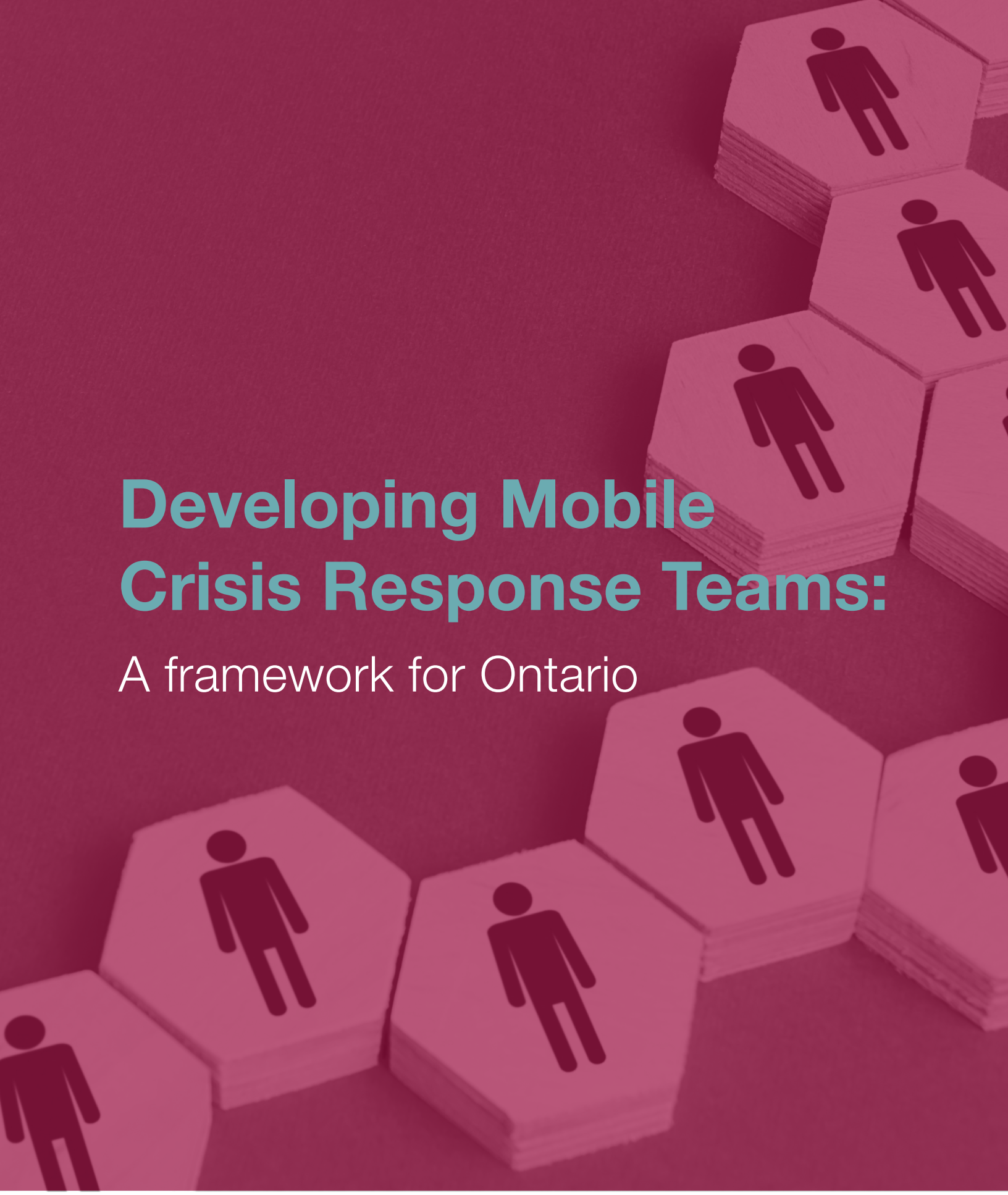

Developing Mobile Crisis Response Teams:

A framework for Ontario

HSJCC
Human Services & Justice Coordinating Committee

O.P.P.

Canadian Mental Health Association
Ontario

OACP

Ontario Hospital Association

Acknowledgements

This framework was developed in partnership with:

- Provincial Human Services and Justice Coordinating Committee
- Ontario Provincial Police
- Canadian Mental Health Association, Ontario
- Ontario Hospital Association
- Ontario Association of Chiefs of Police
- Ministry of Health
- Ministry of the Solicitor General

Legal disclaimer

Mobile Crisis Response Teams Provincial Working Group

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Provincial Working Group task force

Christine Conrad, Canadian Mental Health Association, Ontario (Co-chair)
Lisa Longworth, Ontario Provincial Police (Co-chair)
Sarah Amon, York Regional Police
Marla Banning, Centre for Addiction and Mental Health
Chris Boddy, Toronto Police Service
Bill Chantler, London Police Service
Brad Davey, ConnexOntario
Leah Dunbar, Michael Garron Hospital
Chantal Dupuis, Ontario Provincial Police
Amy Herskowitz, Ministry of Health
Anjelina Mattai, Ministry of the Solicitor General
Jason McIlveen, York Regional Police
Chris Palmer, York Regional Police
Julie Randall, Ontario Provincial Police
Jenn Ward, Canadian Mental Health Association, Peel Dufferin Branch

Advisory and consultation team

Ashley Baker, Ministry of the Solicitor General
Brandon Boire, Akwesasne Mohawk Police Service
Dianna Cochrane, Ministry of Health
Sara Dias, Canadian Mental Health Association, Kenora Branch
Alana Jaquemet, Akwesasne Health Services
David Michaud, Cornwall Police Service
Cecilia Omole, Ministry of the Solicitor General
Angel Quesnel, Cornwall Hospital
Jacqueline Rousseau, The Ottawa Hospital
Tammi Simcoe, Ontario Provincial Police
Satar Wahidi, St. Joseph's Healthcare Hamilton
Holly Watson, Ottawa Police Service
Brooke Young, Canadian Mental Health Association, Waterloo Wellington Branch

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Angie McCollum, Ontario Provincial Police
Tasha Rennie, Provincial Human Services and Justice Coordinating Committee Secretariat
Jenna Thomson, Ontario Provincial Police
Matt Tomlin, PhD Candidate, Walden University
Ellen Wankiewicz, Office of the Information and Privacy Commissioner of Ontario

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Consultations

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Children's Mental Health Ontario
Community Living Dryden-Sioux Lookout
Community Networks of Specialized Care
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Dr. Kaitlyn McLachlan, Department of Psychology, University of Guelph
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Gerstein Crisis Centre
Greater Toronto Area Policing and Mental Health Working Group
Hong Fook Mental Health Association
Information and Privacy Commissioner of Ontario
International Mobile Services Association
Lanark Community Programs – Autism Services
Ministry of Children, Community and Social Services
Ministry of Health
Ministry of the Solicitor General
Nishnawbe Aski Nation Legal Services
North Bay & District Multicultural Centre
Ontario Association of Chiefs of Police
Ontario Caregiver Association
Ontario Hospital Association
Ontario Peer Development Initiative
Ottawa Community Immigrant Services Organization
Sound Times Support Services
South Asian Legal Clinic of Ontario
Sunbeam Community and Developmental Services – Waterloo Region
TAIBU Community Health Centre
The Centre for Research & Innovation for Black Survivors of Homicide Victims
Thunder Bay Joint-Mobile Crisis Response Steering Committee
Toronto Mobile Crisis Intervention Team Program Steering Committee
Women's Health in Women's Hands Community Health Centre

Executive summary

Developing Mobile Crisis Response Teams: A framework for Ontario has been designed to provide police services and their collaborative health partners in communities across Ontario with the tools necessary to establish effective mobile crisis response teams to support individuals experiencing a crisis. Created by the Mobile Crisis Response Teams Provincial Working Group, a subcommittee of the Provincial Human Services and Justice Coordinating Committee (HSJCC), this framework is meant to supplement Improving Police-Hospital Transitions: A Framework for Ontario as part of an effective crisis response. *Developing Mobile Crisis Response Teams: A framework for Ontario* outlines current best practices and recommendations for the development and evaluation of mobile crisis response teams while remaining flexible to the needs of local communities.

The framework identifies different types of mobile crisis response teams existing in Ontario and provides an overview of the key elements of each model. Universal considerations for all types of models are reviewed, including geography, human resources, security and risk management, governance, privacy and information sharing, funding, training, data collection and evaluation. The accompanying toolkit, *Tools for Developing Mobile Crisis Response Teams in Ontario*, provides templates and resources that communities can utilize to establish or enhance their own mobile crisis response team.

The framework and toolkit are based on established and promising practices in Ontario and are not intended to prescribe how teams should operate. Rather, these resources are designed to help police and community health partners develop mobile crisis response teams using common approaches to assist in ongoing program development, quality improvement and evaluation. Notwithstanding, the police and community health partners are required to abide by applicable legislation, including privacy legislation, as outlined in this document.

This project started in early 2019, with a focus on mobile crisis teams that respond to mental health, addictions, neurodevelopmental and/or other crises where police are called and obligated to attend. These teams pair a police officer with a crisis worker and provide a critical response or resource when attending a police call for service to a situation involving an individual experiencing a crisis. Mobile crisis response teams are one component of a spectrum of crisis services, which also includes community (non-police) mobile teams, drop-in crisis centres, safe beds, and proactive mental health and addictions support. While this framework focuses on police and mental health partnerships, an overview of community (non-police) mobile teams is also included. These non-police teams play an integral role in crisis response and should be considered for future analysis and development. *Developing Mobile Crisis Response Teams: A framework for Ontario* will be helpful to both police and community (non-police) models because it encourages all partners to collaborate with diverse service providers within their communities to ensure an integrated, specialized and holistic crisis response.

We are better together.

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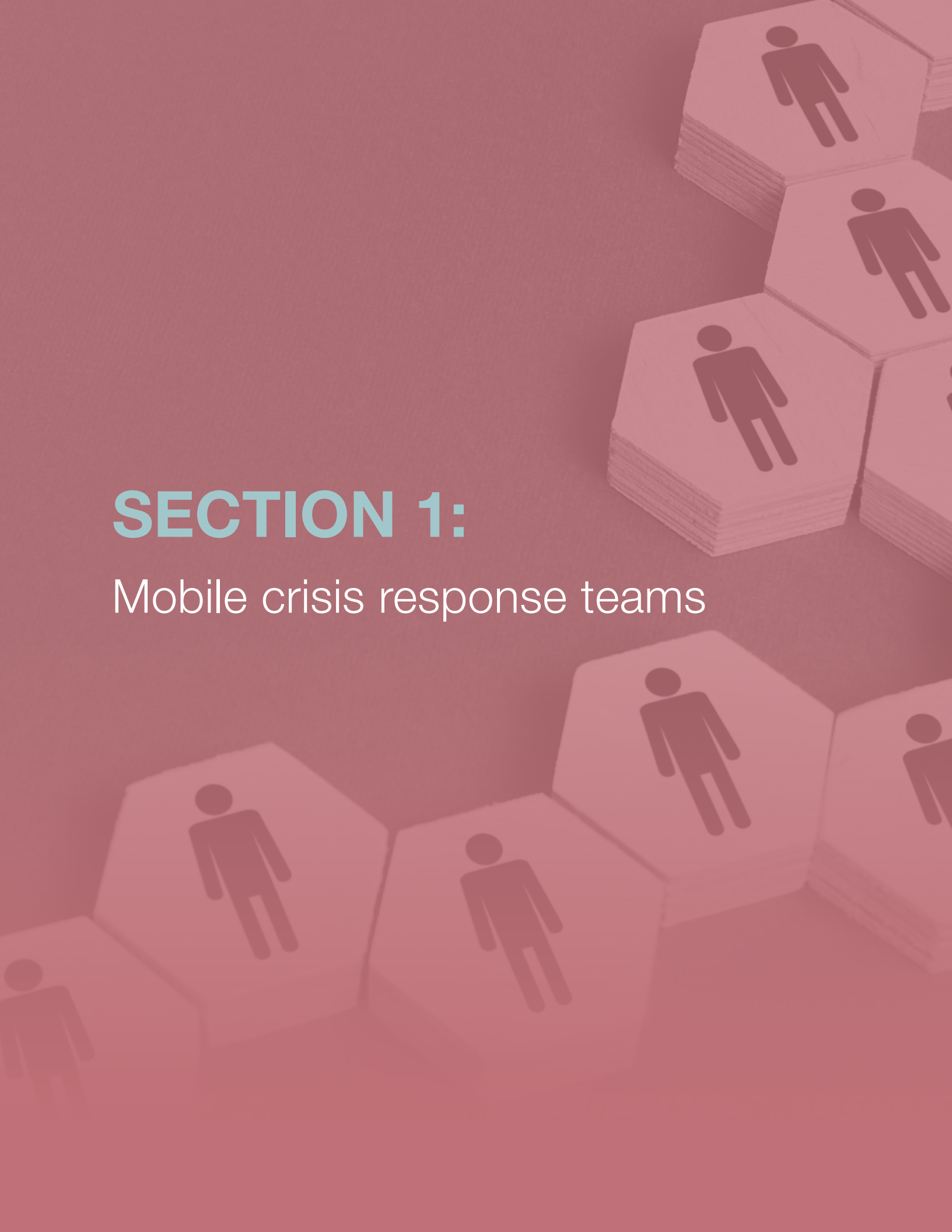
Purpose

Mobile crisis response teams (MCRTs) involve police officers and crisis workers responding together to a mental health, addiction, neurodevelopmental and/or other crisis situation where police have been called to respond. These teams help to de-escalate crisis situations at the scene, divert individuals from emergency departments whenever appropriate and support clients by connecting them to local services in the community. Recognizing that there is no standard mobile crisis response model, the purpose of this framework is to present best practices that can be adapted according to the unique requirements of Ontario's diverse communities.

Over the past five years, mobile crisis response teams involving police and mental health and addictions partners have expanded across the province. Investments in mobile crisis response teams continue to be made while few evaluative studies or guidelines exist to ensure these teams provide the best clinical outcomes. Mobile crisis response teams are primarily accessed through 911 calls for police service, as police are the default crisis responders in Ontario. For this reason, the framework focuses on mobile crisis response teams involving police officers and crisis workers, highlighting promising practices from across the province to guide the development of these teams. However, community (non-police) mobile teams provide critical services across Ontario and are also featured in the framework.

This framework is supported by a toolkit, *Tools for Developing Mobile Crisis Response Teams in Ontario*. The intent of this framework and the accompanying toolkit is to support communities to establish different types of mobile crisis response team models, improve outcomes for individuals experiencing a mental health, addictions, neurodevelopmental and/or other crisis, and promote consistent evaluation practices across the province. There is no expectation that existing mobile crisis response teams change their current program. The framework remains flexible by identifying and describing the different types of mobile crisis response models in Ontario, supporting communities as they implement new teams, and encouraging all teams to collect common data elements to allow for future evaluation and the development of evidence-based practices. This framework and its accompanying toolkit also provide guidance to help mobile crisis response team partners comply with privacy requirements and best practices. Guidance on how to engage in data collection and program evaluation in compliance with privacy requirements and best practices can be found in the Data Collection Template (Tool #11) in *Tools for Developing Mobile Crisis Response Teams in Ontario*.



SECTION 1:

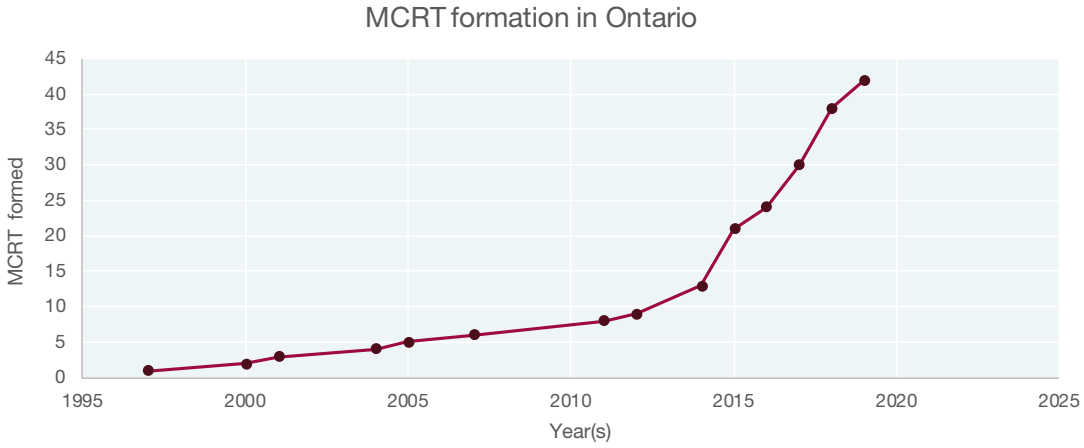
Mobile crisis response teams

Background

Over the past 20 years, there has been ongoing development and implementation of various mobile crisis response teams that involve police and mental health and addictions service providers responding together to a mental health, addictions and/or other crisis[1] situation. This includes a substantial increase in the development of new mobile crisis response teams in Ontario over the past five years, as demonstrated in the below graph.

Mobile crisis response team formation dates in Ontario

*Note: This graph is based on data collected in a provincial survey by the working group in September 2019 (described further in the **Environmental scan** section). It only includes teams that responded to the survey and does not include every mobile crisis response team currently operating in Ontario.*



The primary purpose of mobile crisis response teams is de-escalating situations where an individual may be experiencing a crisis. In addition, these teams aim to:

- Improve client outcomes by providing community assessment to determine links to appropriate community services
- Divert individuals from unnecessary hospital emergency department visits[2] and reduce pressures on the health care system

1 This framework uses the term "crisis" to describe any situation in which a person's behaviour puts them at risk of hurting themselves or others or prevents them from being able to care for themselves or function in the community. The crisis may be related to a mental health issue, addiction, a neurodevelopmental disability, dementia, an acquired brain injury and/or any other condition that impacts the person's behaviour. Anyone who calls the police may be experiencing a crisis, such as a traffic accident, assault, intimate partner violence, theft, etc. For this framework, "crisis" refers only to calls that police code as "mental health and/or addictions-related," which includes calls related to neurodevelopmental disabilities, dementia and other conditions.

2 An "unnecessary hospital emergency department visit" refers to a situation in which an individual does not appear to represent a danger or threat to themselves or others. The individual can be safely and effectively supported in the community and would therefore not be appropriate for hospital admission under the *Mental Health Act*.

- Divert individuals from unnecessary criminal justice system involvement[3] and reduce pressures on the court and correctional systems
- Mitigate the impact on police resources in relation to mental health and addictions crisis response
- Improve individual and/or caregiver experiences
- Decrease stigma of individuals living with mental health and/or addictions issues
- Build and maintain effective partnerships between police services, health care providers and communities

Provincially and internationally, there has been limited research conducted on mobile crisis response models. Although the few existing studies have shown positive results (see **Appendix A – Literature review**), further research, analysis and evaluation are needed to determine the viability and effectiveness of these models. In Ontario, existing mobile crisis response models vary significantly in how they have been developed, implemented and evaluated. Without further research, it is difficult to demonstrate which model is best at meeting the aims listed above.

In the fall of 2018, several sectors and organizations in Ontario were independently engaging in discussions about core components for mobile crisis response models. It was quickly acknowledged that the lack of shared information and evaluation of these models created gaps in measuring their outcomes and successes, including demonstrating the need for operational sustainability. As mobile crisis response teams across Ontario become more coordinated with each other, their community sector partners and their funding partners, it is timely to share subject matter expertise and evidence-based best practices for the development, implementation and evaluation of these types of program models. This includes best available practices in community engagement, partnerships and stakeholder investment, program development, scope of practice, regulatory considerations, risk management, operational standards, data collection, evaluation and sustainable funding approaches.

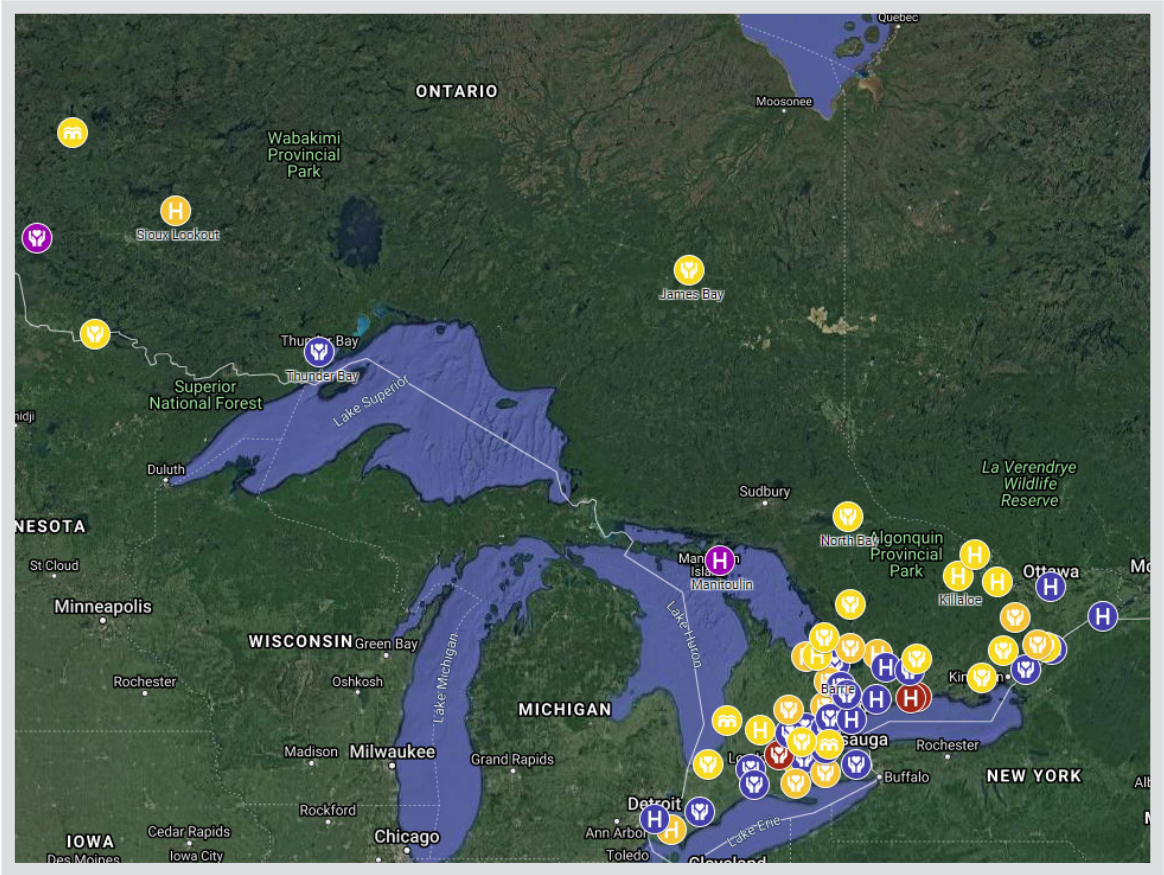
3 "Unnecessary justice involvement" refers to a situation in which an individual is deemed unsuitable for criminal detention by police because any minor offence alleged to have been committed is due to mental health and/or addictions issues or other health-related issues. The individual would be more effectively served by the health and community services sectors than being remanded into police custody. This includes options such as pre-charge diversion and verbal or written warnings or cautions.

Environmental scan

In the spring and summer of 2019, an environmental scan survey was disseminated to existing and developing mobile crisis response teams in Ontario. The survey was distributed through the Human Services and Justice Coordinating Committee (HJSCC) Network, the Ontario Association of Chiefs of Police, the Local Health Integration Networks, Ontario Provincial Police (OPP) detachments and Canadian Mental Health Association (CMHA) branches.

From 83 respondents in September 2019, 40 existing mobile crisis response teams were identified across Ontario as operational police and mental health embedded or co-response models. Another 17 teams were identified as "in development", did not involve police and health partners or did not fully complete the survey. Since the survey was disseminated, as of August 2020, approximately 62 mobile crisis response teams exist across Ontario.

Mobile crisis response teams involving police and health partners in Ontario



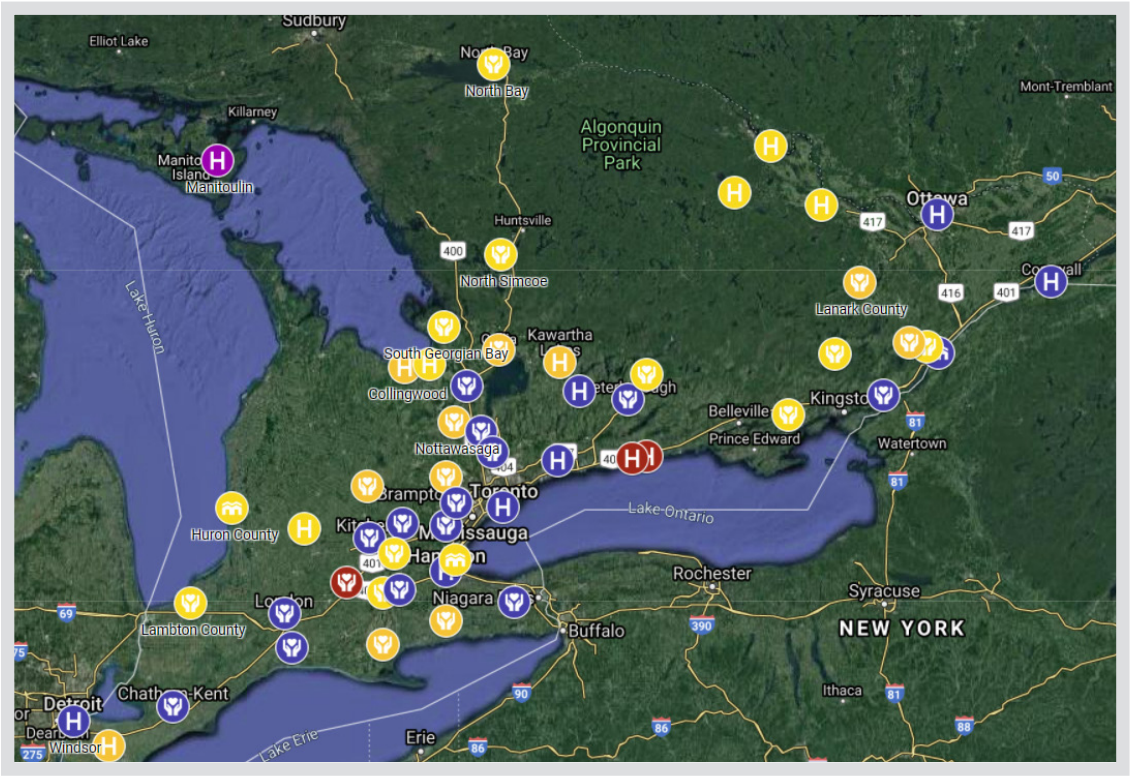
Type of police partner

- Municipal police service
- Ontario Provincial Police (OPP) detachment
- Both municipal and OPP
- First Nations police service

Type of health partner

- Hospital
- Community organization
- Both

Southern Ontario inset

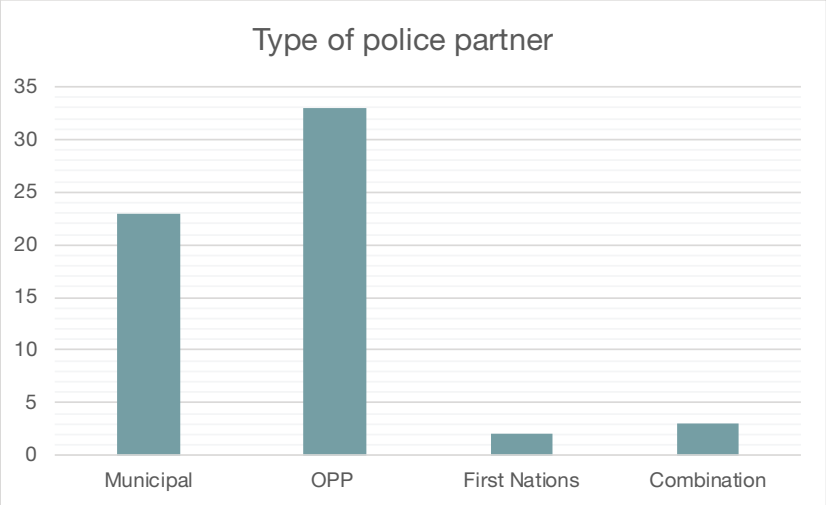


Note: In addition to the 40 teams that completed the survey conducted by the working group in September 2019, this map also includes 22 new teams or teams that did not complete the survey. Many of these teams were in development when the survey was disseminated. All 62 teams on the map meet the working group's definition of "mobile crisis response team" and were operational as of August 2020.

The preceding maps demonstrate the variety of collaborations existing in communities across Ontario. Mobile crisis response teams occur in both rural areas, where the OPP typically provides policing services, as well as large and small urban centres, where municipal police services are usually the justice partners. Often, both types of police services collaborate on mobile crisis response teams serving a city and its surrounding rural areas. Two mobile crisis response teams involving First Nations police services were identified, often working in partnership with the OPP.

Both community organizations and hospitals partner with municipal, provincial and/or First Nations police services across the province, depending on resources and historic relationships. More frequently, police services and health partners are working collaboratively to develop response models that provide consistent and equitable access to service across the province.

Type of police service that partners on mobile crisis response teams in Ontario



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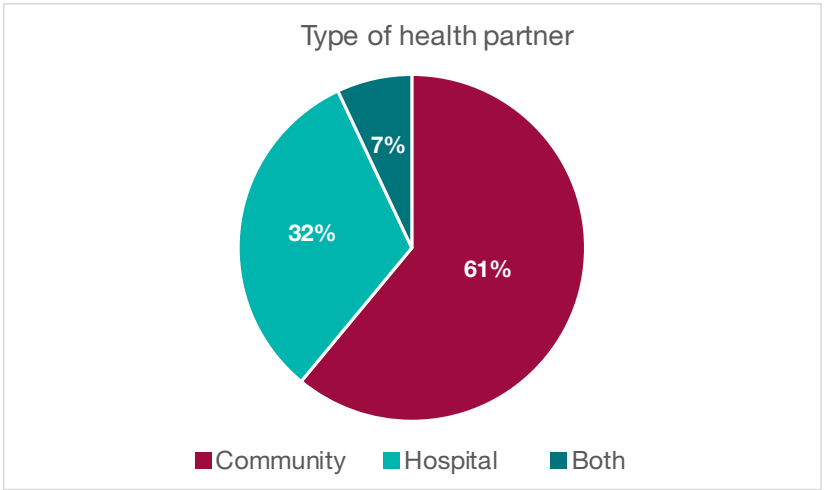
Type of health organizations that partner on mobile crisis response teams in Ontario



Note: In addition to the 40 teams that completed the survey conducted by the working group in September 2019, this graph also includes 22 new teams or teams that did not complete the survey. Many of these teams were in development when the survey was disseminated. All 62 teams in the graph meet the working group's definition of "mobile crisis response team" and were operational as of August 2020.

The preceding graph demonstrates that either a community organization or a hospital is usually the mental health partner in a mobile crisis response team in Ontario. However, it is highly recommended that all local health providers are included in the development of a mobile crisis

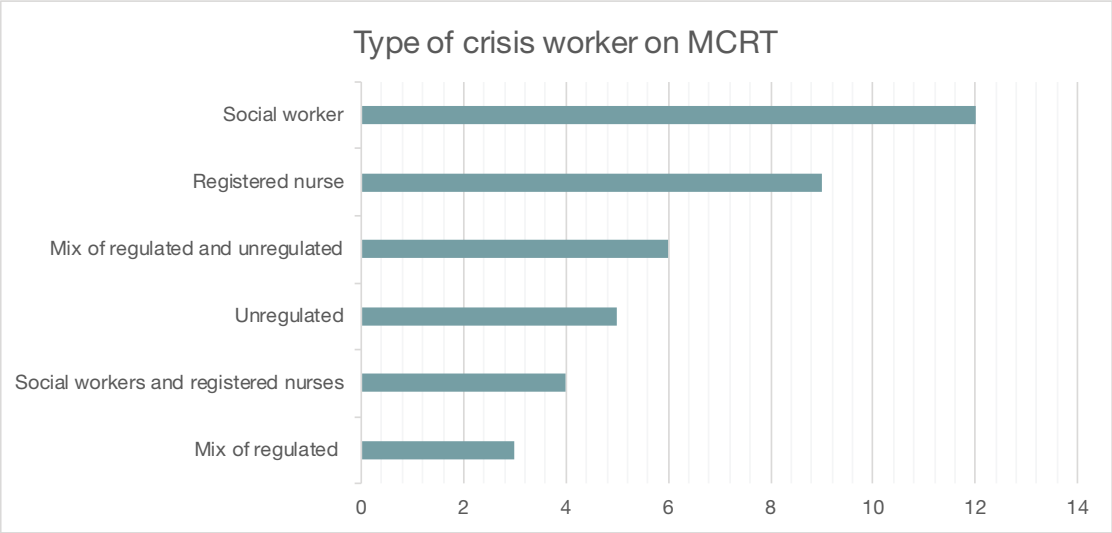
service. This is because it is likely that some individuals will be apprehended by police and brought to a hospital for a psychiatric assessment under the *Mental Health Act*. It may be the mobile crisis response team who responds to the individual experiencing the crisis and assesses the need for an apprehension, as recommended in Tools for Developing Police-Hospital Transition Protocols in Ontario. This is the case whether the health partner is a hospital or a community organization. Therefore, it is important to ensure that all local health providers are involved as integral partners in the planning of a mobile crisis response program.

Conversely, after an individual experiencing a crisis interacts with a mobile crisis response team, or is brought to hospital for assessment, appropriate referrals to community organizations will be required. Community partners provide long-term support and services to persons who have experienced a crisis, ensuring they have the resources they need to successfully live well in the community. Including a variety of local partners in service development discussions will promote effective police-hospital transitions and appropriate referrals to community organizations.

Crisis workers that partner on mobile crisis response teams in Ontario

Type of partner	Definition
Social worker	All crisis workers on the team are social workers (a regulated health profession)
Registered nurse	All crisis workers on the team are registered nurses (a regulated health profession)
Mix of regulated and unregulated	The crisis workers on the team include regulated health professionals, such as social workers and registered nurses, and unregulated mental health and addictions professionals
Unregulated	All crisis workers on the team are unregulated mental health and addictions professionals with varying titles, degrees, and experience, such as child and youth workers, addictions workers or Indigenous Elders
Social workers and registered nurses	The crisis workers on the team are all social workers or registered nurses (both are regulated health professions)
Mix of regulated	All crisis workers on the team are regulated health professionals, such as social workers, registered nurses, occupational therapists and/or registered practical nurses

In the above table, the terms “regulated” and “unregulated” are meant to signify whether the worker is authorized to perform a controlled act within the meaning of the *Regulated Health Professions Act*. Note, however, that mental health and addictions workers who are not regulated health professionals within the meaning of the *Regulated Health Professions Act* may, nonetheless, be subject to the *Personal Health Information Protection Act, 2004* (PHIPA).



Note: The above data was collected by the working group in a survey that identified 40 mobile crisis response teams in Ontario as of September 2019. This graph shows 39 communities, as one community did not provide data for their crisis worker.

The data from the environmental scan demonstrate that there are many different mobile crisis response models in Ontario. Measuring success from a comparative lens is difficult when there is such variance in the partners, community size, resources and geography served by each team. Still, the results of the environmental scan identified key considerations in program development for any model of mobile crisis response team (see **Universal considerations in program development** section in this document).

Types of Models

The working group conducted an environmental scan of existing mobile crisis response teams in Ontario in September 2019 (see **Environmental Scan** section). From the data provided by the 40 participating mobile crisis response teams in the survey, the working group identified three distinct models operating in Ontario.

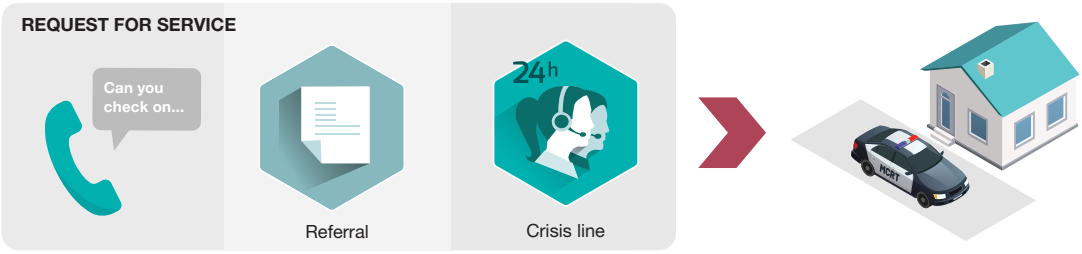
Model 1: Embedded live response

Police officer and crisis worker ride together in a police vehicle and respond to immediate 911 calls for police service

Benefits	• Crisis worker is embedded with the police service and immediately available to officers for live response to mental health and addictions-related crisis calls for service, as well as consultation • Other officers may be dispatched simultaneously • Crisis workers build trusted relationships with their police officer partners, and may mutually gain specialized skills and knowledge • Informal learning and knowledge transfer between the crisis worker and the officer • Timely and efficient response • Options for immediate debriefing following any call
Risks	• Crisis worker may be exposed to risk while in a police cruiser • Crisis worker may overhear or be unnecessarily involved in calls for service unrelated to a mental health and/or addictions crisis • Risk of a privacy breach, including the unauthorized collection, use and disclosure of personal information and personal health information in contravention of applicable privacy legislation • If the mobile crisis response team is the first on scene, the safety of the crisis worker may be at risk before the scene is assessed for safety (this risk could be mitigated if the crisis worker remains in the vehicle until the police partner indicates that it is safe for the worker to attend) • Different and sometimes conflicting mandates between the police officer and crisis worker • Visit by a police officer in a police vehicle at the client's home may be stigmatizing to the client and/or their family members
Resources & costs	• Clients experiencing an immediate mental health and addictions crisis may be more likely to be apprehended under the *Mental Health Act* by police officers, increasing hospital emergency department visits and police wait times • Additional safety measures must be considered such as radios, body armour, uniforms, identifying clothing, etc. • Additional staff for both police services and mental health and addictions services may be required to maintain coverage over large geographical areas • Infrastructure costs (laptops, Internet connectivity, privacy protection, etc.) • Appropriate liability insurance may also be required
Examples	• Durham Region – Mobile Crisis Intervention Team (MCIT) • Leeds & Grenville County – Mobile Crisis Intervention Team (MCIT) • Niagara – Mobile Crisis Rapid Response Team (MCRRT) • Norfolk County – Mobile Crisis Rapid Response Team (MCRRT) • Northumberland County – Mental Health and Engagement Response Team (MHEART) • Toronto – Mobile Crisis Intervention Team (MCIT)

Model 2: Embedded follow-up response

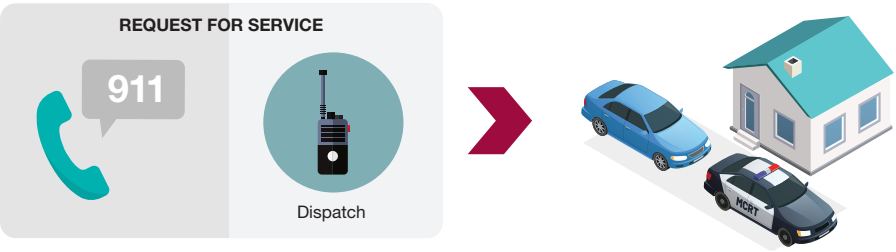
Police officer and crisis worker ride together in a police vehicle and visit individuals for follow-up based on referrals from other officers or crisis line



Benefits	• Provides collaborative community policing and community mental health and addictions within one service type • Bridges the gap between the mental health and justice systems and reduces wait times for mental health and addictions programs • Provides time for system navigation and service co-ordination, increased capacity for case management, and symptom stabilization • Proactive visits (such as on the anniversary of a known trigger date for the client) can prevent a future crisis • Less urgent calls for service can be handled by this team, freeing other officers to respond to more urgent calls • Client that does not need immediate crisis support is safely supported in the community
Risks	• Immediate crisis response is not provided • Crisis worker may overhear calls for service unrelated to a mental health and/or addictions crisis • Risk of a privacy breach, including the unauthorized collection, use and disclosure of personal information and personal health information in contravention of applicable privacy legislation • Follow-up services may be just as effective when provided by other organizations that would not be as costly • Follow-up by a police officer in a police vehicle at the client's home may be stigmatizing to the client and/or their family members
Resources & costs	• Clients experiencing a mental health and addictions crisis may be more likely to be apprehended under the *Mental Health Act* by police officers, increasing hospital emergency department visits and police wait times • Safety equipment such as radios and body armour for the crisis worker may not be required and may therefore reduce costs • Additional staff for both police services and mental health and addictions services may be required to maintain coverage over large geographical areas • Infrastructure costs (laptops, Internet connectivity, privacy protection, etc.) • Appropriate liability insurance may also be required
Examples	• Brockville – Community Outreach Partnership • Lindsay – Community Response Unit • Windsor – Community Outreach and Support Team (COAST)

Model 3: Live co-response

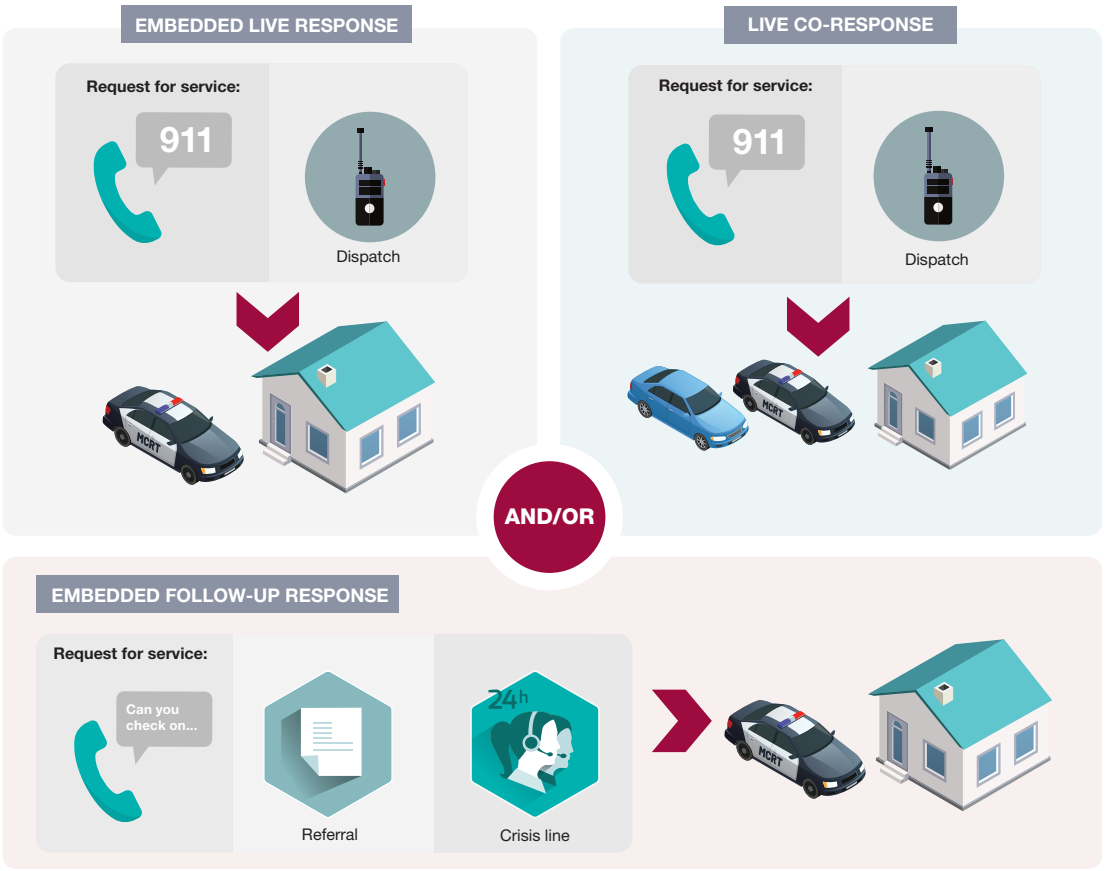
Police contact crisis worker who drives separate vehicle to scene of immediate call for service once scene is deemed safe



Benefits	• Crisis workers' expertise is more widely available as they are not tied to a specific officer on any given shift • On some calls, where appropriate, the police partner can be released to ensure more officers are back on the road (this may reduce any stigma experienced by the client because the police vehicle and/or officer are no longer on the scene) • Crisis workers can provide proactive decision-making support about appropriate use of their clinical resources • Crisis workers are not exposed to calls that may not be relevant to their expertise and are less likely to overhear personal information unrelated to their services • Options for debriefing following any call
Risks	• Clients experiencing an immediate mental health and addictions crisis may be more likely to be apprehended under the *Mental Health Act* by police officers, increasing hospital emergency department visits and police wait times • Crisis could escalate while officer is awaiting the arrival of the crisis worker • Slower response times could impact client outcomes • Although service response times are slower, the scene should always be determined to be safe prior to the crisis worker arriving in their own vehicle • Officers may be less likely to call the crisis worker if their response times are typically lengthy and the matter is urgent • Risk of a privacy breach, including the unauthorized collection, use and disclosure of personal information and personal health information in contravention of applicable privacy legislation • Different and sometimes conflicting mandates that may be harder to reconcile when the partners are not embedded or co-located • Visit by a police officer in a police vehicle at the client's home may be stigmatizing to the client and/or their family members
Resources & costs	• The health partner will be required to provide a vehicle or reimburse mileage and fuel for the crisis worker's personal vehicle; appropriate liability insurance may also be required • Two vehicles are involved in attending every crisis call (the police vehicle and the crisis worker's vehicle) • Police time waiting for the crisis worker • Appropriate liability insurance may also be required
Examples	• London – Mobile Response Team • Ottawa – Mobile Crisis Team; Mental Health Unit • Thunder Bay – Joint Mobile Crisis Response Team

Combination (hybrid) response

Many communities in Ontario have combined various aspects of the three model types identified above to create unique hybrids. These combination models are responsive to the communities and populations they serve and can continue to adapt as needs change.



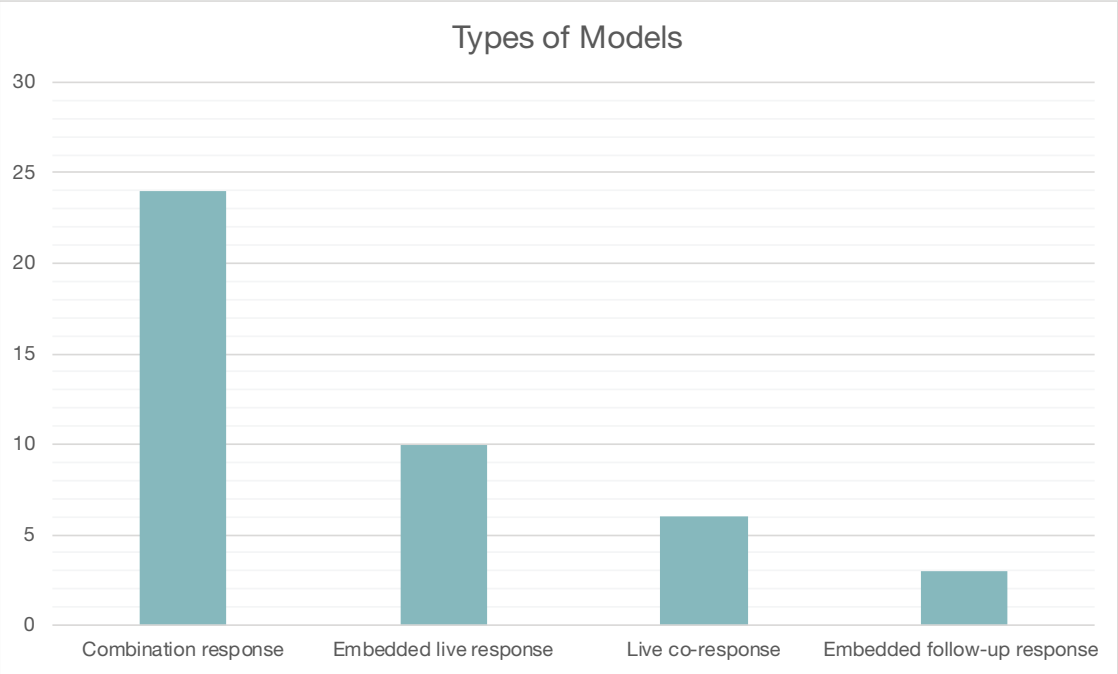
Examples	• Hamilton: Community Outreach and Support Team (COAST) and Mobile Crisis Rapid Response Team (MCRRT) • Guelph, Waterloo Region and Wellington County: Integrated Mobile Police and Crisis Team (IMPACT) • Peel Region: Community Outreach and Support Team (COAST) and Mobile Crisis Rapid Response Team (MCRRT)

Mobile crisis response is a flexible, collaborative partnership between police and mental health and addictions service providers. Any model can be customized to suit the unique needs and resources of the community being served.

Environmental scan results - MCRT model type

In September 2019, the working group disseminated an environmental scan to all mobile crisis response teams in Ontario (see **Environmental Scan** section for more information). The 40 survey respondents described their team and working group members categorized each team using the model types described previously.

Types of mobile crisis response models utilized in Ontario



More than half of the survey respondents indicated that their mobile crisis response team was a combination of the three models identified. This demonstrates the utility of a hybrid response model in adapting to the needs of diverse communities across Ontario. The embedded live response model is also popular across Ontario. The least common type of model in Ontario is an embedded follow-up response without a live response component.

Universal considerations in program development

The environmental scan identified several program models of mobile crisis response teams across Ontario, each uniquely responsive to the needs and resources of its community. Regardless of the type of model employed, there are universal considerations in the development of any mobile crisis response team, including community need, collaborative partners, geography, co-location, scope, human resources, recruitment, security and risk management, privacy and information sharing, funding, governance, culture and joint training.

Need

Deciding whether to develop a mobile crisis response team should initially involve a collaborative discussion amongst key stakeholders regarding need. Too often, programs and projects are initiated because they have become popular, rather than being based on community needs. A **needs assessment** that includes reviewing and evaluating community, hospital and police data, and comprehensive discussion amongst partners, is highly recommended.

Information to be considered in a needs assessment may include:

- Volume of crisis calls that a police service/detachment receives, any relevant increases over a given period of time, hospital emergency department wait times and peak call times to police, including days of the week, time of day, etc.
- Local hospital emergency department data (for instance, by municipality) such as crisis and repeat visits for mental health reasons by peak days of the week, times of day, etc.
- Number of claims by the hospital to the Ontario Health Insurance Plan (OHIP) for psychiatric assessments related to a Form 1 under the *Mental Health Ac*t
- Data from partners specializing in mental health and addictions relating to peak service use, as well as lived client experiences of police interactions
- Risk-driven Tracking Database (RTD) data related to community trends and risk factors collected at multi-sectoral risk intervention models, such as situation tables
- Other relevant information such as social determinants of health or social risks for particular communities provided by partners including local public health units
- Discussion about the state of readiness and willingness among key stakeholders to develop a team
- Qualitative and quantitative data collected from community consultations and multiple sources of data, which are legislated, required components of community safety and well-being plans (see **Section 2: Community Crisis Response and Resources**)

Only **non-identifiable information**, such as de-identified or aggregate information, should be used for these purposes and not personal information or personal health information. Special consideration should be given to smaller and rural communities and high-profile interventions, where smaller population numbers or the nature of the interventions can lead to re-identification of individuals or a reasonable deduction of their identity (such as small cell size data collection). Guidance on how to engage in data collection and program evaluation in compliance with privacy requirements and best practices can be found in the Data Collection Template (Tool #11) in *Tools for Developing Mobile Crisis Response Teams in Ontario*.

Collaboration and partnership

Every community in Ontario is different and will have diverse resources available to develop a mobile crisis response team. A best practice to get started is to invite high-level leadership from key stakeholder partner organizations. These partnerships may already exist as a police-hospital committee as per the recommendations of *Improving Police-Hospital Transitions: A Framework for Ontario*, or through a municipal community safety and well-being planning advisory committee.

Mobile crisis response team planning partners may include:

- Police services (OPP, municipal, First Nations) in the geographical area that the model will serve
- Hospitals in the geographical area that the model will serve
- Community mental health and addictions services in the geographical area that the model

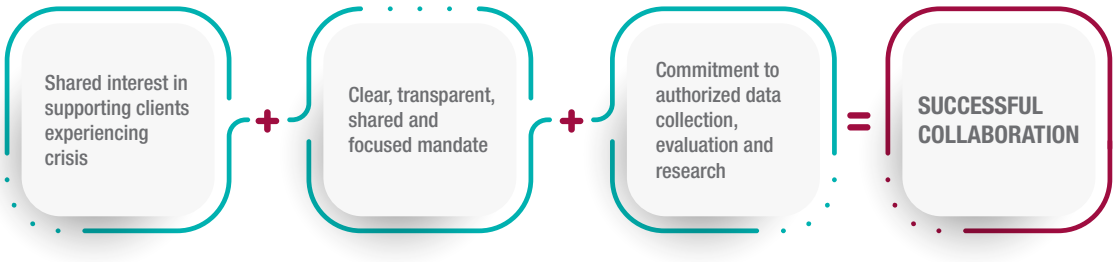
will serve

- Client and caregiver advisors (persons with lived experience and/or who have utilized services)
- Indigenous leaders, Elders, Senators (Métis Elders)
- Organizations serving African, Caribbean and Black clients
- Organizations serving racialized clients
- Indigenous service organizations (Friendship Centres, healing lodges)
- Organizations serving clients with neurodevelopment disabilities and related conditions
- Children and youth mental health services
- Older adult service providers
- Supportive housing providers, crisis centres and safe bed program providers
- Education providers
- Newcomer services
- Faith-based services (churches, mosques, sweat lodges, synagogues, temples and other places of worship)
- Community Health Centres and Aboriginal Health Access Centres
- Victim services
- Emergency medical services
- French language and other linguistic service providers

The initial planning meeting is an opportunity to present the needs assessment and demonstrate the value and purpose of the team to the community. While the actual mobile crisis response team will not include all of the partners invited to the planning meeting, it is imperative that all relevant community providers and high-level leadership are informed and consulted. Community engagement is especially important to develop a model that meets the needs of and is governed by an Indigenous community. Clients and families are key partners in defining care and facilitating their involvement in the design, development and evaluation of service delivery is vital. Support from all stakeholders will encourage operational success and will be necessary for evaluation, future development, and funding requests. Collaboration can also help ensure better coordination and integration of local services, programs and initiatives in the community going forward.

Collaborations that are rooted in mutual respect and understanding of differences in organizational culture are essential to ensure the success of any mobile crisis response team. Collaboration is a complex process and is most successful when partners willingly engage. One of the most exciting aspects of mobile crisis response model development is that it is truly a "process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible," (Gray, as cited in Rich, et al., 2001). Successful collaboration requires all parties to focus on their shared purpose, respect each other's values and strengths, follow privacy requirements, trust the expertise at the table and participate in program development and evaluation.

It is important to note that not all community organizations may have had positive interactions



Source: Based on a graphic developed by Linda Young, Michael Garron Hospital

with individual members of the police service. Collaboration during the initial planning stages of a mobile crisis response team provides an opportunity for the police to build trust with the community. Facilitating a consultation with community members, police and mental health and addictions partners will provide a platform for everyone to share their vision for the mobile crisis response program and how local services would like to be involved. The police service can strengthen this new relationship with community by hosting quarterly or annual meetings to hear ideas and opportunities to further enhance the mobile crisis response program.

Engaging all community service providers in the initial planning stages will increase the mobile crisis response team's awareness of community resources, ensuring all clients are connected to the most appropriate service to meet their needs. This will ensure the best outcomes for clients and build capacity to prevent further crisis team interactions. Planning partners can also be approached to help develop and/or deliver training to the mobile crisis response team and other police officers (see **Training and Orientation** section).

Considerations for First Nations policing

Most (106 out of 133) Indigenous or First Nations communities in Ontario receive front-line policing services through a three-party agreement under the federal First Nations Policing Program (FNPP) which includes:

1. Self-administered First Nations police services
2. Dedicated policing from an existing police service (such as the OPP)
3. Dedicated policing from First Nations constables administered by the OPP

Indigenous communities that are not included in the FNPP are policed directly by the OPP or municipal police services.

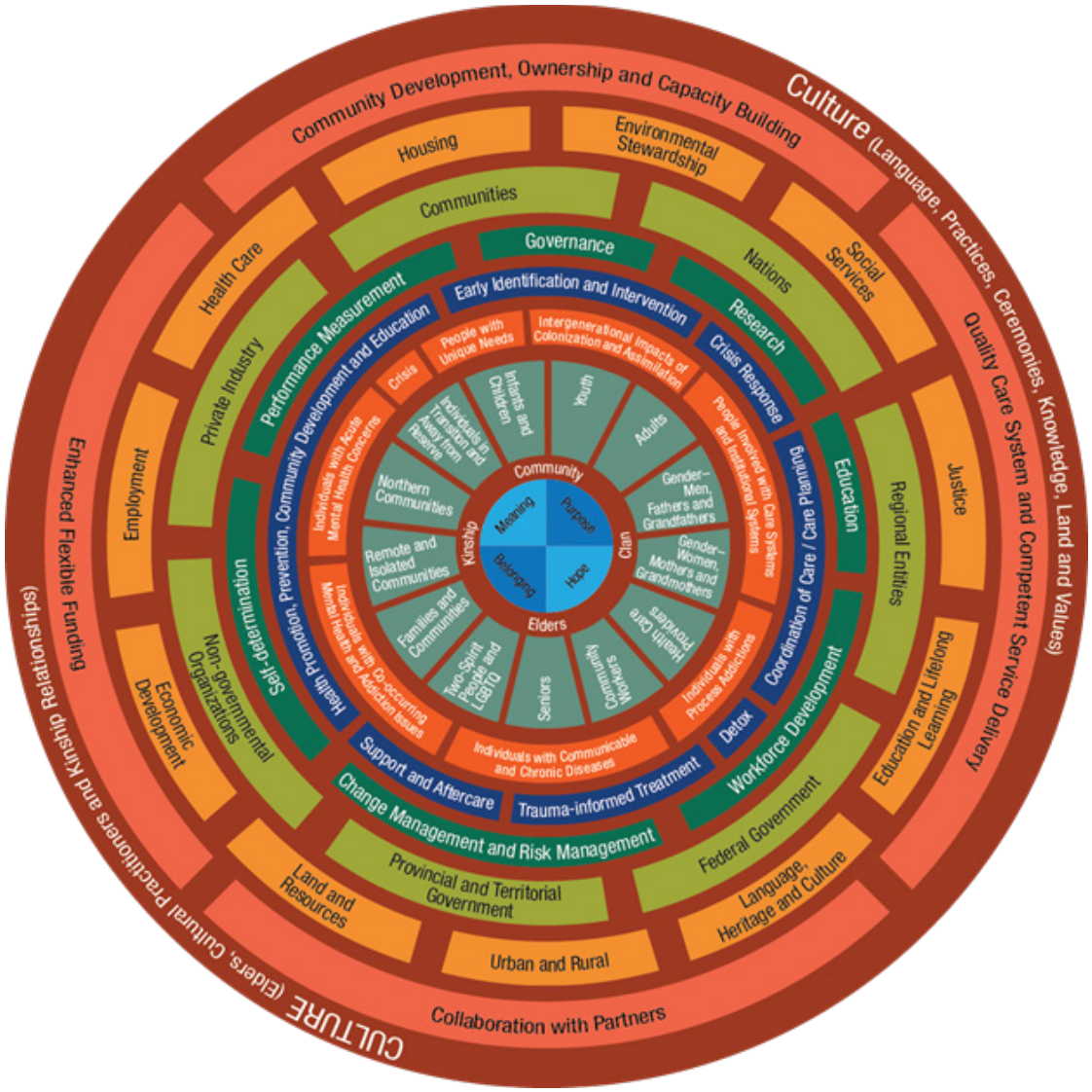
First Nations police services are a critical piece of the broader solution that addresses safety and well-being in Indigenous communities. First Nations police services and their police boards often have connections with Indigenous community members and agencies to proactively help those in need by addressing social issues before they require a crisis response (Council of Canadian Academies, 2019).

It is also important to consider that in remote regions, where access to social services may be limited, police are more relied upon to perform social service functions such as first aid, transportation and crisis intervention (Landau, 1996).

When building a mobile crisis response model that involves a First Nations police service, First Nations health partners and/or a First Nations population, a primary consideration will be to embed the *First Nations Mental Wellness Continuum Framework* in all stages of the development process. This is a national framework that addresses mental wellness among First Nations communities in Canada. It was developed in 2015 through collaboration between the Assembly of First Nations, Health Canada's First Nations and Inuit Health Branch, Thunderbird Partnership Foundation, First Peoples Wellness Circle, and other community mental health leaders.

This continuum is a necessary resource for developing mobile crisis response teams that will serve First Nations communities, as it identifies ways to enhance service coordination among various systems and supports culturally safe practices and service delivery. The framework can help ensure that mobile crisis response development involves a holistic approach where key elements are embedded to address the needs of First Nations communities. This includes building capacity, enhanced flexible funding and partnerships, all of which are integral components of mobile crisis response team development.

The First Nations Mental Wellness Continuum Framework may not apply to Inuit or Métis communities as it has not been validated with these Indigenous populations. When developing mobile crisis response teams that serve Métis or Inuit communities, it would be advisable to use a framework based on Métis or Inuit knowledge of their population.



The First Nations Mental Wellness Continuum, as shown in the above diagram, is rooted in cultural knowledge and emphasizes First Nations' strengths and capacities. It builds upon the *Honouring Our Strengths* framework published by the Assembly of First Nations, Thunderbird Partnership Foundation and Health Canada in 2011.

Mobile crisis response teams that serve First Nations communities will likely include cultural practitioners such as Elders, be based on First Nations knowledge and seek to address collective outcomes for the entire community. First Nations are federally funded and therefore may have unique needs and challenges including:

- Funding for mobile crisis response teams
- Human resources and access to regulated health professionals. Non-regulated health professionals including Elders and healers should be considered
- Relationships with and proximity to hospitals, which may impact data sharing
- Governance may involve several communities as policing and health services may be shared

- Existing Mental Wellness Teams may have a mandate to respond to crisis situations in multiple communities

Governance

Governance is the role of the local community partners involved in developing and implementing the mobile crisis response team. The type of governance model is often determined by the size of the community and the partners involved. The funder (Ministry, Ontario Health Team, Ontario Health Region, or other funding body) may rely on the mobile crisis response team's governing body to report on the financial and program outcomes.

In large urban communities where there are multiple stakeholders involved, there may be a need for a steering committee to guide the development and implementation of the mobile crisis response team. Often, executive leadership such as hospital Chief Executive Officers and police chiefs attend regular steering committee meetings and report to the funder. In smaller communities, or in models where there are fewer partners, governance may only be provided by the police and health care partners. In either model, regular meetings to evaluate and discuss challenges and successes using de-identified or aggregate information will help promote positive program outcomes. Once again, special consideration should be given to smaller and rural communities and high-profile interventions, where smaller population numbers or the nature of the interventions can lead to re-identification of individuals or a reasonable deduction of their identity. Guidance on how to engage in data collection and program evaluation in compliance with privacy requirements and best practices can be found in the Data Collection Template (Tool #11) in *Tools for Developing Mobile Crisis Response Teams in Ontario*.

Police-hospital committees continue to develop across Ontario, following the release of *Improving Police-Hospital Transitions: A Framework for Ontario*. These committees may become platforms for mobile crisis response team governance and oversight, either in an advisory capacity or as a steering committee.

Geography

The landscape across Ontario differs significantly from the busy southern borders to remote northern communities. The time and distance to travel across any geographical area will impact the type of model that a community chooses. In rural areas of the province, program considerations should include means of transportation, seasonal conditions and the resources available. For example, in fly-in communities, ice roads may only provide ground transportation in the winter months.

Police services are obligated to provide equitable services within their geographical areas as designated by the Ontario government. Similarly, health care partners may be funded to provide programs and resources within or across certain boundaries. Neither partner can deny service to clients within their catchment area; however, both partners can provide support beyond their geographical boundaries. In other words, any mobile crisis response team must serve all the clients within the catchment areas of both the police partner and the mental health and addictions partner. Mobile crisis response teams that include a collaboration between an Ontario Provincial Police detachment, a municipal police service and a health care partner may agree to work across all of their respective boundaries to ensure seamless mobile crisis operations.

New mobile crisis response teams should consider geography, along with other factors such as the health-based human resources available, means of transportation, employee safety and peak call times, as important elements to explore in service development. In order to best meet the needs of each community, partners should review the times and locations of high-volume calls for service in a geographical area to determine where the mobile crisis response team should be dispatched.

Co-locating

The physical location of a mobile crisis response team depends on partner resources, geographical considerations, and the size and scope of the team. The size of the police service or detachment and the staffing component located on site will influence whether crisis workers can co-locate within the physical space of the police service/detachment. The same is true for mental health and addictions organizations or hospitals that may host police partners.

Large police services and mental health and addictions organizations or hospitals may have both the physical space and the human resource capacity for a dedicated unit, including office space that could be shared by the mobile crisis response team. Police officers may sit in a community organization one day and the crisis workers may sit in the police service on other days. A space to engage in private phone conversations will be required in all shared work spaces.

In smaller police services, detachments or mental health and addictions organizations, office space may be limited, and creative solutions should be considered. For example, the crisis worker might have a desk in the constable's office. Many hospitals have designated waiting spaces for police partners to complete reports.

In any co-locating arrangements, reasonable steps must be taken to ensure that personal information, personal health information and any other confidential information is protected against theft, loss and unauthorized collection, use or disclosure and to ensure that the records containing this information are protected against unauthorized copying, modification or disposal (including, proper encryption and passwords). If space is shared, a lockable desk or secure area will be required for any computing devices or records containing personal information, personal health information or any other confidential information that may be stored when the team is off site or off duty.

Scope of program

When determining the scope of a mobile crisis response program, it is recommended that partners provide services to clients across the lifespan. Although some mobile crisis response teams across Ontario are specialized to serve older adults or children and youth, this does not mean these teams should not provide services to individuals of all ages.

Specialized teams are only recommended as an enhancement after a general mobile crisis response team is established. The police officers on these teams receive specialized training on interacting with the target population, and the crisis worker has expertise providing crisis intervention services to the specific group. While this expertise is beneficial, all mobile crisis response teams, including specialized teams, must respond to all appropriate crisis calls,

regardless of the age of the person experiencing the crisis. Police officers have an obligation to respond to all calls for service in their catchment areas. Services cannot be denied because the person does not fit an age category that a specialized team is designed to serve.

Knowledge of services within the community for older adults, children and youth, Indigenous, Black and racialized individuals, persons living with neurodevelopmental disabilities, and other priority populations is essential. Engaging with these service providers early on will ensure the mobile crisis response team knows where to refer or transport all individuals in need of specific crisis support.

Human resources

When developing a mobile crisis response model, each community will want to ensure quality care and expertise for their program delivery. Whenever possible, registered health or social service professionals are recommended for the role of crisis worker on a mobile crisis response team. This includes registered nurses, registered practical nurses, registered social workers (and/or social service workers) and occupational therapists. Regulatory colleges set standards for admission and remaining in good standing and are mandated to investigate complaints and discipline members when appropriate. For liability reasons, some mobile crisis response teams will prefer to work with regulated health professionals.

However, it is recognized that in many circumstances, unregulated professionals, which may include child and youth workers, community Elders or addictions counsellors, may have existing trust with community members and may be the most available option in remote communities. Ultimately, a combination of relevant education, training and experience in community mental health and addictions and crisis response will help the individual fulfill their role on a mobile crisis response team.

Depending on the size of the community and its partner agencies, there may be limits to the number of crisis workers and/or officers available to be designated partners on a mobile crisis response team. Some police services may have the human resource capacity to provide dedicated officers to a team, whereas others may rotate officers to work with the crisis worker each shift. All police officer partners that participate on a mobile crisis response team should have relevant crisis response training, as discussed in the **Training and Orientation** section.

Recruitment and background checks

Each partner organization will be responsible for selecting qualified candidates to fill the mobile crisis response team roles and will already have their own standard qualifications and required credentials for staff.

In the designated officer model, the selection process for police should include, at minimum, a first-class constable rank with additional training or experience in mental health and addictions, excellent interpersonal skills, and above average oral and written communication skills.

The crisis worker should be experienced in delivering crisis services and community-based assessments. Knowledge and competency in the following areas would be beneficial and are highly recommended:

- Risk assessment
- Family dynamics
- Solution-focused brief therapy
- Suicide intervention and assessment
- Crisis prevention and intervention
- Mental status exam
- Addiction and harm reduction
- Collaborative conflict resolution
- Trauma-informed approaches
- Diversity and inclusion
- Psychiatric symptomology and pharmacology
- Privacy and confidentiality of personal information and personal health information

A willingness to engage collaboratively within the team is paramount in encouraging co-operation between the partner organizations. The selection process for all mobile crisis response team positions should also evaluate the appropriate demonstration of skills, abilities and attitudes. Members of the team must have demonstrated a proven ability to respect the privacy of individuals and the confidentiality of their information and to collect, use and disclose information in compliance with privacy legislation that governs both the police officers and the crisis workers.

As the crisis workers may be privy to regular radio and/or computer-aided dispatch (CAD) communications, they should be required to sign a confidentiality agreement. Likewise, the police service should have to sign an agreement acknowledging any confidentiality requirements of the mental health and addictions organization. Confidentiality agreements can be used to help support compliance with privacy requirements. Notwithstanding the signing of a confidentiality or other agreement, neither the police officer nor the crisis worker may collect, use, or disclose personal information or personal health information, without the consent of the individual to whom the information relates, unless permitted or required to do so under the applicable privacy legislation. Additional forms may also need to be signed, such as the police service's ride-along agreement.

The crisis worker should also complete a Canadian Police Information Centre (CPIC) background check, which includes a criminal records check and vulnerable sector check.

Security and risk management

While mobile crisis response teams rely on successful collaboration to ensure each call is resolved safely, the security and risk management of each partner will remain the responsibility of their respective employer. Risk management considerations must be adapted for crisis workers working as civilians in a police environment, which requires additional risk factors and security requirements.

Security clearance level requirements may differ based on the police service involved in a mobile crisis response team. These requirements specify the level of security needed to safeguard

sensitive information (including personal information and personal health information), assets, work sites and record management systems. In many models, the crisis worker will be travelling in a police vehicle or embedded at a detachment site, so their security clearance level should reflect the fact that they will be privy to sensitive information. An appropriate oath of secrecy is required and may need to be amended to allow the crisis worker to discuss aspects of their work with their home organization. Such discussions should be limited to what is necessary to enable the employer to properly and safely supervise the crisis worker and must comply with privacy legislation.

The safety equipment required for the mobile crisis response team members should be determined based on the type of model employed and the resources of the police and health care partners. In a follow-up mobile crisis response team model where the team is engaging in post-crisis wellness checks (but not responding to immediate crisis calls), it may be more appropriate for the crisis worker to attend in plain clothes. In mobile crisis response team models where the crisis worker is embedded at the police service or detachment and riding along with police to immediate calls for service, the partners may decide that the crisis worker should wear protective safety equipment. This may include a safety vest, body armour or uniform that identifies the crisis worker as such and carrying a radio and/or an identifying badge. These items may be sourced by the mental health and addictions organization, or supplied by the police partner. The safety and risk management of the crisis worker remains at the discretion of their respective employer, as the risk management of the officer lies with their police service. The provision of safety equipment and the required liability insurance coverage from each partner organization should be determined during program development and included in budget considerations as some equipment and the required insurance can be costly.

Appropriate training and orientation will also support the safety and security of the mobile crisis response team members and is discussed in the **Training and Orientation** section of this framework and in the supplementary document, *Tools for Developing Mobile Crisis Response Teams in Ontario*.

Privacy and information management

There are critical considerations related to privacy and information sharing in developing, implementing and managing a mobile crisis response team. Initial considerations during the development phase include:

- Ensuring a private and secure physical space for crisis workers and police officers to complete client-related calls and documentation
- Ensuring that information management systems are kept separate and secure (for instance, health information does not enter police databases and vice versa, the information is protected against theft, loss and unauthorized collection, use or disclosure and records are protected against unauthorized copying, modification or disposal)
- Shared understanding of the health providers' and police officers' duty to report (child abuse, suicide risk, etc.)
- Understanding and abiding by the applicable privacy legislation governing police officers and crisis workers relating to personal information and personal health information

- Ensuring that the mobile crisis response team partners, both police and crisis workers, receive appropriate privacy training with respect to applicable privacy legislation and have a clear understanding of the permitted collections, uses and disclosures of personal information and personal health information at the various stages of a crisis response
- Ensuring that information is kept private and secure by taking steps that are reasonable in the circumstances to ensure that personal information and personal health information are protected against theft, loss and unauthorized collection, use or disclosure, and that records containing this information are protected against unauthorized copying, modification or disposal through the implementation of administrative, technical and physical safeguards (confidentiality agreements, encrypted and password-protected devices, etc.)
- Ensuring the mobile crisis response team is accountable and transparent to the public and the individuals whose information it handles by providing publicly-accessible information about the purposes for the collection, use and disclosure of information; the privacy policies, information practices and safeguards implemented; and the name of the contact person who can address questions or concerns

Additional information is found in the **Privacy and Information Sharing** section in this framework, as well as in the accompanying resource, *Tools for Developing Mobile Crisis Response Teams in Ontario*, including in **Key privacy considerations for mobile crisis response teams**.

Funding

This framework has outlined core components for various models of mobile crisis response teams in Ontario, in order to develop evidence-informed practices, including data collection. De-identified or aggregate data will help demonstrate the value and cost-savings of mobile crisis response teams, which may result in future opportunities for sustainable and annualized provincial funding of these programs.

Historically in Ontario, there have been a variety of funding sources for mobile crisis response teams. As mental health and addictions falls under the scope of health care, there are a number of mobile crisis response teams funded through Ontario Health Regions/ legacy Local Health Integration Networks (LHINs). This may include re-purposing funding for crisis response services in a community, leveraging hospital budgets as part of emergency department diversion planning or obtaining new funding through provincial initiatives. Mobile crisis response teams serving First Nations communities may be funded by the federal government.

Communities may also choose to apply for pertinent grant programs for mobile crisis response team funding, particularly to support pilot projects or for initial implementation. There are many grants available across sectors that could support this type of work. For example, some communities have been successful in securing grant funding from the Ministry of the Solicitor General's Proceeds of Crime – Frontline Policing or Community Safety and Policing grant programs. The opportunity to apply for a grant will be based on its individual eligibility criteria and program requirements. Grants are often time-limited and are not a sustainable or annualized source of funding; however, they may be utilized and beneficial for start-up costs or piloting new programs. Throughout the pilot program stage, mobile crisis response teams should collect data to assess the outcomes, efficiency and cost-effectiveness of the team, as part of an effort to demonstrate the need to secure sustainable funding. Guidance on how to

engage in data collection and program evaluation in compliance with privacy requirements and best practices can be found in the Data Collection Template (Tool #11) in *Tools for Developing Mobile Crisis Response Teams in Ontario*.

Different funders set out different requirements for funding and will consider a variety of factors including:

- State of readiness
- Demonstrated need
- Collaborative partnership(s)
- Funders' priorities and objectives
- Budget adherence
- Reporting ability
- Data collection, including baselines and targets
- Measurable outcomes

If receiving funding through a grant program, the role of the funder is to provide high level support and direction, establish standards for reporting and review regular reports from the partners related to how they are meeting outcomes and targets set out in the funding agreement. The role of the mobile crisis response team governing partners is to develop, implement and evaluate the mobile crisis response team program and meet the funder's reporting requirements.

In many collaborative programs, there will be components of in-kind funding from all parties. For example, a police service or detachment may provide office space and telephone line use for the crisis worker. Some partners have been flexible in re-assigning existing resources, recognizing that the new program will likely reduce caseloads and pressures in other areas.

Cross-sector training

Human services and policing function under two different institutional cultures, each with its own views and mandates, common terminology and privacy implications. There may be varying desires to collaborate, which tend to improve once the program partners become familiar with one another. Joint training, orientation and conflict resolution mechanisms are important from program inception.

Establishing clear roles and responsibilities for each partner is critical from the initial development stage. Communicating roles and expectations to front-line staff (police officers and crisis workers) and planning joint training and/or joint orientation sessions will support positive cross-sector organizational culture. Setting out clear guidelines at program initiation, such as where partners will be located and where they can and cannot move freely within partner organizations, will also assist in developing and maintaining professional boundaries. It is also essential that partners have a good understanding of their own, and a reasonable understanding of each other's, obligations under applicable privacy legislation. This includes a clear understanding as to when and what type of information can be collected and used as well as disclosed between the partners. Where police are working with cultural practitioners such as Elders on a mobile crisis response team, cultural safety and cultural competence training will be required.

Ongoing training and orientation should be a key consideration prior to implementing a mobile crisis response team and is explored further in the **Training and Orientation section** of this framework.

Agreements

Once universal considerations have been contemplated and discussed by all members of the collaborative partnership, it is highly recommended that a contractual agreement be put into place. Most common for mobile crisis response teams is a **memorandum of understanding** (MOU) between the collaborating partners.

Police and crisis workers should also sign confidentiality agreements that require their adherence to privacy and security directives and applicable privacy legislation throughout their participation in the mobile crisis response team.

It is important to consider that smaller municipal police services may have more flexibility in developing unique MOUs with each collaborative partner, whereas a larger police service such as the Ontario Provincial Police will likely have a standardized MOU for all detachments in the organization.

It is recommended that any agreement created by program partners includes the universal considerations captured in this document. The supplementary toolkit to this framework has a template MOU that includes these standard elements.

After exploring options under the universal considerations in program development and determining the type of model to be used, mobile crisis response team planning partners should also review the core components outlined in the remainder of the document. Core components should be embedded in all mobile crisis response programs, regardless of geography, partners or type of model. The next sections provide a more comprehensive approach to provincial program development and offer detail on key topics such as training and orientation, privacy, roles and responsibilities, and data collection.

Training and orientation

One of the benefits of collaboration is the opportunity to pool knowledge and resources to increase the skills of both the police officer and crisis worker. All of the partners represent different professional sectors, each with its own training and education standards. Respecting the specialized training and expertise of each profession will promote positive working relationships and ensure the success of the program. However, it is recommended that all police service members, including those who are not partners on a mobile crisis response team, receive ongoing crisis intervention and de-escalation training. **Joint training** is encouraged to foster team building, knowledge exchange and mutual understanding. **Ongoing training** opportunities will ensure all partners have up-to-date and relevant knowledge and skills.

Ongoing training should include sessions on **specialized populations** such as children and youth, older adults, Indigenous populations, Black and racialized populations, and individuals

living with neurodevelopmental disabilities, acquired or traumatic brain injuries and related conditions. By engaging early with community partners who serve specialized populations, a comprehensive and diverse training program can be developed, ensuring police officers are equipped to identify clients with unique needs and respond appropriately. Training should be informed and, where possible, supported by people with lived experience of mental health, addictions and other conditions, as well as involvement with police or the criminal justice system. These individuals should be compensated for their time if they are not already employed by a community organization.

The training and orientation examples listed below are currently utilized by mobile crisis response teams across Ontario. Specific training resources are included in the supplementary document, *Tools for Developing Mobile Crisis Response Teams in Ontario*. De-escalation and mental health training are recommended for the full police service membership, including those who are not partnering on a mobile crisis response team.

Orientation for police officers

Topics addressed during the orientation of police officers assigned to the mobile crisis response team should include:

- Post-traumatic stress disorder (PTSD), operational stress injury (OSI), compassion fatigue, vicarious trauma and officer self-care
- Overview of mental health and addictions:
    - Mental illnesses and other mental health issues
    - Addictions and concurrent disorders
    - Suicide and self-harm risk assessment and intervention
    - Trauma and stigma
- Neurodevelopmental disabilities and acquired or traumatic brain injuries
- Anti-Indigenous racism and anti-Black racism training, including specific cultural sensitivity training
    - Multi-generational trauma including historical distrust of police
    - Cross-cultural responses
- Gender-specific and 2SLGBTQ+ sensitivity training
- Crisis de-escalation, stabilization techniques and mediation skills
    - Communication skills
    - Scenario-based training
    - Trauma-informed responses
- Privacy and information sharing (such as permitted collections, uses and disclosures of personal information and personal health information)
- Data collection
- Training on mental health screeners and crisis response forms

- Police-hospital transition protocols and how mobile crisis response teams will support positive transition outcomes
- Community resources (invite local service providers to deliver training):
    - After hours referrals and crisis centres (see **Section 2: Community Crisis Response and Resources**)
    - Homelessness and housing alternatives (such as safe beds)
    - Military and veterans-specific resources
    - Culturally-relevant services
    - Resources for children, youth and older adults
- Post-incident debriefing
- Community safety and well-being planning and situation tables (see **Section 2: Community Crisis Response and Resources**)
- General orientation for all officers about how the mobile crisis response team operates and how to foster relationship building with mental health and addictions partners

Training provided by clients, family members or organizations representing those with lived experience of mobile crisis response, mental health and/or justice system involvement is highly encouraged. Such training destigmatizes mental illnesses and addictions as officers interact with clients in a non-crisis situation. This allows clients and caregivers to provide insight into their crisis experiences, share first-hand knowledge of local community resources and offer dynamic, trauma-informed training for officers.

It is important for police officers to understand that certain communities have not had positive interactions with a police service or individual police officers. For example, refugees who may have experienced or witnessed violence by soldiers or police officers in their home countries may have a negative reaction to anyone in a uniform. Survivors of domestic violence may be fearful of any large or commanding person, such as a male police officer. The individual may not be deliberately responding to that specific officer but may be reacting automatically because of being triggered by their past abuse by someone in power. By learning to identify a trauma response, officers may be able to modify their behaviour (take their hand off their baton, lower their voice) or allow their mental health and addictions partner to take the lead in de-escalation if it is safe to do so.

Orientation for crisis workers

Topics addressed during the orientation of crisis workers assigned to the mobile crisis response team should include:

- Training on how to use any safety equipment provided
- Use of force model and what to expect on calls for service with police (this may be accomplished through joint training where crisis workers observe officers' use of force training)
- Knowledge of referral processes and available community services such as situation tables, addictions treatment options, the nearest Schedule 1 facility and any appropriate referral services within the community
- Privacy and information sharing (such as permitted collections, uses and disclosures of personal information and personal health information)

- Data collection
- Anti-Indigenous racism and anti-Black racism training, including specific cultural sensitivity training
- Gender-specific and 2SLGBTQ+ sensitivity training
- Ride-along with existing mobile crisis response team or police
- If the crisis workers will ride along with their police partner:
    - Orientation to police vehicle
    - Use of force and other equipment worn by the officer
    - Any equipment the worker may wear
    - How to respond in an emergency (for example, if the officer is incapacitated, emergency features in the car and on the radio, etc.)
- If the crisis worker will be embedded at a police service or detachment:
    - Touring the space
    - Ensuring the worker is aware of any spaces that may be off limits
    - Visitor/appointment regulations and procedures
- Familiarization with the phonetic alphabet
- General understanding of police ranks
- General understanding of police computer database programs
- Understanding of and compliance with the Oath of Secrecy
- Understanding of police service internal employee wellness policies, procedures and resources, should the need arise to refer officers who may seek support from the crisis worker (see **Roles and Responsibilities section** for further detail)

Joint privacy training

It is recommended that police and crisis workers be required to complete joint privacy training to ensure that the partners have knowledge and clarity with respect to:

- Their respective roles and obligations under the applicable privacy legislation
- The principles of privacy, including the individual's rights to have their information kept confidential and secure
- The circumstances in which personal information and personal health information can be collected, used, or disclosed, as the case may be, by either the police or crisis worker, with a focus on the circumstances in which such information can be disclosed between mobile crisis response team partners and disclosed to others (such as family, other persons on scene, health care providers at the destination facility, etc.)
- Security safeguards and practices to protect the privacy of the information and to keep it confidential
- How to manage and report a privacy breach
- Other relevant privacy obligations set out in the applicable legislation
- How to best protect privacy at the scene of the crisis

Privacy and information sharing

Privacy and information sharing can present challenges when police services and health care organizations first start working together. Both want to ensure the best outcomes for their clients and for public safety, and both are governed by differing legislation that determines what

information can be collected, used, and disclosed as well as when disclosure is appropriate. Provincial police will follow the *Freedom of Information and Protection of Privacy Act* (FIPPA) while municipal police will follow the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA). For many crisis workers, the *Personal Health Information Protection Act, 2004* (PHIPA) applies. First Nations police services and health partners should determine which privacy legislation they must comply with or, if no such legislation applies, how the privacy guidance in this document and the accompanying *Toolkit* can be adapted to help ensure that the privacy of the individuals they serve is protected. In addition, other legislation may apply to police and health care collaborations, for example, the *Police Services Act, Mental Health Act, Substitute Decisions Act* and any other applicable provincial legislation.

It is imperative that the partners have a clear understanding of their privacy obligations with respect to the personal information and personal health information they collect, use and disclose in providing mobile crisis response. For example, each partner must have the authority to disclose, and the other partner must have the authority to collect and use the personal information and/or personal health information at issue.

It is also important to note that the fluidity of the crisis situation will likely have privacy implications. For example, when a mobile crisis response team responds to a person experiencing a mental health and/or addictions-related crisis, the roles of the crisis worker and the police officer should be explained to the person as soon as possible. In particular, it should be explained that where the risk of harm has been reduced or eliminated, the consent of the individual to share their personal information or personal health information any further will be required unless the information sharing is otherwise permitted or required by law.

During a crisis, the relevant privacy laws allow the partners to disclose personal information and personal health information where there are reasonable grounds to believe that disclosure is necessary to eliminate or reduce the significant risk of harm. Where the risk of harm has been reduced or eliminated, the consent of the individual to share their personal information or personal health information any further will generally be required. Accordingly, once it is safe to do so, the partners should consider whether it is necessary for the police officer to hear further discussions with the individual that involve personal health information. If it is not necessary, the crisis worker should, with the police officer's assistance, determine whether it may be possible for the worker and the individual to continue discussions apart from the police officer. In such circumstances, unless the individual provides their express consent to the officer hearing the individual's personal health information, the officer should keep sufficient distance so as to ensure the individual's privacy as long as it is safe to do so, or the crisis worker should refrain from further discussions involving personal health information.

For a detailed discussion of the privacy considerations at the various stages of a crisis response, please see **Key privacy considerations for mobile crisis response teams** in *Tools for Developing Mobile Crisis Response Teams in Ontario*.

The crisis worker may potentially have access to additional personal health information about the individual in their own health database(s). This information may assist the crisis worker in providing an appropriate response at the scene. However, personal health information remains protected from others, including police officers, unless the client provides their express consent to the disclosure of their information or the disclosure is otherwise permitted or required by law.

As set out in section 18 of PHIPA, consent:

- Must be the consent of the individual to whom the information relates;
- Must be knowledgeable;
- Must relate to the information; and
- Must not be obtained through deception or coercion.

As noted above, within a mobile crisis response model, there will be times where information sharing is critical to ensure the safety and well-being of both partners, the client and the public. The police officer and crisis worker may disclose information to one another without consent, as permitted or required by law, where it is required for the appropriate administration and delivery of services; however, limiting principles under relevant privacy laws apply. Personal information and personal health information cannot be collected, used or disclosed if other information will serve the purpose and no more personal information or personal health information can be collected, used or disclosed than is reasonably necessary to meet the purpose.

There may be times where the police officer or crisis worker refuses to disclose any information at their discretion for multiple reasons, including:

- Protecting client confidentiality
- Safeguarding the confidentiality of third-party information or informants
- Preventing interference with, or disclosure of, law enforcement information, investigations or techniques
- Other reasons, according to the laws of the province of Ontario

At times, the members of the mobile crisis response team may be required to collect information during the administration of the program and its services. Information collected by police will be captured with their mandated police records management systems and information collected by the crisis worker will be collected in their client management system. The maintenance, storage, retention, disclosure and disposal of information by either police or mental health and addictions partners will be in accordance with their respective policies, procedures and applicable provincial legislation.

Assessing and evaluating performance and program outcomes is a core component of any mobile crisis response program. However, only **non-identifiable information** may be collected, used and disclosed for the purpose of assessing and evaluating performance and program level outcomes. All identifying information must be removed such that it is not reasonably foreseeable in the circumstances that the information could be utilized, either alone or with other information, to identify the individual. When it comes to ensuring that information has been properly de-identified, special consideration should be given to smaller and rural communities and high-profile interventions, where smaller population numbers or the nature of the interventions can lead to re-identification of individuals or a reasonable deduction of their identity (such as through small cell size data collection).

In addition, no identifiable client-related information should, at any time, or for any purpose, be disclosed between the parties or with others without first obtaining the consent of the client, unless the disclosure is permitted or required by law.

Privacy and information sharing processes should be a comprehensive component of any mobile crisis response team's MOU or contractual agreement that outlines how the partners will work together. For a template MOU, please see the accompanying *Toolkit*. Furthermore, each member of each mobile crisis response team should enter into a confidentiality agreement, which sets out the requirements to maintain the privacy and confidentiality of the client information and to keep the information private and secure.

Joint privacy training for the police officer and the crisis worker in the mobile crisis response team is discussed in the previous section entitled ***Training and Orientation***.

Roles and responsibilities

Setting out roles and responsibilities in any partnership is imperative for success. When each party understands their role and the role of their partner, things will inevitably run more smoothly. Regardless of the type of mobile crisis response model, once police officers and crisis workers arrive on scene, their respective roles differ, despite having a common goal to assist the person experiencing a crisis. It is crucial that the crisis worker recognizes that the police officer is ultimately responsible for the direction, safety and outcome of any police call for service, including a mental health and/or addictions crisis call. For a helpful checklist for each partner at the scene, see *Tools for Developing Mobile Crisis Response Teams in Ontario*.

Wellness supports for MCRT partners

Police officers and crisis workers who partner on a mobile crisis response team may develop personal bonds as a result of the time spent together. This is particularly true when sharing crisis situations, which can be emotionally-charged experiences. Police may turn to their mental health and addictions colleagues when experiencing their own challenges at work or in their personal life, which is why it is important to establish professional boundaries at the outset of initiating a mobile crisis response model to safeguard the working relationships.

Officers and crisis workers should be encouraged to connect and debrief to discuss calls they have worked on, particularly the more stressful ones. This may involve checking in at the beginning or end of a shift to discuss how everyone is feeling, how they are preparing for the work ahead (emotionally, physically, tactically, etc.) and if any additional support is required. This check-in process ensures that police officers and crisis workers are addressing their own mental wellness as a proactive measure, particularly when faced with difficult calls.

Any discussions involving the disclosure of identifying information about the individual, whether personal information or personal health information, would require the consent of the individual to whom the information relates unless the disclosure would otherwise be permitted or required by law. Even where non-identifiable information is used, the police officers and crisis workers must take care not to disclose information that would allow members of the same community to reasonably deduce the identity of the individual. For this reason, it is suggested that such discussions be held in private settings or by phone away from others who could overhear the conversation.

There may also be times when the crisis worker may be exposed to a critical incident that requires them to be involved in a more formal police debrief. In these cases, the crisis worker should be included with the officers for mutual support. However, **the role of the crisis worker within a mobile crisis response model is not to provide direct support in the way of counselling or case management to officers inside or outside of the workplace**. Front-line staff need strong managerial leadership and assistance to clarify the scope of their roles, as well as to provide training and guidance to maintain professional boundaries. This will protect crisis workers from the burden of feeling obligated to perform additional duties while putting their boundaries at risk.

The extent of support from crisis workers to officers should be limited to system navigation and information/referral to appropriate resources where officers can access personal supports (employee assistance programs, employee health care benefits, etc.). It may be helpful to provide an in-service orientation of the support services available to police officers and crisis workers prior to the implementation of any mobile crisis response team's service.

Crisis workers may experience heightened stress and anxiety in their role on a mobile crisis response team. These workers may witness incidents on calls for service with police officers they would not have observed in their previous roles. Burnout within the mental health and addictions sector is known to be high, so these partners should be encouraged to seek extra support while participating in the mobile crisis response program.

Depending on the employer, employee assistance programs and benefits may be available to the crisis worker. For regulated crisis workers, the professional college or organization may offer resources to its members. Peer support networks for crisis workers can help connect workers with others in similar roles.

The following services can be accessed online or by phone for all Ontarians:

- ConnexOntario: Call **1-866-531-2600** for mental health, addictions and problem gambling support. Available 24/7.
- 211 Ontario: For information and referrals to services including mental health resources across Ontario, call 211 or **1-877-330-3213**. Live web chat is also available.
- BounceBack: A free, evidence-based cognitive behavioural therapy (CBT) program that offers guided mental health self-help supports for adults and youth 15+ using workbooks, online videos and phone coaching. Call **1-866-345-0224**.
- Hope for Wellness Helpline: Indigenous individuals can call **1-855-242-3310** for immediate mental health counselling and crisis intervention across Canada (available in some Indigenous languages). Live web chat is also available.

Data collection for the purposes of program evaluation

Data collection and evaluation are critical components of successful mobile crisis response team programming.

Data can help police and health care partners evaluate the success of their mobile crisis response team, including for the purpose of communicating with funders. Effective data capture can also improve service delivery and determine where specific services or resources are needed in the community, as well as inform broader service planning (for example, data can inform the community safety and well-being planning process).

Privacy requirements for data collection and program evaluation

When it comes to evaluating and monitoring mobile crisis response team programs, a number of privacy-protective and equity-related measures will be critical to ensuring compliance with privacy requirements and best practices.

First, it is important to consider the type of data collected (e.g. direct identifier, quasi-identifier, or non-identifiable information) and the context in which data is collected in determining whether data must be characterized and protected as personal information and/or personal health information. This includes circumstances where the data does not contain any direct identifiers (e.g., name or address) but does contain various quasi-identifiers (sex, race, etc.) and may, as a result, create a composite description that could be used to identify individuals served by a mobile crisis response team. In addition, sociodemographic data collection raises additional privacy-related considerations, for example where raced-based data collection are involved. Whatever the circumstances, great care must be taken to ensure that the personal information and personal health information of all individual served by a mobile crisis response team is protected.

Other key responsibilities for mobile crisis response team partners participating in data collection and analysis include the following:

- only collect or compile the minimal amount of information that is necessary for the purposes of measuring and evaluating the effectiveness of the mobile crisis response team program, identifying, monitoring, and eliminating systemic discrimination, and advancing equity in mobile crisis response team service delivery;
- with regard to information collected *solely* for the purposes listed above, only collect this information directly from the individual to whom it relates **and** with the individual's express consent (or the consent of the individual's lawful substitute decision-maker);
- secure the information and restrict access to personnel who require such access for the purposes listed above;

- as soon as reasonably possible, remove any direct identifiers and de-identify[4] the information as much as possible while allowing for necessary analysis;[5]
- ensure that any disclosures, including in public reports and reports to steering committees and funders, do not contain any personal information or personal health information: this requires that the data be fully de-identified;
- be transparent with the individuals to whom the information relates, and the public, about the collection, use and disclosure of this information; and
- provide regular (e.g., annual or semi-annual) reports to the public about the mobile crisis response team organizations' progress on eliminating systemic discrimination and advancing equity in mobile crisis response team service delivery.

Further guidance on how to engage in data collection and evaluation in compliance with privacy and equity laws, requirements and best practices can be found in the Data Collection Template (Tool #11) in *Tools for Developing Mobile Crisis Response Teams in Ontario*.

Data collection components

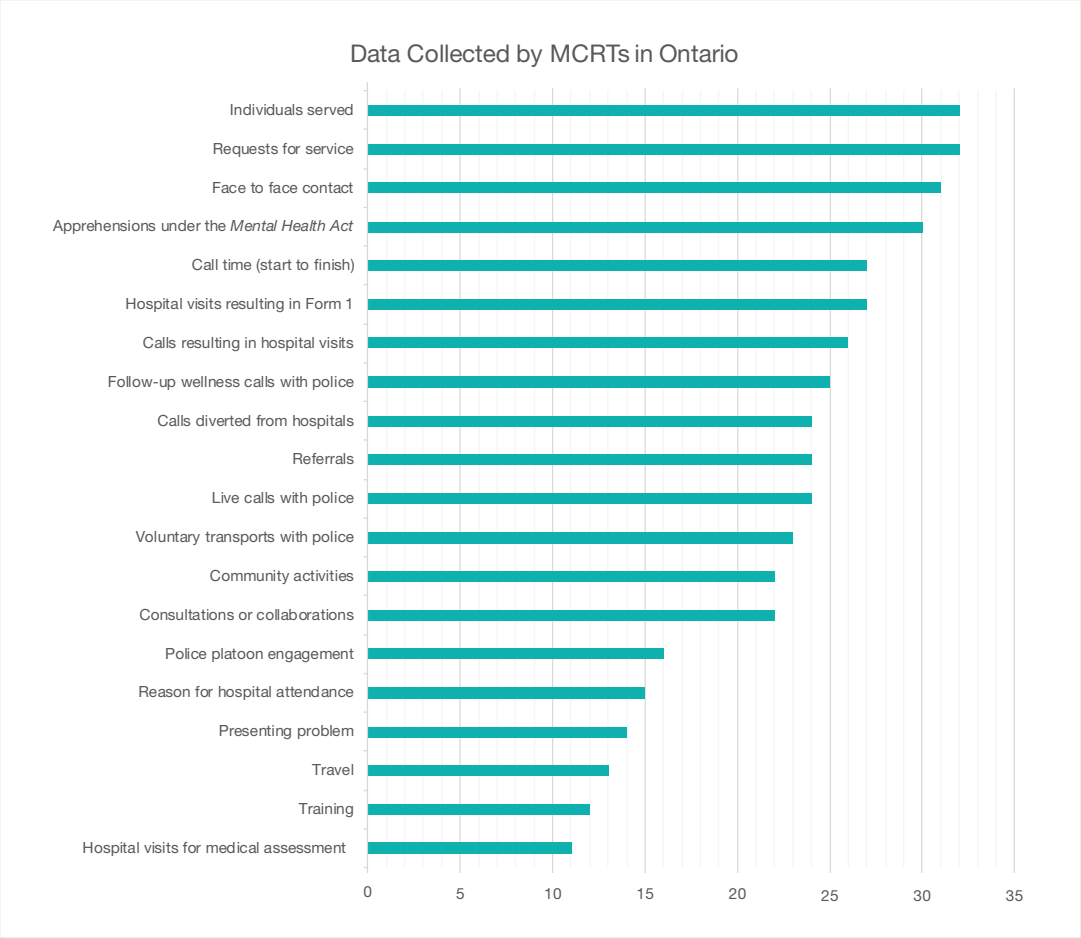
Baseline data related to police calls for service (such as data drawn from the interRAI Brief Mental Health Screener®) should be the first consideration to assist in determining the need for a mobile crisis response team, selecting the best type of model for the community, and scheduling operations based on high volume days and times. In addition, data drawn from local mental health and addictions crisis services, hospital emergency departments (such as Mental Health Act apprehensions), situation tables and provincial sources (such as ConnexOntario or Public Health Ontario) may provide critical insights.

Before moving ahead with any data collection, it is critical to determine what data will be collected, who will collect the data, and how the data will be synthesized, analyzed, validated, used and reported, all while complying with privacy laws and requirements. Many mobile crisis response teams in Ontario are already collecting data using pen and paper or sophisticated screeners. Some software programs can allow information to be shared easily and securely among health care and police partners, although protocols need to be developed to facilitate this transfer. Even basic software programs like Microsoft Excel can be used to track such data and evaluate the effectiveness of a mobile crisis response team. Programs vary by cost, so the data collection method chosen will depend on the team's operating budget. Regardless of the method used, data collection must comply with privacy laws and requirements.

4 For further information about de-identification and the secure collection, retention and handling of identifiable information, consult the Information and Privacy Commissioner of Ontario's De-identification Guidelines for Structured Data.

5 Where analysis uses information that is not fully de-identified, it must be treated as personal information or personal health information, as the case may be, and there must be legal authority for the collections, uses and disclosures of such information.

Data collected by mobile crisis response teams in Ontario



Note: This graph represents data collected in a provincial survey disseminated by the working group in September 2019. Some survey respondents indicated their team collects all data in a mental health screener rather than selecting the data points above. These results are not included in this graph.

As illustrated in the table above, mobile crisis response teams in Ontario are already collecting some evaluation-related data. When common data elements are collected by different mobile crisis response teams, practices can be monitored and assessed, and evidence-based best practices can be identified and shared provincially to the benefit of all models.

This framework, prepared by a provincial working group including representatives from the Ministry of the Solicitor General and the Ministry of Health, encourages all mobile crisis response teams in Ontario to collect evaluation-related data in compliance with all privacy laws and requirements. Once properly de-identified, this data may be shared provincially to inform the development of evidence-based practices and criteria for long-term and sustainable funding, while creating consistency among measures to track the success of each program model. Collecting data for program evaluation is important to demonstrate need and success in the community and is a necessary component that funders consider and rely on to understand their value. By reporting de-identified data to government, mobile crisis response teams can demonstrate their effectiveness, cost-avoidance and overall value.

A consistent provincial data set could include:

1. Number of live calls attended by/with mobile crisis response teams
2. Number of follow-up calls by/with mobile crisis response teams
3. Number of connections/referrals made
4. Number of diversions from hospital emergency departments
5. Number of apprehensions under the *Mental Health Act*
6. Percentage of apprehensions resulting in hospital admissions (Form or voluntary)
7. Sociodemographic data (race[6], gender, age, sexual orientation, religion, immigration status, income, etc.)
8. Presenting issue (mental health issue, addiction, neurodevelopmental disability, physical disability, homelessness, intimate partner violence, etc.)

Evaluation

Regular, data-driven assessment of a mobile crisis response team is critical to ensure the program achieves its objectives. Evaluation can help steering committees determine whether expansion is needed and where, if specific populations are being served appropriately, while also addressing budget decisions and other issues that may have arisen. These decisions must be based on non-identifiable data rather than personal information or personal health information. Evaluation can be conducted through a more formalized research study or through continuous quality improvement (QI) cycles. Whichever method is chosen, it is important to regularly evaluate the function and progress of the program and to ensure this evaluation complies with privacy laws and requirements.

Sharing accurate, complete and up-to-date non-identifiable information about a mobile crisis response team's progress and impact with respect to eliminating systemic discrimination and advancing equity is essential to garner trust and gain support from funders, as well as for the sustainability and growth of the program. The evaluation process must be transparent to the partners and the de-identified results should be shared with the public on a regular basis. This will allow the team to demonstrate short-term success and long-term achievements, providing senior leadership from partner organizations with evidence to justify requests for future investments. The MCRT partner organizations should also be open to receiving feedback from the community, the media, public officials, and the police officers and crisis workers comprising the team. It should also ensure public interests and concerns are reflected in the development of the program.

Continuous evaluation can also promote QI, a systemic process to improve care for clients and

6 This framework recommends all mobile crisis response teams in Ontario collect race-based data for every interaction, following extensive consultations and advice received from individuals and organizations serving Indigenous, Black and other racialized communities. This data will provide opportunities for teams to further improve client outcomes and enhance their engagement with communities.

practices for staff. QI includes local interdisciplinary teams using non-identifiable information to identify causes of problems, barriers to quality or flaws in system design, piloting different ideas to improve care, and conducting frequent and targeted measurement of quality for instant feedback on changes. Non-identifiable data can be compared each month, quarter and year to demonstrate the progress of the program when compared with original baseline data. This analysis can also lead to identification of areas for improvement and refinement of the program and its policies and procedures over time.

Any monitoring and evaluation process should include:

- Key indicators of success to be achieved
- Pre- and post-program launch evaluation to measure the progression of the key indicators of success
- Timed intervals for when the data should be gathered
- Routine reporting back to the mobile crisis response team steering committee and police and mental health delegates with decision-making authority
- An annual review of the program and updates as required

Client experience

Feedback from clients and their family members is an important measure of a mobile crisis response team's success. Standardized tools are available to gather client feedback on the quality of care received across both community and hospital settings. For example, the Ontario Perception of Care (OPOC) Tool for Mental Health and Addictions has been used by one follow-up model to evaluate client experiences two months after interacting with a mobile crisis response team in Ontario. In other communities, peer support workers debrief with clients after a crisis and lead the evaluation, ensuring clients are honest and not worried about repercussions.

Police-hospital transition framework

In Ontario, a person experiencing a mental health and/or addictions-related crisis may be apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care. This process can have negative impacts on everyone involved, such as the care of the person experiencing the crisis, an increase in demands on police and hospital resources, and longer wait times.

In 2012, the Provincial HSJCC began a provincewide project to examine these issues and identify innovative practices adopted by police services and hospitals throughout Ontario. A comprehensive *HSJCC Info Guide: Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario* was created to review existing practices. What became evident was that there was a need for a provincewide framework addressing police to hospital transition practices.

In 2015, the Ministries of Health and Long-Term Care and Community Safety and Correctional Services (as they were then called), in partnership with the Provincial HSJCC and CMHA Ontario, convened a provincial task force made up of experts from across the health care and policing sectors, including the Ontario Hospital Association, Ontario Association of Chiefs of Police, and several client groups. The task force consulted with the Information and Privacy Commissioner of Ontario and incorporated their privacy guidance. The task force developed *Improving Police-Hospital Transitions: A Framework for Ontario*, which was designed to provide police services and hospitals in communities across Ontario with a roadmap to establish effective police-hospital transition protocols.

The model for the framework is based upon evidence and best practices that were already in operation in Ontario. It provides information on how to implement process changes that are intended to:

1. Improve health outcomes for individuals apprehended under the *Mental Health Act*
2. Improve transitions between police officers and hospital staff
3. Improve coordination and collaboration among partners involved in the transition

Tools for Developing Police-Hospital Transition Protocols in Ontario is a complementary guide designed to assist with the implementation of the framework. These tools and resources were developed based on existing promising practices in Ontario. They are meant to help police, hospitals and others comply with legal requirements (as found in Ontario's mental health, human rights, policing and privacy legislation) and support the adoption of best practices. Many of these tools can be tailored to the specific needs of local communities.

For more information, please visit:
https://hsjcc.on.ca/our-work/projects/police-hospital-transition-framework/

On June 3, 2019, the Ministry of the Solicitor General and the Ministry of Health jointly endorsed and recommended the use of the framework and toolkit at a police-hospital transitions provincial education forum held in Toronto. This event brought together leaders from the policing and health care sectors to mark the release of *Improving Police Hospital Transitions: A Framework for Ontario* and discuss the implementation of effective police-hospital transition protocols across the province.

On August 9, 2019, the Hon. Christine Elliott, Deputy Premier and Minister of Health, Hon. Sylvia Jones, Solicitor General, and Michael Tibollo, Associate Minister of Mental Health and Addictions, publicly announced the new framework and toolkit at the launch of Sarnia's new mobile crisis response team. This dual announcement confirmed that mobile crisis response teams are an integral part of the police-hospital transition process.

Mobile crisis response teams play an important part in police-hospital transitions by diverting individuals experiencing a crisis away from unnecessary hospital emergency department visits when it is safe to support the individual in the community. The police-hospital transition framework recommends that mobile crisis response teams respond to any police calls for a person experiencing a mental health and/or addictions crisis. A mobile crisis response team may assist by:

- Completing a community assessment and mental status examination and sharing necessary information with the hospital's acute care team to assist in making an appropriate treatment plan
- Supporting the individual experiencing the crisis during a difficult time
- With consent of the individual, referring and following up with community supports upon discharge

Alternative considerations in special circumstances

During the development of a new mobile crisis response team, it is important to be prepared and plan for the impacts on daily service delivery in cases of unanticipated special circumstances such as a health pandemic, mass casualty or natural disaster. Under these special circumstances, appropriate measures may be required to modify service delivery to protect the health and safety of clients, police officers, crisis workers and the general public.

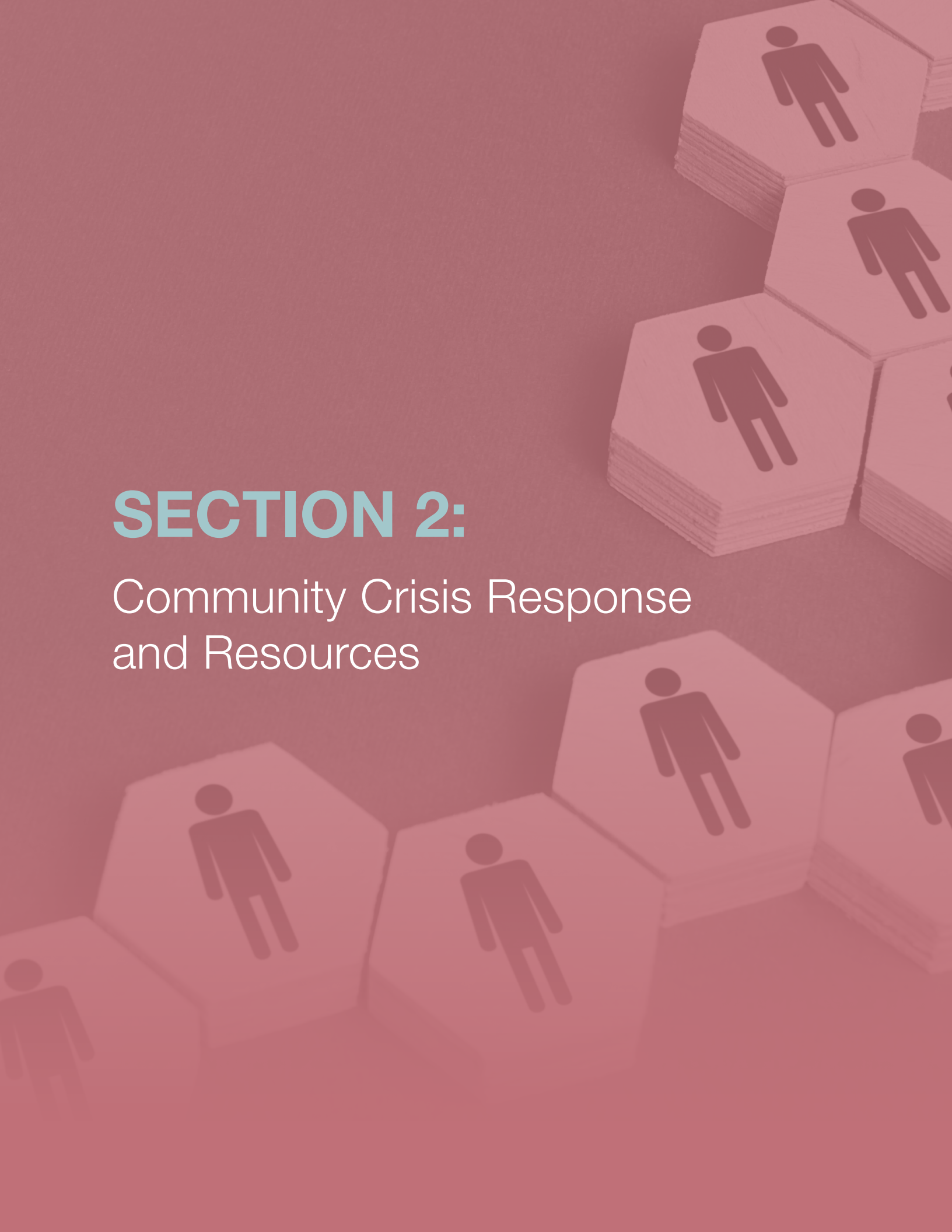
Modifications for consideration and implementation in special circumstances may include:

- Police and health care partners working closely to ensure mutual agreement for any modifications to mobile crisis response team operations, with measures taken to protect the health and safety of all parties.
- Recognition that any changes made during the special circumstance are temporary and to re-evaluate and assess the ability to return to regular operations when it is safe to do so.
- Appropriate adaptations to risk management processes. Mobile crisis response teams are equal collaborative partnerships between the police service and the mental health and addictions partner. Risk management and employee safety remain the responsibility of each respective employer. Any modifications made during a major event are covered under the existing mobile crisis response team MOU as long as both partners are in agreement. Teams must operate based on the guidance and consent of the health partner organization's instructions and prevailing government direction.
- Staying up-to-date and informed and focusing on flexibility, agility and responsiveness to

support safe and fiscally-responsible practices for service delivery. Reassure mobile crisis response team members that there will be an eventual return to regular practices when it is appropriate to do so.

Below are some examples of modifications made to mobile crisis response team delivery in Ontario during the COVID-19 pandemic:

- Separate vehicles used for the crisis worker and the police officer, and all vehicles wiped down after each use
- Police officers responded to crisis calls in person while the crisis worker was available to provide support by phone
- Calling clients instead of visiting them for low-risk calls or follow-up support
- Police officers and health partners collaborated to screen clients without unnecessarily accompanying them into a hospital



SECTION 2:

Community Crisis Response and Resources

Community crisis response and resources

Mobile crisis response teams and police services are encouraged to build connections with community-based mental health and addictions organizations. These organizations provide necessary services and help support clients in the community, reducing ongoing hospital and justice system involvement. Below are some examples of community initiatives which may provide opportunities for additional collaboration and leveraging resources.

Community (non-police) mobile teams

Community (non-police) mobile teams are typically composed of crisis workers who may have different areas of expertise, and respond to crisis situations or provide follow-up visits or wellness checks in the community. These non-police teams de-escalate crisis situations, offer medical assistance and provide therapeutic interventions. Community (non-police) mobile teams do not attend police calls, unlike the mobile crisis response teams highlighted in the rest of this document. Community mobile teams also provide "warm referrals" to community organizations, meaning the client is brought to the organization or directly connected to an individual working there by the team.

Calls to a community (non-police) mobile team are generally made through a crisis line when a police response is not required. These models may act in tandem with a police-partnered mobile crisis response team and are often linked to a community crisis centre or 24-7 crisis line.

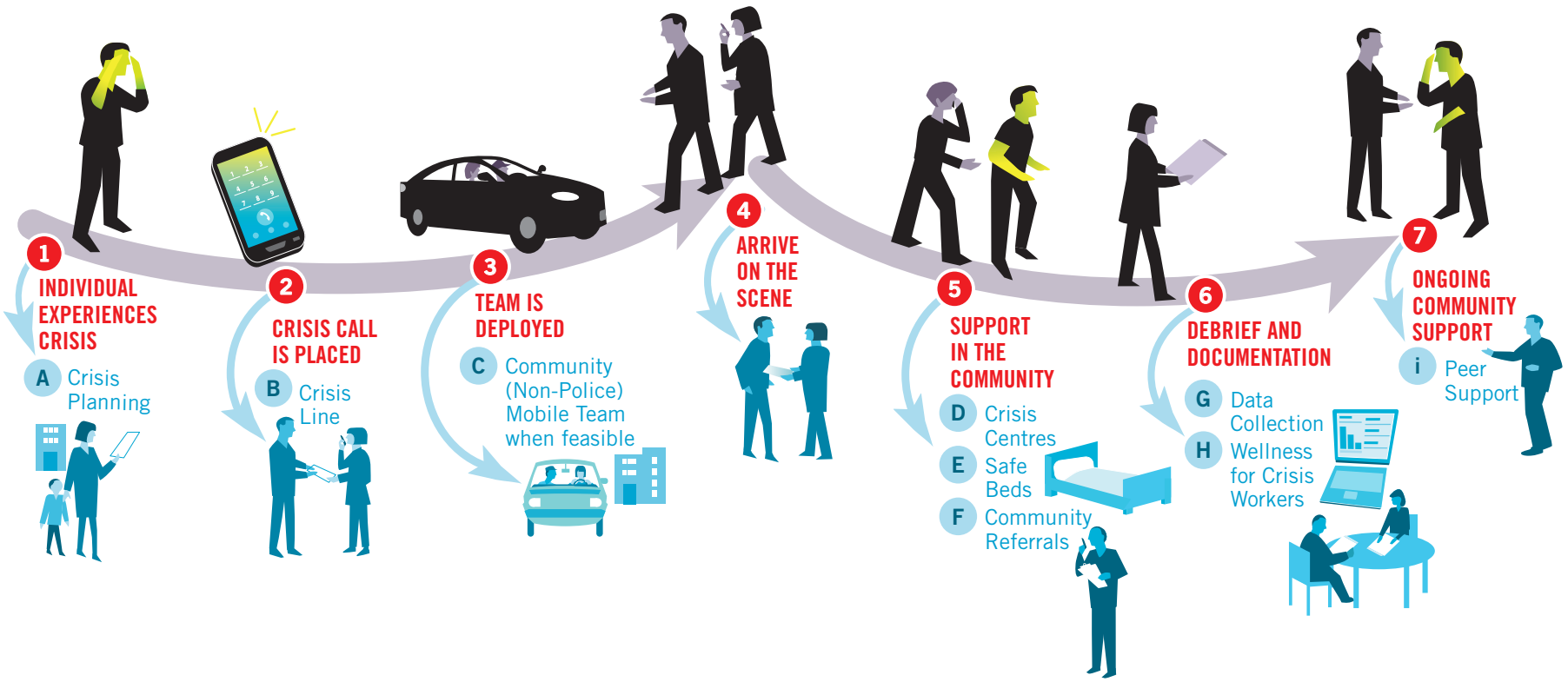
The community mobile team visits the client in their home or in the community, ensures the individual does not have immediate safety concerns, assists with daily living activities, delivers necessary medications, and provides counselling and crisis management planning. The goals of these teams are to ensure the client is stable in the community and connected to the services they need, to mitigate the risk factors that led to the crisis situation, and to prevent future calls for service or hospital visits, if possible.

Many community (non-police) mobile teams may be comprised of unregulated crisis workers, community volunteers, or other individuals who are not subject to privacy legislation. Moreover, some community mobile teams may be comprised of a mix of regulated and unregulated professionals, e.g., a crisis worker who is a health information custodian subject to the *Personal Health Information Protection Act, 2004* (PHIPA) and another individual who is not subject to PHIPA.

Regardless of the make up of a community mobile team, *privacy* remains an important consideration at all stages of a crisis intervention. Community (non-police) mobile teams are therefore encouraged to read and adapt this *Framework* and the accompanying *Tools for Developing Mobile Crisis Response Teams (Toolkit)* as they design, deliver and evaluate mobile crisis response services. Special attention should be paid to the privacy-protective measures outlined in the Memorandum of understanding (Tool #4), Key privacy considerations for mobile crisis response teams (Tool #8), and the Data collection template (Tool #11) of the *Toolkit*.

Please note: It is strongly recommended **that only police-partnership mobile crisis response teams respond to high-risk or potentially violent crisis calls**. This is to protect the safety of the crisis workers and the liability of their employers.

STAGES OF A COMMUNITY (NON-POLICE) MOBILE TEAM INTERACTION



HSJCC Human Services & Justice Coordinating Committee

O.P.P.

OHA Ontario Hospital Association

OACP

Canadian Mental Health Association Ontario | Association canadienne pour la santé mentale Ontario

For more information visit **www.hsjcc.on.ca.**
Graphic by: **Rose Zgodzinski**

STAGES OF A COMMUNITY (NON-POLICE) MOBILE TEAM INTERACTION

1 INDIVIDUAL EXPERIENCES CRISIS

A crisis is any situation in which a person's behaviour puts them at risk of hurting themselves or others or prevents them from being able to care for themselves or function in the community. The crisis may be related to a mental health issue, addiction, neurodevelopmental disability, dementia, acquired brain injury or any other condition that impacts the person's behaviour. When an individual is experiencing a crisis, the person requires care and attention to address their physical and mental health needs while ensuring that they and others are kept safe in a difficult and often unfamiliar situation. There are many individuals that may be involved to provide support during a crisis situation, such as an individual's family and friends, crisis centres, police communication operators, police officers, paramedics and emergency medical services, hospital staff, emergency nurses and doctors, community mental health and addictions organizations and peer support workers. In many communities, there are crisis services available that may be called before 911, including 24/7 community crisis lines and walk-in crisis centres. **ConnexOntario** hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions-related concerns. For more information, visit: ***www.connexontario.ca***

A CRISIS PLANNING

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

2 CRISIS CALL IS PLACED

When someone is experiencing a crisis, additional help for the individual may be required, and the individual or their family may not know where to go for help.

B CRISIS LINE

Friends, family members or the individual themselves may call a crisis line to seek assistance, such as **ConnexOntario** which operates a free, 24-hour crisis response line at **1-866-531-2600**.

3 TEAM IS DEPLOYED

Community (non-police) mobile teams include a pair of crisis workers responding to an individual experiencing a crisis. The team assesses the individual experiencing the crisis and refers them to the appropriate place in the community for care, such as a crisis centre or community-based mental health and addictions service provider.

C COMMUNITY (NON-POLICE) MOBILE TEAM

Typically composed of crisis workers who may have different areas of expertise, and who respond to crisis situations or provide follow-up visits or wellness checks in the community. These non-police teams de-escalate crisis situations, offer medical assistance and provide therapeutic interventions. Calls to a community mobile team are generally made through a crisis line when a police response is not required. These models may act in tandem with a police-partnered MCRT and are often linked to a community crisis centre or 24/7 crisis line. ***Developing Mobile Crisis Response Teams: A Framework for Ontario*** **strongly recommends that only police-partnership MCRTs respond to high-risk or potentially violent crisis calls. This is to protect the safety of the crisis workers and the liability of their employers.**

4 ARRIVE ON THE SCENE

The community (non-police) mobile team will work together to de-escalate the crisis situation and determine appropriate next steps.

5 SUPPORT IN THE COMMUNITY

One of the goals of community (non-police) mobile teams is to divert individuals from unnecessary hospital emergency department visits and reduce pressures on the health care and criminal justice systems. The goals of community support are to ensure the client is stable in the community and connected to the services they need, to mitigate the risk factors that led to the crisis situation, and to prevent future calls for service or hospital visits if possible.

D CRISIS CENTRES

Where available, community crisis centres provide short-term, voluntary, community-based intensive care and treatment on a drop-in basis. Crisis centres employ a multidisciplinary team of mental health and addictions professionals and ensure a number of services and programs are available to the client.

E SAFE BEDS

Safe bed programs offer short-term community accommodation to persons experiencing a mental health and/or addictions crisis. Both safe beds and crisis centres allow individuals to be safely stabilized and supported in the community.

F COMMUNITY REFERRAL

The team will make appropriate referrals to community mental health and addictions organizations that provide clinical services, therapeutic support and case management. This may involve calling third parties, booking appointments and facilitating follow-up support. **ConnexOntario** can connect individuals in crisis (youth and adults), family and friends, and professionals with information on types of services/programs and estimated wait times for support within their community.

6 DEBRIEF AND DOCUMENTATION

At the end of a shift, the team is encouraged to discuss the approach taken during the call, any lessons learned and how to incorporate these moving forward, as well as to check-in to determine if any wellness support is required. The partners will complete documentation related to crisis assessment, consent from the individual, risk, etc., including de-identified or aggregate data collection.

G DATA COLLECTION

Data can help health care professionals improve service delivery, demonstrate the effectiveness of a community mobile team, determine where specific services or resources are needed in the community, and inform broader service planning. Only **non-identifiable information**, such as de-identified or aggregate information, should be used for these purposes.

H WELLNESS FOR CRISIS WORKERS

Periodically or after a noteworthy interaction, the team may wish to meet to discuss the approach taken during the call, any lessons learned and how to incorporate these lessons moving forward. This check-in process ensures that crisis workers are addressing their own mental wellness as a proactive measure, particularly when faced with difficult calls. Partners should be made aware of and encouraged to utilize resources such as employee benefits and professional peer support networks.

7 ONGOING COMMUNITY SUPPORT FOR INDIVIDUAL

Recovery from a crisis is experienced differently by everyone. For many, it is important that the proper community supports are put in place and connections or referrals to community programs are provided. Support from family, the community, and having access to the social determinants of health (for example, housing and food) are key to increasing wellness and preventing individuals from coming into contact with police or experiencing unanticipated visits to the emergency department.

I PEER SUPPORT

Some hospitals and community mental health and addictions organizations have peer support workers available within their facility that can play a key role in supporting an individual who has experienced a crisis. Peer support can help the individual, family or other support people have conversations with someone that is familiar with their situation and can assist with planning for any potential future crisis situations that may arise.

Community (non-police) mobile teams - Case studies from Ontario

Kenora Makwa Patrol - Kenora, Dryden, Red Lake and Sioux Lookout

- Collective of organizations led by Kenora Chiefs Advisory, Kenora OPP and Kenora District Services Board (KDSB)
- Community-based solution to crime prevention, intending to provide a sense of safety, solidarity and belonging to both its members and to the communities they serve
- Operates 24-7 to assist in helping marginalized persons, who may be in compromised positions or conditions, get from the streets to various services
- Provides culturally safe response without further stigmatization to the person served
- Responds to the Truth and Reconciliation Commission's Calls to Action recommendations and draws direction from Indigenous traditional philosophies and practices
- Members patrol during OPP peak call hours and businesses can call the patrol as a first option to non-violent incidents
- Kenora Makwa Patrol responds in a non-violent, non-threatening, non-judgmental and supportive manner primarily through relationship building and reconciliation
- If police are required, patrol members can call police to assist and then continue to provide services if possible
- Kenora Makwa Patrol provides an early response to crisis situations and assists in searches for missing persons
- Patrol members carry first aid kits, automated external defibrillators, naloxone kits, food and hygiene products
- Provide rides, escorts, referrals and connections to community organizations
- Work closely with the police, KDSB, Mobile Outreach Programs, other emergency services, Morningstar Detoxification Centre, and the Lake of the Woods District Hospital to ensure people in need receive prompt and appropriate care
- Kenora Makwa Patrol Community Council consists of representatives from local police, municipal and Indigenous governments and community organizations as well as a Community Elder and Representative

York Support Services Network – York Region

- Respond to calls made to 24-7 crisis line (310-COPE)
- Risk assessment completed over the phone before community visit is made (where possible)
- Provide easy access to mental health services in York Region and South Simcoe, as well as children and youth services and behavioural support services for older adults
- Also partner with York Regional Police on a mobile crisis response team

Gerstein Crisis Centre – Toronto

- Respond to calls made to 24-7 community crisis line integrated into a crisis centre that includes mobile teams, crisis beds and follow-up
- Qualified crisis workers from a variety of backgrounds including lived experience, a broad understanding of mental health and substance use issues and the impact of social determinants of health and recovery; trauma-informed and harm reduction approach
- Mobile teams visit person's home or in the community
- Crisis centre in a home-like environment offering 10 crisis beds for three-to-five-day stays to stabilize and connect with service providers
- Strong capacity for de-escalation; however, when safety cannot be assured or agreed upon, intervention could include calling 911
- Concurrent/Substance Use Crisis Team offering mobile team visits, access to crisis beds in partnership with other community organizations and follow-up for up to 30 days
- Mobile Crisis Intervention and Follow-up Team targets downtown core to serve people living with homelessness who may be referred from street outreach and/or presenting in St. Michael's or St. Joseph's (Unity Health) Hospital emergency rooms who would benefit from a wellness check or follow-up visit
- Provide follow-up and referrals to case management, health services and other beneficial community services
- Recovery programming for individual who experienced the crisis including recovery groups and peer-led social and physical activities in the community; lived experience is valued and represented at all levels of the organization
- Strong community partnership model to improve access to services for individuals who are marginalized (this includes crisis beds offering longer stays of up to 30 days, 15 crisis beds for individuals in crisis and currently homeless, nine mental health and justice beds, Safe Bed Support Network and after-hours urgent response for individuals living with dual diagnosis (i.e. mental illness and neurodevelopmental disability), seven crisis beds for concurrent disorders/serious substance use, and collaboration with Crisis Outreach Services for Seniors)

CMHA Peel Dufferin Branch – Peel Region

- Integrated with police mobile crisis response teams (Peel Regional Police and OPP Caledon) and 24/7 community crisis line to offer a continuum of services which reduce barriers to receiving mental health and addictions support
- Two mental health professionals (social worker, registered nurse or occupational therapist) visit client in their home or community
- Visit lower-acuity clients or situations involving multiple clients in need of clinical support and assessment (such as older couple with limited supports and declining health and cognitive function)
- De-escalate the crisis situation, thoroughly assess safety and well-being utilizing clinical documentation, provide recommendations for treatment planning and make referrals to additional community resources
- With consent, forward comprehensive crisis assessment to primary care team (general physician and/or psychiatrist) to relay current clinical presentation and advocate for services requiring physician approval
- Often a mobile crisis response team will attend a crisis call and request the community team to attend and provide additional support without the presence of police
- Complete mobile screener prior to every visit to ascertain worker safety and identify potential safety issues
- Workers rotate on community team, follow-up mobile team, live response mobile crisis response team and 24/7 crisis line call centre to ensure full understanding of all models and avoid burnout

Community (non-police) mobile teams in Ontario

This list is a non-exhaustive inventory of community (non-police) models. Further research in the form of an environmental scan, analysis of any data gathered and development of best practices by existing community (non-police) mobile teams in Ontario is needed.

Community	Health partner	Program name and phone number (Program hours of operation are subject to change)
Barrie	CMHA Simcoe County *	*Mobile Support* (daily 10AM - 10PM) 1-888-893-8333 (24/7)
Chatham Kent	CMHA Lambton Kent *	**CMHA First Response Team** (24/7) 1-866-299-7447
Cochrane District	North Eastern Ontario Family and Children's Services	**Mobile Crisis Response Service** (children and youth, 24/7) 1-800-665-7743
Durham Region	Durham Mental Health Services	**Crisis Access Linkage Line** (24/7) 1-800-742-1890
Halton Region	CMHA Halton Region*	**Crisis Outreach Program** (24/7) 1-877-825-9011
Kenora	Anishinaabe Abinoojii Family Services	Makwa Ganaatamaaget - Youth Crisis Team (daily 7:45 PM – 4:15 AM) 1-866-420-9990
Kingston	Addiction and Mental Health Services - Kingston Frontenac Lennox & Addington*	**Kingston & Frontenac Mobile Crisis Services** (weekdays 8 AM – 12 AM, weekends & holidays 8 AM – 8 PM) 1-866-616-6005 (24/7)
London	CMHA Thames Valley Addiction & Mental Health Services*	**Reach Out** Call 1-866-933-2023, text 519-433-2023 or **web chat** (all 24/7)
Napanee	Addiction and Mental Health Services - Kingston Frontenac Lennox & Addington*	**Lennox & Addington Mobile Crisis Services** (weekdays 8:30 AM – 4:30 PM) 1-800-267-7877 (24/7)
Ottawa	The Ottawa Hospital*	**Mobile Crisis Team** (daily 9 AM – 9 PM) 1-866-996-0991 (24/7)

Community	Health partner	Program name and phone number (Program hours of operation are subject to change)
Owen Sound	CMHA Grey Bruce*	Urgent Response Team (24/7) 1-877-470-5200
Oxford County	CMHA Thames Valley Addiction & Mental Health Services*	Reach Out Call 1-866-933-2023, text 519-433-2023 or web chat (all 24/7)
Peel Region	CMHA Peel Dufferin*	24.7 Crisis Support Peel Dufferin 905-278-9036 (Mississauga & Brampton) 1-888-811-2222 (Caledon & Dufferin) Both lines 24/7
Sarnia Lambton	CMHA Lambton Kent*	CMHA First Response Team (24/7) 1-800-307-4319
St. Thomas	CMHA Thames Valley Addiction & Mental Health Services*	Reach Out Call 1-866-933-2023, text 519-433-2023 or web chat (all 24/7)
Sudbury & Manitoulin	CMHA Sudbury Manitoulin, Compass Child and Family Services, Health Sciences North*	Crisis Intervention Services (daily 10 AM – 10 PM) 1-877-841-1101 (24/7)
Thunder Bay	CMHA Thunder Bay*	Crisis Response Mobile Unit (weekdays 3-11 PM) 1-888-269-3100 (24/7)
Timiskaming District	North Eastern Ontario Family and Children's Services	Mobile Crisis Response Service (children and youth, 24/7) 1-866-229-5437
Toronto	Anishnawbe Health Toronto	**Mental Health Crisis Service** (Indigenous clients) 1-855-242-3310 (24/7)
Toronto	Gerstein Crisis Centre	Mobile Crisis Team 416-929-5200 (24/7) Phone line serves Etobicoke and North York as well
Toronto	WoodGreen Community Services	Crisis Outreach Service for Seniors (adults aged 65+, daily 9 AM – 5 PM) 416-217-2077 or 1-877-621-2077 (weekdays 9 AM – 8 PM, weekends and holidays 9 AM – 6 PM, in 100+ languages)

Community	Health partner	Program name and phone number (Program hours of operation are subject to change)
Toronto	Youthdale	Mobile Response Team (youth) 416-363-9990 (24/7)
Waterloo-Wellington	CMHA Waterloo Wellington*	Here 24/7 (24/7) 1-844-HERE247 (437-3247)
Windsor	Assisted Living Southwestern Ontario, CMHA Windsor-Essex County, Family Services Windsor-Essex, Hôtel-Dieu Grace Healthcare*	Mobile Outreach and Support Team (street-involved) Call or text 226-787-5724 (Monday to Friday, 5:30-9 PM) Call crisis line 519-973-4435 (24/7)
York Region & South Simcoe	York Support Services Network*	Mobile Crisis Response Team (daily 10 AM – 10 PM) Call 1-855-310-COPE (2673) TTY 1-866-323-7785 (both 24/7) Text 1-855-310-2673 or web chat (both daily 7 AM – 12 PM)

*Organization also partners with local police on a mobile crisis response team

Crisis centres

Crisis centres provide short-term, voluntary, community-based intensive care and treatment. Many crisis centres employ a multidisciplinary team of mental health and addictions professionals. Crisis centres ensure a number of services are available to the client and work in tandem with other programs highlighted in this section. Crisis centres are also less restrictive and costly than hospital visits.

The goals of a crisis centre include:

- Stabilization of the crisis situation
- Mental health assessment
- Counselling
- Management of medications
- Health education
- Warm referrals to community organizations
- Discharge planning

Crisis centres usually prioritize clients brought by police and often have a “no wrong door” policy, ensuring all clients brought by police will be accepted.

Crisis lines

Crisis lines are phone lines that usually operate 24/7, ensuring the client is never left waiting to speak to someone. The crisis worker is trained in de-escalating crisis situations over the phone and can provide therapeutic interventions to a person experiencing a crisis. The crisis worker can also provide a warm transfer, meaning the client can be directly connected to a person at a community organization.

Some crisis lines are connected to a mobile crisis response team, either a civilian or mixed police-civilian model. The mobile crisis team may respond (if available and appropriate) to the individual who called the crisis line, either immediately, or for a follow-up check. In some circumstances, crisis lines may also call 911 if the crisis worker believes the caller may harm themselves or others.

ConnexOntario assists individuals with access to addictions, mental health, and problem gambling services. Please call toll-free 1-866-531-2600, available 24/7.

Safe bed programs

Safe bed programs offer short-term community accommodation to persons experiencing a mental health and/or addictions crisis. The program allows individuals to be safely stabilized and supported in the community.

Some safe bed programs are designated for referrals from police officers or mobile crisis response teams. In order to be accepted into a **police-accessed safe bed program**, the individual must be referred:

- By police directly;
- By a mobile crisis team;[7] and/or
- By a hospital after being apprehended by police under the *Mental Health Act*. The individual would be deemed inappropriate for hospital admission by a medical professional, then referred to the safe bed program.

Eligible individuals must be medically stable, inappropriate for arrest or detention by police, and not at risk of harming themselves or others. They must also be in need of short-term mental health and addictions support.

These programs are voluntary, meaning the client must agree to the requirements of the safe bed program. Some programs may include requirements such as not using substances in the residence.

The goals of safe bed programs are to divert individuals from inappropriate incarceration, justice system involvement and/or unnecessary hospitalization. The safe bed program helps to de-escalate and stabilize individuals in the short-term and connect them to services and supports in the community, as needed, over the long-term.

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7 For the purposes of the safe bed program, the mobile crisis team does not have to include a police partner, but police must have referred the individual to the safe bed program.

The core activities of a safe-bed program include:

- Temporary housing
- Provision of basic living needs (food, clothing, personal care items)
- A safe, supportive environment to stabilize and manage symptoms and the crisis situation
- Mental health and addictions support services
    - Crisis support and counselling
    - Information and referrals to ongoing treatment, rehabilitation and support services
- Assistance with daily living skills (cooking, housekeeping, hygiene) as needed
- Advocacy and linkages to community-based services and supports, such as:
    - Income support (Ontario Works, Ontario Disability Support Program)
    - Supportive housing
    - Peer support
    - Vocational support
    - Legal services
    - Physical health (primary care)
- Support for the appropriate use of medication

Community follow-up

Calls to a community outreach team are generally made through a crisis line and referred when a police response is not required. These models may act in tandem with a mobile crisis response team and are often linked to a community crisis centre or 24/7 crisis line. The outreach team visits the client in their home, ensures the individual does not have immediate safety concerns, assists with daily living activities, delivers necessary medications, provides counselling and crisis management planning, and makes warm referrals to community organizations who can provide ongoing support. The goals of follow-up are to ensure the client is stable in the community and connected to the services they need, to mitigate the risk factors that led to the crisis situation, and to prevent future calls for service or hospital visits if possible.

Community crisis outreach may be less stigmatizing to clients as police vehicles and uniforms are not involved in the response. This framework strongly recommends that only police-partnership models respond to high risk or potentially violent crisis calls. This is to protect the safety of the crisis workers and the liability of their employers.

Peer support

Peers are individuals who have had mental health and/or addictions issues and voluntarily share their experience and recovery journey with others. Peers may be paid by an organization or volunteer to provide connection and support to those in recovery. Evidence suggests that peer support programs are effective at helping individuals cope with mental health and addictions-related issues, including a reduction in symptoms, decreased substance use, increased confidence, development of coping and interpersonal skills, improved daily functioning and quality of life, increased goal-setting and recovery planning.

Peers also benefit from their roles, experiencing fewer and shorter re-hospitalizations, improved ability to deal with distress, skill development and increased self-efficacy. Peer support has also been shown to increase client satisfaction with treatment and lead to better communication between clients and care providers. Peers are often able to connect with individuals and decrease stigma among mental health service providers.

For information on peer support programs, please visit:

- For clients: Centre for Innovation in Peer Support
- For family members: Ontario Caregiver Association

Case management

Case management services are a key component of support for people living with mental health and/or addictions issues. Case management is usually provided by a mental health and addictions case worker usually employed by a community organization. Intensive case management promotes independence and quality of life through the coordination of appropriate services and the provision of ongoing support as needed by the service recipient.

Integrated case management refers to the partnerships that case managers have with other services and supports, either within their own community agency (supportive housing, peer support, counselling, etc.) or more broadly with community sector partners, such as primary care, justice services (bail beds, legal aid), and other community resources.

Prevention

Seeking regular and ongoing support is important to maintain good mental health. Similar to an annual physical check-up with a family doctor, regular appointments with a therapist, counsellor, peer support worker or other mental health professional can help identify emergent mental health issues, develop therapeutic treatment plans and maintain overall mental health.

Access to the social determinants of health, such as housing, nutritious food, safety, income security, equity and education have been demonstrated to directly impact mental health.

Mental health resources:

- ConnexOntario: 1-866-531-2600 (24-7) or web chat
  Connects individuals to local addictions, mental health and problem gambling services

- BounceBack: 1-866-345-0224
  Free skill-building telephone program to help individuals aged 15+ manage low mood, mild-to-moderate depression and anxiety, stress or worry

Neurodevelopmental resources:

- Developmental Services Ontario: Access point for adult developmental services and system navigation funded by the Ministry of Children, Community and Social Services in Ontario

Family members, witnesses and survivors

When one person comes into contact with the justice and/or mental health and addictions systems, their entire community may be impacted. Family members, friends, witnesses and survivors may all experience challenges on a financial, physical, psychological and emotional level.

Family members and friends

Friends and family members may feel frightened, confused or unsure about how best to support their loved one in the future. These caregivers may be required to help the client navigate the hospital system, the justice system, and a network of community organizations and supports.

Many family members benefit from peer support, where they can connect with other caregivers whose loved ones have also been impacted by mental health and/or addictions issues. The Ontario Caregivers Association has developed a **peer support network for caregivers** of individuals living with mental health and/or addictions issues in Ontario. For more information, please visit https://ontariocaregiver.ca/find-support/peer-support/.

Witnesses

If a witness is asked to testify in a criminal court proceeding, the **Victim/Witness Assistance Program** (V/WAP) funded by the Ministry of the Attorney General can provide assistance to those navigating the court process. Referrals can be made by the police or Crown attorneys, or anyone can call 1-888-579-2888 to make a referral for themselves or someone else.

Survivors

In the Canadian criminal justice system, a victim is anyone who has experienced emotional or physical harm, loss of or damage to their property, or economic loss due to a crime. These individuals may prefer to be known as survivors, a term that is empowering, future-focused and less stigmatizing than “victims” of crime.

Victim services are programs that support people as they navigate the criminal justice system. These programs provide emotional support to the victim, share information on navigating the justice system, and make referrals to additional services as needed. Accessing victim services can be instrumental in mitigating any negative mental health impacts caused by participating in the justice process.

Ontario Victim Services funds services for victims and survivors of crime through organizations like the Victim Crisis Assistance Ontario Program, Victim Quick Response Program, Sexual Assault Centres, the Victim Support Line and the **Victim/Witness Assistance Program** (V/WAP) which supports victims and witnesses as they navigate the court process. Anyone can call **1-888-579-2888** to make a referral for themselves or someone else to be connected to the Victim Support Line or V/WAP. This toll-free line connects callers to services across Ontario, in most languages spoken in the province.

Even where a mobile crisis response team is able to provide support to a survivor following a crisis, a referral should always be made to Victim Services.

Community safety and well-being planning

Community safety and well-being planning involves working collaboratively across sectors to identify and address local priority risks to safety and well-being before they escalate and result in situations of crisis. It also involves reducing the number of incidents that require enforcement by shifting to more proactive, preventative efforts that focus on the long-term benefits of social development and prevention and in the short-term, risk intervention.

The *Police Services Act* requires every municipality in Ontario to prepare and adopt a community safety and well-being plan in consultation with police services, health, education, community services and children and youth services. Municipalities have the discretion to develop joint plans with other municipalities and/or First Nations communities, which may be valuable in order to leverage resources and address the unique needs of the community. Through this collaborative planning process, communities can ensure better coordination between local partners, not only through crisis response, but by developing and implementing proactive programs and strategies that address local priority risks and improve the social determinants of health (such as education, housing, mental health), thus alleviating long-term pressure on the criminal justice and emergency health systems. This holistic approach will help ensure that the needs of vulnerable populations are being addressed by the most appropriate providers and ultimately, save lives, enhance community well-being and prevent crime.

As part of community safety and well-being planning, communities may look to implement mobile crisis response teams to fill gaps in services identified in a plan through a coordinated, collaborative approach to incident response. Alternately, where a mobile crisis response team exists, the non-identifiable information collected by these teams related to risk factors and protective factors in the community may assist with informing the priorities of a municipality's community safety and well-being plan.

More information can be found in the Ministry of the Solicitor General's *Community Safety and Well-Being Planning Framework: A Shared Commitment in Ontario*.

Situation tables

A situation table consists of human service providers from different sectors working together to provide immediate, coordinated and integrated responses to address emergent situations facing individuals and/or families at acutely elevated risk, as recognized across a broad range of service providers. Situation tables come together to discuss acutely-elevated risk situations that have been brought forward by an agency sitting at the table. Within 24 to 48 hours, the relevant service providers help connect that individual and/or their family members with the appropriate supports and services to address their acute needs.

Within the collaborative partnership of a mobile crisis response team, there may be opportunities for some level of involvement in situation tables. In some communities, the mobile crisis response team may identify individuals who would be an appropriate referral to a situation table, given they may be deployed through a response to an incident that requires a more holistic solution to address multiple identified risks. In other communities, the mobile crisis response team may participate as members of the situation table to support the community. Situation table data can be a good resource for crisis planning and can inform the development and operations of a mobile crisis response team.

The following training opportunities are recommended for partners participating in a situation table:

- Situation Table Learning Package (Ontario Provincial Police and Wilfred Laurier University)
- Guidance on Information Sharing in Multi-sectoral Risk Intervention Models (Ontario Ministry of the Solicitor General)

Conclusion

For the past several years, community mental health and policing experts, supported by the Provincial Human Services and Justice Coordinating Committee have developed this framework and toolkit to share knowledge, resources and lessons learned with communities across the province. It is hoped that these documents guide further development, investments and evaluation of mobile crisis response teams in Ontario.

The Mobile Crisis Response Teams Provincial Working Group intends to continue working together to examine Ontario's crisis response network and identify opportunities for further research and enhancement. For more information, please visit www.hsjcc.on.ca.

Glossary

The terms referred to throughout this document are defined below. Some are among the common lexicon of mobile crisis response team partners in Ontario while others are from provincial government and international sources.

Addiction – Problematic patterns of substance use or behaviours that interfere with a person's life and can lead to physical and/or psychological dependence. Addictions can be either substance-related (such as the problematic use of alcohol or cocaine) or process-related, also known as behavioural addictions (such as gambling or internet addiction).

Community (non-police) mobile teams - Typically composed of crisis workers who may have different areas of expertise, and respond to crisis situations or provide follow-up visits or wellness checks in the community. These non-police teams do not attend police calls, unlike mobile crisis response teams.

Co-response – A mobile crisis response team model. Using their own means of transportation, a crisis worker is dispatched to meet a police officer at the scene of a crisis once the police officer deems it safe to do so.

Crisis – Any situation in which a person's behaviour puts them at risk of hurting themselves or others or prevents them from being able to care for themselves or function in the community. The crisis may be related to a mental health issue, addiction, neurodevelopmental disability, dementia, acquired brain injury or any other condition that impacts the person's behaviour. Anyone who calls the police may be experiencing a crisis, such as a traffic accident, assault, intimate partner violence or theft. In this framework, "crisis" refers only to calls that police code as "mental health and/or addictions-related," which includes calls related to neurodevelopmental disabilities, dementia and other conditions.

Crisis worker – Describes all health care partners on mobile crisis response teams. This framework encourages regulated health care professionals such as social workers, nurses or occupational therapists to be considered for participation on a mobile crisis response team. However, unregulated professionals who may be community Elders, addictions counsellors or children and youth workers with mental health training may have existing trust with community members and may be the most available option in remote areas. All crisis workers must comply with privacy requirements and should have experience in community mental health and addictions, as well as relevant crisis response experience in order to respond to crises and determine if individuals require urgent psychiatric or medical care, or if they can be safely stabilized in the community.

Dispatch – Method by which the mobile crisis response team is engaged.

Diversion – Providing appropriate, alternative services within the community without the need for hospital emergency rooms or inpatient care, as well as the discretionary option by justice officials to redirect individuals with mental health and/or addictions issues from the criminal justice system (such as incarceration) to appropriate community services.[8]

Embedded – A mobile crisis response team model. The crisis worker and police officer are co-located and attend mobile crisis calls in the same vehicle.

Follow-up – A police officer and crisis worker, or a pair of crisis workers, provide non-urgent support to an individual based on a previous interaction or referral from other police officers, mental health partners, a crisis line or another source to ensure that the individual is safe and connected to services in the community. Follow-up may be provided by a mobile crisis response team or by a community (non-police) outreach team.

Live response – Police officer and crisis worker respond to 911 immediate calls for police service.

Mental health issue – An alternative phrase to *mental illness or mental disorder* used throughout this document as a preferred, less stigmatizing term. A person may experience a mental health issue without having a formal diagnosis and/or a formal diagnostic history may not be known to the MCRT partners. Unless referring to a known history of mental illness, this document uses the term *mental health issues*, which may or may not include a formal diagnosis of a mental illness.

Mobile crisis response team – Collaborative program between police and mental health and addictions partners to respond to crisis situations in the community. Three model types exist in Ontario: embedded live response, live co-response and embedded follow-up, as well as combinations of the three.

Peer support – Individuals with lived experience of mental health and/or addictions issues providing support to others in recovery, also known as "peers" or "peer support workers." Peers may work or volunteer within mental health advocacy organizations, and they may be trained professionals, whether regulated or unregulated. Peer support workers can offer hope that recovery is possible while providing practical support and assistance navigating the mental health system. Peer support considers the wellness of the whole person and focuses on health and recovery rather than illness and disability. Peer support services are intended to complement clinical care and vice versa.

8 Note that "mental health court diversion" is an official definition, according to the Ministry of the Attorney General's Crown Prosecution Manual (2017) that refers to "community based programs [that] hold the mentally ill accused accountable for criminal conduct by requiring the completion of rehabilitative programs that effectively respond to the nature of the offence, the accused, and the needs of the community." For this framework, "diversion" also includes formal and informal pre-charge diversion programs, warnings, and referrals to community services.

Safe – A term used by police to determine when a civilian can enter the scene of a crisis or whether further police back-up is needed. The police partner should always enter the scene of a mobile crisis response team visit first and determine when it is physically appropriate for the crisis worker to engage with the individual experiencing the crisis. Crisis workers are not first responders and therefore should not enter the scene until directed by the officer that it is safe to do so. A safety protocol is recommended to support risk management and clarify that both partners share responsibility for their safety.

Schedule 1 facility - Designated psychiatric facility under the *Mental Health Act* as set out by the Ministry of Health.

Substance use – Consuming drugs, alcohol, aerosols or other materials that cause a physiological effect. Problematic substance use ranges from mild (feeling hungover, being late for work) to severe (substance use disorder). A person who keeps using substances despite the harmful consequences may develop a substance use problem, which is a form of addiction. "Addictions" is used in this document to include substance use and process-related behaviours (such as gambling, internet use).

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Appendix A – Literature review

There is limited literature regarding mobile crisis response teams in Ontario. Still, the existing literature suggests that mobile crisis response teams may reduce emergency department visits, arrests and use of force, while increasing community linkages.[1] Furthermore, individuals who have interacted with a mobile crisis response team have reported positive perceptions of the program.

In 2014, the Honourable Frank Iacobucci released *Police Encounters with People in Crisis*, which recommended police services across Ontario reassess their day-to-day interactions with people experiencing a mental health and/or addictions-related crisis.[2] Although his report focused on use-of-force encounters, the underlying theme addressed how police services could enhance de-escalation as it related to encounters with people with mental health and/or addictions issues. While the report was not a direct indictment of police services in Ontario, it did offer recommendations which challenged existing police culture and training that pertained to police interactions with persons experiencing a mental health and/or addictions crisis. From a broader outlook, Justice Iacobucci's recommendations included enhancing and supporting collaborative crisis response models.

Research suggests mobile crisis response teams decrease unnecessary hospital visits, although not all studies support this claim. For example, a 2016 study found that a live, embedded mobile crisis response team in Ontario reduced emergency department visits, a finding that has been affirmed in Australia.[3] Studies from the United States and Australia have found that police calls occurring outside the mobile crisis response team's coverage times were much more likely to result in emergency department visits.[4] A 2018 study also found that the number of *Mental Health Act* apprehensions by a mobile crisis response team in Ontario was lower than the number of apprehensions by traditional police intervention when only involuntary transports were considered.[5] Research from Australia in 2019 found that most (67.2 per cent) of the individuals who interacted with a mobile crisis response team remained out of hospital and only a few (12.2 per cent) presented at hospital within two weeks of the crisis intervention.[6] A 2015 study of a co-response model in the United Kingdom demonstrated a decrease in police-hospital detention rates during the team's operating hours.[7] However, two studies from the United States in 1995 and 2018 did not show a reduction in emergency department visits associated with mobile crisis response teams.[8] One possible explanation for these findings is the availability of community resources and supports that are essential in reducing hospitalization.[9]

Mobile crisis response teams may also reduce criminal justice system involvement. Studies from the United States have found that mobile crisis response team interactions rarely resulted in arrests and successfully diverted individuals from the criminal justice system.[10] Further American research on these teams in 2016 revealed improved relations between police partners and individuals experiencing a crisis, and better utilized police resources.[11] Studies have also demonstrated that mobile crisis response teams may reduce use of force encounters and decrease injuries to clients.[12]

Clients seem to prefer mobile crisis response teams to a traditional police-only response. An Australian study from 2017 found that clients whose involuntary hospitalization was connected with a mobile crisis response team had more favourable views of procedural justice than

those who were apprehended by police officers alone.[13] However, both groups of clients had equal perceptions of coercion by police, which the authors suggest may have been due in part to the involuntary admission process. Research on three mobile crisis response teams in Ontario in 2010 found that individuals who interacted with the teams had more confidence in service provision, more favourable experiences in emergency departments, decreased justice system contact and decreased time in hospital.[14] Individuals who had interacted with a mobile crisis response team in a 2017 Ontario study perceived the team to be more competent in de-escalation and mental health knowledge than clients who interacted with police only.[15] Research from the United States found both clients and family members viewed the mobile crisis response team interaction and follow-up services favourably (the caregivers more so than the clients).[16]

While it is encouraging that clients prefer interacting with a mobile crisis response team than police only, these studies did not examine whether clients would have preferred a civilian response. At an operational level, multiple studies have indicated that marked police vehicles and police uniforms may be distressing and stigmatizing to clients.[17]

Although the existing literature is positive, the lack of consistent measured outcomes and local variability make it difficult to compare studies and types of mobile crisis response models. [18] Furthermore, the studies do not all examine the operational details of the model being used.[19] Lastly, hospital and criminal justice system diversion rates could be significantly impacted by the availability of local community-based supports.[20] It is currently unclear what components of a mobile crisis response model might promote a certain outcome, such as a decrease in emergency department visits or improvement in the clients' experiences. This framework suggests that consistent data be collected by all mobile crisis response teams in Ontario, so that the outcomes of each team can be evaluated and support the development of evidence-informed approaches.

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