with mobile crisis teams, utilize a real-time regional bed registry to support efficient connection to needed resources and schedule outpatient follow-up appointments to support ongoing care following a crisis episode (SAMHSA, 2020). Since the TCCS is embedded into the emergency services system and can be accessed through 911 or 211, it is available 24/7 for anyone who is in crisis that requires support. Another potential area to explore for the program is the incorporation of GPS-enabled technology which allows better coordination of services between the mobile crisis teams and available crisis beds, or other community resources as needed.

From the literature review, one of the main components that allow a crisis intervention service to function effectively is by having a central and identifiable drop-off location or available psychiatric beds with a no-refusal policy and rapid streamlined intakes. Indeed, long wait times for hospital transfers can result in low response rates (as for the case of CITs and CRTs) because the teams are constantly being held up at ED and are unable to respond to other service calls. One of the recommendations proposed by Marcus & Stergiopoulos (2022) was to change legislations to enable crisis workers to detain service users. This approach will help decrease over-reliance on police in certain situations where apprehension is required. However, there should be clear criteria and guidelines

established to ensure the safety of crisis workers when detaining an individual without the assistance of the police.

Client-centred service delivery

Second, having a client-centred service delivery is important to ensure the crisis is addressed at the time and place of crisis identification. Providing crisis service in the community and at the person's home allows PMIs to feel comfortable in a familiar setting while also giving the crisis worker an opportunity to observe environmental factors and how the PMIs react to them (Sawicki, 1988). A mobile crisis intervention team is expected to include a licensed clinician capable of assessing the needs of PMIs, available whenever and wherever the person is, respond without law enforcement accompaniment unless special circumstances warrant such inclusion, and connect PMIs to facility-based care as needed through warm hand-offs (Sawicki, 1988). A "warm-line" service, which includes peer support, is also a preferential approach as opposed to hot-line services (Forchuk et al., 2005; Brennan et al., 2014). In situations where formal responses were required, PMIs preferred general practitioners and mental health case managers to respond instead of police officers (Brennan et al., 2014). In most studies comparing the co-responder models with the police, the role of the mental health nurse is one of the main components that make PMIs feel safer and more comfortable during a crisis (Lamanna et al., 2018; Boscarato et al., 2014). With the TCCS program, there is a built-in component of case management and peer follow-up support to provide holistic crisis care, which aligns with this view. Furthermore, during the interviews conducted in this study, the participants emphasized the significance of mobile crisis teams that match the demographics of the clients and discouraged the use of uniforms that could highlight power imbalances between individuals experiencing mental illness and crisis workers. This aspect is important to make PMIs feel safe and comfortable in the presence of the crisis teams.

Another critical component of client-centred service delivery is adopting a trauma-informed and person-centred approach. This approach is similar to the one introduced by Caplan (1970), whereby the expertise of the professionals is transferred to the person in crisis, empowering them to make their own decision and trust they know what support would be best for them during their future crises. This person-centred element also encompasses appreciating sociocultural factors when responding to crises. By understanding each individual's perceptions of what constitutes a crisis and respecting their cultural differences, professionals can avoid imposing their own ethnocentrism on the way a crisis should be addressed. According to Hoff et al. (2009), "ethnocentrism" fosters a person's cultural identity and a sense of belonging in a social group. However, when exaggerated, it can become destructive in resolving crisis situations among different ethnic groups by imposing their values and customs on others (Hoff et al., 2009). Ethnocentric attitudes can also interfere with effective communication and de-escalation in a crisis situation (Hoff et al., 2009). This aspect of providing culturally appropriate services is critical for a program such as the TCCS, where more than half of the population the program serves is identified as a visible minority. Adopting a culturally sensitive lens is echoed throughout the interviews with participants who are working as front-line crisis

workers, stressing the importance of understanding the communities they serve and respecting the sociocultural aspects that influence one's own perceptions of mental health.

Prior knowledge of service and public education

Building community awareness towards the program is a factor that is usually not considered important in studies involving crisis intervention. However, according to Sawicki et al. (1998), the greater the community's awareness, the greater the chance of intervention acceptance. Participants in this study have expressed the necessity for improved public awareness campaigns of the program to reduce the time it takes for 911 operators to explain it to first-time users. Moreover, individuals who call the emergency line during a crisis are often not in a sound mental state to trust a new program. Therefore, it is important for a crisis service to be well-publicized to achieve greater community acceptance and trust toward the intervention.

Another element associated with the implementation of a non-police crisis intervention service is reducing the stigma around mental illness. Stigma towards people with mental illness is generally inferred from explicit cues, including psychiatric symptoms, social-skills deficits, physical appearance, and common diagnostic labels (Cohen & Galea, 2011). Commonly held stereotypes about people with mental illness include violence, incompetence, and weak character. These types of stereotyping can lead to the endorsement of negative responses (e.g., "I am afraid of people with mental illness because they are violent"; Cohen & Galea, 2011). These prejudices can often lead to public stigma (when members of the public take negative action against PMIs) or self-stigma (when PMIs internalized the stereotypes and accept these notions as facts) (Cohen & Galea, 2011). Data that are available about non-police crisis teams suggest that these teams can help decrease the stigma and burden for both service users and families (Joy et al., 2008). In addition, there is a higher chance that trained mental health professionals are more likely to exhibit compassion and understanding towards PMIs, which help reduces the self-stigmatization PMIs exhibit. Policing in mental health also contributes to the increasing prevalence of PMIs in jail instead of treatment facilities (Teplin, 1984). By replacing the police with mental health professionals as front-line responders to mental health calls, the likelihood of PMIs being arrested and criminalized is minimized.

Most studies have highlighted that PMIs prefer an informal crisis response involving family members and friends (Brennan et al., 2014). However, most family members and friends aren't knowledgeable enough to respond to crises, and hence, having to rely on emergency services most of the time. The TCCS program, through its public education efforts, has the potential to provide family members and friends of PMIs with the necessary information on how they can provide support to PMIs during future crises in a safe and effective manner.

Along with public awareness campaigns to introduce the TCCS to the community, the TCCS program has the ability to leverage its unique positioning by partnering with

grassroots organizations to provide psychoeducation tailored specifically to each geographical area it serves. These psychoeducation efforts can be beneficial to (1) raise awareness about the program, (2) increase community capacity to respond to crises, and (3) reduce the stigma associated with people with mental illnesses.

Flexibility of service

As mentioned earlier in the paper, the MIND charity organization has established the following crisis provision to deliver an effective crisis intervention program: offer flexibility, do no harm, offer anonymity, autonomy, including choice of treatment, opportunities to talk through the underlying causes of distress, take a holistic approach, safeguard resources from psychiatric hospitals for mental health services, offer safety when needed. In addition, provision should be established in a familiar and emotionally safe environment, as well as allow people to withdraw from the service gradually and be linked to longer-term support if needed. Several characteristics of the TCCS program align with this provision. First, the flexibility of service links back to the person-centred approach to crisis response which recognizes and respects an individual's unique needs during a crisis and allows the service users to co-design crisis management plans. This avoids imposing a Eurocentric view which may contradict dearly held values and jeopardize a person's sense of autonomy. As such, having a diverse crisis response team that closely mirrors the demographics of the population they serve is important to ensure culturally appropriate services are provided.

Second, recognizing that PMIs often battle other social issues (such as homelessness and poverty), crisis response teams need to remain flexible and creative to attend to the various needs of those individuals. Oftentimes that can include transporting PMIs to shelter beds, linking them with social housing supports, or simply providing them with warm blankets and toiletry to ensure their immediate physical well-being. However, as criticized by all participants in this study, the lack of community resources to address some of those social needs, especially the lack of housing support, often leaves the service users through "a revolving door". This is when PMIs' needs are not met, they often end up circling through the system and repeatedly requiring support from crisis teams. As introduced earlier in the paper, Lindenmann (1944) established the dual role of crisis workers as (1) reducing the impact of the stressful event and (2) helping those affected to solve their present problems so that they can build their capacity to respond to future crises. However, if the social needs of PMIs are not met (for example, needs for shelter beds or community housing), they won't be able to solve their problems or build their capacity to respond to future crises. This will also negatively affect the trust PMIs have in crisis workers. Therefore, a crisis intervention program needs to be backed up by a solid support system (including facility-based care, housing support, and other services that align with the PMIs' assessed needs) to ensure needs are being met and a continuum of care is provided.

Overall, characteristics of an effective crisis intervention service include timely and accessibility of service, responding without law enforcement accompaniment unless special circumstances warrant such inclusion, connecting PMIs to facility-based care as

needed through warm hand-offs, empowering PMIs to make their own choices by taking a client-centred approach, building community trust and rapport through engagement and psychoeducation, and providing flexible services to meet the unique needs of PMIs.

Limitations of the Research

The initial intention of the paper was to evaluate the effectiveness of the TCCS program. However, since the program is still in its pilot phase, limited data were available at the time of the research. As such, a different approach was adopted to explore the characteristics of an effective crisis intervention program using the TCCS as a case study. There are several anticipated as well as unanticipated limitations and challenges throughout the course of the study, which will be described in this section below.

The first limitation is the small sample size of the study (n=6). This is due to the low response rate from the email invitation and social media engagement with targeted participants. A possible reason for the low response rate is the failure to follow up with targeted participants. To address this challenge in the future, invitations should be sent earlier and with sufficient time for follow-up, to increase the response rate.

Second, the participants are selected based on their understanding and involvement with the TCCS program. Hence, this paper only captures their perspectives and can be subjected to personal biased. However, given that the TCCS is a new program, it is important to interview participants who have knowledge of the program, which limits the participant pool. Interviews with individuals from the Toronto Police Services and other first responders (e.g., fire and paramedics) would have been helpful to diversify the findings by capturing their perspectives and experiences collaborating with the TCCS program. Future research can explore the perspectives of first responders about the TCCS program.

Third, due to ethical concerns, this research did not interview service users and hence could not capture their experiences nor evaluate whether the TCCS program was able to address their needs. A second evaluation report of the TCCS program conducted by a third-party evaluator, which will be published toward the end of 2023, will capture this data. Lastly, since the research explicitly uses the TCCS program as a case study, this affects the generalizability of the research. However, characteristics of an effective crisis intervention program are further explored in the analysis section, which provides insights that can be generalized to other crisis intervention programs.

Future Considerations for the TCCS

As previously indicated in the literature review section, evaluation approaches of crisis intervention models often involve either process outcomes or stakeholder-focused outcomes and lack control groups. As such, most studies are of descriptive nature only and lack pretrial data or a control group to compare results. Future studies can look at evaluating the TCCS program using a control group or pre- and post-intervention data to examine the effectiveness of the program (for example, comparing outcomes between

areas that have the TCCS program with other areas without the intervention). Further, as suggested by one of the participants in this study, quantitative data examining the diversion rates of PMIs from the ED should determine the appropriateness of each case where PMIs are transferred to the ED by monitoring the length of stay and rate of admissions. As well, the appropriateness of service referrals should be examined by measuring the tendency to use community mental health services after referrals from the TCCS (similar to a study conducted by Kim & Kim, 2017), and triangulating quantitative data with qualitative data from service users, front-line crisis workers, nurses at the ED, police officers, and call center staff.

In addition, certain aspects that were mentioned by the participants during the interviews were not explicitly elaborated on in this paper. However, they could be potential topics for future studies to explore. Specifically, some participants have indicated the linkage between removing police from front-line response to crisis calls with reducing the stigma associated with mental health. It would be interesting to examine to see if there is any causal relationship between those two. Another aspect that was briefly discussed in the interviews was front-line staff retention and resiliency. This topic was discussed in the six-month evaluation report and will most likely be explored further in the second report. Front-line staff often experiences burnout due to the nature of their role in dealing with PMIs and working non-conventional hours. Future studies should look to examine the mental health of frontline responders to ensure adequate resources are provided to staff to overcome traumatic incidents during their day-to-day work.

Conclusions

Mental health crisis has a direct impact not just on those experiencing mental illness and their families but also on governments and the broader economy. According to the Centre for Addiction and Mental Health's website, the annual economic cost of mental illness in Canada is estimated at over $50 billion per year[3]. Individuals with mental illness are much less likely to be employed, contributing to the loss of productivity for the economy. Alarmingly, COVID-19 has further exacerbated this issue, with fewer Canadians reporting having good mental health since the onset of the pandemic (Statistics Canada, 2020). Furthermore, certain socio-demographic groups are over-represented in analyses of police contact with PMIs. Specifically, homeless citizens are one of those groups due to their visibility in public spaces, their frequent engagement in survival offences, and their high rates of mental health disorders and substance abuse (Huey et al., 2021). Policing in mental health has further exacerbated disparities among PMIs, especially those from equity-deserving communities. Increased interactions between PMIs and the police have led to increased rates of arrest, increased hospitalization, inappropriate care, and stigmatization of PMIs.

Crisis intervention provides an opportunity to positively effect change at a turning point in an individual life to help decrease the likelihood of such behaviour in the future. The police aren't necessarily equipped to provide effective care for those who are in crisis. *"A health*

[3] This includes health care costs, loss of productivity, and reductions in health-related quality of life.

crisis should be responded to with a health care approach, not a criminal justice approach" (P4). That sentiment was echoed by all participants I interviewed for this research paper. The introduction of a non-police crisis intervention program such as the TCCS is a promising stepping stone in changing the way mental health crises should be responded to. Several characteristics of an effective crisis intervention program are explored, using the TCCS program as a case study. Those characteristics include the following (but are not limited to): the immediacy of response, responding without law enforcement accompaniment unless special circumstances warrant such inclusion, connecting PMIs to facility-based care as needed through warm hand-offs, empowering PMIs to make their own choices by taking a client-centred approach, building community trust and rapport through engagement and psychoeducation, and providing flexible services to meet the unique needs of PMIs. The role of a non-police crisis intervention team is to respond to low-acuity crisis calls while limiting the involvement of law enforcement with mental health crisis calls. Further role clarity between the TCCS program and other crisis response services is critical to ensure effective collaboration between all parties involved. In addition, improved and targeted public education about the program can help achieve community acceptance and trust towards the intervention while reducing public- and self-stigma associated with mental illness.

The success of a crisis intervention program is only as great as the resources behind it. Investment in mental health care has been proven to produce net cost benefits and provide a positive return on investment. Further investment in community-based resources, including shelter beds, housing, stabilization centers, and support to front-line staff are needed to ensure a consistent continuum of care for PMIs.

Leveraging from the lessons learned with the TCCS program, other jurisdictions should explore similar crisis intervention models to ensure appropriate and effective care is provided for people in crisis. An effective crisis intervention program requires support from different levels of government. This can be achieved through collaboration between federal, provincial and local governments to provide funding and resources to crisis intervention services and the wrap-around support system. With a solid mental health care and social support system, a crisis intervention program will not only be a band-aid solution but is able to mend the disparities in care that people with mental illness are currently experiencing and ensure that people in crisis receive the care they need to recover and move forward.

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APPENDIX

Appendix A. Interview Invitation Email Script

Dear Mr/Ms. XX:

I am a student in the Master of Public Policy, Administration and Law program at York University. As part of my major research paper for the capstone *Topics in Public Policy* course, I am conducting research about the Toronto Community Crisis Service (TCCS).

I have done considerable reading on the program from a variety of sources, but there are questions that I cannot answer. As such, I would be grateful for the opportunity to have a short interview with you given the role you played, and the perspective you have, in regard to the program and/or expertise in working with persons with mental health issues. Please note that due to ethical concerns and as part of the ethics review approval, I am not intended to interview anyone who identifies as Indigenous.

The interview is between 30-45 minutes and will be scheduled at your convenience. We can meet in-person or Microsoft Teams (or other platform), or alternatively speak on the telephone. I will send you the questions in advance.

The interview is confidential and the research has received ethics review and approval by The School of Public Policy and Administration Ethics Committee, which has delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board. Prior to the start of the interview you will need to sign an Informed Consent Form.

I might note that I am also interviewing other key participants and experts about the TCCS.

Thank you for considering this request.

Sincerely,

Appendix B. Individualized Consent Form

Informed Consent Form

Date: January 22, 2023

Study Name: An examination of the Toronto Community Crisis Service

Researcher name: Nicole Khuc. Student in the Master of Public Policy, Administration & Law program at York University. I am the Principal Investigator.
Email: mkhuc@yorku.ca

Purpose of the Research:

In 2022, the City of Toronto piloted a non-police, community-led crisis intervention model called Toronto Community Crisis Service (TCCS). The research project will examine the effectiveness of crisis intervention model as an alternative to police enforcement with regard to persons with mental illness (PMIs).

I am conducting interviews with key participants and experts in the mental health fields for my major research paper for my program of study.

What You Will Be Asked to Do in the Research:

I am asking if you might agree to be interviewed for approximately 45 minutes. A list of questions will be sent to you 1-2 days in advance of the interview. You will be asked to share your perspective towards whether a civilian-led crisis intervention model is an effective alternative to police enforcement.

Risks and Discomforts:
We do not foresee any risks or discomfort from your participation in the research. This research will not involve interviewing Indigenous people.

Benefits of the Research and Benefits to You: This research will provide insights into whether a program such as TCCS can reduce the number of police interactions with PMIs. Recommendations will be provided to address any challenges the program might face to improve implementation and service delivery to best address the needs of persons with perceived mental illness during crisis.

Voluntary Participation and Withdrawal: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality:

Unless you choose otherwise all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name and position will not appear in any report or publication of the research. If you agree to permit the interview to be video recorded using Microsoft Teams platform, the recording will be password protected and saved in a file in my computer and only the researcher (myself) and my supervisor will have access to it. The file, and any notes that might be made

from it, will be deleted on April 30, 2023. Confidentiality will be provided to the fullest extent possible by law.

This study will use the Microsoft Teams to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP address or other information which could link your participant to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact Nicole Khuc at mkhuc@yorku.ca for further information.

Recordings (audio/video) will be saved in a password protected file to the researcher's local computer, not the cloud-based service. The file will only be accessible to the researcher (myself) and my professor.

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact me at mkhuc@yorku.ca or my supervisor, Professor Thomas Klassen at tklassen@yorku.ca and/or 416-736-2100 x. 88828. You may also contact the Master of Public Policy and Administration Program at lapssppa@yorku.ca and/or 416 736 5384.

This research has received ethics review and approval by The School of Public Policy and Administration Ethics Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I <<fill in participant name here>>, consent to participate in the study about the Toronto Community Crisis Service conducted by Nicole Khuc. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature ______________________ **Date** ____________________
Participant

Signature ______________________ **Date** ____________________
Principal Investigator

Additional consent (where applicable)

1. **Video recording or use of photographs**

I ____________________ consent to the use of images of me (including photographs, video and other moving images), my environment and property in the following ways (please check all that apply):

In academic articles	☐ N	☐ Y
In print, digital and slide form	☐ N	☐ Y
In academic presentations	☐ N	☐ Y
In media	☐ N	☐ Y
In thesis materials	☐ N	☐ Y

Signature ______________________ **Date** ______________________

Participant Name:

2. Consent to waive anonymity.

I, <<insert participants name>>, consent to the use of my name in the publications arising from this research.

Signature ______________________ **Date** ______________________

Participant Name:

Appendix C. Interview Guide

Date:
Interviewer: Nicole Khuc   Interviewee:

Area of Interest	Question	Probe
Icebreaker	• Can you tell me about yourself and your work involving with the TCCS?	• How long have you worked there?
Familiarity with TCCS	• What is your level of involvement with the program? • How familiar are you with the TCCS program?	• How has the implementation of TCCS affected your current work in any capacity? • What has been your experience being involved in this program?
Role clarity	• From your experience dealing with/having knowledge about persons with mental illness (PMI). What kind of support do you think PMIs need the most during crisis? • Who should response to service calls involving PMI in crisis?	
Police role	• What is your perspective on the role of police in responding to crisis calls involving PMIs?	• *Can you think of a situation where the police might need to get involved during a crisis call?*
Effectiveness of crisis intervention program	• What are some of the challenges your team has faced when implementing TCCS? • What would help your team overcome those challenges? • What have been the experience of front-line staff working in the program? What do staff feel being involved in a program like this? • What are some of the challenges staff might face in providing effective crisis intervention for PMIs? • What elements need to be looked at to evaluate the effectiveness of TCCS before launching it on a larger scale?	• *Do you think together with other crisis services (MCIT, CIT training etc..), with the introduction of TCCS, is it adequately in addressing the needs of PMIs? Please explain.* • What do you think need to be done to integrate the TCCS with the rest of the mental health services and programs to create an effective support system for PMIs? What might that system look like?

	◦ This may mean more community organizations be involved with the program, and with such a diverse group of stakeholders, how have your experience with engaging or working together with them? • What are some of the challenges TCCS might face when being launched on a larger scale?	
Effectiveness of TCCS	• *What are some factors contributing to an effective crisis intervention program for PMIs?* ◦ *What are some barriers PMIs might face getting help during a crisis?* • Do you think the current mental health support system is adequate in providing PMIs with the services and support they need? ◦ What are some of the system level barriers?	• How do you think the introduction of a community crisis service such as TCCS can change the landscape of mental health service system in Toronto? ◦ How can TCCS affect the broader society, for example public perceptions about mental illness or redefine the role of first responders in some instances?