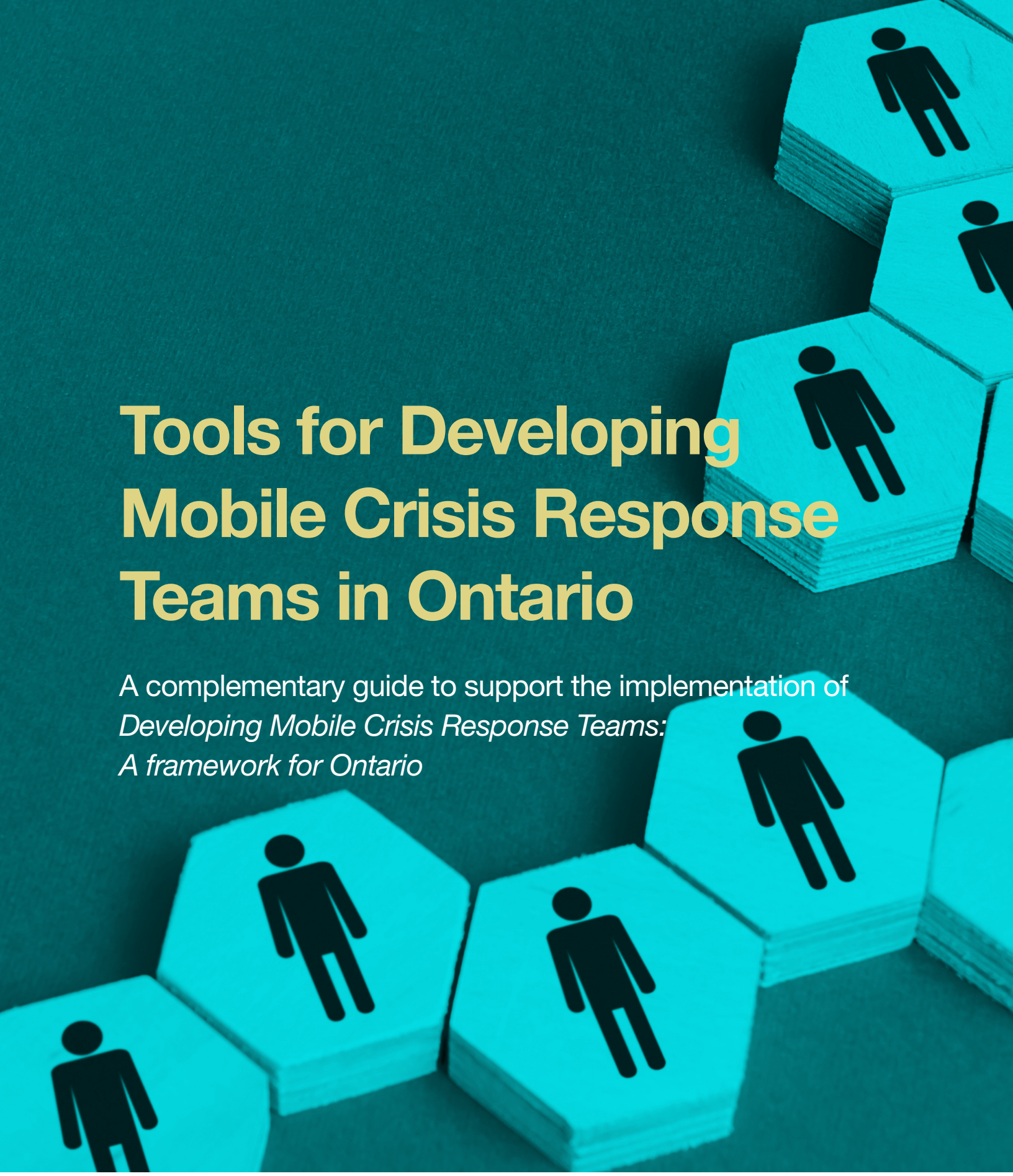

# Tools for Developing Mobile Crisis Response Teams in Ontario

A complementary guide to support the implementation of *Developing Mobile Crisis Response Teams: A framework for Ontario*

HSJCC Human Services & Justice Coordinating Committee

O.P.P.

Canadian Mental Health Association Ontario

Ontario Association of Chiefs of Police 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

We would like to express our gratitude to all the members of the Mobile Crisis Response Teams Provincial Working Group for their advice and guidance in the development of this framework. The Provincial Working Group Task Force met bi-weekly over the course of a year to develop the background and structure of this document, share existing resources and best practices, and write and edit the framework itself. The advisory and consultation team provided invaluable guidance and expertise throughout the development and review of this document.

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# Consultations

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Addictions and Mental Health Ontario
Association of Black Law Enforcers
Canadian Mental Health Association Branches: Elgin-Middlesex; Grey Bruce; Haliburton, Kawartha, Pine Ridge; Kenora; Lambton Kent; Muskoka-Parry Sound; Niagara; Peel Dufferin; Thunder Bay
Centre for Innovation in Peer Support
Children's Mental Health Ontario
Community Living Dryden-Sioux Lookout
Community Networks of Specialized Care
Council of Consumer/Survivor and Family Initiatives
Dr. Kaitlyn McLachlan, Department of Psychology, University of Guelph
Empowerment Council
Fred Victor
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 Heath
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

# Overview

The following tools and resources have been developed as a complementary guideline to support the implementation of *Developing Mobile Crisis Response Teams: A Framework for Ontario*.

These tools and resources were developed based on existing promising practices in Ontario. Their use is not mandatory, but intended to help police services, hospitals and community mental health and addictions organizations comply with legal requirements (as found in Ontario's mental health, human rights, policing and privacy legislation) and best practices. These tools can be tailored to the specific needs of local communities.

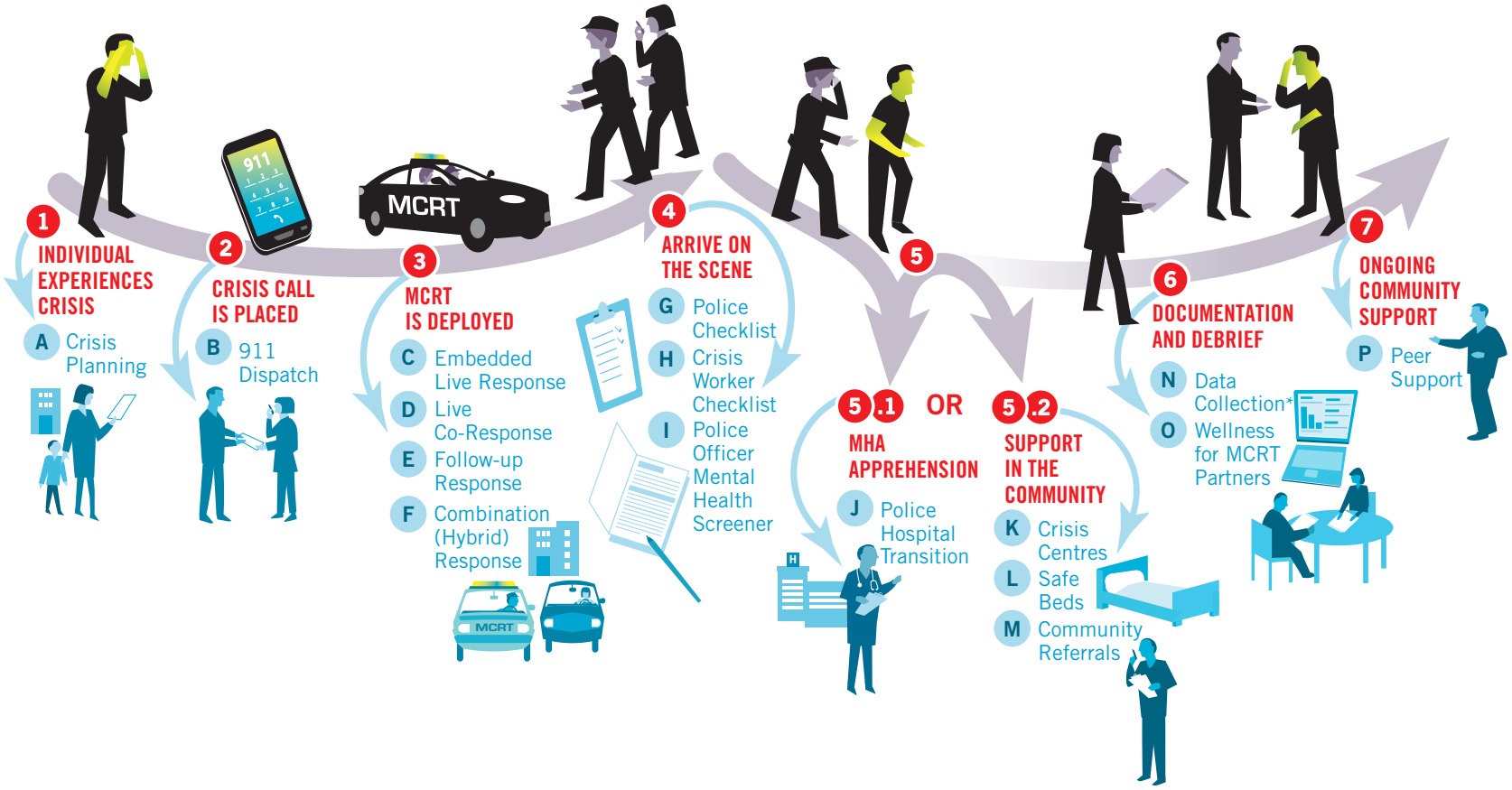
# Table of contents

Tool 1

# Stages of a mobile crisis response

## STAGES OF A MOBILE CRISIS RESPONSE TEAM INTERACTION

Police Officer and Crisis Worker Teams




* Appropriate timing of data collection may vary (e.g. on scene and/or during a follow-up call).

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 MOBILE CRISIS RESPONSE 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.

### 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 911 DISPATCH *

If crisis lines are not available within a community, or a police response is required, then 911 may be called for help. Where available, mobile crisis response teams (MCRTs) may be dispatched to assist the individual experiencing the crisis.

### 3 MCRT IS DEPLOYED*

MCRTs include a police officer working alongside a crisis worker, responding to an individual experiencing a crisis. MCRTs generally arrive on the scene after the area has been made secure. The MCRT assesses the individual experiencing the crisis and refers them to the appropriate place in the community for care, whether it is a hospital or a community-based mental health and addictions service provider.

### C EMBEDDED LIVE RESPONSE*

The crisis worker and police officer are co-located and attend 911 immediate calls for police service in the same vehicle.

### D LIVE CO-RESPONSE*

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.

### E FOLLOW-UP RESPONSE*

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.

Typically, the police officer and the crisis worker ride together in a police vehicle. This model may occur in conjunction with the embedded live response model or the live co-response model, or as a stand alone model.

### F COMBINATION (HYBRID) RESPONSE*

The model types identified above may be combined to create unique hybrids. These combination models are responsive to the communities and populations they serve and can continue to adapt as needs change.

### 4 ARRIVE ON THE SCENE*

The police officer will enter the scene first and determine when it is safe for the crisis worker to enter. Once on the scene, both partners will work together to de-escalate the crisis situation and determine appropriate next steps.

### G POLICE CHECKLIST

For an example of a checklist police officers can follow at the scene of a crisis, see ***Tools for Developing Mobile Crisis Response Teams in Ontario,*** available at ***www.hsjcc.on.ca***

### H CRISIS WORKER CHECKLIST

For an example of a checklist crisis workers can follow at the scene of a crisis, see ***Tools for Developing Mobile Crisis Response Teams in Ontario,*** available at ***www.hsjcc.on.ca***

### I POLICE OFFICER MENTAL HEALTH SCREENERS

Provide police officers with a tool to assist in identifying persons experiencing a mental health and/or addictions crisis. These tools enable police officers to record their observations about the individual experiencing the crisis and articulate their observations to appropriate health care professionals.

### 5.1 MHA APPREHENSION*

Under the *Mental Health Act* (MHA), police officers have the responsibility to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. The police officer remains with the individual until transfer of custody to the hospital occurs.

### J POLICE-HOSPITAL TRANSITION

In 2019, the Ministry of the Solicitor General and Ministry of Health jointly endorsed ***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. For more information including privacy considerations, please see ***Tools for Developing Police-Hospital Transition Protocols in Ontario,*** available at
https://hsjcc.on.ca/our-work/projects/police-hospital-transition-framework/

**OR**

### 5.2 SUPPORT IN THE COMMUNITY*

One of the goals of MCRTs is to divert individuals from unnecessary hospital emergency department visits and reduce pressures on the health care system. If the individual does not appear to represent a danger or threat to themselves or others, based on the observations of both the police officer and the crisis worker, the individual would not be appropriate for hospital admission under the *Mental Health Act*. Instead, the individual can be safely and effectively supported in the community. 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.

### K CRISIS CENTRES

Where available, community crisis centres provide short-term, voluntary, community-based intensive care and treatment. 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.

### L SAFE BEDS

Safe bed programs offer short-term community accommodation to persons experiencing a mental health and/or addictions crisis, and some are designated for referrals from police officers or MCRTs. Both safe beds and crisis centres allow individuals to be safely stabilized and supported in the community.

### M COMMUNITY REFERRAL*

The MCRT partners 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. For more information call **1-866-531-2600** or visit **www.connexontario.ca**

### 6 DEBRIEF AND DOCUMENTATION*

At the end of a shift, MCRT partners are 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.

### N DATA COLLECTION*

Data can help police and health care professionals improve service delivery, demonstrate the effectiveness of a mobile crisis response 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.

### O WELLNESS FOR MCRT PARTNERS*

Periodically or after a noteworthy MCRT engagement, the partners 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 police officers and 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.

### P 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.

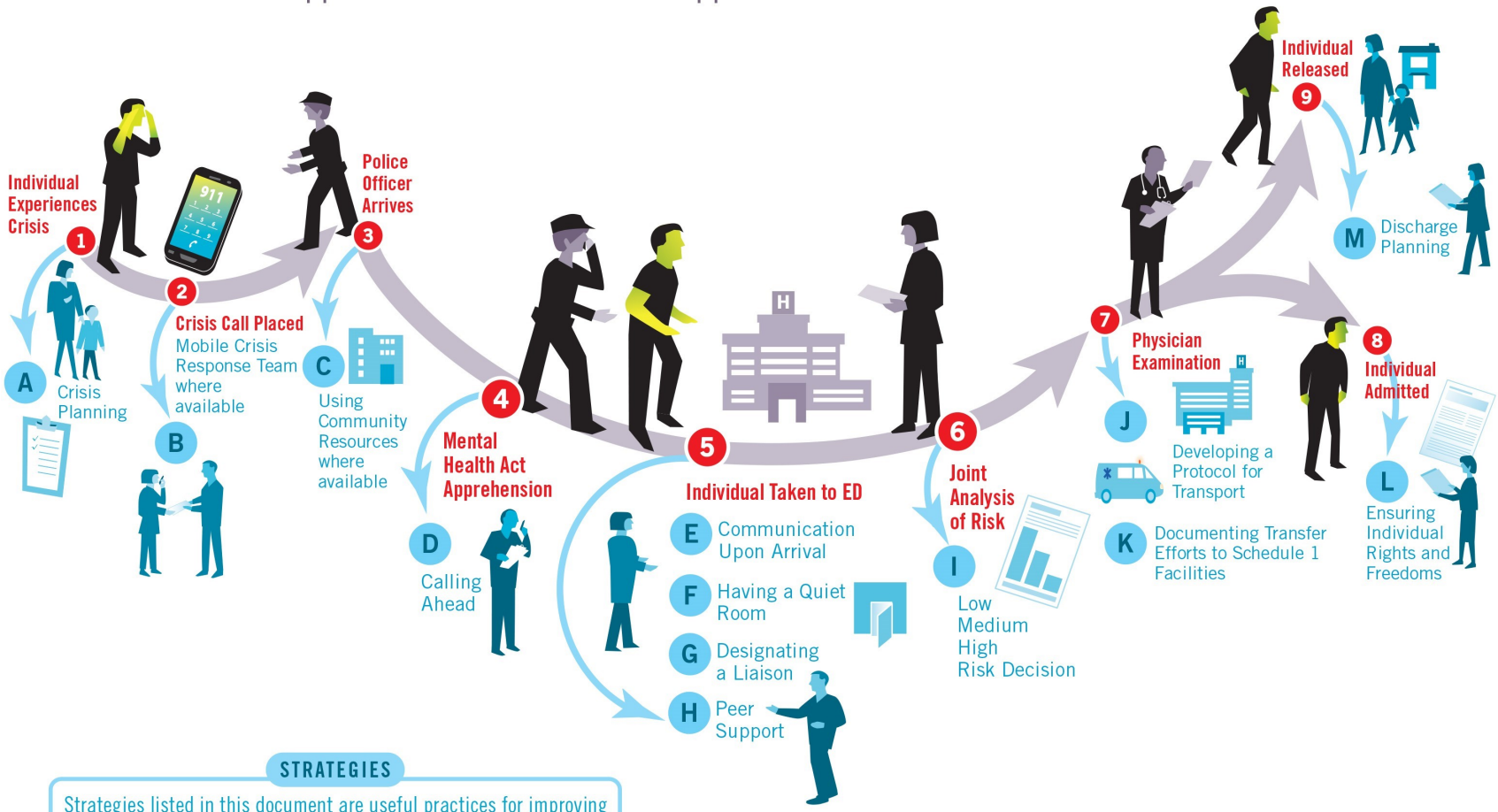
*See **Key Privacy Considerations for Mobile Crisis Response Teams** in ***Tools for Developing Mobile Crisis Response Teams in Ontario,*** available at **www.hsjcc.on.ca.**

Tool 2

# Stages of a police hospital transition

This diagram is part of Improving Police-Hospital Transitions: A Framework for Ontario and Tools for Developing Police-Hospital Transition Protocols in Ontario. It outlines the steps taken when an individual is apprehended under the *Mental Health Act*. At Step 2, it is recommended that a mobile crisis response team respond to a crisis call where available. For more information, please visit https://hsjcc.on.ca/our-work/projects/police-hospital-transition-framework/

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




**STRATEGIES**

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

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

Artwork by Rose Zgodzinski
For more information please visit **www.hsjcc.on.ca**

**Addictions, Mental Health, and Problem Gambling Treatment Services**
**Available 24/7:** 1-866-531-2600
www.connexontario.ca

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tool 3

# Funding proposal

This is a business case template that can demonstrate to funders how an investment in mobile crisis response will benefit the community. Local data that demonstrates the need for investment in crisis response can help strengthen any business case.[1]

## Purpose

<<Include high level and general purpose of the mobile crisis response team. This could include the goals and objectives of the partnership/program, the type of model being proposed, such as live embedded response model, live co-response model, follow-up model, or a combination model.>>

<<Include the need for continued investment to focus on care improvements in a number of areas. Consider including local and regional health and community safety priorities in brief.>>

## Partners

<<Include key stakeholder partners who will work together to implement the MCRT.>>

<<Include community engagement process and the initial partners included in preliminary discussions, consultations and/or needs assessment.>>

## Previous state

<<This section is to be used if there is a current MCRT in the community that will be enhanced. Include data on the current MCRT and highlight the positive outcomes/results of the team. Only include de-identified or aggregate information. Personal information and personal health information shall not be included.>>

## Current state and demonstrated need

<<This section is to be used to demonstrate changes needed to enhance the previous state if building on an existing MCRT, or as a stand-alone section to demonstrate gaps in services if this is a new team.>>

<<Include data to support the need for enhancing an existing team or creating a new team. The data must be limited to de-identified or aggregate information. Personal information and personal health information shall not be included.>>

<<Indicate the need for additional funding to meet the identified need.>>

## The model

<<Describe the model and use visuals to showcase how the model works in practice.>>

## Scope of service

<<Recommend providing a table of “in scope” and “outside scope” services.>>

*This funding proposal template is based on one provided by the Ministry of Health and adapted by the Ontario Provincial Police (2020).*

1 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).

Tool 4

# Memorandum of understanding (MOU)

This tool is a template for Ontario communities to use to assist with establishing a mobile crisis response team between a police service and a mental health and addictions partner. Communities can adapt and change this template to meet their local needs using available resources. It is recommended that the service or agency's own legal counsel review this document. The purpose of this MOU document is to clearly outline the role and scope of the mobile crisis response team, including the team's objectives and key contact information for matters relating to mobile crisis response teams. A memorandum of understanding does not supersede legal obligations and requirements under applicable privacy legislation.

## <<Insert name of community>> MOBILE CRISIS RESPONSE TEAM MEMORANDUM OF UNDERSTANDING

### BETWEEN

<<Insert police service here>>
(hereinafter referred to as the "Police Service")

### AND

<<Insert name of mental health and addictions partner>>
(hereinafter referred to as the "Health Partner")

(individually, the "Party" and collectively, the "Parties")

### PREAMBLE

This memorandum of understanding (MOU) has been developed to govern the partnership between Police Service and Health Partner as it relates to the mobile crisis response team. This document will serve to set out the conditions and procedures for the operation of the program, the responsibilities of the partnered services and to regulate the exchange of information between the partnered services.

### WHEREAS …

### AND WHEREAS …

### AND WHEREAS …

*This template was developed by Ontario Provincial Police and Ministry of the Solicitor General, Legal Services Branch, and has been adapted to be applicable for any police service and respective partner.*

# The parties therefore agree to the following:

## 1. Definitions

*Common definitions could include:*

CMHA [or other community partner], crisis, consent [as defined in s. 18 of PHIPA], MCRT, personal health information [as defined in s. 4 of PHIPA], personal information [as defined in MFIPPA and FIPPA], police officer, qualified physician, etc.

## 2. Statutory authorities, duties and responsibilities

- *Police Services Act* ("PSA");
- *Mental Health Act* ("MHA");
- *Personal Health Information Protection Act* ("PHIPA");
- *Freedom of Information and Protection of Privacy Act* ("FIPPA");
- *Municipal Freedom of Information and Protection of Privacy Act* ("MFIPPA");
- *Substitute Decisions Act* ("SDA"); etc.

## 3. Goals and objectives

3.1 *What is the purpose of the MOU? What are the goals and objectives of the partnership/ program? What type of model is being created, for example, live embedded response model, live co-response model, follow-up model, or a combination model?*

3.2 The Parties shall develop and implement any policies, procedures and practices necessary to ensure compliance with this MOU.

## 4. Administration and management

*Who oversees the program? Is the police service providing a dedicated officer to form part of a team? Is the crisis worker stationed at the police service/detachment or vice versa? Is this a large urban community that may require a steering committee and operations management committee? Joint administration of the team is recommended.*

*If there is a requirement for regular meetings (recommended), this should be included here as well.*

## 5. Duties of the Police Service

*Set out the duties and responsibilities of the police officers based on the recommendations in Developing Mobile Crisis Response Teams: A Framework for Ontario.*

*Consider this section as a Schedule which includes where police partners are located, roles and expectations, boundaries, orientation and training.*

## 6. Duties of the Health Partner

*Set out the duties and responsibilities of the crisis workers based on the recommendations in Developing Mobile Crisis Response Teams: A Framework for Ontario.*

*Consider this section as a Schedule which includes where crisis workers are located, roles and expectations, boundaries, orientation and training.*

## 7. Training

*Set out details of any orientation and training that each of the police officers and crisis workers must engage in, including joint training. Initial training prerequisites as well as ongoing training expectations should be specified.*

*For example, Crisis Intervention Training (CIT), Mental Health First Aid for Police, privacy training, orientation for the crisis worker, and police debriefings for officers. See Tool 9, Training and Orientation in this Toolkit for more information.*

## 8. Independent contractor

8.1 This MOU shall not serve to create a partnership, an association, a joint venture, or an employer-employee or agency relationship among the Parties.

## 9. Financial arrangements

9.1 The police officer shall remain an employee of the Police Service during the term of this MOU and shall receive her/his salary and employer paid benefits from the Police Service. The Police Service shall maintain all other employment benefits, including all work-related insurance programs, throughout the duration of this MOU.

9.2 The crisis worker shall remain an employee of the Health Partner during the term of this MOU and shall receive her/his salary and employer paid benefits from the Health Partner. The Health Partner shall maintain all other employment benefits, including all work-related insurance programs, throughout the duration of this MOU.

## 10. Term

*Set out the term of the MOU, and whether or not the MOU may be renewed.*

## 11. Confidentiality and the collection, use, retention and disclosure of information

11.1 The Police Service and the Health Partner shall keep confidential, at all times, any information or documents collected, retained, used or disclosed during the MOU, including any personal information and/or personal health information (collectively "Information or Documents").

11.2 The Police Service and the Health Partner shall take reasonable and necessary steps to securely retain, store and dispose of the Information or Documents in accordance with applicable privacy requirements and best practices.

11.3 The Police Service and Health Partner shall only collect, retain, use and disclose the Information or Documents for the purpose of carrying out the objectives of this MOU in accordance with applicable privacy legislation.

11.4 The Parties acknowledge that, absent a disclosure required by law, each may, at its discretion, refuse to disclose to any person(s) any Information or Documents for any reason including but not limited to:

a. The protection of client/patient personal information, including personal health information;
b. The protection of the confidentiality of a third party's information or informants;
c. The prevention of the interference with, or the disclosure of, law enforcement information, investigations or techniques;
d. Otherwise in accordance with the laws of Ontario.

11.5 The Health Partner shall not disclose personal information, including personal health information, to police officers relating to the clients of MCRT without the express consent of the individual to whom the information relates, except to the extent the disclosure is permitted or required by law.

11.6 Each Party shall take reasonable steps to ensure that only designated crisis workers and designated police officers carrying out duties and responsibilities under the MCRT, and those permitted by law, shall have access to any Information or Documents exchanged in the course of the administration of the MCRT and that access is only provided where it is needed in the performance of those duties and responsibilities and the access is permitted or required by law, including but not limited to PHIPA, MFIPPA and FIPPA.

11.7 The Parties shall each apply their respective standards and/or policies and procedures to the administration, technical and physical safeguarding of Information or Documents exchanged pursuant to the administration of MCRT and the performance of this MOU, provided they comply with PHIPA, MFIPPA, FIPPA, PSA, and other applicable legislation.

11.8 Each Party shall immediately provide notification to the other in the event of any loss, theft or unauthorized access, use or disclosure of personal information and/or personal health information of which Police Service or Health Partner staff may become aware.

11.9 The Parties shall ensure that their respective employees, agents or sub-contractors, if any, to which any personal information and/or personal health information may be disclosed, agree to the same restrictions and conditions to which the Parties are subject under this MOU.

11.10 All Parties acknowledge that during the performance of the MOU, each Party may have access to information of a confidential or proprietary nature of another Party that is provided to the other for the purposes of this MOU (excluding personal information and personal health information), which shall be known as "Business Information." It is essential to the conduct of each Party's business that the Business Information be kept confidential.

11.11 All such Business Information shall be deemed to be and remain the sole property of the Party that produced or generated the same. No Party during the term of this MOU and/or at any time thereafter shall, directly or indirectly, use the Business Information or disclose the Business Information except with the prior written approval of the Party to whom the information belongs or as otherwise authorized by law.

## 12. Professional conduct/conflicts of interest

12.1 It is understood that this MOU shall apply in accordance with the applicable rules of ethics, professional conduct and conflicts of interest.

## 13. Intellectual property

*If there are resources and/or documents to be created that will become the property of the Police Service, Health Partner or the MCRT jointly through this MOU, consider including the following paragraph:*

13.1 All intellectual property developed in accordance with this MOU shall be the property of the Parties named in this MOU.

## 14. Equipment

*If there will be equipment purchased/leased/loaned or supplied, set out the details here.*

*A full funding-sourced budget, including equipment, should be accompanied as a Schedule (see Tool 6,* **Budget Template** *in this document as an example).*

14.1 All safety equipment for the crisis worker will be determined within the MOU and will remain the cost responsibility of the Health Partner employer to ensure the safety of their employee.

14.2 Any information or communications-related services or equipment chosen for use by members of the MCRT must incorporate features that protect the privacy, confidentiality and security of the Information or Documents collected, accessed, used, disclosed, retained or transferred using the services or equipment, including through the use of encryption and password protection.

## 15. Representatives

*Include names and contact details of the Representatives of each Party for the purpose of the MOU.*

## 16. Insurance/indemnification

16.1 Each Party is responsible for any damages caused to the equipment or facilities of the other Party.

16.2 Each of the Parties will provide immediate notice in writing of any tribunal or legal proceeding, which, without limiting the generality of the foregoing shall include:

a. criminal proceedings;

b. civil proceedings; or

c. a fatality inquiry or coroner's inquest which may impact upon any party.

16.3 The Health Partner hereby agrees to indemnify and hold harmless the Police Service from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, (collectively, "Claims"), by whomever made, sustained, brought or prosecuted, including for third party bodily injury (including death), personal injury and property damage, in any way based upon, occasioned by or attributable to anything done or omitted to be done by the Health Partner, its subcontractors or their respective directors, officers, agents, employees or independent contractors in the course of performance of the Health Partner's obligations under, or otherwise in connection with, this MOU. The Health Partner further agrees to indemnify and hold harmless the Police Service for any incidental, indirect, special or consequential damages, or any loss of use, revenue or profit, by any person, entity or organization, including without limitation the Police Service, claimed or resulting from such Claims. The obligations contained in this paragraph shall survive the termination or expiry of the MOU.

## 17. Evaluation

*Consider including details to collect data and measure outcomes.*

*See Tool 12:* **Data Collection Template** *in this document.*

## 18. Dispute resolution

18.1 The parties undertake to foster the resolution of disputes arising from the interpretation or application of this MOU in a spirit of conciliation, co-operation and harmony.

*A conflict resolution plan/process may be attached as a Schedule.*

18.2 In the event of a dispute arising from the interpretation or operation of this MOU, it shall be referred to the Representatives set out above who shall attempt to resolve the matter.

If such negotiation fails, the Parties agree to refer the matter to the Police Service (insert name of appropriate person) and the Health Partner (insert name of appropriate person).

## 19. Termination

19.1 This MOU may be terminated under the following conditions:

a. by any Party, where attempts at dispute resolution pursuant to paragraph 18 above have failed, upon thirty (30) days written notice; or

b. at any time, by any Party, after a ninety (90) days written notice, even if there is no default committed by another Party.

19.2 Termination does not release a Party from any obligations which accrued while the MOU was in force.

## 20. Amendments

20.1 This MOU may be amended by the mutual consent of the Parties. In order to be valid, any amendments to this MOU must be made in writing, dated and signed by the Parties.

## 21. General

21.1 This MOU shall be governed by and interpreted in accordance with the laws in force in Ontario.

21.2 Should any provision of this MOU be declared null, void or inapplicable by a competent court, all other provisions of this MOU not related to the provision declared null, void or inapplicable shall retain full force and effect; moreover, the Parties agree to remedy such nullity, invalidity or inapplicability as soon as possible so that this MOU's objectives can be achieved.

## 22. Notice

22.1 Any notice, request, information or any other document required with respect to this MOU shall be deemed to be served if mailed or transmitted by fax or electronic mail. Any notice sent or transmitted by fax shall be deemed to have been received one business day after it was sent; any mailed notice shall be deemed to have been received five (5) business days following its mailing.

22.2 All correspondence shall be sent to the following:

| For the Police Service: | For the Health Partner: |
| --- | --- |
| Attention: | Attention: |

22.3 Each Party shall notify the other Parties in writing of any change of address or phone number.

Tool 5

# Steering Committee terms of reference

This tool is a template for Ontario communities to assist with establishing a steering committee to support the development of a mobile crisis response team. Communities can adapt and change this template to their local needs using available resources. Larger communities may benefit from additional guidance beyond their operational partners, while this may not be necessary in a smaller community. The purpose of this terms of reference document is to clearly outline the role and scope of the steering committee, including the committee's objectives, membership, frequency of meetings and key contact information.

*This template is based on the terms of reference developed by the Toronto Mobile Crisis Intervention Team Steering Committee (2019).*

## <<insert community name>> Mobile Crisis Response Team Program Steering Committee Terms of Reference

### Background

The mobile crisis response team (MCRT) is a collaborative partnership between participating <<Health Partner(s), Police Service(s) and Funders [Legacy Local Health Integration Network (LHIN)/Ontario Health (OH) Region/Grant]>>. The program partners a crisis worker and a specially-trained police officer to respond to situations involving individuals experiencing a mental health and/or addictions crisis.

### Mandate

The MCRT steering committee was established to build opportunities for Health Partners, Police Services, Funders, clients/family representatives and community service providers to work together to support persons experiencing a mental health and/or addictions crisis and their families. There is recognition that this support benefits the individual, their family/loved ones and the broader community while promoting effective utilization of justice and health systems resources.

The goals of the steering committee are to:

- Ensure the MCRT remains responsive to the needs of clients experiencing a crisis and their families and contributes to system planning for health care
- Oversee co-ordinated, standardized program delivery in all areas of the community
- Ensure the MCRT protects the privacy, confidentiality and security of the personal information and personal health information of clients and families
- Review robust and timely analysis and reporting of outcome focused de-identified and aggregate data to inform strategic and operational decision making

There is fundamental recognition by the Funders, Police Service and Health Partner that each will respect their independent priority-setting and operational processes. While respective priorities will be established separately and independently, the Steering Committee will identify strategic alignments so the MCRT services operate as a program across multiple sites (if relevant) and synergies are identified to improve service stability and outcomes.

## Terminology

Include definitions from *Developing Mobile Crisis Response Teams: A Framework for Ontario*.

## Membership

The steering committee may be composed of members who represent the following key stakeholder groups:

- Health Partner
  - Chief Executive Officer
  - Mental health and addictions program or crisis services director
  - Mobile crisis response team project manager
  - Funder
  - Privacy office
- Legacy LHINs/OH Regions, etc.
- Police Service
  - Command or senior leadership or designate
  - MCRT champions (for example, community service officer)
  - Privacy office
- Persons with lived experience
- Other community partners (community mental health and addictions organizations, hospitals, housing supports, shelters, safe bed programs, children and youth programs, older adult programs, organizations serving Indigenous, Black and/or racialized clients, organizations serving clients with neurodevelopmental disabilities and other conditions, peer support programs, crisis centres, settlement services, etc.)
- Police-hospital committee members
- Community safety and well-being planning advisory committee members

## Co-Chairs

The steering committee will be co-chaired by the Health Partner and Police Service executive leadership.

## Meetings

Meetings will be held as required, but not less than once per quarter. Meetings will take place in person or by video conference when necessary. As a general rule, discussions at meetings must not include, or refer to, mobile crisis response team clients in a manner that could identify a client unless the client has previously provided their express consent or the disclosure is otherwise permitted or required by law.

## Minutes

The minutes from each meeting will be distributed by the MCRT project manager for referring purposes only. Minutes must not include any personal information or personal health information.

## Accountability

The steering committee is accountable to the Funders. The steering committee will engage the community (provider and public) consistent with the Funder's community engagement guidelines.

## Deliverables

The MCRT steering committee will work to identify initiatives and opportunities to align services in response to the needs of individuals experiencing a crisis. The MCRT steering committee will identify strategic and operational issues that impact MCRT services to clients and may identify sub-groups to conduct further work on these issues as necessary.

The steering committee will ensure the MCRT protects the privacy, confidentiality and security of clients' personal information or personal health information. On an ongoing basis, members of the MCRT steering committee will exchange de-identified or aggregate information, including on mutual priority populations. Personal information and personal health information shall not be exchanged for this purpose.

The MCRT steering committee will create a lasting strategic partnership between Police Service, Health Partner, Funders, hospitals, community mental health and addictions service providers and clients/persons with lived experience.

## Review date

The terms of reference will be reviewed every [insert timeline here].

## Evaluation

Personal information and personal health information shall not be exchanged for this purpose. The MCRT steering committee will evaluate performance against the stated deliverables/ outcomes annually and determine any adjustments or refinements as necessary. The evaluation process will only involve the use of de-identified or aggregate information. Personal information and personal health information shall not be used or disclosed in the evaluation process.

Tool 6

# Budget template

| Health partner costs | Type | Amount |
|---|---|---|
| Salaries, benefits & expenses for 2.0 FTE:<br>• Crisis worker (2.0 FTE) @ $ each | Ongoing | |
| Communication & information technology (laptops, phones, printer, software, etc.) | One time | |
| Communication & information technology (internet, phone plans, etc.) | Ongoing | |
| Administration (rent, ancillary admin services, supplies, etc.) | Ongoing | |
| Uniform, vests and other safety equipment for mental health and addictions partner | One time | |
| Training | Ongoing | |
| **Police partner costs** | **Type** | **Amount** |
| Police partner costs<br>Salaries, benefits & expenses for 2.0 FTE:<br>• Police constable (2.0 FTE) @ $ each | Ongoing | |
| Communication & information technology (laptops, phones, printer, software, radios) | One time | |
| Communication & information technology (computer, internet, phone plans, etc.) | Ongoing | |
| Administration (rent, ancillary admin services, supplies, etc.) | Ongoing | |
| Vehicle | One time | |
| Vehicle (fuel, maintenance, insurance) | Ongoing | |
| Uniform and vests for police partner | One time | |
| Other equipment | One time | |
| Training | Ongoing | |
| | TOTAL ONE-TIME | |
| | TOTAL ONGOING | |

Tool 7

# Job descriptions

These job descriptions are examples that may be tailored to meet the needs of any mobile crisis response team that is hiring new staff.

*Both job descriptions were developed by York Regional Police (2019).*

## MCRT Officer Job Qualifications

Beyond the regular duties of a front-line police officer, the mobile crisis response team officer must also be able to demonstrate the following competencies and qualifications necessary to respond to calls for service to assist individuals experiencing a mental health and/or addictions crisis.

### Position requirements:

- Co-operate with a crisis worker to assist front-line officers at calls for service to manage crisis situations involving mental health and/or addictions
- Work with a crisis worker to review calls for follow-up to provide resources and crisis management planning (depending on the model)
- Ensure the safety and security of the crisis worker at all times
- Successfully completed a Crisis Intervention Training course or equivalent
- Be familiar with signs and symptoms of mental illnesses, addictions, substance use and neurodevelopmental disabilities
- Be conversant with verbal communications, interpersonal skills and de-escalation techniques

### Desirable qualifications:

- Ability to work independently
- Ability to multi-task and work in a fast-paced, demanding environment
- Demonstrated proficiency in fostering teamwork and two-way communication
- Strong interpersonal and organizational skills
- Develop and maintain an effective working relationship with internal police units, government agencies and community partners
- Knowledge of mental health and addictions issues, neurodevelopmental disabilities, dementia and social determinants of health
- Familiarity with privacy and confidentiality

# Crisis Worker Job Qualifications

The crisis worker, as part of a team serving the community, is responsible for the provision of community support to individuals, and the family members of individuals, who may be experiencing a mental health and/or addictions crisis situation. The crisis worker is responsible for providing crisis assessment, intervention and stabilization to individuals who have serious mental health, addictions and/or other concerns and, as necessary, link individuals to appropriate ongoing mental health, addictions and/or other services.

## Requirements:

- Relevant education and member of regulatory body, if applicable
- Minimum three years related experience
- Knowledge and practice of short-term urgent response, psychosocial rehabilitation approach and advanced clinical, crisis and assessment skills are essential
- Experience working with individuals living with a serious mental illness, substance use issue, addiction, neurodevelopmental disability, dementia and/or other conditions is essential
- Demonstrated ability to de-escalate crisis situations using trauma-informed and culturally-responsive techniques
- Experience and knowledge of the social determinants of health
- Experience working in collaboration with police and/or other emergency responders to assess and manage appropriate interventions is an asset
- Experience and knowledge of the criminal justice system is an asset
- Knowledge of local mental health, addictions and social service providers is essential, as well as awareness of provincial mental health, addictions and social service systems
- Familiarity with privacy and confidentiality

Tool 8

# Key privacy considerations for mobile crisis response teams

This document was developed by the Information and Privacy Commissioner of Ontario, in collaboration with the Provincial Human Services and Justice Coordinating Committee, and provides guidance with respect to privacy considerations that arise at various stages of a mobile crisis response team interaction involving police officer and crisis worker partnerships. The information in this document is intended for information purposes only. It does not provide legal or medical advice.

## Glossary

- **Crisis worker** – Describes all health care partners on mobile crisis response teams. *Developing Mobile Crisis Response Teams: A Framework for Ontario* encourages regulated health care professionals such as a 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. In most cases, the crisis worker will be a health information custodian or an agent of a custodian, as defined under PHIPA. While this document was developed with a focus on MCRTs that include crisis workers who are subject to PHIPA, the document reflects privacy practices that will generally be useful to crisis workers who are not subject to provincial privacy legislation, including where such workers are deployed within community (non-police) mobile teams.
- **Embedded live response** – A mobile crisis response team model. The crisis worker and police officer are co-located and attend mobile crisis calls in the same vehicle.
- **FIPPA** – The *Freedom of Information and Protection of Privacy Act*.
- **Follow-up response** – 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. For MCRT models, the police officer and the crisis worker ride together in a police vehicle to perform follow-up or wellness checks based on referrals. This model may occur in conjunction with the embedded live response model or the live co-response model, or as a stand-alone model.

- **Live 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.
- **MCRT** – Mobile crisis response team involving police officers and crisis workers.
- **MCRT partners** – Generally includes one police officer and one crisis worker.
- **MFIPPA** – The *Municipal Freedom of Information and Protection of Privacy Act*.
- **PHIPA** – The *Personal Health Information Protection Act*, *2004*.
- **Police officer** – A police officer or other member of a municipal, provincial or First Nations police service who acts as an MCRT partner with a crisis worker, providing police services. References within this document to 'police officer' refer to the police MCRT partner.
- **Provincial privacy legislation** – Refers to PHIPA, FIPPA and MFIPPA.

## Privacy considerations relevant at every stage for both MCRT partners

### The sharing of personal information and personal health information

***Personal information and personal health information:*** Information sharing between MCRT partners concerning an individual believed to be experiencing a crisis will typically involve both the individual's personal information and their personal health information. For example, a police officer's observations about the individual will be the individual's personal information. When the crisis worker collects and uses information for the purpose of providing health care to the individual, the information is the individual's personal health information.

***The statutory framework for information sharing:*** In sharing information, the police officer and the crisis worker must be cognizant of their privacy-related obligations under provincial privacy legislation. This means that an MCRT partner must have the authority to disclose and the other MCRT partner must have the authority to collect and use the personal information and/or personal health information at issue. These obligations generally apply whether the collection, use or disclosure involves oral or recorded information.

In performing MCRT work, personal information and personal health information should generally only be collected, used or disclosed for the purpose of providing the MCRT services and for no other purpose. In addition, even when the MCRT partners are working together providing MCRT services and they have signed a confidentiality agreement, police officers and crisis workers must only share identifying information in compliance with provincial privacy legislation.

***Consent-based information sharing:*** MCRT partners are encouraged to seek the individual's express consent to the sharing of their personal information or personal health information whenever possible. While provincial privacy legislation permits MCRT partners to share personal information and personal health information without consent in order to reduce or eliminate a significant risk of serious bodily harm, an MCRT partners may still seek the individual's consent out of respect for the individual and are encouraged to do so whenever it is practical.

***Information sharing without consent:*** The key privacy provisions that permit police officers and crisis workers to share identifying information for the purposes of delivering MCRT services in the absence of consent are those provisions that relate to the prevention or reduction of a risk of harm. Under section 40 of PHIPA and the comparable "compelling circumstances" provisions found under FIPPA and MFIPPA,[1] MCRT partners may disclose personal information, including personal health information, where there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

A police officer is also permitted to disclose personal information about a person experiencing a crisis to their crisis worker if the disclosure is for a crisis response-related purpose that is the same as or is consistent with the purpose for which the personal information was originally compiled or obtained by the officer. Such "consistent purpose" disclosures are only permitted if the affected individual might reasonably have expected such a disclosure. To the extent that a crisis worker is an employee or agent of a health care provider that is also an institution under FIPPA or MFIPPA (such as a hospital or a board of health), they may also be permitted to make such "consistent purpose" disclosures to their police partner.

Additional collections, uses, or disclosures (for any other purposes), generally require the express consent of the individual to whom the information relates, unless such further collections, uses and disclosures are permitted or required by law.

***Crisis response is a dynamic and fluid process:*** The risk of harm relevant to a particular crisis an individual is experiencing can fluctuate. 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 MCRT partners should consider whether is it 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 crisis 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, or the crisis worker should refrain from further discussions involving personal health information.

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1 Under sections 42(1)(h) of FIPPA and 32(h) of MFIPPA, a police officer may disclose personal information to the crisis worker partner in "compelling circumstances affecting the health or safety of an individual." Before disclosing personal information for health or safety reasons, the officer must be satisfied that:

- there are compelling concerns about an individual's health or safety, having considered:
  - the likelihood of the harm occurring
  - the severity of the harm
  - how soon the harm might occur and
- the disclosure is reasonably likely to reduce the risk of harm to the individual if the police officer decides to disclose

The police officer should limit the disclosure to the information relevant to reducing the risk. Note that, after disclosing personal information under section 42(1)(h) of FIPPA or section 32(h) of MFIPPA, a police officer must make reasonable efforts to provide written notice of the disclosure to the affected individual (in person or at their last known address).

***Universal data minimization requirements:*** Throughout, crisis workers must generally comply with the limiting principles set out in section 30 of PHIPA. Section 30 generally requires that no personal health information be collected, used or disclosed if other information will serve the purpose and that no more personal health information be collected, used or disclosed than is reasonably necessary to meet the purpose. Similar limiting principles also apply to the collection, use and disclosure of personal information by police officers under FIPPA and MFIPPA. In addition, reasonable care should be taken by both the police officer and the crisis worker to ensure that information sharing is limited to information that is as accurate, complete and as up-to-date as possible.

## Protecting personal information and personal health information once it has been collected

Provincial privacy legislation requires that MCRTs take reasonable steps to ensure that personal information or personal health information in their custody or control is protected against theft, loss and unauthorized collection, use and disclosure, and that the records containing the information are protected against unauthorized copying, modification or disposal. MCRTs must also ensure that records of personal information or personal health information are retained, transferred and disposed of in a secure manner.

The handling of paper and electronic records must be done in a manner that complies with the partners' respective standards and/or policies and applicable legislation with regards to the administrative, technical and physical safeguarding of information contained, stored or transmitted in these formats.

***The use of mobile devices:*** Mobile devices, such as smartphones, tablets, laptops and USB keys have added a new layer of complexity to this task. The great advantage of these devices – portability – is also their greatest vulnerability, making them susceptible to loss and theft.

For that reason, personal information and personal health information should only be stored on mobile devices if necessary, and even then, the MCRT partners must take steps to minimize the risks to privacy. MCRT partners should consider whether personal information or personal health information really needs to be stored on the device and whether there are alternatives to storing such information on the device (such as retaining the information in de-identified form). If it is necessary to store personal information or personal health information on the device, ensure the information is encrypted and password protected. Additionally, the MCRT partners should store the least amount of information possible, for the shortest amount of time.

***Privacy breaches:*** Any privacy breach, or suspected breach, involving personal information or personal health information must be reported to the respective employer at the earliest opportunity. At the earliest opportunity, the respective agencies must also provide breach notification to each other in accordance with the applicable memorandum of understanding. A privacy breach includes, but is not limited to, the theft, loss or unauthorized collection, use or disclosure of personal information or personal health information and the unauthorized copying, modification or disposal of this information.

## Privacy considerations for each stage of a MCRT response

Please refer to **Tool 1 - Stages of a mobile crisis response team interaction** - Police officer and crisis worker teams

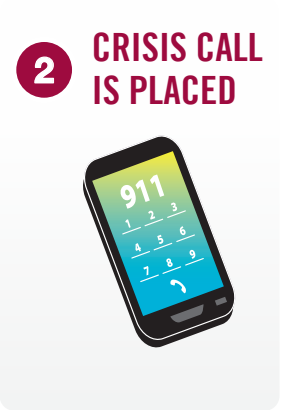
### *Before the crisis call*

In some embedded MCRT models, crisis workers and police officers may overhear or view communications which may involve the personal information or personal health information of individuals not related to an MCRT call. Even where a dispatch is MCRT-related, a crisis worker may be exposed to additional information beyond what is necessary for a crisis response (e.g. prior arrests, warrants, etc. that are not relevant to the crisis call). Similarly, police officers may be exposed to additional information should crisis workers need to discuss MCRT cases or other unrelated cases with their home agencies while sharing office space with police.

## SPECIFIC PRIVACY CONSIDERATIONS BEFORE THE CRISIS CALL

One MCRT partner should not disclose personal information or personal health information that is unrelated to, or not necessary for, a crisis response to the other MCRT partner. In addition, the MCRT partners should not collect or use unrelated or unnecessary information. Reasonable steps should be taken by the MCRT partners to prevent each other from overhearing or viewing personal information or personal health information that is unrelated to, or not necessary for, a crisis response.

## Crisis call is placed (Stage 2)




### *Embedded live response*

Both the police officer and the crisis worker may hear the incoming crisis-related dispatch call, discuss the crisis situation and the individual experiencing the crisis, and begin to plan and prepare to respond together in the same vehicle. Even where a dispatch is MCRT-related, a crisis worker may be exposed to additional information beyond what is necessary for a crisis response (e.g. prior arrests, warrants, etc. that are not relevant to the crisis call). Similarly, police officers may be exposed to additional information should crisis workers need to discuss MCRT cases or other unrelated cases with their home agencies while sharing office space with police.

### *Live co-response*

Only the police officer hears the crisis-related dispatch call. The police officer provides the crisis worker with necessary information about the crisis situation and the individual experiencing the crisis.

### *Follow-up*

Either the police officer or the crisis worker may receive a referral request for a non-urgent follow-up or wellness check on the individual from another officer or crisis worker. The referral may be transmitted verbally, via encrypted email, by telephone or through a secure application as vetted by both partners (such as RMS Task in Niche/RMS, Health IM/interRAI).

Referrals for a non-urgent follow-up or wellness check on the individual may also come from other sources such as concerned family members or someone in the community (by telephone) or in writing (by email) from sources such as other crisis workers or service providers. Wellness checks may also be conducted proactively, for example on the anniversary of a known trigger date.

## SPECIFIC PRIVACY CONSIDERATIONS AT STAGE 2

### *Embedded live response and live co-response*

In the absence of the consent of the individual to whom the information relates, or other lawful authority, police officers should not disclose personal information to crisis workers that is unrelated to, or not necessary for, a crisis response, and crisis workers should not collect or use this information. Similarly, crisis workers should not disclose personal health information to police officers that is unrelated to, or not necessary for, a crisis response, and police officers should not collect or use this information. Reasonable steps should be taken by the MCRT partners to prevent each other from overhearing personal information or personal health information that is unrelated to, or not necessary for, a crisis response.

### *Follow-up*

Since follow-up and wellness checks generally do not involve crisis situations, provincial privacy legislation provisions that allow for the sharing of personal information or personal health information in situations involving a significant risk of serious bodily harm will likely not apply. Therefore, prior to proceeding, police officers and crisis workers should generally obtain the express consent of the individual in order to share that individual's personal information or personal health information with their MCRT partner. For example, where a crisis worker receives a referral for a follow-up or wellness check, the crisis worker should speak to the individual and ask for their consent to share any personal health information with the police officer before doing so.

## MCRT is deployed (Stage 3)


### *Embedded live response*

Traveling in the same vehicle as the police officer, the crisis worker may be privy to overhearing and/or viewing other radio and/or computer-aided dispatch communication.

### *Live co-response*

En route to the crisis, the crisis worker (traveling alone) may contact their own agency or the officer to seek additional relevant information related to the individual experiencing the crisis to prepare for the interaction.

### *Follow-up*

Generally, when necessary and in the absence of other appropriate resources, both MCRT partners may attend a follow-up or wellness check together in the same vehicle. However, when appropriate and safe to do so as per the crisis worker's own agency policy and procedure, the crisis worker may conduct the follow-up or wellness visit independently of the police.

## SPECIFIC PRIVACY CONSIDERATIONS AT STAGE 3

### *Embedded live response and live co-response*

Since the possibility of overhearing some unrelated or unnecessary information may be inevitable in some cases (for example, while in the same vehicle during an embedded live response), it is critical that members of an MCRT conduct themselves with the utmost discretion, consistent with the requirements set out in the applicable confidentiality agreements and memoranda of understanding. This includes complying with statutory duties not to create a written record of or use or disclose personal information or personal health information that the MCRT partners are prohibited from collecting.

### *Follow-up*

Police officers and crisis workers should generally obtain the express consent of the individual in order to share that individual's personal information or personal health information with their MCRT partner. Assuming that express consent is provided, these disclosures would also be subject to data minimization requirements. Disclosures must be kept to the minimum amount of personal health information necessary for the purpose and personal health information should not be disclosed where other information will serve the purpose. The same steps should be followed by a police officer who receives a referral for a follow-up or wellness check.

## Arrival on the scene (Stage 4)

### *Embedded live response*

The MCRT partners will jointly assess the situation, confer together and communicate with the individual, others at the scene and/or others away from the scene (such as police dispatch, other police officers, firefighters, paramedics, people familiar with the individual, residents).


### *Live co-response*

On arrival of the crisis worker, the MCRT partners will further assess the situation, confer together and communicate with the individual, others at the scene and/or others away from the scene (such as police dispatch, other police officers, fire fighters, paramedics, people familiar with the individual, residents).

### *All models*

MCRT efforts and decision making (assessing risk, de-escalating the situation and planning an effective resolution to the crisis call) are generally conducted jointly except where the circumstances or the function being performed dictate otherwise.

## SPECIFIC PRIVACY CONSIDERATIONS AT STAGE 4

Crisis workers and police officers should be aware of the risk that bystanders or other third parties present at the scene may overhear MCRT discussions that involve personal information and/or personal health information. MCRT partners should take reasonable steps to protect

the privacy of the individual involved. This may include asking bystanders to move back or consider leaving the scene. However, where the police officer or crisis worker believes that the disclosure of personal information or personal health information is necessary to reduce or prevent a significant risk of serious bodily harm, provincial privacy legislation permits the disclosure to any person it would be reasonably necessary to inform, including a family member, friend or other individual.

It is critical that crisis workers and police officers be aware that if the risk of harm has been reduced or eliminated, the consent of the individual is generally required to share their personal information or personal health information any further. Accordingly, once it is safe to do so, the MCRT partners should discuss whether it is necessary for the police officer to hear further discussions with the individual. If it is not necessary, the crisis worker should, with the police officer's assistance, determine whether it may be possible for the crisis 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 if safe to do so, or the crisis worker should refrain from further discussions involving personal health information.

## Mental Health Act apprehension (Stage 5.1)


Under the *Mental Health Act*, police officers have the authority to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department.

### *Embedded live or follow-up response*

Typically, when a *Mental Health Act* apprehension occurs, the individual experiencing the crisis will be transported by ambulance and/or police officers only. However, depending on geography or circumstances, the police officer, the crisis worker and the individual experiencing the crisis may travel in the same police vehicle to the appropriate health care facility.

### *Live co-response*

The police officer and crisis worker travel in separate vehicles. If an apprehension occurs, the individual experiencing the crisis will be transported by ambulance and/or police vehicle. Depending on the situation, the crisis worker may be asked to meet the transporting party at the health care facility. Otherwise, the crisis worker will be cleared to leave the scene and attend to other work.

### *All models*

En route and/or upon arrival at the health care facility, one or both MCRT partners will share relevant information with the health care facility staff. For example, police officers may assist with knowledge transfer to hospital or community support or advocate on behalf of the apprehended person to obtain medical treatment.

## SPECIFIC PRIVACY CONSIDERATIONS AT STAGE 5.1

In the course of transporting an individual apprehended under the *Mental Health Act* to a health care facility and transferring custody of that individual over to the facility, police officers may disclose relevant information about an individual's demeanor, behaviour and circumstances to appropriate staff at the health care facility. For more information and guidance about privacy issues associated with police-hospital transitions in the context of *Mental Health Act* apprehensions, see the provincial police-hospital transition framework and toolkit documents.

In the same context, crisis workers may share relevant personal health information with health care facility acute care teams and/or assist at the health care facility if an apprehension is made. This is permitted under PHIPA if there is an ongoing need to reduce or eliminate a significant risk of serious bodily harm to a person or group of persons.

Where there is no such risk, PHIPA permits health care providers to disclose personal health information to certain other health care providers if the disclosure is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the individual's consent in a timely manner. In this case, however, any disclosure would be subject to applicable lock box instructions.[2]

Further, where the individual is being transported to a psychiatric facility within the meaning of the *Mental Health Act*, PHIPA allows the crisis worker to disclose personal health information to the officer in charge to assist in making certain decisions, such as arrangements for the provision of health care.

### Support in the community (Stage 5.2)

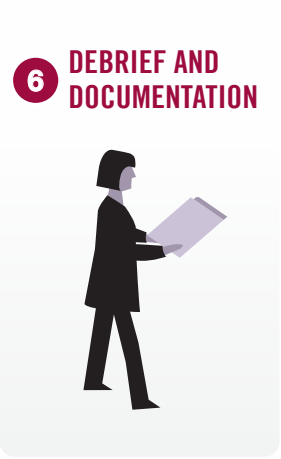

The crisis worker will make appropriate referrals to community mental health and addictions organizations, including community crisis centres, safe bed programs and case management. This may involve calling third parties, booking appointments and facilitating follow-up support. Information may also be shared with a primary care provider and/or relevant specialists.

## SPECIFIC PRIVACY CONSIDERATIONS AT STAGE 5.2

The crisis worker and the police officer may generally only share personal information or personal health information about the individual with others (peer support, family and community organizations to support the individual's safety and well-being, employers, landlords, etc.) with the individual's express consent.

2 The "lock-box" is not a defined term under PHIPA. It is a term commonly used to describe the right of individuals to withhold or withdraw their consent to the collection, use or disclosure of their personal health information for health care purposes. Individuals may expressly instruct custodians, or their agents, not to use or disclose their personal health information for health care purposes without consent, where PHIPA would otherwise permit a use or disclosure for such a purpose. Lock-box restrictions do not apply in certain circumstances.

## Debrief and documentation (Stage 6)




Under all MCRT models, police officers and crisis workers are encouraged to check in with one another at the beginning or end of a shift to discuss how everyone is feeling, how they are preparing (emotionally, physically, tactically, etc.) for the work ahead 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.

Periodically or after a noteworthy MCRT engagement, the police officer and crisis worker may wish to meet to discuss the approach taken during the call, any lessons learned and how to incorporate these moving forward. Such discussions may occur between the two MCRT partners or between an MCRT partner and their own supervisor. In addition, crisis workers may be exposed to a critical incident that raises the question as to whether they might be permitted to participate in a "formal police debriefing" (a briefing involving police officers other than the crisis worker's MCRT police partner).

## SPECIFIC PRIVACY CONSIDERATIONS AT STAGE 6

Provincial privacy legislation generally permits MCRT partners and their home agencies to use personal information or personal health information that has been collected during the crisis response for the purposes of evaluating a program, program or risk management and quality of care improvements. This means both police officers and crisis workers may share information with their own employer organization for these purposes. In addition, MCRT partners may discuss and debrief with each other about crisis calls they responded to together, insofar as they limit their discussion of identifiable information to that which was previously shared between them. However, a crisis worker is generally not permitted to disclose personal health information at a "formal police debriefing" without the express consent of the individual to whom the information relates.

## DATA COLLECTION AND ANALYSIS

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).

Tool 9

# Training and orientation

The following orientation guide for police officers and crisis workers is an example only. Each community should determine additional orientation topics and training based on the type of model they implement and regional considerations such as geography, special populations and cultural considerations. The links and resources provided may be considered for formal training and/or certification or for information and continuing education on relevant issues for mobile crisis response teams.

Joint, ongoing (for example, annual) training including all MCRT partners is highly recommended. Training should be informed and, where possible, supported by people with lived experience of mental health and addictions conditions and/or the criminal justice system.

| Topic | Key points |
|---|---|
| Tour and orientation to police service building (for crisis workers) | • Discussions related to privacy and information sharing<br>• Understanding of locations that are appropriate for crisis workers and those that are not (property room, gun range, etc.)<br>• Understanding entrances and exits, access to building<br>• Shadowing existing mobile crisis response team |
| Tour and orientation to hospital or community organization (for police officers) | • Discussions related to privacy and information sharing<br>• Understanding of locations that are appropriate for police officers and those that are not (private offices, counselling rooms, etc.)<br>• Understanding entrances and exits, access to building |
| Introduction to officers (for crisis workers) | • Ensure every opportunity is taken to meet and greet all police officers, communications/dispatch, civilian members, maintenance staff<br>• Goal is to build trust and make crisis workers known to police members |
| Introduction to hospital or community organization staff (for police officers) | • Ensure every opportunity is taken to meet and greet relevant hospital or community organization staff<br>• Goal is to build trust and make police officers known to partners |
| Memorandum of understanding (MOU) (for both partners) | • Understanding type of model and operations<br>• Overview of MOU and impact on both partners<br>• Opportunity to discuss pertinent, high-level issues that impact the mobile crisis response team (risk management, confidentiality, etc.) |

| Topic | Key points |
|---|---|
| Operations of police service (for crisis workers) | • Hierarchy<br>• Shifts and platoons<br>• Acclimation to police vehicles (if embedded model)<br>• interRAI Brief Mental Health Screener© or related forms or applications (depending on police service)<br>• Culture<br>• Use of force model |
| Operations of hospital or community organization (for police officers) | • Departments/units and directors/supervisors<br>• Shifts and roles of each unit/department |
| Privacy and information sharing (for both partners) | • *Freedom of Information and Protection of Privacy Act*<br>• *Municipal Freedom of Information and Protection of Privacy Act*<br>• *Personal Health Information Protection Act*<br>• Additional related legislation (such as *Substitute Decisions Act*)<br>• Discussion of all relevant legislation<br>• Understanding privacy implications of all police-related databases (such as Canadian Police Information Centre, Niche/RMS) as it relates to the Oath of Secrecy<br>• Understanding privacy restrictions on personal information and personal health information<br>• Standards, policies and practices with respect to safeguarding personal information and personal health information in both physical and electronic form (technical, physical and administrative safeguards) and the prevention of privacy breaches<br>• Training on the appropriate and lawful sharing of personal information and personal health information in relation to the performance of MCRT functions, including in the crisis response context as discussed in **Key privacy considerations for mobile crisis response teams** (Tool #8) |
| Communication and correspondence (for both partners) | • Referral processes<br>• Team communication<br>• Positive communication between police and crisis workers |
| Boundaries and relationships (for both partners) | • Trust and rapport<br>• Understanding police wellness services for members<br>• Understanding wellness resources for crisis workers<br>• Establishing and maintaining healthy boundaries<br>• Managing challenges related to healthy boundaries |

| Topic | Key points |
|---|---|
| Risk management (for both partners) | • Any equipment used (such as radio)<br>• Emergencies (emergency button in cruiser and in hospital or community organization)<br>• Managing information<br>• Modifications in special circumstances |
| Data collection and evaluation (for both partners) | • Ensure that the collection, use and disclosure of data complies with privacy requirements, as discussed in the **Data collection template** (Tool #11).<br>• Accountability and reporting schedule<br>• Evaluation processes |
| Understanding police-hospital transitions (for both partners) | • Orientation to police service's agreement with hospital<br>• Understanding the *Mental Health Act* and impact on policing (Section 17 apprehensions, etc.)<br>• Orientation to stages of police-hospital transitions |
| Ongoing training (for both partners) | • This will differ from community to community based on resources<br>• Formal and informal opportunities<br>• Understanding police training of mental health and addictions<br>• Shared learning opportunities |
| Team support and workplace health and safety (for both partners) | • Clear understanding of workplace health and safety issues working with police<br>• Clear communication related to workplace health and safety and conflict resolution<br>• Support available to crisis workers on the mobile crisis response team due to exposure to trauma and different style of crisis service delivery |

# Training and information resources

## Crisis intervention

**Nonviolent Crisis Intervention Training (NVCIT)**

**Crisis Intervention Team (CIT) International**

Includes training for police-based crisis response models, and promotes partnerships, community ownership, dispatch training, crisis centres, evaluation and research, and outreach.

**Canadian Police Knowledge Network (CPKN)**

Online courses for professional development in policing, including topics on crisis intervention and de-escalation, mental health, addictions, racial bias, 2SLGBTQ+ issues, homelessness and more.

## Mental health and addictions

**LivingWorks**
**Applied Suicide Intervention Skills Training (ASIST)**
**safeTALK** (suicide prevention training)
**Mental Health Commission of Canada**
**Mental Health First Aid**
The Working Mind

## Anti-racism and equity

**San'yas**: Indigenous Cultural Safety Training
**Ontario Human Rights Commission**: Call it Out (racism and discrimination interactive e-course)
**Canadian Federation of Nurses Unions**: Equity and Inclusion Toolkit

## Neurodevelopmental disabilities

**Community Networks of Specialized Care**: Developmental Disabilities Justice Toolkit
**FASD Ontario**: Ongoing training
**Canadian FASD Research Network**: Online training

## Dementia

**Behavioural Supports Ontario**
Training for police officers and others working with older adults and adults with age-related conditions.

## Information and Privacy Commissioner of Ontario

**Frequently Asked Questions: Personal Health Information Protection Act**
**Fact Sheet - Safeguarding Privacy on Mobile Devices**
**Privacy Breaches: Guidelines for Public Sector Organizations**
**Responding to a Health Privacy Breach: Guidelines for the Health Sector**
**De-identification Guidelines for Structured Data**
**Yes You Can: Dispelling the Myths about Sharing Information with Children's Aid Societies**

## Provincial Human Services and Justice Coordinating Committee (HSJCC) Network

**Police-hospital transitions**
Ongoing human services and justice **conferences and events**
Ongoing and archived human services and **justice webinars**

Tool 10

# Checklists

The following checklists are recommended to guide police officers and crisis workers responding to a person experiencing a crisis.

## Checklist for the police officer(s) at the scene

- ☐ Check police databases (local police records system, neighboring police records if available, Canadian Police Information Centre [CPIC], criminal records, Canadian firearms records, etc.) to provide as much relevant background as possible on the person experiencing the crisis and/or the residence/address. Determine any possible safety risks and plan, in conjunction with the crisis worker, an effective resolution to the call or follow-up.
- ☐ Assess the situation from a police perspective.
- ☐ Attend the scene first, assess the risk of harm to yourself, the individual and the crisis worker(s), to ensure the scene is safe for the worker to engage with the individual.
- ☐ Perform first aid if appropriate (including use of naloxone) and/or call Emergency Medical Services (paramedics) if necessary.
- ☐ Notify police communications if the assistance of any other entity (fire, paramedics, further police response, animal control, victim services, etc.) is required.
- ☐ Work with the crisis worker whenever possible and appropriate to de-escalate the situation and/or determine if the individual requires apprehension and transport for examination under the *Mental Health Act*.
- ☐ Where the risk of harm has been reduced or eliminated, refrain from listening to discussions between the crisis worker and the individual, unless the individual provides their express consent to the officer hearing the individual's personal health information.
- ☐ Engage other appropriate service providers as needed (such as child protection or victim services).
- ☐ Assist with appropriate knowledge transfer to community organization or hospital staff and advocate on behalf of the apprehended person to obtain medical treatment (if applicable).

## Checklist for the crisis worker(s) at the scene

This checklist is designed to help crisis workers who partner with police on a mobile crisis response team.

☐ Complete mobile risk screener:

| | Yes, no or unknown | Details |
|---|---|---|
| Columbia Suicide Severity Rating Scale (C-SSRS) score | | |
| Criminal history | | |
| Current history of aggressive behaviour | | |
| Weapon(s) in the home | | |
| Triggers for escalation (loud noises, police, etc.) | | |
| Animal(s) in the home | | |
| Home environment (pests, hoarding, clutter, etc.) | | |
| Physical health concerns | | |
| Communicable illness | | |
| Other | | |
| Client aware of visit | | |
| Client aware of police presence (if applicable) | | |

☐ Check pertinent health databases (electronic medical records, etc.) to gather relevant information about the individual experiencing the crisis including demographic information, presenting concerns, previous involvement with the program, risk factors, supports available and the goals of the mobile visit.

- [ ] Develop care plan in partnership with team, individual or family members, other community supports and/or police as appropriate.*
- [ ] Call individual/family member to arrange mobile or virtual visit as per plan.
- [ ] Identify yourself as a member of the health care agency and as a crisis worker to any front-line police officers and to the individual.
- [ ] Conduct an assessment of the individual's physical and mental health, including any neurological conditions and any substance use and/or risk of opioid overdose, as well as risk of harming themselves or others.
- [ ] Assist any police officer(s) present by consulting and providing expertise in determining apprehension criteria and/or resolution strategies through de-escalation techniques.
- [ ] Where the risk of harm has been reduced or eliminated, refrain from discussing the personal health information of the individual with the police officer(s) or any others present unless the individual provides their express consent to the third party receiving the individual's personal health information.
- [ ] Develop crisis management and/or safety plans in collaboration with the individual and their family.*
- [ ] Provide relevant resources and supports for the individual and their family or loved ones.*
- [ ] Obtain consent from the individual for referrals to other services, make appointments, etc. and facilitate subsequent follow-up with community resources.
- [ ] With the consent of the individual to whom the information relates, share or communicate information with the primary care provider and/or relevant specialist.
- [ ] Assist at hospital if an apprehension is made.
- [ ] Complete documentation related to crisis assessment, consents, risk, data collection, etc.

* Information sharing must be in accordance with privacy requirements, including those related to consent and data-minimization.

Tool 11

# Data collection template

## The collection of sociodemographic data and other related information

The collection and analysis of information, including sociodemographic data, can help police and health care professionals evaluate the effectiveness of a mobile crisis response team, improve service delivery, determine where specific services or resources are needed in the community, and inform broader service planning (such as community safety and well-being planning and ongoing engagement with community organizations). Such information can also provide insights about the individuals served by the mobile crisis response team program, the types of mental health and addiction-related issues involved, and the manner and outcome of mobile crisis response team crisis intervention. This information can be used to determine whether the team partners, and the mobile crisis response team program as a whole, are achieving the intended results.

## Data collection, quasi-identifiers and privacy

When collected alongside an individual's name, address or other direct identifier, information such as that found in the data collection template on pages 48 - 51 below is personal information and, given the mental health context, personal health information. Moreover, even when recorded without any direct identifiers, data such as an individual's presenting health issues, gender, age, race, immigration status and sexual orientation, may be a "quasi-identifier" that on its own, or in combination with other information, can reasonably be expected to identify an individual and therefore continues to be personal information or personal health information. In addition, it should also be noted that the foreseeable risk of quasi-identifiers being used to identify an individual is greater in smaller communities (e.g., through small cell size counts).

In any case, the collection of the detailed information listed in the data collection template below creates a de facto composite description of the individuals served by a mobile crisis response team. As such, even when stored without direct identifiers like names or case numbers, it must be characterized - and protected - as personal information and/or personal health information.

## The context in which the information is collected and the role of express consent

Personal information and personal health information collected during a crisis intervention for the purpose of providing crisis intervention services may generally also be used by mental health crisis workers for measuring and evaluating program effectiveness. However, when considering collecting additional information for the sole purpose of program evaluation (e.g., race, immigration status, income, religion, etc.), it must be collected **directly** from the individual to whom it relates (or their substitute decision-maker) and with the individual's **express consent** (or that of their substitute decision-maker). Personal information and personal health

information may only be collected indirectly from another source where permitted or required by law. In addition, when disclosing personal information or personal health information for the purpose of program evaluation, express consent is required. This includes any disclosures of personal information or personal health information between mobile crisis response team partners.

For the consent to be valid, it must be the consent of the individual or their lawful substitute decision-maker and must be **knowledgeable**, must relate to the information, and must **not be obtained through coercion or deception**.[1]

Note that information collected solely for evaluation purposes should only be used for the purposes of measuring and evaluating the effectiveness of the mobile crisis response team program, ensuring the program is administered in an equitable and non-discriminatory manner, eliminating systemic discrimination and advancing equity in mobile crisis response team service delivery. Moreover, the individual, or their lawful substitute decision-maker, must be informed of the purposes for the collection and subsequent use and disclosure of the information and that they may withhold or withdraw their consent without fear that it will have an impact on, or deprive them of, a program, service or benefit provided by the mobile crisis team. Furthermore, they should be provided contact information they can use to obtain further information about the organizations' data collection practices.

Finally, with regard to collecting and/or using evaluation-focused information, mobile crisis response team partners may need to determine the most appropriate time to approach the individual (or their lawful substitute decision-maker) to discuss the purposes of sociodemographic data collection and seek express consent. For example, consent may be sought once the individual has had their safety and well-being needs assessed and addressed or after the crisis response intervention, as part of a follow-up call.

## Ensuring privacy protection in the collection of sociodemographic data and other related information

Due to the character and sensitivity of the information involved, mobile crisis response team partner organizations are strongly encouraged to review relevant privacy legislation (e.g. FIPPA, MFIPPA, or PHIPA) to ensure that they fulfill their statutory responsibilities with respect to the collection, retention, use, and disclosure of personal information and personal health information.

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1 See subsection 18(1) of the Personal Health Information Protection Act, 2004 (PHIPA), which provides the elements of a valid consent of an individual in the context of the collection, use or disclosure of personal health information by a health information custodian. To be valid, the consent must: be a consent of the individual; be knowledgeable; relate to the information; and not be obtained through deception or coercion. It is recommended that police also ensure that all applicable consents satisfy these elements, at least to the extent that they participate in collecting information for the purpose of mobile crisis response team program evaluation.

While police and crisis workers are not currently subject to the *Anti-Racism Act, 2017*, (ARA) mobile crisis response team partner organizations that are considering collecting - or already collecting - race-based data, should commit to developing and adopting policies and procedures consistent with the privacy-protective rules found under sections 6 – 9 of the ARA, as well as all the standards and guidance in Ontario's *Anti-Racism Data Standards*.[2]

Together, these privacy and equity-related statutory obligations, data standards and guidance materials provide a comprehensive set of rules for the collection, retention, use and disclosure of race-related information. In addition, the Anti-Racism Data Standards include guidance that expressly address key privacy and human rights-related issues under headings such as: assess, plan and prepare; the collection of identifiable information; the protection and management of identifiable information (including with respect to its protection and de-identification); the analysis of information collected; public release and reporting; and standards for participant observer information. The Anti-Racism Data Standards also call for ongoing consultation with relevant sectors of the community.

## Key examples of privacy-protective and equity-related responsibilities

With regard 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. 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 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;

2 Note that this approach is consistent with the guidance provided by Ontario's Anti-Racism Directorate:

> Organizations that are not authorized or required to collect personal information in regulations made under the ARA may also be authorized to collect, use and disclose personal information for the purpose of identifying and monitoring systemic racism and racial disparities under other Acts, including the Ontario Human Rights Code. In such cases, organizations must follow the requirements of relevant legislation, such as *the Freedom of Information and Protection of Privacy Act (FIPPA) or the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*. Organizations may consider the Standards and the related guidance in developing and implementing any program to identify, monitor, and eliminate systemic racism and advance racial equity.

- as soon as reasonably possible, remove any direct identifiers and de-identify[3] the information as much as possible while allowing for necessary analysis;[4]
- ensure that any disclosures, including in public reports and reports to steering committees and funders, do not contain any personal 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.

## Data collection components

The following template contains data components that all mobile crisis response teams in Ontario are recommended to begin collecting, in so far as teams do so in compliance with the privacy requirements outlined above. Consistent data collection will allow mobile crisis response teams to evaluate their programs and monitor changes over time. Some of this data is already being collected by mobile crisis response teams across Ontario, while the remaining data is recommended based on the practices described in the Anti-Racism Data Standards and consultations with community members. This template can be printed off for teams to fill out on the road, or the components can be added using drop-down menus to software programs. It is recommended that the mental health partner on the MCRT collect the data rather than police officers.

In addition to ensuring that the information on these forms and documents is lawfully collected, secured and protected from the risk of a privacy breach, the information recorded must be limited to what is necessary, including when using printed documents, software programs, free text fields, etc. Finally, personal information and personal health information collected for the purpose of measuring and evaluating program effectiveness should be stored separately from other records and access to this information should be subject to role-based access controls.

3 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*.

4 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 component | Checkbox and notes | |
|---|---|---|
| Live call attended by mobile crisis response team | ☐ | |
| Follow-up/wellness check call attended by team | ☐ | |
| Connections/referrals made, including follow-up with caregivers or primary care (with consent) | ☐ | |
| Diversion from hospital emergency department | ☐ | |
| Apprehension under the *Mental Health Act* | ☐ | |
| Hospital wait time | ☐ | |
| **Demographic data** | | |
| Age | | |
| Child (0 – 14 years) | ☐ | |
| Youth (15 – 24 years) | ☐ | |
| Adult (25 – 64 years) | ☐ | |
| Older adult (65 years and older) | ☐ | |
| Gender† | | |
| Female | ☐ | |
| Intersex, non-binary/enby, gender non-conforming | ☐ | |
| Male | ☐ | |
| Trans – female to male | ☐ | |
| Trans – male to female | ☐ | |
| Two-spirit | ☐ | |
| Other (please specify): | ☐ | |
| Race* | | |
| Black (African, Caribbean, African Canadian) | ☐ | |
| East or Southeast Asian (Chinese, Korean, Japanese, Taiwanese, Filipino, Vietnamese, Cambodian, Thai, Indonesian or other descent) | ☐ | |
| Indigenous (First Nations, Métis, Inuk/Inuit) | ☐ | |
| Latino (Latin American, Hispanic descent) | ☐ | |
| Middle Eastern (Arab, Persian, West Asian descent, Afghan, Egyptian, Iranian, Lebanese, Turkish, etc.) | ☐ | |

| Data component | Checkbox and notes | |
|---|---|---|
| South Asian (East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean or other descent) | ☐ | |
| White (European descent) | ☐ | |
| Religion and/or spiritual affiliation* | | |
| Buddhist | ☐ | |
| Christian | ☐ | |
| Hindu | ☐ | |
| Indigenous Spirituality | ☐ | |
| Jewish | ☐ | |
| Muslim | ☐ | |
| Sikh | ☐ | |
| Immigration status† | | |
| Born in Canada | ☐ | |
| Immigrated to Canada | ☐ | |
| Year arrived (if known): | ☐ | |
| Sexual orientation† | | |
| Asexual, non-sexual | ☐ | |
| Bisexual | ☐ | |
| Gay | ☐ | |
| Heterosexual, straight | ☐ | |
| Lesbian | ☐ | |
| Queer, pansexual | ☐ | |
| Two-spirit | ☐ | |
| Other (please specify): | ☐ | |
| Annual income† | | |
| $0 - $19,999 | ☐ | |
| $20,000 - $29,999 | ☐ | |
| $30,000 - $39,999 | ☐ | |
| $40,000 - $59,999 | ☐ | |

| Data component | Checkbox and notes | |
|---|---|---|
| $60,000 or more | ☐ | |
| Presenting issue (select all that apply)[x] | | |
| Dementia or age-related condition | ☐ | |
| Eating disorder | ☐ | |
| Homeless, street-involved, precariously -housed | ☐ | |
| Intimate partner violence, domestic abuse, gender-based violence | ☐ | |
| Mental health issues and symptoms | ☐ | |
| Anxiety | ☐ | |
| Bipolar disorder | ☐ | |
| Depression | ☐ | |
| Erratic behaviour (please describe): | ☐ | |
| Obsessive-compulsive disorder (OCD) | ☐ | |
| Panic attack | ☐ | |
| Post-traumatic stress disorder (PTSD) | ☐ | |
| Psychosis | ☐ | |
| Schizophrenia | ☐ | |
| Other (please describe): | ☐ | |
| Neurodevelopmental disability | | |
| Acquired or traumatic brain injury | ☐ | |
| Autism spectrum disorder | ☐ | |
| Fetal alcohol spectrum disorder | ☐ | |
| Learning disability | ☐ | |
| Other | ☐ | |
| Personality disorder | ☐ | |
| Physical disability (please specify): | | |
| Substance use | | |
| Alcohol | ☐ | |
| Barbituate | ☐ | |

| Data component | Checkbox and notes |
|---|---|
| Benzodiazepine | ☐ |
| Cannabis | ☐ |
| Inhalant (aerosol, paint, gasoline) | ☐ |
| Hallucinogen | |
| Ecstasy, MDMA | ☐ |
| LSD | ☐ |
| Magic mushrooms, psilocybin | ☐ |
| Narcotic | |
| Codeine | ☐ |
| Fentanyl | ☐ |
| Heroin | ☐ |
| Morphine | ☐ |
| Oxycodone | ☐ |
| Stimulant | |
| Amphetamine | ☐ |
| Crack | ☐ |
| Cocaine | ☐ |
| Methamphetamine | ☐ |
| Other (please specify): | ☐ |
| Suicide | |
| Attempt (means) | ☐ |
| Self-harm (describe) | ☐ |
| Thoughts, suicidal ideation | ☐ |
| Other (please specify): | ☐ |

***** *These demographic categories were developed from Ontario's Anti-Racism Data Standards in order to help organizations collect, analyze and report on race-based data in a manner consistent with the requirements and best practices set out in the Anti-Racism Act, 2017, and the Anti-Racism Data Standards.*

**†** *These demographic categories are from the Toronto Central Local Health Integration Network's Measuring Health Equity Participant Manual, 2018.*

**x** *These demographic categories were developed in consultation with people with lived experience and with community organizations serving clients who interact with the criminal justice and mental health systems.*

The full data spreadsheet below was designed by the Ontario Provincial Police (2020).

## MCRT Data Collection

### REQUESTS FOR SERVICE / SOURCE OF REQUEST

| DATE | Live Calls with Police (# of urgent police calls where MCRT attended) | Follow-up Calls (# of non-urgent calls/referrals) | Individuals Served (# of unique individuals served) | MONTHLY TOTALS | A Platoon/ Division /Team | B Platoon/ Division/Team | C Platoon/ Division/Team | D Platoon/ Division/Team | Mental Health Partner | Community Crisis Line | Other (desribe) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| January | | | | 0 | | | | | | | |
| February | | | | 0 | | | | | | | |
| March | | | | 0 | | | | | | | |
| April | | | | 0 | | | | | | | |
| May | | | | 0 | | | | | | | |
| June | | | | 0 | | | | | | | |
| July | | | | 0 | | | | | | | |
| August | | | | 0 | | | | | | | |
| September | | | | 0 | | | | | | | |
| October | | | | 0 | | | | | | | |
| November | | | | 0 | | | | | | | |
| December | | | | 0 | | | | | | | |
| TOTALS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### SERVICE PROVISION / POLICE MEMBER SUPPORT

| DATE | Community Activities | Consulation/ Collaboration | Documentation and Planning | Operations (including travel) | Staff support, training, supervision | Visits (face to face) | Visits (non-face to face) | Member Support Visits (# of police member support/resource visits) | Hours of Member Support (# ofhoursMCRT spent providing member support resources) |
|---|---|---|---|---|---|---|---|---|---|
| January | | | | | | | | | |
| February | | | | | | | | | |
| March | | | | | | | | | |
| April | | | | | | | | | |
| May | | | | | | | | | |
| June | | | | | | | | | |
| July | | | | | | | | | |
| August | | | | | | | | | |
| September | | | | | | | | | |
| October | | | | | | | | | |
| November | | | | | | | | | |
| December | | | | | | | | | |
| TOTALS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### HOSPITAL CONTACT

| DATE | Calls Diverted from Hospital (# of live calls that did not result in a visist to hospital) | Calls Resulting in Hospital Visit (# of live calls that resulted in a visit to hospital) | Voluntary Transports* (# of individuals that were voluntarily transported to hospital) | Mental Health Apprehensions (# of individuals that were apprehended under the MHA) | Hospital Visits Resulting in a Form 1 (# of hospital visits that resulted in a Form 1) |
|---|---|---|---|---|---|
| January | | | | | |
| February | | | | | |
| March | | | | | |
| April | | | | | |
| May | | | | | |
| June | | | | | |
| July | | | | | |
| August | | | | | |

### TOP ISSUES IDENTIFIED

| DATE | Suicidal ideation | Relationship conflict | Depression | Anxiety | Agitation | Alcohol use/abuse | Drug Use/abuse | Impairment insight/ judgement | Delusions/ hallucinations | Angry/hostile | Risk of self-harm behaviour | Suicidal behaviour | Impulsive actions | Living environments | Paranoid/ suspicious | Caregiver burden | Concentration/ attention difficulty | Trauma | Risk of harm towards others | Grief/loss | *Other: (additional issues may be listed as per model preference) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| January | | | | | | | | | | | | | | | | | | | | | |
| February | | | | | | | | | | | | | | | | | | | | | |
| March | | | | | | | | | | | | | | | | | | | | | |
| April | | | | | | | | | | | | | | | | | | | | | |
| May | | | | | | | | | | | | | | | | | | | | | |
| June | | | | | | | | | | | | | | | | | | | | | |
| July | | | | | | | | | | | | | | | | | | | | | |
| August | | | | | | | | | | | | | | | | | | | | | |
| September | | | | | | | | | | | | | | | | | | | | | |
| October | | | | | | | | | | | | | | | | | | | | | |
| November | | | | | | | | | | | | | | | | | | | | | |
| December | | | | | | | | | | | | | | | | | | | | | |
| TOTALS | | | | | | | | | | | | | | | | | | | | | |

Tool 12

# Media and communications

When a mobile crisis response team is established, it is important to spread awareness to key stakeholders and to educate the community. Developing a communications strategy including a media release, social media and key messages can assist in promoting the new program. As milestones are reached and as the program continues to grow, a communications strategy will help to inform stakeholders and the public about the successes of the program. This will ensure strong community partnerships develop and grow.

The information sheet and wallet cards can be shared within the police service to promote engagement with the mobile crisis response team when appropriate.

Care must be taken to ensure that communications and other public documents do not reveal information that could be used to identify clients serviced by mobile crisis response teams. Communications and other public documents must remove all information that could be used, either alone or in combination with other information, to identify any clients. Only de-identified or aggregate information must be used in communications and other public documents. The challenge of ensuring that information is de-identified or aggregated is often greater in smaller or rural communities, as well as in higher profile crisis interventions. In such circumstances, further de-identification or aggregation may be needed to reduce the risk that a client's identity might be deduced from otherwise non-identifiable information.

*The key messages were adapted from those used by the Ontario Provincial Police (OPP) and Canadian Mental Health Association (CMHA), Ontario (2020).*

*The information sheet and wallet cards were adapted from Health Sciences North in partnership with the OPP (2020).*

# Mobile crisis response team (MCRT)

# Date: TBD

## Key messages

- <<Health Partner>> and <<Police Service>> have partnered on a new initiative that will provide a better response and care for people experiencing a mental health and/or addictions-related crisis in <<community>>.
- Launching on <<date>>, the mobile crisis response team (MCRT) is a new mobile crisis intervention program that will consist of police partners and <<Health Partner>> crisis workers responding together to support individuals experiencing a mental health and/or addictions-related crisis where police are called to assist. The MCRT will provide persons experiencing a crisis, their families and caregivers with timely and appropriate crisis intervention.
- Under this new program, the crisis workers can help police de-escalate crisis situations, determine whether there's a need to apprehend someone under the *Mental Health Act* or divert an individual to community-based mental health and addictions supports. Through MCRT, the crisis worker will be able to assess the individual on the scene, offer assistance, provide referrals and even accompany the individual to the hospital if necessary.
- In addition to helping people experiencing a crisis find the right supports in a timely manner, partnering crisis workers with police members may lead to fewer emergency department visits.
- At every stage of each MCRT intervention, both police officers and crisis workers will protect the privacy of the individuals experiencing a mental health and/or addictions-related crisis and protect the confidentiality and security of their information.

## Quotes

"The MCRT program is a huge step forward for our community that enables both <<Health Partner>> and <<Police Service>> to provide the best possible response to an individual in crisis. Our crisis worker will be able to evaluate a crisis in the moment and direct that individual to appropriate supports immediately."

- Chief Executive Officer, <<Health Partner>>

"Supporting people experiencing a mental health or addictions crisis with empathy, dignity and respect is a top priority for the << Police Service>>. This partnership with <<Health Partner>> will provide a healthier experience for individuals experiencing a crisis and their families, reduce apprehensions, and decrease use of hospital services and police resources. More efficient and effective access to community supports will ensure people who need mental health and addictions care can get it when and where they need it."

- Chief of Police, <<Police Service>>

# Questions and answers:

**Q: How many police services in Ontario have mobile crisis response teams (MCRTs)?**

**A:** While not every police service in Ontario has an MCRT, there are many provincial, municipal and First Nations police services with some type of MCRT. In some communities, municipal, provincial and/or First Nations police services work together along with local mental health and addictions partners to respond to crisis situations. Each MCRT is unique to the geography, resources, partnerships and needs of the community.

**Q: What types of calls require an MCRT?**

**A:** An MCRT responds to calls involving individuals who may be experiencing a mental health and/or addictions-related crisis. Service recipients of an MCRT include individuals presenting with symptoms of mental illnesses, substance abuse, behavioural disorders, or people in acute crisis situations.

**Q: What are the benefits of using an MCRT?**

**A:** An MCRT leverages the partnership between an officer and a trained crisis worker to de-escalate a situation and support individuals. The MCRT attempts to streamline access to mental health crisis supports in emergent situations to help ensure the needed level of care is accessible. An MCRT also helps to reduce the number of unnecessary referrals to the emergency department.

**Q: When and how are officers being trained?**

**A:** The type of training will differ from police service and health partner. It is recommended that police officers and crisis workers involved on MCRTs participate in ongoing, joint training that is developed and/or led in partnership with persons with lived experience and/or their family members when available. Both partners will also be trained on privacy and information sharing to ensure individuals' privacy will be protected during an MCRT intervention.

**Q: Are there standard operating procedures for an MCRT?**

**A:** There is no 'cookie-cutter' model. There are many different models across Ontario. The type of model may be live response, co-response and/or embedded or not embedded within the police service. There may be many services involved such as provincial, First Nations or municipal police services, and it may involve other partners beyond a primary mental health partner (such as children's mental health or a hospital).

**Q: How was the idea of an MCRT developed?**

**A:** MCRTs have evolved over the past two decades where collaborative partnerships have existed. Since approximately 2013, these collaborations have been evolving and enhanced to include mental health experts riding along, or co-responding, with police.

**Q: Do you have the support of hospitals and mental health and addictions organizations to establish an MCRT in other communities?**

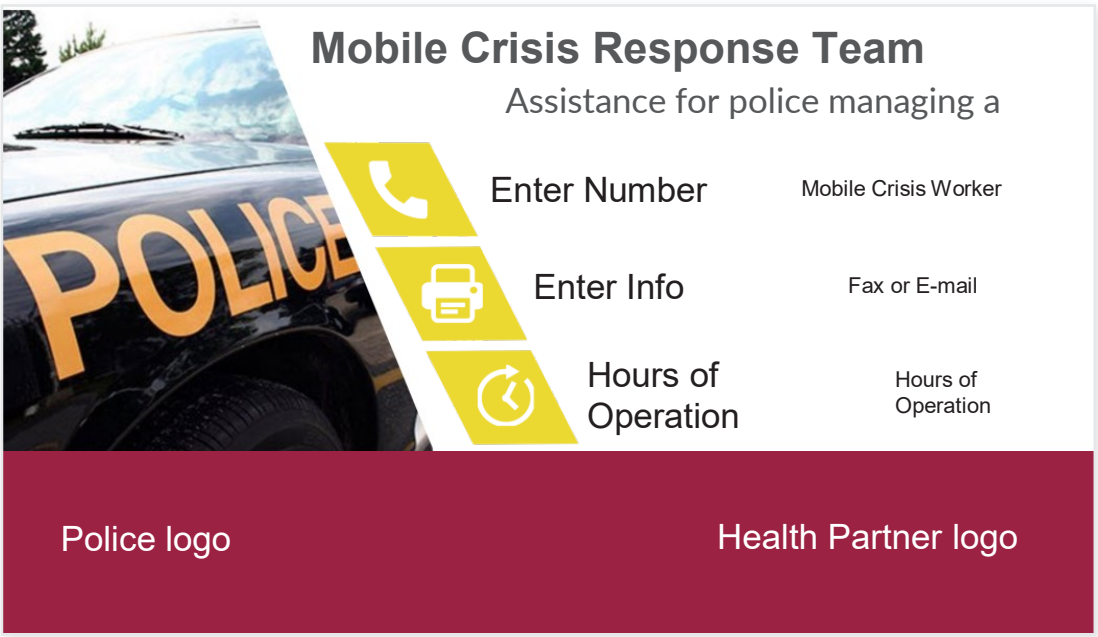
**A:** Over the past few years, the provincial government has announced funding to support the development of MCRTs in Ontario. This has assisted and encouraged police, hospitals and community mental health and addiction organizations to work together in partnership to develop local MCRTs.

**Q: Will MCRTs become a standard throughout Ontario?**

**A:** Due to the positive response and outcomes from existing teams, the provincial government is encouraging and providing some funding for continued development of MCRTs. In 2020, the Provincial Human Services and Justice Coordinating Committee, in partnership with the Ontario Provincial Police, Canadian Mental Health Association, Ontario Division, Ontario Hospital Association and the Ontario Association of Chiefs of Police, produced *Developing Mobile Crisis Response Teams: A Framework for Ontario* to assist communities to develop teams with core components and common approaches to service delivery.

**Q: How are we ensuring that local hospitals and their emergency room staff know about this initiative?**

**A:** In communities where partners develop an MCRT, the local hospital is encouraged to participate in the development stages. MCRTs that do attend the hospital emergency department with an individual are well versed in the police-hospital transition process. Hospitals have the opportunity to participate in the development, implementation, evaluation and support of MCRTs. In some MCRTs, the hospital may be a primary partner for service delivery.




# Mobile Crisis Response Team (MCRT)

Assistance for police managing a crisis response

Enter Phone Number — Mobile Crisis Worker

Enter Fax Number — Fax or Email referral if applicable

Enter Hours of Operation — Hours of operation

# INFORMATION SHEET

## How to Refer

Shift supervisor/designate or officer on scene to determine if the call is appropriate for mobile crisis response.

Decision made as to most appropriate response indicated:

- Joint police/mental health response for crisis/risk assessment/safety planning/brief intervention
- Meet at the nearest emergency department to provide assessment, support and follow-up
- Phone consultation with client
- Delayed referral (seen later in day or next day) by Mobile Crisis Worker (MCW)
- Phone consultation with police

## Who to Refer

Persons age _____ residing within _____, who are not violent or aggressive and medically stable, experiencing a mental health and/or addiction crisis such as:

- Intense feelings of hopelessness or helplessness
- Excessive worry / overwhelming fears
- Thoughts of suicide or of harming others
- Life interfering mood changes
- Postpartum depression/psychosis
- High anxiety
- Altered perception of reality (symptoms of psychosis)
- Addiction issues, including problem gambling, substance/alcohol abuse or misuse of prescription drugs and able to participate in assessment process
- Reaction to traumatic events / dealing with grief
- Decrease in level of functioning including the elderly, due to mental health and/or addictions issues

Persons who would benefit from follow-up support and referrals

Persons who may be deferred from hospital with MCRT support

Persons who are repeatedly experiencing crises and may require additional supports or services to stabilize

**If police are managing a crisis outside of MCRT hours of operation, you can... Call/fax/e-mail referral to the MCIT using contact information above**

**Police Logo** **Health Partner Logo**

HSJCC
Human Services & Justice Coordinating Committee

O.P.P.

Canadian Mental Health Association
Ontario

OACP

OHA Ontario Hospital Association