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The Regional Municipality of Durham Report

To:	Committee of the Whole
From:	Commissioner of Health & Medical Officer of Health and Commissioner of Social Services
Report:	#2024-COW-5
Date:	January 17, 2024

Subject:

A Community Mental Health Crisis Response Service for Durham Region

Recommendation:

That the Committee of the Whole recommends:

That this report be received for information.

Report:

1. Purpose

1.1 The purpose of this report is to provide a summary of community engagement findings for a community mental health crisis response service in Durham. This team of highly trained mental health professionals would respond to individuals experiencing a non-violent crisis helping to avoid emergency room visits, reduce police calls, and be part of a coordinated mental health system in Durham.

1.2 The community mental health crisis response service should be accessible through multiple channels, including 911, another phone number (which could be 211, 988, or its own number), and online or text options. The service should also be accessible as a secondary responder to police and paramedic calls, when requested.

2. Background

2.1 In July 2020, Council passed a motion to investigate a non-police led crisis response team in Durham Region, now referred to as a Community Mental Health Crisis Response. Regional Council requested that the Region's Health and Social Services departments; alongside the Durham Regional Police Services (DRPS) Board, and in collaboration with community partners take certain steps including the review of best practices.

2.2 In June 2022, the services of the International Crisis Response Association were engaged to lead community engagement initiatives that would explore a mental health crisis response, identify gaps in mental health crisis services, understand impacts of police response to mental health calls, and make recommendations for a mental health crisis response service that are informed by the needs of Durham residents.

2.3 In July 2022, an Advisory Committee overseeing this work was established and included: DRPS Board Chair, CAO's Office, Regional Diversity, Equity and Inclusion (DEI) Office, Community Safety and Wellbeing, Commissioner of Social Services, DRPS, Region of Durham Paramedic Services, Lakeridge Health Mental Health and Addictions and other regional staff.

2.4 Community engagement involved interviews with 14 mental health community agencies and 16 community focus groups that were held both virtually and in-person. Focus groups included individuals with lived experience, family/caregivers, staff within mental health agencies, DRPS and RDPS. Focus groups were conducted in both south and north Durham.

2.5 Demographic information was not collected from focus group attendees; however, individual focus groups were specifically held for members of Indigenous communities, Black communities, 2SLGBTQI+ communities, individuals with disabilities, and North Durham residents.

2.6 The Region of Durham established an on-line survey to gather feedback on a mental health crisis response in Durham. The survey was open from October 2022 to March 2023 and received 1,426 responses.

2.7 In April 2023, the Health Department reported on Mental Health and Opioid use in Durham Region. The report identified that in Ontario, the impact of mental health, mental illness, and addictions on life expectancy, quality of life, and health care utilization is more than 1.5 times that of all cancers and more than 7 times that of all infectious diseases.

3. Previous Reports and Presentations

3.1 Presentation to Regional Council on Non-Police Led Crisis Response provided an introduction to mobile crisis response on November 25th, 2020.

3.2 #2023-INFO-33: Mental Health and Opioids in Durham Region provided an update on local trends and strategies to address mental health and opioids in Durham Region.

3.3 Presentation provided by the Region of Durham Health Department and Lakeridge Health on local mental health and addictions to the Health and Social Services Committee on May 4th, 2023: Local Mental Health & Addictions Services Updates.

4. Community Engagement Feedback Report Themes

4.1 Indigenous Communities

a. Elevating Indigenous voices and perspectives will require a thorough community engagement process, led by Indigenous Peoples. The Manager of Indigenous Relations, within the CAO's Office, will provide support to this facilitation and community engagement.

4.2 Black Communities

a. Black communities have been disproportionately impacted by over-policing and often face many barriers to accessing mental health treatment, including stigma, racism, and a lack of culturally responsive services.

- 88.1% of Black survey respondents said that they believe the Region would benefit from a community mental health crisis response service.
- A mental health crisis response service must support the needs of Black communities and be co-designed by those communities.

4.3 Supporting People with Disabilities

a. People with disabilities are five times as likely as people without disabilities to experience mental health challenges.

- Focus group participant with disabilities described difficulty accessing mental health services because service providers are not trained in supporting dual diagnosis (cognitive disabilities as well as mental health disabilities). Lack of care was described as contributing to deterioration of their mental health.
- A number of participants spoke to situations of discrimination and lack of understanding for their child with autism, including being denied care and being spoken down to.
- Several participants stated that they were afraid to call the police when they, or their loved one, were experiencing a mental health crisis, due to their disability. Parents of autistic children, especially those who are nonverbal, worried their children might be misunderstood and therefore seen as a threat.

4.4 Supporting Deaf Community Members

a. First Responders may not be aware of how to access an American Sign Language (ASL) interpreter, or initially recognize that someone is Deaf. This response can lead to assumptions that the First Responder is being ignored.

- Several Deaf community members commented that being handcuffed or restrained by police or hospital staff is traumatic, as it takes away their ability to communicate.
- Other aspects of police procedure, such as shining a flashlight towards someone's face, may also be harmful for Deaf community members, as it impairs their ability to read lips.

4.5 Supporting North Durham Residents

a. North Durham residents were identified as a priority group for community engagement due to the unique challenges they face when accessing healthcare and other services within their rural communities.

- Focus group participants described challenges with service coordination across jurisdictions, lack of proximity to supports, insufficient availability of mental health services in North Durham, and insufficient accessibility to public transit.
- Many North Durham residents access care in York Region rather than in Durham Region because York Region services may be geographically closer than travelling to Oshawa or Ajax.
- Eligibility for some services is dependent on living within a particular region; for example, a service in York Region may be closer to a particular Durham Region resident's home than a similar service in Durham Region, but the York Region service may not serve Durham Region residents.
- Mental health crisis services are not readily accessible to North Durham residents, and a lack of family physicians adds to residents feeling isolated and dependent on services outside their local community.

4.6 Experiences with Police

a. In 2022, Durham Regional police responded to 2,677 mental health related calls. Some of these calls are responding to people who may experience multiple police contacts per year due to mental health concerns. These calls result in a significant use of police time and resources, and often do not lead to individuals with mental illness receiving the help they need.

- Police contact can lead to people with mental health challenges becoming entangled in the criminal legal system, rather than being connected to appropriate mental health services.
- Due to the strong association between police and crime or violence, some participants believed that police response to non-violent mental health crisis calls is stigmatizing.
- A primary goal of the community mental health crisis response service is to reduce the burden of mental health crisis calls on police.
- In other jurisdictions across Canada and the US, the proposed model has proven to reduce the number of "familiar faces" police are in contact with by connecting individuals with effective wraparound services that meet their mental health needs.
- The proposed model aims to achieve its outcomes through a mutually trusting partnership with Durham Regional Police Services.

4.7 Experience with Hospitals

a. Focus group participants described systemic and structural barriers within the hospital/healthcare system in Durham for those experiencing mental health crisis. Feedback outlined that when accessing mental health services, it feels like a 'revolving door'. Long wait times in emergency departments, and a lack of beds exacerbate the situation for individuals in a mental health crisis, and their family/caregivers. People described hospitals as limited in their capacity to help someone experiencing a mental health crisis, however, turn to them because of a lack of appropriate community mental health support.

4.8 Experience with Paramedic Services

a. Many people experiencing a mental health crisis are transported to hospital by ambulance, leaving paramedics waiting in emergency departments with individuals for several hours until the person is assessed and/or admitted. In 2021, RDPS spent 2,088 hours in emergency departments with mental health patients waiting for them to be admitted or released. Those 2,088 hours cost the Region of Durham approximately $396,767.

5. Best Practices of Community Mental Health Crisis Response

5.1 International models for mental health crisis response can include calls related to mental health, substance use, suicidality, welfare checks, and unhoused individuals. Teams can provide de-escalation, mental health assessments, safety planning and basic medical care. Models vary in design and across Canada and the United States there are 92 programs that divert non-violent mental health crisis calls made to 911 to a civilian-led crisis service. These services can accept 911 calls through direct integration to the mental health crisis team, or through a warm transfer model where 911 transfers to the team. Some models include when a person calls 911, they are asked: "Do you need fire, police, ambulance or mental health?"

5.2 City of Eugene's CAHOOTS (Crisis Assistance helping Out On The Streets) is a mobile crisis intervention program that has been well embedded in the community for nearly 30 years. Calls for CAHOOTS are received through emergency 911, or the non-emergency line. Diversion rates for 2021 are reported between 3% - 8% of police calls for service.

5.3 Waterloo-Wellington, Ontario's Here 24/7 program launched in 2014 as a community responder model. It is an integrated "front door" to all mental health services in the Waterloo-Wellington region. 24/7 phone-based crisis support and civilian-led mobile crisis support is available. All mental health services can be accessed through Here 24/7.

5.4 In the Fall of 2023, City of Toronto council expanded their Community Crisis Service pilot into a citywide stand-alone emergency service, alongside paramedics, police, and the fire department. City of Toronto's pilot of a similar model in the first year (2022) identified that police received 37,508 calls involving a person in crisis - 3,596

of which were referred to the new community crisis program. City of Toronto's community crisis program saw 96 per cent of the 5,868 calls received to this program in the first-year resolve without any other emergency services involved.

5.5 Edmonton's 24/7 Crisis Diversion program launched in 2013 and is operated by a community mental health agency, REACH Edmonton. The service is staffed by crisis workers and is dispatched via 211 and is accessible via warm transfer through 911. In 2021, the service received over 29,000 calls, 11,000 resulted in mobile dispatch.

6. Existing Community Mental Health Response Programs in Durham

6.1 DRPS Mental Health Programs

a. Durham Region has police-mental health collaborations. The community mental health crisis response service must collaborate with these existing services to ensure that it is not replicating or replacing these models.

6.2 911 Call Diversion Program

a. Durham Region launched a 911 call diversion program in 2022, which embeds a mental health clinician in the 911 communications centre. The goal of this program is to divert non-emergency mental health calls away from an in-person police response. 410 calls have been successfully diverted by the 911 call diversion program in its first year of operations.

6.3 The Mental Health Support Unit (MHSU)

a. The MHSU is a co-responder program that pairs a specially trained Police Constable with a Registered Nurse from Lakeridge Health to respond to mental health related police calls. This program is a secondary response model, meaning that it is not dispatched directly via 911. Police officers on scene make a request for the MHSU. This unit is available between 7:00 a.m. to 12:00 am seven days a week.

6.4 Region of Durham Primary Care Outreach Program

a. The Primary Care Outreach Program (PCOP) is a partnership between the Region's Health and Social Services Departments. This specialized program has two teams comprised of an advanced care paramedic and social worker who provide outreach services, including service navigation and medical and mental health support, to vulnerable populations including individuals who are homeless or at-risk of homelessness in the community. PCOP teams are available seven days a week.

6.5 Region of Durham Mental Health Outreach Program

a. The Mental Health Outreach Program (MHOP) is a mobile unit that consists of two social workers providing mental health outreach and counselling to individuals experiencing, or at risk of homelessness. MHOP provides support Monday to Friday in various locations across Durham.

6.6 Region of Durham Outreach Workers

a. In May 2023, Council endorsed hiring 10 outreach workers. The primary goal of these 24/7 teams is to respond to individuals living unsheltered, aiming to facilitate safe accommodations. Two additional outreach workers will be hired to support Durham Region Transit.

6.7 Lakeridge Health Durham Mental Health Services (DMHS)

a. Provides phone-based and mobile crisis support throughout Durham Region. The phone-based service is available 24/7 and the mobile service is Monday to Friday from 11:00 a.m.to 7:00 p.m. DMHS staff can provide crisis intervention, resources, and referrals over the phone, or they can provide mobile response to support the person in their preferred location. Short-term crisis beds are also available for community members to access.

6.8 Assertive Community Treatment Teams (ACT Teams)

a. ACT Teams consist of multidisciplinary professionals, including a social worker, psychiatrist, occupational therapist, and nurses, who provide in-home and community-based care. These clinical teams provide crisis intervention, treatment, recovery, and support services to individuals with a serious mental illness who require a high degree of support in their community.
b. Access to ACT Teams in Durham is coordinated through Canadian Mental Health Association Durham and Ontario Shores

7. Community Mental Health Crisis Response Goals

7.1 To divert people who don’t need to be in the hospital out of hospital to appropriate and accessible community supports.

7.2 Reduce the burden of mental health crisis calls on police.

7.3 To complement traditional policing and conserve police resources for responding to crime and violence.

7.4 To divert people away from criminal legal interactions and towards mental health treatment.

7.5 To ensure families have the support they need and access to services for their loved ones with mental health challenges.

7.6 To reduce “familiar faces” with police interactions by connecting people in crisis to community-based care.

7.7 To be part of a mental health and substance use service continuum in Durham.

7.8 To complement data collection efforts that identify service gaps and inform community planning.

8. Components to a Community Mental Health Crisis Response Service

8.1 Community Mental Health Crisis Response does not respond to calls involving violence and/or weapons.

8.2 Key components to a team of mental health professionals responding to a non-violent crisis include a service that is accessible through multiple pathways, including 911.

a. A service that responds to self-referrals, family/caregiver calls and other third-party callers such as emergency responders. Integrated service in neighbouring municipalities is also important for areas of north Durham where residents access York Region for needed service.
b. Availability to provide quick response time, as in Toronto, where mental health crisis response is reported to be within 22 minutes. A response team located in north Durham will ensure an improved response to residents.
c. Available 24/7 providing mental health response to non-violent related crisis.
d. The service be part of a continuum of care with existing community services and mental health resources available in Durham.
e. Peer workers within a mental health crisis response provide important and valuable lived experience skills and knowledge to a crisis team.

9. Relationship to Strategic Plan

9.1 This report aligns with/addresses the following strategic goals and priorities in the Durham Region Strategic Plan:

a. Community Vitality: To foster an exceptional quality of life with services that contribute to strong neighbourhoods, vibrant and diverse communities, and influence our safety and well-being.
b. Social Investment: To ensure a range of programs, services and supports are available and accessible to those in need, so that no individual is left behind.

10. Considerations

10.1 DRPS has reviewed the consultant's report on a Community Mental Health Crisis Response and subsequently met with the consultant to discuss considerations of implementing a pilot in Durham Region.

10.2 A formal response from DRPS regarding a Community Mental Health Response in Durham can be found in Attachment #2 of this report.

11. Next Steps

11.1 Regional staff from the Health and Social Services Departments, as leads, will explore the financial costs of implementing a community mental health crisis response pilot in Durham to include both urban and rural areas.

11.2 Mental health crisis response exploration within Indigenous communities, will be led by Indigenous communities and supported by the Region's CAO Office.

11.3 Health and Social Services staff, with support from the Diversity, Equity and Inclusion Division, will establish program pilot key performance indicators, evaluation framework as well as identification of key stakeholders for a made in Durham model.

11.4 A copy of these findings be provided to the Durham Regional Police Services Board and 9-1-1 Board for their consideration.

11.5 A fulsome report back to Regional Council with a comprehensive plan by June 2024.

11.6 Durham residents be updated on the community engagement findings and next steps through the Durham/YourVoice webpage.

12. Attachments

Attachment #1: Report on Durham Region Community Mental Health Crisis Response Team

Attachment #2: DRPS Comments on a Community Mental Health Response in Durham

Respectfully submitted,

Original signed by

Stella Danos-Papaconstantinou
Commissioner of Social Services

Original signed by

R.J. Kyle, BSC, MD, MHSc, CCFP, FACPM
Commissioner & Medical Officer of Health

Recommended for Presentation to Committee

Original signed by

Elaine C. Baxter-Trahair
Chief Administrative Officer

Attachment 1

Report on Durham Region Community Mental Health Crisis Response Team

October 2023

Prepared by the International Crisis Response Association

Acknowledgements:

This report was prepared by the International Crisis Response Association, in partnership with Region of Durham Social Services Commissioner's Office staff. We are grateful to the Regional staff who supported this work, particularly Samantha Billingham, Allison Hector-Alexander, Patricia Hines, Marusia Laschuk, Hanna Mohammed, Danielle Thibaudeau, Heather Thompson, and Tracey Tyner Cavanagh.

We are also grateful to the community agencies who supported us in hosting focus groups, distributing our survey, and providing their own feedback used in this report. We would specifically like to thank Abilities Centre, Back Door Mission, Brock Community Health Centre, Canadian Mental Health Association (CMHA) Durham, Community Care Durham, Community Development Council Durham (CDCD), Durham Community Health Centre (formerly Carea Community Health Centre), John Howard Society Durham, Kinark Child and Family Services, Lakeridge Health, North House, Nourish and Develop Foundation, Ontario Shores, and Pinewood Centre.

We are grateful to our colleagues who assisted our focus group facilitation and notetaking, and in the preparation and review of this report. We would like to particularly acknowledge Olivia Alambo, Grace Baric, Roshan Bliss, Beth Brannon, Ben Brubaker, Liz Beeforth, Elicia Chamoun, Sally Fouché, Asante Haughton, Amanda Hoover, Amos Irwin, Jeffery Jordison, Heather Kelley, Nishat Lawal, Nadine Reid, Claire Ryder, Jason Tan de Bibiana, and Isabella Votto for their assistance.

Finally, we would like to extend our most heartfelt thanks to all community members who participated in our community engagement process and shared their stories with us. We could not have prepared this report without your courageous, thoughtful, and honest contributions.

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Executive summary

On July 29, 2020, Durham Regional Council voted to explore the development of a community mental health crisis response service that could provide civilian-led response to mental health crisis calls across the Region. The Council motion directed the Region of Durham Paramedic Services, the Durham Regional Police Service, and the Social Services Department to collaborate to explore the development of this new service. In July 2022, the International Crisis Response Association (ICRA) was engaged as a consultant to support the Region in developing proposed recommendations for the launch of this service. ICRA is an organization specializing in the development of community mental health crisis response services across Canada and the United States.

Currently, 92 community mental health crisis response services are operational across Canada and the United States, including models in Toronto, Peel Region, Edmonton, New York City, Chicago, and San Francisco. These models conserve police resources so police can more effectively respond to crime. The models also divert service users away from unnecessary hospitalizations and interactions with the criminal legal system and reduce stigma toward mental health challenges. They provide rapid access to high quality mental health care for individuals in crisis, connect service users with resources and ongoing support to prevent them from going into crisis again, and provide client-centred, holistic care that respects the dignity, autonomy, and self-determination of individuals in crisis.

ICRA, in partnership with Durham Region staff, conducted sixteen focus groups and launched a survey that received 1,426 responses to hear from Durham residents what they want to see in the proposed community mental health crisis response service. Durham residents overwhelmingly supported the development of a community mental health crisis response service, and recommended that the service be delivered in partnership with community agencies, available 24/7, and accessible via both 911 and other methods, possibly including 211 or its own number. This report summarizes the feedback provided by community members throughout the engagement process and the recommendations stemming from that process. This report also provides information about community mental health crisis response services across Canada and the United States that can serve as examples for Durham Region to develop its model in accordance with best practices.

Recommendations

The primary recommendations from this report are summarized below:

Given the input/feedback received from community members and service providers as well as the research into best practices around the world, it is clear that there is a significant demand for a service that is responsive to residents' needs. Durham Region should therefore develop a community mental health crisis response service available 24/7 throughout the Region. The service should provide de-escalation, family and service user support, referrals, follow-up, and transportation where appropriate. The team should provide rapid mobile response within about twenty minutes of receiving a call. Sufficient hubs and partnerships will need to be established, particularly in rural areas of Durham, to achieve this goal.

Service development:

- The service should be delivered in partnership with community agencies and coordinated centrally by Durham Region.
- A Request for Proposals (RFP) process should be developed to determine which community agencies should operate the service.
- Collaborative proposals (between several community agencies) should be encouraged.
- At least one crisis service should be Indigenous-led, developed by and for Indigenous communities.

Staffing the service:

- Staff should be employed by the partner agencies, and could include peer workers, paramedics, nurses, social workers, therapists, case managers, addiction specialists, and on-call physicians.
- People with lived experience should be represented on each team. Each team should have no more than three crisis workers, to avoid service users feeling overwhelmed or intimidated by the number of staff responding.
- The service should be staffed based on 911 call data in various parts of the Region; for example, parts of the Region that receive more mental health crisis calls should have a greater number of teams operating at any given time.
- Staff should be trained to provide culturally responsive care rooted in anti-racism, equity, diversity, and inclusion.

Accessing the service:

- The community mental health crisis response service should be accessible through multiple methods, including 911, another phone number (which could be 211, 988, or its own number), and online or text options.
- The service should also be accessible as a secondary responder to police and paramedic calls, when requested.
- The service should provide proactive street outreach and should prioritize serving individuals who have frequent police interactions.
- The service should respond to non-violent mental health calls, while the MHSU or primary response units should continue responding to mental health calls that may pose a safety risk.
- The service should collaborate with DMHS, PCOP, MHOP, and other Region initiatives to avoid replication or duplication of existing services.

Publicizing the service:

- A thorough, multi-pronged communications strategy should be developed to ensure the service is publicized through many channels, including social media, traditional media (including newspapers, television, and radio), and partnerships with community agencies (including libraries and schools).
- Crisis team staff should also provide community education to share information about the service with service users as well as existing service providers in the Region.
- The Region should develop a co-design process through which community members can have continued input into and information about the implementation of the new service.

Complementary and ancillary services:

- Additional funding should be provided to existing community agencies in conjunction with the launch of the new service to scale up existing wraparound services and develop referral pathways for crisis service clients to get access to crisis beds, counselling, and other ongoing care.
- A peer respite centre and other crisis stabilization services should be developed to provide support to Durham residents.
- Durham Region may also wish to explore the development of a service similar to Here 24/7 in Waterloo-Wellington, Ontario, which would provide integrated access to mental health care within Durham Region and may promote the efficacy of the community mental health crisis response service.

Pilot and operational phases of the service:

- The Region should begin by launching three pilots in different parts of Durham Region, with a prospective launch date in 2025.
- The Region should plan for these pilots to run for one or two years prior to expansion across the Region.
- Robust evaluation should be conducted to inform the pilots and further expansion.
- When the service is fully operational, there will likely be at least five teams serving the following catchment areas: Beaverton/Cannington/Sunderland, Uxbridge/Scugog/Port Perry, Newcastle/Bowmanville/Orono, Whitby/Oshawa/Courtice and Ajax/Pickering.
- The first three pilots should include at least one urban and one rural location.
- The Region should develop a community advisory board to provide input and oversight to the pilots.
- The Region should support a detailed analysis of 911 call data to determine the likely number of calls that could be diverted by the pilots and the most effective staffing models based on the number of calls throughout the day and throughout the Region.

Funding the service:

- Adequate funding and staffing must be allocated to the development of this crisis service to ensure its success.
- Investment in these pilots will ensure a systematic and coordinated approach to mental health crisis response across the Region to more effectively meet the needs of Durham Region residents.
- Investment in this responsive approach will decrease pressures on other emergency response services, such as police and paramedics.

Community feedback word cloud summaries

Who Durham residents think should staff the proposed crisis service:

How Durham residents think the proposed crisis service should be accessed:

Elements Durham residents think the proposed crisis service should have:

How Durham residents think the proposed crisis service should be advertised:

Foundational work

A mental health crisis is not a crime. Yet Durham Regional Police Service responded to 4,937 non-criminal mental health crisis calls in 2022. These calls divert substantial police resources away from responding to and solving crime, thereby reducing crucial police capacity and requiring officers to operate outside of their scope. This scope creep forces police officers into the role of mental health professionals. In July 2020, Durham Regional Council voted to explore a better way to respond to mental health crisis calls - a civilian-led community mental health crisis response team. This report details Durham Region's exploration of a community mental health crisis response model to divert mental health crisis calls away from police and send trained crisis workers instead.

Upon receiving direction from Council, the Region contracted with the International Crisis Response Association (ICRA) to lead a community engagement process and create a report with recommendations on how to design a new community mental health crisis response service. ICRA is an organization specializing in the development of community mental health crisis response services across Canada and the United States.

Rachel Bromberg, the Executive Director of ICRA, worked closely with Durham Region staff and community partners between July 2022 and October 2023 to develop recommendations on how to meet the needs of the Durham community. Bromberg previously supported the City of Toronto in the development of their community mental health crisis response service. She has also supported similar work in Barrie, ON and in several American cities, including Northampton, MA, New Orleans, LA, and Rochester, NY. Bromberg's experience includes community engagement, safety considerations, media navigation, and implementation strategy. In addition to Bromberg's expertise, the ICRA network provides access to discussions and resources related to best practices and lessons learned from dozens of cities across Canada and the United States.

Background:

Community mental health crisis response programs (often known as community responder programs) are models that send trained civilian staff to respond to mental health crisis calls rather than police. Typically these services are staffed by some combination of a medical professional such as a nurse or paramedic, a clinician such as a social worker or therapist, and/or a peer support worker. These services are typically accessible via 911, and often accessible via other methods in addition to 911, such as via 211 or their own ten-digit phone number.

Community responder models have been present in North America since the CAHOOTS team in Eugene, Oregon launched in 1989. Canadian teams have seen more recent additions, including Edmonton's 24/7 Crisis Diversion program, which launched in 2013, and Toronto's

Community Crisis Service and Peel Region's crisis service, both of which launched in 2022. As of June 1, 2023, there are 92 community responder models operating across Canada and the United States.

Evaluations of these models consistently show benefits for service users and their families, community members, other first responders, and the mental health system as a whole. These benefits include freeing up police resources to respond to crime, diverting service users away from unnecessary hospitalizations and unnecessary interactions with the criminal legal system, and reducing stigma towards mental health challenges. Some models also report reductions in crime in the areas in which they operate. These models provide immediate access to high quality mental health care for individuals in crisis, connect service users with resources and ongoing support to prevent them from experiencing another crisis, and offer client-centred, holistic care that respects the dignity, autonomy, and self-determination of individuals in crisis.

Staff safety:

Data from these 92 models further demonstrates that the vast majority of mental health crisis calls do not pose safety risks to civilian crisis team staff but rather create opportunities for referrals, connections and relationship-building. Community responder models only respond to non-violent calls. 911 call data from Ontario demonstrates more than 80% of mental health related 911 calls are non-violent. Crisis team dispatchers receive extensive training in determining which calls are non-violent and therefore appropriate for the community mental health crisis response team, and which calls might require police intervention. For the few calls that pose safety risks, police continue to be dispatched.

Crisis team staff generally receive physical self-protection and situational awareness training. They are taught not to remain on scene if safety risks become apparent, such as if a service user is behaving violently or if an environmental hazard is identified. Staff are able to call for police support when needed, and this occurs during approximately 1-3% of calls, depending on the crisis team; for example, Oakland's MACRO team calls for police support on approximately 1% of calls, while Eugene's CAHOOTS team calls for police support on approximately 2% of calls, and Toronto's TCCS calls for police support on approximately 2.1% of calls. Notably, the majority of calls for police support are not due to safety risks; they are in fact due to teams requesting support for making an apprehension under the *Mental Health Act*, which only police are able to do per Ontario law. For example, more than half of Toronto's TCCS's calls for police support are likely attributable to *Mental Health Act* apprehensions.

No community responder team member has ever been seriously injured or killed during a call, and minor injuries are generally not caused by service users. For example, some teams report injuries incurred through minor vehicle collisions on the way to a call. San Francisco's SCRT program reports zero incidences of violence from service users, while Durham, North Carolina's HEART program and Aurora, Colorado's AMRT program report that staff have never had to call for police assistance due to a safety risk.

In conjunction with the launch of a community mental health crisis response service, the Region will need to prioritize a thorough public information campaign to dispel the myths associated with mental illness and violence. The public information campaign should include expectation setting for community members about the types of calls to which the team can respond. Ensuring the community has access to available safety data and information about low rates of violence in mental health crisis calls may help to alleviate fears for staff safety.

Community engagement description:

Staff and leadership from many community organizations in Durham Region were consulted on how the Region should develop a community mental health crisis service. These organizations included:

- Lakeridge Health
- Ontario Shores
- Pinewood Centre
- Canadian Mental Health Association (CMHA) Durham
- Community Development Council Durham (CDCD)
- Carea Community Health Centre
- John Howard Society Durham
- Community Care Durham
- Back Door Mission
- Brock Community Health Centre
- North House
- Nourish and Develop Foundation
- Abilities Centre
- Kinark Child and Family Services

Between October 2022 and April 2023 sixteen focus groups were conducted. These focus groups were conducted with the following partners, in addition to five online focus groups that were open to all community members:

- Lakeridge Health
- Ontario Shores
- Pinewood Centre
- CMHA Durham
- CDCD
- Durham Community Health Centre (formerly Carea Community Health Centre)
- The Abilities Centre
- The Nourish and Develop Foundation
- McLean Community Centre
- Kujenga Wellness
- Durham Family Cultural Centre

An additional focus group was conducted for Durham Regional police officers and paramedics. Each focus group had between four and 30 attendees.

A community engagement survey was created and publicized, which was open for responses between October 2022 and March 2023. This survey received 1,426 responses.

Questions posed to participants in the focus groups included:

- What are the biggest challenges/gaps in crisis services within Durham Region?
- Tell us about your experiences accessing crisis resources in Durham Region.
- What do you think the proposed new service should look like/do?
- How can we make you feel comfortable accessing the new service?
- What organizations within Durham Region have you had positive/negative experiences with?
- How should we share information about this service?
- Do you have any other suggestions or thoughts to leave us with?

Questions asked in the police and paramedic focus group included:

- Tell us about your experiences responding to people experiencing mental health crises in the community. In your opinion, what are the greatest challenges/needs these individuals have?
- What do you know so far about the civilian-led crisis response service the Region is developing?
- What are your preliminary thoughts about this service?
- How do you think a civilian-led crisis response service might be able to support the Region in responding to mental health crisis calls?
- What are some barriers/challenges the Region might face in implementing a civilian-led crisis response service?
- How do you think we might overcome those barriers/challenges?
- How do you think the new service can work most effectively/collaboratively with DRPS/RDPS?
- Imagine you are responding to a call and identify that a community member is experiencing a mental health crisis. What would make you feel comfortable calling the new service to respond?
- How can we build trust between DRPS/RDPS and the new service?
- What are your concerns or thoughts regarding ensuring the safety of civilian-led crisis team staff and community members?
- Do you have any other feedback for us?

Substantive (non-demographic) questions asked in the survey included:

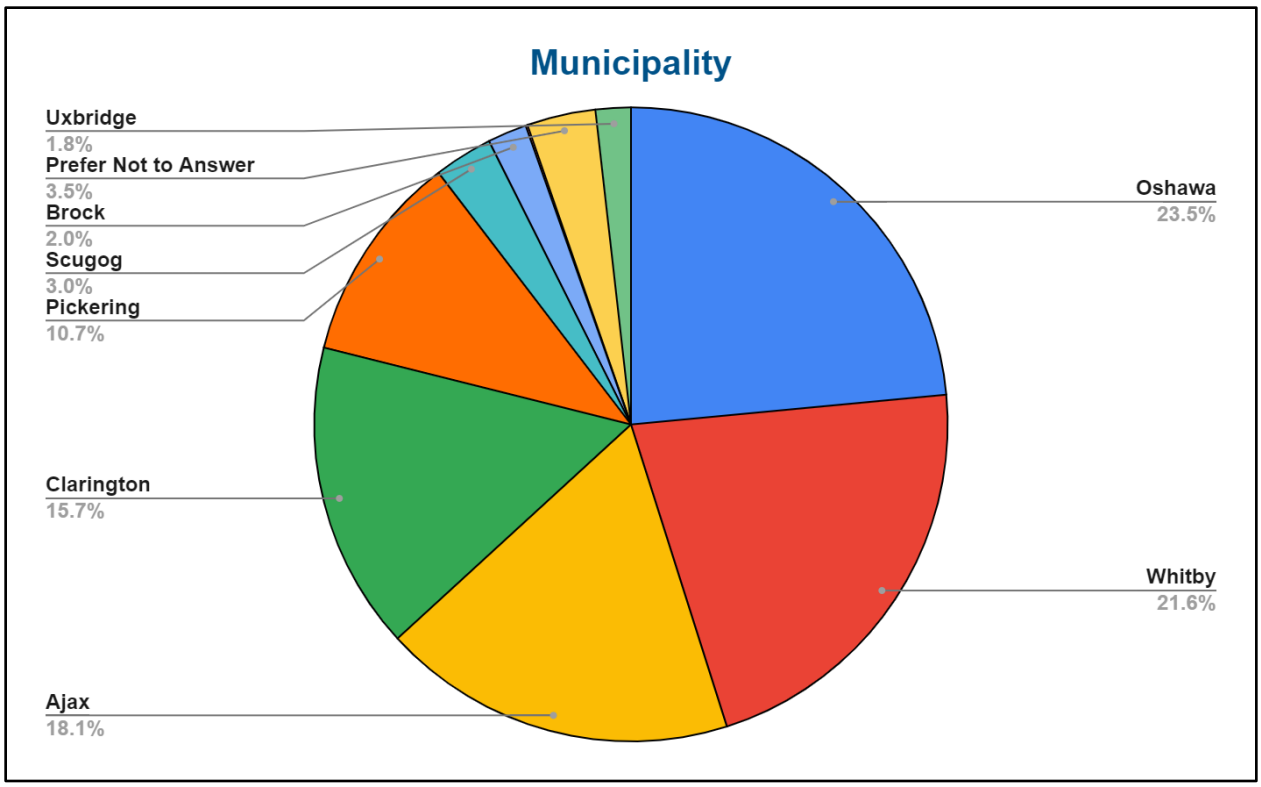
- Have you, or someone you know, had experience with existing mental health crisis services in Durham Region? (Crisis services can include a hospital emergency room, police or paramedic response to a 911 call, community-based mental health services or private therapy.)

- Please indicate the type of mental health crisis services you, or someone you know, has experienced in Durham.
- Please indicate how you have interacted with mental health crisis services in the community.
- Tell us about your experiences with existing crisis services in Durham Region.
- Do you think residents of Durham Region would benefit from a Non-Police Led Crisis Response?
- If the Region develops a new Non-Police Crisis service, what would you like this program to look like?
- How would you like to access the new non-police crisis services? (e.g., By calling 911, through 211, through other methods)
- What would make you feel safe accessing the new service?
- How can we ensure the new service meets the needs of diverse communities within Durham Region, particularly 2SLGBTQI, people with disabilities, seniors, Black and Indigenous Communities?
- How do you learn about new services in your community? (e.g., through Facebook, through word of mouth from family and friends, through community agencies you are already connected with)
- How do you think we should share information about the new service to ensure people hear about it?
- Do you have any additional feedback for us?

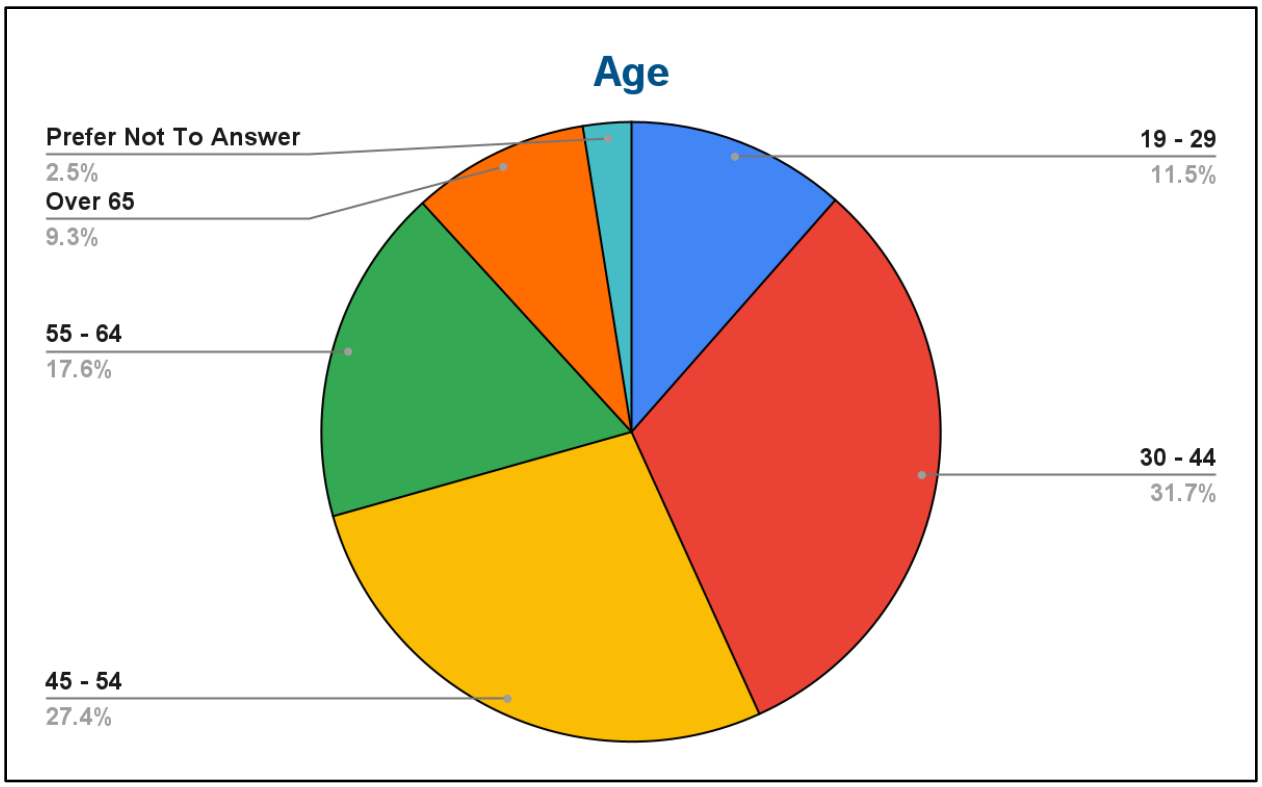
Community engagement demographic information:

Demographic information was not collected from focus group attendees; however, individual focus groups were specifically held for members of Indigenous communities, Black communities, 2SLGBTQI+ communities, individuals with disabilities, and North Durham residents. Community engagement work was conducted through the lens of intersectionality, with priority placed on understanding how community members' identities might impact their experiences and how multiple identities (e.g., being Black and having a mental health diagnosis) might coalesce to add further complexity.

Further community engagement, particularly with Indigenous communities, is being supported by the Region's Diversity, Equity, and Inclusion Office. More information about this engagement process will be provided at a later date.

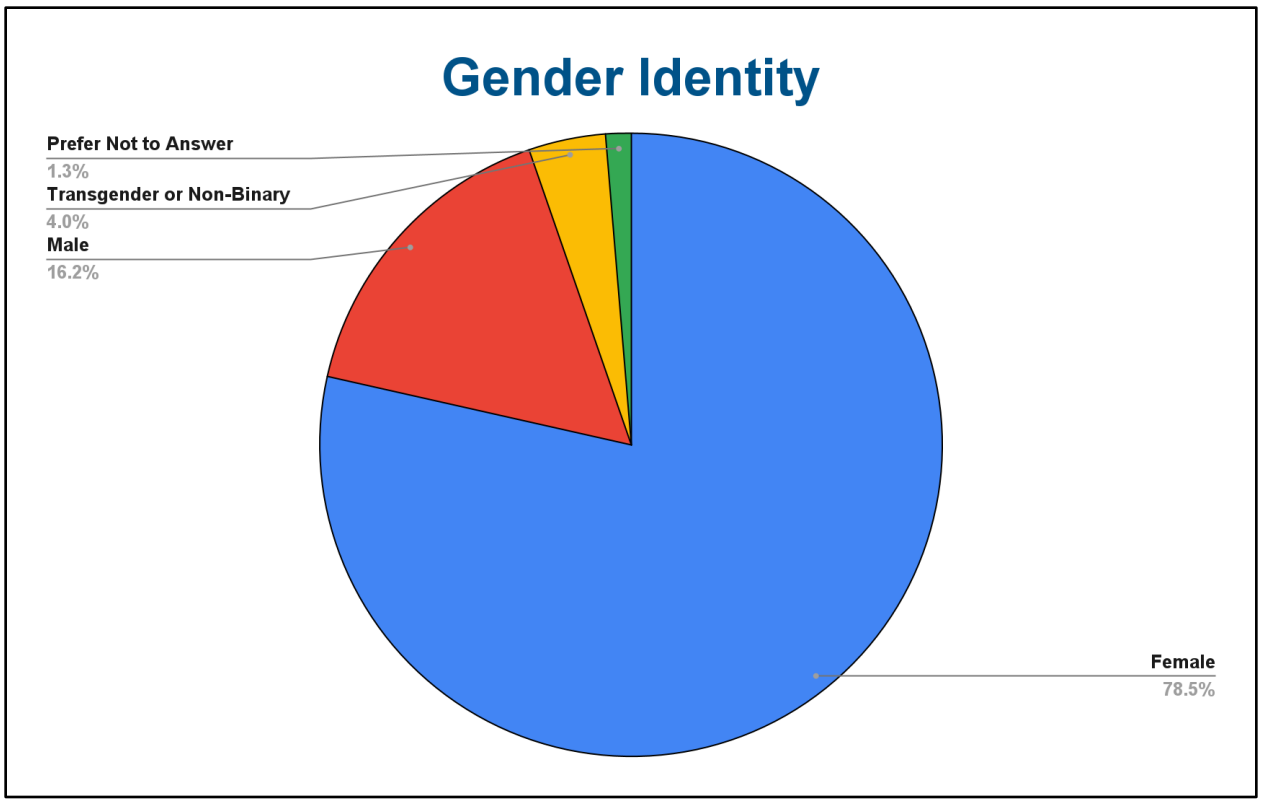


Of the individuals who filled out the survey, 23.5% live in Oshawa, 21.6% live in Whitby, 18.1% live in Ajax, 15.7% live in Clarington, 10.7% live in Pickering, 3.0% live in Scugog, 2.0% live in Brock, and 1.8% live in Uxbridge. 0.1% reported no fixed address, and 3.5% preferred not to answer.

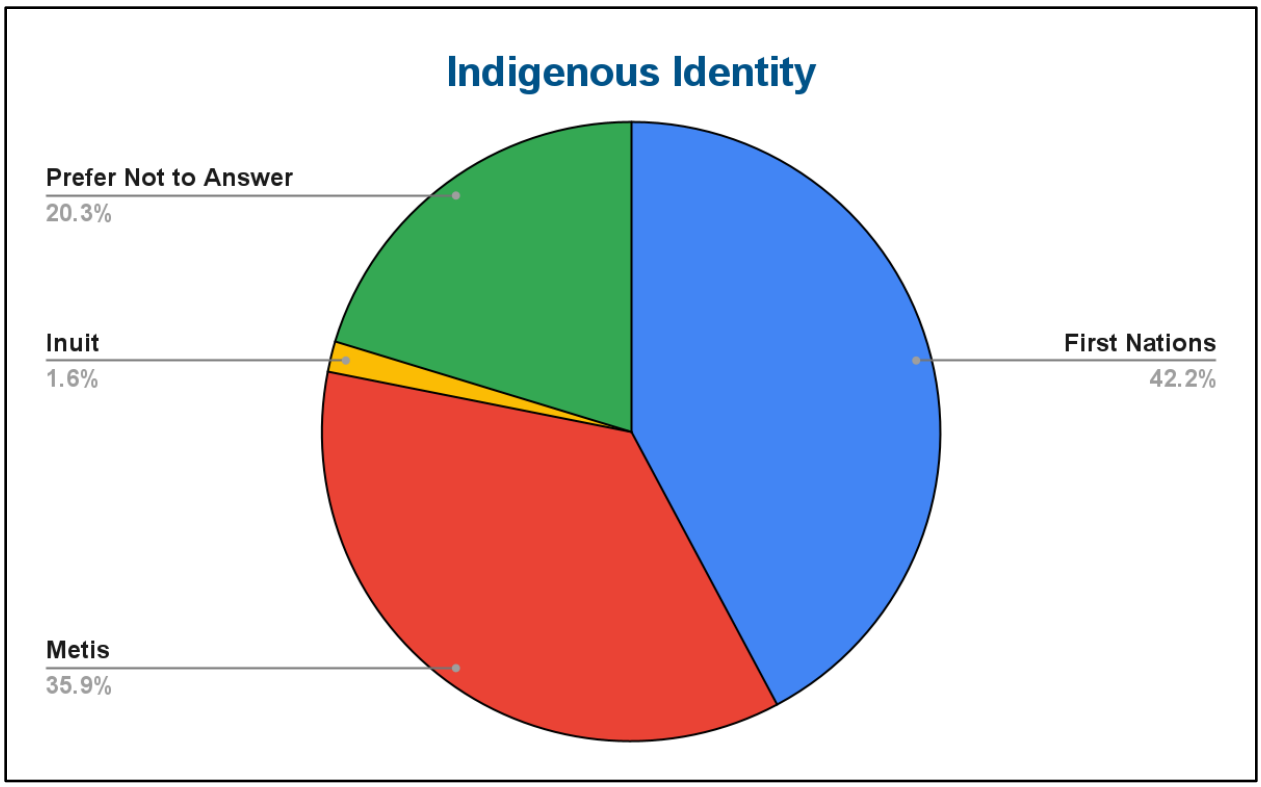


There was a relatively even split amongst age groups filling out the survey, with 11.5% being between the ages of 19 to 29, 31.7% being between the ages of 30 to 44, 27.4% being between the ages of 45 to 54, 17.6% being between the ages of 55 to 64, and 9.3.% being above the age of 65. 1.6% preferred not to answer.

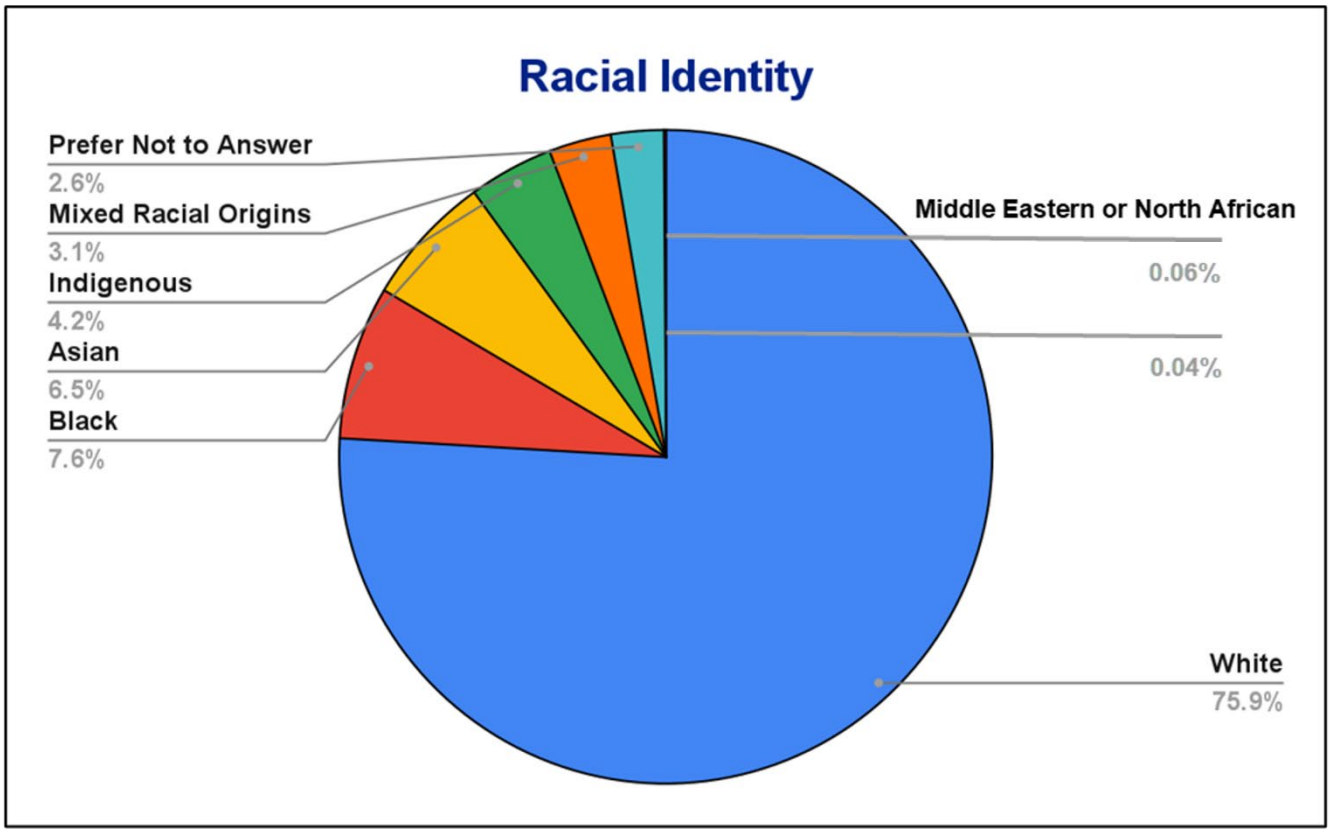
The underrepresentation of those under age 30 and those over age 65, as well as the low percentage of respondents living in rural areas, is likely explained by the fact that the survey was primarily distributed through service providers (e.g., people who work at mental health agencies, shelters, food banks, libraries, etc.). Given the dearth of services available in rural areas, these service providers likely disproportionately reflect 30- to 65-year-olds living and/or working in more urban areas of Durham Region.



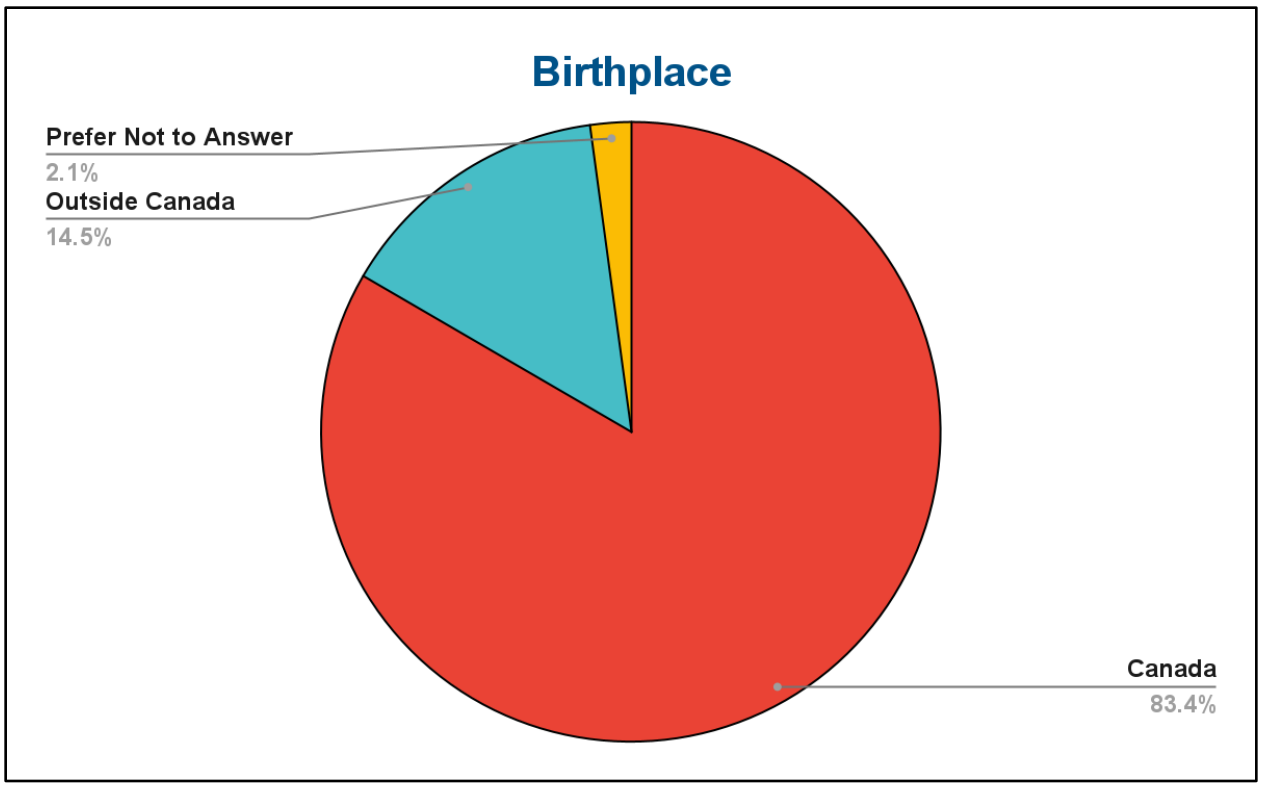
The majority (78.5%) of survey respondents were female. 16.2% of respondents were male, while 4.0% identified as gender fluid, gender diverse, non-binary, transgender, or Two-Spirit. The remainder of participants skipped the question or selected “prefer not to answer.”



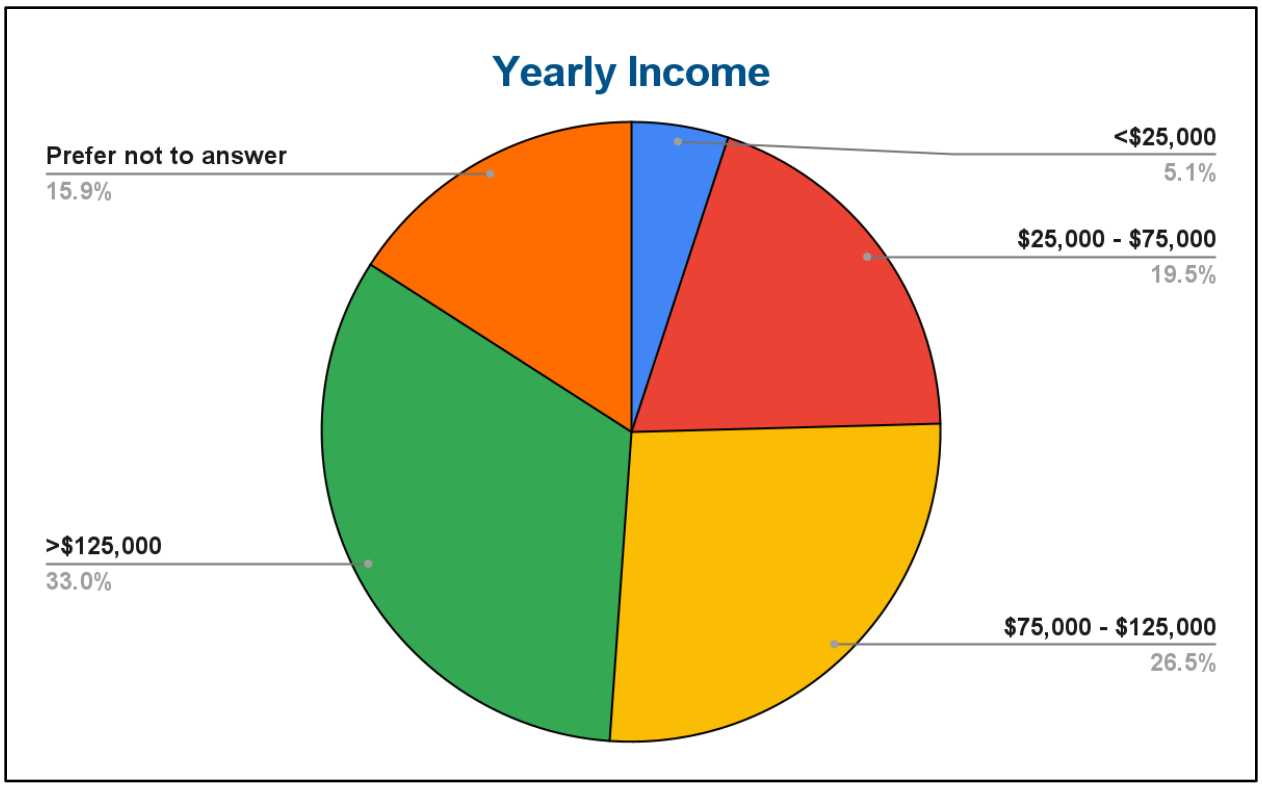
4.2% of respondents identified as Indigenous. Of those, 42.2% identified as First Nations, 35.9% identified as Métis, and 1.6% identified as Inuit.



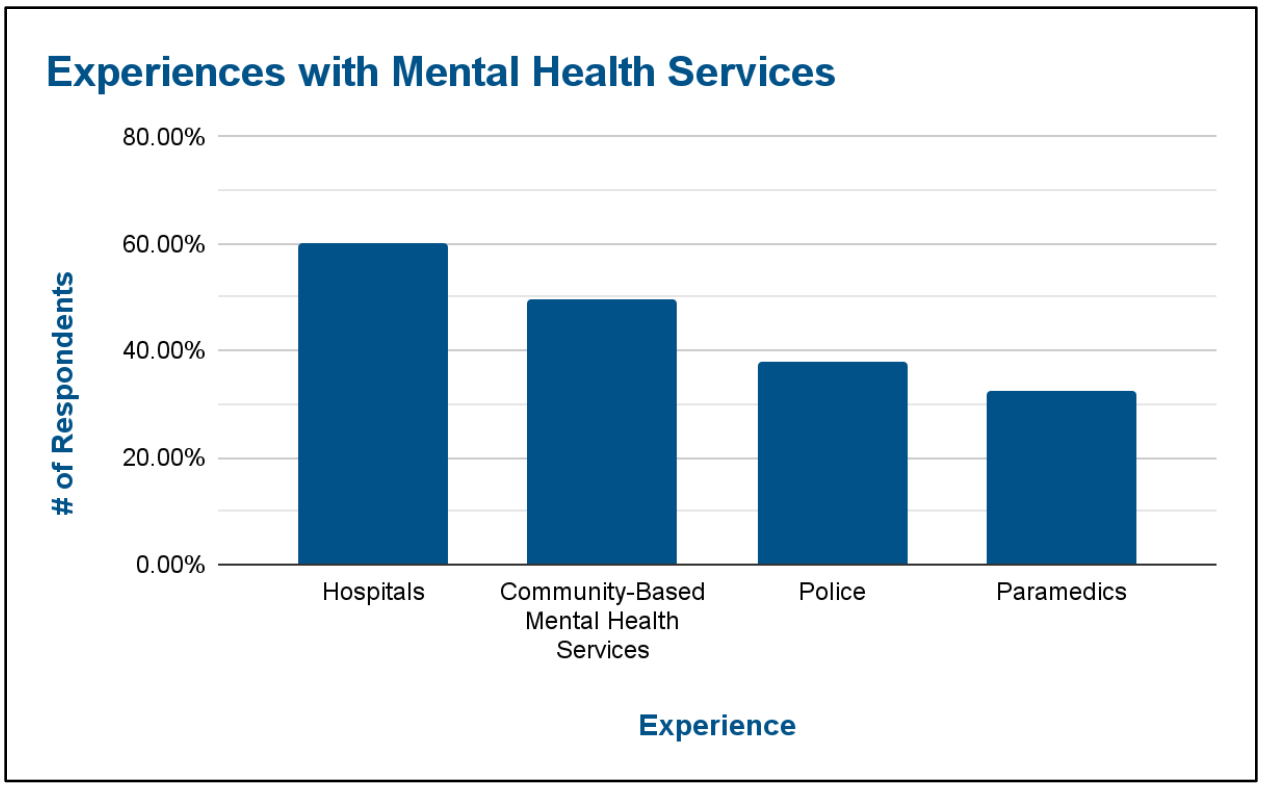
75.9% of respondents identified as white, while 7.6% identified as Black, 6.5% identified as Asian, 3.1% identified as having mixed racial origins, 0.06% identified as Middle Eastern or North African, and 0.04% identified as Hispanic or Latino.



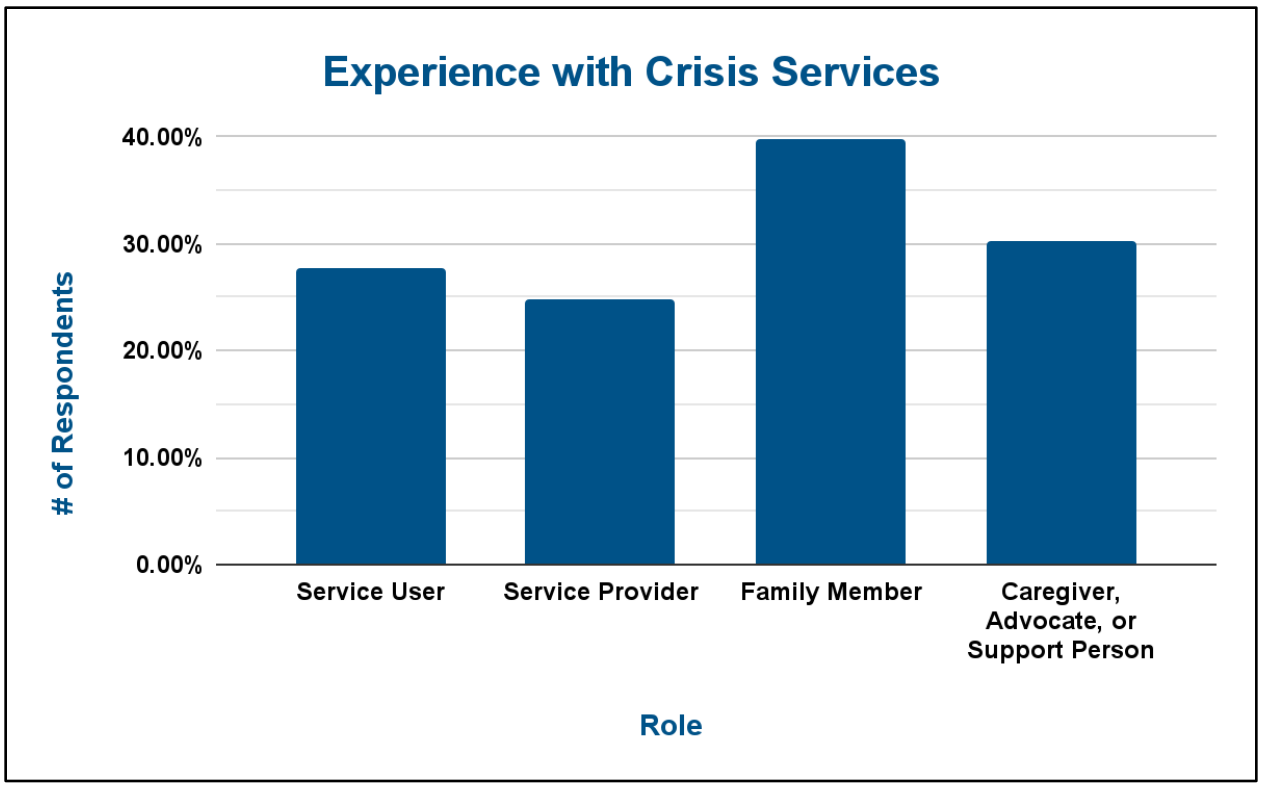
83.4% of survey respondents were born in Canada, while 14.5% were born outside of Canada and 2.1% preferred not to answer.



5.1% of survey respondents have a household income of less than $25,000 per year, while 19.5% have a household income between $25,000 to $75,000 per year, 26.5% have a household income between $75,000 to $125,000, and 33.0% have a household income of more than $125,000 per year. People with high incomes were therefore overrepresented in the survey respondents.



The majority of respondents (78.0%) indicated that they or someone they know have had personal experience with mental health crisis services in Durham Region. Of these respondents, 60.1% indicated having experience with hospitals, 49.6% indicated having experience with community-based mental health services, 37.8% indicated having experience with police, and 32.5% indicated having experience with paramedics. However, these results should be interpreted with caution, given that a number of people selected that they had experience with all of the above services, but then did not identify having personal experience with any crisis services in their written responses elsewhere in the survey.



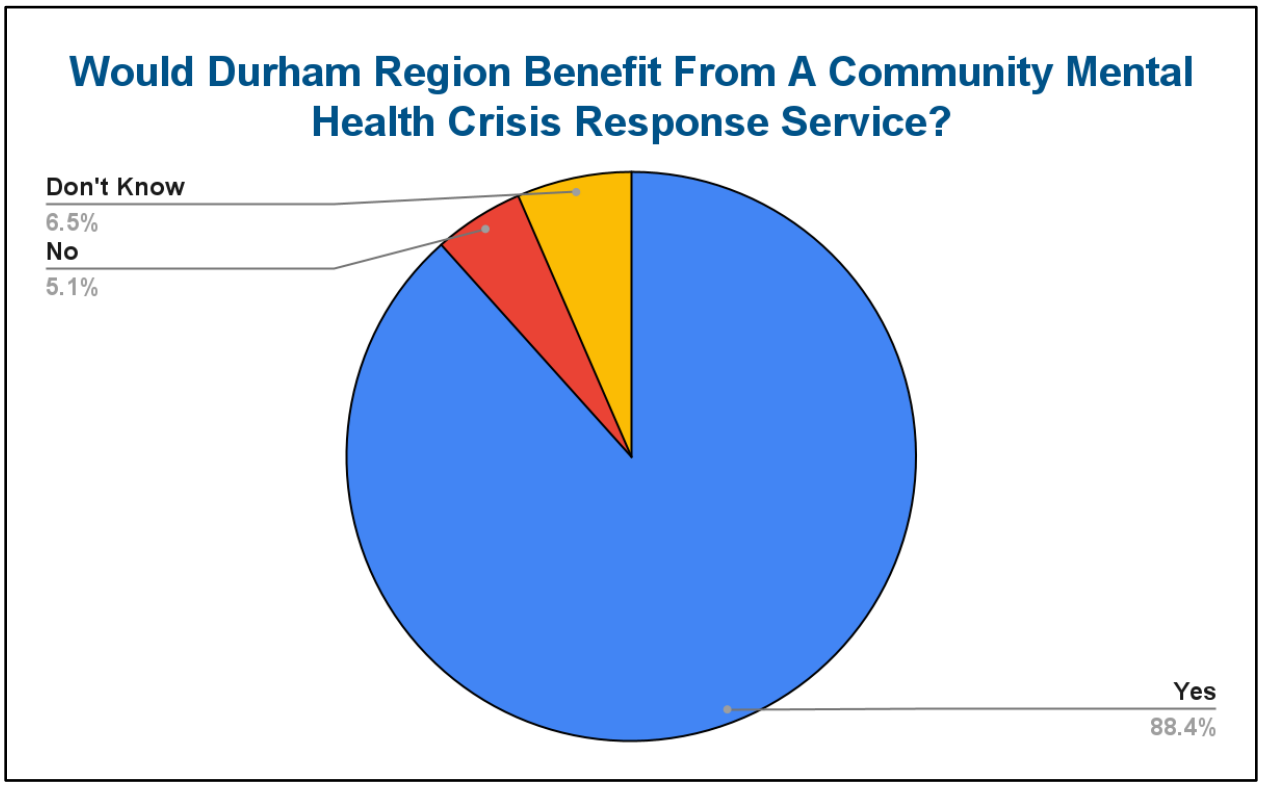
27.8% of these respondents indicated that they had experience with crisis services as service users, while 24.8% indicated that they had experience with crisis services as service providers. 39.8% of respondents indicated that they were family members of a service user, while 30.3% indicated that they were a caregiver, advocate, or support person. However, these results should also be interpreted with caution, because many of the people who selected experience with all of the services mentioned in the previous question also selected having experience with all of the roles mentioned in this question. Additionally, the terms “service user,” “service provider,” and “caregiver, advocate, or support person” were not defined in the text of the survey, so respondents may have had varying interpretations of what they refer to.

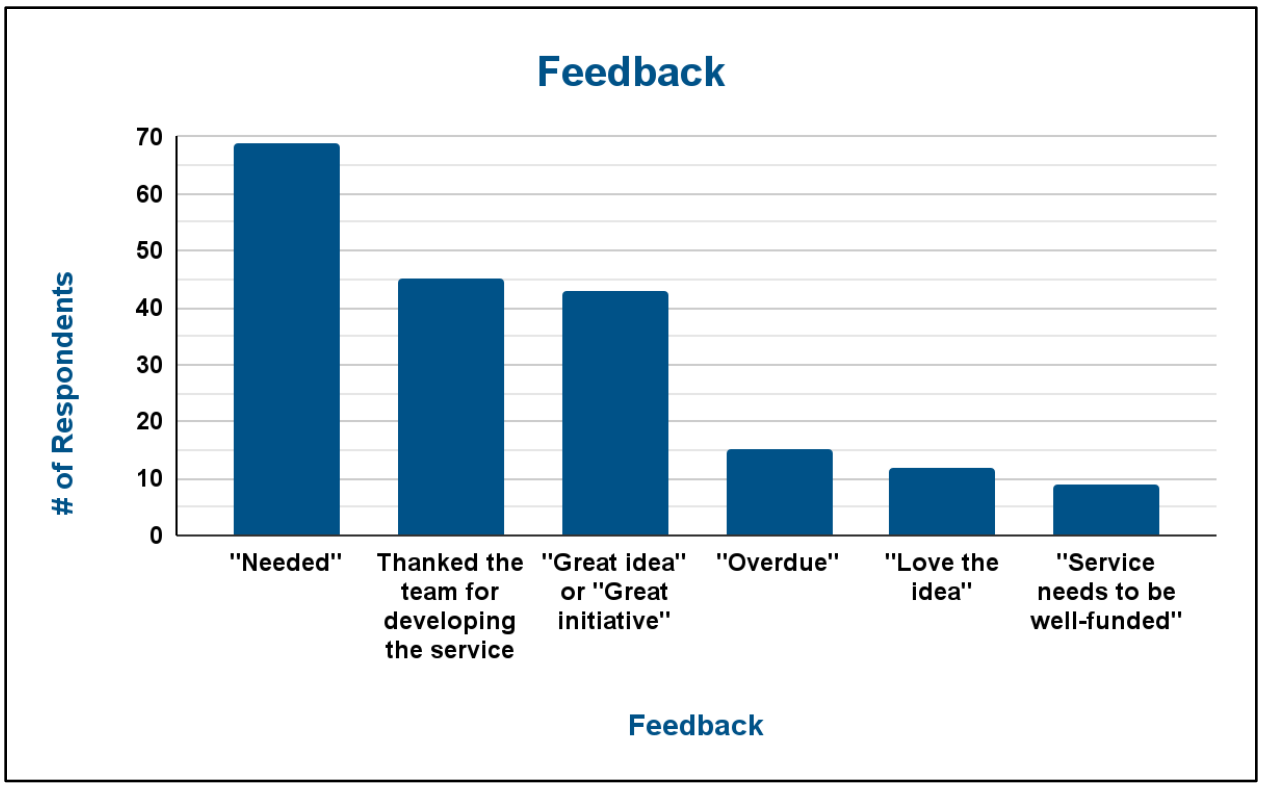
From the text of the survey responses, it appears that a high percentage of respondents were family members of service users, and as such the data received may be skewed towards family perspectives rather than service user perspectives, which differ in some substantial ways (discussed further below). For example, many service users identified existing services as being insufficiently consent-based; they experienced crisis response as coercive, forceful, and restrictive. Many of them indicated that in order to feel safe using the service, they would need to be assured that they would not be involuntarily hospitalized. Conversely, family members typically experienced crisis response services as being *insufficiently* forceful or restrictive; they typically stated that services did not do enough to involuntarily hospitalize their family members and that hospitals released their loved ones as soon as they no longer met *Mental Health Act* (MHA) criteria without providing what the family members believed was essential (though involuntary) care. Family members were also typically concerned about not receiving sufficient

information about their loved ones' conditions, while service users were concerned about information being improperly shared with others against their will and wanted to ensure their privacy and confidentiality were maintained.

Community perceptions of the proposed community mental health crisis response service:

Generally, community engagement participants felt positively about the development of a community mental health crisis response service. 88.4% of survey respondents said that they believe the Region would benefit from a community mental health crisis response service, while 5.1% said "no" and 6.5% said "I don't know." The reasons respondents provided for selecting "I don't know" varied; some respondents were concerned about the safety of staff on a community mental health crisis response team, while other respondents were concerned that the crisis team might replicate existing coercive mental health services rather than providing transformative, client-centred care. Other respondents were concerned that the Region might not provide adequate funding to ensure the success of the program, or that additional resources may be necessary to ensure the program's success. Several respondents who selected "I don't know" indicated concerns that existing services, such as the Mental Health Support Unit and Durham Mental Health Services, may not have been sufficiently consulted with in the proposal for a new service.





43 survey responses characterized the proposed crisis service as a “great idea” or “great initiative.” 69 survey responses described the proposed crisis service as “needed,” including 6 responses that described the service as “desperately needed” and 16 that described the service as “very needed,” “very much needed,” or “much needed.” 15 survey responses described the service as “overdue.” 12 survey responses stated that they “love” the idea of this service. 9 survey responses highlighted the need for the service to be well-funded. 45 survey responses thanked the team for working to develop this service.

Representative comments from the community engagement work included:

- “Please launch this service.”
- "This is what every community needs."
- "This would be a game changer! Please implement."
- "It's AWESOME this is potentially happening!”
- "I am excited to see this transformation within the Region."
- "I’m hopeful Durham can be a leader in caring for our residents."
- "I am pleased that the region that I live in has recognized a need and is working to deal with it. Hopefully, we won't lose too many before the program is in place."
- "I am happy to see this is being considered. Hopefully Durham Region can set an example and be a leader in this globally needed initiative."
- "Offering a community mental health crisis response is very positive in trying to alleviate the STIGMA around mental illness. There is no health without mental health."

- "I have worked in community mental health and substance use for 15+ years and am in full support of community-based MH response vs police. Community based services are vastly more skilled and equipped to respond to MH crisis, being trauma informed and effective, with a supportive response vs punitive/judicial response."
- "I wish you the best in this undertaking. It will definitely provide a worthwhile service for residents."
- "This would be a great initiative! There's lots of evidence supporting non-police led models."
- "A specialized mental health team for Durham region would be a blessing, especially during this surge in mental health post pandemic. I would love to see this come to fruition."
- "This program could make a significant impact on the lives of individuals experiencing mental health concerns, especially those with multiple intersections of oppression."
- "Its existence will make people feel safer."
- "I am very glad to hear that this is something that the Region is developing. It will help the community so much and take some of the workload off of police officers who have so much to deal with and navigate through when responding to calls."
- "This is a necessary service and worth the investment. This is a reason to stay in Durham region; we have the hope of respect even while in crisis."
- "I hope my daughter never has another admission, but if she does, that your planning will result in less trauma."
- "This is a much-needed service in the community so thank you for moving forward with this - mental health is an illness not a crime."
- "If we have mental health professionals as the first responders, I think we can save many lives."

The community engagement participants who were opposed to the development of a community mental health crisis response service generally stated that they were concerned that civilian crisis team staff might be injured by violent service users. 22 survey responses mentioned this perceived risk. More information about crisis response teams and safety is provided in the staff safety section of this report. It will be important for the crisis response service and trusted Durham Region leaders to embark on a public education campaign to dispel myths related to safety and make sure the public is provided with accurate information on the minimal risks to civilian staff on community mental health crisis response teams, as well as steps being taken to ensure the safety of these staff. Additionally, a small number of participants expressed stigma toward people experiencing mental health challenges and/or to unhoused people. These responses demonstrate the need for greater awareness about mental health, substance use, and homelessness, and for greater support provided to those who are struggling. Providing enhanced support, resources, and effective response measures to the Region's most marginalized members will likely set a positive example and thereby reduce stigma towards those in need.

A small number of respondents raised broader political concerns in their responses (e.g., criticizing what they perceive as “radical progressive ideology,” stigmatizing comments about mental illness or homelessness, comments about “wasting taxpayer money,” etc.). Some of these respondents followed up their comments with an expectation that their responses will be filtered out and results will be “cleaned” to exclude their voices. Results indicate that most respondents are in support of a community mental health crisis response team; however, approximately 2-3% of survey respondents expressed strong opposition to this initiative, citing for example the belief that a radical political agenda is being pushed that is not in the best interests of Region residents.

Additionally, some feedback received in the survey or focus groups was beyond the scope of this project (e.g., people recommending changes be made to the *Mental Health Act*). These comments have been filtered out for the purposes of this report, which is focused on a narrower goal than the entire mental health system in Durham Region.

Limitations:

The sample of survey and focus group participants is likely not representative of the people who are most likely to use or be most impacted by the proposed community mental health crisis service. For example, survey respondents were disproportionately white and with high income. North Durham is also substantially underrepresented. Therefore, the feedback received may not be fully generalizable.

Additionally, it is likely that people who responded to the survey or attended focus groups may have had particularly positive or particularly negative experiences with existing crisis services within the Region of Durham. It is therefore important to note that extremely positive or extremely negative experiences may be overrepresented in the report. The feedback provided by community engagement participants may not be representative of the full range of experiences Durham Region residents may have with police, paramedics, hospitals, community mental health agencies, or any other services.

Furthermore, some survey responses contained conflicting or discrepant statements. This made it challenging to accurately determine people's wishes or know what their answers would have been if they had interpreted the questions as they were intended. For example, some people suggested that 211 be used to dispatch the service but then made comments later in the survey that indicated that they did not know what 211 was.

Additionally, a substantial minority of respondents indicated that they want the Region to develop a non-police crisis team, but then stated below that they feel that a police officer should accompany the civilian crisis workers. This makes it difficult to know whether the respondents misunderstood the questions or objective (i.e. to develop a *non-police* team), whether they think a non-police crisis team is a *bad* idea and would only support a team pairing a police officer with one or several crisis workers, or whether their preference would be for an officer to be on the team but they would still support a fully non-police team.

Many respondents suggested that the Region consider developing a co-responder model that pairs police with a mental health worker, such as Toronto's MCIT or Hamilton's COAST; however the Region already has a co-responder model, the Mental Health Support Unit (MHSU), which many respondents seemed to be unaware of. As the new service is proposed and developed, it would likely be beneficial to highlight the existence of the MHSU and how the new community mental health team will complement the existing co-responder model. For example, it might be beneficial to frame the community mental health crisis response team, the MHSU, and the primary response units of the police service as a "continuum of care" where low-risk non-violent calls will go to the community mental health crisis response team, higher-acuity calls will go to the MHSU, and calls involving serious danger will continue to be responded to by DRPS primary response units.

Additionally, a small but notable number of respondents had strong misgivings about a community mental health crisis service, citing concerns that crisis workers would be injured by violent service users. Others perceived that the project is a “defund the police” initiative and highlighted the value and importance of police services in communities. It may be beneficial to share information with the community about how a new crisis response service would be funded, in order to combat these concerns. This project will require a strong partnership with Durham Regional Police Service and other first responders in order to succeed, and as such it may be beneficial to provide public education and information about the community mental health crisis response service, emphasizing the importance of partnerships with first responders.

International landscape:

Services provided:

Community mental health crisis response teams typically respond to calls related to mental health, substance use, suicidality, welfare checks, and unhoused individuals. Many teams, such as Dayton, Ohio's Mediation Response Unit (MRU), respond to verbal disputes between community members, including domestic disputes and disputes involving juveniles. Teams can provide de-escalation, mental health assessments, safety planning for suicidal service users, harm reduction services, basic medical care such as wound care and prescription support, supplies such as bottled water and warm clothing for unhoused service users, information and referrals to other community-based services, and transportation to voluntary services such as shelters, healthcare services, and crisis beds. Some services also provide street outreach and community education. For example, Olympia, Washington's Crisis Response Unit (CRU) provides community outreach to unhoused populations in Olympia's downtown core, and Eugene, Oregon's CAHOOTS program provides community education in schools.

Prevalence:

There are approximately 92[1] programs across Canada and the United States (as of June 1, 2023) that divert non-violent mental health crisis calls made to 911 to a civilian-led crisis service. Dozens more such models are currently in development. These models are not co-responder models like Durham's Mental Health Support Unit (MHSU); they do not pair civilian staff with police officers to respond to calls together. These models are also not community-based crisis teams that are accessed solely through their own ten-digit number, such as Durham Mental Health Services (DMHS). They instead are able to accept 911 calls either via direct integration with 911 or via a warm transfer model in which 911 is able to transfer a mental health crisis call to the service. Some of these models are incorporated into 911 such that when a community member calls 911, they are asked, "Do you need fire, police, ambulance, or mental health?" Many cities, including Toronto, have designated this service as a fourth branch of the emergency response system.

The Vera Institute of Justice, the Law Enforcement Action Partnership, and the Center for American Progress have conducted detailed data analysis of 911 calls in many cities. They have concluded when community responder models are fully operational, they can likely respond to between 19-39% of 911 calls initiated by the public. Many cities are already diverting

[1] These programs include 89 American programs described by this directory, as well as programs in Toronto, Peel, and Edmonton.

high proportions of their 911 calls to these models, and will increase the number of calls diverted as the programs expand and become better known by their communities.

Models:

There are several emerging models for these programs. One model contracts with community agencies in the catchment area to deliver the service. The municipality might coordinate the service centrally, but the staff of the crisis team would be employees of the community agency. This model has the benefit of leveraging existing agency expertise to provide crisis services and is particularly beneficial when a well-established community crisis response service already exists in the municipality. This model also is likely to be perceived as trustworthy by community members who already have a relationship with the contracted agency. Cities that use the community agency model include Eugene, Oregon, whose CAHOOTS program is delivered in partnership with the White Bird Clinic; Minneapolis, Minnesota, whose Behavioral Crisis Response (BCR) program is delivered in partnership with Canopy Roots; and Toronto, Ontario, whose Community Crisis Service (TCCS) is delivered in partnership with four lead agencies.

Another model creates a new municipal department to house the crisis service. This model has the benefit of greater stability and staff retention, given that the staff are city employees. This model may also have increased legitimacy since the department is run by the city as a fourth emergency service similar to police, fire, and EMS. Cities that use the municipal department model include Albuquerque, New Mexico's Community Safety Department (ACS); Northampton, Massachusetts's Division of Community Care (DCC); and Sacramento, California's Department of Community Response (DCR).

Several cities have hybrid models in which one staff member on the crisis team is employed by a community agency and the other staff member is a city employee. For example, Phoenix, Arizona's Community Assistance Program (CAP) consists of one city employee and one employee from Terros Health, a mental health agency that has been contracted by the city to provide crisis response.

Other municipalities house their community mental health crisis response services in the Fire Department, EMS, or the police department. For example, Portland, Oregon houses its Portland Street Response (PSR) program within the Fire Department, and New York City houses its B-HEARD program within its fire and EMS services. In many American cities, EMS is housed within the fire department. One benefit of this model is the use of existing infrastructure, since fire departments are already spread across most municipalities. Crisis teams working out of fire stations can therefore be strategically located to provide efficient response times. Another benefit of this model is that communities generally have strong trust in their fire and paramedic services. Brooklyn Park, Minnesota's Alternative Response Team (ART) is housed within the police department and is staffed by a social worker and community paramedic.

Routes of access:

Typically, community mental health crisis response services are accessible via 911. Most services employ a direct dispatch model. Crisis team staff are directly dispatched via 911 dispatchers, in the same way that police, paramedics, and firefighters are dispatched. Many crisis team staff also carry first responder radios and have mobile computer aided dispatch (CAD) systems so that they can communicate easily with 911 dispatchers and other emergency services such as police and paramedics if necessary. Additionally, they can self-dispatch to some calls that come over the police radio. One drawback to this model is that in some municipalities, to use first responder radios, individuals may have to pass stringent background checks, which may preclude some people with lived experience from being hired on the crisis teams.

Another model for ensuring access via 911 is a "warm transfer" model in which 911 is not the primary dispatcher, but can transfer calls to an external dispatcher. Edmonton's 24/7 Crisis Diversion service and Toronto's TCCS service use 211[2] as the primary dispatcher of the service; 911 call-takers are trained to screen mental health-related 911 calls, and if they determine the call is appropriate for diversion to the community mental health crisis response service, they transfer the call to 211 for community mental health crisis response team dispatch. Community members are also able to call 211 directly to access the crisis service. In the Toronto team's first six months of operation, 62% of calls were received via 911 warm transfer, while 21% were received via 211 directly. Other calls were self-initiated during street outreach or received via the anchor agency's own crisis lines.

Other crisis teams that can be accessed via 211 include Rochester, New York's Person In Crisis Team (PIC) and Contra Costa, California's Anyone, Anywhere, Anytime (A3) team. Several cities, including San Diego, California's Mobile Crisis Response Team (MCRT) and Anaheim, California's Community Care Response Team (CCRT) have partnered with local or regional crisis lines to ensure that their services can be accessed via the crisis line numbers. Berkeley, California's Specialized Care Unit (SCU) is accessible via both 911 and its own direct line. Sacramento, California's Department of Community Response (DCR) is accessible via both 911 and 311[3]. Some crisis services may also become available via 988[4] later this year.

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[2] 211 is a hotline that provides information, referrals, and connections to social services, including mental health services. 211 is available in the province of Ontario. Many American jurisdictions have their own 211 services.

[3] 311 is a hotline that connects residents to non-emergency municipal services and provides information about public services such as transit, sanitation, and emergency preparedness. Durham Region has a 311 service, as do most Canadian and American cities.

[4] 988 is an amalgamation of suicide crisis lines across the United States, which provides 24/7 phone and text-based support. On November 30, 2023, Canada's suicide crisis services will also be amalgamated into an accessible 988 number.

Staffing:

Most crisis teams send two staff members out on each call. Two staff members is generally considered a best practice. For safety reasons, less than two responders is ill advised, but more than two people can overwhelm someone in crisis. Cities that send three staff members include San Francisco's Street Crisis Response Team (SCRT); New York City's B-HEARD team; Durham, North Carolina's HEART team; Long Beach, California's Community Crisis Response Team (CCRT); Portland, Oregon's Portland Street Response (PSR) team; and Athens-Clarke County, Georgia's Alternative Response Team (ART). These cities generally send three staff members in order to provide broader holistic care; one staff member is a mental health clinician, one staff member is a medical staff member such as a paramedic or a nurse, and one staff member is a peer support worker or peer navigator. A notable exception is New York City. New York's B-HEARD team is staffed by two paramedics and one social worker, due to rules set by the paramedic's union stipulating that paramedics cannot be the sole paramedic on scene at a given time.

Many teams pair a mental health clinician with a medical professional, such as a nurse or paramedic. However, some teams hire trained community mediators, such as Dayton, OH's MRU. Other teams prioritize hiring peer support workers. Some teams develop a specific role for a peer support specialist. For example, Toronto's TCCS service; San Francisco's SCRT service; Durham, North Carolina's HEART team; Contra Costa, California's A3 team; Phoenix, Arizona's CAP service; Portland, Oregon's PSR team; Athens-Clarke County, Georgia's ART team; Long Beach, California's CCRT team; San Diego, California's MCRT service; Fairbanks, Alaska's Mobile Crisis Team (MCT); Hartford, Connecticut's HEARTeam; and New Haven, Connecticut's COMPASS team all hire peers to work alongside clinicians and/or medical staff.

Other models do not create a unique peer support specialist role but instead create a "crisis worker" position and prioritize hiring people with lived experience to fill that role. Services using this model include Washington, DC's Community Response Team (CRT); Eugene, Oregon's CAHOOTS team; Dayton, Ohio's MRU; Saint Petersburg, Florida's Community Assistance and Liaison (CALL) team; Winston-Salem, North Carolina's Behavioral Evaluation and Response (BEAR) team; Irvine, California's Mobile Crisis Response Team (MCRT); Northampton, Massachusetts's Division of Community Care (DCC); Modesto, California's Community Health and Assistance Team (CHAT); Louisville, Kentucky's Crisis Call Diversion Program (CCDP); the Specialized Assistance for Everyone (SAFE) teams in Cotati, California, San Rafael, California, and Rohnert Park, California; and the Be Well mobile response teams in Garden Grove, California, Huntington Beach, California, and Newport Beach, California.

Community partnerships:

Community mental health crisis response teams are only part of a broader community crisis support system. Municipalities that have implemented these services emphasize the importance of avoiding the creation of a "road to nowhere" whereby service users are stranded due to a lack

of community resources to support them after their crisis is stabilized. Community mental health crisis response teams in most jurisdictions are augmented by other services such as crisis beds, peer respite centres, sobering centres, and harm reduction sites. Additionally, many cities are developing innovative comprehensive crisis response systems to meet the needs of individuals at all stages of a crisis, including preventative care, mobile services, and follow up support. These frameworks often include “someone to call, someone to come, and somewhere to go” - phone-based support, mobile support, and crisis beds or peer respite centres. For example, Baltimore has received a $45 million grant to transform its crisis services over five years. This funding will develop a regional call centre to efficiently divert mental health crisis calls away from police and towards appropriate resources; expand capacity of Baltimore’s community mental health crisis response teams to make them available 24/7; expand same-day virtual and walk-in mental health services so people in crisis can quickly access them; and develop extensive community education and outreach programs to raise awareness of and build trust with these services.

Examples of existing programs:

Below are descriptions of several existing programs with particularly innovative, successful, and/or longstanding models.

Waterloo-Wellington, Ontario’s Here 24/7 program:

One model that has developed effective integrated referral pathways to avoid a “road to nowhere” is the Here 24/7 service in Waterloo-Wellington, Ontario, which launched in 2014. Here 24/7 is not a community responder model; however, its effective consolidation of services may serve as an example for the Region of Durham’s proposed community mental health crisis response service. Here 24/7 is an integrated “front door” to all mental health services in the Waterloo-Wellington region. Here 24/7 provides phone-based crisis support and civilian-led mobile crisis support. Here 24/7 is also the hub for mental health services in the region. All mental health services can be accessed via Here 24/7, and prospective clients can reach out to Here 24/7 in order to find out which resources are available, which services will best meet their needs, and which services will be available soonest. Here 24/7 can put service users directly onto wait lists for each mental health agency in the region, and can triage existing wait lists to ensure clients with the greatest needs get served expeditiously. Here 24/7 is therefore able to provide multi-level support to service users, including preventative care, phone-based support, in-person mobile support, direct referrals, and service coordination.

Toronto’s Community Crisis Service (TCCS):

Toronto’s TCCS model launched four pilots in 2022 and recently released an evaluation of its first six months of operation. TCCS is a partnership between the City of Toronto and lead community agencies in four parts of the city. Its anchor agencies are the Gerstein Centre in Downtown East, the 2-Spirited People of the 1st Nations in Downtown West, CMHA Toronto in

the Northwest, and TAIBU Community Health Centre in Scarborough. These catchment areas were selected as pilots because they are the four areas with the highest concentration of mental health-related 911 calls. The Toronto pilots include an Indigenous-led crisis team called Kamaamwizme wii Naagidiwendiiying, which is discussed further in the Indigenous voices section of this report.

Toronto's crisis service is dispatched by 211; however, it is also accessible via 911 and via some of the anchor agencies' own phone lines. For example, the Gerstein Crisis Centre has its own crisis line through which people can request access to Gerstein's TCCS team. The service responds to calls in the following 911 call types: Thoughts of Suicide/Self-Harm, Person in Crisis, Wellbeing Check, Distressing/Disorderly Behaviour, Dispute, and Advised. TCCS staff are multidisciplinary and include peer support workers, crisis workers, nurses, social workers, and therapists. The service is available 24/7.

In its first six months of operation, TCCS received 2,489 unique calls, including 1,530 calls via 911. Toronto police data shows that 70% of calls sent to TCCS were successfully diverted and were handled by TCCS without police attendance. Of the remaining 30%, the majority of these calls were dispatched to police due to factors unrelated to safety; for example, in 98 events the caller requested both TCCS and the police, in 95 events 211 determined that the call was not within the scope of the pilot or within the pilot area and TCCS was never dispatched, and 49 events are described in a Toronto Police Services Board report as, "Officers were dispatched prematurely, or prior to offering the TCCS to the caller." TCCS staff themselves called for police backup only 52 times (2.1% of calls), generally for reasons unrelated to safety risks. Diversion rates and the number of calls resolved without police attendance are expected to increase as implementation continues and processes between the partner agencies are fine-tuned.

The average time for the crisis team to arrive on site was 22 minutes. TCCS was projected to have saved police officers 5,816 hours in its first six months of operation. Service users generally reported positive experiences with the service.

Edmonton's 24/7 Crisis Diversion program:

Edmonton's 24/7 Crisis Diversion service launched in 2013. The service is available 24/7, and is operated by a community mental health agency, REACH Edmonton. The service is staffed by crisis workers and is dispatched via 211. It is also accessible via warm transfer from 911. The service responds to calls involving unhoused individuals, as well as mental health and other crisis calls. In 2021, the service received over 29,000 calls, 11,000 of which resulted in mobile dispatch.

Eugene, Oregon's CAHOOTS program:

Eugene, Oregon's CAHOOTS program is the longest-running community responder model in North America. It launched in 1989 and is a partnership between the City of Eugene and the White Bird Clinic, a community health clinic that delivers the service. CAHOOTS is available

24/7. CAHOOTS is dispatched directly via 911, and its staff carry police radios so they can receive dispatches and self-dispatch to calls; for example, if a call is for an address that CAHOOTS has responded to in the past. CAHOOTS can also be requested by the Eugene Police Department to provide secondary response after police have attended the scene; for example, if police are initially dispatched due to a safety concern, but police then determine there is no safety concern. CAHOOTS is staffed by one crisis worker and one medic, and generally they prioritize hiring staff with their own lived experience of mental health challenges. CAHOOTS responds to calls involving unhoused individuals, mental health, suicide threats, self-harm, substance use, welfare checks, non-emergency medical issues, and conflict resolution. CAHOOTS provides de-escalation, assessments, basic medical care, supplies such as blankets, food, and bottled water, and transportation to medical and/or mental health care. In 2021, CAHOOTS responded alone to 14,212 911 calls and co-responded with police to 1,958 911 calls. CAHOOTS requested police backup on 301 of those calls – approximately 2% of calls to which they responded alone.

Contra Costa, California's Anyone, Anywhere, Anytime (A3) program:

The A3 program in Contra Costa, California was launched in 2022. The service is one of the most holistic and flexible community responder models within North America. The service is accessible via three different methods, including 911, 211, and a community crisis hub. The service provides three different levels of service. Level 1 service is for welfare check and other low-risk calls. A peer support specialist is paired with an EMT to respond to Level 1 calls. Level 2 service is for more acute or serious behavioural health crises or where a person requires a clinical assessment. A peer support specialist is paired with a licensed clinician and/or a substance abuse counselor to respond to Level 2 calls. Level 3 service is for acute or serious behavioural health crises that may involve safety concerns. A peer support specialist and a licensed clinician are paired with a police officer to co-respond to Level 3 calls.

The service is available from 8 am to 12:30 am daily. In 2022, the program served 2,986 callers. 75% of calls were resolved over the phone, while 25% required a mobile response. Mobile response time is generally within 1-2 hours. A3 is ramping up its service and hiring additional crisis team members, with the goal of being able to provide response in less than an hour by the end of 2023. A3 is currently developing a campus that will provide on-site crisis services, peer respite, a sobering centre, and urgent care, in order to create "a place to go" for people experiencing crisis in the community.

Olympia, Washington's Crisis Response Unit (CRU):

Olympia, Washington's CRU service launched in early 2019. The service is staffed by crisis workers and is available from 6:00 am to 3:00 am seven days a week. This service involves substantial street outreach in Olympia's downtown core. CRU can be accessed via 911 direct dispatch; its staff use police radios to receive calls and self-dispatch where appropriate. CRU may also be requested by other emergency services, including police, fire, and paramedics. However, the majority of CRU interactions are self-initiated by CRU team members, who spend

most of their shifts doing outreach in Olympia's downtown core and responding to individuals who appear to be in distress or in need of support. CRU provides supplies such as food, bottled water, blankets, and clean clothing to unhoused Olympia residents. CRU can also provide voluntary transportation to help individuals access services. Olympia further offers a Familiar Faces program in which peer support specialists provide support and resources to individuals who frequently interact with law enforcement. CRU responds to over 2,000 calls per year; since its inception, no staff have ever been injured, and police backup has only been required due to safety concerns on two calls.

Denver, Colorado's Support Team Assisted Response (STAR) program:

Denver, Colorado's STAR team launched in June 2020. The service is available from 6 am to 10 pm daily. STAR pairs an EMT and a behavioural health clinician to respond to calls related to mental health, substance use, poverty, and homelessness. The service is dispatched via 911 and can also be accessed through its own direct number. Between January 1, 2022 and July 1, 2022, STAR responded to 2,837 total calls. The team has only once had to call for police backup due to a safety issue, and no staff have ever been injured since the program's launch. An evaluation of STAR conducted by Stanford University found that since STAR's launch, crime has been significantly reduced in STAR's areas of operation, compared to other parts of Denver.

San Francisco's Street Crisis Response Team (SCRT):

San Francisco's Street Crisis Response Team launched in November 2020. The service is available 24/7 across the city and is staffed by a community paramedic, a mental health clinician, and a peer support specialist. The service is dispatched via 911. SCRT responded to 14,230 calls between November 2020 and November 2022. Its average response time is approximately 17 minutes to arrive on scene. 97% of calls were able to be resolved without police intervention; for the 3% of calls in which SCRT requested police support, the majority of these calls were not violent and did not require restraint.

Indigenous communities:

Incorporating Indigenous leadership and Indigenous cultural practices is a high priority for the proposed community mental health crisis response team. Historical, intergenerational, and present-day harms inflicted on Indigenous communities, including cultural genocide, residential schools, the Sixties Scoop, and ongoing disparities in health outcomes and incarceration necessitate trauma-informed, strengths-based, culturally responsive care led by Indigenous communities themselves.

Elevating Indigenous voices and perspectives will require a thorough community engagement process, led by Indigenous Peoples. The Diversity, Equity, and Inclusion Division at the Region of Durham will be supporting the facilitation of further community engagement with Indigenous communities throughout 2024, with the goal of developing an Indigenous-led crisis response service. Additionally, Durham Region will soon be listing a job posting for the role of Manager, Indigenous Relations.

The Region is exploring existing Indigenous-led crisis response models, including the Kamaamwizme wii Naagidiwendiiying Indigenous-led crisis response team in Toronto. Kamaamwizme wii Naagidiwendiiying is one of four Toronto Community Crisis Service pilots that launched in July 2022. The service is run in partnership between the 2-Spirited People of the 1st Nations, the ENAGB Indigenous Youth Agency, and the Parkdale Queen West Community Health Centre. The service provides crisis intervention, primary care, harm reduction, traditional wholistic[5] supports, mental health support, family support, system navigation, referral coordination, and access to basic life needs such as food, water, clothing, sleeping bags, and tents. The service is relational, trauma-informed, culturally responsive, and rooted in community. The service employs crisis workers, case managers, nurses, harm reduction workers, and peer support workers. It is available 24/7 through 211 or 911. It is also available through the 2-Spirited People of the 1st Nations' Indigenous Mental Health Crisis Response phone line.

The Region has already received 59 survey responses from Indigenous community members, and has facilitated a focus group at Carea Community Health Centre for Indigenous community members, with 26 attendees. Additionally, the Durham Region Aboriginal Advisory Circle and Dnaagdawenmag Binnoojiiyag Child & Family Services were consulted for their feedback. Themes from this community engagement are summarized below.

[5] Wholistic theory is a concept integral to many Indigenous teachings. This perspective views the "whole person" as being connected to "all my relations," including the Spirit.

Community engagement themes:

Several community engagement participants specifically identified the Toronto-based Kamaamwizme wii Naagidiwendiiying crisis response model as one that Durham should emulate. For example, one participant said, "I've read about the Indigenous-led crisis response pilot program in Toronto and think that model and those principles would benefit Durham Region, Indigenous and non-Indigenous residents included."

Participants stated that the service should operate in alignment with Indigenous principles and should focus on the collective and take a wholistic approach to support. They recommended that traditional Indigenous medicines and cultural practices should be incorporated in crisis and post-crisis care, including healing circles, smudging, sacred fires, and sweat lodges. They further suggested that Elders, Traditional Knowledge Keepers, and Indigenous staff members be hired to provide crisis support to Indigenous communities. One participant said that hiring Indigenous staff is “an important part of reconciliation.” Another participant highlighted the importance of valuing and prioritizing Indigenous cultural knowledge and hiring staff based on this knowledge, rather than prioritizing western ways of knowing.

Many participants suggested hiring an Indigenous person as a consultant to lead the development of an Indigenous-led crisis response service. They further recommended that this role be permanent and adequately compensated commensurate with the crucial importance of the role and the lived experiences and trauma of their communities. Other participants suggested that the community mental health crisis response team should have an Indigenous advisory board, with honoraria provided for attendance and feedback.

Participants also provided advice on how to engage respectfully with Indigenous communities. They suggested that Regional staff conducting Indigenous engagement will need to familiarize themselves with Indigenous norms, including understanding that “Indigenous information is sacred” and that there are culturally normative ways to respectfully request Indigenous knowledge. Specifically, participants suggested that facilitators will need to be mindful of how certain questions are asked, given that much of the information requested may be tied to trauma Indigenous communities have experienced and continue to experience with social services (health, education, police services, etc.) Participants highlighted the need to enter Indigenous spaces “as guests and as listeners,” and to recognize how difficult these conversations are to have. They further recommended that Indigenous engagement work be done in the spaces where Indigenous communities already gather, rather than asking Indigenous participants to commute to other areas.

Finally, participants emphasized that the service should respect Indigenous self-identification, rather than requiring individuals to show a status card or identify themselves as belonging to a particular band. Due to the historic and ongoing impacts of colonization, many members of Indigenous communities have been alienated and disconnected from their traditional and home communities and may not have "formal" status as per the *Indian Act*. This should not preclude any community member from accessing and benefitting from the Indigenous crisis team.

Indigenous engagement strategy:

Throughout the next year, the Diversity, Equity, and Inclusion division at the Region of Durham will facilitate a comprehensive Indigenous engagement strategy to support the development of an Indigenous-led service. Funding will need to be allocated by Council to hire Indigenous consultants to inform how the service should be designed. Regional staff and consultant partners will regularly re-engage with community members to share progress and updates, as many community members are eager to hear more about this initiative. Future Indigenous-led engagement could include focus groups, partnerships with existing community organizations, participation at community events, and other initiatives. This engagement will require additional time, resources, and trust-building to ensure this service meets the needs of Indigenous community members. A separate report will be prepared at the conclusion of this community engagement process with a proposed service delivery model and detailed plan for the implementation of an Indigenous-led crisis response team.

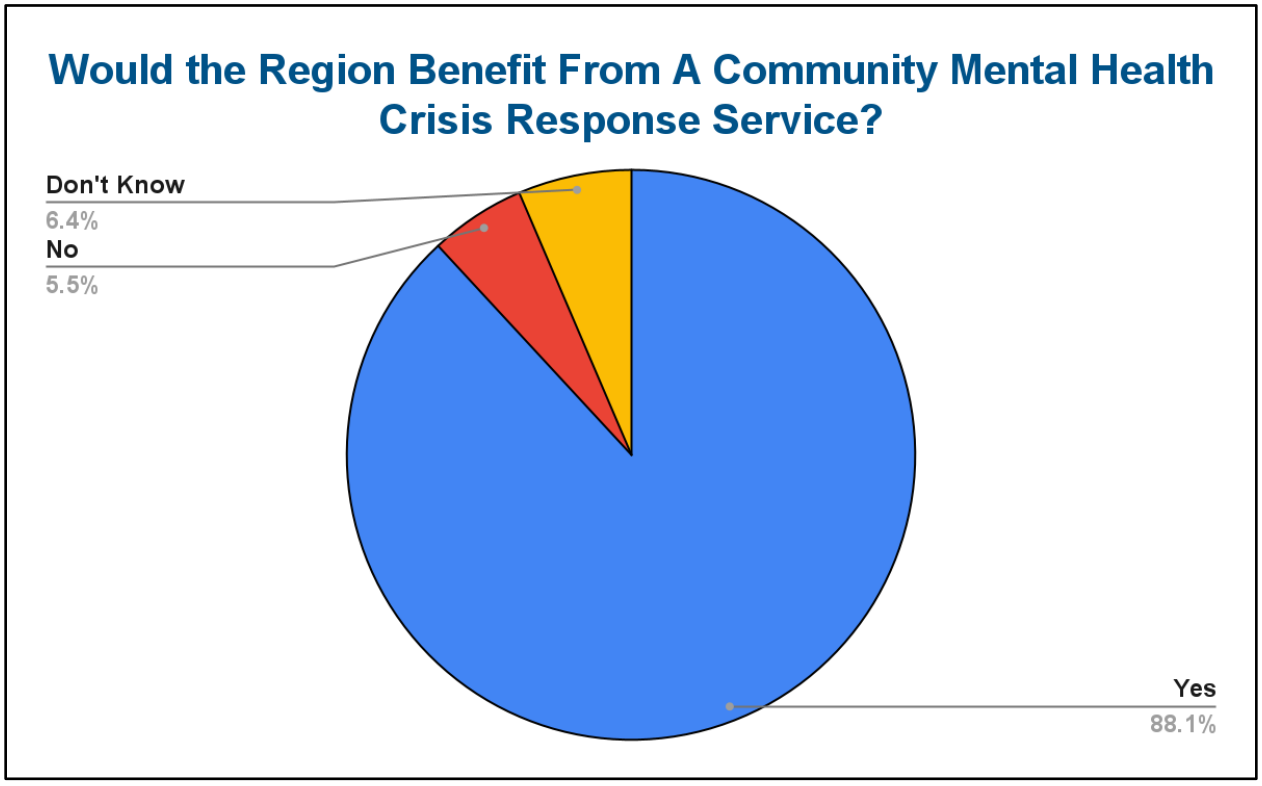
Black communities:

Black communities have been disproportionately impacted by over-policing and often face many barriers to accessing mental health treatment, including stigma, racism, and a lack of culturally responsive services. It is essential for a community mental health crisis response service to support the needs of Black communities and to be co-designed by those communities. The Region of Durham will continue its engagement with Black community members throughout 2024.

The Region has already received 109 survey responses from Black community members, and has facilitated a focus group specifically for Black communities in Durham Region. Themes from this community engagement are summarized below.

Community engagement themes:

Generally, the majority of Black survey respondents favoured the development of a community mental health crisis response service. 88.1% of survey respondents said that they believe the Region would benefit from a community mental health crisis response service, while 5.5% said no and 6.4% said “I don’t know.”



A significant portion of Black participants described negative experiences with police and/or fear of calling the police when they or their loved one was in crisis. Many participants therefore suggested that a civilian-led crisis response service be developed. One Black female participant said, “Uniformed police shouldn’t be first responders for those in crisis, it only aggravates and triggers already vulnerable people, especially those who are racialized/marginalized.” Another Black female participant said, "There is still a lack of trust between marginalized communities and the police." Another Black female participant recounted her loved one’s many experiences with police while in mental health crisis and stated that her loved one “feels threatened by the presence of police.” A Black male participant said, “Cops make crisis calls worse for the one seeking help.”

Other participants described frightening experiences with police. One Black female participant described a police interaction her loved one had experienced by saying, "Cops threatened to arrest a person in crisis with guns drawn. They were dismissive and had no clue on de-escalation.” A Black male participant said, “My close friend’s son had a mental health issue and police [were] called. They were forceful, which [escalated] the situation." A Black female participant said, "Situations with DRPS were at times more [triggering] for the individuals experiencing a [mental health] crisis. [I] witnessed officers unsure of how to handle [mental health] calls which led to an escalation of the situation."

Another Black female participant described her friend being in a mental health crisis and said, “The police officers who came were honestly quite aggressive and ended up tackling my friend. They called a female officer after the fact to help and she was even aggressive and impatient with someone who was clearly having a mental health breakdown…My friend was traumatized by the fact that she was basically arrested and put in cuffs." Another Black female participant described police threatening to arrest someone who was experiencing a mental health crisis. She said some white people may experience police as “kind and caring,” but that Black people disproportionately experience police as “traumatizing.” She concluded, “Black people’s experiences are always inequitable.”

One Black female participant described having no other resort other than to call the police due to the under-resourcing of the mental health system. “It feels hopeless at times,” she said. “Scary, because when someone is in crisis and cannot be de-escalated, the only and last resort is calling the police. On a person we love and want to see safe. That is often a very fearful call." Another Black female participant stated that she would not feel safe calling the police if her loved one was in crisis, saying, “Particularly in a crisis situation I would fear injury and death coming to my loved one at the hands of the police.”

Other participants described negative experiences in hospitals and identified racism, microaggressions, and lack of diversity in these settings. One Black female participant described hospital staff assuming her young adult Black son was a “drug addict” when he was in crisis. Another Black female participant said, "I work in the mental health field and the amount of racism that occurs between service providers and service users is appalling."

Participants generally described barriers to accessing mental health care, including long wait times both in the emergency department and at community-based services, a lack of availability of services, services being too complex to navigate, and private care being too expensive to access. One Black female participant described her experience trying to access help for her loved one, identifying “significant delays because the resources are not there, or processes are not clearly identified and streamlined. I can't imagine the barrier for those with less time to attempt to navigate the various hoops."

Participants described the importance of cultural sensitivity and responsiveness, as well as the necessity of developing crisis teams that reflect the communities they serve. 44% of Black participants specifically mentioned hiring representative diverse staff. One Black female participant stated, “The present services and providers do not reflect the diversity of certain parts in Durham. Please improve this and culturally relevant approaches."

Many participants further commented on the importance of staff members understanding culture, religion, and intergenerational trauma, and receiving training in anti-Black racism. One Black female participant said, "My experience in a mental health crisis was definitely impacted by my race." Another Black female participant said, "Black people appreciate representation and speaking to someone who doesn't have a preconceived notion of how we are. Respect is also very important." Another Black female participant said, “Think beyond the white norm.”

Participants noted the importance of co-design with Black communities and other communities of colour, and of meaningful engagement to ensure the service meets the needs of these communities. They further identified linguistic diversity and engagement with religious communities as necessary to meet this goal. One Black female participant said, "In North America religious [communities] are excluded from the support team…However the layers of the Black community [are] entangled in church and culture. This part of the community must be present at the table for support.” This participant suggested partnering with churches and other religious institutions to engage Black communities in co-design and ensure the responsiveness of the service to their needs.

Experiences with police:

When a person calls 911 because they or someone they care about is experiencing a mental health crisis, police are generally dispatched to respond. In 2022, Durham Regional Police responded to 2,677 mental health related calls. Some of these calls are responding to people who may experience multiple police contacts per year due to their mental health concerns. These calls result in a significant use of police time and resources, yet often do not result in individuals with mental illness getting the help they need. These contacts can also lead to people with mental health challenges becoming entangled in the criminal legal system, rather than being connected with appropriate mental health services, often due to the under-resourcing of social services in Durham Region.

One primary goal of developing a community mental health crisis response team is to reduce the burden of mental health crisis calls on police. Police are not formal mental health crisis workers. Police are tasked with preventing, responding to, and investigating crime, violence, and other dangerous situations, while mental health workers are tasked with de-escalating, supporting, and providing resources for people experiencing mental health crises. The proposed community mental health crisis response team will allow police to direct their resources to their mandate, while mental health crisis workers can step in to support people in crisis with their own mandate. In other jurisdictions across Canada and the US, the proposed model has proven to reduce the number of “familiar faces” police contacts through connecting these individuals with effective wraparound services to meet their mental health needs, as well as by diverting these calls at the point of entry before they get dispatched to police.

In order for a community mental health crisis response team to successfully achieve this outcome, the team will need to build a mutually trusting partnership with Durham Regional Police. While the community mental health crisis response team will typically respond to calls without police presence, there may be instances where the community mental health crisis response team and the police attend the same call concurrently or consecutively. For example, in other jurisdictions, a high number of calls to community mental health crisis response teams are initiated by police officers. A police officer may arrive on scene only to realize that an individual is experiencing a mental health crisis, and the officer may then call the community mental health crisis response team to the scene to provide their expertise. For example, in Denver, Colorado, 34.8% of calls to their community mental health crisis response team, STAR, are initiated by police officers on scene.

In addition, police, paramedics, 911 call-takers, the community mental health crisis response team, and all others involved in first response will need to have a thorough understanding of each other’s roles, processes, and procedures. This can be accomplished through cross-team training, informal networking between the teams, weekly status meetings, disseminating information about the new service to existing first responders, and having crisis team staff attend police and 911 parades. Finally, it is essential that the proposed community mental

health crisis response team not be framed as an anti-police initiative. The proposed team will require partnership and cooperation from all existing first responders in order to achieve its goals, and framing the service as anti-police will lead to a perceived loss of legitimacy both with first responders and with the broader community.

Existing police/mental health programs:

Durham Region already has several police-mental health collaborations. The community mental health crisis response team should collaborate with these existing services to ensure that it is not replicating or replacing these models. The community mental health crisis response team should determine how to best complement existing models to develop a tiered response system wherein some calls will be more appropriate for a police-mental health partnered model and others will be appropriate for the community mental health crisis response team.

The Mental Health Support Unit (MHSU) is Durham Region's co-responder program. This program pairs a specially trained Police Constable with a Registered Nurse from Lakeridge Health to respond to mental health related police calls. This program is a secondary response model, meaning that it is not dispatched directly via 911. Instead, frontline officers currently on scene can make a request for the MHSU to be dispatched to assist them. The MHSU is available between 7:00 a.m. and midnight seven days a week, and the team responds in an unmarked police vehicle and in plainclothes.

Generally, community engagement participants reported positive experiences with the MHSU, when they were able to access it. Participants commented that the MHSU's limited staffing meant that they were often unable to access the MHSU even where it may have been beneficial. However, when the MHSU was able to respond, participants generally had positive experiences, describing the team as "awesome," "fantastic," "very helpful," "patient," "understanding," "providing excellent support and care," and "a significant asset."

Durham Region launched a 911 call diversion program in 2022, which embeds a mental health clinician in the 911 communications centre. The goal of this program is to divert non-emergency mental health calls away from an in-person police response. Instead of dispatching police, the call is transferred to the mental health worker, who can de-escalate the crisis and provide referrals and resources over the phone. 410 calls have been successfully diverted by the 911 call diversion program in its first year of operations.

Durham Regional Police already receive substantial training from the Police College in responding to mental health calls. This training will continue to be offered. Many community engagement participants made suggestions or recommendations for the improvement of police training; however, police training is outside the scope of this report and of the community mental health crisis response team implementation.

General themes from community feedback:

Many community engagement participants discussed police in their survey or focus group responses; approximately 22% (311 total) comments mentioned police. Of these comments, 11% raised concerns around the safety of civilian staff on a community mental health crisis response service, while 10% commented on police training. 26% of comments discussing police mentioned the importance of having a civilian-led service. This section describes the themes community engagement participants expressed during surveys and focus groups. This section does not intend to imply numerical representativeness of each theme; for example, some themes were raised more often than others. However, all themes that were raised by multiple participants and were relevant (i.e., commenting on experiences with mental health crisis responses from Durham Regional Police) are included here. Themes related to training are not included in this section, because training is beyond the scope of this report and because many of the comments about training (i.e., that Durham Regional Police "receive no training" in mental health) were inaccurate.

Many participants commented on the important role police play in responding to crime and to violent or dangerous incidents. Due to the strong association between police and crime or violence, some participants believed that police response to non-violent mental health crisis calls is unnecessarily stigmatizing. The majority of community engagement participants believed that a community mental health crisis response team should respond to non-violent mental health crisis calls, while a police-led or police-partnered team (such as the MHSU) should respond to calls involving weapons, violence, or danger.

Some participants (approximately 11% of participants who discussed police, or 34 total) described police in positive terms, either in general or in reference to specific police officers they had encountered during their or their loved ones' mental health crisis. For example, police were described as "helpful," "supportive," "respectful," "understanding," "kind," "caring," "compassionate," "professional," "empathetic," "resourceful," "attentive," "sympathetic," and "calming." Unfortunately, few of these participants provided detailed anecdotes about their experiences with DRPS; generally, positive adjectives were the extent of their response. Additionally, many of these same participants (and others) raised concerns that even the kindest, most compassionate police response still unnecessarily criminalizes and stigmatizes mental health challenges. For example, one participant noted, "Calling the police makes it seem that the individual [family member with schizoaffective disorder] was doing something wrong when in reality we are just concerned about the person's mental wellbeing and the wellbeing of those around them."

Participants further noted that the police role is limited insofar as the police are not mental health workers and are therefore not qualified to do formal mental health assessments on the spot. Therefore, the person in crisis is often apprehended under the *Mental Health Act* and brought to the hospital so an assessment can be done there. In 2022, 1,962 people (or approximately 73.2% of mental health calls that were dispatched to police) were apprehended

under the *Mental Health Act*. Participants also described negative ancillary aspects of police response that felt overwhelming, frightening, embarrassing, and/or stigmatizing, such as handcuffs, weapons, uniforms, marked police cars, lights and sirens on police cars, and a large number of officers showing up. Participants described these challenges as reducing the likelihood that they or their loved ones would reach out for help when they need it.

Limitations of police role:

Participants described the role of police as providing limited assistance in resolving their or their loved ones' mental health crises. Specifically, they observed that police knowledge and expertise generally relates to criminal and legal matters, such as whether a criminal act is being committed or whether an individual meets the criteria for involuntary apprehension under the *Mental Health Act*. While some police officers gain knowledge of mental health challenges and community resources that may support those living with mental health challenges through their years on the job, participants often felt that providing referrals to appropriate community resources is outside the mandate of the police role and that civilian mental health workers may be more suited to this task.

Police sometimes arrive at a scene to find themselves unable to help because the expertise required to resolve the issue is not within their scope; for example, if no crime has been committed and *Mental Health Act* criteria are not met for an apprehension. This mismatch between police scope and the scope of the crisis can lead to frustration and dissatisfaction on both sides. Police often genuinely want to help but lack the ability to do so, and the person in crisis and/or their family may feel like their needs were not met. One community engagement participant noted the burden mental health crisis calls place on police by stating, "We ask so much of our police officers. [We shouldn't] expect them to be [mental health] professionals [too]."

Due to the limited mandate of policing, some participants explained that police officers had laid criminal charges against them, their loved ones, or their clients with the perceived aim of getting them mental health help through the criminal legal system. However, participants commented that this approach can inadvertently entangle people in crisis in years of legal troubles and sometimes lead to their incarceration. This approach can also frustrate families who called the police for help, only to have their loved one arrested. One participant stated, "As a criminal lawyer I have frequently represented individuals charged with offences as a result of their loved ones calling 911 for intervention, not for the purpose of charging and jailing their loved ones."

Additionally, participants noted that police response rarely provides an effective connection with ongoing community services, as police response focuses on the immediate crisis rather than supportive follow up, and community supports are often not immediately available due to lack of resourcing. Once police left the scene, participants often felt that they were left alone to manage the same factors that had led them to experience a crisis in the first place. Participants stated

that police were often unable to provide linkages to ongoing community supports, due to a lack of knowledge or availability of these services.

Finally, as one participant commented, "Police officers are not trained to deal with mental health crises; they are trained to deal with physical danger." Many participants noted that the tactics that are effective in responding to physical danger are not a good fit for responding to mental health crisis calls. Participants believe that police are being asked to play too many conflicting roles, leading to frustration and dissatisfaction for officers themselves and those they aim to serve.

Ancillary aspects of police response are stigmatizing, criminalizing, and/or humiliating:

As one participant stated, "Having a police response to mental health crisis triggers further anguish and reactive behaviours for individuals who are in crisis, creates fear in neighbours, and builds more mental illness stigma." Many participants described aspects of police response such as handcuffs and the presence of multiple police officers at their home as “terrifying,” “embarrassing,” “intimidating,” “humiliating,” “threatening,” and “stigmatizing,” leading people to fear reaching out for help in the future. Participants noted that police officers carrying guns or Tasers can be scary, as well as “triggering to people who have lost loved ones to gun violence." Other participants noted that police uniforms can be triggering or frightening. Generally, police responses were described as harmful and sometimes traumatic.

For example, one participant stated, “A police officer traumatized my 15-year-old daughter; handcuffed her and put her in the back of a police car. She was alone, in a park, in daylight, crying and upset. She'll never trust police again.” Another participant said, "My husband was suicidal and I called police. They were kind; however, handcuffing him to take him to the hospital when he was not aggressive in any way was traumatic and left more damage." Another participant described her eighteen-year-old autistic son being taken to the hospital in the back of a police car when he was thinking about hurting himself as “traumatic,” “frightening,” and “stigmatizing” for the entire family.

Many participants described multiple police cars and officers showing up in residential neighbourhoods as creating stigma, embarrassment, and humiliation for service users and their families. For example, one participant explained that her neighbour had been experiencing a mental health crisis and was handcuffed and spoken to by police in front of her house. She said, “It presented to onlookers the optics that a criminal act was occurring versus a health crisis…Once all is sorted out, the neighbour will have to return to the community, and because of the way the situation was handled by the police, I am concerned she will be labelled a criminal.” Another participant stated, "Having police cars at my residence was very much stigmatizing (especially to on-lookers and neighbours on my street)." Another participant commented, “Arriving in a residential area in cars marked as Durham Police and wearing uniforms is both threatening to the patient and fails to provide confidentiality."

A service user stated, "It really sucks having people come into my house with guns on their hips, and then to be put in the back of a police cruiser because I'm feeling suicidal. I need compassion, not the risk of brutality or death, and the embarrassment of my neighbours watching me interact with law enforcement. This is not a legal issue and does not deserve an enforcement response against vulnerable people." Another service user said, "The treatment by the police [being handcuffed and tackled while being transported to hospital after experiencing sexual assault and being in crisis as a result] scarred me more than the initial assault and has left me terrified of our police force." A friend of a service user said, "My friend was traumatized by the fact that she was basically arrested and put in cuffs."

One service user commented on the embarrassment she felt due to police response to her crisis by saying, "[I was] put in the back of a cop car like a criminal. Police in front of my house. I was not in hysterics; there was no reason for such a spectacle." Another service user said, "Being tackled by a police officer and handcuffed wasn't necessary." Finally, a service user said that her experience with police during her crisis left her "feeling small, powerless, isolated, ashamed, and absolutely terrified of reaching out for help again."

Many officers showing up is overwhelming:

Many participants described a large number of police officers showing up to their or their loved one's mental health crisis, heightening feelings of overwhelm, embarrassment, and stigma. For example, one participant stated that she had called police on behalf of her partner who was experiencing a mental health crisis, and nine police officers and the K9 unit showed up, which was frightening for both her and her partner. Another participant stated that she had four police cars show up when she was in crisis and that it had been "overwhelming" to see that many people. Another participant called 911 on behalf of his son who was experiencing a crisis, which was responded to with seven police officers and a police dog. He felt that this response "escalated [the crisis] unnecessarily" due to "too much police presence." A mother whose adult son was in a mental health crisis called 911 to have him taken to the hospital for assessment and said, "There were over 12 Police cars, a SWAT vehicle, and 2 ambulances…It took a long time for my neighbors not to be concerned when they walked past our home. I have lived here since 1979."

Variability of police response:

Many participants commented on the variability of police responses, depending on the individual officer responding to the call. Participants often found this lack of continuity and consistency frustrating. One participant said, "I'm always hesitant to call 911 because I don't know what I'm going to get." A service provider participant described two separate incidents on consecutive days with different clients reporting thoughts of suicide; the client on the first day was responded to by "fantastic" police officers, while the client on the second day was responded to by "rude, dismissive" officers. The variability in these experiences makes this service provider hesitant to call police again. Another participant said, "Some police are well trained and supportive; others are focused on quick resolutions and have escalated situations into much more serious crises."

Several participants also commented that they may experience differential treatment based on their race. For example, one Black female participant described a situation in which a police officer pointed their taser at a Black thirteen-year-old in crisis. A Black male participant described an incident where he had been approached by police in a hotel because “they were looking for someone who was having a mental health crisis and I fit their description…There were at least 5 officers who responded. They approached me in the hotel lobby and they did not announce themselves or explain why they were there…Thankfully, I was calm and things were fine, but that situation was very scary for me. If I was going through a psychotic episode and hearing voices/in distress, my response would have likely been different. What if I ran out of fear? That situation could have been much worse for everyone involved."

Fear leads people to not reach out for help:

Due to the experiences noted above, many participants expressed fear or hesitancy to call police in a crisis. Other participants said that they would not reach out for help during a crisis due to fear that a police record (including a record of a *Mental Health Act* apprehension) could limit their future employment opportunities and/or have child welfare implications. For example, one participant worried that a *Mental Health Act* apprehension could lead to the other parent gaining custody of their children after a separation, or to a Children’s Aid Society apprehending the children. The participant stated that she doesn’t “want to have a record of being unwell or unfit.” Another participant noted, “A lot of moms I know share similar fear that children are going to be ‘taken away’ if you need mental health support." Additionally, individuals in crisis may worry about what will happen to their children or pets if they are apprehended. One participant said, "It is incredibly difficult to convince my family member to seek help when they are paranoid and worried about being away from their children."

Other participants were concerned that calling the police would not lead to a positive outcome. Several participants commented that “it’s a roll of the dice” whether the responders would be able to help or not, and that police response might do more harm than good. This fear was particularly salient for family members of autistic individuals. One focus group participant said that she has an autistic son who is physically large and non-verbal and she is afraid to call the police when he is in crisis because she worries he might be seen as a threat and physically harmed as a result. Another focus group participant said, “My brother is a very large, visibly Indigenous man with autism. His disability hinders his ability to control high emotions and every time he has an emotional episode I fear for his life if police show up and use deadly force like has happened with men like him multiple times in the past.” Another participant said, “I have a young autistic teen who is starting to gain independence, going out for lunches with friends without parents etc., and I have a real fear for what might happen to him if he is involved in an altercation or public meltdown as he does not ‘appear autistic’ to those without true understanding.”

Several participants commented that seeing the police arrive makes people in crisis feel like “they did something wrong” or “are in trouble,” which can cause “escalation.” Another participant

said, “Sometimes just the sight of police presence escalates a person's already agitated emotions/mental health.” Another participant said, “Service users have difficulty receiving crisis interventions from police due to a history of trauma working with police.” Another participant agreed, stating, “Police often make the situation worse, not because they aren’t doing things right but because people have past trauma that involves police, so it escalates the situation rather than de-escalating."

Other participants noted that they are afraid that calling the police would lead to their loved ones being arrested, injured, or killed, particularly if their loved ones were people of colour. One participant said, "Right now I would never call the police, as someone would likely end up dead or arrested inappropriately and go to jail rather than a hospital." A Black female participant was particularly concerned about police response to racialized communities, due to the historical and present day implications of the “complexities of racism [and] oppression.” She stated that she would not “trust calling the police,” because “I would fear injury and death coming to my loved one at the hands of the police in a crisis situation.” An Indigenous female participant agreed, stating, "How many people have called 911 for themselves or a loved one with a mental health crisis only to be shot or arrested? That shouldn't even be a concern!" Another participant said, “After knowing someone shot and murdered by police for a mental health crisis call, it’s very important to me that police do not show up for these calls.”

Several participants commented that their past negative experiences with police have made them hesitant to reach out for help in the future. One family member participant said, "[Our experience calling police for a loved one in crisis] left us all feeling to NEVER call the police or ask for a wellness check." A service user participant described her fear when police became involved in her mental health crisis, stating, “I felt scared for my safety and my life,” and adding that she would not reach out to the police for help again. Another participant said, "I have mental health issues but honestly I wouldn’t ever want to call police to get involved. That’s more terrifying than anything."

Durham Regional Police focus group feedback:

In March 2023, a focus group was conducted with eleven Durham police officers and six Durham paramedics. Feedback related to paramedics is included in the paramedics section of this report. Our focus group asked police officers about their current experiences attending mental health crisis calls, what their thoughts were about the proposed community mental health crisis response service, how a community mental health crisis response service could support the Region and the police themselves in responding to mental health crisis calls, and how effective partnerships can be built between the new service and existing first responders. For a full list of the questions asked at this focus group, please see the background section of this report. The following are themes that emerged from police officers during this focus group.

Generally, police expressed frustration at the number of mental health crisis calls they respond to and the limited options they have for managing this high volume of calls. One officer stated,

“We’re not trained mental health workers.” Police officers identified that their job is to deal with crime, and that being asked to take on a mental health crisis response role is beyond the mandate of their role and expertise. Police described particular frustration with “familiar faces” who are not able to access the help they need due to lack of resourcing of community-based mental health services and continue experiencing police contact as a result.

Police participants stated that there is a lack of existing resources to refer people in crisis to; wait lists are long and the hours of community services are often limited. As Durham’s population has grown, its mental health budget has failed to grow with it. Underfunding of the mental health system therefore leaves police with few options to support people in mental health crisis and leads to people cycling in and out of emergency rooms and jails. Police officers suggested that a new service should prioritize ongoing support, follow up, and case management for service users to prevent these individuals from continuing to cycle through police interactions.

Police participants also commented that community members, including service providers, often call the police too readily when the situation is outside the scope of the police role. They identified a “revolving door” of certain service providers calling police about the same service users, where police are unable to get the person the help they need. This leads to a situation of “hot potato,” where the community agency ostensibly providing care to the individual calls the police, the police take the individual to the hospital, the hospital sends the person home with a referral back to the agency for outpatient services, the agency calls the police again, and the whole cycle starts over, without the person in crisis getting adequate services. “Hot potato” situations such as this one place substantial strain on police (and hospital) resources.

Furthermore, police participants identified frustration with spending hours in hospital emergency rooms “acting as armed security.” When the police apprehend a person under the *Mental Health Act*, they are legally required to stay in the emergency room with that person until the hospital officially takes custody. It can often take several hours for the person in crisis to be seen by hospital staff and for the hospital to take custody; on average, police spend close to two hours in emergency rooms waiting for apprehended mental health patients to be assessed. The time spent sitting in emergency rooms ties up police resources and leads to slower responses to actual crimes or imminent risks occurring in the community.

Additionally, when police apprehend someone under the *Mental Health Act* and bring them to the hospital, and then the hospital determines that the person does not meet criteria for involuntary admission and discharges them, the amount of time the police spent in the waiting room turns out to have been for nothing. One officer noted how frustrating it is to spend multiple hours in the emergency room with someone only for that person to be sent home, and that this experience is often equally frustrating for the person in crisis and their family members. The officer said that family members sometimes call back asking why their loved one was discharged; the police are being held responsible for situations outside their scope.

Police participants recommended that medical staff such as doctors or nurses should be available at minimum on an on-call basis to the community mental health crisis response team. One officer noted that police often spend hours in emergency rooms simply waiting for doctors to provide an assessment or medication support. They suggested that having medical staff available to attend a person's location or to consult with video technology would prevent officers from needing to transport people to emergency rooms and then wait with them for hours.

Police participants further indicated that the community mental health crisis response team will need to be available 24/7 and provide immediate response, within minutes of an initial call. If police need to wait hours for the team to be dispatched, they will not call in the community mental health crisis response team as a secondary responder, as the delayed response time will require police to stay on scene for longer than necessary. Additionally, if the team is only available within limited hours, or if there are not enough crisis workers to meet the need, police will still be sent to respond to calls that could be more effectively responded to by the community mental health crisis response team simply because police availability is greater. Police participants strongly urged that for the team to be effective and useful, it must be sufficiently staffed to take calls away from the police. Police also highlighted the importance of the community mental health crisis response team being available to respond quickly to North Durham. Existing community-based crisis services are typically anchored in southern parts of the Region, meaning that response times to North Durham are inadequate. Police are therefore called to respond to mental health crises in North Durham that might be better served by a community mental health crisis response team, simply because police will arrive more quickly.

To prevent mental health crisis calls from being made in the first place, police suggested that the community mental health crisis response team do proactive outreach, particularly in smaller communities such as Beaverton and Cannington and especially for "familiar faces" and community members most at risk. Police further indicated the importance of determining dispatch protocols and ensuring that all existing first response and dispatch services are knowledgeable about the new service and in alignment with protocols. They suggested that coordination with 911 call-takers may be beneficial in order to ensure that calls are appropriately vetted and directed to the right responder, whether that responder is police, paramedics, or the community mental health crisis response team.

Additionally, police participants recommended that frontline police officers be informed about the work being done to develop the community mental health crisis response team and that police partners should be involved with the development of the service. Officers indicated that there is currently very little knowledge of the work being done to develop a community mental health crisis response team. This could lead to a lack of trust if a new service launches, given that officers may feel that they were not informed or involved at earlier stages. Relationships will need to be built with each police division to share and gather knowledge. Officers suggested that information should be shared through email, through management, and through on-site visits from the community mental health crisis response team once the team launches. Officers noted that they will need to know what the service does, how to access it, its hours of operation, and which catchment areas it is operating in, so they can make most effective use of the service.

Police participants also indicated that roles and qualifications of both the police and the community mental health crisis response team staff will need to be made clear to one another, particularly if crisis team staff and police attend a call for service together or consecutively (e.g. if police call the community mental health crisis response team as a secondary responder). Both services will require role clarity about what each staff member's scope is and who is in charge of the scene in various circumstances. Officers recommended cross-team training and team-building connections between community mental health crisis response team staff and police, as well as regular meetings between the community mental health crisis response team and the police divisions in its catchment area to share progress and challenges and to work collaboratively to serve their community.

Police participants shared recommendations for training of the community mental health crisis response team. They suggested that the team should receive training to ensure that they are able to consider and respond to all aspects of a situation, including doing risk assessments, assessing for domestic violence and child abuse, and identifying environmental hazards. They further recommended that newer staff should shadow more experienced staff for significant lengths of time prior to taking calls independently.

They also stated that information sharing and data management protocols will need to be developed in collaboration with police, paramedics, and other healthcare services, in order to align with provincial legislation as well as best practices for community mental health crisis response teams. Participants further highlighted the importance of coordination and collaboration with existing services to avoid duplication of services or "double dipping," wherein people access many different services instead of being referred back to their existing care team.

Police participants raised concerns around existing legislation such as the *Personal Health Information Protection Act* and the *Mental Health Act*, as well as legislation around ambulance refusal, legislation around consent to care (particularly for minors), and legislation around transportation. These issues will need to be further explored by the Region's legal team to ensure that community mental health crisis response team protocols are in alignment with legislation.

Additionally, police participants raised concerns around legal liability and Special Investigations Unit investigations, such as the concern that they may be investigated and/or held legally liable if they called the community mental health crisis response team to the scene and a crisis worker was injured. While this scenario has never occurred on any community mental health crisis response team internationally, it is important to ensure that regulatory and oversight bodies (including the SIU) are aware of community mental health crisis response team protocols and procedures, so that officers are not unfairly investigated or threatened with liability for following Regional policies around mental health crisis call diversion.

Finally, police officers highlighted the emotional toll that responding to mental health crisis calls is likely to take on community mental health crisis response team staff. They recommended that staff should be adequately supported through supervision, debriefing, and wellness resources. This issue is further discussed in the staff hiring and training section of this report.

Conclusion:

The goal of the proposed community mental health crisis response team is to act as a complementary service to traditional policing, in order to conserve and concentrate police resources on responding to crime and violence, to divert people away from criminal legal interactions and towards mental health treatment, to get families the supports they need to cope with their loved ones' mental health challenges, and to reduce "familiar faces" police interactions by connecting people in crisis to community-based care. The service will further define the roles of various emergency services to ensure the team with the right tools attends the crisis call. Paramedics will continue to attend medical emergencies, the fire department will continue to attend fire emergencies, police will continue to attend calls involving crime or violence, and the community mental health crisis response team will attend calls involving non-violent mental health crises. Police and other first responders are essential partners, and the service will need to develop collaborative relationships with other first response services to ensure its efficacy.

Experiences with hospitals:

When people in a mental health crisis are apprehended by police, they are typically transported to a hospital for an assessment to determine if they meet criteria for admission under the *Mental Health Act*. The *Mental Health Act* allows people to be involuntarily admitted to a hospital under the following conditions: if they have caused or are likely to cause "serious bodily harm" to themselves or someone else, or if they are suffering from a mental disorder that has been successfully treated in the past and that when untreated is likely to cause serious bodily harm to themselves or someone else, or substantial physical or mental deterioration. However, the majority of individuals who present to hospital emergency departments for mental health support in Durham Region do not meet criteria for admission to the hospital. Data from Lakeridge Health indicates that 70.7% of mental health emergency department attendees in 2021 were not admitted and were instead discharged directly from the emergency department, often after sitting in the emergency department for hours. Data from Lakeridge Health shows that the average time spent by a mental health patient in the Lakeridge Health emergency department between 2019-2021 was 9.5 hours.

These experiences stem from under-resourcing of healthcare services, and they create frustration for individuals in crisis, their families, service providers, and the healthcare system. Attendance at emergency departments of people who do not require emergency healthcare intervention slows down the provision of care for others who do require emergency healthcare. Unnecessary emergency department attendance can also cause exposure to physical illnesses and thereby increases physical health risks. Overcrowding of emergency departments increases the risk of burnout for committed, caring healthcare professionals, who are overstretched and overburdened by rising numbers of patients without adequate resourcing to match the needs. Additionally, emergency department attendance often fails to resolve the factors that led to the crisis developing; 39% of mental health-related emergency department visits at Lakeridge Health between 2019-2021 were repeat visits within 180 days of a previous hospital visit.

One of the goals of a community mental health crisis response team is to ensure greater congruence between emergency department attendance and admission such that those who will benefit from and qualify for admission will attend the emergency department and all others will be diverted away. Effective diversion will reduce frustration, keep people who don't need to be in hospitals away from hospitals, lessen the burden on healthcare professionals, and promote expeditious care in the community where possible. Data from international community responder models demonstrates that most of these calls can be resolved without emergency department attendance; for example, only 8% of Toronto Community Crisis Service (TCCS) calls result in hospital attendance, and of those 8%, 6% of hospital attendances are voluntary, 1% involve a medical crisis, and only 1% involve police. Similarly, only 1.9% of Portland Street Response crisis calls result in hospital attendance, and fewer than 2% of Oakland MACRO responses involve transportation to a hospital.

General themes from community feedback:

For the purposes of this report, when using quotes from people discussing their experiences with hospitals in Durham Region, the hospital names have been replaced with “[the hospital]” in order to protect the privacy of community engagement participants. All experiences shared by participants took place in Durham Region hospitals unless otherwise stated. Discussion of experiences participants had as hospital inpatients are included in this section due to the number of participants who discussed these experiences and in order to accurately reflect participants’ priorities and concerns.

The experiences shared by participants should be understood in the context of Ontario’s underfunded healthcare system, insufficient resourcing and staffing of nurses and other healthcare professionals, and the COVID-19 pandemic which has further increased the burden on healthcare staff. Many participants described positive interactions with nurses, doctors, or other healthcare professionals, and generally expressed the view that these professionals are working hard to provide compassionate patient care in under-resourced and overstretched environments.

Participants generally described systemic and structural barriers, rather than singling out individual healthcare professionals or hospitals. For example, many community engagement participants spoke about their experiences accessing or attempting to access hospital care and the barriers they encountered. Participants frequently characterized their experiences with hospitals as a “revolving door.” They described attending the emergency department only to be sent home and then to return again days or weeks later, just to be sent home again. Often this revolving door was exacerbated by a lack of beds available in hospitals due to under-resourcing.

Participants described long wait times in the emergency department, a lack of follow up care, experiencing stigma in hospitals, challenges related to the physical design of hospitals, a lack of resources and therapeutic supports available upon admission, and experiencing restraints and/or seclusion in hospitals. These experiences make participants less likely to reach out for help in the future.

However, participants often stated that they were unable to access alternatives to the emergency department, so they attended the emergency department even where they did not wish to do so or where they had found hospital attendance unhelpful in the past. Some participants (generally family members) believed that hospitals were too cautious in admitting individuals who needed help and stabilization. Other participants (generally service users) believed that hospitals were too keen to admit them against their will and feared attending hospitals as a result.

Revolving door and lack of follow up:

A substantial number of community engagement participants used the term “revolving door” to refer to their or their families’ experiences with hospitals, indicating the troubling effects of healthcare under-resourcing. A participant who has had several family members experience mental health crises said, "Without long-term follow-up in the community my personal experience is the mental health system has a revolving door. Over the years of our continuous hospitalizations, we saw the same patients time after time on the mental health wards. Long-term help is imperative for recovery." A service provider participant said that hospital attendance is “just a Band-Aid,” because it often does not resolve the underlying needs that led the person to attend the hospital in the first place. Another participant expressed her frustration with her child being regularly directed to hospitals that provide little support, stating, “As a parent, my child's safety and wellbeing is always my #1 priority. I'm constantly told by doctors, teachers, therapists, billboards, ad campaigns etc. to call 911 or go to the nearest emergency department to seek help in a mental health crisis. And when we do, it is usually met with a ‘safety plan’ (we already have 10+) and rinse and repeat.”

Additionally, many family member participants believed that hospitals had discharged their loved ones too quickly, before adequate care or stabilization was provided. Other participants commented that the hospital had failed to take steps to ensure the safety of themselves or their loved ones after discharge; for example, one participant was discharged without shoes and left to fend for herself to get home. A service provider shared that her client was discharged wearing only a hospital gown, and participants from North Durham described being discharged from South Durham hospitals without adequate transportation arranged to get them home. Another participant said, “Some hospitals don’t call family members. They release the person in crisis even if they have no identification, transportation, [or adequate housing].”

Participants further identified a lack of follow up or referrals for outpatient services provided to people discharged from hospitals. One participant said, “[I spent] 16 hours in the [emergency department], to leave with no diagnosis and a handful of handouts. Solved nothing." Another participant said, “My wife has depression. One of her depressive episodes took us to [the hospital]. She was in crisis. I could not stay with her because of covid protocols at the time. I left her alone. Scared. She was eventually told that there was nothing they could do for her and she left. No referral to [outpatient] hospital [services]. No follow-up call. No follow-up call with her GP. It was very disheartening. Heartbreaking. And confirmed why she was hesitant to go in the first place. Please, we don't turn away people with serious physical ills from hospitals. Why are we turning away people with ill minds?"

Participants described the inadequacy of support received in hospitals leading to deterioration in their or their loved ones’ mental health and increasing the risk of suicide. One participant said, "My friend was suicidal. We have brought him in and out of the hospital for a few years. They would sober him up and release him. He died of suicide." Another participant stated, “Myself and other community members get told that our mental health crises are not serious or

important and are told to leave, without care. Friends have been told to go to the hospital by crisis phone lines, and when they arrive with serious suicidal ideation (plan for imminent death) they were turned away. Two are now dead."

Participants consistently reported that hospitals are currently unable to provide the support people in crisis need and identified a lack of community resources available post-discharge. One participant said, "The reality is that hospitals don't provide crisis treatment…only [a] safe environment for those at immediate risk to themselves or others. The hospital has its place but that is not where recovery or treatment happens." Another participant said, "We can't keep taking people to emergency and then when they calm down we release them back to where they were with no support."

Long wait times:

Many participants described waiting between five and twelve hours in the emergency department before being assessed or released, due to under-resourcing and underfunding. Participants also described a lack of available mental health beds at hospitals leading to long waits in the emergency department. For example, one participant described waiting for 36 hours in the emergency department before being transferred to a hospital in Toronto because there were no mental health beds available at Durham hospitals. Another participant who attended the hospital in a mental health crisis said, "I stayed in a chair for two nights in a dialysis room and was moved to a stretcher in the hallway for another two nights." Another participant said, "I've waited in the hallway on a stretcher with no form of engagement, not even a book, for days after being put on a Form and there being no beds in the psych ward." A family member of a service user said, "There are not enough resources. Several of our stays in hospital were spent in the hallway for a few days until a bed could be found. Twice we were transported to other hospitals due to a shortage of beds."

As mentioned above, long wait times in the emergency department can be frustrating not only for people in crisis, but also the first responders waiting with them. Legally, police or paramedics must wait in the emergency department until the hospital takes official custody of the patient or chooses to release them. This can take up paramedic and police resources and tie them up from responding to urgent calls. For example, in 2021, Durham paramedics spent 2,088 hours in emergency departments with mental health patients, reducing the availability of ambulances for other community members.

Waiting can be a traumatic experience for people in crisis and their families. One family member of a service user said, "My son was in crisis and I took him to emergency. They kept him waiting and waiting. It was like trying to keep a caged animal from escaping." Another participant described her hospital experiences as, "Long wait times in stressful, anxiety-provoking, and sometimes traumatic settings/environments (ex. Hospital general waiting areas, hospital locked observation/isolation rooms)." Another participant commented that it is "much harder to convince someone to seek help when it takes hours and hours to see a care provider."

A number of participants described feelings of intense isolation while waiting in the emergency department. One family member of a service user said, “My daughter was having suicidal thoughts and no beds [were available at the hospital, so she] was left in the hallway for 6 days…6 days in a hallway with no one to talk to is damaging for your mental health.” Another participant said, “In [the] hospital emergency room, my daughter was told to wait by herself (due to Covid) during [her] mental health crisis because she was above the age of 16. 12 hours later, [she still hadn’t seen] the psychiatrist on call. So she decided to leave without seeing the doctor. My point [is, the emergency department is] not a great place for mental health crisis unless someone is dying." As this service user did, people experiencing isolation or trauma in emergency departments may give up and go home without accessing care at all.

Another service user described his experience of isolation and lack of support in the emergency department by saying, “It was as if I didn't matter." Another service user said, "To have to sit in emerg for endless hours wanting your life to end is almost as traumatizing as the events that led to my being there."

Stigma in hospitals:

Several participants commented on feeling criminalized while in hospitals for mental health crisis, especially when put in rooms where they were being supervised by security. One service provider participant said, “My client felt dehumanized laying on a gurney by the bathroom, watched by a security guard, in a place where no one had privacy.”

Other participants stated that some staff are particularly cautious around people with mental health diagnoses, assuming that those people are likely to be violent or explosive, and that this attitude is stigmatizing. Some participants described not being taken seriously due to their diagnoses (particularly schizoaffective disorder, schizophrenia, bipolar disorder, and borderline personality disorder). Several participants experienced discrimination due to stereotypes about people who use substances, while other participants experienced stigma or discrimination due to their racial or ethnic background, or due to their gender identity.

One service provider stated, “Low income, racialized, unsheltered patients and people experiencing mental health crises are profiled as drug-seeking, dangerous, or difficult/unstable and are dismissed, kept waiting and in some cases, removed by security." A family member of a service user said, "Our loved one was misgendered and disrespected by hospital staff.” Several other service users identified similar challenges due to their gender identity, including staff not using their preferred pronouns. Other participants noted that the stigma of mental health treatment can follow patients through their health records and lead to stigma or discrimination on future visits for physical health matters.

Participants further commented that their hospital experiences made them feel like a “burden,” that they are “wasting people’s time,” or that they “aren’t worth saving” after a suicide attempt. One participant said, “Hospitals are incredibly cold and mental health patients are made to feel like burdens on the [emergency department] systems. The wait among [the] sick/injured is painful [because] you feel like you shouldn’t be taking up space.” Another participant said, “It is unacceptable in this day and age that people with depression, anxiety etc. are treated like they are wasting people’s time."

Physical and structural design of hospitals:

Participants described hospitals as physically cold and sterile, which can make them feel uncomfortable or unwelcoming. Many participants further described emergency departments as busy and overwhelming, which can be particularly difficult for individuals with disabilities or neurodivergence such as autism, or when people are in crisis. Emergency departments are generally noisy, with bright lights, and with many ill people who may be vomiting, bleeding, or exhibiting other physical symptoms. One participant stated, “The last thing you [want to] do when you’re in a [mental health] crisis is sit in a waiting room with 40 other people.” Another participant said, “[The emergency department] felt like it was the worst place I could have brought [my daughter in mental health crisis].”

Another participant described attending the hospital with severe postpartum depression. She was admitted for evaluation and “placed on a stretcher in the hallway beside the nursing station. One of the aggravating factors contributing to my depression was lack of sleep. Being placed in the bright hallway on a stretcher beside a busy nurses’ station did not help with that. I was kept in a hallway on a stretcher for 4 days straight with very little contact from any of the hospital staff. The lights were on and the hallway was busy and noisy (as would be expected in an emergency department). The small amount of medication that was provided to me did nothing to assist me with sleeping and starting my recovery process."

A participant noted that hospitals tend to want patients to sit still, and that staff may see movement such as pacing as an escalation or a threat. However, sometimes people experiencing anxiety or people who are neurodivergent (such as autistic individuals or those with ADHD) may need to move around as a coping mechanism. This can lead to conflict in the emergency department and sometimes to the use of restraints or seclusion. Furthermore, participants described hospital care as “isolating” and explained that hospitals remove people from their community and social supports. One participant said, "I found the mental health hold to be unproductive and ultimately an impairment to my mental health…my depression was increasing due to lack of access to my support system."

Other participants commented that hospitals separate people from their coping mechanisms, often due to the structural constraints of the hospital environment. For example, one participant said, "I did not want to go to the hospital even though I needed to because after past experiences of [being on an inpatient ward], I did not want to feel so disconnected from people,

isolated, in a different environment that I wasn't comfortable in, and separated from my coping strategies again; an example being my phone where I have my music and [ambient] sounds for sleep. The way the ward is set up I wouldn't be allowed to have my phone and so it would be harder for me to cope with being there, because what I use to regulate is not allowed." Another participant said, "I know that certain activities will help to speed up my recovery and overall well being. For me, that was exercising, something that I was not really able to do in the hospital...The only options available for stimulating or distracting your mind from any negative thoughts while being treated were watching a small TV on the wall or coloring. Again, how are people expected to recover more quickly and more thoroughly (thus reducing the chances of re-admittance which drains hospital resources) when there are so few options available?"

Another participant said, "[A] barrier a friend of mine experienced was the fear of having to be held in the hospital for several days alone due to his suicide attempt. I had to convince him to even get into the ambulance. He told me, 'Please, I don't want to be put in a psychiatric hold where I can't see anyone. I already feel alone. Please don't make them take me.' Part of the reason he didn't go to the hospital in the first place was out of fear of being confined and having his dignity and agency taken away." Another participant said, "Mental health units are boredom prisons - people need activities or programs."

Lack of resources or therapeutic supports:

Many participants identified a lack of therapeutic supports provided from hospitals due to a lack of resourcing; the primary treatment available was medication. One participant said, "My dad had severe anxiety and depression and needed care at the hospital. When he was taken to the hospital, he was left in a hallway for hours. Once finally admitted, his treatment consisted of medication. No therapy. Optional group sessions only. Basically, the policy was to medicate until the patient is stable, and then send them back home again." Another participant said, "Medication appears to be prioritized as there is insufficient funding for other viable treatment options such as psychotherapy, cognitive behavioural therapy, EMDR etc."

A service user participant said, "My hospital visit…was solely based on medication and not conversation (sorting through trauma and anxiety). The psychiatrist told me her primary role is to provide medication and I could not afford her if I needed therapy." A family member of a service user said, "When my family member is hospitalized she is treated with medication and nothing else. No therapy, no community support upon discharge." Another participant said, "The solution is always more medication or different medication. Let's be honest here, nothing is that easy of a fix. If we used bandages over leaking pipes, the truth is the leak is still there, we just delay it starting again. While medication can absolutely be essential, it should not be the ONLY form of support provided when there is evidence-based research that shows other methods to consider in terms of crisis support."

Restraints and seclusion:

Several participants described they or their loved ones experiencing restraints or seclusion during their hospital stay, which were experienced as traumatizing and are linked to physical or psychological harms. One family member of a service user said, “For my daughter being in the hospital ended up escalating her and she ended up being restrained.” Another participant said, “A close friend of mine tried to access services at [the emergency department] and was put in a locked room with a bed. She sent me photos from the inside and was terrified.” These experiences lead to people being hesitant to access help again in the future.

Lack of alternatives to hospitals:

Many participants described attending emergency departments because they were unaware of or unable to access alternatives (e.g., because of limited hours of other services). One service provider described this experience by saying, "There were many times that a client would say…they wanted to go to the [emergency department], but could not express what the goal of accessing [mental health] support there was, their identified goal would not be met by [the emergency department] (e.g., wanting to be ‘taken care of’ due to a stable condition that caused distress but did not pose any safety risks), or their goal could be met by a community program that they weren't aware of (e.g., detox, crisis beds, shelters). There seemed to be a lack of knowledge regarding what type of [mental health or crisis] support the [emergency department] can provide, but was often seen as a default/first step towards care. At times, [emergency department] visits did not result in the outcome they were expecting, leading the client to feel like they had not been helped, though the hospital may not have been the most appropriate option to begin with.”

Another participant said, "Supports are limited, so crisis supports at the hospital are sometimes the only services available in a timely manner." Another participant said it was too hard to access a psychiatrist, so attending an emergency department when in crisis is “the only real option.” Another participant said, "The person in crisis called 5 different doctors/agencies on the day of admission; none called her back to intervene. If it wasn't for another friend calling, she would have taken a bottle of pills. Then it was an 8 hour wait in emerg.” Another participant said, “It takes people forever to access services and often they end up in hospital when they could have more easily dealt with issues at home if counselling and outpatient [care] was available." A family member of a service user said, "[Our] crisis occurred overnight. The crisis beds did not accept anyone after hours, [and] there was no mobile team working at that hour. We had to bring my family member to the hospital, where they sat in the [emergency department] for 8 hours and ended up leaving."

A parent described trying to figure out what services were available for her child in crisis as “confusing…frustrating…scary…[and] difficult. And unfortunately, everyone’s first response seems to be, bring them to the hospital. Access emergency services. That was not what they

needed." A service user participant said, "I had a bit of a setback recently but was unable to speak to my psychiatrist due to his busy schedule. I was advised by his office to go to emergency. I told her I didn't feel that I needed the emergency department but was not advised of any alternative route…I felt like I was on my own."

Negative experiences make people less likely to reach out for help:

Cumulatively, these negative experiences make people less likely to seek help when in crisis. One participant said, “I know the [emergency department] doesn’t have [enough] resources, so I won’t go in because others need the help more than me.” A family member of a service user said, “My loved one has been traumatized and has vowed never to go to a hospital again even if she's dying.” A service user said, “I would rather die by suicide than attempt to get any help from [the hospital] again.”

Conclusion:

One primary goal of the proposed community mental health crisis response service is to keep people who don’t need to be in the hospital out of the hospital and to get people who do need to be in hospital prompt care. The community mental health crisis response team will need support in developing appropriate in the field assessment protocols so they can effectively determine whether a person in crisis requires hospitalization, in order to reduce the number of people unnecessarily transported to emergency departments. Expedited assessment and admission protocols will need to be developed to ensure that when the community mental health crisis response team does bring someone to the hospital, that person can be assessed and admitted rapidly so the team isn’t tied up for hours in the emergency department. Durham Region can look to the protocols the Centre for Addiction and Mental Health has developed with the Toronto Police Service as an example for expedited admission procedures. The community mental health crisis response team will also need to work closely with hospital partners to develop strategies for reducing load on hospitals and creating effective diversion procedures. Additional funding and resourcing should be provided to hospitals in Durham Region to address the barriers identified by community engagement participants and to ensure adequate support for those experiencing mental health crises. For example, some participants commented that emergency departments can be re-designed using the EMPATH model to be more comfortable and responsive to people experiencing mental health challenges. Funding and support should be provided to hospitals for these kinds of innovations.

Experiences with paramedics:

Currently, paramedics sometimes co-respond to mental health crisis calls with police. They rarely attend mental health crisis calls alone, except where a mental health crisis call may have been incorrectly flagged as a medical emergency. However, many people experiencing a mental health crisis are transported to the hospital by ambulance, leaving paramedics sitting in emergency departments with these individuals for many hours until the person is assessed and/or admitted. This reduces the availability of ambulances for other medical crises and takes up substantial paramedic resources. For example, according to data from the Region of Durham Paramedic Services, in 2021, Durham paramedics spent 2,088 hours in emergency departments with mental health patients, waiting for those patients to be admitted or released. Those 2,088 hours cost the Region of Durham approximately $396,767.50.

The proposed community mental health crisis response service aims to address these problems by enabling crisis team staff to do mental health assessments at a client's location, rather than requiring transportation to a hospital for assessment. The crisis team would be further empowered to do voluntary transports, reducing the need for paramedic involvement. This intervention would likely reduce paramedic offload delay hours and improve the availability of ambulances for community members in need.

This section includes information about existing paramedic/mental health partnerships, feedback compiled from the community engagement process about paramedics, and information directly from the paramedic focus group conducted with six paramedics.

Existing paramedic/mental health partnerships:

The Primary Care Outreach Program (PCOP) pairs an advanced care paramedic and a social worker to provide support to vulnerable populations within Durham Region, including unhoused individuals. PCOP provides primary care such as administering medication (including long-acting anti-psychotic medication), blood glucose testing for diabetic service users, flu and COVID-19 vaccinations, and wound care. PCOP also provides system navigation and brief mental health and addictions counselling. PCOP has recently expanded to include two teams that are available seven days a week. Community engagement participants (including police focus group participants) reported positive experiences with PCOP. The community mental health crisis response team should collaborate with PCOP and other paramedic partnerships as part of a continuum of care; for example, the crisis team may provide referrals or warm transfers to PCOP, and PCOP may provide referrals or warm transfers to the crisis team.

Community engagement themes:

Community engagement participants reported generally positive experiences with paramedics. Paramedics were described as “phenomenal,” “wonderful,” “caring,” “helpful,” “supportive,” “respectful,” “empathetic,” “professional,” and “compassionate.” Several participants suggested paramedics could benefit from additional mental health training. One service user experienced being chemically restrained with ketamine by paramedics, which the service user described as “traumatic.”

Some participants commented that ambulances take too long to arrive (due in part to long offload times at hospitals; offload times in Durham are substantially higher than the Ontario average). Several participants commented that they would prefer paramedics to come alone rather than with police, because they felt more comfortable interacting with the paramedics. One participant stated that lights and sirens of ambulances increase agitation, and it would be better for an unmarked vehicle with no lights or sirens to provide transport.

Paramedic focus group themes:

Paramedics expressed enthusiasm for a community mental health crisis response team that could provide transportation, either to a hospital or to another safe place. They stated that having a community mental health crisis response team would reduce the burden on paramedics who spend unnecessarily large amounts of time sitting in emergency rooms. Additionally, paramedics explained that legally, they are only allowed to transport service users to a hospital because of legislation governing ambulance transports. They stated that a community mental health crisis response team that is authorized to take people to other community services (such as shelters or medical clinics) would be helpful, since service users do not always benefit from or require hospital attendance. Paramedics further suggested that the community mental health crisis response team would need to review legislation related to refusal and consent to care.

Experiences with community-based services:

Durham Region has many community-based services that provide crisis care and/or ongoing mental health and addictions support. The goal of the community mental health crisis response service is to augment and expand existing services, rather than to replicate or replace these services. Durham Region will need to develop partnerships with existing services to deliver the proposed community mental health crisis response service. Additionally, the Region will need to provide greater resources to existing services to avoid creating a "road to nowhere" in which the community mental health crisis response team has nowhere to refer service users to, leading to a "revolving door" of clients repeatedly accessing the community mental health crisis response service.

Existing community-based crisis services:

Durham Mental Health Services (DMHS) offers phone-based and mobile crisis support through Durham Region. This service provides 24/7 phone-based service and mobile service from 11 am-7 pm, Monday to Friday. DMHS can be accessed by phone at 1-855-888-3647. DMHS staff can provide crisis intervention, resources, and referrals over the phone, or they can provide mobile response to support the person in their preferred location. DMHS also offers short-term crisis beds available for community members to access, and mental health safe beds available to access for community members who are in contact with the justice system.

The Durham Distress Centre offers support to Durham residents experiencing mental health or addictions challenges via text, online live chat, or its phone number, 1-800-452-0688. The service is available 24/7. The Distress Centre also provides ongoing support via phone to seniors in Durham Region to reduce social isolation and ongoing support via phone to others with limited supports and resources. The Distress Centre also provides education and trainings to community members and support to individuals who have lost loved ones to suicide.

Talk Suicide Canada is a suicide prevention service available across Canada, available 24/7. Individuals can contact Talk Suicide Canada via text or via its phone number, 1-833-456-4566. Crisis responders can provide suicide intervention, de-escalation, and resources and referrals in a caller's home community. Crisis responders can also provide support to people who are worried about their loved ones, and can provide suggestions for how to best support and intervene if a loved one is considering suicide.

There are many organizations across Durham Region that offer ongoing or walk-in mental health and addictions support. In addition, Durham Region residents may be connected with family doctors or psychiatrists who provide medication support and referrals to other services as necessary.

General themes from community feedback:

Generally, when Durham Region residents were able to access mental health and crisis services, they found the workers compassionate and the organizations helpful. Youth participants in the community engagement process commented that text-based services were particularly helpful for them. Participants stated that active listening, person-centred care, ongoing support, non-judgment, and empathy from workers were beneficial, and they generally praised the mental health and addictions services that offered this kind of care.

However, community engagement participants' experiences of the healthcare system itself were much more negative. One participant described their experiences attempting to access mental health services as "traumatizing, dehumanizing, [and] disappointing." This sentiment was echoed by many other participants. Sometimes the complexities of navigating the healthcare system led to people falling through the cracks, precipitating involvement in the criminal legal system, or, in some cases, death via overdose or suicide. A substantial number of community engagement participants were parents whose children had died due to struggles related to mental health or addictions, and these parents emphasized the urgency of transforming Durham's mental health system in order to prevent these tragedies in the future.

Common themes highlighted throughout the community engagement were:

- Lack of knowledge of existing services.
- Understaffing of phone-based crisis services.
- Long wait times to access care.
- Limited hours and availability of services.
- Lack of services to serve some populations.
- Insufficient availability of crisis beds across the Region.
- Lack of affordable housing contributing to crises.
- Difficulty finding a psychiatrist.
- Gaps related to family doctors.
- Service gaps falling on agencies unequipped to manage these challenges.
- Lack of holistic support.
- Lack of service coordination and referral pathways.
- The challenge of having to explain a problem over and over to different service providers.
- Lack of community-based resources leading people to call the police or 911 or attend emergency rooms.
- Negative experiences leading people to not reach out for help at all and to suffer alone.

Healthcare system gaps:

Many participants mentioned gaps within the healthcare system more generally, and with crisis services in particular. One participant said, "It is impossible to get urgent care, and very scary when you are desperate and are in crisis and have nowhere to go." Another participant agreed, stating, "[There is] not enough support until it hits a critical point. You basically have to hit rock bottom to get help." Other participants described their experiences attempting to access care as, “Horrifying and dehumanizing,” “It felt like no one cared,” “It feels like there is nothing we can do,” and, “It feels like no one cares to help until you’re too far gone.”

Other participants highlighted the need for additional preventative services to stop people from experiencing crises. Participants commented that the mental health system in general is underfunded and understaffed, and that ongoing services are hard to find and have long wait times to access, leading to crises that could otherwise be avoided. Additionally, participants emphasized that since the pandemic, many more people are experiencing mental health challenges and needing support, putting even more strain on an already overstretched system. Some participants, including librarians, school principals, and business owners, commented that due to the lack of resources available to help people, such crises often occur within their spaces, requiring them to act as first responders. They identified this as a disservice to those in need, as providing this type of support is beyond their scope and they are not trained for crisis response.

Lack of knowledge of services:

A substantial number of community engagement participants mentioned being unaware of services in Durham Region (or being unable to access them) and going to Toronto or York Region to access services instead. For example, one participant said, "Services used are at Princess Margaret Hospital in Toronto, as we have no services here in Durham that I am aware of." Additionally, many participants were unaware of existing crisis lines in Durham Region, were unaware of Durham Mental Health Services, and/or were unaware of 211. A service user participant said, “There is little knowledge of resources that exist. I wouldn’t know who to call in an emergency.”

Many family members of people with mental health challenges found system navigation particularly challenging, and may have had misconceptions about existing services. For example, some family members believed that they could not access community-based crisis services on behalf of their loved one and that 911 was their only option. One family member identified “service navigation challenges and not knowing what support is out there and the process to get loved ones connected." Another family member participant said, "Learning about what services were available took time and research…I found it ridiculous that the services weren't better advertised." Another family member participant said, “Many people do not know where to reach out to. Information is not centralized."

Other participants indicated that they lack knowledge about the scope of mental health services and which ones should be accessed when. For example, one participant said the system is “difficult to understand and navigate with varying hours, limitations and rules, and multiple agencies providing overlapping or unclear services." Another participant said, "I found it difficult to understand which crisis resources were for what purpose - it’s not clear enough, and not visible enough.”

A service provider participant said, “Before I refer a person I call a service myself to ascertain the experience (how long is the telephone message, how complicated is it to listen to X options, what is the best direct dial number, how long before a call back). I have been shocked the number of times I get an answering machine and sometimes don't know what message to leave, even though I am a service provider who is not in a state of crisis. The entrance to service requires skills that people in crisis do not have." Another participant said, “The bouncing around or waiting for hours and then being turned away is traumatic.”

Understaffing of phone-based crisis services:

Many community engagement participants highlighted a lack of trust in phone-based crisis services, generally because these lines have long wait times and/or no live person answering the phone. Some participants commented that they, their loved ones, or their clients had called crisis lines, only to be put through to a voicemail machine. Some of these participants left a message, but did not receive a call back. This led to dissatisfaction with the service and a disinclination to reach out for help again. One service user participant described having to leave a voicemail as “defeating.” Several participants attended emergency rooms after not receiving adequate or timely responses from crisis lines.

One service provider participant said, "Clients that I speak with are deterred from calling a crisis line where there is no-one answering the phone - they do not want to leave a message and be called back." Another service provider participant described calling a crisis line 42 separate times to try to get help for her client and wasn’t able to ever actually get through to a live human. A service user participant said, "I had a time this year [when] I felt I was a danger to myself, felt at utterly rock bottom and was afraid, although not in immediate danger of ending my life. I chose to call a crisis line for the first time. I got an automated system indicating calls were full, and to call back another time - it hung up. I called back three times without being able to speak to anyone. I am APPALLED there was no queue at the very least! To have that contact hang up on you is a horrific, sad, and dangerous oversight by the region.”

Long wait times:

Long wait times to access services, often of a year or longer, were mentioned in every focus group and in the majority of survey responses that commented on community-based services. Long wait times were particularly a problem for youth mental health services. Community engagement participants indicated that long wait times lead to “people having more serious crises, and attempted suicides,” and described wait times as “atrocious,” “deplorable,” “devastating,” and “[making people feel] just so hopeless.” One participant said, “People who suffer from mental health difficulties cycle through periods of readiness to obtain help. Every time they feel ready and take that courageous step, only to be told that they need to wait for months, makes them less likely to take that step." One service provider participant said, “[Services] are strung so thin that the clients we serve are not being supported in the way that they need to be.”

Limited hours and accessibility:

Many community engagement participants commented that limited hours and accessibility of services are a barrier to accessing care. For example, most mental health services in Durham Region are available during business hours on weekdays, with limited coverage in the evenings or on weekends. As one participant noted, “Crisis doesn’t have a clock. It happens when it happens.” Another participant said that it can be “hard for people who are homeless to access services when they do not have a residence [or] phone number that they can be reached at…to complete an intake [or make an appointment].” Another participant said, “Finding reliable transportation [to get to appointments] can be a challenge…especially in more rural communities.” One participant summarized by saying, “We have phenomenal staff who are under-resourced and therefore services are incredibly difficult to access in the moment they are needed. It is wonderful to have supports available, but if you cannot easily and reliably access them during a crisis they are not meeting the needs of our community.”

Lack of services:

Community engagement participants stated that many services simply are not available in Durham Region. One participant said, “The need far exceeds the availability of resources."

For example, many participants commented that there are few preventative services to intervene early enough to stop a crisis from occurring. Other participants noted that there are insufficient services to follow up and connect people with ongoing care after a crisis has happened.

Participants stated that due to a lack of resources, individual therapy is limited and services are instead frequently offered in group formats, which may not be beneficial for individuals who have experienced trauma. Participants further stated that many services that exist are time-

limited due to lack of resources, and that the typical 6-12 sessions offered are not sufficient to support people who have experienced trauma or have complex diagnoses. The only alternative is private therapy, which can cost hundreds of dollars per session and is therefore unaffordable for most Durham residents. Participants noted that funding for day programs has been cut in recent years, and they commented on a lack of services addressing intimate partner violence in Durham Region. Participants described difficulties accessing mental health or learning disability assessments, and that generally these assessments are very expensive. However, these assessments are often necessary for people to qualify for services and/or to receive accommodations.

Participants stated that there are few services addressing substance use in Durham Region, and that many of the services that do exist are abstinence-based rather than grounded in harm reduction, which acts as a barrier to people reaching out for help. Other participants commented on a lack of services for transitional-aged youth who no longer qualify for children's services, as well as a lack of culturally responsive services, particularly for Black and Indigenous communities. Participants also highlighted the need for interim services to support individuals who are on wait lists for more intensive services.

Additionally, many participants had been turned away from services due to being "too high needs" or "not high needs enough." Participants voiced frustration with needing to be "just the right amount of unwell" to access help. One service user participant said, "[I] have been turned down by many agencies. I have Bipolar II. If I'm hypomanic, I won't get service. If I'm too depressed, I won't get service. I have to be in the sweet spot to get service." A service provider participant said, "Clients have been turned away for being 'too mentally ill' - that is verbatim what I have been told." Several family member participants said that they were told their loved one was not eligible for services because they had not done anything to harm themselves. One family member participant said, "Being told that the person in crisis has to harm themself or others before they get treatment is not right."

Many participants noted that not everyone can push past the barriers listed above to advocate for themselves and get access to services, so many people do not get the help they need. Additionally, several participants highlighted that not all mental illnesses are easy to treat, and that substantial resources need to be allocated to each client in order to provide the care they need, rather than promoting a "one size fits all" approach of 6-12 sessions.

Insufficient crisis beds:

Many participants commented that there are not enough crisis beds available in Durham Region, leading people to attend the emergency room unnecessarily. One service provider participant said, "More often than not, we're told that crisis beds are full." Other participants stated that the limited amount of time clients are permitted to stay in crisis beds renders them ineffective. One service provider participant said, "[Durham Region] offers too few crisis beds, and the crisis program is ineffective - what can you truly sort out from a crisis/mental health

perspective in a 2-4 day stay?" Another service provider participant said, "Crisis beds are not useful with only a five-day stay." Another service provider stated that some of her clients were requested to "pre-book" to access crisis beds, which defeats the purpose of the crisis beds.

Participants stated that additional funding should be allocated to crisis beds and other stabilization supports. A family member participant said, "[We] need more crisis centers built as the wait lists are too long for a bed. [The] person might be dead before they are admitted." Several other participants described crisis beds turning away service users in need due to these service users being unable to comply with stringent rules or not meeting specific criteria. One participant said, "Crisis beds are full or have such stringent rules that clients needing support are not welcome. Many are too sick to live on their own, too sick for crisis beds and not sick enough for a hospital stay. The gaps are HUGE and cannot be navigated without a strong advocate who has time and patience. Patients are frustrated, families are frustrated, and those professionals who work with the population are too."

Lack of affordable and/or supportive housing:

One service provider participant said, "A lack of affordable housing is the number one challenge in us [as service providers] being able to do what we need to do." Durham Region has long wait lists for affordable housing, which leads to some individuals using the emergency room as a shelter, particularly in cold weather. Participants suggested that additional funding allocated to affordable housing would reduce emergency room attendance and thereby free up healthcare resources. Additionally, participants commented that when individuals do not have adequate shelter, it is very difficult to adequately treat mental health or substance use challenges. Participants suggested that Durham Region allocate more money toward housing first[6] initiatives and that the proposed community mental health crisis response service should help service users access affordable housing. Systems-level capacity gaps in key support services such as housing have impeded crisis services' success in other jurisdictions; community engagement participants urged the Region to expand capacity to ensure that Durham does not experience similar challenges.

Difficulty finding a psychiatrist:

Many participants highlighted the difficulty of finding a psychiatrist in Durham Region. Many psychiatrists are not accepting new patients or have wait times of 1-2 years. Participants sometimes attended emergency rooms in the hope that this would get them access to a psychiatrist. These emergency room attendances would have been unnecessary if community-

[6] Housing first initiatives focus on moving unhoused people rapidly into independent permanent housing, without creating additional conditions or barriers. Individualized supports are then provided to help these individuals maintain their housing.

based psychiatric care was available, and attending the emergency room often did not result in ongoing access to a psychiatrist.

Family doctor gaps:

Many participants highlighted challenges finding or interacting with family doctors. Some participants did not have a family doctor; they stated that few doctors within Durham Region are taking new patients. This problem is particularly acute in North Durham, leading residents to rely on walk-in clinics. Participants indicated that many walk-in clinics do not provide adequate care for mental health challenges, given the short length of time allocated for appointments and the lack of ongoing care. Individuals may not trust a walk-in clinic doctor who they have just met to discuss their mental health challenges with, and may be worried about experiencing discrimination.

Additionally, some participants who do have family doctors do not trust that their family doctors will be able to support their mental health needs, and therefore they do not disclose their struggles to their doctors. Some participants were worried about doctors being mandated reporters and that if they disclosed their mental health challenges, their doctors might call the Children's Aid Society. Other participants stated that their doctors were simply not very aware of or understanding of mental health challenges, leading to doctors being unable to diagnose, provide appropriate referrals, or prescribe appropriate psychiatric medications. Several participants described having to educate their doctors about their own mental health needs and about mental health resources in Durham Region, as their doctors were unaware of services.

Service gaps falling on agencies unequipped to manage:

Due to the service gaps noted above, many individuals and organizations that are not trained in providing mental health crisis support are left to manage crises on their own. For example, several librarians who completed our survey noted the increase in people going into crisis at public libraries in the past few years, and how library staff are left to navigate these crises without much training or support. School principals, teachers, and administrators who filled out our survey stated that many of their students are struggling with mental health and that school staff have become de facto crisis responders. One school administrator said, "We frequently have students attempting to navigate the healthcare system in Durham. The struggle is that when they are in need of support, they access hospital and are released, sent home and return to school. We are educators, but are often supporting complex mental health needs. The long wait times, difficulty navigating the system and the lack of access to mental health supports make it difficult for families to receive the care they need." Additionally, mental health agencies that provide ongoing mental health support, but not crisis support, are often forced to provide crisis care to agency clients simply because there are no after-hours or crisis services available to refer clients to.

Lack of holistic support:

Many participants described a lack of holistic care offered, particularly a lack of long-term therapy. Some participants stated that the only or predominant options they were offered involved medication, which they may not have wished to take or may have found unhelpful or to have intolerable side effects. They described wanting access to therapy and other non-medication supports, but that these were in short supply. Several participants described having psychiatrists who refused to continue to work with them because they wished to stop (or did not wish to start) medication. One participant summarized, "Service is minimal - pushing medications without therapy or short [term] therapy, then sent back to [their] family doctor so [the] family doctor can continue prescribing meds, but there is no ongoing specialized/psychiatric treatment. This has resulted in multiple visits to the hospital which only refer back to [the] family doctor to increase med dosage." Other participants described their family doctors or psychiatrists as being unaware of non-medication therapeutic supports to refer clients to.

Participants described a lack of services in Durham Region for concurrent disorders and substance use more broadly. One family member participant said, “[Services] often compartmentalize individuals needing support. The addiction [services] would say we need to deal with my son’s mental health first. The mental health side would say that he needed to deal with addiction first. We need to be able to see the WHOLE PERSON and see the individual, not just the box they fit in.” Another participant said, “My family member has both addiction and mental health issues, and there is little, or nothing, to address concurrent issues within the public health system. She was specifically REFUSED access to residential addiction health services until she had her mental health conditions ‘under control,’ but the level of care she needs for her mental health conditions is sadly lacking.”

Other participants described a lack of services available for individuals with complex diagnoses. One parent whose child had several complex diagnoses said, “Everybody would assess him, but nobody would treat him.” She described agencies as “playing hot potato” with her child. She stated that no agency would commit to taking care of her son or guarantee that the next provider would, and every service her family was referred to had a long wait list. Participants also described a lack of support for individuals with intersecting physical disabilities and mental health challenges. One participant said, “Some individuals I work with have very complex mental health difficulties on top of the medication, seizures and other life challenges that can come with epilepsy, and crisis services may not have the understanding or background about seizures and the different reactions that can come after having one.”

Participants described having care denied or postponed because of co-occurring diagnoses or because of having a highly stigmatized diagnosis. This was particularly the case for autistic service users and for service users with Borderline Personality Disorder, as many agencies stated that they were unequipped to provide support for such service users. One participant said, “If supports [could be developed] specifically for people with BPD, that would be very

helpful. We see a number of clients who have a diagnosis of BPD and they have been advised to NOT ever mention/disclose that diagnosis because it will create a stigma that limits their access to resources."

Lack of service coordination/referral pathways:

Participants described a "duplication and fragmentation of services," and a lack of referral pathways. Participants stated that organizations do not coordinate or communicate well with each other, leading to frustration for service users and their families. One family member said, "It is incredibly hard to navigate mental health services in Durham. Everything is very fragmented…It has taken trial and error and persistence to get help for our loved one. I am educated and resourceful…It isn't easy to get help in place as things are so fragmented and these various groups don't talk to each other very well. If an individual or family in crisis does not have the skills to navigate this, it must be difficult to get help."

Other participants described accessing care as taking an "extreme amount of advocating," leaving some people to just give up in frustration. One participant said, "We called to get information on inpatient treatment and we were directed to too many places and still did not get the information we required. Frustration took over and the individual did not want to inquire any more." Another participant said, "The person in crisis called 5 different doctors/agencies on the day of admission; none called her back to intervene," so she attended the emergency room instead. Participants highlighted that service users need support in accessing referral pathways, often including transportation to the agency where they need to access service, rather than just being handed a list of pamphlets and expected to do their own advocacy.

Overwhelming to explain the problem over and over:

Participants described the fragmentation of services leading to them needing to tell their story over and over to different service providers, which can be overwhelming, particularly when someone is in crisis. One participant said, "I wish there was a way where you didn't have to repeat your story so many times. It retraumatizes you." Another participant commented that the lack of funding and high burden on mental health workers leads to significant staff turnover, which creates a poor experience for service users. That participant said, "Patients feel helpless when having to retell everything to a new crisis worker."

Lack of resources leads people to call 911/police or attend emergency rooms:

Many participants stated that they, their loved ones, or their clients called police or attended the emergency room after unsuccessfully seeking help from community-based services. Several participants described reaching out to several crisis lines, being “unable to reach a real human,” and calling 911 as a last resort. One participant said, "My husband called the crisis line and was disconnected. They did not attempt to call back. He called DRPS and they came and took him to the hospital. My husband was very disappointed that crisis services did not follow protocols to call him back," leading to his attendance at the emergency room.

Negative experiences lead people not to reach out again:

Some participants described negative experiences with community-based services that led them to not reach out for help when they needed it in the future. One participant said, "My traumatic experience with crisis response [services] may stop me from ever trusting such services again.” Another participant said, “I have personally attempted to use crisis services. It was after a suicide attempt. I felt that the person I was speaking with thought I was attention seeking, that I was overdramatic of what was going on at the time. I was not being heard. In various ways I was being dismissed. I have spoken with many people who have had similar experiences. Because of that experience there is a reluctance to reach out to services.”

Conclusion:

A crisis service is only as good as the non-crisis services surrounding it. In order for the community mental health crisis response service to be successful at providing expeditious access to care and diverting service users from unnecessary police and hospital interactions, existing mental health and substance use services need additional funding and resources in order to meet the needs of Durham Region residents. Programs need additional resources to provide preventative services that will reduce the need for crisis responses, as well as for wraparound care to support people after they have experienced crises. In addition, Durham Region requires more crisis beds in order to prevent unnecessary hospital admissions and provide low-barrier support to people who are struggling. To give the community mental health crisis response service its best chance for success, investments must be made in the broader mental health and substance use service continuum.

Supporting families:

According to Lavoie and Shore's analysis of Ontario 911 call data, a high proportion of people reaching out for mental health crisis support were family members or friends of those in crisis, reaching out on behalf of their loved ones. Family members and friends of those in crisis are therefore essential stakeholders of the proposed community mental health crisis response team, given that they will often be the ones calling for service. Families are frequently the first line of support for people experiencing mental health challenges. They therefore have valuable information that may assist the community mental health crisis response team in effectively responding to their loved one, and may further benefit from resources to support them in caring for their loved one and for themselves. Importantly, "family" is defined here as "chosen family," encompassing anyone the person in crisis considers to be their family or natural supports, rather than simply referring to "family of origin."

Existing family support services:

The Family Navigation Project at Sunnybrook Hospital supports youth and their families with navigating mental health and addictions services in the Greater Toronto Area (including Durham Region). The service is available to youth between the ages of 13-26 and their families, for no cost.

FAME at Reconnect Community Health Services supports individuals who are acting as caregivers to loved ones struggling with mental health and/or substance use. FAME offers peer support groups, individual counselling, and specific services for caregivers supporting seniors. FAME also offers support for children and youth whose family member is experiencing mental health or substance use challenges.

The Family Care Centre at CMHO is a hub of resources for parents of children with mental health struggles. The Centre connects parents with peer support, provides written resources such as a "parent survival guide" and "tips for managing crisis," and supports families with system navigation.

The Ontario Caregiver Organization provides supports to caregivers across Ontario. The organization runs a 24/7 caregiver helpline, provides learning modules and webinars on caregiving and on managing one's own mental health and stress levels, provides peer support and counselling, hosts an online resource library and many caregiving toolkits, and offers a caregiver coaching program.

The Mood Disorders Association of Ontario (MDAO) provides peer support, counselling, and educational resources for families of people experiencing mental health challenges. MDAO also hosts presentations to families and caregivers to help them recognize signs of mood disorders in youth. MDAO provides an early intervention program to support families of youth and young adults who have been diagnosed with psychotic disorders.

The Institute for Advancements in Mental Health provides phone-based counselling for families of people experiencing mental health challenges. IAM also provides system navigation and connections with early intervention for psychosis. IAM provides caregiver education support groups and cognitive behavioural therapy informed caregiver workshops.

NAMI offers educational workshops and courses to support caregivers. NAMI courses are offered free of cost. NAMI also offers a resource list and recommended books and articles to help caregivers learn more about mental illness and substance use.

The Hearing Voices Network provides information and support for families of people who hear voices or have been diagnosed with psychotic disorders, from a strengths-based and de-stigmatizing perspective.

Community engagement themes:

Many community engagement participants felt that family members are often left out when crisis responses are provided. They noted that caregivers experience their own mental health challenges, stress, and exhaustion when caring for a loved one with mental illness or addictions, and that caregivers should receive information and support from a crisis team about how to better support their loved ones, as well as how they can seek out support for themselves. Specifically, some participants stated that when their loved one was responded to either by police or by a community-based crisis service, they did not receive any information about what their loved one was experiencing or how they could help.

While information provided to families must align with the *Personal Health Information and Privacy Act* and other laws around consent-based care, families can benefit from receiving general information about how they can best support their loved one. Families can also benefit from receiving referrals to support services for themselves such as the ones listed above, in addition to services that may support their loved one's recovery. The crisis team can provide further information about what the "next steps" might be for the family and their loved one. The crisis team may also provide emotional support to family members where appropriate.

Community engagement participants also noted that family members are generally much more familiar with the person in crisis than the crisis team will be; as such, it is important for the crisis team to gather information from family members to better understand what might be happening. For example, the crisis team can ask family members what behaviours or symptoms they have witnessed, how long these behaviours or symptoms have been going on, and what strategies have been helpful or unhelpful in the past. Finally, participants emphasized the importance of families being able to access the community mental health crisis response team on behalf of their loved ones, and that information about the new crisis service should be provided to families so they know they are welcome to call.

Supporting youth

Youth are a priority population for the proposed community mental health crisis response service to respond to, given the relative lack of youth crisis supports within Durham Region proportionate to the number of youth within the Region struggling with their mental health. As such, the Region solicited feedback from youth, parents, and child and youth workers to hear what recommendations these groups had for developing a new crisis response service. Thirteen surveys were completed by youth under age 19, and many other surveys were completed by parents of youth under age 19. Additionally, a focus group was convened for child and youth workers across Durham Region, with six attendees.

Existing services for youth:

Kinark Child and Family Services provides mental health support for children up to age 12 and their families. Kinark offers individual and family therapy, family skills building services, intensive home-based services, autism services, and forensic services. Kinark provides mobile crisis support in York Region through the 310-COPE helpline; however, mobile crisis services are not available for youth in Durham Region. Phone-based crisis support is available to youth and families in Durham Region through Kinark, as well as expedited office-based appointments (same day or next business day).

Frontenac Youth Services provides mental health support for youth aged 12-18 and their families. Frontenac offers individual and family therapy, day treatment, dual diagnosis services, live-in treatment, and crisis services through the Frontenac crisis support phone line. The Frontenac crisis line is available from Monday to Friday between 9:00 am to 5:00 pm.

Chimo Youth and Family Services provides mental health support to children and youth aged 0-18 and their families living in North Durham and Kawartha Lakes. Chimo offers individual and family therapy, family skills building services, day treatment, school-based services, a sexual abuse response program, respite services, intensive treatment services, youth mental health court diversion, and crisis intervention. Crisis intervention is provided from Monday to Friday between 9:00 am to 5:00 pm, via Chimo's crisis support phone line. Support is typically provided over the phone, with follow up supports available in-office or in-home.

Lakeridge Health offers comprehensive outpatient treatment for children and youth aged 5-18 and their families. Lakeridge also offers urgent care services and short-term inpatient care.

Kids Help Phone offers anonymous and confidential phone-based counselling and referrals to youth across Canada.

General themes from community feedback:

Participants throughout our community engagement sessions emphasized the importance of providing crisis supports for youth. Additional themes that emerged included service gaps for adolescents and young adults, a lack of knowledge of services, long wait times to access services, and aging out of services while waiting for access.

Service gaps for adolescents and young adults:

Participants stated that young adults who have aged out of youth services often feel uncomfortable using adult services, and may not access care as a result. Support for young adults transitioning into adult services should therefore be made available, where possible. Youth services may also benefit from having a flexible definition of “youth,” so that young adults who have accessed services at a given agency are able to continue receiving support for a period of time after their eighteenth birthday. Additionally, several participants highlighted the need for age-appropriate peer support services; an eighteen-year-old or nineteen-year-old may not consider a forty-year-old or a fifty-year-old a “peer.”

Participants also noted that there are gaps in services for younger teenagers and “tweens.” One participant shared that her ten-year-old daughter sometimes has moments of crisis and talks about self-harm, but she has grown out of younger child services and the hospital is not set up to provide appropriate support to a ten-year-old. Another participant described a crisis her fourteen-year-old child experienced and not having adequate services available because the child was too old to access children’s services but too young to feel comfortable accessing services geared towards teenagers.

Finally, participants described a lack of providers being willing to take on higher-acuity service users with complex needs. For example, one participant said, "[My] child was suicidal, [and I] reached out to so many services. Very few responded.”

Lack of knowledge of services:

Many participants mentioned being confused about which youth services exist, when those services are available, and what those services do. They also stated that there are too many different phone numbers and that these phone numbers are poorly coordinated. Several participants described the transition towards 310-COPE as “confusing” and “disjointed.” Other participants said that lack of knowledge of youth services often leads parents to bring their children to emergency rooms rather than calling a community-based service that might better meet their children’s needs. One participant stated, "Children are very much at risk and parents unfamiliar with resources need easier access."

Long wait lists:

Many participants described long wait lists for youth mental health services. One participant's young daughter was on a counselling wait list for two years, while another participant's child waited for three years. Another participant's son waited eleven months to access a psychiatrist. That participant said, "Having a suicidal child is scary enough, [but it was even scarier to be] told you just have to wait - with the implied - that they'll survive the wait." One participant's daughter waited two and a half years to see a child psychologist, as her family doctor was hesitant to prescribe antidepressants until the child spoke to a psychologist. The participant said, "My daughter is now off to university, still unmedicated, and we are frustrated that because she's not in danger of self-harming, she's not important enough to get more immediate help." A teacher participant said, "My high school students are constantly on wait lists, can't access services, and are experiencing a true mental health systemic crisis."

Other participants described long wait times in emergency rooms and how these environments further escalated or traumatized their children. One mother described the trauma her child experienced in the emergency room, with little privacy and surrounded by adult psychiatric patients. Another mother waited in the emergency room with her daughter for over five days before she was able to access an inpatient bed. Another mother brought her young son to the emergency room and waited over six hours. She said, "During his wait, he said to me, 'I can see why people kill themselves.'"

Many participants commented that parents bring their children to the emergency room with the goal of expediting their care and getting them access to psychiatry; however, often their children do not end up getting a psychiatric assessment and instead end up sent home or being put on "endless wait lists."

Aging out of youth services:

Several participants mentioned young people aging out of youth services due to extensive wait lists. Sometimes being taken off the youth wait list means that individuals are unable to access care. For example, one participant said, "[My] grandson reached the age of 18 and was taken off the [wait] list [for youth services] - he is considered an adult and no longer on the youth list. Now 22 years [old], and still dealing with mental health issues." Another participant noted that when adolescents age out of youth services while on a wait list, they are put into adult services, which may not be developmentally or socially appropriate.

Feedback from child and youth workers:

The child and youth workers who attended our focus group generally agreed with the themes listed previously above. Additionally, they highlighted the importance of the community mental health crisis response service familiarizing itself with the *Child, Youth and Family Services Act* and related legislation governing interactions with children and families, including laws related to consent to care for minors, sections of the *Education Act* relevant to working in or attending schools, and laws regarding parental notification and duty to report.

The child and youth worker participants also suggested that it may be beneficial for the service to build relationships with the Durham Children's Aid Societies (CAS), given that some families who interact with the crisis service will have had previous involvement with CAS and/or may wish to utilize CAS for respite care of their child. However, relationship-building with CAS should be done with caution and the community mental health crisis response service should remain at arm's length from CAS at all times, recognizing the negative associations Black and Indigenous communities in particular may have with CAS. Having too close a relationship with CAS may make such communities less likely to reach out for help when they need it.

Conclusion:

Generally, participants were dissatisfied with the state of youth mental health services in Durham Region and are eager for improvement. As one community engagement participant said, "It's a disgrace what is available for our youth…My child and I have been left to struggle and scramble for years as they fight mental health issues. I have no confidence that help is available. We have been left stranded too many times to count." The Region of Durham and the proposed community mental health crisis response service need to change this reality. It will therefore be essential to develop a crisis response service that can meet the unique needs of Durham youth and their families. The Region should continue collaborating with existing service providers and exploring regional and international models to determine best practices for youth crisis supports. It will likely be beneficial to ensure that the initial pilots of the community mental health crisis response service can serve both adults and youth, while at least one specialized youth crisis team should be developed to launch in the second phase of implementation.

Supporting people with disabilities:

People with disabilities were identified as a priority group for community engagement, given the intersections between disabilities and mental health challenges and the unique needs of this population. For example, people with disabilities are five times as likely as people without disabilities to experience mental health challenges. The Region of Durham facilitated a focus group for people with disabilities (including physical, cognitive, and developmental disabilities) in partnership with the Abilities Centre, an organization in Whitby that serves people with disabilities. Twenty-seven people attended this focus group. Additionally, many survey respondents mentioned their own or their loved ones' disabilities and how these disabilities impacted their experiences with crisis response services. Themes from this community engagement are summarized below.

General themes from community feedback:

Themes that emerged from our community engagement can be grouped into several categories. These categories include experiences of discrimination accessing mental health services due to disability, fear of calling police due to disability, ideas for how the proposed community mental health crisis response service can support people with disabilities, and specific feedback about supporting Deaf community members.

Experiencing discrimination due to disability:

Many participants shared that it is difficult to access mental health support due to their disabilities; this is largely because many service providers are not trained in supporting dual diagnoses (cognitive disabilities as well as mental health challenges) or neurodivergent identities such as autism or ADHD. One participant shared that she has been on a wait list for years to access mental health support because she has an intellectual disability; the organizations that serve people with intellectual disabilities generally do not provide mental health support, while the organizations that provide mental health support may not be comfortable treating community members with intellectual disabilities. The lack of care this participant received has led to the deterioration of her mental health and to worsening self-injurious behaviours.

Another participant shared that her autistic child had been denied care in the emergency room for a mental health crisis because the doctor failed to understand the intersections between the child's autism and mental health and felt unequipped to provide treatment to an autistic patient. Several other autistic participants mentioned challenges in accessing appropriate services and experiencing discrimination due to their autism. Another participant said, "As someone with disabilities one [problem I experience when seeking mental health care] is being spoken down to like a child. Or made to feel I'm weak and need to be coddled. This is also an issue for some seniors."

Several participants mentioned that their mental health diagnoses have led to discrimination when seeking treatment for their physical health. These participants stated that their mental health record “followed” them when they sought help later on. One participant said, "As someone with disabilities, it has been my experience that once I've identified I've experienced a mental health issue, I become an unreliable narrator of my physical health and my symptoms become attributed to my anxiety. Just because I have a mental illness doesn't mean I can't identify when something is wrong with my physical health, and practitioners should not [doubt] a person's ability to know themselves."

Fear of calling police due to disability:

Several participants stated that they were afraid to call the police when they or their loved one were experiencing a mental health crisis, due to their or their loved one’s disabilities. This fear was particularly salient for parents of autistic children and young adults, especially if that young person was nonverbal. Parents worried that their children might be misunderstood and therefore seen as a threat.

Supporting people with disabilities:

Participants stated that community mental health crisis response team staff must be knowledgeable about various disabilities and organizations that support these disabilities to provide useful referrals. For example, some agencies that provide mental health support in Durham Region do not have accessible physical locations, or do not have staff members onsite who are fluent in ASL. Community mental health crisis response team staff will need to be knowledgeable about which organizations are appropriate to refer service users with disabilities to, in order to ensure they receive accessible care. Several participants suggested that the community mental health crisis response team build partnerships with community agencies that serve people with disabilities, such as the Abilities Centre and the Brain Injury Association of Durham.

Participants made many suggestions about training crisis team staff should receive to learn how to effectively support people with disabilities. For example, participants suggested that staff should receive training in working with non-verbal service users, in identifying and working with service users with “invisible disabilities,” and in supporting people who have experienced seizures. Participants further recommended that crisis team staff receive training to better understand the needs of Deaf service users and Deaf culture, including hearing children of Deaf parents. Participants stated that staff should also receive training in supporting individuals with cognitive impairments, including communicating using plain language. Additionally, several participants suggested that crisis team staff receive training regarding stroke survivors and how stroke survivors might react to mental health crises; for example, stroke survivors may find it more difficult to communicate, which may further escalate them in a crisis.

Many participants recommended that crisis team staff receive training in responding to autistic service users, including how autistic people might respond differently than neurotypical people to crisis situations and what factors might escalate or agitate autistic people (such as bright lights or loud noises). Training about supporting autistic people should generally be conducted by autistic peers themselves, rather than contracting clinical or caregiver-led organizations to provide this training. For example, Autistics for Autistics and Autistics United Canada are autistic-led advocacy groups that provide autism training to organizations.

Finally, participants highlighted the importance of the proposed community mental health crisis response service proactively addressing accessibility needs. For example, advertising materials sharing information about the new service should be provided in Braille as well as in print, and the crisis team's vehicles should be wheelchair accessible.

Supporting Deaf community members:

Participants stated that current first responders to mental health crises, including paramedics and police, are often not equipped to adequately support Deaf individuals. For example, first responders may not be aware of how to access an ASL interpreter, or they may not initially recognize that someone is Deaf and might therefore respond as if the Deaf person is ignoring their instructions on purpose, rather than simply not being able to hear them. Additionally, several Deaf community members commented that being handcuffed or restrained by police or hospital staff is traumatic, as it takes away their ability to communicate. Other aspects of police procedure, such as shining a flashlight towards someone's face, may also be harmful for Deaf community members, as it impairs their ability to read lips.

Participants further suggested that all frontline crisis team staff be trained in basic sign language and that frontline staff should have access to an interpreter or ASL-speaking staff member who is able to attend the scene expeditiously to support Deaf community members. They emphasized that ASL interpretation must be provided in person rather than by video. They also recommended that children of Deaf parents should have access to ASL interpretation where appropriate; for example, if a hearing child is in crisis at their family home, an interpreter should be provided to the Deaf parent, so the Deaf parent is able to share information about their child's condition with the crisis team. Hearing children should never be in the position of needing to interpret for their Deaf parents during a crisis.

Supporting North Durham residents:

North Durham residents were identified as a priority group for community engagement due to the unique challenges they face when it comes to accessing healthcare and other services within their rural communities. As one community engagement participant said, “[North Durham] is a high risk population with few services and supports.” North Durham residents have unique needs, and their voices are essential to the design of a community mental health crisis response service. The Region of Durham facilitated a focus group with North Durham residents in Cannington, in partnership with the Nourish and Develop Foundation. Twelve people attended this focus group. Additionally, 98 North Durham residents filled out our survey. Themes from this community engagement are summarized below.

Existing services in North Durham:

Brock Community Health Centre is a community health centre with locations in Cannington and Beaverton. Brock CHC offers primary care services, community wellness programming, social work, nutritional support, health promotion, physiotherapy, dental services, and service navigation.

North House provides housing supports and adjacent services to low-income residents of North Durham. North House provides assistance with accessing affordable housing and provides financial support for low-income residents at risk of homelessness. North House also supports low-income residents with completing their taxes, replacing lost or stolen IDs, and accessing the Landlord & Tenant Board.

The Nourish and Develop Foundation provides food and nutrition support to North Durham residents. The Nourish and Develop Foundation operates a food bank, a mobile food market, community lunches, community cooking classes, and other wellness and community programming.

General themes from community feedback:

Themes that emerged from community engagement include challenges with service coordination across jurisdictions, lack of proximity to supports, insufficient availability of mental health services in North Durham, and insufficient accessibility of public transportation.

Challenges with service coordination:

Many North Durham residents access care in York Region rather than in Durham Region, because York Region services may be geographically closer than travelling to Oshawa or Ajax. However, services in York Region are often poorly coordinated with services in Durham Region, which makes it difficult for North Durham residents to access care and referrals. Eligibility for some services is dependent on living within a particular region; for example, a service in York Region may be closer to a particular Durham Region resident's home than a similar service in Durham Region, but the York Region service may not serve Durham Region residents. Additionally, Durham Region Transit does not provide transportation within York Region, making it challenging for North Durham residents to access care in York Region.

Lack of proximity to supports:

North Durham residents commented that they are generally far from hospitals, so if they need urgent care, this care is sometimes delayed. North Durham residents further noted that crisis services based in the south, such as Durham Mental Health Services, can take over an hour to arrive due to traffic and geographic distance. As such, North Durham residents are reluctant to call crisis services based in the south and instead end up relying on police for crisis support, due to their faster response times. Additionally, sometimes crisis services based in the south refuse to come to the north due to the time commitment of travelling. One North Durham resident said, "Crisis workers do not like to come to the North and request that clients get themselves down to South Durham."

Insufficient availability of mental health services in North Durham:

North Durham residents described a dearth of supports that are located in or accessible to their communities. Residents in North Durham are spread out over large geographic distances, with few (or no) public transit options, so services located in one small community may be inaccessible to a resident living in another small community. Services are generally available on weekdays from 9 a.m. to 5 p.m. and are rarely available in the evenings or on weekends. Additionally, some services are only available on certain days of the week or month, or on a part-time basis. Several North Durham residents stated that they did not have a family doctor or had difficulty finding a family doctor, because few doctors in North Durham are accepting new patients. As such, residents rely on walk-in clinics, which may require them to travel outside their communities to access. North Durham residents also commented on the lack of social supports and community events available in North Durham, leading to a sense of isolation, particularly for seniors, and potentially exacerbating mental health challenges.

North Durham residents described having to leave their communities to access mental health support. One resident said, “There isn’t really anything in Uxbridge. Everything is organized in Port Perry or Oshawa/Ajax/Pickering…For people to actually receive a decent amount of services, we have to leave Uxbridge, and that can cause a variety of new challenges.” Other residents described having to travel to York Region, South Durham, or Toronto for care. Others stated that they simply do not access care when they need it. One resident said, “You just deal with it on your own.”

Insufficient availability of public transportation:

North Durham residents highlighted a lack of accessible and reliable public transportation in their communities. Due to these transportation gaps, it can be difficult for North Durham residents to access mental health services, because they have no way to get there or are concerned that transportation may not be reliable enough to get them home after. For example, one resident described missing healthcare appointments due to the Durham Region Transit On Demand service not arriving on time, and then being permanently discharged from healthcare agencies as a client due to missing too many appointments. North Durham residents emphasized the importance of a community mental health crisis response team meeting people in their locations rather than requiring people to travel to access care. Additionally, they suggested that the crisis team should be able to directly transport people to other services.

Conclusion:

North Durham is a priority area for the proposed community mental health crisis response service, and at least one pilot should be developed in North Durham. Several other community engagement participants echoed this theme, making comments such as, "Please keep North Durham and accessibility in mind when creating these supports.” As one North Durham resident put it, “We are not a part-time municipality, and we need more than part-time services.” A community mental health crisis response service, available 24/7 in North Durham, could be of great benefit to its residents.

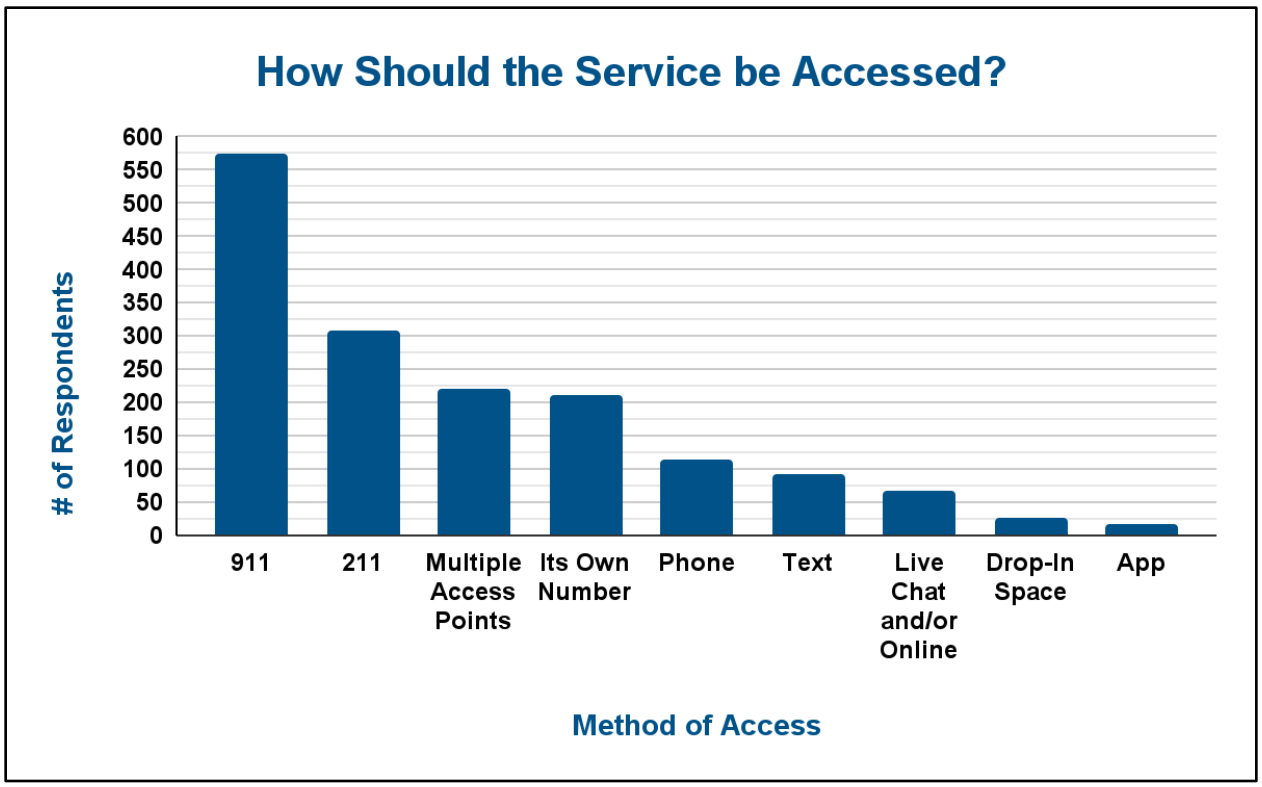
Accessing the service:

Municipalities in Canada and the United States generally have several methods through which their community mental health crisis response services can be accessed. The majority of municipalities ensure that their services are accessible via 911. The team may be directly dispatched via 911, with staff carrying first responder radios in order to receive dispatches. Most American municipalities use this 911 direct dispatch model. Some Canadian municipalities use a 911 “warm transfer” model, in which 911 is not the dispatcher but can divert calls to the crisis team dispatcher through direct transfer. For example, Toronto’s Community Crisis Service and Edmonton’s 24/7 Crisis Diversion program are both dispatched by 211; 911 call-takers are trained to directly transfer mental health crisis calls to 211 for dispatch of the community mental health crisis response team.

Other crisis services are accessible via their own direct number, via existing crisis lines, and/or via 988 in the United States, in addition to accessibility via 911. Crisis services also receive a significant proportion of calls via secondary dispatch from police; for example, police officers may attend a scene and determine that support from the community mental health crisis response team would be beneficial, so they call in the crisis service as a secondary responder. Some crisis services self-initiate a substantial number of interactions; for example, teams doing street outreach may identify individuals who could benefit from support. Models for accessing community mental health crisis response teams across Canada and the US are discussed in more detail in the international models section of this report.

General themes from community feedback:

The survey asked respondents how they would like to access the proposed community mental health crisis response service. The survey was open-ended rather than multiple-choice, so respondents were free to write in as many or as few options as they chose. 567 survey respondents (39.8%) said the service should be accessible via 911. 307 survey respondents (21.5%) said the service should be accessible via 211. 211 survey respondents (14.8%) said the service should be accessible via its own number. 115 survey respondents (8.1%) said the service should be accessible via phone. 91 survey respondents (6.4%) said the service should be accessible via text. 66 survey respondents (4.6%) said the service should be accessible via live chat and/or online. 26 survey respondents (1.8%) said the service should be accessible via a drop-in space. 18 survey respondents (1.3%) said the service should be accessible via an app. 222 survey respondents (15.6%) said the service should be available via multiple access points, with 7 survey respondents specifically saying the service should take a “no wrong door” approach. Other suggestions for accessing the service included street outreach, referrals from doctors, and the Durham Mental Health Services crisis line.



The percentages noted do not add up to 100%, because many survey respondents did not provide an answer to how they would like to access the service, and other survey respondents provided multiple answers. Where survey respondents provided non-specific answers indicating that they would like multiple access points (e.g. “the team should be accessible through as many ways as possible”), their responses were coded only as “multiple access points.” Where survey respondents provided multiple answers (e.g. “the team should be available via both 911 and 211”), their responses were coded as the specific access points they suggested as well as “multiple access points.” Where survey respondents used the specific phrase “no wrong door,” their answers were coded as “multiple access points” and “no wrong door.”

The survey results recommending access via 211 should be interpreted cautiously. The question asking how people would like to access the service included both 911 and 211 as examples for ways the service might be accessed. Several survey respondents who suggested access via 211 indicated later in the survey that they did not know what 211 was and believed it was a new three-digit number that would be created specifically for this service. When 211 as a point of access for the service was discussed in focus groups, most participants indicated that they had not heard of 211. Therefore, it is likely that many survey responses recommending the use of 211 are not based on the specific services 211 provides, but based on the fact that people would like a three-digit number (other than 911) to link to the service.

Importance of 911 integration:

Most survey respondents wanted the service to be accessible via 911 in some manner. 87 survey respondents specifically said that 911 is the number people know to call in a crisis, and that people may have a hard time remembering to call another number. For example, one survey respondent said that 911 “is ingrained as emergency, and in crisis there’s no time to fumble for another number.” Focus group participants were generally in agreement with this sentiment.

Community engagement participants described 911 as “easy to remember,” “the simplest thing for individuals to remember in a crisis,” “accessible because everyone knows it already,” “already widely known,” “the default for an emergency,” “well known,” “easy to access,” “familiar,” “when a family [member] or stranger needs to get help, it’s the universal number,” “the first thing one usually thinks of in a crisis situation,” “everyone’s go-to,” “the quickest way to get a response,” and a “universally known emergency number.” Participants were doubtful that the service would be effective at diverting calls if 911 was not involved and suggested that developing a new number would be “confusing” or “redundant.” Another participant commented that “no one knows the other numbers” for community-based crisis services, while they do know 911.

Community engagement participants described several other benefits of 911 integration. One participant noted that pay phones, phones without minutes, and locked smartphones can still call 911, while these phones are unable to dial (or look up information for) other numbers. That participant stated that 911 integration will therefore be necessary to ensure ease of access from any phone. Another participant noted that “many people may not be able to properly assess the situation and make an appropriate determination about the style of intervention required.” Some people may call 911 thinking police intervention is appropriate, but the call may in fact be better suited for a community mental health crisis response team response, and 911 call-takers should be trained to make these assessments and divert the call accordingly. Relatedly, one participant highlighted that 911 integration “would allow all emergency calls to be directed to the appropriate service, even when callers aren't aware of the non-police response options.” Additionally, when crises unfold in public spaces, often more than one bystander will call 911, so if the service is not integrated into 911, 911 may dispatch police without realizing that the crisis team is already on the way, leading to a duplication of services. If a second bystander calls 911 after a team has already been dispatched, the 911 dispatcher is also able to tell the caller that a team is already on the way.

Finally, participants indicated that 911 integration would “legitimize the status of the service and not be a poor inaccessible cousin." Many participants suggested that 911 integration would de-stigmatize and normalize accessing the service, and that when people call 911, they should be asked, “Fire, police, ambulance, or mental health?” 911 call-takers in some American cities, notably in Austin, Texas, already greet 911 callers this way, thereby de-stigmatizing and raising the profile of their community mental health crisis response service.

Other considerations for 911 integration:

Many participants recommended that 911 not be the only access point for the community mental health crisis response service, due to the association many community members have with 911 and the police. As a result, 911 can be experienced as “triggering,” “scary,” and “stigmatized.” Participants stated that community members may feel “wary” of calling 911 “due to a fear of…police being sent” rather than the community mental health crisis response team. Participants suggested that one way to combat this would be to ensure consent-based dispatch; for example, when someone calls 911 and requests the community mental health crisis response team respond, police should not be sent without the caller’s consent. Participants recommended that in addition to 911, the service should also be accessible via another number, and that this number should not transfer calls to police without the caller’s consent.

Community feedback about alternative access points:

Community engagement participants emphasized that using any number other than 911 would need to be “advertised heavily to be sure that people know that the service is there and available to help." Participants further suggested that information about what will happen when someone calls that number should be advertised and promoted, so that community members know what to expect and feel more comfortable calling. Participants recommended that community education be provided to help potential callers learn how to accurately identify and describe mental health occurrences to call-takers, to ensure that the crisis team gets dispatched rather than police in appropriate circumstances. Participants suggested that alternative access numbers should be as short as possible, rather than using ten-digit numbers. 988 may be a good candidate for an easy-to-remember three-digit number, once it launches later this year. It may also be beneficial to look to Toronto and Edmonton as examples for how they advertised and integrated 211 access.

Conclusion:

Based on both Durham Region community feedback and international best practices, it is clear that some form of 911 integration will be essential to the success of a community mental health crisis response service. Durham would also benefit from developing at least one other method of accessing the service, either via 211, 988, and/or its own number, to create a “no wrong door” approach. If an existing service such as 211 or 988 is involved, coordination between that service and 911 will be essential to avoid redundancy and ensure compatibility of data collection methods.

911 integration:

As identified by community engagement participants, 911 is the number people know to call in a crisis. As such, 911 integration will be essential to the success of a community mental health crisis response service. 911 integration will lead to greater use of the service and therefore greater diversion from unnecessary police and hospital interactions. 911 integration will legitimize the crisis team as a fourth branch of emergency services and will thereby spread awareness and reduce stigma. 911 integration will also promote safety by ensuring all calls sent to the community mental health crisis response service are screened for violence, weapons, and medical emergencies by trained 911 call-takers. Finally, 911 integration will promote efficiency and reduce redundancy; for example, when multiple 911 calls are made about the same incident, 911 staff will be able to tell the callers that a team is already on its way, rather than sending out police because of call-takers not being aware that the crisis team has already been dispatched. A direct dispatch model, discussed below, will likely be most effective and efficient at dispatching the crisis team in a timely manner without undue burden on 911 call-taker staff.

How police dispatch works:

When a person calls 911 in Durham Region, their call is routed to Durham's 911 call centre, where their call is answered by a call-taker from that centre. The call-taker asks the caller if they require fire, ambulance, or police assistance. If a fire or medical emergency is occurring, the caller will be transferred to a separate line for paramedics or the fire department to be dispatched. If there is no fire or medical emergency, the call will remain within the police line by default.

Next, the call-taker will screen the call to gather relevant information to assign the appropriate call type (e.g. person in crisis, theft in progress, mischief) and the priority level of the call. The call-taker will also screen the call to determine whether violence or weapons may be present. During this information gathering process, the call-taker types notes about the call into their computer-aided dispatch (CAD) system, which creates a unique file for that call and adds identifying information such as the caller's phone number and GPS coordinates.

This file is passed to the police dispatcher, who assigns each call to a police car through the CAD system in police vehicles. The police see the file and relevant information about the call pop up on their mobile screens.

Elements of a direct dispatch model:

The direct dispatch model for dispatching crisis teams is easier to implement than other dispatch models because it does not add many additional steps to the call-taking process described above. The direct dispatch model involves mostly the same steps as above. First, the call-taker asks whether the caller requires fire, ambulance, or police (and may also ask if they require mental health) assistance. If there is no medical emergency or fire, the call-taker screens the call to determine the call type and priority level. Municipalities that implement community mental health crisis response services typically designate specific call types as appropriate for these crisis teams; for example, person in crisis calls, welfare checks, unwanted person, and suicide calls are often selected as presumptively appropriate for the crisis team. If the call is one of the designated types, the call-taker will then conduct additional screening to determine whether a medical emergency, violence, or weapons are present, or whether the caller requires police-only action such as filing a police report or entering a locked vehicle.

If none of these red flags are present, and the call is one of the designated types, the call-taker will make a note in the call file that the call is appropriate for the crisis team. The call file will then be transferred to the police dispatcher, who will read the file and dispatch the community mental health crisis response team rather than the police. The crisis team may receive the dispatch through their own mobile data terminal or may be called over their first responder radios. The crisis team will then head to the call.

For this process to work, 911 data analysis will need to be conducted to determine appropriate presumptive call types for the crisis team, and 911 call-takers will need to be trained in efficiently identifying these call types. 911 call-takers will also need training in adjusting their screening of calls; while 911 call-takers already screen for violence, weapons, and medical emergencies, they will need further training in screening for police-only action within the designated call types. Crisis teams will also need to be equipped with mobile data terminals and/or first responder radios so they can efficiently receive dispatches.

Efficiency of dispatch models:

One primary concern in developing an effective dispatch model is ensuring that the dispatch process does not unduly burden 911 call-taker staff and infrastructure. While a direct dispatch model requires some upfront training of 911 staff to familiarize them with the model, data from other cities using this model demonstrates that effectively implementing a direct dispatch model does not increase either 911 call “talk times” or 911 queue times. Conversely, a 911 warm transfer model such as the model used in Toronto and Edmonton may increase 911 talk and queue times, and therefore this model is not recommended for Durham.

Data from Toronto shows that the average TCCS call requires 9 minutes 36 seconds of talk time for a 911 call-taker. More than half of this call time consists of gaining the caller's consent to transfer the call to 211, reading a privacy statement about transfer to 211, waiting on hold for 211 to pick up the call, and then explaining the details of the call to the 211 call-taker. It is not recommended that 911 call-takers in Durham secure explicit consent to dispatch the crisis team, as this is likely to increase call talk times; most cities that implement a direct dispatch model consider the caller to have provided "implied consent" for the crisis team to be dispatched unless the caller expressly requests police, in which case police will be dispatched. When implied consent is implemented and the call is directly dispatched as noted above, call talk and queue times do not increase.

Training and support for 911 call-takers:

911 call-takers in Durham Region are already overstretched and under-resourced in their vitally important roles. It is essential to build relationships with 911 call-taker staff and to ensure that the proposed crisis response service does not add further stress or burden to them. Part of this will be accomplished through developing efficient dispatch procedures. Other aspects of this task include reducing redundancy and data collection challenges, providing additional resourcing and funding to 911 staff, and holding focus groups and listening sessions to better understand the perspectives of 911 staff, their hopes, and their concerns. 911 staff already have experience screening and transferring calls to alternative programs, such as the call diversion program currently operating in Durham Region; training and support to 911 staff should prioritize integrating and emphasizing processes they are already familiar with, rather than developing completely new protocols unlike those currently in use.

911 call-takers will need to receive extensive training about which call types and incidences are appropriate for the community mental health crisis response team to respond to, and will need substantial time and support to build comfort and confidence in transferring calls to this team. Cross-training between 911 call-takers and the community mental health crisis response team will be beneficial in achieving this. Call-takers will need training to help them understand when the subject of a call may be experiencing mental illness, even when the person calling may not be using accurate language to describe this occurrence, such as when the caller may not themselves recognize the incident as involving mental health. Call-takers may also require additional training to determine whether a call might pose safety risks and therefore need a police response or when a call is non-violent and therefore should be responded to by the community mental health crisis response team. Some cities have developed sophisticated decision trees to help their 911 call-takers make these determinations accurately. Durham Region can benefit from the expertise of these municipalities.

911 call-takers may be provided with a script for explaining to callers what the community mental health crisis response team does and why it might be beneficial for the community mental health crisis response team to respond to their call, as many callers are unfamiliar with the service and may initially request police response simply because they lack knowledge of the community mental health service. 911 call centres will need to be evaluated over time to identify and correct deficiencies in training and/or process, and to ensure that implicit biases aren't inappropriately routing calls. For example, rigorous evaluation should be conducted to ensure that people of colour aren't disproportionately being routed towards the police while white people are routed to the community mental health crisis response service.

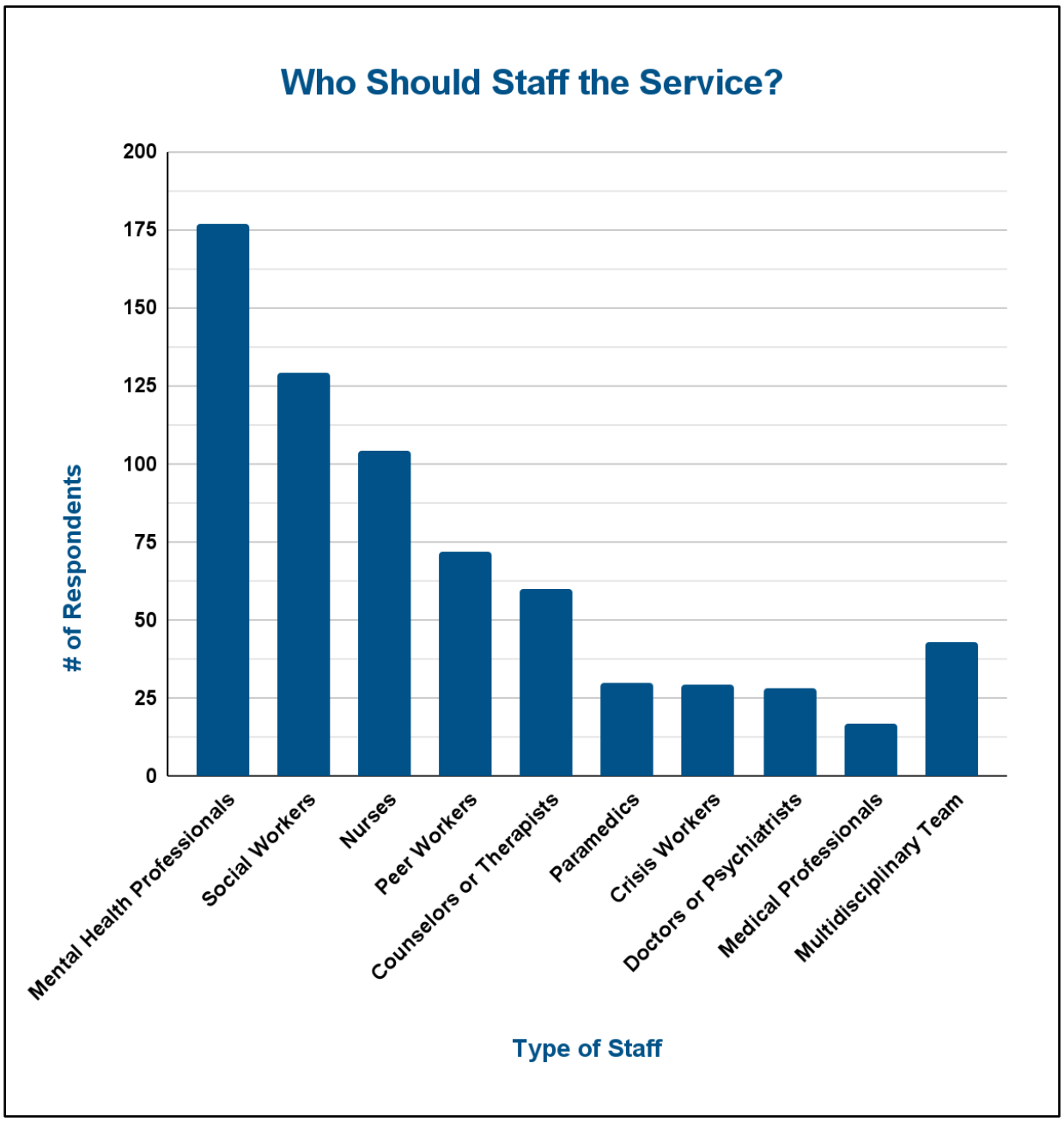
Staff hiring and training:

Municipalities in Canada and the United States generally hire some combination of the following workers to staff their community mental health crisis teams: peer support workers, crisis workers, social workers, therapists, mediators, violence interrupters, paramedics, and nurses. Some teams also offer access to virtual or on call doctors or psychiatrists. Typically crisis services will employ two staff members per team, often one mental health staff member such as a social worker and one medical staff member such as a paramedic, although some cities employ three staff members per team (typically to include a clinical staff member, a medical staff member, and a peer support specialist). More details about staffing across international jurisdictions are provided in the international models section of this report.

Crisis team staff are generally multidisciplinary, with emphasis on hiring people from the communities they serve in order to build trust and ensure representativeness. Additionally, crisis teams prefer to hire individuals who already have experience doing crisis work or serving marginalized populations. Crisis teams typically prioritize the strengths and skills of an individual candidate over rigid educational credentials, given inequities in access to higher education and given the need for community trust-building. Crisis team staff receive thorough training, including substantial field training, discussed below in this section.

General themes from community feedback:

The survey did not directly ask which staff should be hired for the team, but many respondents shared their suggestions anyway. 177 survey respondents (12.4%) said the service should be staffed by mental health professionals. 129 survey respondents (9.0%) said the service should be staffed by social workers. 104 survey respondents (7.3%) said the service should be staffed by nurses. 72 survey respondents (5.0%) said the service should be staffed by peer workers. 60 survey respondents (4.2%) said the service should be staffed by counselors or therapists. 30 survey respondents (2.1%) said the service should be staffed by paramedics. 29 survey respondents (2.0%) said the service should be staffed by crisis workers. 28 survey respondents (2.0%) said the service should be staffed by doctors or psychiatrists. 17 survey respondents (1.2%) said the service should be staffed by medical professionals. 43 survey respondents (3.0%) said the service should be staffed by a multidisciplinary team. Other suggestions included social service workers, community workers, harm reduction workers, case managers, addiction counselors, psychologists, developmental service workers, and child and youth workers.



The percentages noted do not add up to 100%, because many survey respondents did not include information about which staff members should be hired for the crisis team, and other survey respondents provided multiple answers. Where survey respondents said they would like a “multidisciplinary” or “interdisciplinary” team, their responses were coded as “multidisciplinary.” Where survey respondents provided multiple answers (e.g. “social workers and nurses”), their responses were coded as the specific staff members they suggested as well as “multidisciplinary.” Where two or more staff members were recommended, respondents generally suggested that a mental health worker (e.g. a peer worker, a social worker) and a medical worker (e.g. a nurse, a paramedic) should work together, given that some issues can be medical in nature.

Many community engagement participants indicated that it would be important to have medically trained staff on the community mental health crisis response team to identify whether an issue might be medical rather than mental health-related; for example, several respondents noted that a diabetic crisis can look similar to a mental health crisis, but require different treatment. Participants noted that no more than three people should staff each team, given that a large number of staff responding to a call may be experienced as intimidating or overwhelming for individuals in crisis. Participants were divided about whether psychiatrists should be part of the team; some people have had poor experiences with psychiatrists, while others think quick access to psychiatrists is essential. Generally, most participants were in support of an “on call” model for psychiatrists, where psychiatrists attend calls only upon request. Many participants emphasized the importance of hiring peer workers and people with lived experience to work on the community mental health crisis response team.

Representative staffing:

429 survey respondents (30.9%) specifically indicated that hiring diverse staff is essential to the success of a community mental health crisis response service, and that the diversity of Durham should be reflected in its staffing. One survey respondent said, “I would love to see it if people could see themselves represented” in the service. Another survey respondent said that “seeing someone who looks like me and understands the cultural sensitivities and stigmas" would help her feel more comfortable accessing the service. Community engagement participants further stated that crisis team staff will need to have knowledge of and skill working with the diverse cultures within Durham Region. Participants suggested that one way to do this would be to partner with agencies whose staff already reflect the communities they serve.

Participants emphasized the need for the crisis team to hire staff who can provide service in multiple languages, as engaging an interpreter is inefficient and should be avoided where possible. Some participants suggested that callers should be able to request a staff member from their own cultural or racial background, where available. Other participants recommended that callers should be able to request a participant who is *not* from their own cultural or racial background, given that some communities are small and callers may be concerned about social overlap and interaction with staff in the community. Participants suggested that hiring of the crisis team should prioritize a diversity of skill sets as well as racial and cultural diversity. Several participants further recommended that the hiring process should provide scoring bonuses for certain types of lived experience and that the hiring process should not use an APS (applicant tracking software), which might filter out the diverse staff members the service needs to hire. It may also be beneficial to create a “blind” application process where the names and identifying details of applicants are redacted.

Staff training:

The following trainings were recommended by community engagement participants to be provided to crisis team staff:

- Cross-team training to help the crisis team understand the roles of police and paramedics and to help police and paramedics understand the role of the crisis team.
- CPR and First Aid training.
- Naloxone training.
- Harm reduction training.
- Mental Health First Aid training.
- Suicide intervention training, including ASIST training.
- De-escalation training.
- Motivational interviewing training.
- Trauma-informed training.
- Hearing Voices training and other trainings about working with individuals experiencing psychosis.
- Training in working with survivors of intimate partner violence.
- Training in working with people with disabilities, including Deaf individuals, non-verbal individuals, autistic individuals, and people with invisible disabilities.
- Equity, diversity, and inclusion training, including training on anti-racism and on intersectionality.
- Training in Indigenous history and Indigenous cultural competency and safety, including Indigenous philosophies and intergenerational trauma.
- Substantial field training, including ride-alongs.

Additional best practices in training from international models include:

- Ensuring training is ongoing and regularly updated in accordance with the needs of the service and the community.
- Providing training on maintaining boundaries and navigating potential dual relationships (especially in smaller communities, such as those in North Durham).
- Providing training on situational awareness and personal safety.
- Providing training on safe operation of vehicles, including defensive driving.
- Providing training on existing community resources and referral pathways.
- Providing training on organizational operations and logistics, such as record-keeping and database management.
- Providing training on relevant legislation, such as privacy legislation (*PHIPA*) and the *Mental Health Act.*

Preventing burnout/turnover:

Many community engagement participants and international crisis team staff and managers cautioned that the potential for burnout in crisis work is very high. All possible efforts should be made to ensure staff retention and prevent burnout and turnover, given the complexities of hiring and training new staff and the importance of staff continuity. Community engagement participants suggested that providing competitive salaries and benefits would reduce staff turnover. In particular, providing pay equity for peer workers and opportunities for advancement within the organization will help attract and retain peer workers, given that peer workers often have high turnover rates due to low wages and benefits. Additionally, participants stated that adequate staffing will be essential to preventing turnover; if enough staff are not hired for the team, crisis workers will feel pressured to move quickly from call to call. If staff do not have enough downtime in their shifts or adequate time for debriefing after difficult calls, they are more vulnerable to burnout.

Community engagement participants highlighted the importance of providing adequate support to staff, including thorough training and mechanisms for providing feedback to improve the service and/or their working environments. Participants suggested that staff should have access to “critical incident stress management support” and that debriefings and supervision, including peer supervision, should happen regularly (i.e. at least weekly). Staff and managers should receive training on preventing and managing vicarious trauma. Wellness activities and a focus on self-care and collective care should be incorporated into the workplace. Vacation time and other paid time off should be generous, and employer-based health insurance plans should include generous funding for mental health and other wellness services.

International best practices for crisis team staff schedules vary; however, these schedules should be flexible and optimized to prevent burnout and staff turnover. Some teams choose to staff twelve-hour shifts three or four days a week, while others choose to provide six or eight-hour shifts. Downtime and supervision time should be built into staff schedules. Some cities are exploring hybrid mobile and site-based schedules to provide staff some days when they will not be in the field but instead working at crisis centers or hubs as a way to reduce burnout.

Developing career pathways:

Community engagement participants suggested that Durham Region pursue partnerships with secondary and post-secondary schools to raise awareness of the service and to develop career pathways for interested students. Participants stated that presentations at high schools and universities might lead students to consider working on this team as a future career. Internationally, several crisis response programs have developed partnerships with local colleges and universities to encourage or incentivize students to work on these teams, either as placement students or upon graduation. Participants also suggested that the crisis service provide encouragement and funding for its staff to engage in continuing education, including receiving certifications and pursuing additional training.

Conclusion:

While community members made many suggestions for the qualifications of staff on the community mental health crisis response team, ultimately the final decision for which staff to hire should be left to the community agencies the Region partners with to operate the service, similarly to the Toronto model for staffing. The service should be flexible in its hiring and thorough in its training. It should aim to prioritize representativeness of the community it serves, and it should ensure that peer workers are included on the crisis team. Peer work will be discussed further in the next section.

Peer support:

Peer support is support provided by individuals with lived experience of their own mental health or substance use challenges, as well as extensive training in peer support values and principles. Peer support is generally trauma-informed, strengths-based, and recovery-oriented (i.e. peer supporters believe that recovery is possible). Peer supporters aim to foster self-determination, autonomy, and empowerment in service users, and believe that people are experts of their own experience. They treat service users as equals and work to foster and encourage hope for the future. Peer support values include dignity, respect, authenticity, trust, collaboration, and integrity. Peer supporters may support service users through active listening, effective use of self, modeling recovery, advocating for service users and/or helping them advocate for themselves, and helping service users with practical tasks, including navigating services. Peer support is generally flexible and directed by the service user in accordance with their needs. Peer support training is often extensive and is offered by many organizations in Ontario, including PeerWorks, Support House, and Stella's Place. Many organizations also offer peer support training certifications.

Benefits of peer support:

Peer support promotes better outcomes for service users due to the high quality of care trained peer workers provide. Because peer workers have experienced mental health challenges and recovery themselves, they often have a strong intuitive sense of how to support others experiencing similar challenges. Service users often feel particularly well-understood by peer support workers and are able to develop quick and powerful rapport, trust, and a genuine sense of connection and safety. Peers may additionally find it easier to build trust with marginalized service users and/or service users who have experienced past trauma accessing formal mental health services. The peer role is less hierarchical than traditional clinical or medical roles, so service users who have experienced coercion while accessing formal mental health services in the past may be more comfortable working with peers.

Peer support can also promote hope and recovery for service users in crisis. Service users in crisis are often feeling hopeless and overwhelmed. Having a peer worker to support them can help them look outward and imagine the possibility of recovery and a future worth living, as they see the peer worker as someone who has been through crisis and come out the other side of it. Peer support can also have benefits that ripple beyond the individual in crisis and into broader communities. For example, peer workers model emotional regulation and coping strategies to service users, who then may take those skills and share them with family, friends, or other community members. Seeing emotional regulation and coping strategies modeled in this way can make these skills feel more accessible for service users than being taught the skills didactically from a mental health clinician.

Additionally, peer support can reduce stigma and shame for service users in crisis. Often people who struggle with mental health feel isolated and ashamed of their struggles. Seeing a peer worker can help service users reframe their mental health struggles not as a personal failing, but as an asset they may be able to use to help others in the future. Peer support can help service users develop more positive self-identities and learn to value the strengths and wisdom they've gained through their struggles.

Peer support and crisis response:

Peer support workers are typically employed on crisis response teams using one of two models. The first model is to create a specific role for peer support staff. Often peer support staff work on crisis teams alongside medical or clinical staff, such as paramedics, nurses, social workers, or licensed therapists. Crisis teams that create specific roles for peer support workers include San Francisco's Street Crisis Response Team, New Haven, Connecticut's COMPASS team, and Durham, North Carolina's HEART team. Some benefits of this model include role clarity for the peer worker and the promotion of peer support values. Additionally, it can be beneficial for service users to know that the person they are interacting with is a peer worker; this can reduce stigma and model hope and recovery, as mentioned above.

The second model is to give all staff the designation of "crisis worker" and prioritize the hiring of people with lived experience for these roles. Eugene, Oregon's CAHOOTS team, Northampton, Massachusetts's Division of Community Care, and Toronto's Downtown East Community Crisis Service use this model. One benefit of this model is that it can be easier to enshrine pay equity between peer and non-peer staff, since all staff have the same formal title. This model may also reduce stigma for peers within the work environment, so that peers do not feel singled out or pressured to share their own lived experiences. This model also prevents a hierarchy from forming between clinical and peer staff, and may make it easier to hire peers for most roles. Teams that use the "designated peer support role" model typically only have one peer worker on their team, which can lead to hierarchy or marginalization of peer workers on crisis teams and thus reduce the benefits of having peer workers on these teams. Conversely, teams that use the crisis worker model may have all staff members on their team be peers. These teams generally experience less hierarchy between staff with peer backgrounds and staff with non-peer backgrounds.

Best practices in employing peers:

Peer workers can provide strong outcomes for service users of crisis response services. Organizations need to ensure they are creating supportive and evidence-based environments for peers to work in to maximize the benefits they provide. Organizations should ensure that lived experience and lived knowledge of the recovery process are weighted highly during the hiring process, to ensure that formal education does not take precedence over real-world experience. Additionally, diversity of peer workers should be prioritized in the hiring process, including diverse lived experiences and diverse ethnic and cultural backgrounds.

Organizations should ensure pay equity between peer workers and other staff providing crisis services. Organizations should also ensure that there are pathways for peer workers to advance within their roles; otherwise they will be vulnerable to staff turnover. Organizations should offer flexibility wherever possible, including options for part-time roles or reduced workloads. Role clarity, accessibility, open communication, and respect for the uniqueness of the peer role should be emphasized. Organizations will benefit from training in understanding and supporting the peer role within their workplaces, in order to create de-stigmatizing environments for peers and to ensure that peers feel respected and well-equipped to succeed in their roles. Other staff of the organization may also benefit from this training, and should be comfortable working on multidisciplinary teams with peer colleagues. It may be beneficial to hire clinicians who have been peers themselves in the past.

Peer workers should receive peer-specific training on the fundamental principles of peer support, how their role is different from clinicians, peer-specific boundaries, and how to navigate challenges between disciplines or within organizations. Peers should also receive ongoing peer-specific training and supervision from other peers, including via communities of practice, which are networks of peer colleagues who provide support to one another in a safe and confidential setting. Communities of practice can be spaces for peers to debrief challenging calls, generate ideas for navigating particularly complex cases, reflect on and improve responses to difficult situations, and share skills and knowledge as an aspect of professional development. Organizations may develop their own communities of practice for their peer staff to be part of, or they may allocate time for their peer workers to attend external communities of practice, such as those developed by the Centre for Innovation in Peer Support, the Centre for Addiction and Mental Health, and/or PeerWorks. Peers should be supervised by other peer workers rather than by clinicians. Peer supervisors should also have access to communities of practice, either within the organization or externally. The Centre for Innovation in Peer Support offers a Provincial Peer Supervisor Network that peer supervisors may benefit from attending.

Key ingredients for a new service:

Accessing the service:

- **Accessible via multiple pathways, including 911.** Participants suggested that the service be available as a primary responder through 911, an additional phone number, and internet and text-based methods. Participants also suggested that the service be accessible as a secondary responder via police and paramedics calling for support from the team.
- **Responds to both self-referrals and third-party callers.** Participants suggested that people should be able to self-refer to access the service, and that loved ones and service providers should also be able to call on behalf of someone who is struggling.
- **Allows service users to self-define "crisis."** Participants suggested that if the caller thinks it's a crisis, the crisis team should respond, rather than the service itself setting the criteria for access.
- **Integrated with services in neighbouring municipalities.** Participants noted that many North Durham residents, for example, access care in York Region rather than in Durham itself. The service will need to be able to provide referrals and direct access to care in neighbouring Regions.
- **Advertised widely, including via community partnerships.** Participants emphasized the need for the service to be heavily promoted and suggested that the service should build partnerships with organizations already serving the community, in order to share information about the service. For example, participants suggested collaborating with religious organizations, community centres, libraries, schools, and existing mental health services, as well as traditional and social media.

Availability of the service:

- **Quick response times.** In Toronto, the average time for the crisis service to arrive on scene is 22 minutes; in San Francisco, the average time for the crisis service to arrive on scene is 17 minutes. As one community engagement participant put it, "Crisis doesn't press pause or wait."
- **Rapid response times in North Durham.** Participants suggested that the service should have at least one location in North Durham to ensure rapid access.
- **Available 24/7.**

Services provided:

- **Provides response to non-violent mental health related calls.** Participants suggested that mental health crisis calls that pose safety concerns could be responded to by the Mental Health Support Unit co-responder team and/or police alongside the new crisis service.
- **Provides a continuum of flexible support.** Participants suggested that the service should provide phone-based preventative care, resources, information, and referrals, in person crisis response, transportation, and follow-up care.
- **Provides support to families.** Participants recommended that family be identified as "chosen family," rather than "biological family" or "family of origin." Participants recommended that family members receive information, support, and referrals to access their own family support services.
- **Provides transportation to other services.** Participants suggested that the service should be able to provide transportation to crisis beds, shelters, harm reduction sites, and healthcare services.
- **Provides expedited transport and admission to the hospital, if desired.** Participants recommended that the crisis team develop protocols with Durham Region hospitals to facilitate expedited admission if a service user chooses to attend a hospital. Additionally, participants recommended that the crisis team develop protocols to facilitate admission to Ontario Shores inpatient units. Participants further recommended that the team should provide support to service users who choose to attend the hospital in planning what will happen to children or pets while they are hospitalized.
- **Provides basic medical care, medication support, and prescription renewal.** Participants suggested that access to doctors and/or psychiatrists could be through an on-call model, and that medical staff such as nurses or paramedics could be employed as frontline staff.
- **Provides supplies to service users.** Participants recommended that crisis team staff carry care items such as bottled water, food and food vouchers, hygiene items such as toothpaste and menstrual products, blankets, sleeping bags, weather-appropriate clothing, first aid supplies, Naloxone, and harm reduction supplies.
- **Provides harm reduction and substance use services.** Participants suggested that the service should provide mobile RAAM (rapid access addiction medicine) services and should have expertise in substance use and concurrent disorders.
- **Provides follow up and case management.** With service user consent, the service should offer at least one follow-up call and three- or six-month case management to each individual seen by the crisis service.
- **Provides referrals and access to community resources.** Participants suggested that services referred to should not have wait lists, or that wraparound care should be provided while service users are on wait lists. Additional funding and greater coordination within the mental health sector will be necessary to achieve this goal. Additionally, the community mental health crisis response team may partner with community agencies to provide expedited access to service users.

- **Provides proactive street outreach.** Participants recommended that the service provide street outreach to unhoused community members to develop trust prior to a crisis occurring, as well as to educate community members about the service.
- **Provides support to suicide survivors and victims of crime, including survivors of intimate partner violence.** Participants suggested that if a loved one dies by suicide, the team could be dispatched alongside other emergency services to provide support to surviving family members. Participants also suggested that the crisis team could provide support to individuals who have experienced intimate partner violence.
- **Includes a 24/7 drop-in space for service users to access in-person support.**

Principles of care:

- **Provides de-stigmatizing, compassionate, client-centered, holistic, and trauma-informed care.**
- **Provides adequate time to de-escalate the crisis.** Crisis team staff should not feel pressured to wrap up calls quickly to get onto the next call, and should instead be supported in spending as much time with each service user as necessary.
- **Provides consent-based care.** Participants emphasized that the service should collaborate with service users; it should not use physical force or restraints and should not involuntarily hospitalize service users. One participant said, “It is crucial that people feel safe to share how they feel without needing to fear a sudden breach of their confidentiality." Another participant said, "I needed to be in control of what ‘happened’ to me [when I sought help]. If, for example, anyone had tried to stick me in a residential program or lock me up (including arrest) at any point in my process of seeking help, I'd have fled and you would not have seen me again and I might well have ended my life.”
- **Provides transparent care.** Participants recommended that accessible, plain-language information be disseminated so service users can know what to expect when they call the service, as well as what to expect if they attend the hospital.
- **Provides confidential care, and anonymous care upon request.** Participants recommended that service users should have the option of which information about themselves they want to provide (including no information at all), and that they should also have the option to have information recorded and shared with subsequent crisis workers if they choose. Participants recommended that information provided should never be recorded in law enforcement databases or shared with law enforcement.

Service quality:

- **Provides sensitive and responsive feedback mechanisms and clear pathways for complaints.** Participants emphasized the importance of periodic evaluations and check-ins with service users to solicit feedback about their experiences with the service and suggestions for improvement.

- **Evaluated rigorously.** Participants suggested engaging an external evaluator, and that the service should be adapted based on evaluation data. Participants further suggested that the evaluation should focus on qualitative outcomes, such as service user's subjective experiences with the service, rather than on the number of people served, as genuine support takes time.

Cultural responsiveness:

- **Culturally safe and responsive; grounded in principles of intersectionality, anti-oppression, anti-racism, and equity.**
- **Provides culturally-responsive care.** In particular, the crisis team should develop an Indigenous-led service, and should provide culturally-specific supports for Black and racialized communities where possible.
- **Offered in multiple languages.** Participants suggested that multilingual staff should be hired who can provide care in languages other than English, rather than needing to hire an interpreter.

Trauma-informed, client-centred principles:

- **Uses discreetly marked vehicles and clothing.** Participants recommended that the vehicles used by the crisis team should not have lights, sirens, or obvious markings, in order to promote service users' confidentiality and to reduce stigma. Additionally, participants recommended that uniforms should be subtle so as not to look like police uniforms and should not include bullet-proof vests. Participants suggested that staff could wear hoodies or t-shirts or lanyards with the crisis team logo on them. Uniforms should balance discretion with the need for community members witnessing a crisis to recognize that professionals have arrived to respond.
- **Uses service users' preferred names, pronouns, and identity labels.** Participants highlighted the importance of being asked for and referred to by their preferred names and pronouns, and of not being misgendered by staff members. Participants also highlighted the importance of being referred to by the terms they use for themselves. For example, many individuals prefer to be referred to as "autistic" rather than "people with autism." Crisis team staff should follow the service user's lead.
- **Provides choice of responder, where possible.** Participants recommended that service users should be able to request a crisis responder of the same gender or from their own cultural or racial background, where available. Additionally, participants recommended that service users who have previously had a positive experience with a particular crisis worker should be able to request that crisis worker again, if the worker is available to respond.
- **Includes people with lived experience (peer support workers) in the design and implementation of the service, and as frontline staff.**

If this information is required in an accessible format, contact 1-800-372-1102 ext. 2760.

Attachment: 2

DRPS Comments Regarding Community Mental Health Response

The prevalence and growth in mental health-related calls for service and individuals experiencing mental health crisis in our community is of a concern to the Durham Regional Police Service (DRPS) as it is to our partner agencies/stakeholders and impacted members in our community. We have been active at many tables, working groups and committees to demonstrate our commitment to collaboration in recognition of the complexity for response and care models for persons with mental health concerns and addictions. DRPS has implemented a number of programs and partnerships to address this growing concern.

DRPS has had the opportunity to engage with the consultant regarding a non-police response model to share our thoughts and views. In reviewing the final report there are a number of areas of concern that will require further consultation and investigation before any pilot or project could be implemented.

They include:

- The use of Communications 911 and adding a 4th tier which would be a substantial undertaking for DRPS and have a significant impact to operations within 9-1-1, the Region, DRPS Communications unit, and the structure for regional response to these types of events and impact on emergency calls.
- Collectively, we all want to see better outcomes for our most marginalized and vulnerable citizens who may be living with complex mental health concerns and addictions. Changing a response model will not, in itself, correct system issues and gaps around wait times for care, access to treatment, lack of accessible resources that are equitable and appropriate for impacted individuals, system integration and lessen the impact on police services. It is important to understand a response model, such as the one that is proposed, will not proactively address the complex factors that can have a role in mental health and addictions, and can lead a person into a crisis state. Mitigating factors can include high rates of unsuitable or inadequate housing, high rates of unemployment, food instability, chronic disease and complex mental health diagnoses. The root causes of the mental health state cannot be addressed through a team that responds when the individual is in crisis, and cannot provide solutions to the underlying circumstances, therefore will not reduce the calls for service that emergency services are required to attend, on the level that is suggested in this report.

DRPS is cognizant of the context within which conversations surrounding a non-police led mental health crisis response are grounded. There has been significant attention paid to the ways individuals experiencing mental health crisis, particularly when considered through the intersection of race, are disproportionately represented in highly-publicized incidences of officer use of force.

With respect to use of force* (UOF) in Durham Region:

- In 2021, DRPS attended 113,352 calls for service. Of these 220 (0.2%) involved police use of force.
- In 2022, DRPS attended 112,604 calls for service. Of these 187 (0.1%) involved police use of force.
- 31.8% of UOF incidents involved someone noted as experiencing a mental health crisis or illness.
- 92% of UOF incidents involving someone experiencing a mental health crisis or illness were citizen-generated. In other words, 92% of the incidents had a police presence because a citizen called DRPS.
- Males (105 of 124) and people perceived as White (81 of 124) made up the largest proportion of those involved in mental health-related UOF incidents.
- The rate of drug impairment during the incident was almost double for those noted as experiencing a mental health crisis or illness compared to those not experiencing a MH crisis or illness (18.5% versus 9.4% of subjects).

**Use of force is a broad term for police interaction that can include open-handed interaction, aerosol or impact weapons use, conducted energy weapon drawn or used, K9 apprehension, handgun drawn or pointed.*

Over the past five years, mental health-related calls have continued to increase, as calls have become more complex in nature. These include both MHA apprehensions and non-apprehensions. Additionally call duration and dispatch delay have increased.

Year	**2019**	**2020**	**2021**	**2022**	**2023**
Total mental health GO Incidents (Flagged as "MH")	4426	4041	4857	4939	5249

Year	**# Calls**	**Median Call Duration (min.)**	**Median Dispatch Delay (min.)**
2019	4,799	197	3.41
2020	4,403	195	3.18
2021	5,237	197	3.18
2022	5,347	225	3.42
2023	5,690	225	3.65

How we assist and interact with those in mental health distress and how we ensure the best outcomes for those individuals, is of utmost importance. DRPS has instituted a number of initiatives in order to ensure the best outcomes possible for interactions with individuals in mental health crisis or experiencing mental health-related issues – a non-exhaustive list includes:

- The onset of mandatory, virtual, scenario-based, de-escalation training for responding to individuals in mental-health crisis.
- Participation in a research study involving in-person scenario training in response to MH crises, with real-time evaluation by mental health clinicians.
- Launch of the mental health support unit (MHSU) – a secondary response program that pairs officers with mental health nurses from Lakeridge Health, expanded with the support of the Region, to five teams from 7 am to midnight, 7 days a week.
- Launch of the crisis call diversion (CCD) program in partnership with Lakeridge Health – a system within which 911 call takers divert eligible calls to a mental health clinician who is a social worker.

We continue to monitor the results of these programs in order to evaluate their success; however, the data we are seeing does not yet support the notion that a non-police response will lead to better outcomes for individuals.

We know through our data that the 10 most frequent callers through the CCD program, made up 63% of all calls in 2023. Further, five (5) individuals made up 25% of MHSU officers' hours, across the Region, in 2023. Of these familiar faces, individuals are currently connected to a number of partner agencies for supports Upstream, comprehensive care is required for individuals, prior to any police contact, if we intend to improve outcomes for people.

A positive impact of a non-police response on individual outcomes is also not yet supported by evaluations of the Toronto Community Crisis Service (TCCS), a city-led program designed to provide a non-police response model for responding to crises. The TCCS is a response to calls for connecting those experiencing a crisis with access to more appropriate services – the right person/service provider at the right time. Unfortunately, initial evaluations of the program do not provide a sufficient assessment as to the impact of the TCCS on the service users. The evaluation does not ascertain if this intervention strategy prevents those who have connected with TCCS from having future contact with police. Data on the number of referrals made to community-based follow-up supports or post-crisis case management also cannot prove the TCCS users' successful and meaningful engagement with those supports. Additionally, a third party report indicates stakeholders also expressed concerns about system-level capacity gaps. As such, we currently do not have an empirical assessment of the TCCS program that speaks to its ability to improve outcomes for those experiencing mental health crises.

It is of vital importance to determine whether existing community services and agencies have the capacity to provide meaningful and impactful support that would be required with the introduction of a non-police response.

9-1-1 Communications

The biggest concern regarding the consultant's report is in regard to adding a 4th tier to 9-1-1 Emergency Communications.

The 9-1-1 System is a universally incorporated number designed specifically for emergencies (police, fire and ambulance). Any change to the 9-1-1 system would have to have the approval of the CRTC (if for example the suggestion was for a 9-1-1 call centre to answer with "Police, Fire, Ambulance or Mental Health".) The Region could not arbitrarily make that change without CRTC approval.

Any calls to the 9-1-1 system that are not emergent in nature increases workload and potentially ties up emergency lines, impacting our ability and capacity to answer emergency calls. Soliciting more traffic to a 9-1-1 system, which should only be for emergencies, could have potentially high-risk impacts to our ability to answer emergent calls for service, as well as place incredible risk to public safety. In fact, services such as Toronto and Ottawa use a system separate from 9-1-1.

DRPS is also the Primary Public Safety Answering Point (PPSAP) for the Region of Durham, so we are not only responsible for managing police 9-1-1 calls, but triaging all 9-1-1 calls for Fire and EMS as well, and to ensure those calls are answered in an expeditious manner, and re-directed to those call centres so they can dispatch the appropriate resources.

The 9-1-1 Management Board consists of stakeholders of all emergency services on the system in the Region of Durham including Police, Fire, EMS, Region and Council. Any potential change to the 9-1-1 system that may impact core service delivery for emergency services within the Region need to be appropriately considered and voted on by the Board. DRPS cannot make changes arbitrarily.

Canadian Radio-television and Telecommunications (CRTC) - the Public Safety Answering Point (PSAP), in Canada requires CRTC approval and that includes the Primary PSAP (DRPS) and the secondary PSAP's (Fire, CACC, etc.). The Region would have to go through the CRTC to get approval to designate an additional PSAP. The only current PSAPS in Canada outside of Police, Fire, Ambulance that have this designation and approval through the CRTC are the Coast Guard, Canadian Military, E-Comm (which is the Primary and Secondary PSAP for the majority of British Columbia) and Northern 9-1-1 which are a VOIP (Voice over IP) service provider for all of Canada.

In 2023 the CRTC implemented **9-8-8,** a three-digit mental health crisis hotline, to support mental health. Unlike 9-1-1, people calling the 9-8-8 line can remain anonymous, which they might not understand from a privacy perspective.

Next-Generation 9-1-1 (NG9-1-1) will also have some impacts to our capacity with RTT 9-1-1, which is scheduled to launch in March 2025 and will add to call processing times for text 9-1-1 calls. Volumes are unknown at this time, but it is expected a RTT 9-1-1 call (text to 9-1-1) will take up to 5 times longer to process than a voice call.

There are a number of questions that need to be addressed if the Region further explores a NPL with a 911 or 211 model that will impact already growing intake times and response times.