The Police Accountability Coalition (PAC) is a coalition of over 100 community-based organizations committed to seeking meaningful change to address police violence and systemic racism. Our brief, Community Based Organizations Call for Police Accountability and Reallocation of Resources, lays out recommendations for all levels of governance on policing and Justice systems. Our coalition includes Black and Indigenous led as well as allied organizations.

A Case for a Civilian Led Community Based Crisis Response

Objectives:

1) People in medical crisis receive a medical response first.
2) Winnipeg Police Service (WPS) no longer responds to calls for service that are outside their scope or expertise.
3) A reduction in overall calls for service for WPS.
4) Better service to the community through a more effective evidence and community-based approach.

Proposal:

Replication, within the Winnipeg context, of the Toronto Community Crisis Service model to establish community led response units, based in community organizations throughout the city that are accessed through 911, 211 and directly through the host organizations.

Reasoning:

Winnipeg's Alternative Response to Citizens in Crisis' (ARCC) pilot project was launched in 2021 on a false premise. WPS Police Chief Danny Smyth claimed: "...the reality is that police will always need to play a role in these calls for service as these situations can be violent and unpredictable, and usually occur with limited information."[1] This position was also held by ARCC's clinician provider partner, Shared Health, despite the successful implementation of alternative approaches in other jurisdictions.

Non-police led, community-based crisis response models are gaining traction in Canada and the US, with around 107 programs operating as of August 1, 2023.[2] These models show that in the vast majority of mental health crisis calls there is no safety risk to the civilian crisis team, and instead present an opportunity to connect the individual in crisis with client-centered and trauma-informed resources.[2]

Two alternative models, Crisis Assistance Helping Out on the Streets (CAHOOTS) founded in 1989 and one of the newest, the Toronto Community Crisis Service (TCCS) launched in 2022, will be discussed in more detail below.[2,3] The main difference between these two programs and the ARCC approach is that

these alternative approaches only involve police services when deemed necessary by either a trained dispatch operator or the clinician and community host teams.

ARCC:

While ARCC is described as a partnership between the WPS, Shared Health, other government, and community-based organizations, it is still primarily accessed through 911.[1] As a result, the WPS remains the default first response for the majority of wellness check calls for service irrespective whether a police presence is needed or not. It then becomes the general patrol officers' responsibility to decide to call in or even consult with ARCC.[4,5] The risks and harms of the "police first" response model are further detailed below.

ARCC pairs a member of the WPS and a clinician provided through Shared Health. Publicly available information on what mental health and de-escalation training general WPS patrol officers currently receive is inadequately detailed. It is also unclear what augmented training an ARCC officer receives. A direct request to the WPS for more information was denied.

ARCC can also be accessed through the Crisis Response Centre's (CRC) direct crisis line.[6] When someone contacts the CRC and meets a certain risk threshold, beyond what is deemed acceptable for the Mobile Crisis Service (MSC), CRC can send an ARCC team because "a police response may otherwise be required".[7] ARCC is a police response. There is a fully armed WPS ARCC team member. Further an ARCC Shared Health Clinician has stated that "[w]orking with an officer provides a shield for my safety. I wouldn't go to some of these calls in community if I didn't have an officer with me."[8] The ARCC team wears a militarized uniform with the WPS ARCC team member having all weapons available and on display.

In practice, the above scenario prioritizes the lives of the responders over those the systems are meant to serve and protect. Erika Hunzinger from Crisis Response Services stated that: "ARCC enables the CRC to send one of its clinicians with police officers to situations the CRC would not have been able to go to before because of safety concerns".[5]

Firstly, risk assessment can be extremely problematic. Assessment criteria can be set unrealistically high for a person in crisis. Secondly, some occupations inherently carry more risk than others. However, in our need to protect our responders, we have relegated the lives of those who need services to secondary status.

Appendix 2 details a 2023 lived experience incident that demonstrates the dysfunction of our current approach. Appendix 3 provides an overview of the police involved deaths and injuries where mental health has been considered a factor.

Police First Response:

Some highlighted findings. Please see Appendices 4 and 5 for more information:

1) A 2022 study, *Re-examining Mental Health Crisis Intervention: A Rapid Review Comparing Outcomes Across Police, Co-responder and Non-police Models* underlines the conclusion that despite new

measures from law enforcement to manage these situations, "mental health-related calls continue to result in negative outcomes".[9] It also shows that police interventions in mental health crisis can be "traumatic or extremely stigmatizing".[10]

2) The 2005 Canadian Mental Health Association's statement, *Police and Mental Illness: Increased Interactions*, explains the impact of police led response on people with mental illness resulting in both unnecessary trauma and the criminalization of illness-induced behaviour.[11] Furthermore, "when police respond to a person in mental health crisis as they are trained to respond to a typical criminal emergency situation – with a show of force and authority – they may in fact escalate the crisis to a point of risking injury or death for police or the public, but most often for the person in mental health crisis."[11]

3) Many sources have studied police officers' misinterpretations of mental illness manifestations, supporting the idea that law enforcement, even with training, is not the appropriate response. *Policing and the Mentally Ill: International Perspectives* (2013) states that police officers may misinterpret people in crisis behavior and *Crisis Intervention Teams and People with Mental Illness: Exploring the Factors that Influence the Use of Force* (2012) indicates that "people with mental illness may behave in ways that many police view as bizarre, nonresponsive or even hostile".[12,13] *Police Use of Deadly Force in British Columbia: Mental Illness and Crisis Intervention (2011)* also highlights that "the actions exhibited by persons with a mental illness can sometime be misconstrued as an aggressive act, indicating the need for the use of coercive force".[14]

4) The persistent reliance within law enforcement on the term 'excited delirium' (EXD) to justify the use of force and restraints is another indicator that police do not have the necessary expertise to work with people in crisis. EXD is often cited as a cause of sudden, unexpected death during police custody and/or encounters. However, the term is highly contentious and, consequently, has been rejected by medical examiners and coroners across Canada and the U.S.[15,16] It has since been rejected by the American College of Emergency Physicians (ACEP), the organization that led the research to confirm this diagnosis in 2009.[17] However, in 2021, ACEP then changed the label from EXD to "hyperactive delirium accompanied by severe agitation".[18] Ultimately, this is simply a change in language that allows the continuing narrative that all people in distress are dangerous, reducing law enforcement's responsibility to keep them safe.

The ARCC pilot review report demonstrates it was a qualified success. However, the metrics for success were set low and access to the program was very limited. ARCC was involved in 882 police-related incidents, interacting with only 530 individuals.[7,8] Of these incidents:

- 82 per cent of engagements were able to be resolved by ARCC intervention alone;
- 91 per cent of clients served primarily by ARCC remained in the community after receiving on-site mental health support, rather than being transferred to emergency departments; and
- the number of patients brought to emergency departments by police for a mental health assessment was reduced by 29 per cent".[7]

In 2021, ARCC's launch year, the WPS responded to 20,704 citizen-generated wellness check calls for service.[8] While the limited nature of the pilot meant that ARCC could only respond to a fraction of these calls, CAHOOTS and TCCS are evidence that it is possible to have an approach that better meets

everyone's needs. While ARCC can report a nominal savings of police hours spent in emergency rooms (cumulative 39 days in 12 months), both the TCCS (84%) and CAHOOTS (81%) can report the number of interventions that required no police presence at all.[2,19] In the case of TCCS, the percentage would have been even higher as they only asked for Toronto Police Service (TPS) assistance in 240 of their 6,351 completed calls.[2] With CAHOOTS, out of all of calls initially attended without police, the CAHOOTS team only asked for police in approximately 1% of those calls.[19]

Alternative Models in Detail:

Launched in 1989, CAHOOTS is a partnership between the White Bird Clinic and the Eugene and Springfield Police Departments through a community policing grant.[20] They currently operate 24/7 in the Eugene-Springfield Metropolitan area attending calls related to mental-health related crises, welfare checks, substance use, suicide and more.[19] CAHOOTS teams consist of a crisis intervention worker and Emergency Medical Technician (EMT) with new staff receiving 500 hours of training and 30 hours of classroom learning.[19] The teams work collaboratively with other programs and organizations. Requests for CAHOOTS are made through 911 or non-emergency police lines and are diverted to CAHOOTS whenever possible. CAHOOTS teams wear branded shirts and use the organizations van for travel.[21] According to the White Bird Clinic the annual budget for CAHOOTS in 2019 was $2.2M USD, compared to the combined Eugene and Springfield police departments budget of approximately $90M.[22] In 2019, CAHOOTS answered approximately 17% of the Eugene Police Department's call volume representing an approximate $8.5M annual savings.[19] CAHOOTS dispatchers are trained in non-violent situations with a behavioral health component.[22] The team when called assesses the situation, provides immediate stabilization in case of urgent or psychological crisis, makes referrals, engages in advocacy and when warranted provides transportation to the next step in treatment.[22] The White Bird's CAHOOTS provides consulting and strategic guidance to communities across the US who are seeking to replicate the CAHOOTS' model.[22]

Toronto's TCCS pilot launched on March 31, 2022.[2] The pilot is a partnership between the City of Toronto and four community organizations, one organization per operational area.[2] This approach allowed TCCS to prioritize an Indigenous led organization in one area as the most appropriate partner to meet that community's needs.[2] In the first 13 months, the pilot successfully completed calls for service related to persons in crisis, well-being checks, distressing/disorderly behaviour, thoughts of suicide/self-harm, and disputes.[2] Based on the pilot's success, TCCS is being expanded to cover the entire city.[23]

There are three ways to access the TCCS, through 911, 211, and directly through the partnering organizations.[2] When 911 is the first point of access, an initial assessment is done and if TCCS criteria are met and the caller agrees they will be transferred to 211.[2] A secondary safety assessment is then done to determine an appropriate response.[2] TCCS data shows that 911 was the primary source for intake but that calls to 211 are trending upwards indicating that it could become the primary source for intake.[24]

The TCCS teams operate 24/7 but team compositions vary due to differences in the partnering organizations.[2] TCCS has a core 5-week training program covering a multitude of knowledge areas.[25] These include suicide intervention, effective crisis response, and scenario training to improve active listening and empathic communication skills with a focus on connection and de-escalation.[25] On-going

evaluation continues to ensure gaps and barriers in training will be identified and addressed. Please see Appendix 6 for more information.

TCCS teams wear identification lanyards and drive vehicles with the city and partner organizations' logos as their only identifiers.[26] TCCS has not yet provided a cost effectiveness analysis similar to that of CAHOOTS. However, TPS data shows that in 64% of instances where police attended an event eligible for but not diverted to TCCS, no apprehension was made. This possibly further demonstrates that no police presence would have been required had TCCS had the capacity to attend.[2] TCCS also provides a pathway to follow-up care. One thousand, one hundred and sixty (1,160) service users receiving follow-up support including mental health referrals, housing support, case management, as well as a range of culturally relevant supports, with the majority of the follow-ups done within 90-days.[2]

Of special note, the community-led approach taken by the City of Toronto allowed TCCS to launch Kamaamwizme wii Naagidiwendiiying ("Coming together to (heal or look after or to take care of) each other") on July 11, 2022.[2,27] This Indigenous-led pilot project in West Downtown is a partnership between 2-Spirited People of the 1st Nations (2-Spirits) and the City of Toronto.[2] This partnership led to the launch of an Indigenous mental health crisis support line on May 1, 2023.[24] This line is now an additional entry point for TCCS, receiving 459 calls between the launch date and September 2023.[24] The City of Toronto is currently working to expand this program to make it city-wide in order to provide culturally appropriate and relevant resources while serving as a back-up response team if other local organization teams are engaged.[24] This Indigenous-led model could be especially useful in Winnipeg given that we are home to the largest urban Indigenous population.[28] Winnipeg's Indigenous Peoples are over-represented and make up approximately 68.2% of the unsheltered population according to the *Winnipeg Street Census 2022*.[29] The 2023 *Campaign 2000 Manitoba Child and Family Report Card: Poverty, the Pandemic and the Province* outlines how over-represented Indigenous people are in poverty going on to note the detrimental health, including mental health, effects of poverty.[30] For example, youth in the lowest income quintile are more than four times more likely to die by suicide than the other four income quintiles combined.[30]

Please see Appendix 7 for a demographic comparison between Eugene and Springfield, OR, Toronto, ON, and Winnipeg, MB.

Conclusion:

PAC authored the safety chapter in *Winnipeg at a Crossroads: The Alternative Municipal Budget* 2022. We demonstrated that there is growing concern regarding the cost and effectiveness of our long-standing practice of defaulting to the WPS to address societal failures.[31] The report cites a 2020 Angus Reid poll finding that 26% of Winnipeggers had an unfavourable view of the service, the highest of any major prairie city.[31] A full 36% supported a reduction to the police budget.[31] A 2020 IPSOS poll found that 51% of Canadians supported a reallocation of police funding to other government services, but that both Saskatchewan and Manitoba were higher than the average at 56%.[31] Further, a 2022 PAC commissioned Probe poll demonstrated that when asked about where funds should be allocated to reduce crime, 62% of Winnipeggers said poverty reduction while only 19% said more on policing.[31] More recently, a 2023 Leger report indicates that although trust in the police is 65% in Manitoba and Saskatchewan, this is the lowest of all Canadian jurisdictions sampled.[32] Additionally, a 2024 Prairie

Research Associates poll conducted for the Winnipeg Police Board, shows that Winnipeggers are increasingly dissatisfied with the WPS with ratings for quality, confidence, and meeting expectations all decreasing over the past few years.[33]

Our current approach to people in addictions and/or mental health crisis is led by two systems, Justice and Health. Both have unresolved issues with systemic racism, sexism, ageism and genderism. Both systems are hierarchical and authoritative in nature and culture. In contrast, community-based organizations, while not immune to the above, can approach their work and participants from a place of equity and equality. Given that they are more grounded in the communities they serve, they can adapt more quickly to changing and emerging needs.

Personal staff safety is a concern for community-based organizations. However, what non-police led crisis intervention models prove is that the very fact that they are not perceived as the 'authority' but a service rooted in community, relationship is centered and that routinely yields better results for all concerned.

The Manitoba NDP government, elected in October 2023, promised 100 clinicians to work with police.[34] These resources can be better spent by replicating the TCCS model. In a January 2024 WPS media conference, Chief Smyth noted only 0.33% of WPS calls for service result in any use of force.[35] Chief Smyth then compared ARCC dispatch criteria to that of TCCS saying they were the same.[35] Given the similarity in criteria and TCCS has been able to meet the needs in the vast majority of cases they were called to, then it should follow that a police presence is not the necessity it was declared to be at the 2021 ARCC launch.

Proposed Implementation:

A steering committee of community, municipal and provincial representatives be formed to:

1) Develop terms of reference for the committee that would include membership, role, governance and reporting mechanisms. Community committee member make-up must prioritize racialized groups given they face systemic racism in both Justice and Health.
2) Review and adopt the research on which it will base its recommended model.
3) Develop and recommend a set of guiding principles on which the initial and future call for proposals will be based.
4) Provide oversight for the initial roll out of the program.
5) Work with the municipal and provincial governments to establish ongoing oversight of the program.

Please see Appendix 8 for more on reallocating funds away from policing.
Please see Appendix 9 for a jurisdictional scan of police and non-police led crisis response.

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Appendix 1: Current ARCC and Shared Health Approaches

Alternative Response to Citizens in Crisis (ARCC) is a co-response model to respond to 911 calls that require additional support for people experiencing a mental health crisis. When a call is received, first "officers respond and confirm a situation is safe", and then only if deemed safe do they decide to send alternative supports to "address the psychological and social needs of persons in a mental health crisis.[1.1] ARCC is a police-led response with teams comprised of an officer and a specialized mental health clinician acting as a dispatchable resource to assist WPS general patrol (GP) officers when needed.[1.1]

In 2022, the WPS released *Bringing a Human-centered Approach to Crisis Response* which describes "four modes of engagement by the teams: on-scene assist, referral/follow-up, GP phone consultation, and pre-dispatch consult" [1.1] This report describes each mode of engagement as follows:

- "On-scene assistance (ARCC team physically at the scene of the crisis)". "This engagement occurs when GP officers request ARCC to attend their location or the team is dispatched simultaneously."[1.1]
- "Referral/follow-up occurs when GP has requested ARCC attend and check on someone they encountered on a previous call or ARCC follow-up with someone they interacted with previously." [1.1]
- "As ARCC cannot attend every call GP attends, the ARCC team makes themselves available for phone consultations. GP officers are able to phone the ARCC team and explain the situation and have the clinician provide support and direction where possible. The clinician may also be able to speak with the individual while GP is on-scene." [1.1]
- "Pre-dispatch consults became an early service delivery enhancement due to potential safety risks present that limited ARCC's response capability. To compensate, ARCC started calling the person in crisis, as the call waited in the police dispatch queue. This practice allowed the clinician to begin the de-escalation process with the individual and conduct the initial assessment over the phone, much like they would do if the person called Mobile Crisis or attended CRC". [1.1]

Addition of Services: Crisis Response Centre's

The Crisis Response Centre (CRC) provides mental health services "through walk-in services, mobile services and scheduled appointment services".[1.2] Since the ARCC pilot project began in 2021, ARCC "has evolved to include support for individuals calling the CRC's crisis line when a police response may otherwise be required.[1.3] Currently, the Mobile Crisis Service (MCS), one of the CRC services, is available to provide on-site assistance to individuals and/or families and service providers to assist individuals experiencing a mental health crisis.[1.4]

Mobile Crisis Service

MCS is a multi-disciplinary team based in Winnipeg specialized in crisis intervention that provides on-site assistance/home visits, mental health assessments, and short-term follow-ups for adults experiencing a mental health crisis.[1.5] Individuals, family members, and service providers can call for assistance using the CRC direct line. Available 24 hours a day, 7 days per week, MCS receives approximately 10,000 calls/contacts per year.[1.2,1.4] MCS provides crisis intervention, mental health assessment and psychosocial assessment, telephone consultation and support, health education on mental illness, medication, coping strategies and preventative techniques, liaison and referral to

community resources, support to family members and other concerned individuals, psychiatric consultation and assessment, and short-term follow-up.[1.4]

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Appendix 2: A Winnipeg Lived Experience Example of the Current Response

On an early morning in March 2023, my roommate was going through a mental health crisis. I was away and they were not responding to any communication. I was afraid they had either attempted or completed suicide. I called 911 and my roommate was placed in rotation for a wellness check. The 911 operator asked me to inform them if the situation changed.

By the next afternoon, my roommate began to respond to my texts. I called 911 and informed them my roommate was alive. Since no check had yet been done, I requested that it still go ahead. I then called the Mobile Crisis Service (MCS) in case they would be better/quicker. I was told that since I had involved 911 first, they were the lead and would assess the situation and call in MCS if deemed appropriate. The system denied us direct access to MCS which caused further delay. I have since learned that had I tried MCS first, I might still have been turned away if they assessed the situation as too high risk and my roommate would have received the same inappropriate police response. Two uniformed and armed WPS members finally arrived that evening. They in turn informed me that my roommate was fine.

Having been in conversation with my roommate, I could tell they were not themselves much less fine. When I arrived home, it was clear they were in a complete breakdown. With two friends to provide additional support, we were able to get my roommate to the crisis centre on Bannatyne where they were finally admitted for a stay of almost three weeks due to the mental breakdown that included manic and schizophrenic episodes, hallucinations, and indications of a multiple personality disorder.

Clearly the current process which should have at least included an ARCC referral/consultation support given the time lapse between my initial call and general patrol officers finally arriving is inadequate. General patrol officers were either incapable of recognizing symptoms or were negligent. My roommate had pulled an electrical socket out of the wall because that was what the voices were telling them to do. They received multiple shocks as a result.

The current larger systems programs through the police and Shared Health are not grounded in community and the need to respond appropriately to a medical crisis is not being met. If they are unwilling to meet people where and when they are in need, then these systems need to be over-hauled until the needs they are meant to be addressing are indeed met.

Appendix 3: Summary of police involved death or injuries when there is mental health crisis

Given the lack of a national government agency that collects and disseminates data on Canadian use of force incidents, including deadly force cases, the Canadian Broadcasting Corporation (the CBC) created a deadly force dataset that tracks cases since 2000.[3.1] The CBC reports that between 2000 and 2017 there were 461 fatal police encounters across Canada, of which "… more than 70 per cent of victims suffer[ed] from mental health and substance abuse problems".[3.2] These deaths took place in a legal context where: "police are lawfully authorized to use up to deadly force — which includes using a firearm — where they believe that they're in imminent danger of being seriously injured or killed".[3.2]

For Manitoba, the CBC data shows that there were 22 fatal encounters with WPS between 2000 and 2020.[3.2] Similarly, the Winnipeg Free Press compiled the dataset called *A Pattern of None and Done*, which counts 29 times since 2003 when lethal force was used in Manitoba, of which the WPS were responsible for 21 deaths, the RCMP for seven and the Manitoba First Nations Police Service for one.[3.3] In the year 2023, three men were shot by WPS officers and a fourth died while in WPS custody.[3.4,3.5,3.6,3.7]

A Pattern of None and Done also indicates that "the majority of fatal shootings by police in Manitoba — roughly 60 per cent in the last 20 years — have involved Indigenous victims".[3.3] In Winnipeg, the CBC data indicates that "Indigenous people represent on average 10.6 per cent of the population, but account for nearly two thirds of victims" of fatal police encounters.[3.2]

In Winnipeg, the *Police Use of Force Report* indicates that, based on population estimates drawn from the 2016 Canadian Census, WPS had a use of force rate of "121.5 per 100,000" (per capita) in 2019.[3.1] Additionally, the *2022 WPS report to the Winnipeg Police Board* shows that the "WPS dispatched calls for service totaled 234,212 in that year".[3.8] The report indicates that within these calls, "780 incidents resulted in either the application of force or the presentation of a weapon by police members to gain compliance".[3.8] This represents "0.33% of calls required the use of or a presentation of force" or "approximately one use of force encounter for every 300 calls for service".[3.8] The report also states that of the 780 use of force reports, police officers faced situations when the subjects were resistant. The upper level of resistance is defined as "Aggravated Active Aggression", which "accounted for 20.64% of the overall aggression".[3.8] WPS attribute these encounters to the increase in the use of methamphetamine by individuals which for the WPS, justifies the use of force since "individuals under the influence of methamphetamine often have a high tolerance to pain and are far less responsive to de-escalation techniques, including verbal and physical".[3.8]

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Appendix 4: Excited Delirium

When police officers respond to a mental health crisis, they may encounter an individual who is agitated, disorganized and/or behaving erratically due to mental illness, intellectual or developmental disabilities, neurocognitive disorders, substance use, or extreme emotional states.[4.1] Mental health professionals, such as psychiatrists and psychologists, are prepared to assess and intervene, whereas police officers typically have minimal training and no diagnostic expertise.

In Canada, EXD was used seven times in different cases between 2007 and 2019. In 2007, Howard Hyde tragically lost his life after being stunned with a taser in a Halifax jail. Initially attributed to excited delirium resulting from his mental illness, schizophrenia, the cause of death was later revised in 2010.[4.2] The revelation indicated that Hyde's death was not linked to excited delirium but rather to the restraint techniques used by the guards, which potentially interfered with his ability to breathe, as reported by CBC News.[4.2]

In 2008, Gordon Walker faced a similar fate following his arrest in Calgary. In this case, "the medical examiner's report said Bowe's death was caused by excited delirium due to high levels of cocaine". [4.3] After his death, the "provincial court Judge Heather Lamoureux had nine recommendations, including the Canadian Association of Chiefs of Police create a database to record and share details about deaths due to excited delirium".[4.3]

Years later, in 2013, Sammy Yatim, holding a small knife on an empty Toronto streetcar, was shot multiple times by a police officer.[4.4] The defense position cited Yatim's "aggressive" body language and apparent state of excited delirium as factors leading the officer to believe an attack was imminent.[4.4]

In 2015, in Vancouver, Myles Gray's arrest and subsequent death at the age of 33 were described as "acute behavioural disturbance".[4.5,4.6] Despite attempts to attribute the incident to the disproven theory of excited delirium, the pathologist concluded that Gray's death was due to "intentionally inflicted" injuries by another person.[4.5]

Moving on to 2016, Abdirahman Abdi's death during a police encounter in Ottawa was described by the officer as marked by signs of excited delirium.[4.7] The officer included the description of an "apparent superhuman strength, erratic behavior, and ignoring commands..." to justify his defense.[4.7]

In 2017, Taumas Justin LeBlanc's death in Winnipeg after a struggle with the police raised questions as well, with the judge reporting "medical conditions and a state of excited delirium" as contributing factors.[4.8] However, the autopsy stated "...chronic alcoholism, cardiomegaly (abnormal enlargement of the heart) and physiological stress due to the struggle with officers as contributing factors"; therefore, the way police officers managed the situation played a crucial role.[4.8]

Finally, in 2019, Aaron Ross died in Winnipeg after being restrained by the police near the riverbank on Assiniboine Avenue.[4.9] The death was "determined to be anoxic brain injury due to cardiac arrest, which in turn was caused by the excited delirium".[4.9] As in the previous case, it was also associated with "physiologic stress of struggle and restraint by police".[4.9] The IIU report attributed the excited delirium to substance use, as reported by CBC News.[4.9]

These cases collectively underscore the ongoing debate and scrutiny surrounding the concept of excited delirium in law enforcement contexts. However, "EXD is not a currently recognized medical or psychiatric

diagnosis according to either the Diagnostic and Statistical Manual of Mental Disorders (DSM-IVTR) of the American Psychiatric Association or the International Classification of Diseases (ICD-9) of the World Health Organization".[4.10] It is not recognized in the last version of DSM-V as a diagnosis or as a condition for further study.[4.11] In addition, the American Psychiatric Association (APA) report (2020) shows that "there have been no rigorous studies validating excited delirium as a medical diagnosis".[4.1] In contrast, the American College of Emergency Physicians (ACEP) has explicitly recognized excited delirium as a medical condition in the *White Paper Report on Excited Delirium Syndrome* in 2009, even when ACEP also stated that the etiology and pathophysiology of ExDS as well as its criteria were unclear.[4.12]

EXD and its use further underscores the systemic racism within policing. The American Psychiatric Association released a position statement in November 2020 regarding EXD. The institution explains that EXD "has been invoked in a number of cases to explain or justify injury or death to individuals in police custody, and the term excited delirium is disproportionately applied to Black men in police custody".[4.1] Similarly, Gary Chaimowitz, a forensic psychiatrist and president of the Canadian Psychiatric Association, said that "the use of excited delirium as a cause of death can be particularly harmful towards Black, Indigenous and People of Colour, who are often overly-represented with the term in police-involved incidents".[4.13]

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Appendix 5: Police preparedness to approach mental health crises

Diverse sources have studied the effect of law enforcement attending mental health-related crises with conclusions drawn of negative results for both the people experiencing the crisis and for the officers attending. Research highlights that despite new measures from the law enforcement to manage these situations, "mental health-related calls continue to result in negative outcomes" and the literature suggests that police interventions in mental health crisis can be "traumatic or extremely stigmatizing" for civilians.[5.1] Moreover, police intervention in a mental health crisis can lead to "unnecessary and damaging trauma [and] criminalization of illness-induced behaviour".[5.2]

Concerns are not just for those experiencing crises, but also for the police officers. Research from Canada and the United States highlights concerns in two areas. The first is the officers' lack of knowledge to recognize mental health crises-related behaviours and expected outcomes, and the second is the trauma these encounters can have on the police officers.

Regarding officer knowledge, different sources have found that police officers may "misinterpret (people in crisis) behavior and demeanor" and view people's reactions as " nonresponsive, or even hostile".[5.3,5.4] Based on these facts, "the actions exhibited by persons with a mental illness can sometimes be misconstrued as an aggressive act, indicating the need for the use of coercive force".[5.5] Police officers' misinterpretations of mental illness manifestations support the fact that this is outside law enforcement's practice and knowledge, even when trainings take place. The same can be said for expected outcomes. A person in a mental health or substance use crisis is expected not to respond as an individual with the use of all their mental faculties. However, a person in an "acute mental health crisis can appear to be ignoring a police officer when really they might not be able to understand the officer's instructions".[5.3] This may indicate to police the "need for the use of coercive force", ultimately making people in crisis "responsible for the decisions they make that perpetuate harm".[5.5,5.6]

Finally, in a context where "police respond to a person in mental health crisis as they are trained to respond to a typical criminal emergency situation – with a show of force and authority" the potential impact on police can also be problematic given "police officers have been traumatized by the police shooting deaths of persons in mental health crisis".[5.2]

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Appendix 6: Toronto Community Crisis Service Training

From its inception, the Toronto Community Crisis Service (TCCS) has relied on community partners to help create, implement, and provide training to staff. This has resulted in training that varies somewhat from organization to organization. However, with the help of the community partners led by the Gerstein Centre, a 5-week core training course for staff was created.[6.1] This training was provided by content experts and aimed to be both participatory and engaging. The goal was to build relationships between the partners and to promote understanding of the different approaches each organization brought to the work.[6.1] Training included suicide intervention, effective crisis response, and scenario training aimed at improving active listening and empathic communication skills with a focus on connection and de-escalation.[6.1] Although cultural safety is always important, particular attention was paid to Indigenous cultural safety, to ensure that crisis workers were prepared and able to engage in a culturally safe manner. The training also included the following skills or knowledge areas: trauma, consent, language, oppression, neurodiversity, drug use and overdose, harm reduction, client-centred care, communication, cross-cultural training, safety, stress, first aid, and privacy and related laws.[6.1]

Each partner organization also has their own training requirements more specific to the populations they serve. Some topics covered in this training were also offered in the core 5-week training curriculum such as suicide intervention training. 2 Spirits included case management software training and how to make your own bundle, CMHA-TO provided AODA and their internal systems, and Gerstein provided training on data recording.[6.1]

Some barriers and shortcomings to the training were found while evaluating the start of the program.[6.1] First, core training was only offered at the initial role out, with staff who had not received the training feeling less prepared.[6.1] It was also found that although organizations were equipped to potentially provide the training internally, it was burdensome and expensive for them to do so, and therefore a need for the City of Toronto to help coordinate was identified.[6.1] 911 and 211 staff received organization level training which felt hurried and varied depending on when it was offered.[6.1] The Toronto Police Service received presentations on the TCCS.[6.1]

Recommendations have been made in both the six-month and year evaluation reports to enhance training, including:

- expanding the training to include TCCS partners such as TPS, 211, and 911.[6.1,6.2]
- offering the core training coordinated by the City of Toronto but supported by partner agencies more often to train new and recent hires to ensure equitably-delivered trainings,
    - the delivery should be flexible enough for those with irregular hours to attend.[6.1]
- implementing a centralized maintenance training curriculum for all staff, including anti-Indigenous racism training and one which is responsive to lessons learned from calls.[6.2]
- having all training materials preserved and readily available for new and existing staff.[6.2]

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Appendix 7: Demographics of Eugene, Springfield, Toronto, Winnipeg

		Eugene OR (2022 Census)	Springfield OR (2022 Census)	Toronto ON (2021 Census)	Winnipeg MB (2021 Census)
Total Population		177,923	61,400	2,761,285	736,660
Indigenous Ancestry	**American Indian and Native Alaskan alone***	0.6%	1.4%	---	---
	Indigenous Ancestry	---	---	0.8%	12.4%
Visible Minority Population	**Foreign Born Persons****	6.9%	5.9%	---	---
	Visible Minority Population	---	---	55.7%	34.4%

* US Census data only demarcates Indigenous Ancestry in the case of single origin ancestry

** US Census data does not identify members of visible minority populations, only those born outside of the US.

Social demographics serve to inform decision-making. When looking at the various existing alternatives in other jurisdictions it is important to explore how their demographics compare and to ensure that any crisis response developed reflects the community which it intends to serve.

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Appendix 8: Summary of *Rethinking Community Safety: A Step Forward For Toronto* and *Defunding the Police: Defining the Way Forward for HRM*

Introduction: There are two recent reports in Canada that outline the need to reallocate funds away from policing, and the benefits that would result - one done by Toronto Neighborhood Centres, and one commissioned by the Halifax Board of Police Commissioners. Using different terms, **"refocusing resources"** in Toronto's report and **"defunding the police"** in Halifax's report, both call for a paradigm shift in addressing social and mental health issues. The prevailing notion is to move away from punitive measures and invest in community-centric resources and civilian-led responses that have historically been underfunded and dismissed. The transition is not simply about reallocating funds but is instead a fundamental change in power dynamics, equipment distribution, and the use of force. The vision is to replace the current punitive system embodied in the police approach, which negatively impacts Black, racialized, and Indigenous communities, with an ethic of care emphasizing community safety, mental health, and social well-being.

Defining defunding, detasking, and retasking: Defunding is defined as a call to decrease police budgets, size, scope, and power while simultaneously investing in alternative community safety models. The objective is to reduce reliance on forceful responses to maintain control which inhibit the potential for de-escalation in the case of mental health crises and to redirect resources to community-centred safety initiatives. This shift encompasses a spectrum of action and intervention, ranging anywhere from social development and prevention to risk intervention and emergency response. By refocusing resources and detasking police, tasks will be performed by appropriate organizations and health institutions. This would reduce the negative consequences of police engagement and solve a fundamental problem: the fact that using law enforcement when it comes to a mental health or substance use crisis continues to uphold the criminalization of mental health concerns.

Narratives for Change: Criminalization of mental health is the current narrative in society. Both reports emphasize the need for narrative shifts crucial to achieve destigmatization.[8.1, 8.2] Different policy lenses, such as health and disability and Afrocentric and Indigenous perspectives, inform these changes.[8.1] The reports also align with international human rights standards to do so.

Budget implications: Government spending, in conjunction with narrative changes can improve by following this initiative. The Toronto report highlights different areas where organizations and mental health centres taking civilian-first responses are already in place, so reallocating resources to them implies a lower cost and better outcomes for both the public and the government.[8.2] The report shows that by funding care, and not policing, over $150 million annually would become available to provide services to people with mental health crises in the city. Similar projections were made regarding homelessness, youth, and the justice system, which takes into account the intersectionality of the aforementioned communities and their connections to those systems.

Four Pillars of Defunding: The Halifax report identifies four pillars of community-centered reforms:
•Pillar #1: Reforms to police practices, oversight, and accountability.
•Pillar #2: Reforms aimed at "detasking" police and "retasking" more appropriate community service providers.
•Pillar #3: Legislative, regulatory, and policy reforms intended to promote community safety.

•Pillar #4: Financial reforms aimed at tying police budgets to clear performance metrics and encouraging public participation in municipal budgeting. The ultimate intent of these reforms is to decrease budgetary allocations to police and increase allocations to community-based social services.[8.1]

<u>Areas for Change</u>: The Halifax report highlights specific areas where defunding can lead to positive change regarding interventions in mental health crisis, poverty and homelessness, policing in schools, drug use, and traffic enforcement.[8.1] For mental health, the proposal suggests transitioning to a civilian-led mental health crisis response, aligning with the Mobile Mental Health Crisis Team; for substance use, the report discusses the Vancouver proposal for addressing drug consumers' stigma and criminalization. The Vancouver proposal is focused on the decriminalization of drug possession (under a threshold amount), for personal consumption, for those 19-years and old, and the promotion of supervised consumption sites and/or overdose prevention sites, both based in the harm reduction principles. This proposal recognizes that addressing substance use with the legal system creates additional harm and prevents people from starting treatments.

<u>Facts Setting the Backdrop</u>: Key facts emphasize the urgency of defunding and detasking police. The Halifax report states that "one in three Canadians experience mental health issues or illness annually" and that it is the leading cause of disability in Canada.[8.1] Untreated mental health illnesses and issues cost approximately $51 billion per year in Canada as of 2015.[8.1] Rates of mental health illness and issues are higher among racialized populations, people living in poverty, members of the 2SLGBTQIA+ community, and women" (p.116).[8.1] In addition, both reports also share the fact that "police themselves admit they are not suited to respond to mental health crises", a role that is stated in Section 14 of the *Involuntary Psychiatric Treatment Act, SNS 2005, c 42*. (p.116).[8.1]

<u>Comparative Approaches</u>: The Halifax report explores approaches taken by other Canadian and US jurisdictions.[8.1] In Canada, most still involve the police. In the United States, successful models emphasize civilian-only or civilian-oriented response teams, contrasting with the limitations of police-led interventions.

<u>Best Practices</u>: The overarching theme is that a police-led approach is not aligned with best practices. Best practices dictate treating mental health issues with mental health professionals and using the police as a backup when necessary. Therefore, the Halifax report suggests a shift from police-led responses to align with proven successful models that prioritize community responders and civilian-led crisis interventions directed by mental health professionals.[8.1]

<u>Conclusion</u>: Both reports envision a full restructuring of public safety and advocate for defunding the police as a means to invest in healthier and safer communities.[8.1, 8.2] The proposed changes reflect a nuanced understanding of the complexities surrounding social issues and a commitment to fostering community-centred safety and well-being.

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Appendix 9: Jurisdictional Scan of Non-Police Led and Police Led Crisis Responses

This jurisdictional scan is no means exhaustive and is likely to be missing organizations and polices forces in Canada and the US which have crisis teams.

Non-Police Led Responses[9.1]

Canada

Peer+ - Teams with a designated spot for a peer worker who is paired with clinicians and/or crisis workers.

Name	Location
Peer Assisted Care Team	North Shore BC
Community-Led Crisis Response Team	Victoria, BC
Peer Assistance Care Team [PACT]	New Westminster, BC

Crisis Worker - Teams staffed by people with a blend of formal education, professional experience, and personal backgrounds. Peer workers are often included in the mix.

Name	Location
Eskasoni Mental Health Crisis & Referral Centre	Eskasoni, NS
Gerstein Crisis Centre Mobile Crisis Team (connected with TCCS)	Toronto ON
TAIBU Community Crisis Service (connnected with TCCS)	Toronto, ON
CMHA Community Crisis Service (connected with TCCS)	Toronto, ON
Kamaamwizme wii Naagidiwendiiying (connected with TCCS)	Toronto, ON
24/7 Crisis Diversion Team	Edmonton, AB
Southern Chiefs Organization Mobile Crisis Response Team	Southern Manitoba, MB
Manitoba Keewatinowi Okimakanak Mobile Crisis Response Team	Manitoba

Clinician - Teams staffed entirely by formally educated mental health professionals who are usually required to be professionally qualified or officially licensed.

Name	Location
Social Diversion Team	Red Deer AB
Saskatoon Mobile Crisis Service	Saskatoon SK
Mobile Response Team	Calgary, AB
Mobile Mental Health Units	Provincewide, PEI
Community Assisted Response	Medicine Hat, AB
Crisis Response Pilot Project	Brampton and Mississauga, ON

Medic+ - Teams comprised of a medic (e.g., EMT, paramedic) paired with mental health clinicians, crisis workers, and/or peer workers.

Name	Location
Ottawa Paramedic Service Mental Health Wellbeing Response Team	Ottawa, ON
Mental Health and Addictions Response Team	Niagara, ON

Undetermined/In Development Programs - Either do not have sufficient information to categorize into a program type or are in the pre-implementation stage.

Name	Location
Community Mobile Crisis Response Pilot (accompagnied by police during first several months of pilot)	Calgary, AB
Moderate Crisis De-Escalation Team	Vancouver, BC
Mental Health Response Team	Ottawa, ON
Peer Assisted Care Teams (Peer+)	Kamloops, BC
Peer Assisted Care Teams (Peer+)	Prince George, BC
Peer Assisted Care Teams (Peer+)	Comox Valley, BC
Maskwacis Mobile Mental Health	Maskawacis, AB

USA

Peer+ - Teams with a designated spot for a peer worker who is paired with clinicians and/or crisis workers.

Name	Location
Common Ground Mobile Crisis Intervention & Recovery Teams	Oakland and Genesse Counties, MI
Centerstone Mobile Crisis Response Unit	Multiple locations, IN
Centerstone Mobile Crisis Response Unit	Multiple locations, KY
Compassionate Allies Serving our Streets	New Haven, CT
Mobile Crisis Outreach Teams	Salt Lake City, UT
Mobile Crisis Response Teams	San Diego, CA
Centerstone Mobile Crisis Response Unit	Multiple Locations, FL
Centerstone Mobile Crisis Response Unit	Multiple Locations, IL
Centerstone Mobile Crisis Response Unit	Multiple Locations, TN
Community Response Team	Washington DC
Fairbanks Crisis Now Mobile Crisis Team	Fairbanks, AK
Community Mobile Crisis Response Team	Philadelphia, PA
Oaklawn Mobile Crisis Team	South Bend, IN
West Central Mobile Crisis Response Team	Upper Valley and Sullivan County, NH
Contra Costa Health's Mobile Crisis Response Team	Contra Costa County, CA
Mobile Crisis Response	DuPage County, IL
Hartford Emergency Assistance Response Team	Hartford, CT
Specialized Care Unit	Berkeley, CA
Community Mobile Team	Columbus, OH
Crisis Response Team	Long Beach, CA
Triton Compassionate Response [CORE] team	UC San Diego, CA
LRMHC Mobile Crisis Response Team	Laconia, NH
Clinician-Led Community Response program	Indianapolis, IN
Mobile Outreach Support Team	Arlington, VA
Crisis Mobile Response	Monroe, MI
Mobile Crisis Response Services	Quincy, IL
Community Crisis Response Program	Richmond, CA
Community Response Team	Cornell University, Ithaca, NY
Crisis and Incident through Community-Led Engagement (CIRCLE) program	Los Angeles, CA

Crisis Worker - Teams staffed by people with a blend of formal education, professional experience, and personal backgrounds. Peer workers are often included in the mix.

Name	Location
First Response Alternative Crisis Team	Chicago, IL
Columbia River Daytime Mobile Health Unit & Night Crisis Team	Clark County, OR
Mobile Crisis Intervention Unit	New Orleans, LA
NYC Mobile Crisis Team	New York City, NY
Olympia Crisis Response Unit	Olympia, WA
Terros Health Mobile Crisis	Phoenix, AZ
Policing Alternative and Diversion Initiative	Atlanta, GA
911 Deflection	Louisville, KY
Northern Rivers Mobile Crisis	Albany, NY
Trusted Response Urgent Support Team [TRUST]	Santa Clara County, CA
Youth Mobile Crisis Outreach Team	Utah County, UT
Be Well OC Mobile Crisis Response Team	Orange Couny, CA
Mobile Crisis Intervention	Multiple counties, ME
Crisis and Incident through Community-Led Engagement	Los Angeles, CA
Bangor Community Action Team	Bangor, ME
Crisis Response Team	Duluth, MN
Trusted Response Urgent Support Team [TRUST]	Palo Alto, CA
Trusted Response Urgent Support Team [TRUST]	Gilroy, CA
Mental Health Community Mobile Crisis Response Pilot Program	Worchester, MA
Elevate Mobile Crisis Response Team	Southeast, IA

Gallatin Mobile Crisis Team	Gallatin, MT

Clinician - Teams staffed entirely by formally educated mental health professionals who are usually required to be professionally qualified or officially licensed.

Name	Location
Alameda Mobile Crisis Team	Alameda County, CA
ACDMH Mobile Crisis Team	Albany, NY
Comprehensive Psychiatric Emergency Program	Binghampton, NY
Buffalo and Erie County Mobile Outreach Program	Buffalo, NY
Regional Education Assessment Crisis Services Habilitation	Charlottesville, VA
Mobile Crisis Team operated by Frontling Service	Cleveland, OH
Crisis Support Team	Dakota County, MN
Crisis Stabilization on Site Mobile Outreach	Detroit, MI
Mobile Crisis Outreach Team	Statewide, TX
CommUnity Mobile Crisis Response	Johnson, IA
Hinds Behavioral Health Services Mobile Crisis Team	Jackson, MS
Crisis Mobile Triage	Multiple locations, ME
Psychiatric Mobile Response Teams	Los Angeles, CA
Banyan Health Mobile Crisis Response Team	Miami, FL
Crisis Mobile Team	Multiple locations, WI
COPE Crisis Outreach Team	Minneapolis, MN
Beth Israel Hotline Mobile Outreach	Newark, NY
Devereaux Advanced Behavioral Health Mobile Crisis Services	Orlando, FL
Opportunity Alliance Mobile Crisis Response Services Team	Portland, ME
Rochester Mobile Crisis Team	Rochester, NY
Crisis Support Services	Santa Barbara, CA
Community Assistance and Life Liaison	St. Petersburg, FL
Gracepoint Mobile Crisis Response Team	Tampa, FL
Community Responders for Equity, Safety & Services	Amherst, MA
Texana Centre	Statewide, TX
Expanded Mobile Crisis Outreach Team	Statewide, TX
Community Regional Crisis Response	Statewide, VA
Children's Mobile Response and Stabilization Services	Statewide, NJ
Mobile Crisis Teams	Statewide, CT
Psychiatric Emergency Teams	Los Angeles, CA
Delaware Guidance Services for Children & Youth Mobile Response Team	Wilmington, DE
Project Respond Crisis Team	Portland, OR
Integrated Insight Therapy Mobile Crisis Unit	San Miguel County, CO
Baltimore Crisis Response Inc Mobile Crisis Team	Baltimore, MD
Memorial Behavioural Health Crisis Response Team	Multiple Sites, IL
Freedom House Mobile Crisis Team	Miami, FL
Mobile Crisis Intervention Services	Statewide, AZ
Youth Villages Specialized Crisis Services	Statewide, TN
Person In Crisis	Rochester, NY
Mobile Crisis Intervention Services	Statewide, CT
Care 7 Mental Health Response Team	Tempe, AZ
Albuquerque Community Safety Behavioral Health Responders	Albuquerque, NM
Stabilization & Mobile Response	Multiple locations, UT
Mobile Crisis Response Teams	Richmond, VA
Expanded Mobile Crisis Outreach Team [EMCOT]	Austin, TX
Sante's Mobile Crisis Team	Multiple areas, MD
Behavioral Crisis Response Team	Minneapolis, MN

Mobile Crisis Team	Maricopa County, AZ
Mobile Crisis Outreach Team	Shasta County, CA
Mobile Crisis Assessment Team	Orange County, CA
Mobile Crisis Services	Statewide, GA
Mobile Crisis Response	Statewide, IL
Mobile Crisis Teams	Harford County, MD
Network180's Mobile Crisis Response Team	Kent County, MI
Children's Mobile Crisis Response Team	Urban areas, NV
Mobile Crisis Team	Monroe County, CT
Mobile Crisis Team	Multiple Counties, Eastern NC
CriSyS Mobile Crisis Team	Mecklenburg County, NC
Montgomery County Mobile Crisis Team	Montgomery County, PA
Mobile Crisis Response	Multiple Counties, IA
Alternative Response Team	Bellingham, Washington
Holistic Assistance Response Team	Harris County, TX
Behavioral Evaluation and Response [BEAR] Team	Winston-Salem, NC
Marin County Mobile Crisis Response Team	San Rafael, CA
Community Medical Centers Response Team	Stockton, CA
Mobile Crisis Response Team	Linn County, OR
Aspen Hope Center Mobile Crisis	Aspen, CO

Medic+ - Teams comprised of a medic (e.g., EMT, paramedic) paired with mental health clinicians, crisis workers, and/or peer workers.

Name	**Location**
Aurora Mobile Response Team	Aurora, CO
Alternative Response to Crisis	Cincinnati, OH
Support Team Assisted Response Program	Denver, CO
Crisis Assistance Helping Out On The Streets	Eugene, OR
Community Alliance Response and Engagement (CARE) team	Flagstaff, AZ
Mobile Crisis Services	Statewide, GA
Hayward Evaluation and Response Team - Mobile Integrated Health Unit	Hayward, CA
Community Alternative Response Emergency Services	Madison, WI
Behavioral Health Emergency Assistance Response Division	Statewide, NY
Portland Street Response	Portland, OR
Crisis Response Team	Providence, RI
Street Crisis Response Team	San Francisco, CA
inRESPONSE Mental Health Support Team	Santa Rosa, CA
Specialized Assistance for Everyone	Sonoma County, CA
Mobile Integrated Health	Atlanta, GA
Crisis Assistance Response and Evaluation Services [CARES]	El Centro, CA
SLO Mobile Crisis Unit	San Luis Obispo, CA
HEART Community Response Teams	Durham, NC
Mobile Assistance Community Responders of Oakland [MACRO] Program	Oakland, CA
Anchorage Mobile Crisis Team	Anchorage, AK
Albany County Crisis Officials Responding and Diverting	Albany County, MA
Alternative Response Unit	Santa Fe, NM
Community Assessment Response & Engagement	Alameda, CA
Alternative Response Team	Atlanta, GA
Mobile Support Team	Missoula, MT
Alternative Response for Community Health	Ames, IA
Community Alternative Response Emergency Services	St. Paul, MN
Alternate Response Team	Colorado Springs, CO

Crisis Assistance Response & Engagement [CARE] Program - Alternative Mental Health Response Team	Chicago, IL
Responders Engaged and Committed to Help [REACH]	Nashville, TN
Mobile Mental Health Response Team	Kingston, NY
UC Santa Cruz's Campus Mobile Crisis Team	Santa Cruz, CA
Alternative Response Team	Brooklyn Park, MN
Alternative Response Team	Tulsa, OK
Specialized Assistance For Everyone [SAFE] program	San Rafael, CA
Crisis Assistance Response and Evaluation Services [CARES]	Half Moon Bay, CA
Angelo Quinto Community Response Team	Antioch, CA
Specialized Assistance For Everyone [SAFE]	Rohnert Park and Cotati, CA
Mobile Crisis Unit	Springfield, OH
Clear Creek Health Assistance Team	Clear Creek County, CO

Mutual Aid - Teams staffed entirely by community members and volunteers who are trained to respond to crises.

Name	Location
Mental Health First Oakland	Oakland, CA
Mental Health First Sacramento	Sacramento, CA
Revolutionary Emergency Partners	South Mineapolis, MN

Undetermined/In Development Programs - Either do not have sufficient information to categorize into a program type or are in the pre-implementation stage.

Name	Location
Resolve Mobile Crisis Unit	Pittsburgh, PA
Mobile Crisis Services	Raleigh, NC
Mobile Crisis Intervention Services	Northern Delaware, DE
Mobile Crisis Intervention Services	Southern Delaware, DE
Mobile Crisis Services	Essex, NY
Coordinated Access Resource Entry System Crisis Mobile Outreach Team (likely a Clinician Model)	Statewide, HI
Cambridge Holistic Emergency Alternative Response Team [HEART] (focus on Mutual Aid)	Cambridge, MA
Alternative Response & Community-led Response	Boston, MA
Mobile Mental Health Team (likely clinician model)	Gary, IN
Lessen the Incidence of Grief, Harm and Trauma [LIGHT] (will be medic+)	Las Cruses, NM
Civilian Crisis Response	Seattle, WA
Mental Health Crisis Response Unit	Tacoma, WA
Unarmed Response Team	Washtenaw County, MI
Mobile Crisis Assessment Team [MCAT]	Bend, OR
Crisis Response Team	Dayton, OH
Burlington CARES	Burlington, VT
West Hollywood Care Team	West Hollywood, CA
Alternative Crisis Response Team	Knoxville, TN
Mobile Crisis Response Team	Jackson County, OR
Fullerton Police Department Social Worker Program (will be clinician)	Fullerton, CA
CareforCLE	Cleveland, OH

Police Led Responses

Canada

Name of Program	Police Service
Car 87	Vancouver Police Department (BC)
Assertive Community Treatment (ACT)	
Mental Health Unit	New Westminster Police Department (BC)
Car 22	West Vancouver Police Department (BC)
Police and Crisis Team (PACT)	Lethbridge Police Service (AB)
Police and Crisis Team (PACT)	Calgary Police Service (AB)
Police and Crisis Response Team (PACT)	Edmonton Police Service (AB)
Police and Crisis Response (PACT)	Grande Prairie RCMP
Police and Crisis Team (PACT	Saskatoon Police Service (SK)
Police and Crisis Team (PACT)	Regina Police Service (SK)
Police and Crisis Team (PACT)	Moose Jaw Police Service (SK)
Police and Crisis Team (PACT)	Prince Albert Police Service (SK)
Mental health initiative with smart phones	Brandon Police Service (MB)
Alternative Response to Citizens in Crisis (ARCC)	Winnipeg Police Service (MB)
Mobile Crisis Rapid Response Team	Halton Regional Police (ON)
Mobile Crisis Intervention Team (MCIT)	Toronto Police Service (ON)
Crisis Outreach and Support Team (COAST)	Barrie Police Service (ON)
HELP Team	Chatham-Kent Police Service (ON)
Mobile Crisis Unit	
Vulnerable Sector Mobile Acute Response Team (VSMART)	Cornwall Community Police Service (ON)
Mental Health Support Unit (MHSU)	Durham Regional Police Service (ON)
Mobile Crisis Rapid Response Team (MCRRT)	Greater Sudbury Police Service (ON)
Integrate Mobile Police and Crisis Team (Impact)	Guelph Police Service (ON)
Mobile Crisis Rapid Response Team (MCRRT)	Kingston Police (ON)
Community Outreach and Support Team (COAST) – not rapid response	LaSalle Police Service (ON)
Crisis Outreach and Support Team (COAST) – not rapid response	Niagara Regional Police Service (ON)
Mobile Mental Health and Addiction Response Team (MMHART)	Owen Sound Police Service
Mobile Crisis Intervention Teams	Peterborough Police Service (ON)
Crisis Outreach and Support Team (COAST)	South Simcoe Police Service (ON)
Mobile Crisis Response Team (MCRT)	Strathroy-Caradoc Police Service (ON)
Mobile Crisis Rapid Response Team	Timmins Police Service (ON)
Mobile Mental Health and Addiction Response Team (MMHART)	West Grey Police Service , Hanover, Saugeen Shores (ON)
Community Outreach and Support Team (COAST) – not rapid response	Windsor Police Service (ON)
Mobile Crisis Reponse Team (80% of detachments have one)	Ontario Provincial Police (OPP) (ON)
Équipe de soutien aux urgences psychosociales (ESUP)	Service de police de la Ville de Montréal (QC)
Unité d'intervention de crise (UNIC)	Service de police de la Ville de Gatineau (QC)
Equipe mixtes d’intervention – policiers et intervenants communautaires (EMIPIC)	Surete du Quebec (QC)
Mental Health Mobile Crisis Team	Halifax Regional Police (NS)
Crisis Teams exist in some detachments nationwide	RCMP

USA

According to the University of Memphis there are 2 645 local and 351 regional crisis intervention teams.[9.2] These teams are made up of patrol officers who have 40 hours of additional crisis training.[9.2]

There are also co-responder teams throughout the USA, but due to time constraints there are likely more not found in this scan.[9.3]

Name	Location
Crisis Assessment Team and Psychiatric Emergency Response Team	Orange, CA
Colorado Department of Human Services Co-Responder Teams	Multiple Locations, CO
Denver Co-Responders	Denver, CO
Summit County Smart Team	Summit, CO
Meridian Behavioral Healthcare Co-Responder Team	Gainesville, FL
Johnson County Mental Health Center	Johnson County, KS
Pawnee Mental Health Services	Riley County, KS
Office of Mental Health	Harford, MD
Bernalillo County Behavioral Health Service Mobile Crisis Teams	Bernalillo County and Albuquerque, NM
City of Rochestor Co-Response Team	Rochestor, NY
Town of Chapel Hill Crisis Unit	Chapel Hill, NC

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9.3 1M4. (2022). *Mobile crisis units & co-responders in the United States: A guide to saving lives*. https://movementstrategy.org/wp-content/uploads/2022/04/1M4-MCU-CO-RESPONDER-DOWNLOADABLE-EBOOK-compressed.pdf