An Integrated Crisis Care Framework:

A community-informed approach

Ontario, Canada

Acknowledgments

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Executive Summary

In this report, we outline the findings of a study of mental health crisis care in Ontario, Canada, and the resulting crisis care framework. In what follows, we provide background information, our research methods, our key findings, ways of engaging with the framework, and make recommendations for both practice and policy.

Our aim in this study was to better understand what practices and models of care can provide appropriate, high-quality support for individuals in distress in need of emergency mental health support. The intent was to highlight and develop practices that appropriately support all members of the community with particular attention to those lacking financial resources, Black and Indigenous communities, People of Colour, 2SLGBTQ+ and immigrant communities who have faced higher rates of disproportionately negative interactions with emergency mental health services. We had particular interest in non-medicalized supports and approaches that extend beyond the biomedical and criminal justice systems.

For this study we interviewed 53 participants, a total of 60 participants completed a primarily open-ended survey, and we conducted document analysis. Participants represented roles such as paramedic, police officer, emergency telecommunications dispatcher, ED physician, ED nurse, social worker, psychiatrist, psychotherapist, management and frontline staff from community-based mental health and social service organizations, advocates, and those with lived experience of mental health emergencies, including family members.

Our key findings form the foundation of our integrated crisis care framework, outlining the key components of effective crisis care approaches and the factors that enable these approaches to succeed. The development of the framework is informed by participants' insights into what is currently working well in crisis care, what they envision for future care, and elements they identified as most important for a model of crisis care. Additionally, we present findings related to safety considerations for care recipients and responder, and responder and care provider support and wellness.

Safety is not identified as a separate component of this framework, rather it is intended that the conditions of care developed by these components support the conditions of safety and lead to safer care interactions for all involved. The approach of individual care providers is imperative, and so are the systems in which they have the options to provide care. Addressing these pieces has the potential to lead to more positive, trauma-informed and recovery-oriented interactions for care recipients and care providers. Further, care providers require adequate supports in the form of resources, training, and working conditions that can adequately prepare and sustain them for this work. This is crucial for both their own wellbeing and the responses they are able to provide.

Background

For people experiencing a crisis or mental health emergency in the community, the response they receive and their options for support and care profoundly affect their immediate wellbeing[1-3] and future interactions with mental health supports.[4] In Ontario, current responses to crisis or mental health emergencies may involve 9-1-1 dispatchers, paramedic services, police services, hospital emergency department (ED) services, and a variety of other community services that differ by region and population.[2,5-7] As demand for emergency mental health care increases, concerns are growing for the substantial, and potentially life altering consequences of these responses both in Canada and internationally.[2,8-11] Within the Ontario context, in 2020, the deaths of two people, Regis Korchinski-Paquet and Ejaz Choudry, each during mental health crises, stimulated increased calls for a change in response to mental health crisis. Within Toronto, these events contributed to the piloting and ultimately development of the Toronto Community Crisis Service.[12] Many current responses to mental health crisis throughout the province however, consistently fail to adequately meet the needs of individuals experiencing a mental health crisis, leaving people with unmet needs, a lack of connection to appropriate supports, and lacking follow-up care.[2,8-11,13]

Challenges with crisis responses include: paramedics and police often lack adequate training to address mental health emergencies,[2, 14] hospital EDs frequently serve as the only available destination from which to seek support or continuing care,[2,7,14] and gaps exist in community-based mental health care intended to provide ongoing care and support,[14-16] among others. Paramedics and police, while available 24/7 for rapid response may have a different approach for meeting community needs than community-based organizations and differ in both level of training and organizational mandate. Many people experience repeated interactions with emergency services, repeat visits to the ED, and experience violence and coercion when receiving emergency mental health services.[3,17-18] Further, despite dominant narratives and public perceptions that people experiencing mental health challenges are violent, evidence indicates that those experiencing mental health challenges are more often the victims than perpetrators of violence.[5, 19-21] A number of systematically marginalized groups face higher rates of disproportionately negative interactions with first responders. These include racialized, Black, Indigenous people, Two-Spirit, lesbian, gay, bisexual, trans, queer + (2SLGBTQ+) people, people with limited economic resources, and those with mental health diagnoses, among others.[10, 22-27] Within many communities in Ontario, police and paramedics remain the only options when experiencing crisis.

Through this study we developed a framework of mental health crisis care to inform practices in Ontario and potentially beyond. Our goal was to bring together the perspectives and insights of the paramedics and police attending to many of these calls, the ED, the community-based organizations who provide services ongoing and during crisis, the perspectives of people with lived experience who access emergency services for mental health supports or who have had these services called for them. Drawing from existing literature, innovative programs and services already in practice, and learning from participants' needs, the goal was to amplify these perspectives and honour the work already being done and calls to action that exist in these spaces.

Key Research Questions

Informed by acute care and community-based institutions, what practices and models of care can provide appropriate, high-quality support for individuals who need of emergency mental health support? In particular, what non-medicalized supports may improve comprehensive care in this area?

What training, resources and skills may be developed to best support practitioners providing care and support for emergency mental health needs?

Methods

We received ethics approval from the Humber Institute of Technology and Advanced Learning Humber Research Ethics Board. Our study employed a critical qualitative ethnographic case study design structured into three phases. Phase 1 (the community-based dimension) and Phase 2 (the acute care institution dimension) occurred simultaneously. Phase 3 (customizing a model or framework of care) followed the completion of Phases 1 and 2. We carried out semi-structured interviews, open-ended surveys, and document analysis. Data collection was conducted between January 2022 and June 2024. All participants provided informed consent prior to their participation.

Semi-structured interviews

We recruited interview participants using purposive, and snowball sampling techniques. A total of 53 participants took part in the semi-structured interviews representing roles such as paramedic, police officer, emergency telecommunications dispatcher, ED physician, ED nurse, social worker, psychiatrist, psychotherapist, management and frontline staff from community-based mental health and social service organizations, advocates, and those with lived experience of mental health emergencies, including family members. Many of the participants indicated they had held multiple roles. Some participants discussed their lived experiences with mental health, or the challenges with accessing urgent mental health care. We also heard from participants who primarily spoke of their professional role as what brought them to the interview but made either passing or more in-depth mention of personal challenges with mental health or shared this after the interview. Additionally, while some individuals spoke only of their professional roles, their workplaces identified that the employees at the organization held lived experience of mental health challenges, indicating that was a perspective brought to the thoughts they shared. Interviews lasted between 40-90 minutes in length.

Surveys

When a manager or leader in an organization participated in an interview, they were invited to share survey links with frontline staff and service users of their organizations. While some managers indicated that they did share the links, we do not know which or how many organizations did. In total 60 participants completed primarily open-ended surveys from three different surveys: a survey for front-line emergency workers (40 paramedics, 3 police); a survey for frontline workers in community-based organizations (9); a survey for service users with lived experience (8).

Participants represented roles such as:

- people with lived experience of mental health crisis
- family of people with experience of mental health crisis
- paramedic
- police
- dispatcher
- emergency department nurse
- emergency department physician
- social worker
- peer support worker
- housing and shelter service worker
- harm reduction worker
- psychologist
- psychiatrist
- crisis response team member
- leaders or managers in organizations
- front line workers

Document Analysis

To gain a solid understanding of both existing and emerging programs or pilot projects for crisis care, we conducted document analysis of media and grey-literature articles published between January 2022-December 2023.

Data Analysis

Interview transcripts and survey data were coded and critically analyzed using Braun and Clarke's reflexive thematic analysis approach[28]. Findings from Phases 1 and 2 were synthesized in Phase 3 to collaboratively develop a framework for crisis care, in partnership with our participating organizations. Once a draft framework was developed, additional feedback was sought from key informants within community organizations and from service users who had expressed willingness to contribute further. The feedback was then integrated into the final framework.

A diversity of perspectives and representation was explicitly sought from participants and organizations reflecting diverse geographies (urban, suburban, rural, and remote Ontario), race, gender, sexual orientation, immigration experience, use of English as an additional language, socioeconomic status, and mental health diagnoses.

Theoretical Framework

The research study, its analysis and this report were guided by critical theory. This lens emphasizes the importance of centering, amplifying, and empowering the perspectives of service users, and those who have suffered harms from the existing mental health and response systems. To prioritize this, community-focused responses were sought, particularly those that extend beyond biomedical and criminal justice systems. With this lens we critically examined structures and approaches that perpetuate oppression and discrimination based on identity and sought approaches that account for the social determinants of health and other structural and systemic barriers.

Findings

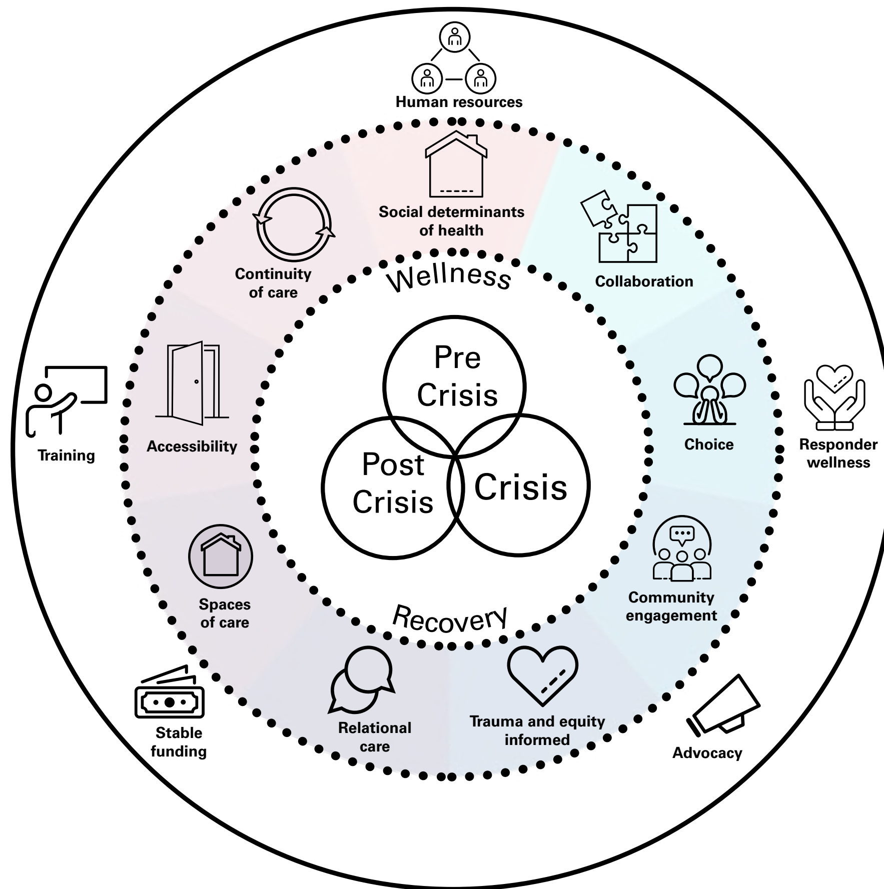
Our key findings form the basis of our crisis care framework. In this study we adopted a broad and inclusive definition of "crisis" which is also consistent with our participants' perspectives. Crisis, in this context, refers to any circumstance or event of distress occurring, in which support is needed or sought from outside of one's immediate social network. The framework outlines the key components of effective crisis care approaches and the factors that enable these approaches to succeed. The development of the framework was informed by participants' insights into what is currently working well in crisis care, what they envisioned for future care, and elements they identified as most important for a model of crisis care. Additionally, we also present findings related to safety considerations, support, and wellness for care recipients and responders.

Crisis

Crisis in this context refers to any circumstance or event of distress occurring, in which support is needed or sought from outside of one's immediate social network.

Further, we identify that by crisis care we refer to pre-crisis, crisis, and post-crisis stages, and that there is fluidity between these three stages of crisis. Based on the themes from the data, we identified nine core components of positive and appropriate crisis care including: relational care, choice, accessibility, spaces of care, social determinants of health, collaboration, community-engagement, trauma and equity informed, and continuity of care. We introduce these themes identifying that they apply across all 3 stages of crisis, and that each of these 9 components are necessarily interconnected – you cannot have one component without the others.

An Integrated Crisis Care Framework



	Relational care	This is the relational and trust-building aspect of care. It honors the caregiver/recipient relationship with emphasis on empathy, flexibility, dignity, and reciprocity. It extends beyond the transactional approach and is attuned to complex entanglements of dignity-promoting care that forefront meeting individual needs/desires and instill hope.
	Spaces of care	This refers to deep consideration of where care is taking place. Priority factors include adequate physical space, privacy, ability to move away from busy, chaotic spaces, sound, ability to engage with wellness tools, potential for social connection, and updates about next steps.
	Accessibillty	This refers to the ease with which an individual can obtain mental health supports, services and wellness promoting opportunities through all aspects of care from prevention, connection to supports, and other management of their mental health. This includes timely access as well as language and cultural accessibility.
	Continuity of care	This refers to care after an initial encounter with a crisis team, hospital, or institution that takes places in a timely manner, ensuring people remain connected between service engagement (including non-medical services), and are not isolated or unsupported in transition to subsequent service usage.
	Social determinants of health	This refers to the ability to address individuals' social and material needs and living circumstances. Alternative options, outside of biomedical or hospital-oriented services are required including housing/shelter, food access/security, employment and opportunities for social connection and recreation.
	Collaboration	This refers to the need for involvement across sectors, professions, and services coalitions, and formal/informal support groups. An ability to draw on resources and make connections for a range of needs including acute de-escalation, ongoing therapy or counselling, alternative non-medical care options including peer support, housing/shelter services, health services, recreational or social activities.
	Choice	This refers to prioritizing consent-based care, where individuals are offered all available options customized to their needs. Where options are prohibitively limited, this is to be explained as part of the consent process. Self-determination is associated with a strengths and empowerment approach and strongly linked to recovery.
	Community engagement	This refers to services being directly community informed, engaged, and driven to ensure that the needs of community members are addressed, and there is full inclusion, participation and empowerment of community. Community refers to the diversity between and within groups, including people who are of lower socioeconomic status, Black, Indigenous, People of Colour, 2SLGBTQ+, immigrant, English as an Additional Language, and those who are mental health service-users among other marginalized groups.
	Trauma and equity informed	This refers to employing trauma-informed approaches in interactions and ensures trauma-informed spaces, inherently embracing anti-oppressive principles. It acknowledges the broad effects of trauma on individuals and their well-being, actions, and circumstances. This includes recognition of distrust of communities in mental health services and the impacts of historical and ongoing trauma.

Nine Core Components of Crisis Care

Relational Care

This is the relational and trust-building aspect of care. It honors the caregiver/recipient relationship with emphasis on empathy, flexibility, dignity, and reciprocity. It extends beyond the transactional approach and is attuned to complex entanglements of dignity-promoting care that forefront meeting individual needs/desires and instill hope.

Participants spoke at length about interpersonal and relational approaches to care that are crucial when someone is experiencing crisis. Participants across sectors and experiences used words to describe a positive encounter during crisis such as openness, listening, kindness, compassion, empathy, encouraging, calm tone and demeanor, and emphasized a slower pace, and taking time to connect. Many highlighted the importance of relationship building and allowing time to work toward building trust. They emphasized not "treating people as a diagnosis" (Participant 009) and referred to a human touch, checking in and finding out what people need. **One participant described it this way**:

"And once someone's going through a mental health crisis or their loved one is, they need a more than business as usual approach. They need some time, they need some compassion and understanding and patience and someone who's going to, you know, give them the right information and listen to their questions"
-PARTICIPANT 037 (LIVED FAMILY EXPERIENCE, CRISIS WORKER, ADVOCATE)

Another participant highlighted what they felt was most important based on their lived experience of crises and interacting with emergency services.

"I think like, someone who just like talks to you and…looks you in the eye. And is listening and compassionate and maybe tries to kind of, I guess, see you as a person rather than, a burden. More see you as, I guess, like a challenge."
– PARTICIPANT 020 (LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED, ADVOCATE, ACTIVIST)

When highlighting the importance of actively listening to people when they are experiencing acute distress, participants described care that was not transactional, but genuine listening and believing what an individual is going through.

One crisis worker stated:

"Having somebody listen to them, which is a lot of what we do is listening. Sometimes people don't want – or at the time - don't want answers, they don't want [you] to tell them a solution. They just want somebody to listen to them. So, having somebody, you know, listening to them, and someone to believe them…and sort of checking with them if this is what I'm doing, is that correct? Am I way off?... I've learned with this role that one size doesn't fit all. And that it has to be individualized and it has to be tailored, also depending on what the situation is…Probe a little bit when need – but also in a very gentle way. I mean when people are having a hard time, the last thing they want to do is for me to ask them a bunch of questions that they don't quite understand."
-PARTICIPANT 014 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING)

When referring to ideal or positive approaches to care and interactions during crisis, participants consistently referred to treating people with humanity, making an effort to develop a relationship with the person, even in small ways, using their name, and ultimately adapting the interaction with flexibility to the person's needs or desires at that time wherever possible.

Participants described kindness and taking the time to build trust and rapport:

I think having a human approach and touch to it - like this is just somebody having a really shitty time in their life, right? And they're wanting help and they're reaching out. You know I'm not here to judge I've had shitty times, I'm sure we've all had shitty times…So I think yeah what works well is that calm approach, having an understanding and appreciation either through life experience and I think preferably life experience and education to be able to truly empathise.

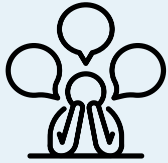
-PARTICIPANT 007 (PARAMEDIC SUPERINTENDENT IN A RURAL SETTING)

Care provider participants also highlighted the ways in which relational care is about being honest with the person, flexible where at all possible and aiming to meet the needs/desires that the person has identified. For example, by letting people know what is going on or what might happen, being transparent about next steps, options, and sharing information about waiting times or other circumstances trust can gradually be built.

The big piece for us is that we're consent based. So, we do not do anything… that the client does not want to do. We are very transparent in regards to what we want to do, but we really tailor the service, the advocacy piece. So, everything to a client and where they're at, whether it's the cultural piece that is also important…It's not about what I want. And to a certain degree, it's not even about what I want to do for my clients. It's about what do they want, and how much of it do they want me to do, and how far do they want me to go.

-PARTICIPANT 052 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING)

Relational care does not require a highly specialized or professionalized skillset, but rather a willingness to help, and have high regard for the relationship and trust built between the care provider and person in distress. It was clear from our participants with lived experience of crisis and from those who provide care, that relational care can be carried out by any responder and has the potential for a huge amount of impact.



Choice

This refers to prioritizing consent-based care, where individuals are offered all available options customized to their needs. Where options are prohibitively limited, this is to be explained as part of the consent process. Self-determination is associated with a strengths and empowerment approach and strongly linked to recovery.

Participants who were care providers repeatedly emphasized the importance of asking open questions and letting the person in distress direct their care, lead it where possible, and include them in decision-making processes. Many highlighted the need to offer multiple options to help maintain a person's sense of control over their health, but with support.

"Each client is very individual, but maintaining a client's sense of control and empowerment rather than attempting to control the situation helps to de-escalate and build trust"
– PARAMEDIC SURVEY 026

Importantly, while offering choice and wanting the person in distress to be able to maintain a sense of control, participants highlighted that at times people may not know what direction they want to take, but they need to have options available and offered.

"And you know sometimes within mental health services that could be a bit challenging and tricky to leave all decisions, a hundred percent decisions on clients. I think from our perspective is that the essential ingredient of that self-determination is the trust that exists between service recipient and service provider and the method or manner of engagement. If it is a very participatory trustworthy, trusting and respectful relationship that is there it's very easy to get to that self-determination as kind of a process of consensus right. So, this is on an individual level. If your relationship…is very respectful and based on trust and engagement and participation…it becomes easy to get to. Even during a severe mental health crisis… we took time to negotiate with the client to make him understand what was happening, what was best for this situation. Took time to kind of have a conversation and then the patient agreed."
– PARTICIPANT 008 (LEADER OF A COMMUNITY HEALTH ORGANIZATION)

Links were made to the significance of empowering people who are experiencing distress or crisis and doing this through offering choice and a sense of control.

One participant with lived experience of a family member requiring emergency crisis services stated:

Offering the options like all their options and allow them to choose from it. So, you make them feel that they are in charge of what's happening to them. So, I think offering the option, also that could be very beneficial. So, they feel they have a choice, even if they are in a vulnerable position, and you may not think they're capable of making these decisions but at least offering the option that is out there. I think that's also important.
-PARTICIPANT 041 (SOCIAL SERVICE WORKER AND FAMILY MEMBER OF SOMEONE WHO HAS EXPERIENCED CRISIS)

Another participant with lived experience described how detrimental it was to feel she had no choice at all when she called for help.

I called 911. Because that is what is taught, 911… especially imagine somebody who just comes to Canada, they have been here for six months or a year…anything goes wrong, call 911... They will come, they will help you.

And I understand that the intention is to help, but it's also how we help... So, the cops showed up to my door, they asked me what's going on. I said, I'm feeling suicidal, and I felt I needed help. And everybody said to call 911, so I called 911…And now when I think about that person of me, I'm like, wow, I was really naive. I was very blindly believing what's being told, and blindly trusting the authorities. And then the cops came, and they said, "OK, we're going to put you on handcuffs, and then we're going to take you to the hospital." …My mom's like, "What? Why?" And then I'm like, "Why?" And they're like, "Protocol." OK, and then they put me on handcuffs, they put me at the back of the cop car and I felt like a criminal…And I'm like, where are they taking me? How long am I going to be kept there? It was one o'clock at night. And then they took me to the nearest hospital... I think I waited for four hours for a social worker to show up. And then at 3:30 or 4:00, a social worker showed up and I spoke to them for an hour. And then I waited a little while and then they discharged me at six o'clock in the morning. And then I got home. And that left an imprint in my head that never call 911 for anything at all.

-PARTICIPANT 048 (LIVED EXPERIENCE OF EMERGENCY SERVICES FOR A MENTAL HEALTH NEED)

This same participant went on to further describe that if a different approach had been taken, it could offer a feeling of greater humanity and ultimately hugely improve the experience of the person in crisis.

And I'm not saying that, never use handcuffs or anything like that and I'm not saying never take them to a hospital to help them see a social worker, but how you do it. If you go on, pulling up the handcuffs and being like, "OK, we're going to take you to the hospital." I'm going to be on the back and be like, "Nope, no, no, no." So, let's go to the hospital, we'll see what's going on, we'll talk to somebody. Whatever. So how to make the de-escalation, the intervention more human as well, instead of making me feel like a cat that you're just going to drag out of the house, instead of making the individual feel like they're a threat to themselves and the community.

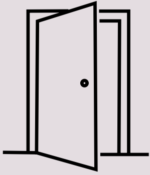
-PARTICIPANT 048 (LIVED EXPERIENCE OF EMERGENCY SERVICES FOR A MENTAL HEALTH NEED)

Participants also highlighted that offering choice and being transparent is crucial across cultures, where it should not be assumed that the same approach will necessarily meet every person's needs. Further, participants described that with the right support people often are able to make choices and understand options even when it might seem that they're not. One participant highlighted the value of lived experience as a peer-supporter and the ability to interact meaningfully with people experiencing delusions or hallucinations.

"When we walk into a situation our job is not to take control, right? If we go in saying, "OK, we're going to take control of this scene and we're taking charge here" …Our job is to slow it down and to figure a way to have a conversation and find the best way to identify what that person is needing and wanting and not using coercion to get people to come with us…we're there to begin a conversation, build a rapport, and connect with them. And also, being able to see what might be perceived as something that might be out of control by other people, but if you have a mental health experience and background you can go in and see that there's opportunity for discussion. Like if someone is having delusions or hallucinations...there's really good ways to connect with people on that way, right? Mental health is health and there is a health response.

–PARTICIPANT 032 (LEADER IN A PEER-LED COMMUNITY MENTAL HEALTH ORGANIZATION, CRISIS RESPONSE).

Where several paramedic participants problematized punitive or coercive "choices" such as "you can go with us, or you can go with police" they also highlighted the value of offering choices to offer the person some autonomy where possible. Examples of constructive and positive choices, included questions such as "would you feel more comfortable walking or would you prefer the stretcher?", "would you like me to give the report for you, or would you rather we do it together?" or "is there anything else you would like to bring with you to feel more comfortable?"



Accessibility

This refers to the ease with which an individual can obtain mental health supports, services and wellness promoting opportunities through all aspects of care from prevention, connection to supports, and other management of their mental health. This includes timely access as well as language and cultural accessibility.

The importance of accessibility was discussed across geographies, communities, and service or sector types. Accessibility related to appropriate options for mental health and related supportive care surrounding crisis. Accessibility considerations included ease of access, publicly funded access, access tailored to geographical needs, and access for specific populations.

Participants spoke at length about the importance of not only access to one type of service, but to a range of services they might need. One individual shared their experience of feeling their access to services was limited to medication when they required other supports for their mental health and wellbeing.

"Because when I told my doctor, he didn't refer me to therapy, he didn't say, "OK, let's get you an appointment for a psychiatrist. Let's get you an appointment for a counsellor. Let's get you an appointment with a nutritionist," something, he just prescribed me pills."
-PARTICIPANT 048 (LIVED EXPERIENCE OF EMERGENCY SERVICES FOR A MENTAL HEALTH NEED)

Participants discussed substantial challenges with publicly funded options either lacking the appropriate options, or substantial wait times if they do exist. Participants highlighted accessibility considerations related to age, culture as well as comfort or preference for non-group therapy when at times that is the only accessible option. It was also highlighted by practitioners that often group therapy, and relatively short-term services are the only available and funded options. While these support some, for many it does not give them time to build rapport and leaves people disconnected after it has concluded. When that short term, group therapy option does not suit people - and they may opt to discontinue it - they are deemed difficult, or non-compliant, when the service was not the right fit for them in the first place.

One psychiatrist discussed significant challenges with publicly accessible care, longer-term access for care, trauma-related distress and for varying levels of crisis.

"I think there's a profound lack of access to longer-term individual therapy. I think there's this idea that people need four months of group-based CBT [cognitive behavioural therapy] and then they're going to be good to go. And the CBT model, while it's great, is not a fit for everybody's difficulties. Folks with complex trauma I find that cognitive level doesn't meet people where they are. They don't resonate with it, they don't want it, it doesn't fit for them culturally, it doesn't fit with their experience. Some folks prefer not to do work in groups…For our folks with complex trauma they don't build trust in four sessions, they just don't. And so, people are experiencing constantly getting bounced either between groups or bounced from…12 sessions of individual here or 12 sessions of individual here and they don't really have access to longer-term treatment. I think honestly that's what would be really stabilizing for a lot of people, having that access to consistent, affordable, longer-term treatments. So that's a gap. Things that do exist you have to wait for months and months and months. It's not great. You're either too sick for the services that exist or you're not sick enough for the other ones. Lots of people are falling in the gap where they're not sick enough yet, so they're…bounced out"
– PARTICIPANT 035 (PSYCHIATRIST, URBAN)

Participants emphasized the need for access to a range of appropriate supports, not a single type of service and not for a single prescribed timeline because individuals differ, and often people benefit from having a longer-term point of connection where they can seek support when needed. Also noted was that long-term medication is often financially supported and accessible, whereas long-term therapy is not. True accessibility cannot be limited to one option, and one option that does not account for the input of the person themselves.

Multiple paramedic and police services participants acknowledged that while 9-1-1 services are extremely accessible to all, as they currently exist, they are not necessarily the right fit, at least not without substantial connection to other resources.

One superintendent in a paramedic service stated:

"I think in the end it's about access. It's not a problem but it is – 911 is always available. Three digits. Easy to remember and we always show up, but at the same time are we the best resource to respond? We'll respond every time, so it makes it a bit easy for… patients with a mental health crisis to call us. And don't get me wrong, there are times where we are required. There is no doubt there but there are other times where there would be another avenue that is as reliable that could be taken, that probably would be a better solution".

– PARTICIPANT 002 (MANAGER, PARAMEDIC SERVICES URBAN/RURAL)

Where it was also identified that inevitably paramedics will attend to calls where there are mental health or crisis-related needs, there need to be multiple options for responders to connect people to care, seamlessly and in a timely way. Appropriate education and options for care contribute to making paramedics both an accessible option and one that can make meaningful connections to other supports.

A substantial challenge identified was the ED as often the only destination for crisis-related care, and participants consistently called for options outside of this.

"We have very few shelters in the [Region] to be able to take those people. And even if we take them to the shelter, there's no guarantee that they're going to get those supports. I won't say mental illness supports, I'll just say those community supports to potentially assist them. I know some organisations here have a grand idea of having a community safe beds program. One facility where it's one door for everybody… But a lot comes down to money, funding, who's going to pay for it? Who's going to staff it? I think we rely far too often on stats. The numbers are – people interpret numbers how they want. And it should be the quality of the service being provided not the quantity. As much as I've referenced some quantitative statistics, I think my personal opinion, we need to focus more on the quality of the service and the services available instead of how often it is or isn't being used."

– PARTICIPANT 006 (POLICE OFFICER, SUBURBAN/RURAL)

An additional accessibility concern related to the onerous process of risk assessment, screening, checklists, restrictive access criteria, and questioning prior to accessing care. In these circumstances, participants discussed avoiding services with so many admission criteria and checklists because it discourages people with such significant focus on "risk".

In terms of geography, where in more populated, urban settings, challenges such as volume of people requiring services, waitlists and costs were central concerns, in rural or remote locations, there were often no services available within an accessible geography, with substantial delays or limitations in access.

One paramedic superintendent who covers a large rural/remote region stated:

"Distance is a huge one. Lack of resources, right? Like we have one ambulance per community with the exception of our community in [region] where they have two ambulances. But to take an ambulance out of our community means that the next ambulance is that much further. Like, our geographical area is just huge. And then I think bed availability, just physician shortage, counselor shortage… There's just so many factors limiting us from having like a super centre if you want to call it. We deal a lot with First Nations in our service. I know that some of the First Nations have opened up treatment facilities for mental health as well as drug and addictions. I would love to…if we had the ability to bring patients there if they could accommodate the capacity.

– PARTICIPANT 012 (MANAGER IN A PARAMEDIC SERVICE, PEER SUPPORT TEAM MEMBER, RURAL/REMOTE)

This example along with other participants emphasized that accessibility means connecting people with the service(s) that is appropriate for them and in a prompt and timely manner, not a one size fits all approach. Accessible supports referred also to specific populations culturally, for children, youth, and youth transitioning to adulthood. Where some participants discussed centralized care at one point as an important access piece, in the cultural context, there is a need for unique options in services and ensuring that community voices are not lost. Accessibility requires specific, culturally appropriate services, such as Indigenous led and run services, services led and centred around Black communities, as well as services that specifically support 2SLGBTQ+ communities, and youth in particular.

Accessibility to appropriate supports was discussed across socioeconomic status, and also among care providers themselves, for their own care, including first responders. Building on the principle that the response received during a mental health crisis significantly affects an individual's wellbeing, participants emphasized the critical need for accessible resources for first responders experiencing distress and mental health challenges. This accessibility is key to enabling responders to provide effective, timely, and appropriate care and for their own wellbeing.

A paramedic underscored this point, stating:

"One of the things that our service did, so our chief … got a contract; so, any staff member at any time can reach out whether it's work-related or personal-related and have unlimited free confidential access to a psychologist, psychotherapist, whatever. And that's been well utilized – I think a third to half of our service have used that. And I'm like that's fantastic because it's accessible."

– PARTICIPANT 007 (COMMANDER IN A PARAMEDIC SERVICE, RURAL)

Spaces of Care

This refers to deep consideration of where care is taking place. Priority factors include adequate physical space, privacy, ability to move away from busy, chaotic spaces, sound, ability to engage with wellness tools, potential for social connection, and updates about next steps.

A "space" of care might include the moment someone is encountered by a care-provider in a community setting, a community mental health organization, an ED, or longer stay settings. Many participants spoke of important features of what and who were included in these spaces, how they are run, and what the care recipient has access to in these spaces. Important features included privacy, space away from chaos or noisy, busy environments, limiting isolation, the ability to interact with others (such as the person's main social connections), a "home-like" feel rather than sterile, the importance of who the care providers are in those spaces, what elements of security are there, and removal of arbitrary time limitations within spaces.

When discussing a hospital stay during a period of crisis, one participant highlighted the pieces they felt were missing and needed for a supportive space of care, including access to wellness tools such as physical activity and purposeful activities.

"I think, also having a robust, positive environment, for people to heal and to work on the challenges that they're having, and to get back on track would go a long way. You know, I think the places that we send people which is usually a hospital needs to be a positive place. And needs to actually have structure. I think a lot of these places, in my own experience, they just, they don't give you anything to do…You're sitting around with little physical activity. You have no one to talk to, unless you're allowed to see your family. And, you have crappy food. It's like, how are you expecting people to then heal and get better?"
– PARTICIPANT 020 (LIVED EXPERIENCE OF EMERGENCY SERVICES FOR A MENTAL HEALTH NEED, ADVOCATE, ACTIVIST)

A front-line worker with over 30 years' experience in a community-based organization described their setting of care, arranged more as a home-like space where people can interact:

"Our setting is not – it's set up different. It's like a big old country house. So, you know, having somebody just see that kind of setting, it also help to settle somebody. Having somebody listen to them, which is a lot of what we do is listening… It's also to give them a different space, a different scenery. Also to get them to, you know, if they are at our place they can interact with other people who are going through similar things. And for them not to feel so isolated or feel so alone or feel like they're the only one, you know, going through it.
–PARTICIPANT 014 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING)

Several participants described a practice of comfort rooms of different sorts, which have been studied and are evidence-based in providing positive care spaces even in acute or emergency situations, but have not, to their knowledge been applied in the Ontario context.

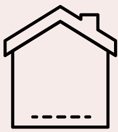
"Quiet rooms…comfort rooms. So, what they would do is … right in the emergency space, where you're going in instead of going right into the emergency, we go into… its comfort rooms, that's what it is. And there's research that's been done…there are quite a few, there in the states. I've never heard of one in Canada… But you go in and it's probably like two rooms in the hospital, where there are peer workers, experienced working with crisis. Quiet, it's all quiet. So, there are spaces that you could sleep. You can have food, you can have music, to have whatever, but you go there first. And the things that you need…you have those. And then you see whether you go on into the emergency or not with a doctor, but a lot of people can with the support, that could be the place. And then what you also get are resources, and suggestions of where you can go to continue this kind of support. So, you're getting that first contact. [Instead of what we currently have] so when you're put off in the corner for 15 hours or 24 hours, whilst struggling with your mental health, you're going to have a peer worker who has had the same kind of experience, and maybe you'll come out of it, right there with that person, who knows. So that's a different experience. So that will change a lot of things if we have that in every single place, but a comfort room would not be, comfort rooms would not be hard to get set up in a hospital.

– PARTICIPANT 034 (SOCIAL WORKER, LIVED EXPERIENCE OF EMERGENCY SERVICES FOR A MENTAL HEALTH NEED)

Participants advocated for spaces of care that do not put arbitrary or unnecessary time restrictions on people and seek to not prioritize a security-heightened space over comfortable places of healing. When there is a need to move with immediacy or force a certain kind of progress, or remove people from a particular space, there is greater likelihood of chemical sedation, physical restraints, or an increase in tension and pressure where violence is used against the person in distress.

The emergency room…what it's like to live in a hospital for a few days or few weeks or a few months. That has to change. White walls, nondescript artwork, you know, you have your free time where you can be in the more public social space, then the rest of the time you're in your room…It's like, I imagine it's what minimum security prison feels like, right? And then there's still the danger of if I say or do the wrong thing I'm going to get thrown to the ground by security and get restrained. Right? …It feels like the nurses are always watching. And security's just around the corner, just – the nurse presses that button you know security's going to…it may not be a nice situation for you. You know. There's one TV that needs to be shared among all the people there…Even, like, playing cards or games or whatever, there's not that much. It feels like a bad day care. And you know, so how do you expect people to get better here? …You barely have any windows. You know, you've got just white walls, nondescript everywhere. The nurses don't really interact with you. They check on you, but they don't really interact with you. You can get restrained at the drop of a hat. You're worried about saying the wrong thing to a psychiatrist, so they'll make you stay longer. The food isn't great. Maybe – you know, someone like me who's large, I probably wouldn't even get enough food to sustain myself, based on I eat a larger volume of food than the average person. Right? So, then I start to feel sick or have headaches all the time. It's not a nice place to be. Right? The other piece is hospitals are not meant to actually get people better. They're meant to get people to a level where they're good enough to release them. It's actually not designed to help people get better. It's designed to help people become stabilized and then you're on your own again, right?

– PARTICIPANT 037 (LIVED FAMILY EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED, CRISIS WORKER, ADVOCATE)



Social Determinants of Health

This refers to the ability to address individuals' social and material needs and living circumstances. Alternative options, outside of biomedical or hospital-oriented services are required, including housing/shelter, food access/security, employment and opportunities for social connection and recreation.

Across sectors and experiences, participants highlighted a holistic and comprehensive understanding of crisis, what leads to crisis, and thus what crisis care supports can or should look like. Participants repeatedly emphasized the importance of ensuring that people's basic needs are met, both preventatively, during crisis, and ensured in follow-up. Often, unmet social and material needs were the crisis and were what led to activation of some type of crisis service in the first place.The ability to address these needs is considered an essential component of a crisis care response.

A psychiatrist working in an urban setting described the importance of meeting basic needs for many of their patients, and the limitations or irrelevance of psychiatric care without having these needs met:

Also of course people just don't have access to basic life stuff that they need. Like so many of my patients are constantly in crisis because they're living in poverty.They got nothing to eat, they're about to lose their housing, they're getting evicted.Their house is full of bedbugs or mould or rats or roaches or their landlord is – you know, whatever. Supportive housing wait lists are – like no wonder people are in crisis, how can you not be in crisis if you have nothing to eat and nowhere to sleep. And there's nothing psychiatry can do about that.You know, like of course you're suicidal and using substances, like it's atrocious. You know, people have minimal social supports, like society is falling apart. Plus, of course, there's the impact of climate change, structural oppression, everything going on in the news. Like how are people supposed to cope with that.You know, people can't, understandably.There's a lot going on that's not about the individual. So that's what I think.That's my rant.You're welcome [laughs].
– PARTICIPANT 035 (PSYCHIATRIST, URBAN)

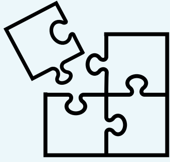
Stable and affordable housing was repeatedly described as a central concern across the province, as well as food, employment, and meaningful and purposeful activities. A person with lived experience highlighted basic needs that need to be met to prevent crisis.

"I think having an amazing preventative culture and you know, tangible programs that can help wellness, like, I think things like having recreational, sports leagues and having things that promote physical activity and the connections between people. Healthy relationships are a huge thing, having more programs like that. I think, having more affordable housing or getting to a point where housing is like less precarious and puts people in tough situations, solving that problem would ease the burden. 100 percent making therapy accessible…I think, the ability to have nutritious food and diet. I think also…building a society that can have less financial insecurity could go a long, long way. I think having a social net, like, a social security safety net is huge.You know, obviously, people are going to struggle if they're on ODSP and they're making, $1,100 a month? Like, how is that - how are you expecting people to thrive if they're getting such a low amount of money?
–PARTICIPANT 020 (LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED, ADVOCATE, ACTIVIST)

Many participants described recreational activities and social connections as crucial determinants of people's mental wellbeing and crucial for both preventing and managing crisis. One director of a community-based organization described how important social activities are for their clients. They described that despite that being the part of their services that the government won't fund, it often seems to be the piece that makes the most difference for people.

And actually, we provide some added value services such as free lunches or free community events, like bowling or going to the movies, golfing, Mini putt in the summertime or barbecue picnic. Every month we have at least two different social activities for our clients. Mainly because we believe that the social aspect of people who have serious mental health illness is largely neglected and not funded at all. Like we don't get any money from the government for this kind of services. Simply because the government is more interested in work or going back to work or going back to school, right? And this is purely for the socialization purpose, right? Which I find equally important but quite underestimated, I think. So, we do organize a lot of those events and outings… And people wait for it, and they love it. And we pay for everything, including lunch and the transportation. But this is money, as I said, that comes from our fundraising money not government funding.
–PARTICIPANT 036 (CLINICAL DIRECTOR, COMMUNITY ORGANIZATION, URBAN/SUBURBAN)

Ubiquitously, meeting social and material needs was identified as a significant component of crisis care and crucial for prevention of crises.



Collaboration

This refers to the need for involvement across sectors, professions, services, coalitions, and formal/informal support groups. An ability to draw on resources and make connections for a range of needs including acute de-escalation, ongoing therapy or counselling, alternative non-medical care options including peer support, housing/shelter services, health services, recreational or social activities.

Mental health and crisis-related service providers consistently spoke of a need to engage with services and support beyond their own immediate organization in order to meet the needs of people experiencing crisis. Many community-based organizations do this a great deal, but many paramedic services, hospital, or ED-based services identified this as an area needing much more attention.

One participant from a community mental health organization indicated that collaboration is a necessary part of their work:

So that's sort of an overall arching philosophy…that there's no wrong door to get through to us. And so, anytime we can create partnerships and connections with other resources we do that because – well, I mean, we could just be a crisis centre, which would be ineffective. It needs to be a crisis centre that goes somewhere for people, that we connect people to resources, et cetera. So that's sort of how we came about, and we've evolved over the years.
–PARTICIPANT 032 (LEADER IN A PEER-LED COMMUNITY MENTAL HEALTH ORGANIZATION, CRISIS RESPONSE).

Several services described that connecting to and collaborating with other services and resources is crucial given limits to their own available resources, as well as acknowledging that people may already have connections that work for them, and the need to work together.

So, we don't have many resources. So, what I do, I try to make connections. So, say, for instance, if clients say, "Oh, I was seeing this psychiatrist. I was going to this community service centre. I was talking to this housing worker." Guess what? I get the name, the numbers and I build up that relationship, because I could use that network for another client. So, I don't know how everybody else does it. But that's how I do it. Because we don't have all of the resources – we have no resources. We only have [our organization].
–PARTICIPANT 051 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING)

Paramedics identified that they may continue to see individuals repeatedly and in isolation, with little connection to other resources other than the ED. For some who meet paramedics or police through the 911 system, the emergency system is the only connection they have. Given that emergency services continue to be accessed at times exclusive of other community services, there is a need for integration and coordination between these systems. Participants identified that without collaboration across multiple sectors and services, people will repeatedly engage with emergency services, and not develop longer term solutions. Enabling dialogue and recognizing strengths and contributions across services was seen as crucial for providing holistic support to individuals experiencing crisis and supporting them through all stages of crisis including prevention.

One police service described that they recognized a need to adapt their ways of working to work with and bring different service providers together:

We've changed our role a little bit…It's one of those things that we figured out that we had to adapt to…we tend to be the hub of bringing the services together, and actually getting everybody on the same page and getting everybody talking, because we tend to deal with the individuals more than any other service. The other services aren't even aware that we're dealing with them [the client] on a regular basis, because their clients aren't telling them that they're getting in trouble or that they're obtaining our services. Many clients don't like to admit that they actually get along with the police and the police help them... Just really sharing that information and making sure that everybody has the same information, is on the same page and can best support…We have our regular clients that were utilizing police resources by calling in just for minor things that aren't police matters. They can't get through to the crisis line, so they were calling the police. They weren't able to deal with, I'll say minor issues, to us, but major issues to them where their anxiety levels just went through the roof, and so, they would self-admit to the hospital using EMS [Paramedic] resources for transport, or police, and as well as using the hospital, just because they needed somebody to talk to.
–PARTICIPANT 016 (POLICE OFFICER, RURAL)

For those, particularly in more rural areas, or for paramedic responders with few or no existing formal collaborations beyond police services, participants indicated a real need for improved collaborations and this as a primary means to meet the needs of people in crisis or distress. Importantly, those working in hospital settings did indicate the importance of other services, but do not always have formal collaborations or smooth connections from ED to other services. At times, mental health services are described as 'siloed', lacking connections between them. This was most frequently described in relation to the ED setting, however essentially all community-based organizations we spoke to described frequent collaboration with other services as a necessary part of their functioning.

Ultimately, a need for mutual respect between service providers and any others interacting with people in crisis was identified for services to collaborate and meet the needs of people experiencing crisis.

We're starting to see each other as just people working for the common goal to mitigate harm, to make an accurate assessment and get these people support without criminal charges, without apprehensions. We need police. We don't have apprehension rights at this time. We cannot apprehend without police present, which is fine. That's not a problem. What's working is this community-based approach.
– PARTICIPANT 053 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING)

Community Engagement

This refers to services being directly community-informed, engaged, and driven to ensure that the needs of community members are addressed, and there is full inclusion, participation and empowerment of community. Community refers to the diversity between and within groups, including people who are of lower socioeconomic status, Black, Indigenous, People of Colour, 2SLGBTQ+, immigrant, English as an Additional Language, and those who are mental health service-users among other marginalized groups.

Mental health and crisis-related service providers consistently spoke of a need to engage with services and support beyond their own immediate organization in order to meet the needs of people experiencing crisis. Many community-based organizations do this a great deal, but many paramedic services, hospital, or ED-based services identified this as an area needing much more attention.

Participants who were service providers described different ways in which community engagement might occur, one of which is representation of the communities being served within the staff providing services. Having Black or Indigenous care providers, for example, was one important example of community-engagement and offering an improved feeling of safety for the person in crisis.

One psychiatrist described the gap and the potential improvement to care with such changes:

And you know what else would be great, I think more culturally specific and responsive services. Like I think people would feel so much more comfortable if they could choose – like for me. I'm a woman, if I go somewhere for treatment I do want to see another woman. I would want to be in a woman-specific program, I would want to be in a setting that matches with my identity. So even though I can't really understand what it's like to experience racism or to be Indigenous or something like that, in my mind it's like when somebody says to me, "I would really much rather work with a racialized therapist." Or, "Can I see a Black psychiatrist,?" Or "Can I see an Indigenous social worker?" … I think we should be able to offer that. I think people would feel so much safer and so much more comfortable if they could be embedded in environments that are culturally a fit for them and they're around people that they feel understood by and are not the source of their trauma…that's what I would like to see.

– PARTICIPANT 035 (PSYCHIATRIST, URBAN)

Repeatedly, participants described the importance of ensuring that mental health and crisis-related supports be aligned with the communities they serve. They advocated that these services be informed by, led by, and in many cases provided by people whose identities align with the person seeking support across race, ethnicity, gender identity, sexual orientation, language, and lived experience of mental health (such as peer supporters).

And I think that well, right off the bat, what's your staff, you know, have you got somebody who can speak my language for one thing? Understands my culture, understand, maybe understand that what somebody's going through, that's a culture and the way it's playing out, when they arrive, if they arrive, where somebody is struggling, is that there's so much culture that, that that is perfect.

–KI 034 (SOCIAL WORKER, LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED)

Other participants, including those with lived experience of engaging with crisis services, their families or loved ones, and service providers describe that representation and embeddedness of community within services is significant. This includes representation for those who are placed in group therapy settings – where being placed in a group of all or almost all white participants, or all middle aged to older participants when the person is racialized and in their 20s is problematic for their level of comfort and feeling of safety to address their own lived experiences.

One organization described their approach to community engagement and working with diverse communities. They emphasized the importance of not pretending to be experts but rather asking and learning from and with the communities they serve, and deeply engaging with the perspectives of their employees from diverse communities. In addition to their employees, they also discussed the importance of bringing in community members from different populations or groups and involving them in the guiding and direction of their work.

We need to be mindful of all the different ways we can do things differently. We need to be humble and ask our employees for guidance. We need to call ourselves in when we – intention versus impact… We name it – again we're not like, whoa, miracle workers; like I don't want to give that impression, like it's hard. We don't always do it right and I would never pretend that we do. However, we have a system… a belief, a commitment; a commitment to doing better you know? So that means having difficult conversations. That means naming our discomfort, naming our fragility. We have anti oppressive, anti racist, diverse policy, procedures.
– PARTICIPANT 030 (DIRECTOR OF A COMMUNITY-BASED SOCIAL SERVICE ORGANIZATION INCLUDING HARM-REDUCTION SERVICES, SUBURBAN/RURAL)

The same participant went on to describe the shifts they have seen because of these organizational changes:

And what we have 100 percent seen, and I hope this is said in a very respectful way, is when people are represented in our services we see a shift, so we saw an increase of Indigenous people come in when we have Indigenous staff. I think it went from 5 percent to 17. We historically did not have people who were Black coming to our services. We did not. I'm just going to name it; we didn't. When we intentionally went into diversity – and you know it's not like – again that place of ignorance is not OK; like our strategies – we didn't have strategies, right? And so we reached out. How do we post our job postings in places where people who are Indigenous are going to be looking for jobs and people who are Black… How do we do this better? So we went on a journey, and we're still on that journey.
– KI 030 (DIRECTOR OF A COMMUNITY-BASED ORGANIZATION INCLUDING HARM-REDUCTION SERVICES, SUBURBAN/RURAL)

The lead of an organization whose priority community to serve is the Black community emphasized the importance of community empowerment and described what this might look like:

We also have a principle such as self-determination. So, what we do is to try to build the capacity of the community, so they are empowered enough to make decisions about their health, whether it is to health education, providing self-help, self-management programs and services, and things like that.
– KI 008 (LEADER OF A COMMUNITY HEALTH ORGANIZATION)

Another participant described successful engagement of peers (those with lived experience of mental health or addictions-related challenges) in emergency settings as another form of community-engagement and empowerment.

So those are some of the things that we advocated for, and sometimes we were successful. And the longer the peers are[were] in the ED, the more information doctors were getting. So really interesting, some of the really glaring successes that the peers had, is that they could build rapport very quickly because they weren't clinicians. They were just people with lived experience. So, they make connections. And as another example working in the ED, there was a reoccurring patient coming back and forth to the ED. When the peers got involved, we found out background information that the doctors, the nurses, the psychiatrist or therapist could not get because we had a conversation. And in that conversation, we found out that there was sexual abuse. And that made a huge difference to the clinicians of how they would move forward in the treatment and care plan of that client. They had no idea why that client was using substances, and what happened. So those are some of the ways that we change the lens of how the clinicians approached the marginalized population. And so, the peers were asked to go talk to and evaluate and assess before the doctor showed up, because they knew that the doctor would not get that information, but the peers could.

–PARTICIPANT 053 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING, PEER WORKER)

Community-engagement highlights the importance of meaningful engagement with and empowerment of communities with humility, continuous, ongoing reflection and a willingness to change how things have been done previously. Importantly, having communities engaged and empowered means acknowledging the impacts of anti-Indigenous racism, anti-Black racism, all forms of racism, homophobia, transphobia, and xenophobia, and having this awareness central in crisis response. There is a need for continued and ongoing concerted efforts to develop policy, ways of doing, and systemic mechanisms to address these barriers.

Trauma & Equity Informed

This refers to employing trauma-informed approaches in interactions and ensures trauma-informed spaces, inherently embracing anti-oppressive principles. It acknowledges the broad effects of trauma on individuals and their well-being, actions, and circumstances. This includes recognition of distrust of communities in mental health services and the impacts of historical and ongoing trauma.

Participants with lived experience of mental health crisis along with many care providers from community-based organizations explicitly called for trauma-informed (as well as trauma-specialized) services. Participants described significant ways in which the "care" and services they receive at a time of crisis are often traumatic in and of themselves in the ways in which they're carried out when they are not trauma-informed.

When you put a tranquilizer into somebody, or you drag them - because I've got this vision right now…of being dragged down the hall by three…because you only have superhuman strength. I mean, it's life and death, right? Dragged down the hall and then given the biggest shot that just took all my – everything away until I woke up the next day, and I didn't know what had happened to me. And that's the worst thing too, you know, all of that. That's trauma, I was traumatized. I was totally traumatized by that experience. So, and of course, you're hearing me over 30 years and I'm there right now, just remembering this.
–PARTICIPANT 034 (SOCIAL WORKER, LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED)

Inherent within trauma-informed approaches to care is prioritizing 'what happened' to people and seeking understanding of their context rather than only seeing 'what's wrong' with someone or what their symptoms or diagnosis are at that time. One participant described her experience with intimate partner violence, where police were called, and despite the intensely traumatic situation she had just experienced, based on her reaction and response, her mental health was called into question. She described that this furthered her reluctance and genuine fear to ever call 911 services again. Other participants also highlighted the importance of mental health and crisis-related supports that see a person and their context rather than 'signs and symptoms' of illness.

And so, I've always had that interest and didn't find my way to the work that I'm doing today until I had a brush with the mental health system in the early 1990s. And the funny thing is that - all the interviews with a psychiatrist and whatever else. Did they ever really asked me what I was doing and what was going on for me, and trying to find out what why I'd find them where I was? Never asked once. And there was no way that I was going to tell them because it wasn't anything that I wanted to talk about…And I was frightened anyway.
-PARTICIPANT 034 (SOCIAL WORKER, LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED)

When considering what trauma-informed spaces and care interactions look like, repeatedly, participants described the significance of who is present in a space of care. Of significant concern is the presence of armed law enforcement. Others identified that having uniforms or police cars arrive was traumatic for individuals and their families. Several racialized participants highlighted the stigma experienced and concerns they had about having police frequently attend their family's home and that this could be particularly problematic within certain neighbourhoods and traumatizing for the person and their family.

One police officer described the experience of a family member who was taken to hospital during a crisis with police officers, and their concerns that this presence worsened the experience.

A family member of mine for example was taken there [the ED] once and the stigma attached to two police officers, especially uniformed, standing there with you while you're in crisis, I think is actually compounding it even more.
-PARTICIPANT 042 (POLICE, URBAN)

One of the ways of carrying out a trauma-informed approach by some participant responders was to change the nature of responding services. These changes include changes to attire, vehicles, not having responders with weapons when there is no indication of active violence, and centering care around consent.

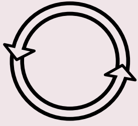
So, we need consent to move forward with any…and we are also trauma informed, and client centred…So we really, as policies and procedures, it's consent based. When we gain consent, we work with them. I tell my clients, "I am your co-pilot, you're the pilot. You tell me what to do, and I will help you do it." That's how we work. My role, and I'll tell you how I look at that, is that I do my best to build rapport with my clients. I'm human, I understand I don't have all the answers.
-PARTICIPANT 053 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING, PEER WORKER)

One region was reported to require that services be trauma-informed to receive funding. A leader in a community-based organization in the region described the ongoing training of new and older staff, and willingness to integrate different programming and means to develop their trauma-informed approaches to care. Importantly, to be trauma-informed means recognizing the many reasons people may have difficulty engaging with mental health-related services.

Being trauma-informed accounts for the historical and ongoing impacts of colonization, racism, homophobia, and transphobia within healthcare and emergency response systems. It acknowledges the harms that have come to people from racialized communities including, Indigenous, Black, and people of colour, as well as 2SLGBTQ+ communities via systems that have professed to care for their health or their mental health. Being trauma and equity informed acknowledges that based on these historical and ongoing lived experiences, interaction with these services in and of themselves may well be traumatizing for people and are likely to increase fear and distress when someone is experiencing crisis. This may be related to past trauma with these services, other emergency services, or other systems and services that are representative of people's traumatic experiences of colonization. To be trauma and equity informed means considering other options and ways of doing in order to provide equitable care. To recognize and account for the distrust in systems, as well as people's logistical and experiential barriers accessing care systems requires patience and flexibility. There is a responsibility for care providers and services to not contribute to ongoing and future trauma.

One of the things that I was kind of shocked of when I first got into this program was that if somebody doesn't return a call, if somebody doesn't show up for their first meeting, they're almost canceled. They're put on the backburner, but dealing with these people, they don't have cell phones, or the cell phone number that they had last week doesn't work, because they don't have that phone anymore, so they're text apps and they're email. They don't have the ability to even check an email, or it may not even be high on their priority for that week. There's very limited ability for the services to follow up. It's the triage. Those that want help, the help is there. Possibly, the help is there. Those that are wavering, they might be the ones that need it the most, and they get pushed to the back.
–PARTICIPANT 016 (POLICE OFFICER, RURAL/URBAN)

Participants described that removing overly restrictive policies and pathways to care for clients is particularly important and may be very dependent on an organization's mandate. Zero tolerance mandates may often miss the mark on being trauma and equity informed and accounting for people's past and current realities. Recognizing that care providers will often have to reach out more than once and allow more time for people to build trust and willingness to engage with services, however, are examples of trauma-informed care in action.



Continuity of Care

This refers to care after an initial encounter with a crisis team, hospital, or institution that takes place in a timely manner, ensuring people remain connected between service engagement (including non-medical services), and are not isolated or unsupported in transition to subsequent service usage.

Both care providers and people who have experience of using services described the importance of decreasing wait times for follow-up care, as well as smoothing transitions from one type of service to another. While the crisis response is often quite immediate, the supports that help manage the challenges that have led the person to a point of crisis need to also be prompt and not leave people isolated in between and at all three stages of crisis.

I think one thing that could be really improved is kind of like an aftercare program. Like after a mental health challenge happens, like a mental health crisis, or, you know, an emergency situation. I think, something that a lot of people will probably struggle with, I know I did, was after. You know, probably many times, you'll end up in the hospital…I think sometimes re-entering the world can be quite intimidating after, in some ways a hospital stay, whether for, a few days, but especially when it's like a month, or even one time where I've been in the hospital, in psychiatric care in [region] for like three months. I think, you are in some ways, institutionalized in that time. And I think having support would go a long way in terms of you know, trying to work through these things and supporting people. I think there's like, three phases that you can look at, you can look at, like the pre-, which is like the before to try and prevent it. And then there's like, the actual response, which is like the middle, which is like, the key time in terms of ensuring safety. But then there's the after, which is so important for preventing it from happening in the future and ensuring wellness in the person.
–PARTICIPANT 020 (LIVED EXPERIENCE OF MENTAL HEALTH SERVICE USE FOR A MENTAL HEALTH NEED, ADVOCATE, ACTIVIST)

One organization that provides crisis response along with a range of other services describes how they have aimed to have rapid follow-up post-crisis.

The de-escalation process then to say… "There's going to be somebody who's going to follow up with you with regard to this A, B, C issues." And our crisis response, case management, post crisis case management response is to call and make contact within 48 hours. Right now, our case load is not that great so it's probably the next day. If it's not the next day, the next day crisis response team would do a quick check in to say, "We responded yesterday, how is it going? Somebody's going to contact you. It will be either today or tomorrow is there anything we can do as well?" So, there's also that check in that makes people feel that somebody is there to support, and they can listen to, and their experiences and situation has been validated.
– PARTICIPANT 008 (LEADER OF A COMMUNITY HEALTH ORGANIZATION)

Limited or no supports after an encounter in the ED were frequently described. Post-hospital supports that are accessible in a timely manner and meet the needs of the individual were identified as a particularly important way to prevent people from repeatedly ending up in crisis. One participant who works in social services for unhoused people described the supportive transitions they could envision from the ED or other hospital stays.

I would love to see supportive housing post-discharge from emergency or post-discharge from surgery. I would love to see that. I would love to see more emergency services for moms and children. Women Shelters are overrun and always at capacity, there's not enough. I would love to see, like I said, supportive housing in general. Also, supportive housing post-discharge from the correctional world…I would love to see more collaboration in actual emergency rooms for people experiencing homelessness. I know that in [region] it's very taxing on our emergency departments right now for having a bunch of people coming in for – because they're just trying to get somewhere safe to stay for the night, so some sort of collaborative piece that maybe we can then piece back together to that supportive housing, being discharged from hospital.
– PARTICIPANT 027 (MANAGER IN A COMMUNITY-BASED ORGANIZATION SUPPORTING UNHOUSED PEOPLE)

Continuity of care after a crisis was often described as something that might happen collaboratively, among different services. Paramedics and police described that if it is emergency services that attend to the crisis, it will likely be a collaborative connection to other service that will be important for ensuring follow-up support. Of real importance is that the referrals that people receive will be made and care accessed.

We do continuity of care planning. And that's a collaborative – and typically that may be people of high acuity, frequent contact with first responders, as well as other services like our own and hospital. And so that involves getting those key players together, and that may include police, paramedics, and come up with a plan – and hopefully it also includes the individual – and come up with a plan that better meets their needs, and often a piece of that is ensuring consistency, consistent messages, some of those pieces, and that can be tremendously helpful. But it can be a lot of work to get everybody together at the same time, the same place. And it can be challenging because people may have different perspectives right? Or – and often it's different perspectives of other services, like you should do more or you should do this. The hospital should just keep this person, or this or that. So, it is – those are two opportunities to learn more about all of the partners and what we do, and we don't do. Which I think any of these opportunities for collaboration are really helpful that way.
– PARTICIPANT 021-022 (SOCIAL SERVICE WORKER, URBAN/SUBURBAN/RURAL)

Continuity of care was also linked into the idea of prevention. Where supports exist for people ongoing, there is less likelihood of people reaching a point of crisis that brings them to the ED. One ED nurse describes some of the preventative care she envisions.

I would love more outpatient resources. Like that, I feel like would be huge. People that can go and depend on a therapist or someone to talk to, week per week or in an emergency. Family doctors who can check in on patients and say, hey, how are you doing? I don't know what other doctors do. But my doctor checks – even with a regular physical checkup, she says, OK, but mentally, how are you doing? I'm like cool. Yeah, great question. Love it. So that I feel, we're really lacking, we're really lacking…And so why don't we help people through that? ...So, I would love to see better and more available outpatient resources for these patients. That I think would prevent at least your middle ground mental health patients, come through.
– PARTICIPANT 046 (ED NURSE, RURAL/SUBURBAN/URBAN)

Safety Considerations for Care Recipients and Responders

Full engagement with this framework is intended to work toward creating the conditions for safety for both the person in need of support or care, and the care provider. Essentially all care provider participants identified that their organisation or team has safety protocols, plans, and policies that included things such as: plans for leaving the scene if needed, connection to outside communication such as a dispatcher, and ability to contact police outside if needed. Also, all participants who shared lived experience acknowledged the importance of having safe spaces and options during crisis. Many of our participants however, problematised the notion that all mental health related calls or people in crisis are violent and dangerous, and rather, there is a need to create the conditions for safe and effective care interactions.

I think, there's some room for change, but…I think the big problem kind of comes down to, people responding who have weapons, because I think, as soon as you respond when you have a gun, there's the possibility that that gun could be used to end someone's life or to hurt someone. So, I feel like, that's like the big difference maker. I think, that's the number one thing is, someone who has a gun has the possibility to use it. And especially when people are in an altered state of mind, or a state of mind that might not be rational or making sound judgement. I think, having those two things into the same room is a recipe for disaster.
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In terms of who ought to be present in spaces of care during a crisis, multiple participants, including those with lived experience of using crisis services, nurses, physicians, paramedics, and crisis workers problematized having police present with someone in a crisis care setting, both at points of contact in the community, as well as in hospital settings.

You know, someone's in high distress, a police officer shows up in uniform, gun on their hip, probably authoritative in their presentation and voice and even their physical countenance, it might be a little threatening for folks. It might cause folks to become even more activated or agitated. You know, folks might have had bad experiences with police in the past and that might escalate a situation. So, there's a lot of risk involved in that respect where situations can get worse instead of getting better when police arrive. And I think, you know, it's easy to just blame police for that, but I think it's a much more nuanced conversation that needs to happen about why it is that way. But regardless, police officers are not the best option. The other part of that discussion is why, you know, they're not the best option because how can they help? Like, police officers are not mental health workers. They're not crisis workers. Not community crisis workers anyway. But they're police officers, right?
– PARTICIPANT 037 (LIVED FAMILY EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED, CRISIS WORKER, ADVOCATE)

Some care providers and some participants with lived experience identified that they had positive interactions with police officers attending a crisis. Systemically, however with the role of law enforcement, and the possession of weapons - specifically a gun - along with uniforms, there is an increase in tension and escalation that very frequently occurs.

And so sometimes that trigger piece is there for a lot of our clients when they are seeing police, if our clients are seeing… or PIC[person in crisis] seeing the uniform aspects. So, all of those pieces for us are important and they're all factored into how we decide to engage. And where we decide to engage.
-PARTICIPANT 052 (CRISIS WORKER IN A COMMUNITY MENTAL HEALTH ORGANIZATION IN AN URBAN SETTING)

Specifically, concern for the safety of the person in crisis was highlighted repeatedly for racialized and Indigenous communities. Participants both who identified as being from a racialized community, as well as those working with racialized communities spoke of very real fear and distrust that in particular, Black and Indigenous communities experience with service providers (both police and within the healthcare system). People shared personal experiences and stories as well as referring to recent international events and those local to Ontario.

Importantly though, concerns for use of force and safety issues for those in need of support were not exclusive to police. Participants identified that concerns do exist within some interactions with paramedics and frequently in ED experiences. The feeling of a need for immediate action or intervention, even when other avenues for support exist, does not allow time for de-escalation to be attempted. Subsequently, the use of chemical and physical restraint and sedation was also a significant concern in many situations and identified as immensely traumatic in EDs and by paramedics. There was recognition that often ED spaces are largely not designed for de-escalation and do not have spaces of care designed to support people in mental distress, lead to heightened situations, rapid responses and intervention, and few other options than restraint, sedation, and police presence in these spaces of care.

Participants - both care providers and those who shared lived experience of crisis, spoke of the fear response that many providers have in attending to mental health calls, often perpetuated by media and other commonly held stereotypes about mental health challenges. Participants recognized that based on a person's presenting identity, there are real concerns for how that crisis response will look.

You know, it's hard for me to say what the people who respond think when they kind of see me because I do visibly - I look kind of like, white, but I also am like mixed race. I'm like, half Latino. So, I don't really know, ...how I'm perceived by others, but I'd say I feel like, you know... maybe, not looking incredibly physically imposing is something that [I'm] seen as less of a threat, which...maybe has helped my safety.
-PARTICIPANT 020 (LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED, ADVOCATE, ACTIVIST)

Many participants acknowledged higher rates of criminalization and real safety concerns for these populations based on identity when interacting with emergency services. One participant spoke of concerns for queer, trans, and racialized people during mental health or substance use related crises.

And we know that queer and trans people, racialized people are all overrepresented in terms of the criminal justice system in general.
-PARTICIPANT 038 (SOCIAL WORKER, ADVOCATE, RESEARCHER)

Participants identified that when response to crisis comes from a place of fear, it consistently heightens the situation for all involved, rather than recognising that the person in need of care or support is also afraid and has quite possibly had experiences of violence used against them in the past.

Ideally, we need people...who has the mental ability, the emotional intelligence, to how to deescalate, instead of fear their own safety, or be in that hyper arousal state. So the way I see it is that these cops were, from the beginning, were probably in a hyper arousal state to begin with, and then they acted out of that hyper arousal state, right. So we need people trained enough to try to deescalate the situation, but that begins with them being able to deescalate within themselves, any form of anxiety or fear regarding that situation.
-PARTICIPANT 048 (LIVED EXPERIENCE OF EMERGENCY SERVICE USE FOR A MENTAL HEALTH NEED)

Safety

is not identified as a separate component of this framework, rather it is intended that the conditions of care developed by these components support the conditions of safety and lead to safer care interactions for all involved.

The following care features have significantly, positively impacted care interactions, de-escalated individuals, and avoided violence and further safety concerns:

- Providing choice to the person in distress, and explanation if choices are restricted
- Relational care that builds trust and rapport with the individual, making the person feel safer, and less afraid, since it is often fear that leads to escalation
- Appropriate spaces of care, informed by the needs of people with lived experience
- Addressing people's basic, urgent needs and social determinants of health,
- Having community-engagement and community leadership guiding these approaches in the form of peer response, community-service led response, and representation and diversity across community responders, representative of the communities they serve

The approach of individual care providers is imperative, and so are the systems in which they have options to provide care. Addressing these pieces has the potential to lead to safer, more positive, trauma-informed and recovery-oriented interactions for care recipients and care providers.

Responder and Care Provider Support and Wellness

To implement the framework, it is imperative to note the dependency on support for the responders and care providers interacting with the person in crisis. In terms of support for these calls, challenges related to training and preparation, staffing and resources, lack of additional resources (such as appropriate community referrals and pathways of care), feedback and follow-up information on calls, were discussed. Additionally, responders' own sense of lack of alignment with their roles is also presented as a challenge. Ultimately, ensuring that care providers are supported, and their own wellbeing addressed, will enhance responses to those in crisis.

In both interviews and surveys, many respondents noted the impact to their own mental wellness or stress that comes with a lack of training on mental health, lack of time (going 'call to call'), lack of services within the community and the feeling of not being able to provide the right care. The support that responders must prepare them for calls, and once on scene, is significant for both the call itself, and the wellbeing of the responder. Similarly, the responder's wellbeing has implications for the way they're able to provide care.

One paramedic participant stated:

"Our paramedic system does not work for mental health crisis. We try our best but the only "training" we have is our own learned experiences in our own lives or through dealing with AMH [acute mental health] calls in our career. So, if we have been doing it wrong then we continue to do it wrong. Or we learn from our mistakes but then there was a person on the other end of that mistake.
-PARAMEDIC SURVEY 022

Many participants discussed that their own ability or confidence to respond to persons in crisis, was a result of their own independent training they have been involved in or personal or familial circumstances they have learned from. Many noted the strong need and hope for increased training on mental health crisis care. When asked about what other experience (outside of paramedic training) care providers have that informs their response to mental health-related calls, paramedic survey respondents frequently referred to experience within their personal life:

Experience with my own mental health struggles and navigating the health care system.
-PARAMEDIC SURVEY 034

I have family members that struggle with mental health, so I have learned through them and their supports how to deal with the situations a bit better
– PARAMEDIC SURVEY 040

It is important to recognize that certain challenges for responders with mental health-related calls both lead to increased stress and distress surrounding these calls but also concerns for the type of care that they're able to provide. Both limited feedback, and concern for the appropriateness of their role are examples of these.

Some participants noted that in moving "call to call' there was an inability to be able to learn from challenging mental health calls compounded by limited information sharing related to personal health

information protection. In addition to the interpersonal impact the crisis can have on the responder is the challenge that can come in not knowing the impact of their own response and intervention.

I don't get to see the outcomes of people I have attended to. I don't know if bringing them into the hospital actually resulted in them getting medication that helped them manage their anxiety or depression. I don't get to find out if they spoke to a crisis worker and were set up with counseling to address the childhood trauma that they've been trying to ignore/numb.
-PARAMEDIC SURVEY 012

Another paramedic highlighted that not only do they not know the outcome, but they don't know if the care they provided was competent or appropriate, with little standard to guide them.

How do you measure competency with that? I don't know. And then, you know, there's no feedback for the paramedics to be like, "Hey, you know, you were right about suspecting this" or, you know, "You missed this, these are signs that you could have looked for."
-PARTICIPANT 007 (PARAMEDIC, RURAL)

For paramedics, knowing that they had a meaningful contribution is often easier to measure on other medical or trauma emergencies where the impact feels more tangible. Having further education and awareness about appropriate care for mental health crises as well as further developing de-escalation and relational care skills, could contribute to keeping responders engaged in the work, feeling positive about their contributions, and reducing burnout.

Several police participants acknowledged concerns about whether or not they are the right resource to respond to mental health-related calls. For example, with one police survey respondent selecting: *"I am able to provide some of the care/support, but more options are definitely needed"* (Police Survey #001) and another selecting *"I am not the right service to be providing this support"* (Police Survey#012). It presents important insights and concerns that responders recognize the real limitations to their response, and that they may well not be the appropriate responder. These limitations both impact responder stress and can be reflected in the ways in which calls are carried out.

There is a distinct recognition that responders who have been through personal mental health challenges (be it their own, family, friends, or colleagues close to them), can in fact positively impact how they attend to these calls and may bring them a different perspective. Also, however, is recognition that when responders are feeling unsupported in their skills or the resources that are immediately available to them to attend to these calls, there is concern for both the responder's stress on these calls and the quality of care they provide. Further, outside of only the context of mental health calls specifically, when responders are depleted, distressed and unsupported, there are impacts on their mental health and wellbeing, and the quality of care they are able to provide for those in crisis.

Support for the responders and care providers and ensuring their wellness are necessary and required within this framework. Ensuring that we are not sending depleted and distressed responders to support those in crisis is crucial in considering the conditions of care being provided. The result of supporting responders and promoting their wellness, has real potential to improve conditions for care for the person in crisis. It is crucial to this framework that responder wellness is supported through multiple means and immediate support is available. Support may look like immediate opportunity to take time after a call as needed, feedback, when possible, about the response and intervention the responder provided to the person in crisis, appropriate training, and resources which could enhance provider confidence and skillsets for these calls.

Enablers for Framework Implementation

To support implementation of the framework and best practices, five key enablers were identified: *training, stable funding, human resources, advocacy, and responder wellness.*

Training

Recognizing the need for changes in the ways in which care has historically been provided and by whom, appropriate training is an essential component for implementation of the framework. Training outside of medical and diagnostic categories, in particular, training that pertains to relational care, trauma-informed care, the significance of choice, social determinants of health, and training that is led and informed by the communities being served is required. Anti-Indigenous and anti-Black racism training and engagement is an important element of capacity building efforts to improve cultural humility and safety. Given the identified need to change existing approaches, it is important that this training and education is informed by service users and comes from those who have demonstrated experience in crisis response outside of the 911 system (i.e.: training beyond in-house training from police or paramedics). It is imperative that this training is prioritized and included among required training, versus optional, self-directed learning. Cross-professional training from other social services professions who may also provide avenues for collaboration or follow-up may be particularly beneficial.

Stable funding

Community-based organizations identified that stable, consistent funding of crisis response programming and related supports is crucial, but very challenging to get. This necessarily includes funding for the support related to all aspects of the framework (pre-crisis, crisis, and post-crisis), including for example, programming that supports recreation and social-connection programming for people. Sustainability of programs is frequently inhibited by shifts in political and governance systems, putting effective, and supportive programs at risk. Stable and consistent funding offers opportunity to develop and appropriately consider the effectiveness of such programming, not only quantitatively, but also qualitatively.

Human resources

Appropriate staffing is required and must be prioritized to ensure crisis response services' ability to respond effectively, and to ensure continuity of care, providing follow-up services in a timely manner. Appropriate staffing is also crucial in relation to provider wellness. Pay that is reflective of the magnitude of crisis response work, will be conducive to maintenance of human resources, staff retention, and improvement of morale.

Advocacy

Ongoing advocacy work for systemic changes to not only the ways of delivering crisis services, but advocacy at policy and systems levels to address the structural and social determinants of health and oppressive structures of discrimination that negatively impact people's mental health and create crisis. There is real value in grassroots advocacy, advocacy from those with lived experience, and partnership with academia and policymakers where service users' voices are prioritized and upheld.

Responder wellness

There is an important relationship between responder wellness and how calls will be attended to and the quality of care provided. Ensuring support for responders' own mental health and wellbeing is an enabler of this framework and for quality care being received by those in crisis.

Engagement with the Framework and Recommendations

This framework identifies the foundational and fundamental components of crisis care and crisis response ideals. It does not propose to be a logistical or operational guide on how to develop a crisis response team but rather highlights these essential components that should be at the heart of crisis care approaches.

We consider application and engagement of this framework in three ways:

- **Existing response approaches to crisis care**: The framework is intended to support critical reflection and assessment of current approaches to crisis care and response. Through this reflection and assessment, the framework also offers guidance for changes to current approaches and offers ways forward.
- **New or developing approaches to crisis care**: The framework is intended to support development of new approaches to crisis care, where specific supports and services have not been available or established. Those who are developing new approaches to care are recommended to utilize the framework as they consider what approaches to implement that will meet the needs of their respective, local communities.
- **Supporting and training responders**: While the framework highlights important structural and systems level changes, the framework highlights important areas of learning for responders and care providers that can be employed at individual practitioner levels, where appropriate systems supports are in place. In particular for paramedics, police, and those in emergency mental health care settings, training around relational care, choice, the importance of spaces of care, the social determinants of health, the role of community and being trauma-informed offer distinct areas of focus.

Where we seek to better support and prepare responders and practitioners who are providing crisis care, it is necessary to both equip care providers with appropriate training in these areas and develop systems in which they are able to carry out these fundamental components of crisis care to the best of their abilities.

Key Recommendations

- Working collaboratively across sectors to ensure the right responders are present
- Development of community partnerships and collaboration between crisis response services (emergency services) and community-based organizations (outside of hospitals or policing systems)
- Non-police, crisis response as the primary response to calls where there is not active violence
- Development of a fourth "crisis service" option for 911 calls in regions throughout the province, such as has been piloted and demonstrated to be safe and effective in the Toronto Community Crisis Service
- Alternative destinations for transportation (by paramedics, crisis workers, or police) during crisis or in follow-up, outside of the ED and hospital setting, which are non-medical and provide comprehensive supports for care when no immediate medical needs exist
- Expansion of paramedic pathways for crisis and urgent mental health care including transport to alternative destinations, and increased options for those in crisis
- Further consideration of innovative, community-based, peer-led or involved spaces of care, outside of traditional hospital settings, that promote healing, recovery, and wellness
- Inclusion of people with lived experience in designing and maintaining spaces of care
- Acknowledge the impact of anti-Black racism and anti-Indigenous racism and consider systemic mechanisms and efforts to address these barriers, through use of frameworks such as the Ontario Health Equity, Inclusion, Diversity and Anti-Racism Framework and the First Nations, Inuit, Métis and Urban Indigenous Health Framework
- Training of paramedics for response to mental health calls with emphasis on the perspectives of service users, interpersonal and communication skills development, and the social determinants of health, rather than biomedical training focused on diagnostic categories and safety risk.
- Cross-sector education with and between crisis response teams, paramedics, and police
- Facilitate awareness among paramedics and police of available resources and care pathways through incorporating education and training, memory tools, pre-programmed responder cell phones, and through experiential learning opportunities
- Ensure that preceptors or field training officers who mentor new responders receive explicit training and awareness around available resources and care pathways
- Critical re-evaluation of restraint and sedation policies and training within paramedicine, ED, and in-patient mental health settings
- When police involvement is required, revisit policies and approaches to having people exit their homes with dignity when experiencing a crisis
- Housing policy as a crucial element of comprehensive crisis response
- Consider responder wellness and capacity to respond through organizational factors and supports

Social and Policy Recommendations

The framework developed for emergency mental health crisis care, highlights the need for a comprehensive policy response that addresses both immediate crisis services and the root causes of mental health crises.

Housing as a crucial response to crisis

A crucial finding from our research is the central role of adequate housing in mental health outcomes. Most participants emphasized the significance of housing in preventing crises and providing a safe, stable space where individuals who experience distress can navigate without risk of criminalization in public spaces. These insights align strongly with existing literature relating to housing needs and distress.

Individuals experiencing housing insecurity are significantly more likely to report symptoms of severe, psychological distress compared to those with stable housing.[29] Further, housing programs not only improve housing stability but reduce ED visits and improve quality of life for individuals in mental distress.[30] Where the framework proposed in this report emphasizes trauma-informed care and community engagement, there is a need for policy that goes beyond mere provision of short-term shelter or housing. Supportive housing models that integrate on-site mental health services, peer support, and community-building activities have shown promise in creating environments conducive to recovery and crisis prevention.[31] Additionally, as the framework also highlights the need for intersectoral collaboration in addressing issues surrounding mental health crisis response, housing policies have to be developed concertedly with mental health and social service policies to create a comprehensive safety net that addresses the multiple factors contributing to mental health crises.

The significance of income and financial stability

The framework emphasizes the critical role social determinants of health play in resolving mental health crisis response issues. In this context, bridging the income inequality gap emerges as a pressing concern, demanding urgent attention from both political, economic and public health perspectives. This framework recognizes that mental health outcomes are intrinsically linked to broader socioeconomic factors, and that effective crisis response strategies must encompass measures to reduce income inequality. People living in poverty are disproportionately impacted by challenges with mental health.[32] Chronic financial stress significantly impacts peoples' stress responses and has been found to contribute to experiences of crisis.[32-33] Further, living in poverty limits access to social supports necessary for wellbeing which play a crucial role in protecting people's mental and physical health.[32-33]

Specific, focused attention to support northern and remote communities

The framework encompasses the province of Ontario and perspectives from a spectrum of geographies. Specific attention, however, is required to further understand innovative and effective approaches to supporting northern and remote communities. There has been increased attention on mental health crises in northern and remote Indigenous communities in recent years, however, the unique challenges faced by these communities, including their remoteness, harsh environmental conditions,[34] limited resources, the ongoing impacts of colonization[35] and limited access to culturally appropriate mental health services,[36] compels a more nuanced and culturally appropriate approach. Recognizing the cultural, historical, and social contexts of Indigenous communities is crucial for developing effective mental health supports. Further resources and attention to guide this work must prioritize Indigenous-led research, collaborative, community-led approaches, centre approaches around Indigenous ways of knowing, and promoting self-determination in health research.[37-38]

Feedback/Ongoing Reflection

Aligned with the framework's emphasis on continuous, ongoing, critical reflection of programs and approaches, we acknowledge the need for its ongoing evolution. We actively encourage those engaging with the framework to approach it with this mindset.

This work is an invitation to share lessons through implementation, reflection, and further research, while recognizing this is an ongoing process. Importantly, the perspectives and needs of communities and a focus on community-empowerment through collaboration and active engagement need to remain central with ongoing reflection and adaptation.

Resources

Toronto Community Crisis Service

TAIBU Community Health Centre

Gerstein Crisis Centre

2-Spirit People of the 1st Nations

CMHA Thames Valley Mental Health & Addictions Crisis Centre

The Krasman Centre

First Nations, Inuit, Métis and Urban Indigenous Health Framework (2023-2024)

Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework

Mental Health Crisis Support Rooted in Community and Human Rights

Examining an Alternate Care Pathway for Mental Health and Addiction Prehospital Emergencies in Ontario, Canada: A Critical Analysis

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