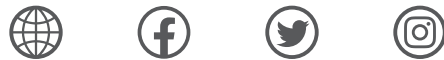




Final Report Summary on Alternative Crisis Response Models for Toronto

NOVEMBER 2020



INTRODUCTION

Toronto emergency services receive 30,000 non-criminal mental health-related calls every year. Currently, police are the first responders to these calls, with the Toronto Police Service's Mobile Crisis Intervention Team being called about 20% of the time. But is a police response the right answer? Toronto residents have long advocated for reform of the City's response to mental health emergencies. The rash of recent deaths of racialized people during mental health or wellness-related interactions with the police have amplified this call for change.

The Reach Out Response Network is a coalition of community stakeholders who believe that mental health crisis is not a crime. A police officer's job is to respond to crime; a mental health worker's job is to respond to mental health crisis. Therefore, our network believes that mental health workers need to replace police in responding to mental health crises across Toronto (Background, Final Report, p. 4). After two years of academic research, learning from organizations who run alternative models in other cities, and interviewing vast swaths of people in the city of Toronto, our network has made a number of

recommendations. The Reach Out Response Network outlined our recommendations for Toronto's new crisis response model in the Final Report on Alternative Crisis Response Models for Toronto, which we submitted to the City on November 23. This summary recaps key findings and recommendations of that report and outlines our proposal for a mental health emergency service.

Based on our research and community engagement, our network proposes that the City of Toronto develop a new civilian-led mental health emergency service, staffed by mental health clinicians (e.g., social workers, psychotherapists, etc.) and peer support workers from the communities that they serve. This service should be accessible both via 911 and its own separate three-digit number, such as 811 or 988. The service should be available across the city, 24/7/365, with rapid response times equivalent to those of other emergency services such as police, firefighters, and paramedics. This team will replace police response to non-violent mental health crises, freeing police officers and police resources to tackle the important work of fighting crime in the city.

What are Other Cities Doing?

Mobile mental health emergency services are already up and running successfully in cities all over the world. To begin building our model, the Reach Out Response Network consulted with organizations already running successful, similar services in other

cities, including Austin, Stockholm, Atlanta, Eugene, Denver, and San Francisco. Thirty-three of these core mobile crisis teams serve as points of reference for our proposal (Final Report, p. 91).

What do Torontonians Want?

Between July and November 2020, the Reach Out Response Network engaged Toronto residents in town halls, surveys, focus groups, and key informant interviews. Town halls were conducted with members of Black communities, members of Indigenous communities, peer workers, service providers, service users, family members of people with mental health or addiction concerns, service providers who work with homeless populations, and lawyers and legal advocates. An additional town hall was open to all Toronto residents. We conducted surveys of individuals experiencing homelessness and of Deaf communities. We held focus groups for Deaf communities and individuals with developmental disabilities. We also conducted individual interviews with high school students and Autistic individuals. Those communities were chosen because they were identified as most likely to be impacted by current and future crisis services. It is essential this service be informed by the diversity of experiences and expertise of people who will use and benefit from it.

We asked Toronto residents to answer the following questions:

- What are your experiences with existing crisis services?
- What gaps do you see in existing services?
- What should a new service look like to best serve Toronto?

- What professionals should staff a new service?
- How should a new service be accessed?

Even with the vast demographic differences amongst the many Toronto residents we listened to, the message they communicated was overwhelmingly similar. Many Toronto residents shared negative experiences with the police (Final Report, p. 6). They described challenges with access to and limited capacity of existing services (Final Report, p. 14 & 18). They spoke in unison for the need for an emergency mental health crisis service that has three essential foundations:

- Immediate response times, 9-1-1 integration, and 24/7 accessibility;
- Civilian-only first responders who are appropriately-trained mental health clinicians; and
- Mental health peer workers from the communities that they serve and extensively trained in trauma-informed crisis support and de-escalation.

These three elements form the foundation of the model we are proposing. Through our research and consultation, we know that they are necessities for any mental health crisis service model that aims to truly serve Toronto and the needs of Torontonians in crisis.

Immediate 24/7 Response Through 911

Mental health crises happen all hours, all night, and all year long. People call for help desperate and in immediate need of support. Participants stated unanimously that a new service needs to respond quickly and around the clock. They described the limited operating hours and inadequate response times of existing, community-based crisis services and shared that these limitations are the main reason people call police instead. Our respondents uniformly stated that a new service needs to have the same availability and rapid response times as police in order to overcome these obstacles.

Nearly all of our participants also felt that the new service needs to be accessible through 911, in addition to another number. Participants agreed that 911 is the number most Toronto residents instinctively turn to in an emergency; this is evidenced by the 30,000 calls

911 already receives a year for mental health crises. Many people in the City of Toronto, even those who work in mental health, are unaware of what existing mental health supports exist, and so these are not a reliable option in the frenzy of an emergency.

Our model demands that the new service be available 24/7 and integrated into 911 dispatch. This service should be the first responders for the majority of mental health crises in Toronto. This will allow Toronto residents to access mental health emergency services with the same ease, consistency, and rapid response that they access other emergency services. It is our hope that this new service will also be accessible through a separate number, such as 811, as well as through online chats, texts, and other means. Details on how this service will be accessed are in the Final Report on page 74.

Non-Police Response

Our focus groups, town halls, and interviews shared many stories of inadequate response to mental health crises from police. Specifically, participants described:

- harmful interactions with the police, such as being handcuffed during a non-violent suicide crisis;
- how stigma and fear associated with police keep people from calling for help; and
- a lack of mental health expertise and resources for support, which keeps police from meaningfully helping in a mental health crisis.

Respondents described negative experiences with physical restraints and violence from police. They spoke of feeling coerced, disrespected, judged, or humiliated by police. They overwhelmingly felt that the police were responding as though a crime had been committed, not as though the person in crisis

needed support. This feeling of being criminalized exacerbated the crisis, traumatized those in crisis, and led to community distrust of the police across all those we interviewed, especially in racialized and marginalized communities, who have a long history of negative police interactions.

Service users, service providers, and family members are reluctant to call for help in a mental health crisis because they know police will be sent. They described how markers of police presence (e.g., uniforms, sirens, guns) exacerbate crisis and/or conflict, adding to the overwhelmed feelings of the person in crisis and creating increased tension all around, especially in racialized and marginalized communities. Service providers reported that they are afraid to call police for fear of putting their clients at risk of bodily harm, negative experiences, arrest, or future legal action. They described the stigma and humil-

iation of having police appear and the concern that police presence stigmatizes individuals in their communities. Service providers also worried that seeming to be partners with police degrades trust in their organizations and negatively affects their ability to serve clients. Overall, we learned that the knowledge that a call would bring police is keeping Toronto residents from calling for help and accessing the mental health services they need.

The majority of participants felt that police officers lack the skills, training, and background to respond effectively to mental health crises. Mental health workers, such as psychotherapists, peer supporters, and social workers, gain this knowledge and these skills over years of courses, professional experience, and mentorship; it is not something police can learn through three days of training. Without mental health skills and experience, police are ineffective and can unwittingly exacerbate mental health crises. In addition, participants believed that police have limited options for supportive action. Police can arrest a person, apprehend

the person under the Mental Health Act and transport them to a hospital, or leave the scene. Participants agreed that many clients do not require incarceration or hospitalization. Instead, they need different forms of care and intervention such as supportive safety planning or referral to targeted and appropriate resources, which police responses cannot offer.

Police officers are not mental health professionals and therefore lack the training necessary to de-escalate and effectively intervene in mental health crises. By sending police to mental health crises, we are setting them up for failure and we are failing Toronto residents in need. **Our model demands a non-police response**, with police as responders only in situations involving weapons or immediate risk to others. Instead, our model is staffed by mental health clinicians and peer workers, who have dedicated years to learn how best to help individuals in mental health crisis, and who have the expertise to support those individuals and their families, both in the moment and through referrals to services for future support.

Peer Workers

Over and over in our interviews, we heard of positive experiences with peer support and peer-led services. In this context, a peer worker is someone with lived experience of mental health challenges or substance use; peer workers are also professionals who have received extensive training through structured training programs, practical experience, and certification in mental health support and crisis intervention. Our respondents praised peer support services for “understand[ing] what [they are] going through.” Often, that sense of being understood alone can de-escalate a situation. Further, someone who has experienced crisis themselves often intuitively knows what kinds of responses are helpful or unhelpful and often feels more comfortable around others in crisis, infusing calm into a tense environment. Having peer workers present offers hope to

those in crisis, allowing them to see someone else who has “come through it,” bringing them out of the pain of the moment and into a vision of what the future might hold. These inherent benefits, along with the dedicated training, expertise, and certification that peer workers bring, make peer workers an essential part of our proposed model.

Respondents also spoke to the benefits of services provided by members of their own communities. It is absolutely essential that any service responding to the varied difficulties of mental health crisis operate from a place of anti-oppression and cultural safety. Participants emphasized the importance of being responded to by someone who “looks like [them],” who shares similar cultural backgrounds, who speaks to service users in their own languages without inter-

pre-emptive intervention, and who understands the unique traditions, practices, and world views of their own community's culture. This is also part of making service users feel understood, and it addresses the dangers of misunderstanding or implicit bias that often plague the current response.

Our model strongly recommends that peer workers from the communities they serve be integrated into the design and frontline operations of the service.

These peer workers receive extensive training and certification in mental health support, models and frameworks of mental wellness and support, and

crisis intervention. They will respond to calls from their own communities, in teams with other mental health workers, providing those in crisis with essential empathetic connection, cultural understanding, and individualized, multi-faceted support. The new model must integrate a wide diversity as rich as that in the city of Toronto into both design and implementation. Peer workers from the communities they serve, rigorously trained in anti-racist, anti-oppressive practice and cultural safety, greatly increase the chances that Toronto's residents will use, be safe with, and benefit from this new service.

Who Will Operate the Service?

In a city the size of Toronto, it may be impractical to have one agency run the service across the entire city. New crisis teams could be run centrally through the city with separate geographic districts to ensure rapid response. This would allow for ease of coordination of services as well as consistency. Alternatively, Toronto could contract with a number of different non-profits, creating a map of service providers that would cover the whole city. A benefit to operating the service through multiple agencies would be that each organization will have a better

sense of the community it serves than a centralized model could. Additionally, local agencies are more likely to be demographically diverse and to have credibility in the communities they serve. In our research, other cities have used both models successfully. Regardless of how operations of the service are distributed, we strongly recommend that the design and operation of the new service integrate professionals from various communities, as well as including existing organizations with mental health crisis intervention service expertise.

How Will Frontline Workers Be Protected from Violence?

There is a prevalent but incorrect belief that people in mental health crisis present a threat or are more likely to engage in violence. Research demonstrates that this belief is a myth. In fact, individuals in mental health crisis are far more likely to be victims of violence than perpetrators. In our sample of thirty-three teams already running existing services similar to our proposed model, **no staff member has at any time been seriously injured or killed during a crisis call.** Minor injuries, such as a team's car being rear-ended in traffic on their way to a call or a staff member being spat at by a client, occurred approximately 1 in every

25,958 calls. In our model, the new crisis teams will not respond independently to highly dangerous situations, such as those involving guns or assaultive behaviour. Crisis team staff will be trained to judge the safety of a situation and will carry police radios to call for back-up if necessary. We've seen that there is a much higher risk of incident, escalation, or injury to callers when police are the first responders to these calls, rather than the types of skilled teams that we are proposing. Our model will provide better outcomes to both callers and responders, leading to a safer, healthier city for everyone.

How Will the New Crisis Teams Be Funded?

Reach Out Response Network was not created out of a desire to defund any existing municipal services. In fact, the 33 model services we examined use a wide variety of funding sources. Approximately half the teams in our sample are funded by the municipality's health budget. Other programs are partially or fully funded through the policing budget, city budget, or taxpayer-funded non-profit organizations.

We estimate the cost for the new crisis teams to respond to approximately 20% of Toronto's 911 calls to be around \$30 million CAD annually. Reach Out Response Network recommends that initially, Toronto fund the new service to operate as a pilot in three diverse areas of the city, with gradual expansion built into the plan. In New York City, the proposed budget for a similar pilot is \$3.3 million USD; Toronto's budget for such a plan would likely be similar.

Cities that have integrated similar mobile crisis services to divert mental health calls from police response actually report significant cost-savings from instituting such programs. For example, Eugene's CAHOOTS program saved an estimated \$8.5 million USD in public safety funding in 2019 and an estimated \$14 million USD in health budget funding due to hospital diversion. CAHOOTS cost only \$2.1 million USD to operate in 2019, meaning the service provides eleven times its own cost in savings. The cost savings in Toronto would likely be similar in ratio.

Regardless of the funding source, it is absolutely essential that this service be funded with a flexible mandate to allow teams to serve a broad range of communities and resourced well and stably enough to provide for program consistency and expansion over time.

CONCLUSION

The time is now for a new approach to mental health crisis. Our research and the increasing public outcry show the need, and existing models in other cities show what is possible. All that remains is for Toronto to commit to a standard of care for Toronto residents in mental health crisis that matches our values as Canadians: inclusive, compassionate, and robust. Toronto must replace police-led response services with a mental health crisis response service staffed by mental health clinicians and peer workers and offering 24/7 rapid response through 911. These foundations are the necessary backbone of any service wishing to be effective and responsive to the input of hundreds of Toronto residents. This service will lead to substantial cost savings and improved healthcare outcomes for everyone in the city. It will also offer Toronto the chance to emerge as a leader and role model for other cities in providing effective, compassionate, and innovative responses to the needs of its people. Let's build this new model together and help Toronto lead the way for the rest of the world.



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