REIMAGINING POLICING MENTAL HEALTH:

A CALL FOR ABOLITIONIST-INFORMED ALTERNATIVES

by

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Dalhousie University occupies

the ancestral and unceded territory of the Mi'kmaq People.

DEDICATION

To all who have endured the control, pathologization, and containment of their bodies, minds, and lives.

To the Mad survivor-organizers, abolitionists, Black, Indigenous, queer, disabled, and all others who have faced the violence of attempted erasure yet continue to lead the fight for liberation.

From involuntary confinement within hospital walls to the violence of the prison industrial complex.

From disenfranchised communities to occupied lands – from Palestine to all places of resistance.

May this work offer one small piece to the broader, ongoing struggles for justice, liberation, and care.

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ABSTRACT

To date, police are the default first responders to crisis calls in Canada. The involvement of police in responding to crisis calls has been termed policing mental health, which represents one aspect of broader carceral mental healthcare practices. Policing mental health has long existed, evidenced throughout Canada's history, and continues to be upheld by sanism and racism. Recently, civilian-led (i.e., non-police staffed) crisis teams have started to gain traction, however research on these teams remains limited. This thesis employs a multi-sited case study design, including three civilian-led crisis teams in Canada, to explore the key processes involved in their conceptualization, development, implementation, and operation. This research takes a prison industrial complex (PIC) abolitionist lens positioned toward transformative justice and is enriched by the theoretical orientations of mad studies and critical race theory. The findings offer insight into the common elements involved in establishing civilian-led teams, while equally sharing site-specific insights. As an early contribution to a growing field, this thesis advances understanding of civilian-led crisis response and offers critical knowledge for reimagining mental health care in Canada.

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CHAPTER ONE: INTRODUCTION

The criminal legal and mental healthcare systems in Canada have distinct priorities and typically operate under separate mandates (Dieleman, 2014) yet are often problematically intertwined, a relationship that has contributed to the criminalization of "mental illness"[1] (Shapiro et al., 2015). This is particularly evident in crisis response programs, where police are the primary first responders, a practice referred to as policing mental health (Koziarski, 2018). Law enforcement officers are not the sole actors in policing mental health; the mental health field itself has also played a significant role in exercising control and perpetuating racial and colonial violence (Wong, 2024). Historical practices within the mental health field, such as eugenics and forced sterilization (discussed later), along with current mandated reporting practices by mental health practitioners, have actively contributed – and continue to contribute – to the policing of mental health (Wong, 2024).

Crisis situations are often characterized by acute distress and have been described as situations where an individual either identifies as being, or is perceived to be, in "a mental state deemed sufficiently erratic, threatening, or dangerous" (Iacobucci, 2014, p. 49). These crises may result in emergency calls to police reporting concerns about the potential harm an individual may pose to themselves or others (Jackson & Bradford,

[1] Here, I place "mental illness" in quotation marks to reflect its socially constructed nature and the ways it has been shaped by prevailing social, political, and ideological forces. It is not a neutral nor an objective term but one that shifts in meaning according to the dominant norms and power dynamics of a given time. Rejecting the pathologization of human emotions and behaviours is not meant to invalidate, deny, or minimize the reality of people's struggles but rather to resist frameworks that individualize, decontextualize, and depoliticize human suffering. Informed by Johnstone and Boyle's (2018) *Power of Threat Meaning Framework*, I avoid terms like *mental illness/disorder/challenges* throughout this thesis, instead employing terms like *distress/acute distress/emotional distress/psychological distress* interchangeably to reflect my positionality against bioreductionist and pathologizing frameworks of human distress.

2019; Pepler & Barber, 2021). People experiencing distress, especially in public spaces, are disproportionately subjected to police contact, as law enforcement is often the default first responder to crisis situations. (Winters et al., 2015). A Canadian study found that relative to the general public, people experiencing distress are 3.1 times more likely to experience police encounters and that associated crisis or acute distress-related calls can comprise more than 60% of all yearly emergency calls placed to police services in a given jurisdiction (Hoch et al., 2009). Moreover, individuals experiencing acute distress are disproportionately subjected to lethal force during encounters with police (Winters et al., 2015).

The tragic murder of Mr. George Floyd on May 25, 2020, sparked a global wave of protests and ignited impassioned calls to address the harms of policing. The incident, where Minneapolis police officer Derek Chauvin knelt on Mr. Floyd's neck for nearly nine minutes, became a catalyst for widespread outrage and a renewed focus on police brutality and racial injustice (Kaba & Ritchie, 2022). In the aftermath of Mr. Floyd's murder, demands to defund the police gained momentum as activists and protesters called for a re-evaluation of policing practices and the allocation of resources (Pasternak et al., 2023). The idea behind defunding the police is not solely about reducing budgets but rather reimagining public safety and reallocating funds to address the root causes of crime, such as education, mental health services, and community programs (Pasternak et al., 2023). Prison industrial complex (PIC) abolition perspectives, which had long since existed, gained increased recognition within mainstream discourse (Kaba & Ritchie, 2022).

PIC abolitionists have long contended for the complete and total elimination of carceral systems, including policing, in society by taking intentional steps to shift away from our society's reliance on these systems. The abolition movement has developed a political vision that invests in the social welfare and well-being of all by building a world without policing and prisons (Kaba & Ritchie, 2022). Abolition calls for inciting strategic and intentional shifts away from society's current reliance on carceral systems while simultaneously challenging these systems wherever possible in the pursuit of forming larger transformative changes for the future (Kaba & Ritchie, 2022). Ultimately, it is about asking "which changes will build, expand, and reinforce the system we seek to abolish, and which will hasten its demise?" (Kaba & Ritchie, 2022, p. 131).

The numerous fatalities of community members during interactions with police in recent years, both nationally and globally, have contributed to increased attention and criticism toward policing's role within society and the appropriateness of the current system (Marcoux & Nicholson, 2018). Public pressure challenging policing's role in crisis response to calls relating to acute distress has prompted the consideration of alternative responses positioned to mitigate the harms caused by police (Kaba & Ritchie, 2022; Eaton et al., 2024). In Canada, these alternatives are typically framed as co-responder models, which involve the pairing of police with mental health clinicians who are dispatched to respond to crisis calls together (Kisely et al., 2010). Despite suggestions that these teams offer the capacity to improve outcomes for individuals experiencing crisis, including reducing police detention, use of force, arrest, and service user fatalities (Ghelani et al., 2023), the evidence remains limited in supporting these claims (Haag, 2022). Most importantly, however, is that despite the growing adoption of co-response

crisis models in Canada over the past two decades, incidences of police encounter fatalities due to the use of lethal force by police have continued to rise (Haag, 2022).

A growing number of acute distress-related response programs are starting to move beyond co-responder teams and toward civilian-led teams, removing police entirely from being staffed on crisis intervention teams (DeLaus, 2020). These teams consist of trained mental health response workers (including, but not limited to, social workers, psychologists, nurses, and/or trained peers) (Eaton et al., 2024). In Canada, civilian-led crisis response programs are gaining traction, however, limited empirical research has been conducted to understand the processes involved in the conceptualization, development, implementation, and operation of civilian-led crisis response teams.

Purpose of the Study and Research Questions

Civilian-led crisis teams are still in their infancy, both globally and in North America (Livingston, 2024). To date, these teams have gone largely understudied despite their potential as a service model that decenters the role of police within emotional and psychological care services. In response, this thesis contributes to the literature by exploring the key processes involved in the conceptualization, development, implementation, and operation of the existing civilian-led crisis response teams in Canada. The knowledge produced by this thesis offers a tangible means of filling a gap in the existing literature. By examining the components involved in establishing civilian-led models, this thesis offers insights for communities, policymakers, and/or practitioners seeking to redesign crisis response systems. These findings hold relevance not only for advancing the decriminalization of emotional distress, or “mental illness”, but also for

shaping future policy reform, funding decisions, and collaborative practices across sectors.

My research is guided by two objectives: 1) to identify the key processes involved in the conceptualization and development of civilian-led crisis response teams in Canada, and 2) to identify how civilian-led crisis response teams have been implemented and organized, and what factors contribute to their operation. To address these objectives, my research will explore the following questions:

- Research Question #1: What are the key processes involved in the conceptualization and development of civilian-led crisis response teams in Canada?
    - 1a: Which members (i.e., trained peer(s), clinician(s), etc.) comprise the team?
    - 1b: What can be learned from existing models to inform broader implementation strategies?
- Research Question #2: How have civilian-led crisis response teams been implemented and organized, and what factors contribute to their continued operation?
    - 2a: How have civilian-led crisis response teams collaborated with relevant key interest holders to enhance their ability to respond to acute distress-related crises without police and enhance the reach of the service (i.e., hours of operation, areas covered, and communities served)?

I define civilian-led crisis response teams as a response model that includes trained psychological or emotional crisis response workers (including, but not limited to, trained peers, social workers, psychologists, and/or mental health nurses) and no law enforcement personnel (i.e., non-police staffed). My thesis employs a qualitative case study design and includes semi-structured interviews with a sample of 10 service providers from three civilian-led crisis teams currently operating in Canada. I have analyzed my data using thematic analysis to identify recurring patterns and key themes that provide insights into the development and operation of these teams.

While I align with the abolition movement as a whole – encompassing PIC abolition, medical industrial complex (MIC) abolition, including its psychiatric dimensions, and broader efforts to dismantle the carceral state – this thesis applies a PIC-abolition-informed lens to crisis response. This means that while my thesis explores resisting police involvement in crisis care, I acknowledge that non-police crisis response teams remain embedded within traditional mental health care systems, which have long functioned as mechanisms of carceral control (Jones & Jacobs, 2024). As such, the focus of this thesis, particularly in its exploration of civilian-led crisis teams, does not fully align with psychiatric abolition. In the discussion section of this work, I offer initiatives that more fully align with both PIC and MIC abolition. It is my hope that this thesis serves as a stepping stone toward advancing systems of care that are not only free from policing but also meaningfully informed by both PIC and MIC abolition, creating space for entirely non-carceral approaches to crisis support.

As a transformative justice study positioned through a PIC abolitionist lens, this thesis is theoretically grounded in critical theories, including mad studies and critical race

theory. These theories serve as the analytic frameworks through which the data is examined, advancing and elaborating on their integration within the context of crisis response – an approach consistent with methodologies in social science and social work research. Ultimately, exploring and synthesizing knowledge specific to the development and implementation of existing civilian-led crisis teams in Canada provides a tangible foundation for informing their expansion. This research is timely, highly relevant, and essential for improving care services in Canada.

Researcher Positionality

As a researcher, acknowledging my positionality is essential to ensuring the rigour and integrity of my work. Positionality refers to the awareness and articulation of how my background, experiences, beliefs, and biases inevitably influence the research process. Recognizing that no research is entirely objective, I acknowledge that my identity and perspective shape the questions I ask, the methods I choose, the data I collect, and how I interpret it. Understanding and naming my social location is essential: I am a white, able-bodied, cisgender woman. I experience financial security, am securely housed, and have consistently had my basic needs met throughout my life. I am a white settler, living and studying in Kjipuktuk, Mi'kma'ki, on the unceded and ancestral territory of the Mi'kmaq people, and I acknowledge the responsibilities that come with this awareness. Western colonial violence continues to manifest in systemic inequalities, including carceral approaches to mental health that disproportionately target and criminalize Black and Indigenous peoples, further entrenching cycles of trauma and oppression.

While I identify as Mad and live with what the biomedical model of so-called mental illness has named anxiety, panic, and depression – oscillating between what mainstream conceptions of mental health might consider "stable" and moments of crisis – my social location protects me from the implications of ableism that are compounded by racism, transphobia, and poverty, among other faces of oppression. Despite my intersecting Mad identity, my voice has never been questioned while seeking care. As a white, financially secure, and so-called sane-presenting person, I am shielded from having my madness mistaken for something dangerous, unpredictable, or insane.

I am also in the field of social work, a profession that has historically played a role in policing and controlling communities deemed othered by white supremacist ideals (Fortier et al., 2024). The field of social work has a complicated history and current relationship with the state (Jones & Jacobs, 2024; Rasmussen, 2024). In Canada, the profession was conceptualized as an active component in the settler state's creation, development, and continued expansion (Fortier et al., 2024). Social work has been instrumental in policies and practices that upheld settler colonial goals, including the assimilation and erasure of Indigenous peoples (Fortier et al., 2024). For example, social workers played a direct role in enforcing residential school policies, removing Indigenous children from their families and communities under the guise of their so-called best interest (Fortier et al., 2024). This legacy persists today: Indigenous children remain disproportionately represented in the child "welfare" system. In 2022, Indigenous children accounted for 53.8% of children in foster care despite making up only 7.7% of the child population in Canada (Statistics Canada, 2022).

Within the mental health field, social workers function as mandated reporters and often work with or alongside police (Jones & Jacobs, 2024; Wong, 2024). The power and scope of social work licensure grants authority to make decisions that can significantly impact individuals' lives, including the ability to initiate involuntary hospitalizations or engage law enforcement. This authority is deeply embedded within systems that often prioritize control and risk management over care and autonomy (Kumbhare, 2022). My Mad identity does not negate the power my social work identity holds, particularly the authority to navigate and enforce systems that regulate, control, and pathologize those labeled as mentally ill. When I advocate for Mad liberation, I do so with deep respect for the decades of work and wisdom of Mad survivor-organizers who have long led this fight. Mad people have tirelessly resisted carceral mental health practices; their lived experience and advocacy provide the foundation for imagining transformative alternatives.

In May 2020, Mr. George Floyd's murder by police officer Derek Chauvin became emblematic of a long-standing and systemic pattern of police violence against Black people in the United States and Canada. While the Black Lives Matter and PIC abolition movement, led by Black communities, have rich histories of advocating against policing and systemic racism that long predate Mr. Floyd's murder, it was his death that propelled these conversations into broader public and media attention, amplifying scrutiny of the policing system on a global scale. In Canada, the deaths of Regis Korchinski-Paquet, a 29-year-old Afro-Indigenous woman who fell from her Toronto apartment balcony during a police wellness check, and Chantel Moore, a 26-year-old Indigenous woman from the Tla-o-qui-aht First Nation, fatally shot by police during a

wellness check in New Brunswick, drew greater public attention to systemic racism in policing. These tragedies also raised critical questions about police involvement in acute distress-related calls and whether law enforcement should be involved in these situations at all.

My white privilege shielded me from having to confront or be warned about the harms of policing. It was not until Mr. Floyd's killing brought these issues into broader public discourse that I began to critically examine my responsibility to involve police as a crisis responder. My continued learning and unlearning journey centers Black, Indigenous, and Mad voices and experiences. It has also required turning the gaze inward to reflect on my own positionality and the power I hold in the systems I work within. The work of abolitionists like Angela Davis, Mariame Kaba, Andrea Ritchie, El Jones, and Shira Hassan, among others, has been particularly instrumental in shaping my understanding of advocating for transformative worlds. Equally, the stories of Mad survivor-organizers who share powerful accounts of how carceral practices within mental healthcare systems have perpetuated harm and trauma have inspired my drive to imagine and work toward alternatives.

As a social worker, these reflections have profoundly shaped my framework of practice and the attention I pay to holding both myself and the field accountable. Social work demands a commitment to justice, equity, and care, yet it is also a field that remains complicit in upholding carceral systems. This duality continues to echo the tension I first experienced as a crisis responder as I now navigate the challenges of working within a profession that often replicates the very systems it claims to challenge. Recognizing this, I strive to align my practice with abolitionist principles, working toward approaches that

prioritize care, safety, and the voices of those most impacted by systemic harm while advocating for transformative change within the field. Social work, with its core commitment to social justice, must stand in support of dismantling carceral practices across all systems (Jones

& Jacobs, 2024). By embracing the belief in a world where everyone is valued and has the potential to self-actualize, social work researchers can help steer mental healthcare toward abolitionist-informed systems. As social workers advocate for systems that uplift rather than oppress, research presents a powerful tool for building a society that respects the inherent worth and dignity of every individual.

I understand that as a white person, particularly a white social worker, the abolition movement was not made for me and will never be led by me. Instead, I wish to leverage my privilege to uplift the movement and its leading voices, while remaining mindful not to co-opt it as my own. I believe in the abolition movement because I believe in liberation. I imagine a world where justice is rooted in care, where harm is addressed without punishment, and where systems of dehumanization such as the PIC and MIC are dismantled. I believe in a world that has dismantled imperialist, colonial empires; I believe in a Free Palestine. I see abolition as the catalyst for reimagining and rebuilding a more just society: *We Do This 'Til We Free Us* (Kaba, 2021).

CHAPTER TWO: LITERATURE REVIEW

This chapter examines the historical and theoretical foundations that have shaped the current state of policing in mental health. By situating contemporary practices within their historical contexts, this chapter demonstrates how colonial legacies, the asylum movement, deinstitutionalization, and neoliberalism collectively laid the groundwork for carceral mental healthcare practices. These histories are not merely background but central to understanding how experiences of acute distress have been pathologized, criminalized, and framed as a tool of social control. In the specific context of transforming crisis response programs, my thesis refines its theoretical approach by integrating key concepts from mad studies and critical race theory to illuminate the current state of policing mental health and provide a foundation to inform transformative, abolitionist-informed changes. Specifically, I draw from the theoretical frameworks of sanism and anti-Black/Indigenous sanism – concepts within mad studies – and critical race theory to understand the influences of anti-Black and anti-Indigenous racism within policing mental health. Together, these theories offer the critical frameworks necessary to understand why and how policing mental health functions to disproportionately target bodies and minds that stray from societal ideals of normativity (Maynard, 2017).

The chapter begins by exploring the theoretical foundations of sanism, anti-Black and anti-Indigenous racism, and anti-Black and anti-Indigenous sanism, situating these frameworks within their historical contexts, including Canada's asylum and colonial projects. It then examines the deinstitutionalization movement alongside the rise of neoliberalism, highlighting how austerity-driven policies deepened the responsibilization of "mental illness", dismantled public mental health services, and reinforced reliance on

punitive systems. The chapter concludes by engaging how (and why) these theoretical and historical foundations have created the current context of policing mental health.

Historical and Theoretical Foundations

Framings of "Mental Illness"

The idea of so-called mental illness has been historically framed in Western societies as a sweeping concept, used to label behaviors that deviate from the prevailing norms and standards of rationality specific to a particular era and context (Foucault, 1961; Herson, 2018). Categorizations of so-called normalcy dictate whose bodies, minds, and behaviours are acceptable while regulating, pathologizing, and containing those deemed unacceptable (Monaghan, 2022, p. 13). Herson (2018) explains that changes to what constitutes madness "emerge alongside disciplinary notions of what normative subjects look like and how they should behave … mental illness has been disproportionately attributed to othered subjects" (p. 10). This framing is not neutral; it is deeply rooted in and upheld by sanism and racism, which position the label of "mental illness" as a tool of social control. Policing, both as a system and a strategy, originated in part to enforce this social control, by containing behaviours/experiences seen as abnormal and disruptive to societal functioning (Maynard, 2017).

Sanism is defined by Poole and colleagues (2012) as the systematic and intentional subjugation of people who have received mental health diagnoses. Sanism legitimizes the marginalization of individuals historically deemed "mad" and encourages their exclusion from normative society (Poole & Ward, 2013). Kalinowski and Risser (2005) explain that sanism breeds stigma toward people considered to be "mentally ill" by contributing to unequal power dynamics, separating people into polarizing,

dichotomous “power up/power down groups” (p. 25). People categorized within the power-up group are perceived as normal, sane, and capable, whereas people in the power-down group (i.e., those deemed “mentally ill”) are labelled as disabled, sick, unpredictable, and dangerous (Kalinowski & Risser, 2005). Chamberlin’s (1990) earlier work tracing the implications of sanism concurs, arguing that sanist logic sees people who are regarded as “mentally ill” as being “incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, violent, and irrational” (p. 2).

The expanding field of mad studies (Poole & Ward, 2013) offers a critical framework to challenge sanism. The term “mad” (or “madness”) has been reclaimed in this context to disrupt dominant discourses that pathologize people experiencing psychological distress, thereby confronting the systems that perpetuate their oppression (C. Boyce, 2021). Emerging from critical disability studies, mad studies re-examines traditional perspectives on psychological distress and provides a foundation for understanding and advocating for individuals who have experienced systemic harm due to their distress-related experiences or behaviours (Poole & Ward, 2013). It also challenges the pathologization, criminalization, and labelling of acute distress and associated behaviours as dangerous. (Poole & Ward, 2013). Mad studies is a field created and led by psychiatric survivors and/or Mad survivor-organizers, who founded the movement as a response to the harms they endured within carceral mental health systems. Grounded in the lived experiences of coercion, institutionalization, and systemic oppression faced by Mad survivor-organizers, Mad Studies challenges biomedical and

psychocentric narratives while calling for the abolition of psychiatry and the MIC (Sweeney, 2016).

The Intersection of Sanism and Racism

Sanism does not operate in isolation; Liegghio (2013) notes that to understand the complete scope of the harm produced by sanism, conceptualizations of sanism must also consider race and racism. As per Meerai and colleagues (2016), "sanism exists on a continuum depending on privilege, and it is always and especially compounded when it is visited on racialized bodies" (p. 22). Understanding the impacts of anti-Black and anti-Indigenous racism is pivotal in grasping the overrepresentation of harm experienced by individuals with the intersecting identities of being Black and/or Indigenous, particularly when experiencing psychological distress, by police and policing strategies. Critical race theorists assert that racism is endemic in society (Badwall, 2022), and consequently, is embedded within all institutions. The subjugation of Black bodies through practices of enslavement produced the context by which anti-Black racism, referring to the "prejudice, stereotyping, and discrimination that is directed at people of Black-African descent" (Benjamin, 2003, p. ii), has been maintained and reproduced overtime. Similarly, anti-Indigenous racism is deeply rooted in the structures of settler colonialism, which have historically positioned Indigenous bodies and ways of being as inherently inferior, requiring control, assimilation, or erasure to uphold the dominance of settler society. Settler colonialism operates as an enduring structure, not a historical event, and its mechanisms of oppression continue to target Indigenous Peoples in all aspects of life (Maynard, 2017). This systemic racism is evident in the ongoing dispossession of land,

the disruption of cultural practices, and the erasure of Indigenous languages, governance systems, and worldviews (Maynard, 2017).

By conceptualizing sanism as inherently intersectional with racism, it becomes possible to understand how it interacts with anti-Black and anti-Indigenous racism to reinforce hierarchies of power and privilege. Meerai and colleagues (2016) define the intersection of anti-Black racism and sanism as "anti-Black sanism" (p. 18), describing the systemic oppression faced by Black individuals whose distress responses are pathologized and criminalized. This framework highlights how the dual forces of sanism and anti-Black racism result in the disproportionate targeting of Black individuals by police, often leading to fatal encounters (Fernando, 2012; Fernando et al., 1998). Additionally, Abdillahi and colleagues (2017) underscore that Black Canadians experience anti-Black sanism within traditional mental health services through heightened involvement with law enforcement and the criminal legal system.

Although anti-Indigenous sanism has not been formally identified in the literature as a framework, it undeniably exists. Historically, the settler state strategically framed Indigenous peoples as "uncivilized savages" (Yee, 2022, p. 48), facilitating their enslavement and later forced containment within Residential Schools (Maynard, 2017). Western colonial ideals are embedded within psychiatry and the biomedical model, which pathologize Indigenous ways of being:

> When ancestral spirits are given a 'literal, ontological reality' Indigenous healers are seen as 'genuinely mentally ill'. When Indigenous individuals hear the voices of those spirits, they too are 'ill' and needing correction and cure" (Meerai et al., 2016, p. 25).

My research recognizes the Western colonial forces that systemically harm Indigenous peoples, including the settler state's continued role in creating and upholding dominant

frameworks whereby Indigenous bodies, minds, and ways of being are conflated with insanity (Free Lands, Free Peoples, 2022; Meerai et al., 2016). Thus, although operating differently than anti-Black sanism, this research equally engages a lens of anti-Indigenous sanism to frame the contexts, outcomes, and state of policing mental health.

Control and Confinement: The Legacy of Asylums and Eugenics in Canada

Asylums and eugenics in Canada functioned as intertwined mechanisms of social control, shaped by both sanism and racism. These institutions regulated and pathologized individuals based on gender, sexuality, race, and class, reflecting broader societal power dynamics (Herson, 2018). While asylums were framed as spaces of care, they primarily functioned to isolate and control individuals who deviated from dominant expectations of behaviour and identity (St-Amand & LeBlanc, 2013). As St-Amand and LeBlanc (2013) argue, asylums were "an instrument of social control for people who violated norms of conduct" (p. 39). For example, women who defied patriarchal ideals (i.e., rejecting traditional gender roles) were often labelled as "insane" and institutionalized (St-Amand & LeBlanc, 2013). Diagnoses like "hysteria" were weaponized to pathologize behaviours that challenged societal expectations, portraying autonomy and resistance as evidence of supposed mental instability (Tasca et al., 2012). Similarly, non-heteronormative sexual orientations and gender identities have been pathologized and institutionalized with the goal of so-called correction (Thomas-Fournillier, 2024). Homosexuality, classified as a so-called mental illness for much of the 20th century, led to forced institutionalization, conversion therapy, and other practices aimed at enforcing conformity. Transgender and nonbinary individuals were similarly subjected to psychiatric interventions designed to impose normative gender expressions (Thomas-Fournillier, 2024).

Canada's Asylum Project (mid-1800s to 1960) introduced an institutional approach to mental healthcare deeply tied to industrialization's political and economic transformations (Allen, 2022). As industrialization reshaped society, productivity and economic contribution became central to notions of individual value, and asylums emerged as tools to manage those who transgressed capitalist logics of productivity and self-sufficiency (DeLottinville, 1976). Class standing and the inability to participate in the workforce were increasingly framed as markers of supposed mental deviance, justifying the institutionalization of those deemed socially or economically "valueless" (DeLottinville, 1976, p. 64). In this context, asylums functioned equally as a means of removing those who were considered obstacles to the economic and social progress of the era. As DeLottinville (1976) notes:

> Why did Canadian citizens continue to build and support [asylums] despite their ineffectiveness? The answer to this question is found not when the asylum is viewed as a hospital for the treatment and care of the “insane”, but when it is seen as an accommodation for economically dependent persons. (p. 3).

The introduction of the Canadian National Committee for Mental Hygiene (CNCMH) is another example of the direct manifestations of sanism throughout Canada’s history, particularly anti-Black and anti-Indigenous sanism. The CNCMH, a precursor to the Canadian Mental Health Association (CMHA), was established in 1918 to promote mental hygiene by better addressing “mental deviance” of Canadians (Wong, 2016). Mental hygiene in this context referred to the “maintenance of mental health, as defined by societal norms and its social context” (Wong, 2016, p. 11). The introduction of the CNCMH aimed to "assist the nation in conserving and developing the mental capacities of Canadians" (Wong, 2016, p. 13), and fuelled a eugenics movement that led

to the forced sterilization of the so-called mentally deviant, disproportionately targeting Indigenous women. This has been described as an attempt to "build a white non-disabled nation" (Wong, 2016, p. 1), reflecting how the CNCMH's policies aligned with broader colonial strategies aimed at erasing Indigenous cultures and controlling Indigenous bodies (Withers, 2024).

The CNCMH equally reinforced deeply entrenched ableism by targeting people with disabilities, particularly those with intellectual or developmental disabilities (Withers, 2024). People with disabilities were labelled as a "drain" on society and as threats to the so-called genetic fitness of the nation (Withers, 2024). These ideologies led to widespread institutionalization, neglect, and forced sterilization, justified under the goal of ostensibly improving public health and ensuring societal progress. The eugenic practices promoted by the CNCMH reflect the broader societal tendency to equate disability with inferiority and to view people with disabilities as expendable (Withers, 2024). The CNCMH's efforts to promote "mental hygiene" were rooted in exclusionary and oppressive ideologies that sought to align Canadian identity with social categorizations of whiteness constructed under white supremacist ideals (Maynard, 2017). These practices laid the foundation for ongoing systemic discrimination within mental healthcare and social policy, demonstrating the enduring impacts of sanism, racism, and ableism in shaping Canadian history.

Deinstitutionalization and Neoliberalism: Unfulfilled Promises

Beginning in the 1960s, Canada's deinstitutionalization process emerged which involved the closing of many psychiatric hospitals and the subsequent discharge of patients into the community (Sealy & Whitehead, 2004). Deinstitutionalization was not a

single event but a process that saw the rapid transfer of patients out of mental health hospitals and into the community. The process of deinstitutionalization and the resulting shift to community mental health care accompanied (and was propelled by) a changing political-economic climate that coincided with the acceleration of neoliberalism (Sealy & Whitehead, 2004, p. 249).

Neoliberalism is "both an ideological framework and a set of practices" that prioritize market efficiency, individual responsibility, and the reduction of state intervention in economic and social matters (Harvey, 2005). Neoliberal thought, initially emerging as an intellectual movement in the post-war period, began to influence global institutions such as the International Monetary Fund and the World Bank by the 1960s (Harvey, 2005). In Canada, its principles started to gain traction in the 1970s, marking a shift toward policies emphasizing market deregulation, privatization, and the reduction of public spending (Harvey, 2005). By the 1980s, neoliberalism firmly shaped domestic social and economic policies, including significant cuts to welfare programs and public services, and continued to evolve throughout the 1990s, reaching its peak as a dominant ideological framework (J. Gill, 2021; Harvey, 2005).

Mukherjee (2022) explains that the neoliberal agenda of prioritizing reduced taxes on corporations and the wealthy prevented adequate funding of public systems such as mental health care. Consequently, as noted by Sealy and Whitehead (2004), deinstitutionalization in Canada outpaced the growth and funding of community-based and publicly funded mental health services. An appropriate transfer of funding from the now-closed asylums back into the community never occurred, and resultantly, deinstitutionalization's aspirations of providing better support for people with mental

illness never materialized. Equally, neoliberalism's emphasis on individual responsibility reinforces the idea that psychological distress is a personal deficit to be managed, rather than a response to broader social, political, and economic forces (Johnstone & Boyle, 2018). This responsibilization shifts attention away from systemic inequalities and structural harms, obscuring the role of power in shaping distress and well-being (Brown et al., 2022).

In what many have termed "the myth of community mental health" (Shimrat, 2013, p. 144), neoliberalism has prevented the formation of any ecosystem of care (Page & Woodland, 2023, p. 138). For one, neoliberalism has contributed to the defunding of social services that uphold community mental health such as housing and income assistance (J. Gill, 2021, p. 4). Public mental health services have continued to remain incapable of meeting all the demands and needs of the growing number of individuals with mental health concerns in the community who require services (Lamb et al., 2001). Faced with insufficient and limited public mental health services, crisis situations have increasingly fallen under police responsibility in recent decades (Mukherjee, 2022). The increase in encounters between police and people experiencing acute distress poses marked cause for concern, particularly due to the sanist and racist perspectives that underlie these interactions (Strong, 2009).

Policing Mental Health

The relationship between mental health services and policing is far from a recent development. Even as they appear to diverge from early approaches rooted in the asylum and eugenics, carceral mental health care practices, including reliance on policing, continue to perpetuate and reproduce sanist and racist framings of responding to

individuals experiencing emotional distress. Kaba and Ritchie (2022), Page and Woodland (2023), and Hassan (2022) all argue that sanism and systemic racism are poignant within systems of policing, particularly policing mental health.

The meaning of Blackness consolidated under Black enslavement resulted in its attachment to attributes such as criminality and dangerousness (Maynard, 2017); Anti-Black racism upholds the perception that Blackness means "criminal, dangerous, and worthy of suspicion" (Giwa, 2020, p. 235). These perceptions have led to force toward Black bodies on behalf of police, in what Maynard (2017) has coined the racialization of crime. Policing in Canada equally reinforces and expands the ongoing settler colonial project, resulting in the purposeful and systematic targeting of Indigenous bodies by police (Free Lands Free Peoples, 2022). Functioning to support the continued dispossession of Indigenous bodies, minds, and lands, the devaluation of Indigenous peoples is facilitated through pervasive surveillance, monitoring, control, and violence by police. As the Indigenous-led group Free Lands Free Peoples (2022) notes, "[policing] undermine[s] the survival of Indigenous peoples" (p. 77).

Ultimately, anti-Black racism fosters the perception that Blackness means "criminal, dangerous, and worthy of suspicion" (Giwa, 2020, p. 235) on the sole basis of skin colour. Anti-Indigenous racism is equally woven into Canada's social and political fabric, representing the insidious legacy of Canada's ongoing colonial project (Free Lands, Free Peoples, 2022; Maynard, 2017). While anti-Black and anti-Indigenous racism alone bias police attitudes toward Black and/or Indigenous people, the intersection between Blackness and/or Indigeneity and mental illness further compounds the risks associated with policing (Meerai et al., 2016).

Mad people, mad scholars, and mental health activists argue that carceral mental health practices – like diagnostic labels, mandated reporting to police, and involuntary hospitalization, which mental health clinicians remain complicit in – are rooted in sanist perspectives that perpetuate the control and subjugation of marginalized individuals (Liegghio, 2013; Page & Woodland, 2023; Wong, 2024). These practices deny individuals' agency over their narratives and experiences (Jones & Jacobs, 2024; Wong, 2024). The very concept of a "mental health crisis" can carry sanist biases, as it is often conceptualized in accordance with dominant societal norms about what acceptable behavior looks like (Wolframe, 2013).

The authority granted to others to initiate police-led wellness checks (i.e., calling in an intervention on behalf of someone) reinforces sanist power dynamics, positioning those in "power up" groups as the rightful decision-makers over those in "power down" groups (Kalinowski & Risser, 2005). Resultantly, individuals labelled as "in a mental health crisis" are often denied the agency and autonomy to define their own experiences and narratives (Wolframe, 2013). Calling in a wellness check on someone without their consent reflects similar dimensions of control that have been used to subject people to institutionalization and surveillance under the guise of care throughout history (St-Amand & Leblanc, 2013; Page & Woodland, 2023). Leblanc and Kinsella (2016) argue that sanism remains so deeply embedded within Western culture that the use of coercive practices and even the use of force toward individuals experiencing/expressing acute distress goes largely uncontested, hence the basis for which police handling of crisis situations has emerged.

In sum, views of people experiencing or expressing distress as being dangerous, unpredictable, incapable, and/or possibly violent have resulted in increased police intervention to "manage this population" (Kara, 2014, as cited in Shore, 2015, p. 10). Sanist logic has contributed to using the label of so-called mental illness to "other" people, justifying their subjection to prejudice and discrimination (Alexander & Link, 2003). As per anti-Black/Indigenous sanism, these narratives are disproportionately applied to Black and/or Indigenous people, particularly during displays of distress (Free Lands, Free Peoples, 2022; Mukerjee, 2022). Mukherjee and Harper (2018) refer to the killing of people in crisis by police as a "state-sanctioned culling of the inferior 'other', particularly the other of colour" (para. 17).

CHAPTER THREE: THE CURRENT STATE OF CRISIS RESPONSE

The existing literature highlights two key points: first, that sanism, racism, and anti-Black/Indigenous sanism contribute to harmful perceptions of individuals with mental illness (C. Boyce, 2021; Poole & Ward, 2013; Maynard, 2017; Meerai et al., 2016). Second, the combination of these biases and the chronic underfunding of community mental health services has positioned police as the default responders to mental health crises (Hoch et al., 2009; Lamb et al., 2002). This dynamic not only perpetuates systemic discrimination but also enables the use of lethal force during crisis calls, with police violence often shielded from public accountability (Haag, 2022). Consequently, individuals in crisis seeking support are frequently met with harm, reinforcing a cycle of systemic injustice in mental health crisis response (Haag, 2022).

The situations that constitute police intervention range from mental health crisis calls made by bystanders witnessing public displays of erratic behaviour, as described by Kouyoumdijan and colleagues (2019), or calls to de-escalate someone agitated because of mental illness, as described by Meerai and colleagues (2016). Very rarely do people experiencing acute distress exhibit violence (Coleman & Cotton, 2010), however due to perceptions of dangerousness and unpredictability, police often respond to these calls under the assumption that violence will occur (Shore, 2015). Findings across several studies indicate that police are inadequately trained to provide appropriate support for individuals experiencing acute distress, introducing the threat of escalating rather than deescalating these situations (Baker, 2009; de Tribolet-Hardy et al., 2015; Strong, 2009). Baker (2009) explains that police are generally trained to "achieve a result and resolve a situation" (p. 297) as quickly as possible, which contrasts de-escalation approaches

requiring slow and calm approaches when working with someone experiencing moments of significant distress. Strong (2009) explains that police are "more likely to go in strong than to back off [when approaching situations requiring de-escalation]" (p. 57).

Research by Johnson (2011) suggests that when police perceive someone to be "mentally ill", they are more likely to exert higher rates of force during the encounter. Borum and colleagues (1998), Godfredson and colleagues (2011), and Johnson's (2020) research indicate that police officers themselves consistently report feeling undertrained, underprepared, and consequently, ill-positioned to respond to crisis calls safely and appropriately. The combination of inappropriate training, coupled with the implications of sanist-and-racist fuelled stigma toward people who are perceived to be/are in distress, operate together to produce lethal outcomes within situations involving encounters between police and people experiencing distress (Bonfire & Barrenger, 2022; Johnson, 2010; Strong, 2009).

Wilson-Bates (2008) and Markowitz (2011) indicate that people experiencing and/or exhibiting distress are likely to face at least one arrest in their lifetime. Supporting this, Chaimowitz's (2011) data reveals that 40% of Canadians who have received a Diagnostic and Statistical Manual of Mental Disorders (DSM) label of mental illness have been arrested, a stark contrast to the 15% arrest rates among the Canadian population who have not received a DSM diagnosis. Adelman (2003) as well as Pepler and Barber (2021) emphasize that when police are solely responsible for handling crisis situations, the person experiencing distress is more likely to be arrested, detained, and in best case scenarios, released (albeit, without any access or opportunity to access community mental health supports). According to J. Boyce and colleagues' (2015) review

of the *Canadian Community Health Survey - Mental Health*, produced by Statistics Canada, "most people with a mental health disorder do not commit criminal acts" (p. 4). Instead, the heightened arrest rates seen among this demographic highlight the over-surveillance and vigilance of people viewed or labelled as mentally ill by the police and the public, such that "members of the public will often contact the police when they encounter a person with mental illness displaying bizarre or nuisance-like behaviors indicative of a mental health crisis" (Markowitz, 2022 as cited in Shore, 2015, p. 5). Data produced by Livingston (2016) found that, within a sample of people who have experienced police-involved crisis response, more than half of the participants reported being handcuffed, forcefully restrained, physically assaulted (e.g., pushed, punched, kicked), or threatened with a weapon.

Recent initiatives have been undertaken to improve crisis response programs by creating alternative approaches that better support individuals experiencing acute distress and reduce the harm caused by police intervention (Haag, 2022). The most prevalent reformed models include Crisis Intervention Teams (CITs) and co-responder teams (Koziarski, 2018).

Crisis Intervention Teams

Following the tragic shooting of a man by Memphis police during a crisis intervention in 1987, the Memphis Police Department proactively sought to enhance its response to crisis situations (Koziarski, 2018; Steadman et al., 2000). This initiative led to the establishment of inter-agency collaborations between the Alliance for the Mentally Ill, the University of Memphis, and the University of Tennessee to create a specialized policing unit positioned to better respond to crisis situations and reduce use of lethal force

during these interactions (Koziarski, 2018; Steadman et al., 2000). This partnership acted as a catalyst for the resulting Crisis Intervention Teams (CITs), often referred to as the Memphis Model (based on its place of origin). CITs are specialized units of police officers trained to respond to crises relating to emotional distress in the community (Wells & Schafer, 2006). CITs quickly gained popularity, resulting in their implementation internationally (Koziarski, 2018). In the Canadian context, CITs exist in Nova Scotia, British Columbia, and Ontario, however, no empirical studies on Canadian CITs have been conducted to date (Koziarski, 2018). The majority of what is known regarding CITs' potential for improving police interactions with service users during crisis calls has emerged from research conducted within the United States (Koziarski, 2018).

While the CIT model sought to improve crisis response outcomes, including reducing police use of lethal force and arrest rates, research on their achievement of these goals remains largely inconclusive (Compton et al., 2008; Compton et al., 2014; Taheri, 2016; Watson et al., 2011). Taheri's (2016) systematic review aimed to gather and evaluate the highest-quality studies on the effectiveness of CIT models and included eight articles that met inclusion criteria. Taheri's (2016) findings provided insufficient evidence to determine whether CITs reduce officer injuries during encounters with individuals experiencing mental health challenges. Their findings did indicate that, at the time of the review, CITs may have little to no effect on arrest outcomes or the use of force by officers. Yang (2018) found that, in a study overviewing police encounter outcomes within a sample primarily consisting of CIT-trained officers, police disproportionately used force during interactions with service users who had mental health challenges (3.9%

versus 0.2% of overall calls). In a more recent literature review consisting of 198 articles, Rogers and colleagues (2019) concluded an overall lack of evidence to support the notion that CITs reduce lethality during police encounters with people experiencing distress. Instead, Rogers et al's (2019) findings indicated that rather than yielding favourable outcomes for service users, CIT training tends to contribute more to officers' self-perception of a reduced use of force during encounters than to the actual realization of these outcomes.

Ultimately, findings pertaining to the CIT model's efficacy in reducing police use of force and arrest rates are inconclusive (Compton et al., 2011; Champlain, 2023; Taheri, 2016; Teller et al., 2006; Watson et al., 2011). Police incident data overtime, however, maintains that people with experiencing acute distress remain at increased risk of being subjected to lethal force during police encounters in comparison to people who are not perceived to be in distress, even when CITs are the first responders (Shadravan et al., 2021).

Co-responder Teams

Co-responder teams offer a collaborative approach to responding to crisis situations (Koziarski, 2018). In contrast to traditional models that rely solely on law enforcement intervention, co-response models incorporate mental health professionals to work alongside police when responding to crisis calls (Koziarski, 2018). This collaborative approach was initiated in part as a response to the inconclusive findings regarding the effectiveness of CITs. The co-responder model aims to create improved response strategies to better serve those experiencing crisis distress (Iacobucci, 2014). As per Rosenbaum (2010), ‘‘these teams are based on the idea that the more police and

mental health workers collaborate, the better the two systems can serve consumers and each other effectively'' (p. 176). Involving the expertise of mental health professionals within the context of crisis emergencies is suggested to bridge the gap between mental health care and the criminal legal system (Iacobucci, 2014).

Co-responder teams have been implemented across many Canadian jurisdictions (e.g., Toronto, Halifax, St. John's, Calgary) over the past couple of decades (Koziarski, 2018). Second to police-only responses, co-responder models are the most common mobile crisis response team in Canada (Kisely et al., 2010). Some of the literature on co-response models finds promising implications. For example, Kisley and colleagues (2010) evaluated the Mental Health Mobile Crisis Team (MHMCT) in Halifax, Nova Scotia using a controlled before-and-after design to compare the intervention area with a similar control area without access to a service of this kind. The findings revealed that individuals who engaged with the MHMCT demonstrated higher follow-up rates with community mental health services compared to those in the control group, suggesting improved linkage to ongoing care (Kisley et al., 2010).

Findings from two separate systematic reviews by Shapiro (2015) and Kane and colleagues (2018) provide general support for positive outcomes of co-responder models such as fewer arrests during crisis interventions (Kane et al., 2018) and increased linkage to mental health care (Kane et al., 2018; Shapiro, 2015). Shapiro's (2015) systematic review synthesized published studies on co-responder intervention models to highlight promising practices within joint mental health workers and police officer response teams. The review exclusively included studies featuring collaborative teams of mental health professionals and police officers, excluding literature on interventions lacking both roles.

Ultimately, 21 articles met the inclusion criteria and were analyzed for insights into effective practices (Shapiro, 2015). Data was analyzed across several outcome domains, including the prevention of crisis escalation and injury, linking individuals in crisis with community services, reducing justice system strain (i.e., decreased arrest rates), and improving officers' perceptions of people experiencing distress. Shapiro's (2015) findings provided some evidence for co-responder models' capacity to promote connection to mental health services as well as to reduce arrest rates. However, the findings did not provide evidence for co-responder models' ability to reduce the use of force or avert crisis escalations, or improve officer perception of people experiencing distress, due in part to limited evaluations on these outcomes across existing literature.

Kane et al. (2018) aimed to systematically review the literature on the effectiveness of police-mental health service interventions. A search was conducted across 29 databases to identify studies for the review. To be included, articles had to "report an objective outcome measure(s) in respect of offending or mental health outcomes and to have an experimental or quasi-experimental design including a comparator group(s) or a pre/post comparison" (Kane et al., 2018, p. 1). Twenty-three studies were selected for inclusion, and findings indicate that the presence of a mental health professional contributes to decreasing arrests and providing linkage to mental health services (Kane et al., 2018). Importantly, while general support was found for the positive impact of co-responder models in reducing arrests and enhancing linkage to care, these outcomes were not consistently observed across all included studies, highlighting variability in results (Kane et al., 2018).

Existing literature has been lacking in its investigation of the use of force during co-responder team interventions. In a systematic review of eight articles, only two of the included articles addressed police use of force rates (Ghelani et al., 2023). Importantly, despite the growing adoption of co-response crisis models in Canada over the past two decades, incidents of police encounter fatalities due to the use of lethal force during crisis calls have continued to rise (Haag, 2022). Moreover, co-responder teams continue to involve the police, often criminalizing what should be a healthcare matter (Eaton et al., 2024). Co-responder teams have been criticized as "reformist reforms" (change that seeks to improve a system without challenging its fundamental structure), in that they further perpetuate the problematic relationship between the criminal legal and mental health field (Eaton et al., 2024; Interrupting Criminalization et al., 2024). In response, many abolitionists, mental health advocates, educators, practitioners, and community members have emphasized the need for crisis response models that are entirely separate from police (Eaton et al., 2024; Haag, 2022; Livingston et al., 2024).

"Reformist" Reforms

Although efforts have been made to reform crisis response, as evidenced through CITs and co-responder teams, arguments have been made that these models do not go far enough (Hassan, 2023; Livingston, 2021; Kaba & Ritchie, 2022; Page & Woodland, 2022). Hassan (2023) argues that so long as the police are involved in crisis response, marginalized groups including Black, Indigenous, and/or Mad people, and many other bodies who do not conform to what society sees as normal, remain at risk. Kaba and Ritchie (2022) elaborate, noting that it is essential to be wary of reforms that do not build

new systems, but that instead reshape current systems while preserving their original power and scope.

Haag (2022) explains that in practice, measures that invest in reorganizing policing's existing structures through sensitivity training (i.e., CITs) or by pairing police with other professionals (i.e., co-response teams), often broaden the scope of policing and contribute to increased police expenditures, further entrenching reliance on the carceral system. These reformist reforms risk perpetuating the same harms they claim to address (Interrupting Criminalization et al., 2022). Hassan (2022) emphasizes that police presence by very nature introduces the threat of violence, surveillance, and/or incarceration that amplifies fear, particularly amongst marginalized groups. Studies suggest that most community members disclose strong preference toward non-police crisis intervention over both co-response and police-only (Boscarato et al., 2014; Pope et al., 2023). Reforms that morph systems into something different but equally as deadly are not enough (Haag, 2022). As per Paynter (2022): "policing cannot be the solution" (p. 44).

Despite the growing adoption of so-called reformed models, incidences of police encounter fatalities have continued to rise (Haag, 2022). The story of Mr. Andrew Loku, a Toronto-based Black father who was killed in 2015 by officers responding to a crisis call made on his behalf, is but one example of the deadly force people experiencing distress are often subjected to by police (Reddekopp, 2017). After only having been on scene for two minutes, police deemed Mr. Loku to be a threat, subsequently firing a fatal shot (Reddekopp, 2017). In 2018, researchers from CBC launched a data tracking initiative called *Deadly Force*, which created the first ever Canadian database to record

all police encounters in Canada that resulted in death (Marcoux & Nicholson, 2018; Singh, 2020). Findings indicated that 68% of people killed in police encounters between the years 2000 and 2020 were individuals experiencing psychological distress (Marcoux & Nicholson, 2018; Singh, 2020). Black and Indigenous people were markedly overrepresented within this percentage (Marcoux & Nicholson, 2018; Singh, 2020). Indigenous people represented 16% of recorded deaths, despite having comprised only 4.21 percent of the population (annualized over 20 years; Marcoux & Nicholson, 2018; Singh, 2020). Similarly, Black people accounted for 8.63 percent of deaths, while having constituted only 2.92 percent of the population (Marcoux & Nicholson, 2018; Singh, 2020). Notably, these rates do not include in-custody deaths, purposeful deaths (e.g., death by suicide on scene), or accidental police-caused deaths (e.g., motor vehicle collisions and/or other traffic incidents).

Abolitionist activist, Wakumi Douglas, emphasizes the necessity for the mental health field to understand the brutality of its history and current role in the surveillance, capture, and punishment of anyone who defies capitalist set norms (Douglas, 2024). The system of policing mental health has an intentional and insidious history of violence that no amount of reform can change (Kaba & Ritchie, 2022). Police involvement in any form within the context of mental health crisis intervention, especially in the absence of available non-police alternatives, presents significant risks of harm and does not align with best crisis response guidelines (Livingston, 2021). Instead, it is recommended that crisis response should only involve police in a situation of confirmed violence (Livingston, 2021). When police are involved in crisis response, persons who have had previous negative interactions with policing or who fear criminalization are less likely to

reach out for support (Eaton et al., 2024). This represents an immense barrier to accessible crisis care services: when there are no available options of non-police involved crisis response services, individuals who fear police risk being left with no access to support (Eaton et al., 2024; Livingston, 2021).

Making transformative demands requires destabilizing systems (Kaba & Ritchie, 2022). Within the context of policing mental health, making transformative demands requires organizing and implementing models of crisis response that do not function with or alongside police (Haag, 2022; Hassan, 2022; Kaba & Ritchie, 2022). Removing police from crisis response and developing, implementing, and expanding civilian-led teams is a means of decentering police from the field of mental health and is well-positioned to build toward larger transformative shifts (Haag, 2022). My research seeks to actualize a tangible means of transformative change within crisis response paradigms.

CHAPTER FOUR: THE CURRENT STUDY

Recently, Canada has seen increased motivation to implement civilian-led crisis response teams. Civilian-led crisis response teams, also called community-based crisis response, peer-based crisis response and/or non-police crisis teams, refer to crisis response models that do not staff police and aim to provide intervention without police (Yousif, 2021). These alternative response programs all have a common feature: they consist of trained, unarmed personnel from a variety of backgrounds who are removed entirely from police (Bazelon Center & Legal Defense Fund, 2022).

Introducing civilian-led crisis response models represents a practice that recognizes the harms of racism, sanism, and anti-Black/Indigenous sanism, along with the perpetuation of these faces of oppression by policing (Bazelon Center & Legal Defense Fund, 2022; Livingston, 2021). For one, civilian-led models have been largely influenced and conceptualized by listening to the accounts of harm from first-person voices, who have advocated to remove police from crisis response (Bazelon Center, 2022; Legal Defense Fund, 2022; Livingston, 2021). These models also staff peers (people who bring with them lived experience of madness, distress, or psychiatric survivorship), which centers Mad wisdom and challenges historical notions of people labelled "mentally ill" as illegitimate knowers, feebleminded, or incapable (Kaba & Ritchie, 2022). While there is a theoretical basis to suggest the potential of civilian-led models – particularly in their ability to reduce reliance on police in mental health care, where responses are often shaped by systemic racism (Abdillahi et al., 2017; Kaba & Ritchie, 2022; Meerai et al., 2016) – research on these models remains in the preliminary stage. My thesis focuses on exploring three civilian-led crisis teams currently operating in

Canada: Toronto Community Crisis Service (TCCS), Peer-Assisted Care Teams – British Columbia (PACT-BC), and 24-7 Crisis Diversion.

The Toronto Community Crisis Service (TCCS) is a civilian-led crisis response program that was introduced in Toronto in 2021 to address longstanding concerns about the involvement of police in crisis response (TCCS, 2022). The program hosts four partner teams, each responsible for responding to crisis calls in different jurisdictions within the Greater Toronto Area (TCCS, 2022). The TCCS offers an alternative to police enforcement by instead providing individuals with a community-based, trauma-informed, and non-police response option to mental health crisis calls and wellness checks (TCCS, 2022). Preliminary data from its one-year pilot study demonstrated that 87% of all calls received to date were handled with no police involvement (TCCS, 2022).

Edmonton's 24/7 Crisis Diversion is a civilian-led crisis response team that has been running since 2013 (REACH, 2023). 24/7 Crisis Diversion was implemented to address gaps in how experiences of acute distress and other non-emergency situations were handled in the community. 24/7 Crisis Diversion teams consist of trained crisis responders, and do not staff police on their teams. 24/7 Crisis Diversion's most recent impact report indicates that the team responded to 11,000 calls in 2021 (REACH, 2023).

The Peer Assisted Care Team (PACT) in British Columbia has been running since 2021 and was introduced to offer an alternative to police-involved interventions. It is a first-in-BC mobile civilian-led team that offers an alternative to police-involved crisis support. PACT-BC teams include pairing of a peer with a mental health clinician and/or an Indigenous elder with a mental health clinician.

Methodology

Research Design

My thesis study employs a multi-sited case study design. Bounded by time and space, a case study approach is a particularly well-positioned research methodology for programs of studies seeking to obtain an in-depth understanding and conceptualization of a given area of interest (Faulkner & Faulkner, 2019). A case study design is an established research design widely used across various disciplines, especially within the social sciences (Faulkner & Faulkner, 2019). Case studies can be used to explain, describe, and/or explore various phenomena, allowing for a better understanding of the case being studied (Yin, 2014). Yin (2014) explains that the case study approach is well suited to capture information that seeks to answer how, what, and why questions. Additionally, a multi-sited case design enriches the study by incorporating multiple perspectives and contexts, facilitating cross-case comparisons. This allows the researcher to identify patterns, contrasts, and unique contributions across different sites, deepening the analysis.

Case Selection

The current research included three case sites: The Toronto Community Crisis Service (TCCS), the Peer Assisted Care Teams British Columbia (PACT-BC), and 24/7 Crisis Diversion. Cases were selected for the current study by generating a search strategy (see Appendix A), composed of pre-determined search syntax, to screen for relevant literature on civilian-led crisis response teams operating in Canada. The compiled literature was reviewed to identify potential civilian-led teams. Additional searches using Google Search Engine were performed, using terms “civilian-led crisis

mental health teams – Canada", "community-based crisis response – Canada" and "non-police crisis mental health response – Canada".

After compiling a list of existing civilian-led crisis teams, cases were selected using eligibility criteria developed specifically for this study to ensure each team aligns with the research's definition of a civilian-led response. These criteria also establish the boundaries of the case (Yin, 2014) – clearly defining what is included and excluded – to ensure consistency across the selected cases by defining the characteristics of civilian-led crisis response teams, enhancing the comparability of the cases for a more meaningful analysis of their respective similarities and differences (Rubin & Babbie, 2016). The eligibility criteria included teams that do not involve police, that specifically address crisis situations related to acute distress (excluding physical health or domestic violence crises), that are available to the public, and that serve as the first point of contact for on-site intervention. This selection approach ensures the study remains focused and relevant to its objectives. Excluding teams that involve police (i.e., co-responder models) and emphasizing the inclusion of trained crisis responders only (i.e., civilian-led teams) positions this research to address a specific gap in the literature by contributing to knowledge about crisis response teams without a law enforcement presence. Each of the included cases met the study's inclusion criteria

Participants

Participant eligibility criteria were created for this study to ensure a range of respondents while also ensuring a standard level of consistency across participants. Eligibility criteria required that service providers have at least six months of experience working with their respective civilian-led team. For this study, the term *service provider*

was used flexibly to encompass a range of roles, including frontline workers, policy and administrative staff, and volunteers. The criteria requiring service providers to have been working with a team for a minimum of six months were established under the understanding that various civilian-led teams are in the early stages of operation.

Participants ($N = 10$) included service providers (e.g., frontline workers, policy/administrative staff) from each of the civilian-led crisis teams included as case sites. A description of participants by their role only (i.e., not presented alongside their pseudonym) is provided in Table 1. Due to ethical considerations outlined in the study's ethics approval, participants' roles cannot be described in connection to their respective teams. This parameter was put in place to ensure the confidentiality of participants.

Table 1

Participants' (n = 10) Roles

Management consultant
Provincial manager
Program manager
Director
Senior manager
Program manager
Assistant manager
Program manager
Crisis team lead
Crisis team lead

Semi-Structured Interviews

Data was collected for the current study using semi-structured interviews. Semi-structured interviews are a widely used method in qualitative, exploratory research due to their flexibility and ability to elicit in-depth insights from participants (Faulkner & Faulkner, 2019). Unlike structured interviews, which rely on a rigid set of questions, semi-structured interviews use a guide with open-ended questions that allow the researcher to explore topics in more depth and follow up on interesting or unexpected responses (Kallio et al., 2016). This approach is particularly useful in exploratory research, where the aim is to understand participants' experiences, perspectives, or behaviours in a context that may not be fully understood (Kallio et al., 2016). By allowing participants the freedom to express their thoughts in their own terms, semi-structured interviews can uncover rich, nuanced data (P. Gill et al., 2008).

Semi-structured interviews are an appropriate data collection method for this study as they allow for both structure and flexibility in exploring the key processes involved in the conceptualization, development, and implementation of civilian-led crisis response teams in Canada. Given the exploratory nature of my research objectives, semi-structured interviews provide the ability to guide the conversation while also enabling participants to elaborate on their experiences and offer insights that may not emerge in a more rigid interview format. By using semi-structured interviews, I can gain a comprehensive understanding of the nuanced processes that may vary across different settings, providing valuable insights into both successful practices and potential challenges (Kallio et al., 2016; P. Gill et al., 2008)

I developed an interview guide for this research, which included questions positioned to inform the study's research questions (see Appendix B). Questions were open-ended and designed to explore team development processes, team composition, and collaboration with other services. The guide was flexible, allowing for follow-up questions and probing into areas of interest based on participants' responses. Participants were purposively selected based on their involvement with the included civilian-led crisis teams. Prior to the interviews, participants were provided with detailed information about the study and gave informed consent (see Appendix C). The interviews were conducted virtually using Zoom for Healthcare, a secure video conferencing platform approved for use in research to ensure confidentiality and compliance with privacy standards. Each interview lasted between 45 and 90 minutes. I audio-recorded and transcribed the interviews for subsequent data analysis.

Data Analysis

Data analysis for this multi-sited case study involved a systematic approach to examining the interview transcripts using qualitative data analysis software, *NVivo*. First, I transcribed all interviews to ensure an accurate representation of participants' responses and to facilitate detailed analysis. Once the transcripts were prepared, I used *NVivo* software to help me organize my analysis. I analyzed the data thematically, allowing for the identification and organization of key themes that emerged from the data. Initial coding involved reading through the transcripts to generate a set of codes that captured meaningful patterns and processes related to the research questions. This coding was iterative, with ongoing refinement; an iterative and ongoing approach involves repeatedly revisiting and refining the data to deepen understanding and capture emerging insights.

The iterative coding approach allowed me to refine codes progressively to ensure they accurately represented meaningful patterns rather than filling gaps. After the initial coding, I identified themes by grouping related codes and examining how these themes illustrated the processes involved in the conceptualization, development, and operation of civilian-led mental health crisis response teams. Given the multi-sited nature of the study, the themes were compared across sites to identify both site-specific insights and broader, overarching themes that could speak to the research questions. This comparative analysis enabled me to explore variations and commonalities across different contexts, helping me identify key factors that contribute to successful team implementation and collaboration with other services (Clarke & Braun, 2014; Nowell et al., 2017). By approaching my analysis thematically, I ensured that both shared patterns and case site-specific nuances were captured (Nowell et al., 2017).

Analytic Rigour

To ensure analytic rigour, several strategies were implemented throughout the research process. An audit trail was used to transparently document each stage of the data collection and analysis procedure, detailing the decision-making at every stage of the process. Inductive coding was used to allow themes to emerge naturally from the data. As a transformative justice study, the current research's data analysis was guided by an abolitionist lens, grounded within the theoretical framework of mad studies and critical race theory.

I engaged in member-checking by sharing the preliminary key themes and subthemes with participants to ensure that the interpretations accurately reflected their perceptives. This process allowed participants to confirm or challenge the emerging

themes, providing an opportunity to correct any misunderstandings or misrepresentations. Of the 10 total participants, none challenged or changed any of the data findings, however, two provided additional details which were then incorporated and reflected in the findings section. Member checking helped enhance the credibility and trustworthiness of my research by incorporating participants' feedback and confirming the findings directly with those who contributed to the data.

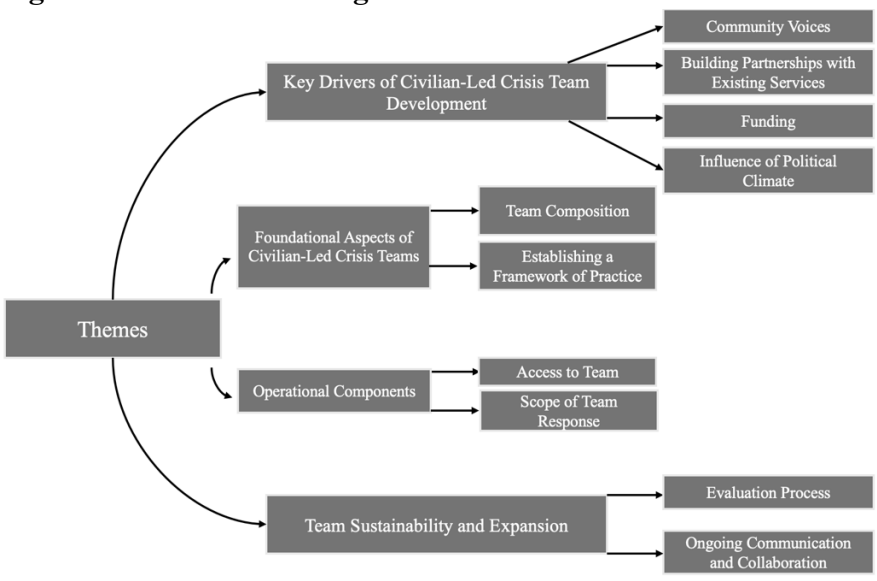
Ethical Considerations

Ethics approval was sought and received from the Research Ethics Board at Dalhousie University (Appendix D). Consideration was given to the possibility of participants being identifiable through their association with the study's sites (i.e., the studied civilian-led crisis teams). To mitigate this, a general pseudonym for each team will be used but will not be associated with participants' roles. Further, all data is de-identified and presented thematically, with pseudonyms used for direct quotes.

CHAPTER FIVE: FINDINGS

A total of ten participants across the three case sites completed semi-structured interviews for the current study. Four primary themes, each with respective subthemes, were identified to address the primary and secondary research questions. The first theme, Key Drivers of Civilian-Led Crisis Team Development explores subthemes of community voices, building partnerships with existing services, funding, and influence of the political climate. The second theme, Foundational Aspects of Civilian-Led Crisis Teams explores subthemes of team composition and training and establishing a framework of practice. The third theme, Operational Components explores subthemes of access to team and scope of response. The final theme, Team Sustainability and Expansion explores subthemes of evaluation process and ongoing communication and collaboration. A synthesis and cross-comparison of findings from case sites will be discussed at the end of each theme, where a table providing a visual representation of similarities and/or differences will be provided after each of the primary theme's subthemes. Figure 1 illustrates the thematic findings.

Figure 1: Thematic findings



Theme 1: Key Drivers of Civilian-Led Team Development

The primary theme, Key Drivers of Civilian-Led Team Development, explores sub-themes of community voices, establishing partnerships with existing services, securing funding, and the influence of the political climate. This theme highlights factors that were consistently identified as instrumental in inspiring and facilitating the development of civilian-led teams. Each sub-theme will be discussed and findings from each site will be presented. The section will close with a synthesis of findings outlining cross-site comparisons.

Sub-Theme 1.1: Community Voices

The influence of community voices and advocacy, particularly those of community members with lived experience, was identified across each site as a key factor in the push to develop a civilian-led crisis response team. Table 1 describes cross-site findings of the sub-theme's key points.

Toronto Community Crisis Service. In exploring the factors that inspired and guided the development and eventual launch of the TCCS listening to community voices emerged as a key element. The City of Toronto's Social Development, Finance and Administration Division led an extensive consultation process, designed to incorporate community voices and ensure the model reflected local needs and priorities. To achieve this, the division issued an expression of interest to identify potential service providers and organized a multifaceted engagement approach, which included two public surveys, a public poll, key informant interviews, and community roundtables. This engagement process was structured with support from a range of community-based organizations. Specifically, 17 community organizations hosted 33 roundtables, engaging over 500

participants with lived and living experiences in crisis response. Additionally, 29 subject matter experts—including legal experts, frontline workers, academics, and mental health activists—participated in interviews to contribute specialized insights.

An overarching accountability structure, the "Alternative Community Safety Response Accountability Table," was established to support and monitor the development of the TCCS. This table included over 50 community organizations working in mental health, harm reduction, homelessness advocacy, healthcare, youth services, and legal support, as well as experts serving Indigenous, Black, newcomer, refugee, undocumented, and 2SLGBTQ+ communities. The table provided a formalized avenue for these organizations to guide the process, ensuring that insights from communities disproportionately impacted by traditional policing were central to the service's design and implementation.

One TCCS participant noted that it was "what community has been saying needs to be the response" for a long time, and that "part of the reason that [the team was developed] is for sure because of the advocacy from the community". Notably, the longstanding advocacy of the community, which far preceded the team's development, was recognized as a key driving force behind its creation:

> Now, I will just say that, you know, community partners, leaders and advocates had been advocating for this type of service for a long time for many, many years before the city, you know, decided to [...] I do not ever want to understate that because that's been consistent for a long time. (TCCS Participant)

Peer Assisted Care Team - BC. Broadly, the initial development of the PACT-BC teams, operating in Victoria, New Westminster, and Northwest Vancouver, involved

a community desire for reform, with one PACT-BC participant explaining that "[the peer assisted care teams were introduced] to really help crisis care reform happen with the right systems change". In 2019, the City of Victoria launched a peer-led task force, consisting of individuals with both lived and living experience, as well as Indigenous-led engagement, to investigate alternative approaches to crisis response. The task force found overwhelming community support for a non-police-involved model for addressing mental health crises. Around this same period, Northwest Vancouver and New Westminster community leaders were similarly exploring non-police crisis response options. Building on the task force's findings, the Canadian Mental Health Association (CMHA) BC Division (the provincial administrator of the PACT-BC programs) put out a "community readiness" call to assess service provider interest in delivering the service. An important aspect for these teams from the beginning was that they were guided by and provided by community-based organizations: "we really do lean in on the concept of the service being community led and entrenched in community" (PACT-BC Participant).

24/7 Crisis Diversion Teams. In 2008, the Edmonton City Council, driven by community input, established the Taskforce on Community Safety, which provided nine recommendations to improve safety and well-being across the city. By the end of 2009, these recommendations laid the foundation for REACH Edmonton, which was officially formed in 2010 to oversee and implement safety and support initiatives, including the 24/7 Crisis Diversion program. One of the recommendations emphasized developing a program to assist individuals in non-emergency situations who did not require a police response. Initially, this program focused on connecting people to Housing First initiatives, with an emphasis on case management. However, as one 24/7 Crisis Diversion

participant explains, “feedback from service providers, users, and the community highlighted a need for a service that was specifically dedicated to mental health and crisis support and diversion”. In response, the focus shifted, and the 24/7 Crisis Diversion program was launched to provide crisis response and support services more aligned with these needs.

Table 2

Cross-comparison of community voices by site

TCCS	**Expression of interest** call to community, led by the City of Toronto’s Social Development, Finance and Administration Division.
PACT-BC	A **task force** was established to explore community-desired alternatives for crisis support. **Expression of interest** call launched by the Canadian Mental Health Association (CMHA) BC Division to assess readiness of community-based organizations to deliver the service.
24/7 Crisis Diversion	Edmonton City Council launched a **task force** on Community

Sub-Theme 1.2: Building Partnerships with Existing Services

Leveraging the expertise of existing services and forming partnerships with established organizations was consistently endorsed across all sites as essential to the development of their respective civilian-led crisis teams. In particular, the creation of each team was facilitated through collaborations between existing services, accomplished by expression of interest calls. Table 2 describes cross-site findings of the sub-theme’s key points.

Toronto Community Crisis Services. The TCCS is overseen by the City of Toronto and emerged from partnerships made between existing community-based services who, as one TCCS participant noted, “were already on the ground and were doing this work and were seen as a really good example”. The partnerships were

established through the expression of interest call made during the initial planning phase of the service. Currently, the TCCS is delivered in partnership with four community-based organizations, who have been providing equity-based, innovative services in the Toronto area for "a long time": the Gerstein Centre, the TAIBU Community Health Service Centre, the Canadian Mental Health Association, 2-Spirited People of the 1st Nations, and the dispatch partner (FindHelp | 211). The TCCS crisis team led by TAIBU Community Health Service Centre offers a focus on African, Caribbean, and Black populations, where the 2-Spirited People of the 1st Nations crisis response team is entirely Indigenous-led. One participant highlighted that the formation of specific partnerships, integral to the establishment of the TCCS, was made possible through:

> bringing folks together and discussing what this [non-police led crisis response team] could look like (...) and tapping into those networks that the City of Toronto were already part of or knew existed, and starting to develop those relationships a little bit more and with particular focus in mind. (TCCS Participant)

Together, these services delivered the initial pilot phase of the TCCS to four areas within the Greater Toronto Area (Downtown East, Downtown West, Northeast and Northwest), covering 64% of the city. According to one participant, each partner brings with them specific expertise, allowing a broader scope of service:

> Each partner brings a unique set of experience and skill. They also bring with them [their own respective] networks. So, it's not just them, they have their own partnerships, and those partnerships support them in terms of broader engagement [of the service], but also the referral pathway and network that exists [within the service]. (TCCS Participant)

Peer-Assisted Care Teams - BC. The PACT-BC teams are delivered in partnership with pre-existing local service providers including the Canadian Mental Health Association – British Columbia (CMHA-BC, North Vancouver), Purpose Society (New Westminster), and the AVI Health and Community Services (Victoria). CMHA-BC is the provincial administrator of the peer-assisted care team program. Initially, an expression of interest call was put out to the community to explore potential partnerships between CMHA-BC and local services to support the delivery of the service. As one PACT-BC participant explains, "it was the position of CMHA BC as [an organization] who has delivered services for the province before to be able to kind of like co-create [PACT-BC] with other community organizations". This "Community Readiness" call resulted in the formation of partnerships between CMHA-BC and the community providers, who, together, support the delivery of PACT-BC. Leveraging existing knowledge and connections within the community was an integral component of the development and eventual delivery of PACT-BC across BC municipalities.

24/7 Crisis Diversion. The 24/7 Crisis Diversion teams were developed through partnerships established between REACH Edmonton, Hope Mission, and Boyle Street. REACH Edmonton is a community organization focused on fostering safety and crime prevention through partnerships and collaborative initiatives, while Hope Mission is a social care agency that provides shelter, food, and support services for vulnerable populations. Boyle Street Community Services is a non-profit organization supporting people experiencing homelessness and marginalization by providing essential services and community assistance. Together, these organizations collaborated to establish the 24/7 Crisis Diversion teams. As per one participant, REACH Edmonton "works as a sort

of convener [to] bring partner agencies together who are already doing work in the community to coordinate their efforts to provide stronger support to the community". As per another participant, Hope Mission and Boyle Street "had already been working with vulnerable communities" prior to their involvement with 24/7 Crisis Diversion, making them well suited to join as partner providers to support the delivery of the crisis teams.

Table 3

Cross-comparison of building partnerships with pre-existing services by site

TCCS	**Overseen by** the City of Toronto **Partnered with** the Gernstein Centre, TAIBU Community Health Service Centre, the Canadian Mental Health Association, 2-Spirited People of the 1st Nations, and the dispatch partner (FindHelp | 211). **Each partner organization were pre-existing services.**
PACT-BC	**Overseen by** the Canadian Mental Health Association-BC (provincial administrator of teams). **Partnered with** the Canadian Mental Health Association, Purpose Society, and AVI Health and Community Services. **Each partner organization were pre-existing services**.
24/7 Crisis Diversion	**Overseen by** REACH Edmonton. **Partnered with** Hope Mission, Boyle Street, and the Canadian Mental Health Association (dispatch provider). **Each partner organization were pre-existing services.**

Sub-Theme 1.3: Funding

Securing and/or navigating funding consistently emerged as a factor that supported the initial establishment, operation, and expansion of civilian-led crisis teams across all sites, allowing them to launch and operate. Table 3 describes cross-site findings of the sub-theme's key points.

Toronto Community Crisis Service. The Toronto Community Crisis Service (TCCS) has secured funding primarily through the City of Toronto's municipal budget. According to one TCCS participant, the funding comes "100% from the tax base" as part of the City's broader effort to restructure crisis response and reduce police involvement

in crisis situations. Accordingly, initial funding came from reallocations within the city's social services and mental health budgets, including resources shifted from the police budget in response to community calls for investing in non-police crisis alternatives. Recently (early 2024), the City of Toronto approved a budget plan that will allocate additional funding to the TCCS, nearly doubling its previous budget. This increased investment is aimed at expanding the TCCS capacity and provision of services in their effort to go city-wide.

Peer-Assisted Care Teams - BC. The Peer Assisted Care Team (PACT-BC) initiative in British Columbia has secured significant financial and structural support from the Province of BC and other funding sources. The first PACT was launched in North and West Vancouver in November 2021, supported by funds from Provincial Civil Forfeiture, Community Foundations Canada, and private donations. Concurrently, the City of Victoria obtained funding from the Union of BC Municipalities Strengthening Communities Fund, enabling community engagement and planning for a local PACT team. In New Westminster, advocacy from municipal leaders and police highlighted the need for alternative crisis responses, leading to provincial funding for a PACT team.

Building on these early efforts, the province committed $1.26 million in 2022 to support the implementation of PACTs in Victoria and New Westminster and to sustain the North Shore program. Later that year, the Safer Communities Action Plan announced further investments to expand the PACT model to 10 communities, including two Indigenous-led crisis teams. By 2023, additional PACT teams were confirmed for Prince George, the Comox Valley, and Kamloops. With the 2024 provincial budget, PACT-BC

transitioned from a pilot to a permanent provincial program, firmly establishing its role in the crisis care ecosystem.

24/7 Crisis Diversion. The funding for Edmonton's 24/7 Crisis Diversion program is primarily provided by the City of Edmonton to REACH Edmonton. REACH is allocated funds specifically for 24/7 Crisis Diversion, which covers most of the program's costs. However, some of REACH's core funding is also allocated to support the 24/7 Crisis Diversion program, to support any costs that are not fully covered by the dedicated funding. The funding is then distributed to the program's partner organizations, based on a rate determined by a steering committee that includes REACH and its partners. This committee, along with the Chief Financial Officer, monitors the budget monthly and reviews it quarterly. In addition to the direct funding, the program relies on in-kind contributions from partners, who pull from other funding sources to help sustain 24/7 Crisis Diversion. Prior to 2024, these in-kind contributions were not systematically tracked, which created challenges in understanding the full cost of operating the program. However, efforts are now being made to identify and report these contributions to provide a more accurate budget to City Council. The most recent budget cycle, spanning from 2023 to 2026, will involve a formal budget proposal process.

Table 4

Cross-comparison of funding by site

TCCS	100% from tax base.
PACT-BC	Initial funding from municipal, provincial, and private sources (e.g., Civil Forfeiture, UBCM grants). Funding channeled through CMHA-BC. Included in BC's 2024 budget as a permanent provincial program.
24/7 Crisis Diversion	Funding received from City Council. Funding is channelled and distributed through REACH Edmonton. Partner organizations also receive in kind funding.

Sub-Theme 1.4: Influence of the Political Climate

The political climate, both globally and specific to a given municipality, was identified across participants as a factor that influenced the inception and uptake of the respective civilian-led crisis response teams. The influence of the political climate was identified to be two-fold. For one, the political will of council members within a given municipality was identified as a necessary facilitator to establish and sustain these teams. Second, broader global discourse regarding the harms of policing influenced the palatability and support of non-police crisis teams. Table 4 describes cross-site findings of the sub-theme's key points.

Toronto Crisis Community Service. In June 2020, the Toronto City Council voted in favour of building a non-police crisis service, thus marking the inception of the TCCS. In early 2024, there was unanimous council approval to expand the service city-wide, further solidifying the role of political will in supporting the sustainability of the program. Political support has been strong and consistent, with both mayors during the service's development being enthusiastic supporters. According to a TCCS Participant:

> We're really lucky in that both mayors that we've had while the service was developed and expanded have been huge champions of the work. And they, you know, support our events, they come and speak publicly about the importance of the service. And, you know, we had unanimous council approval to go city wide. And so that's really great to have that political will in place. Because without that political will, you can't, you cannot start a new service that's 100%, based on the tax base, in what is a very challenging fiscal environment for any government, and specifically, the City of Toronto. So, it's been, it's been really important for us to have that.

Peer-Assisted Care Teams - BC. The political climate significantly influenced the development of PACT-BC, particularly in their early phases of development in 2020, following the murder of George Floyd by police. As one participant noted, "there just seemed to be a window in time where different local governments were able to kind of lean into this in a bit of a different way than they had previously". This period of heightened awareness and demand for change led to municipalities, such as Victoria and New Westminster, pushing for alternative response models. Political advocacy played a crucial role, with funding from the Union of BC Municipalities and COVID-related Safer Communities grants, helping to initiate programs. Furthermore, the provincial government's engagement, inspired by community advocacy efforts, allowed these programs to evolve into a provincially funded initiative, aimed at supporting community-driven mental health crisis response efforts.

24/7 Crisis Diversion. The political climate is a key factor in the funding and sustainability of Edmonton's 24/7 crisis response program, as funding comes directly from City Council. One participant explained, "the majority of the funds that we flow come from that additional funding that we get for 24/7 directly," but acknowledged that these funds don't cover all operational costs. Another participant further noted that the budget proposals go to city council, resulting in "the funding relationship [being] directly tied to city council" thereby operating "within a political realm", underscoring the impact of local government decisions on the program's establishment and ongoing operation.

Table 5

Cross-comparison of political influence by site

TCCS	**Toronto City Council** voted in favour of building a non-police mental health crisis service.
PACT-BC	Broader political climate in 2020 (e.g., the murder of Mr. George Floyd) promoted the palatability and uptake of non-police teams.
24/7 Crisis Diversion	Teams are funded and supported by **Edmonton City Council**, such that the relationship between the teams and the governing body operates "within the political realm".

Synthesis of Theme 1 Findings

The cross-site analysis highlights both commonalities and differences in the development of civilian-led crisis teams in Toronto, British Columbia, and Edmonton, driven by four key factors: community voices, partnerships with existing services, funding, and the influence of political climate. While community engagement was a central driver across all sites, the methods and scale of this involvement varied. In Toronto, the process was highly formalized, involving public surveys, polls, and roundtables, with over 6,000 participants contributing to the design of the Toronto Community Crisis Service. This extensive engagement was instrumental in shaping the team's development. Similarly, PACT-BC's peer-and-Indigenous-led task forces, coupled with the community readiness call, contributed to the team's development. Edmonton's 24/7 Crisis Diversion Teams, while also community-inspired, were developed in response to specific recommendations by the City Council, based on community feedback about the need for non-police crisis support. Here, community voices were integrated into municipal policy recommendations rather than through large-scale public consultations.

Establishing partnerships with existing services emerged as a consistent and critical process in each team's development and successful operation. Each of the teams leveraged relationship building and partnerships between existing services who had already been working in the community, rather than creating the service entirely from ground up. Each team established a minimum of two partnerships.

Funding, although identified as a key process involved in the teams' development and implementation, varied across sites. The TCCS is entirely funded through the municipal tax base, including reallocations from the police budget in response to community advocacy. In British Columbia, PACT-BC teams secured funding through a combination of provincial and municipal grants, with financial and administrative support from CMHA-BC. In Edmonton, the 24/7 Crisis Diversion Team's funding primarily comes from the City Council. The differences in funding provision and acquisition reflect distinction, including differences in political, fiscal, and community contexts, between the areas in which these teams operate.

Finally, the political climate was identified as a critical factor in influencing the implementation of the civilian-led crisis teams. In Toronto, the unanimous support of City Council and the mayors was pivotal in launching and expanding TCCS, reflecting the importance of local political will in driving change. In British Columbia, the political momentum following the global protests denouncing police violence in 2020, particularly after the murder of George Floyd, rendered local governments keen to explore non-police alternatives. In Edmonton, political support from the City Council is necessary for securing ongoing funding, but the program operates within a more localized political framework, where City Council decisions directly affect the team's budget and scope.

The development of civilian-led crisis teams in Toronto, British Columbia, and Edmonton shared common drivers, reflecting key processes involved in establishing these teams. The differences reflect the nuanced landscapes in which these teams operate, suggesting that while common drivers exist in their development, implementing a standardized, uniform process may overlook crucial factors such as specific community needs, available resources, and political climates. These elements significantly shape how the development unfolds in each context, making flexibility essential for tailoring approaches to local conditions.

Theme 2: Foundational Aspects of Civilian-Led Crisis Teams

Common themes across each of the included sites emerged concerning the foundational components that make up a civilian-led crisis team and guided their creation. Accordingly, this theme includes sub-themes of team composition and training, as well as establishing a framework of practice.

Sub-Theme 2.1: Team Composition and Training

The composition of the civilian-led crisis teams was a key aspect of their development, particularly in their deliberate shift away from police involvement. While the specific roles and types of service providers varied across teams, as detailed below, they all shared a common commitment to operating without police. In addition, each team reported crisis training as a key element to preparing service providers for delivery of the service. Table 5 describes cross-site findings of the sub-theme's key points.

Toronto Community Crisis Service. Each partner organization within the TCCS is responsible for its own hiring, with service providers working under general titles such as mobile responder or crisis worker. Although employed by different partner

organizations, the crisis workers typically meet consistent baseline qualifications. TCCS crisis workers possess experience in areas like community health, mental health, crisis intervention, case management, or other social services, with many coming from the shelter system. As a general (but not necessarily required) standard, they are expected to have at least five years of experience and an educational background in a relevant field (e.g., social work, health sciences). The TCCS places particular emphasis on hiring individuals with skills in crisis intervention, risk assessment, and de-escalation techniques.

The TCCS offers both Black and Indigenous-led crisis response teams. Additionally, given the TCCS's community-based approach and the value of being grounded in the community, they also employ peers as crisis workers. A peer in this sense is a skilled and trained crisis worker who also draws on the valuable knowledge and insight gained from their own lived experiences.

Each service provider hired to work for TCCS teams will undergo a series of core training modules, which focus on skills such as: suicide risk assessment (e.g., ASIST), CPR training, crisis intervention and de-escalation training, as well as cultural competency training (e.g., Indigenous ways of working, how to work with families and kinship circles). The training itself also takes both a theoretical approach (e.g., learning about what harm reduction is positioned to do) as well as practice-based work (e.g., response training using scenario-based exercises).

Peer-Assisted Care Teams - BC. Each PACT-BC crisis response team is staffed by two members: a mental health professional and a peer, both chosen according to program standards that require three to five years of relevant experience and a

background in mental health. All team members receive the same crisis response training delivered by CMHA-BC. One participant noted the importance of clearly defining and explaining the role of the peer responders, noting that:

> There's so much work to do to kind of explain what a peer [responder] is and what lived experience is and how that shows up in work and like what it brings to the role. So, I think sometimes when people hear peer, it isn't held in high enough regard. I want people to understand what peers actually bring to the model. It is something that we continue to have to work on to kind of elevate, you know. [Dominant discourse] feels very comfortable with, for the most part, like people in uniform with guns to respond to mental health, but feels less comfortable with somebody who has lived experience to respond, do you know what I mean? (PACT-BC Participant).

24/7 Crisis Diversion. Members of the 24/7 Crisis Diversion team are hired through partner organizations and follow a consistent set of criteria. When hiring for the crisis diversion teams, each of the partner organizations explained that they look to hire people with experience in being relational and being able to connect with people through conversation as a general guideline. The 24/7 Crisis Diversion teams include service providers from a variety of different backgrounds, such as folks with lived experience, graduates from programs such as social work, nursing, as well as other individuals with relevant background training. Overall, as noted by one participant, "there is no strict requirement, instead, there is the important piece of understanding the community and what we're about and also how best we can support the community". Further, all crisis responders receive training in first aid, mental health first aid, trauma-informed care, non-violent crisis intervention with the focus on de-escalation and not on holds or restraints.

24/7 Crisis Diversion teams are also partnered with 211 dispatchers, operated through the Canadian Mental Health Association. There are no specific requirements for 211 crisis dispatch responders, however generally, staff have a background in psychology, social work, or have experience with the mental health field. As per one participant:

> [211's program] definitely looks for folks who have lived experience and fit into the agency's culture, which is non-judgmental, trauma informed, … and yeah, similar to the other organizations, I would say we would look for folks who understand and are there to support folks because they it's who they are as people, as opposed to, you know, just a job. (24/7 Crisis Diversion Participant).

Crisis diversion dispatchers working with 211 receive 12 days of training, which consists of:

> Focusing on a lot of things like Indigenous cultural awareness, being trauma informed (...) there's a lot of on-the-job training that consistently happens throughout the role. [211 Dispatchers] are really never done. There are always new things coming their way to learn. (24/7 Crisis Diversion Participant).

Table 6

Cross-comparison of team composition and training by site

TCCS	**Non-police**, **Partner organizations are responsible for their own hiring. No set requirements but generally looking for individuals with relevant background experience (including lived/living experience).** Black-led teams, **Indigenous-led teams and peer-staffed teams.** **All staff undergo the same training.**
PACT-BC	**Non-police**. Crisis responders are generally mental health professionals and peers. Staff are hired based on program standards (consistently for each PACT-BC team). **Indigenous-led teams and peer-staffed teams.** **All team undergo the same training**.
24/7 Crisis Diversion	**Non-police**. **Partner organizations are responsible for their own hiring. No set requirements but generally looking for individuals with relevant background experience (including lived/living experience).** **All staff undergo the same training**.

Subtheme 2.2: Establishing a Framework of Practice

Establishing a framework of practice, including the purpose and goals of the teams, along with guiding principles and philosophies, emerged as an instrumental aspect of each team's conceptualization. The framework of practice serves to bridge theory and practice and ensure that service delivery aligns with the core values of the team. Table 6 describes cross-site findings of the sub-theme's key points.

Toronto Community Crisis Service. The TCCS was created to offer a crisis response program that does not involve police, representing a foundational aspect of the team's mandate and goals. Further, the TCCS operates on a consent-based model[2]. This means that while a call for service can be made on someone's behalf, the TCCS will first

[2] See pages 90-91 for important considerations regarding the label of consent-based.

confirm with the individual whether they consent to receive assistance, and the team will always respect the individual's decision regarding whether to engage with the TCCS. In addition, the TCCS cannot apprehend someone under the Mental Health Act.

As a service that is grounded in community, the TCCS works within anti-oppressive and harm reduction frameworks, aimed at meeting people where they are and easing the barriers of accessing mental health care. The TCCS is guided by a strong focus on providing culturally aware and relevant care. At its core, the TCCS is a non-police, community led crisis response model. As noted by participants, the TCCS involves a "sharp focus on how to best serve Black and Indigenous folks who are disproportionately impacted not only by police violence but also mental health and other complex challenges because of society" and the "development of innovative approaches that are grounded in equity". For example, TAIBU Community Health Centre and 2-Spirited People of the 1st Nations, partners of the TCCS, prioritize hiring staff who reflect the communities they serve.

Peer-Assisted Care Team - BC. The PACT-BC teams were developed in response to global discussions on the harms of policing and are designed to offer safer, non-police crisis care. Guided by a taxonomy of principles – including consent-based[3] interaction, the absence of authority to apprehend, and fully non-police staffing – PACT-BC emphasizes compassionate, voluntary support. These teams aim to drive fundamental change within mental healthcare systems and are grounded in a systems transformation approach.

[3] See pages 90-91 for important considerations regarding the label of consent-based.

The service uses a community-based, trauma-informed approach aimed at "creating safer frontline responses to mental health crises," as one participant noted, adding that "people want to feel that when they call for [mental health support], they won't be put in handcuffs." As mentioned, the PACT-BC teams' responses are consent-based, and responders cannot apprehend individuals under the Mental Health Act. The service seeks to fill a gap in the mental healthcare system, by offering a non-police response to crisis situations, which often do not require escalated responses such as police intervention.

One PACT-BC Participant notes:

> [PACT-BC teams] are what the crisis care continuum needs, we have a huge gap in [mental health systems], where, we're responding to mental health [crises] with a way higher level of intervention than needed [i.e., police involvement].

24/7 Crisis Diversion. The 24/7 Crisis Diversion teams' mandate is to "divert non-emergency crises away from emergency services such as EMS and police", which was echoed by all service providers interviewed. The 24/7 Crisis Diversion teams operate within a harm reduction framework that emphasizes a "non-judgmental and trauma-informed" approach that "meets individuals where they're at" and is consent-based[4]. One participant emphasized that harm reduction is an overarching approach, extending beyond substance use to serve as an act of care guiding the teams' responses in all situations. This framework allows for non-punitive, non-coercive support without

[4] See pages 90-91 for important considerations regarding the label of consent-based.

imposing change or requirements. In addition, as another participant explained, the teams operate from a trauma-informed lens;

> The idea is that we are providing support from a trauma-informed point of view. So, we are leveraging relationships or relationship building as a main tool to whatever support we're providing in the course of interactions with community members. (24/7 Crisis Diversion Participant).

Table 7

Cross-comparison of framework of practice by site

TCCS	Team goal: Offer a non-police crisis response service. TCCS takes a **community-based** approach, grounded in harm reduction, anti-oppressive, and **trauma-informed** framework. **Consent-based[5] – will not engage unless consented to by service receiver; will not apprehend under Mental Health Act.[5]**
PACT-BC	Team goal: Creating safer frontline response. PACT-BC teams are grounded in a systems transformation approach, pulling from **community-based**, **trauma-informed** framework. **Consent-based[5] – will not engage unless consented to by service receiver; will not apprehend under Mental Health Act.[2]**
24/7 Crisis Diversion	Team goal: Divert non-emergency situations from emergency services such as fire, police, and/or EMS. 24/7 Crisis Diversion takes a non-judgemental **and trauma-informed** approach, operating within a harm reduction framework. **Consent-based[5] – will not engage unless consented to by service receiver; will not apprehend under Mental Health Act.[2]**

Synthesis of Theme 2 Findings

The implementation and organization of civilian-led crisis response teams have been made manifest by their foundational aspects, including team composition and training, and the establishment of a framework of practice. Across each site, team

[5] See pages 90-91 for important considerations regarding the label of consent-based.
[6] It is important to note that while these teams do not enforce the Mental Health Act, they may request police assistance when responding to calls, at which point police may enact the Act. Although public data on call and response patterns suggests this occurs infrequently, it remains a critical consideration.

composition retains one central component: they do not staff, or respond alongside, police. While the exact members of each team differ, they commonly include pairs of mental health professionals or individuals with extensive and relevant backgrounds, or pairs of mental health professionals with peers (i.e., individuals with lived experience). The exclusion of police from these teams represents a fundamental shift in crisis response and is a distinct factor in the organization of civilian-led crisis response teams.

Establishing a framework of practice, referring to the guiding principles and approach by which these teams operate, emerged as a critical element in the conceptualization and development of the teams, as well as a factor that influences their successful operation. Each team had an identified guiding framework that influenced its response and overall team goal. Despite some nuances in the frameworks, each team identified working to provide trauma-informed care, abiding by a harm reduction framework to support the community as best possible.

Theme 3: Operational Components

This theme explores the pathways to accessing care from civilian-led crisis teams, including how service users might get in touch with the team, as well as the scope of the service provided by the teams. It includes sub-themes of access to team and scope of team response.

Sub-Theme 3.1: Access to Team

Establishing a means of accessing crisis response from a civilian-led crisis team emerged as a common theme across each included site. Specifically, whether the team is accessed through a distinct dispatch or embedded dispatch with other emergency services

(e.g., 911, 211) emerged as an important element in the teams' functioning. Table 7 describes cross-site findings of the sub-theme's key points.

Toronto Community Crisis Service. The TCCS has a "no wrong door" approach to accessing their care, meaning that there are multiple ways of getting in touch with the team, including 211, 911, or direct phone lines to each of the partner organizations who operate the teams. The primary access point is 211, who initially became the team's call and intake dispatch provider due to their longstanding experience with community resource navigation. One participant described the process of accessing care from the TCCS as follows:

> We have multiple access points. Our primary access point is 211 (...) so they are our primary door. But we also get calls from 911. So, you can call 911 and if they determine through an assessment or a series of questions that TCCS is the most appropriate service, then they will transfer that person to 211, and 211 will dispatch. And then the other ways are, each of the partners have their own direct lines that people can call. So those numbers are for folks who are much more familiar with a particular organization, and they want to go directly to them. So, they have direct lines, we also have backdoors, with some of them, like long standing hotlines, like the phone lines, mental health phone lines that exist. And we're always looking to kind of expand all of those doors and make sure that there's as many people are able to access the service as possible. (TCCS Participant)

The TCCS collaborates with 911 operators to divert non-emergency crisis calls to non-police responders. This process involves a series of steps: 911 operators assess calls using specific criteria to determine if the TCCS is appropriate, after which the call may be transferred to a 211 Service Navigator who dispatches a TCCS team. Additionally, since

2021, crisis workers from organizations like the Gerstein Crisis Centre are embedded within the 911 call centre to support real-time assessments and ensure suitable crisis response, reducing the need for police involvement in these cases. More recently, the TCCS became positioned as the fourth model of emergency service response, alongside police, fire, and EMS, meaning that if an individual were to contact 911, they could request care from either the TCCS, police, fire, or EMS, depending on the scope of the response required.

Peer-Assisted Care Team - BC. Each of the PACT-BC teams have their own seven-digit number that can be used to get in contact with the team. A dispatcher who is trained to assess the situation responds to calls, determines if a situation is within the scope of the crisis response teams, and if so, will dispatch the teams. Recently, there has been a push of advocacy to integrate the PACT-BC teams into 911 as an access point to reach the team. One participant explains:

> Part of our ongoing advocacy is that 911 integration piece. Everyone across Canada was taught to call 911 for help. And we know the number, the volume of calls that are going into 91 [the number of calls that require] police response are pretty minimal compared to what is possible for mental health professionals to respond to. So it's looking at those opportunities to divert the calls. So, we are getting the right response at the right time. (PACT-BC Participant)

24/7 Crisis Diversion. The general first point of access to the 24/7 Crisis Diversion teams is through dispatch workers from 211, operated through the Canadian Mental Health Association – Edmonton Region. The teams can also take direct referrals from emergency services (i.e., police, fire, EMS), thereby bypassing the 211-contact

point. Similarly, as echoed across multiple participants, calls made to 911 can be directed to 211 to coordinate a dispatch of the 24/7 Crisis Diversion teams. One participant went on to note that:

> Over the past couple of years, there has been (...) conversations and planning for integrated call evaluation and dispatch, which would have everybody kind of housed in one location, and as calls came in, they'd be able to get the right resource going out at the right time (...) We are working right now on getting clearance for some of our 211 staff to be housed in the 911 dispatch center so that when those calls come in, they're able to have a face to face conversation like, "Hey, I've got this call. Is this more appropriate for you?". So, there is that, that recognition that [calls are] dealt with right at the right point of contact. (24/7 Crisis Diversion Participant).

Table 8

Cross-comparison of access to team by site

TCCS	Primary **access to team is by calling 211.** **Each team also has own number.** **Team can take direct referrals from emergency services (911).** Is i**ntegrated with 911** (TCCS recognized as 4th emergency service).
PACT-BC	**Each team has its own number.** **Looking to integrate with 911.**
24/7 Crisis Diversion	**Access to team by calling 211.** **Team can take direct referrals from emergency services (911).** **Looking to integrate with 911.**

Sub-Theme 3.2: Scope of Response

Determining the scope of response, that is, the type of care that a team can provide as well as the situations that they are suited to respond to, was a key element identified in the both the implementation and operation of civilian-led crisis teams. Table 8 describes cross-site findings of the sub-theme's key points.

Toronto Community Crisis Service. The TCCS supports individuals 16 years and older. The TCCS responds to non-violent calls, or calls that have no potential for violence, and where people don't have access to weapons. In the event of a call involving weaponry or violence, the Mobile Crisis Intervention Team (MCIT), which is a co-responder model and thus involves police, will be asked to respond. In terms of balancing the scope of practice of the TCCS versus Toronto's co-responder model, one participant explained that:

> We've always said that TCCS takes lower acuity calls, where there are no threats of violence, no weapons, and MCIT might take on higher acuity calls where there might be more potential for violence and danger. So that's how we've been able to delineate the two services. (TCCS Participant)

Another aspect of the TCCS' scope of practice refers to the continuity of care case management they offer. Specifically, the TCCS offers post-crisis case management for 90 days to support people by offering referrals and connections to other services, resources and information, and other relevant post-crisis follow-up supports. To this extent, developing these referral pathways was an important component of developing the service scope of response. Finally, the TCCS teams' services are delivered 24/7, 365 days of the year, including holidays. Taken together, the TCCS has the goal of breaking the cycle of crisis.

Peer-Assisted Care Teams - BC. The PACT-BC teams support individuals 13 years and older. They respond to calls that involve crises related to acute distress or substance use; they do not respond to calls with a threat for violence, harm, or medical emergencies requiring immediate medical attention. The PACT-BC teams work to connect individuals requiring support to relevant resources within the community, to

ensure a wrap-around care approach to addressing psychological distress crisis situations and substance use concerns. This often includes referrals to mental health services, housing support, substance use treatment programs, or social services, depending on the individual's needs. Presently, the PACT-BC teams are available every day of the week; they are not a 24-hour service; instead, the service is available between 7:30am-12:30am (North Vancouver and Victoria) and 7:30am-11:30pm (New Westminster).

24/7 Crisis Diversion. 24/7 Crisis Diversion teams respond to non-emergency crisis calls and are available 24/7, 365 days a year. Examples of situations that the 24/7 Crisis Diversion teams respond to include a person who is intoxicated or otherwise impaired; a person who feels unsafe (self-identified) but presents no threat of violence (such that they do not possess a lethal weapon, such as a gun); a person who may be experiencing acute distress. Examples of situations that the 24/7 Crisis Diversion team do not respond to include a medical emergency (i.e., an individual who is unresponsive, suspected or confirmed substance poisoning) or situations involving violence/threats of violence (such as an individual is in possession of a firearm). Further, the 24/7 Crisis Diversion program is voluntary; team members are unable to remove folks from a property or apprehend them under the Mental Health Act. The 24/7 Crisis Diversion teams were implemented and funded, as per their mandate, to handle situations that do not require paramedics, fire, or police, thereby redirecting these calls away from emergency services:

> Our mandate is to divert non-emergency crises away from emergency services … We are really looking at how we can improve support to community members themselves. (24/7 Crisis Diversion Participant).

Table 9

Cross-comparison of scope of response by site

TCCS	**16 years and older**. Respond to "non-violent" calls related to mental health or substance use. Provides 90-day post-crisis care/case management.
PACT-BC	**13 years and older**. Respond to "non-violent" calls related to mental health or substance use.
24/7 Crisis Diversion	Respond to "non-violent calls" related to mental health or substance use.

Synthesis of Theme 3 Findings

Across the three sites, the operational components of civilian-led crisis teams reveal both shared approaches and site-specific variations in their access point and the scope of responses. In terms of access to teams, calling 211 and/or 911 was the primary access point for the TCCS and 24/7 Crisis Diversion, where the PACT-BC teams are accessed by their own respective seven-digit phone numbers, despite looking to get embedded with 911. Uniquely, the TCCS has been officially recognized as the fourth emergency service, alongside police, fire, and paramedics.

Concerning the team's scope of response, each of the three teams focus on addressing non-violent distress and substance use crises, though there are distinctions in how they operate within their respective communities. The TCCS responds to non-violent incidents involving no weapons and operates on a consent-based model, ensuring that individuals agree to receive assistance. Additionally, TCCS offers 90-day post-crisis case management, providing wrap-around care and referrals to other services. Similarly, the PACT-BC teams focus on non-violent distress and substance use-related crises. Their work is also consent-based, and they aim to connect individuals with appropriate

community resources for longer-term support. The 24/7 Crisis Diversion program respond to non-emergency situations, including intoxication or feelings of unsafety, but do not handle medical emergencies or violent incidents. Interestingly, the scope of their on-the-ground intervention generally expands beyond their mandate to meet clients where they're at and fill any gaps that the system might not be meeting. While the TCCS and 24/7 Crisis Diversion teams are available at all hours, every day, the PACT-BC teams are not.

Theme 4: Team Sustainability and Expansion

The data consistently highlighted the importance of ensuring the sustainability of civilian-led crisis programs and advancing their broader expansion, whether at the municipal or provincial level. Sub-themes include evaluation processes, describing data collection and evaluation markers of the team to monitor its operation post-implementation, as well as ongoing communication and collaboration, referring to key components of the models' success.

Subtheme 4.1: Evaluation Process

A robust and ongoing evaluation process was described by participants as playing a critical role in ongoing team operation. Regular assessment of program outcomes not only helps measure implementation outcomes and ongoing operations but also provides insights into areas for improvement and long-term sustainability. A comparison of key findings across the three sites is presented in Table 9.

Toronto Community Crisis Service. The TCCS has service agreements with each of the partner organizations involved in operating the teams. These service agreements highlight clear standards regarding the delivery of the service that each

partner organization must meet, including operating the teams 24 hours a day, 365 days a year. A third-party service has regularly evaluated each team since the project's inception. Key components of the evaluation include tracking response times, service outcomes, and client satisfaction. The evaluation process also incorporates feedback from community members and service users to understand how well the service meets the needs of vulnerable populations, as noted by one participant who explained, "we did interviews with each of the partners and kind of looked at opportunities for improvement there as well, and provided a number of recommendations for us all as, as the TCCS to look at in terms of improving". Additionally, the evaluation process examines the collaboration between TCCS and existing services, including emergency response systems, to ensure a seamless and supportive crisis intervention process.

The evaluation framework during the pilot phase was focused on measuring the delivery and reach of the service, including several critical outcomes such as the reduction in police involvement during acute distress situations, and the overall impact based on number of dispatched interventions and subsequent linkage to care. Data from these assessments help inform adjustments to the program, allowing for continuous improvement and adaptation to the unique needs of Toronto's diverse communities. The findings also play a crucial role in advocating for the expansion and long-term sustainability of TCCS. As the teams moved out of piloting and focused on expansion, the evaluation "became more interested on improving all aspects of the service and kind of developing quality assurance standards. So that's what we are doing now and moving forward". The ongoing evaluation of the TCCS, demonstrating the service's success, resulted in its successful expansion city-wide in summer of 2024.

Peer-Assisted Care Teams - BC. The PACT-BC operating in North Vancouver, New Westminster, and Victoria have engaged in an ongoing evaluation process that focuses on how these teams are improving community-based crisis responses. Specifically, the teams have been evaluated on key components including the number of calls handled, reduction in police involvement, client feedback and community sentiments, as well as qualitative outcomes based on peer and clinician observations during interactions.

From January to May 2023, these teams handled over 700 crisis calls with minimal police involvement, demonstrating the effectiveness of a peer-integrated, trauma-informed approach. The feedback from these regions indicates that PACTs are providing a much-needed alternative to police response in crisis situations, offering a compassionate and client-centered approach to care. One participant emphasized that a key challenge in the evaluation process was the limited availability of accessible and transparent data from police-only response models. This data gap hindered the ability to make a strong comparative analysis:

> In the context where we only have our data, but there isn't readily available police data on like, their interactions with the mental health system and persons in crisis in a standardized transparent way, [it was difficult] to initially say this is how we are or not we are impacting it [i.e., crisis calls]. (PACT-BC Participant).

Notwithstanding, the evaluation outcomes of the PACT-BC teams, along with advocacy from CMHA-BC to the province, have successfully inspired the expansion of PACT-BC into other BC municipalities, including Kamloops (partnered organizations: Kamloops Aboriginal Friendship Society and ASK Wellness Society), Prince George

(partnered organization: Prince George Native Friendship Centre), and Comox Valley (partnered organizations: AVI Health & Community Services and K'ómoks First Nation).

24/7 Crisis Diversion. The 24/7 Crisis Diversion teams are evaluated by their overseeing organization, REACH Edmonton. As explained by one participant, "we [REACH Edmonton] have always reported on our outcomes. They're shared with the police commission and whoever, and that's been [the case] since program and inception". Specifically, REACH Edmonton has developed a data-collection system used to track information and statistics relevant to the 24/7 Crisis Diversion teams' operation and impact. Evaluation outcome variables include assessing the number of calls made to 24/7 Crisis Diversion teams, monitoring for a reduction in non-emergency 911 calls, and assessing the number of resource referrals made during 24/7 Crisis Diversion intervention. Additionally, REACH Edmonton collaborates with external third-party evaluators. In 2018, the Social Return on Investment (SROI) evaluation of the 24/7 Crisis Diversion program revealed that for every $1 invested, the program generated a return of $1.91.

Table 10

Cross-comparison of evaluation process by site

TCCS	**Third-party evaluation process.**
PACT-BC	**Third-party evaluation process.** Qualitative outcomes based on peer and clinician observations during interactions.
24/7 Crisis Diversion	Third-party evaluation process. An additional evaluation process by overseeing organization, REACH Edmonton.

Subtheme 4.2: Ongoing Communication and Collaboration

Ongoing communication and collaboration were identified across each included site as a key component to the success of the team(s). The iterative aspect of each of the teams' initial implementation and ongoing operation allows for continuous refinement and adaptation, which is made manifest by ongoing communication and collaboration across team members, service partners, and the community. Cross-site findings of the sub-theme's key points are described in table 10.

Toronto Community Crisis Service. As a community-based service, the TCCS prioritizes ongoing collaboration with its partner organizations and community voices to ensure that the service's reach and mandate are being met. One participant explained that this is facilitated by open-channels of communication and discussion, noting that

> We have monthly check ins, we have monthly meetings with everybody [involved in the team's operation] and have bi weekly check ins with the service providers with each partner. And then we have our, broader city advisory table that they sit on as well. And yeah, so I think it's just like, constant and consistent engagement, communication and collaboration. (TCCS Participant).

Peer-Assisted Care Teams - BC. Ongoing communication and engagement with community emerged as a key element in expanding and advocating for the necessity of the PACT-BC teams. The value of relationship building, both with partner organizations as well as community members highlighted a foundational component of the teams' initial uptake and sustainability. As per one participant, ongoing engagement with community continued to demonstrate that the PACT-BC teams are needed and wanted, thereby further encouraging their resourcing, funding, and expansion:

> Communication is really important. And we're still trying to frame out how to do like ongoing community engagement. But you know, we've read report after report, done engagement after engagement, [which has signalled that], this is what this is what people kind of want. (PACT-BC).

24/7 Crisis Diversion. Communication and collaboration emerged as necessary factors in sustaining the 24/7 Crisis Diversion teams. As per one participant, ongoing and open communication and collaboration across the program's key players are essential to "making what's being done work". One participant noted:

> I think having somebody to kind of do that ongoing, pulling all the pieces together is really kind of that key place you have to invest. It hardly ever happens on its own, unless you have somebody dedicated, and that's their role, right? (...) Collaboration really does need to be intentional. (24/7 Crisis Diversion).

Another participant echoed these sentiments, noting:

> Coordinating all of the different working partners and making sure that we're touching base consistently [is necessary], but I have to say that communication, for me, is the biggest piece. You know, we're in constant communication with one another throughout days, throughout the weeks, and so we're constantly making sure that things are functioning, or that if we need to come up with a group solution to something, that there's always space for that to happen. And I think we're always all trying to achieve the same goals at the end of the day, to support community, to fill in those gaps. And so I think having that same goal in mind and having consistent communication is really key to making it function. (24/7 Crisis Diversion).

The aforementioned data supports the importance of communication across team members and partners. Equally important, however, was the communication with community and advocacy for community, with another participant explaining that:

> Overall, we collaborate as different organizations, then we communicate, and then we collaborate again, and I would also say a lot of advocacy [is a key component]. So like the frontline is advocating on behalf of community members. And sometimes you hit a barrier. But being able to advocate and then leverage it to different levels that maybe not all of the individual partner organizations are at [is instrumental]. Having clear, consistent messaging across the board has been super helpful as well. I think being able to have the relationship across the board, rather than just with one agency is really important. And you know the information sharing, being able to do that openly within this collaboration. (24/7 Crisis Diversion).

Table 11

Cross-comparison of ongoing communication and collaboration by site

TCCS	**Identified open and ongoing communication as a key component of the team's success.**
PACT-BC	**Identified open and ongoing communication as a key component of the team's success.**
24/7 Crisis Diversion	**Identified open and ongoing communication as a key component of the team's success.**

Synthesis of Theme 4 Findings

The sustainability and expansion of each of the teams explored are underpinned by evaluation processes and ongoing communication and collaboration. The TCCS, PACT-BC teams, and 24/7 Crisis Diversion each undergo ongoing evaluation to assess key outcome variables, which are subsequently used to demonstrate the teams' efficacy

and success. These evaluations have played a key role in the teams' ongoing funding, operation, and expansion. Similarly, all three programs emphasize the importance of maintaining open channels of communication between partner organizations, as well as with community. The collaborative efforts across sites not only ensure that each program is adaptable and responsive to the communities they serve but also foster advocacy and resource-sharing, which are essential for long-term sustainability and broader expansion. This consistent feedback loop between evaluation, communication, and collaboration ensures that these programs remain dynamic and capable of evolving with the needs of the communities they support.

CHAPTER SIX: DISCUSSION

Civilian-led response programs are emerging as promising alternatives to police-involved intervention for individuals experiencing acute distress. The implementation of non-police crisis support fills a critical gap in services and provides a necessary step toward separating the criminal legal system from mental health care (Ritchie, 2023). The current research is the first known case study undertaken to better understand key processes in the development, implementation, and operation of non-police crisis teams in Canada. This research contributes to the novel production of knowledge in the field of crisis response programs that have divested from police and seeks to inform and promote the expansion of non-police crisis response teams to support accessible, equitable, and safer support services.

The current study engages with broader conversations about the limitations of police-led interventions. The social climate within the current research has been undertaken is marked by a time where terms such as "reform" or "safer alternatives" are often subject to interpretation, defined in alignment with the speaker's agenda (Interrupting Criminalization et al., 2022). Accordingly, findings will be interpreted through an abolitionist lens enriched by Interrupting Criminalization, Project Nia, and Critical Resistance' (2022) guidelines, *So is this Actually an Abolitionist Proposal or Strategy?* This chapter begins by presenting an overview and interpretation of the research's key findings, discussed alongside their theoretical grounding and in consideration of the broader social context. The latter sections of the chapter will turn to present the findings' implications, the study's limitations, and proposed areas for future research.

Overview and Interpretation of Key Findings

This discussion engages with the research objectives by examining the findings as they relate to the processes of conceptualizing, developing, implementing, and operating the civilian-led crisis response teams of focus. To enhance clarity and provide a concise overview of how the findings align with the research objectives, Table 11 maps each theme to its corresponding objective and highlights the key elements addressed.

Table 11

Alignment of themes with research objectives

Research Objective	**Key Themes**	**Subthemes**
Objective 1: Identify the key processes involved in the conceptualization and development of civilian-led crisis teams in Canada.	**Theme 1**: Key Drivers of Team Development	1. Community Voices 2. Building Partnerships with Existing Services 3. Funding 4. Influence of the Political Climate
	Theme 2: Foundational Aspects of Civilian-Led Teams	1. Team Composition 2. Establishing a Framework of Practice
Objective 2: Identify how civilian-led crisis response teams have been implemented and organized, and what factors contribute to their successful operation.	**Theme 3**: Operational Components	1. Access to Team 2. Scope of Team Response
	Theme 4: Team Sustainability and Expansion	1. Evaluation Process 2. Ongoing Communication & Collaboration

Research Objective 1

The first and second primary themes highlight the critical processes behind the conceptualization and development of civilian-led crisis response teams in Canada. Theme 1 explores the key drivers that have shaped the creation of these teams, including community voices, building partnerships, funding, and the influence of the political climate. Theme 2 examines the foundational aspects of each team, including the team composition and framework of practice.

Community voices were consistently recognized across all sites as pivotal in shaping how each team operates, determining who is involved in the service, and defining other essential aspects of the teams' scope of response. The TCCS and PACT-BC programs both implemented culturally specific outreach strategies, prioritizing Black-and-Indigenous-led engagement and peer-led initiatives to ensure that services were aligned with the needs of individuals who face disproportionate rates of contact and harm by police. These approaches directly respond to the historical failures of traditional mental health systems, which have long been shaped by sanism and racism, and disrupts historical patterns of exclusion and silencing experienced by Black, Indigenous, and Mad people. By embracing an anti-oppressive framework rooted in "working with not for" (Wehbi, 2017, p. 137), these teams enable communities most affected by systemic harms to take an active role in designing mental healthcare services. Resisting traditional top-down service models and centering first voices reflects abolitionist principles, where power is shifted away from institutions and toward the community, such that, *nothing about us without us* (Charleton, 1998). Transformative change is not possible without centering lived experience.

The creation and development of each civilian-led crisis team was made possible through partnerships made between existing community-based services. These partnerships promote the leveraging of each partner organization's respective expertise and longstanding experience in the field, contributing not only to the creation of the teams but also to the quality of their service delivery. Historically, traditional crisis response systems have been rooted in carceral logics that prioritize control over care, perpetuating the harmful assumption that individuals deemed mentally ill, particularly those with intersecting Black and/or Indigenous identities, are inherently "dangerous" or "unpredictable". These partnerships directly counter this legacy by fostering collaborative networks rooted in care and mutual support, as envisioned by abolitionist scholars. Organizing and mobilizing efforts are central components to the abolition movement and creating abolitionist-informed services; Kaba and Ritchie (2022) explain, that, "community groups are working to build and strengthen community relationships and infrastructure to create safety without cops" (p. 242).

As per Kaba and Hassan (2019), "there is no blueprint/map for abolition, we must spend time imagining, strategizing, and practicing (…) we organize and mobilize to address the root causes of oppression and harm" (p. 15). Building networks between organizations that share common perspectives and mandates was identified across each site. The involvement of and partnerships between community-based services represent a crucial step in realizing the potential of community-based care – an ideal that was envisioned but never fully achieved following deinstitutionalization. These partnerships now symbolize a renewed effort to fulfill that promise by fostering collaboration, sharing expertise, and building systems that are responsive to local needs. According to

abolitionist scholars, collaboration and mobilization between organizations, communities, and/or people is central to driving transformative change (Ritchie, 2023). Ritchie (2023) explains:

> The most effective way to impact systems is at the level of critical connections, networks, and communities of practice, rather than focusing exclusively on top-down interventions that target singular components of the system. We effect systems change through relationships (p. 69).

Through relationship building and partnerships between community-based organizations that share a common vision, transformative change can be achieved. Such collaborative efforts strengthen each of the crisis response team's service delivery by mobilizing shared resources and expertise; "it's time we refocus on deepening our relationships and expanding our networks" (Ritchie, 2023, p. 69).

Securing funding, as well as the influence of the political climate – locally, provincially, and globally – impacted the development, implementation, and ongoing operation of each team. These factors remained consistent across each site in their impact on team development and expansion. Funding and influence of the political climate separate subthemes, each playing a distinct role in team development, despite the interaction between the two such that funding is susceptible to impact by political climates. Importantly, here, is the consideration that challenging policing mental health must also challenge funding allocated toward police (Interrupting Criminalization et al., 2022). Critically engaging with how alternative programs are funded is essential, asking questions such as "does the funding for these teams directly reduce police budgets (or do they leave them intact or even expanded)?" (Interrupting Criminalization et al., 2022, p.

33), a consideration that was overlooked in my research, representing a notable limitation.

This research is being presented during a social and political moment that echoes the underfunding of mental health care during deinstitutionalization, as seen in the rapid closure of community-based harm reduction services such as safe consumption sites across Ontario, Canada. Much like the lack of investment in comprehensive community mental health care post-deinstitutionalization, these closures – despite the proven benefits of such services (Yoon et al., 2022) – highlight the precariousness of community-driven initiatives under shifting political agendas. This parallel underscores how systemic disinvestment continues to undermine grassroots efforts aimed at addressing social and health inequities. Nevertheless, the collective efforts of community voices and mobilization of community-based services in support of civilian-led crisis response teams remain a steadfast force, "enabling us to resist increasing authoritarianism" (Ritchie, 2023, p. 69) while championing transformative, community-centred approaches to care.

My thesis' findings indicate that each of the included civilian-led crisis response teams are built upon consistent foundational elements, particularly in terms of team composition and the framework guiding their practice. While there are variations in how team composition and practice frameworks are implemented across different teams, the taxonomy of principles by which they are guided by remains consistent at their core. These aspects represent key processes in the conceptualization and development of these teams. A defining feature of each team is that they are non-police operated, positioning them to challenge the deeply ingrained yet flawed notion that police presence is necessary for ensuring safety (Kaba & Ritchie, 2022). Removing police from crisis

response recognizes the inherent danger that police presence poses, particularly to Black, Indigenous, and Mad people, amongst others. Critical race theory posits that racism is endemic to society (Badwall, 2022) and that policing mental health reinforces systemic inequalities and perpetuates racialized harm. Similarly, mad studies makes visible the oppression experienced by individuals whose distress has been pathologized, othered, and deemed deviant (LeFrançois & Peddle, 2022), with policing mental health being one such example (Kaba & Ritchie, 2022). Creating alternative crisis response programs, ones that are not mired in the carceral state, represents a means of reimagining care through an abolitionist and critically theorized lens that understands the legacies of sanism, racism, and colonialism (Interrupting Criminalization et al., 2022).

Despite consistency across each site in their divestment from police staffing crisis response teams, there were differences in who comprise each team. The experience and background requirements for crisis responders vary across teams, with some adopting a more flexible approach (e.g., TCCS and 24/7 Crisis Diversion, which do not necessarily require a minimum level of work experience), while others have more structured criteria (e.g., PACT-BC, which generally looks for individuals with 3-5 years of experience). The TCCS operates both Black and Indigenous-led teams. With a commitment to anti-racist practice, TCCS' partner organizations – the TAIBU Community Health Centre and the 2-Spirited People of the 1st Nations – provide Afrocentric support and Indigenous-centred mental health services, respectively. PACT-BC has two Indigenous-led teams which recognize the historical and ongoing harms of colonialism and racism in mental health care. Black and Indigenous-led teams focus on countering anti-Black and anti-Indigenous

racism and sanism, particularly within the context of crisis response and recognize importance of offering culturally safe support.

Where the TCCS and 24/7 Crisis Diversion may employ peers as crisis responders, the PACT-BC teams are intentional in their inclusion of peers as required members of each team: PACT-BC teams are comprised of paired peers and mental health clinicians. As previously noted, a peer in this context refers to an individual who brings with them lived experience of mental health challenges, someone who may identify as a psychiatric survivor, referring to having survived carceral mental health services such as interaction with police during a mental health crisis and/or involuntary hospitalization (Liegghio, 2013). Including peers in crisis response challenges sanist connotations of people with "mental illness" as incapable and instead acknowledges their lived experience and wisdom as invaluable (Wong, 2024). Further, given mental health practitioners' (i.e., social work, psychologists, psychiatrists, etc.) inherent ties to policing and carceral mental health care practices, incorporating peers in crisis response offers a deliberate means of further disrupting carceral practices. The leveraging of Mad wisdom and experiences should always guide mental healthcare practices in its overt disruption of sanist framings (C. Boyce, 2021; Wong, 2024).

While divesting from police, incorporating peers, and establishing Black- and Indigenous-led teams are tangible steps toward challenging the carcerality of traditional crisis response models, the continued involvement of mental health clinicians in crisis care reinforces connections to carceral systems. Mental health clinicians, particularly those operating within mainstream psychiatric frameworks, retain the authority to pathologize distress, participate in involuntary hospitalization practices, and engage in

risk-based assessments that can justify coercive interventions (Jones & Jacobs, 2024). This maintains avenues through which individuals in acute distress may still be subject to surveillance, confinement, and psychiatric incarceration (Jones & Jacobs, 2024). Thus, while civilian-led crisis teams begin to resist the power of police in crisis care, they do not fully disentangle crisis response from carceral systems. Further, although each team identified that they do not employ police, and that their team mandate involves offering non-police led crisis response (TCCS and PACT-BC) or diverting non-emergency situations away from police (24/7 Crisis Diversion), these teams do not have a strict policy against involving law enforcement. While rare, each team may involve the police if they determine it necessary due to an escalation during a crisis response. Establishing clear guidelines that explicitly define what constitutes an escalation is critical to minimizing police involvement and ensuring accountability.

While the composition of civilian-led crisis teams represents a foundational aspect of these teams and a distinct shift toward safer systems of care, equally important is their framework of practice. Establishing a clear team mandate and framework of practice was identified across each team as essential to guiding service delivery and intentionally positioning the team's response as a community-centered service. The TCCS, PACT-BC teams, and 24/7 Crisis Diversion program all reported taking a community-led, harm reduction, and trauma-informed approach to practice. A guiding principle of each team's framework of practice is that these programs operate as consent-based models, meaning that crisis responders working on these teams will not initiate an intervention unless they have explicit consent from the potential service user. Importantly, however, this research failed to investigate whether key response components are transparently discussed with

potential service receivers before intervention. For example, it remains unclear whether individuals are informed that civilian-led teams can and may call for police support. Additionally, the study does not examine whether clinical case notes are documented alongside personally identifiable data, or if service users are made aware of how such information may be permanent and potentially weaponized throughout their lifespan. Ultimately, any consent that is not informed consent is non-consensual.

Another aspect of these teams' framework of practice is that they are unable to apprehend any individual under the Mental Health Act (i.e., they cannot detain or force individuals into care without their consent, unlike police or other designated professionals). As mentioned above, it is possible that these teams request subsequent police support, in which case the Mental Health Act may be used. Since civilian-led teams cannot initiate a detention, their approach to crisis response differs significantly from other models, such as co-response or police-only interventions, which have the authority to enact the Mental Health Act. The separation between the point of response and the detention under the Mental Health Act (if decided to initiate) reduces the immediacy of coercive interventions. While this approach does not eliminate all risks of harm, it significantly reduces the likelihood of reinforcing oppressive dynamics by ensuring that interventions occur only when explicitly welcomed.

Honouring the autonomy of people with mental health challenges and denouncing coercive and/or forced approaches to so-called care are central to anti-carceral practice (C. Boyce 2021; Wong, 2024). Civilian-led models begin to acknowledge the profound implications of forced, non-consensual intervention, particularly as they intersect with gender, sex, and race, often compounding histories of trauma such as gender-based

violence and systemic discrimination that disproportionately impact social formations (bodies, minds, identity expressions, etc.) labelled as "othered" (Herson, 2018, p. 4) While civilian-led approaches do not eliminate all risks of harm, they begin to challenge coercive and carceral based practices. Entirely peer-led crisis support models do exist and demonstrate that crisis care can be provided without any ties to psychiatric or carceral systems, clinician and cop alike. Initiatives including the Trans Lifeline Crisis Hotline, the Walls Down Collective Community Care & Crisis Phone Line, Wildfire Alliance, and the Koreatown Community Response represent programs that offer care work entirely removed from carceral actors (police, clinicians). These programs are rooted in community care and mutual aid, with strict, transparent policies ensuring that police involvement is never initiated under any circumstance. Entirely peer-based, strictly anti-carceral care work serves as a powerful reminder that care work can – and does – happen *entirely* beyond carceral frameworks. As civilian-led teams continue to evolve, they have an opportunity to learn from these models.

Research Objective 2

The third and fourth primary themes highlight the strategies used to implement and organize each of the civilian-led crisis teams explored. Theme 3 identifies each team's operational components, including the access point and scope of the response, which facilitated their implementation and service organization. Theme 4 speaks to the components that have led to the successful operation of each team, including team evaluation and ongoing communication and collaboration.

Determining and establishing an access point for each team was identified as an element of their initial implementation and organization. Specifically, navigating the first

point of contact for each team – that is, how individuals can reach the team for a service request. PACT-BC teams each have a seven-digit phone number that can be used to reach the team. While the TCCS teams have multiple avenues of contact, including individual team numbers and 911, 211 is their primary point of access. 24/7 Crisis Diversion's only access point is through 211; upon contacting 211 and requesting crisis response services, a trained dispatcher will assess the situation and dispatch the team. The 211 dispatchers for the 24/7 Crisis Diversion teams work under, and are trained by, the Canadian Mental Health Association; this is important in ensuring that dispatchers maintain a critical lens when responding to service requests.

The PACT-BC program is actively advocating for the integration of the teams' access point with 911, believing that this change would make the teams more accessible and improve response times in crisis situations. Navigating the integration of civilian-led crisis response teams' access points with 911 requires careful and critical consideration. While 911 remains the universal contact point for support, the sense of safety that this practice implies is not universal. For many, contacting 911 may evoke fear or mistrust rather than reassurance, given 911's association with traditional emergency services and carcerality. This can deter people who are placed disproportionately at risk of harm from law enforcement from seeking support. Further, exploring the training requirements of 911 operators as well as their relationship to the police (i.e., if they are represented by the same union; do they share interests?) are critical should a 911-dispatch access point be implemented.

Relatedly, the 24/7 Crisis Diversion is exploring to co-locate their 211 dispatch operators with 911 dispatchers to improve communication and collaboration, allowing

911 calls to be re-routed to more appropriate response models when needed. While this initiative might be successful in quickly and appropriately re-routing calls from 911 to 24/7 Crisis Diversion, it will need to be closely monitored to ensure the opposite doesn't occur—that calls intended for civilian-led responses do not default back to police involvement. Above all is the importance that each team consults the community when making critical decisions about their evolution; a practice that has already been made central to each of these teams' development and ongoing adaptation.

Determining a clear scope of response, meaning the range of situations a team responds to and the services offered during and after intervention, contributed to each team's implementation and successful ongoing operation. Consistent across each site, civilian-led crisis response teams respond to non-violent and non-emergency calls, particularly in the realm of mental health crisis and/or substance use concerns. Non-violent situations were described as situations where there is no threat of harm or violence, and/or where an individual does not have a weapon. Non-emergency calls in this context were defined as situations that do not require immediate medical attention (such as a toxicity poisoning). The criteria for a non-violent situation might benefit from further exploration, which was overlooked by my research. Exploring – and, in lack of transparency, establishing – specific criteria used to determine whether a person is deemed "dangerous", or a situation that is deemed to present "risk of harm or violence", as well as what constitutes as a "weapon" are important considerations (Interrupting Criminalization et al., 2022). The concepts of dangerousness, risk of harm or violence, and even what qualifies as a weapon are often shaped by carceral logic (Interrupting Criminalization et al., 2022), particularly through the conflation of violence with displays

of distress, and how this manifests along sites of race and gender. Thus, there are certain levels of potential sanist/racist connotations that remain upheld by this scope of response, especially where there is a lack of clear/transparent definitions. By interrogating these criteria, we can challenge the underlying assumptions that justify the use of force, surveillance, or incarceration.

Equally important when assessing the scope of response is examining the minimum age individuals must be for teams to respond. Understanding how age thresholds shape the scope of crisis response can help illuminate potential gaps or conflicts in service provision, particularly for youth who might otherwise be funnelled into systems with more entrenched law enforcement connections. If civilian-led crisis teams are unable to respond to individuals below a certain age, young people in crisis may instead be directed to institutions such as child welfare services or hospitals – systems that often have their own legal mandates, including duty to report, that can lead to greater police involvement.

An evaluation process was identified across each site as both an initial and ongoing process involved in the teams' development. Each team's evaluation lent itself to advocating for the team's efficacy in supporting the community, and, for the TCCS and PACT-BC teams specifically, represented a key factor that informed the expansion of the service. Transformative change is a non-linear, iterative process, marked by ongoing "practice and adaptation" (Ritchie, 2023, p. 69). Emerging, transformative strategies require a constant cycle of evaluation, change, and revaluation. The evaluation processes identified across each site, coupled with ongoing engagement in communication and collaboration between community, service providers, and partner organizations, reflect

these principles. The intentional evaluation of each model, which accounts for key outcome variables as well as continuous community input, allows the service to be readily adapted as fit to meet the evolving needs of the community. This commitment to transparency and adaptability reframes mental health services as dynamic and collaborative, breaking away from the rigid, paternalistic frameworks of the past (e.g., the asylum). As per Kaba and Ritchie (2022), "we can focus on advancing the work of greater and more liberatory forms of safety by engaging in grounded assessments of our efforts" (p. 247), which is reflected across each site by their evaluator process. Ultimately, creating greater safety in communities, and working toward anti-carceral transformative change is "an ongoing process, a praxis" (Kaba & Ritchie, 2022, p. 247), which was recognized by each team.

The open communication across partner organizations delivering the team, as well as continued community engagement reflected across each site, were identified as a key component of success for each team's implementation. Creating services that disrupt the status quo and work toward building greater safety takes time and space (Kaba & Ritchie, 2022). Dismantling dominant systems requires collective effort, as no single entity can achieve it alone; liberation is inherently collective. The collaboration process reflected across each team, such that communication and strategizing are iterative and adaptable, embodies the processes of transformative organizing identified across the literature (Ritchie, 2023). New strategies take practice with adaptation, with relationship building centered on communication and collaboration lying at their core (Ritchie, 2023).

CHAPTER SEVEN: CONCLUSION

Implications

My thesis is the first known multi-sited case study design investigating civilian-led crisis response teams in Canada and is among the earliest contributions to the growing body of research in this area. The findings offer insight into the consistencies and variations between processes involved in conceptualizing, developing, implementing, and operating three civilian-led crisis response models in Canada. Above all, findings suggest that civilian-led crisis response teams begin to offer a pathway for systems of care to respond to the realities of sanism, racism, and the historical contexts of mental health care in Canada.

Given the broad thematic consistency across each site, but the variation in how each theme manifested, the current research suggests that there is no universal approach to developing civilian-led crisis response teams. While development and implementation processes followed broadly consistent strategies, intricacies exist based on the local landscape and the needs voiced by communities. Notwithstanding, the themes identified in this research could provide a valuable roadmap that might guide community-based organizations and other key interest holders aiming to establish civilian-led crisis response teams. These findings, coupled with ongoing community-led advocacy for transformative, anti-carceral changes in mental health systems, may contribute to growing knowledge in the field seeking to support the broader adoption of civilian-led crisis response models across Canada. Knowledge translation can be supported by synthesizing these findings into an accessible resource to communicate the research insights to broader audiences.

Limitations

The current research has limitations to consider. As a case study, the current research is bound by space and time, and as such, the findings should be considered as a foundation of knowledge to be continually built upon. Rather than providing definitive or universal conclusions, this study offers context-specific insights that contribute to a growing understanding of the subject. Methodologically, the current research is limited in its use of a single coder (myself) for the thematic analysis. Despite safeguards to promote rigour and minimize bias, such as maintaining an audit trail and conducting member checks, using multiple coders would have further enhanced the trustworthiness of the findings. Additionally – and critically – the current research included a sample of service providers while failing to gather insights from service users or other community members who might possess important knowledge about civilian-led crisis response teams. As a result, the findings may be constrained in scope, particularly as they fail to incorporate the perspectives of individuals who directly receive services from crisis response teams.

Areas for Future Research

The introduction of non-police crisis services is an emerging practice, despite longstanding calls from individuals with lived experience, mental health advocates, and critical scholars. Research exploring civilian-led crisis teams remains in its infancy, and the findings of my thesis have raised important considerations and paths for future research. Building upon the current findings, particularly by investigating more civilian-led teams as they emerge, might provide additional breadth to the research, promoting the scalability of these models.

Applying a critical lens when engaging in any discussion about civilian-led crisis teams is necessary to ensure that these teams remain positioned to drive transformative change rather than inadvertently strengthening the systems they seek to challenge. For example, a longitudinal study of these teams' ongoing operations, including metrics such as the number of calls responded to and the frequency of police involvement, could offer valuable insights into their effectiveness in decentering police. Additionally, critically evaluating a team's connection to 911 – such as through community input – and transparently assessing and articulating their scope of response, along with the rationale behind these decisions, are key approaches for applying a critical lens to future exploration of these teams.

Future research might also consider longitudinally studying key outcomes of existing civilian-led crisis response teams against police-as-sole responder models and/or co-responder model, to provide comparative insights. Tracking the provision of funding for civilian-led crisis teams over time, particularly with a focus on the allocation of resources between police services and non-police teams, might also offer valuable insights into the prioritization of community-based approaches and the broader shift toward non-carceral crisis response models.

Exploring entirely peer-based services or care work, particularly the perspectives of care workers who provide fully anti-carceral support as well as individuals who have received this form of care, could be an area of future research to continue challenging carceral logics within crisis response. By learning from peer-based care models, civilian-led crisis teams could further shift crisis response toward entirely anti-carceral care. Most importantly, the inclusion of community voices, specifically individuals who interact

with/have interacted with crisis teams, is an essential next step in ensuring their accounts are considered as crisis models continue to evolve.

Summation of Contributions

The primary purpose of this study was to explore the conceptualization, development, implementation, and operation of three civilian-led crisis teams in Canada. This work addresses a critical gap in the limited but growing literature on anti-carceral mental health services, offering insights into an emerging and potentially transformative field. Historically, systemic forces such as anti-Black and anti-Indigenous racism and sanism have entrenched a climate where experiences of distress are policed rather than supported. The persistent involvement of police in crisis response reinforces systemic racism, contributing to the disproportionate harm and loss of Black and Indigenous lives in Canada (Haag, 2022). Similarly, sanist ideologies, which frame individuals experiencing emotional distress as requiring control (Liegghio, 2013), continue to underpin many mental healthcare practices, particularly within police-led crisis responses.

Civilian-led crisis teams provide a powerful counter-narrative, beginning to work toward the needed shift away from coercion and control toward community-driven, non-carceral care. Grounded in the theoretical orientations of mad studies and critical race theory, this research examines the historical shaping of mental health care and the exclusion and oppression of individuals with “mental illness” and other so-called "othered" identities. These teams are situated not simply as practical interventions but as early steps toward political and theoretical resistance to deeply entrenched systems of oppression. The findings highlight how these teams build our capacity to reject coercive,

police-led responses by centering community voices, embedding anti-racist and anti-sanist principles, and prioritizing care models rooted in autonomy, consent, and cultural safety. In doing so, this study underscores the transformative potential and possibility of non-carceral crisis response models.

This research makes a significant contribution by mapping the processes of conceptualizing, implementing, and sustaining civilian-led teams, offering both a critique of existing systems and a roadmap for alternative approaches. The findings emphasize the importance of collaborative partnerships and peer-led initiatives, illustrating how grassroots mobilization and the centering of lived experience can drive systemic change. By aligning with abolitionist calls to divest from policing and reinvest in community-based mental health supports, the study addresses the failures of past systems while advocating for a reimagined crisis response rooted in equity and community-driven care.

Through its synthesis of history, theory, and practice, this work underscores the urgency of challenging dominant paradigms in mental health care. Carceral mental health practices, including the policing of mental health, are deeply ingrained in societal systems and structures. Dismantling these practices requires multi-faceted efforts, with the removal of police from crisis response being one essential step among many. Building new systems demands strategic planning, mobilization, and collaboration. These efforts are central to advancing transformative change and collectively working toward "practicing new worlds" (Ritchie, 2023).

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Appendix A

Search Strategy

“mental health” & “civilian crisis response” & “Canada”; “mental health crisis” & “civilian response” & “Canada”; “mental health crises” & “civilian response” & “Canada”; “civilian first responders” & “mental health” & “Canada”; civilian first responders” & “mental health crisis” & “Canada”; “non-police response to mental health in Canada”; “non-police response to mental health crisis in Canada”; “non-police response to mental health crises”; “non-police” & “crisis response”

Appendix B

Semi-Structured Interview Questions

Research Question #1: What are the key processes involved in the conceptualization and development of civilian-led crisis mental health response teams in Canada?

- From your knowledge about the team, can you describe what the initial stages of its development looked like?
    - Was any funding obtained?
    - Was any preliminary research undertaken?
    - Was there an initial "testing phase" of the team? Please describe (i.e., Who oversaw this testing phase? How many members were on the team at that point?).

- Who were the key players involved in developing this team (i.e., policymakers, activists, etc)? How did the idea start?

- Please describe an overview of the functioning of your team. Specifically, how service users access support, how the team responds to these requests for support, and any follow up steps that are taken.

- What challenges have been encountered during the conceptualization and development phases, and how were they addressed?
    - How did your team adapt to the unique needs and challenges of the community(ies) it serves?

- In your opinion, what are the critical components or features of a successful model?

Research Question #2: How have civilian-led crisis mental health response teams been implemented and organized, and what factors contribute to their successful operation?

- Can you describe the organizational structure of civilian-led crisis mental health response teams you've encountered or worked with?
    - Who are the members of your team (i.e., frontline, administrative, policy)
    - How did your team decide which members would act on the frontlines?
    - How do these teams go about identifying and recruiting appropriate team members?
    - What training was required for frontline workers?

- Did your team collaborate with existing mental health care services, emergency services, and other relevant key players?
    - If so, how were these partnerships formed?

    - What strategies have been effective in building partnerships and enhancing collaboration with other entities in the mental health ecosystem?

- In your experience, what factors contribute to the successful operation of your team on a day-to-day basis?

- How does your team navigate challenges related to coordination, communication, and resource allocation?

Appendix C

Letter of Intent and Consent Form

Lead Researcher:
Megan Rowe, Master of Social Work Candidate, Dalhousie University
Contact: mg271665@dal.ca
Supervisor:
Dr. Catherine Bryan, Associate Professor, Dalhousie University
Contact: catherine.bryan@dal.ca

TITLE: Reimagining Policing Mental Health: A Call for Abolitionist-Informed Alternatives

Purpose of Study

This study is being conducted as part of the lead researcher's Master of Social Work thesis project and seeks to investigate the key processes involved in the conceptualization, implementation, and operation of existing civilian-led mental health crisis response teams in Canada. This research defines a civilian-led crisis mental health team as a crisis response team that does not staff police.

Who Can Take Part in the Research Study

The current research is looking to interview *key informants* from existing civilian-led mental health teams in Canada who have been working with the team for a minimum of 6 months. For the purpose of the current research, participants are defined as service providers who work closely with a given team, such as frontline workers, administrative staff, and/or volunteers. Other relevant positions (e.g., policy staff) will also be considered.

What You Will Be Asked to Do

If you decide to participate in this research, you will be asked to attend one interview session led by the lead researcher, Megan Rowe. Interviews will take place over video conference or phone call, based on your preference and/or accessibility needs. Should you elect to complete the interview over video-conference call, the lead researcher will provide a secure meeting link to Zoom Healthcare via email. Should you elect to complete the interview over phone call, the lead researcher will call you from a No Caller ID number at the time of the interview.

At the start of the interview, the lead researcher will review the content of this Letter and Consent Form to ensure that you have a good understanding of the parameters of the study and your rights as participants. Once the interview starts, you will be asked to answer a series of questions pertaining to the key processes involved in the conceptualization, implementation, and operation of the team you work with (e.g., Why were these teams implemented? How was funding obtained? Which partnerships were formed?) to the best of your knowledge.

Please note that all interviews will be audio-recorded using the audio-recording function of Zoom Healthcare software, regardless of whether the interview takes place via video conference call or phone call. Zoom for Healthcare is compliant with Canadian Data Protection regulations, including the Personal Information Protection and Electronic Documents Act (PIPEDA), rendering it a secure software for any audio-recording of confidential information.

Using the audio recording of the interview, the lead researcher will create a summary of key themes based on your answers to the interview questions. You will have the opportunity to review this summary of key themes to ensure that they best reflect your thoughts, opinions, and answers (see the bottom of this letter). If you agree to review this summary, the lead researcher will email it to you in the form of a password-protected Word document. The lead researcher will send the password to this document in a separate email. If you identify any changes that need to be made or have any questions/comments/concerns related to your review of the summary, you will be able to communicate these to the lead researcher over email (mg271665@dal.ca).

How Your Responses Will Be Used

Your interview will be used as data in this research. As explained above, your responses to the interview questions will be audio-recorded using Zoom Healthcare software. The lead researcher will transcribe the interview and use your responses to identify general themes and compare/contrast these themes with those identified in other data (i.e., other participants' interviews). These themes will be used to explore key processes involved in the conceptualization, implementation, and operation of existing civilian-led mental health crisis response teams.

Please note that this study will indicate the names of the civilian-led crisis mental health teams being studied. Importantly, however, your name or your position/affiliation with the team will not be directly linked to or associated with the team's name at any point in the research process (i.e., data storage) or in any of the written/presented findings. Any direct quotes used in any written findings will be entirely anonymized. See the section below for further information.

At no point will your name be linked to the data (i.e., your interview responses). The lead researcher has ensured that several steps will be taken to protect your identity, as outlined below.

How Your Information Will Be Protected

Your participation in this research study will be kept confidential and will only be known by Megan Rowe and Dr. Catherine Bryan. All documents used for the purpose of this research are stored within encrypted, password protected folders stored within a confidential and secure OneDrive server. Only Megan Rowe and Dr. Catherine Bryan will have access to these folders. In addition, your name will not be linked to the audio recording of your interview. Instead, the researcher will save and store all audio recordings using a de-identified code to protect your identity.

Furthermore, no direct identifying information (i.e., your name) will be shared in any written report or presentation (i.e., publication, the lead researcher's final thesis paper)

informed by this research. Any direct quotes will be entirely anonymized. In addition, although the names of the civilian-led crisis mental health teams being studied in this research will be identified, at no point will any direct identifying data be linked with indirect identifying data. Specifically, your name (direct identifying data) as well as your job title/position on the team (indirect identifying data) will not be linked with the name of the team with which you work.

Possible Benefits, Risks and Discomforts

There is minimal risk involved in this study, and it is not expected that you will find participation demanding or stressful. The researcher will ensure that all participants are aware of the study's parameters, as outlined in this letter, and that informed consent is obtained prior to participation.

Participating in the study might not benefit you, but we might learn things that will benefit the current state of the field of mental health crisis response that might lead to personal benefits given your professional designation in this field as a member of an existing crisis response team.

Will I be compensated for my participation?

No.

Participants' Rights

Participation is entirely voluntary: you may withdraw from the interview at any point and may skip any questions that you do not wish to answer without penalty. Should you wish to withdraw from the study after the interview is completed, please contact the lead researcher (mg271665@dal.ca) and your data will not be transcribed and will not be used for further steps in the research process. Please allow for 1-2 business days upon withdrawal request for your data to be digitally destroyed. Please note that you have until August 1st, 2024, to request a withdrawal of data. After that time, the lead researcher's final thesis paper will be underway and transcribed/analyzed data will be in use. Data will be stored until December 15th, 2024. If you wish to have any of your saved/stored data destroyed between August 1st, 2024 and December 15th, 2024, you retain this option however, please note that any request for withdrawal after August 1st, 2024, does not guarantee removal of your data from analyses, merely that any storage of your data will be destroyed. As of December 15th, 20234, all data and study records will be permanently destroyed.

Should you have any questions and/or concerns, please contact Megan Rowe (mg271665@dal.ca) and/or Catherine Bryan (catherine.bryan@dal.ca).

How Do I Express Interest In Participating?

If you are interested in participating in this study, please contact Megan Rowe by email at mg271665@dal.ca. You will be asked to read and sign the current form. Upon expressing interest in participating, Megan Rowe will send you the link to an anonymous DoodlePoll to select participation dates/times. Once a date/time is selected, you will receive a confirmation email.

Further Information:
Any questions about this study and your participation in it may be directed to Megan Rowe (mg271665@dal.ca) and/or Catherine Byran (catherine.bryan@dal.ca).

If you have any ethics concerns, please contact the Dalhousie Research Ethics Board (REB) at 902-494-3423 or ethics@dal.ca. *Please note that REB communicates in English only*

Consent to Participate:
This Letter of Information provides you with the details to help you make an informed choice. All your questions should be answered to your satisfaction before you decide whether or not to participate in this research study. Keep one copy of this Letter of Information / Consent Form for your records and return one copy to the researcher obtaining your consent. You have not waived any legal rights by consenting to participate in this study.

By signing below, I am verifying that:
a) I have read the Letter of Information / Consent Form
b) I am a service provider for a civilian-led crisis mental health response team
c) I have been working for said team for a minimum of 6 months
d) I understand that my interview will be audio-recorded, and that only the members of the research team (Megan Rowe and Dr. Catherine Bryan) will have access to this file
e) I agree that my interview will be audio-recorded
f) I agree that direct quotes from my interview may be used without identifying me
g) I am aware I can reach out to the research team (Megan Rowe and/or Dr. Catherine Bryan) at any point should I have any questions/concerns/comments.
Do you agree to each of the above parameters?
☐Yes ☐No

_____ _____
Signature of Participant DATE
[embed signature link]

Option to Opt-In or Opt-Out of Receiving Summary of Results
You have the voluntary option to receive a copy of a summary written in plain language of the themes (i.e., "main ideas") identified by the researcher based on your interview answers. This will give you the chance to make any changes if you believe any of your answers/responses were not clearly presented, comprehensive, and/or reflective of your opinion.

Would you like to receive a summary written in plain language of the themes (i.e., "main ideas") identified by the researcher based on your interview answers? Please note that your choice will not affect your participation. You can change your response up to two weeks after the participation date.

☐Yes (Please enter the preferred email to send the summary to below):

_____

☐No

_____ _____

Signature of Participant DATE

Appendix D

Health Sciences Research Ethics Board Letter of Approval

Health Sciences Research Ethics Board
Letter of Approval

June 05, 2024

Megan Rowe
Health\School of Social Work

Dear Megan,

REB #: 2024-7163
Project Title: Reimagining policing mental health: A call for abolitionist alternatives

Review Type: Delegated Review
Effective Date: June 05, 2024
Expiry Date: June 05, 2025

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be ethically acceptable in accordance with the *Tri-Council Policy Statement Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

[redacted]

Dr. Jennifer Isenor
Chair, Health Sciences Research Ethics Board
Dalhousie University