Transforming
Calgary's Crisis Response System:
Final Report

centre *for*
suicide prevention

Acknowledgments

PRIMARY CONTRIBUTORS

Kiran Gurm, Saira John, Shannon McInnes, and Naomi Parker: PolicyWise for Children & Families

Robert Olson, Jeff Foster, Akash Asif, Mara Grunau: Centre for Suicide Prevention

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SHARING GUIDELINES

It is the hope of all those who contributed to this project that these findings are shared and used to benefit others and inform policy and practice to improve child, family, and community well-being. PolicyWise and the Centre for Suicide Prevention ask that the intent and quality of the work is retained, and that PolicyWise for Children & Families and the Centre for Suicide Prevention be acknowledged.

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Executive Summary

Throughout Canada, research and practice focused on responding to crisis due to mental health concerns, addictions, and similar challenges is gaining momentum. Calgary is no exception - Calgary's Community Safety Investment Framework (CSIF), a collaboration between the City of Calgary, Calgary Police Services, and community partners, has explored the city's crisis response and identified a need to improve support for Calgarians experiencing crises related to these issues. The city needs an equitable and effective crisis response system to improve the well-being of its citizens.

Project Overview

On behalf of the CSIF's collaborating organizations, Centre for Suicide Prevention and PolicyWise for Children & Families have provided a report including a set of evidence-informed recommendations. The recommendations can guide the creation of an equitable and effective crisis response system in Calgary, one that provides lifesaving mental health care. The report was informed by a rapid literature scan, a current state assessment and analysis of administrative data from crisis response programs and services, identification and review of promising models of crisis response, and intensive engagement with key stakeholders and persons with lived experience of crisis. It is a blueprint for building a comprehensive crisis response system, one that provides lifesaving mental health care. The report builds on many successful crisis response initiatives and processes currently operating in the city and focuses on changes that can be made to strengthen the system, address gaps, and improve quality of care.

Recommendations

The recommendations propose changes that can be made to strengthen Calgary's crisis response system. The recommendations proposed along with implementation considerations can ultimately guide the planning and implementation of an equitable and effective crisis response system.

Principles of a Transformed Crisis System

An equitable and effective crisis response system is: person-centered, coordinated, equity-based, evidence-based, and trauma-informed. The rapid literature scan indicated that crisis response is most effective when the following critical elements are in place:

- There is an integration of services across navigation, emergency services, primary health care, and community-based mental health and social supports that address the multitude of crisis experiences.
- The experience within the crisis system is safe and welcoming.
- There is a region-wide approach to crisis: several facilities in the area are equipped to respond to behavioural health crises 24/7, with opportunities to partner with law enforcement.

(Group for the Advancement of Psychiatry, 2021; Substance Abuse and Mental Health Services Administration, 2020)

System-Based Themes
System-based themes have been identified as foundational to transforming the crisis response system in Calgary to better serve individuals, families, and community.

Theme 1 - Accountable Entity: Establish an accountable entity to oversee and monitor the crisis response system. This entity is dedicated to: coordination of service elements, establishing and maintaining close relationships and formalized partnerships, overseeing system navigation, and collaborating on funding decisions.

> Accountability is often comprised of financial, performance, and political/democratic accountability (Brinkerhoff, 2003). An example of an established accountable entity is the collaboration between Alberta Health Services (AHS) and the City of Calgary during the 2013 flood. This joint leadership created an overall structure for crisis response, ensuring an integrated system for service providers with the appropriate implementation of protocols.

Theme 2 – Community-driven System Responsiveness: The crisis response system is community-driven. Ongoing community engagement informs the development, design, and implementation of crisis response.

> Crisis response and prevention efforts must take into account the diverse identities and needs of Calgarians. A community-driven crisis response system meets the needs of individuals of all ages, genders, abilities, comorbidities (e.g., medical conditions, substance abuse disorders), cultures, languages, and sexual orientations (Group for the Advancement of Psychiatry, 2021). Community engagement in Calgary's crisis response system can be strengthened by creating more opportunities for community members and organizations to engage with the accountable entity and contribute the transformation, implementation, and evaluation of the system.

Theme 3 – Values-based System: The core values identified by Calgary service providers guide the design and operation of every aspect of the crisis response system. This includes the structure of the system, criteria to enter programs, guidelines and protocols for transitioning clients, and interventions with a person in crisis.

> Community service providers identified several barriers faced by individuals and communities in accessing services and receiving inclusive, effective care. The aim of a valued-based approach to crisis response is to support shared decision-making between practitioners, clients, and their families on the basis of 'values' as well as 'facts' (Fulford, 2008; Petrova et al., 2006). The system as a whole also needs to have defined core values, which in turn will create a positive and safe experience for responders, clients, and their families (Group for the Advancement of Psychiatry, 2021).

Operational Themes
Operational themes are identified as essential to the practices within the crisis response system and are rooted in current gaps in Calgary's crisis response.

Accessibility: Ensure the system provides diverse, barrier-free service options rooted in community needs.

An accessible crisis response system must make available all appropriate options and ensure multiple services are accessible in one place. This approach is captured by the integrated care crisis model which includes elements like a crisis call centre (someone to talk to), crisis mobile team response (someone to respond), and crisis receiving and stabilization facilities (somewhere to go; (Substance Abuse and Mental Health Services Administration, 2020). This helps ensure people in crisis are connected to the appropriate resource on every step of their journey.

Peer Support: Create a mechanism to incorporate lived experience through peer support into the crisis response system.

Peer mentorship and peer support are key components of crisis care, having demonstrated successful outcomes that include reduced hospitalization, increased quality of life, greater improvement in symptom ratings, improved treatment satisfaction, and better physical health (Greenfield et al., 2008; Ormerod et al., 2013). A peer support worker can be a member of a mobile crisis outreach team, or even work with law enforcement to help identify individuals at risk.

Cultural Representation: Ensure cultural representation of Calgary's population in crisis response.

A meaningful connection with the Indigenous community is needed in Calgary. There is a scarcity of access to culturally appropriate services, Indigenous peer supports, and opportunities to connect with Indigenous culture in general. A culturally responsive crisis response system must demonstrate a long-term commitment to honouring and respecting all beliefs, cultures, languages, and interpersonal styles (Substance Abuse and Mental Health Services Administration, 2014). One mechanism for implementing this recommendation is through employing cultural brokers, individuals who know and understand the beliefs, cultures, languages, and interpersonal styles of the group being served.

Trauma-Informed Care: Trauma-informed care and client-centered care is woven into all levels of strategy, practice, and policy in the crisis response system.

Trauma-informed approaches seek to better understand individual experiences, and ensure clients have a voice and a sense of belonging within the system. There are ongoing accounts of negative experiences within the crisis response system in Calgary, and there is a need to strengthen trauma-informed approaches that go beyond training and awareness. The most effective way to do so is to implement trauma-informed care as a policy applied to all aspects of the crisis response system.

Training: Crisis response training is ongoing and requires both theory and practice with immersive and applied approaches.

A crisis response training framework should include structure and supports for advancement, refreshers, and practical training. It should also be based on the core values of the crisis system, which could include trauma-informed care, anti-oppression based approaches, cultural supports, and spiritual offerings. Training can also be approached through shadowing, such as first responders spending time with other service providers to understand the clientele being served. For example, Calgary police officers have worked at Drop-in Centres as part of their training.

Transportation: Transportation-related solutions and strategies are explored to address safe and reliable care of individuals in crisis.

Transportation is an essential service within the crisis response system because it provides connections to the required service in which care is received. Currently in Calgary, EMS can transport clients to only a limited number of locations despite the high demand and complexity of crises during client transport requested of EMS. A comprehensive transportation plan is required to ensure individuals can go to and from crisis centres and other location as required along the continuum of crisis response.

Client Information Sharing: Increased understanding of information sharing protocols is attained to facilitate better coordination and care of individuals in crisis.

Clients in crisis with complex needs receive better care when service providers are able to share information in collaboration with each other. For example, Calgary Police Service had a vulnerable persons registry where notes on individual's file indicated their history and any physical and mental health issues. Officers referenced an individual's notes and were able to more accurately assess risk and appropriate response in situations involving that individual. Agreements, infrastructure, and education around client information sharing are needed to address current gaps faced by Calgary service providers.

Next Steps

The proposed recommendations and implementation considerations presented in this report are a guide to transforming Calgary's crisis response system. Achieving a transformed crisis system requires: prioritizing all recommendations, conducting additional research and consultations, planning for implementation, engaging continuously with community (community members, crisis response service providers, sector support), and evaluating and monitoring of implementation.

Glossary

AHS	Alberta Health Services
ARECCI	A Project Ethics Community Consensus Initiative
CSIF	Calgary Safety Investment Framework
CTO	Community Treatment Order
DOAP	Downtown Outreach Addictions Partnership
EMS	Emergency Medical Services
FOIP	Freedom of Information and Protection of Privacy Act
HIA	Health Information Act
LGBTQIA2+	Lesbian, gay, bisexual, transgender, queer/questioning, intersexual, asexual, and two-spirited
MRT	Mobile Response Team
PACT	Police and Crisis Team
PIPA	Personal Information Protection Act
SAMHSA	Substance Abuse and Mental Health Services Administration
TRC	Truth and Reconciliation Commission

Introduction

We begin this report by sharing the story of a person who struggled with navigating and accessing services within Calgary's crisis response system. This individual has a developmental disability and struggles with substance misuse. They had been trying to seek crisis care; however they were unable to find stable and appropriate services. Instead, this individual was in and out of hospital, experienced incarceration, and was turned away from numerous shelters. Over several months, they were passed around from one organization to another, struggling to find care before being admitted to hospital. Their hospital stay focused on stabilization and finding housing. Throughout this experience, their PDD service provider advocated for this individual, reaching out to crisis agencies but was met with refusals due to their substance use. These refusals did not take into account the individual's complex underlying issues such as their developmental disability. The struggle to convey this information and connect to service providers resulted in a very negative experience and increased cost to both health care and law enforcement. This story is one of many heard from Calgary service providers and community members. This story and others[1] highlight the need to strengthen the crisis response system in Calgary.

[1] For additional stories in the form of client vignettes and details on how individuals have experienced crisis response in Calgary please see Appendix A

Project Background

The Community Safety Investment Framework (CSIF)'s definitions of **person in crisis** and **crisis response** are as follows:

- A **person in crisis** is in need of urgent support due to mental or emotional distress, conflict, or a threat to their safety.
- **Crisis response** is the immediate resources required by the individual experiencing a crisis, their families, friends, and support networks.

City of Calgary (2020)

The Community Safety Investment Framework (CSIF) is a collaborative effort between The City of Calgary, the Calgary Police Service, and community partners to connect and identify ways to improve support for Calgarians in crisis due to mental health concerns, addictions, or other similar challenges. This project sought to understand the current landscape of crisis response in Calgary and identify opportunities for its transformation. Although the definition of crisis and crisis response can vary by sector, organization, and individual, as stated above CSIF is primarily focused on behavioural crisis. A behavioural health crisis can include individuals experiencing mental health concerns, substance use disorders, domestic violence, and homelessness. Note, physical health emergency needs are beyond the scope of CSIF and this work.

This report boasts evidence from literature, other jurisdictions, and the Calgary-specific context as heard through interviews with Calgary service providers, consultations in the community, meetings with strategic advisors and the steering committee, and a survey of people who have experienced the crisis response system themselves. Three system-level themes emerged, each with a series of specific operational themes and recommendations from the Calgary context; the literature and best practices support these findings.

What is a transformed crisis response system?

Several overarching principles guide the implementation of a transformative crisis response system. Person-centered, recovery oriented, partnerships, and holistic in crisis response are key principles identified in literature and by Calgary service providers. Additional critical elements to be considered include:

- Service integration: Services across navigation, emergency, primary health care, community-based mental health, and social supports that address the multitude of crisis experiences are integrated.
- Regional approach: Facilities across a region are equipped to respond to behavioural health crises 24/7, with opportunities to partner with traditional law enforcement.
- Safety: The experience within the crisis system is safe and welcoming.

(Group for the Advancement of Psychiatry, 2021; Substance Abuse and Mental Health Services Administration, 2020)

Why does the system need transformation?

There are many diverse, effective, and robust components of Calgary's crisis response system. Unfortunately, these elements can be lost in a large, unwieldy, and often-fragmented system. A disjointed system can be challenging to navigate and can fail to connect individuals to the most appropriate services in their time of need. As a result, 911 has become the default entry to the crisis response system. Calling 911 typically results in the dispatch of police, fire, or EMS, in part due to their 24/7 availability and reliability, regardless of the nature of the crisis. These options are resource-intense and are often not the best fit for a person in a mental health crisis. Transforming the system can provide differentiated care that supports the well-being of Calgarians equitably and effectively. A transformed system will:

- Integrate services to minimize people falling through the cracks.
- Provide flexible services specific to mental health crisis response such as mobile teams and crisis stabilization facilities.
- Help reduce stigma of accessing mental health services, particularly in certain cultural communities.
- Reduce costs by providing the right level of response to crisis thereby reducing hospital readmissions, overuse of law enforcement, and human tragedies.
- Reduce unnecessary engagement with law enforcement and emergency departments (which in turn protects police, EMS, and hospital resources).
- Improve service coordination to reduce critical system gaps that allow people to get lost.

(Group for the Advancement of Psychiatry, 2021; National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016; Substance Abuse and Mental Health Services Administration, 2020.)

This report is a blueprint for building a comprehensive crisis response system, one that provides lifesaving mental health care. It builds on the many successful elements currently operating in the Calgary context, focusing on changes that can be made to strengthen the system, address gaps, and improve the quality of care for Calgarians. It is important to consider that this report is just the beginning, it offers a starting point for conversations and considerations for system transformation. The project steering committee will need to continue and incorporate key players (i.e., City of Calgary, CPS, Fire, EMS, and add AHS).

Project Approach

A large array of data sources informed the recommendations of this report as well as the current state of the Calgary crisis response system. The findings in this report are informed by eight data components:

1. Reviewing the literature (rapid review of the literature)
2. Interviewing jurisdictional exemplars
3. Interviewing Calgary Service Providers
4. Meeting with the Steering Committee
5. Engaging Strategic Advisors
6. Consulting with the Community
7. Surveying People who have Lived Experience of the crisis response system
8. Collecting administrative data

An ethics screen was conducted through Alberta Innovates' *A Project Ethics Community Consensus Initiative* (ARECCI) for the community consultations and lived experience survey components.

Reviewing the Literature

A rapid review of academic and grey literature was conducted to identify existing and emerging models of crisis response, as well as evidence-based practices. The search occurred in two stages. First, a search strategy was established (Appendix C) and executed using academic databases, Google Scholar, and Google. The second stage search targeted literature to build upon themes identified from community consultations and strategic advisor engagements. Some Calgary service providers identified key pieces of literature which were reviewed and incorporated when relevant.

Interviewing Jurisdictional Exemplars

Various jurisdictions in Canada and the United States are examining their crisis response systems; some have implemented new, transformative models. Semi-structured interviews were conducted with thought leaders and individuals involved in developing these emerging crisis response models (Appendix D). The discussions focused on understanding how the newly implemented model filled gaps in the current system, what considerations were taken when implementing the model, and how the new model affected partner relationships.

Interviewing Calgary Service Providers

We held unstructured interviews with many Calgary service providers to gain a deeper understanding of the crisis-related services they provide. Conversations focused on referral pathways (incoming and outgoing), logistics and operations, goals, and relationships with other partners. We also sought to understand how each organization defines crisis response and where they identify themselves within the crisis services system.

Meeting with the Steering Committee

We met regularly with the steering committee, comprised of staff from the City of Calgary and Calgary Police Service. As more knowledge of Calgary service providers and crisis response models was gained, information was shared directly with the steering committee. Data were synthesized and brought to the steering committee for discussion. The steering committee also contextualized findings within the City of Calgary for the project team.

Engaging Strategic Advisors

Strategic Advisors were identified as Calgary-based or Alberta-based organizations whose main objective is to address crisis. Their role is to provide ongoing consultations and feedback on the research conducted throughout this project. Two engagement sessions were held with strategic advisors representing seven unique organizations. In these sessions, strategic advisors reviewed and revised a proposed flow chart of Calgary's response system and discussed evidence-based practices within their current crisis response programs.

Consulting with Community

Community consultations were conducted with Calgary-based service providers who have worked with members of the community who have experienced behavioural health crises. Thus far, five consultation sessions were held with organizations representing services across the continuum and representing numerous target populations. This included primary health, emergency services, mental health, substance use, domestic violence, homelessness, newcomer and immigrant, developmental disabilities, Indigenous, youth, and seniors.

Surveying People with Lived Experience

A survey was developed and circulated to Calgary service providers and clients who have indicated experience with mental health crisis. The survey was adapted from the City of Toronto (2021) survey to include options relevant to the Calgary context. 660 surveys were completed and of those, 98% were completed in full. A copy of the survey can be found in Appendix E. The technical report of the survey results is in Appendix F.

Collecting Administrative Data

Administrative data was requested from more than ten Calgary service providers. Despite multiple requests, meetings, phone and email follow-ups, data was only secured from seven organizations. It is challenging for organizations to provide administrative data. It can be a labour-intensive process, particularly during COVID-19 when staff are stretched.

Much work was needed to analyze the data that was secured. Each organization collects data differently. Criterion differences, including definitions, time periods, and collection procedures limit the degree of analysis that can be performed.

Calgary Crisis Context

Calgary Crisis Response System Overview

Based on interviews with service providers, a system map was created demonstrating how clients currently move through Calgary's crisis response system (see Figure 1). Figure 1 demonstrates client entry points, service navigators, first and secondary responders, and links among service providers. For simplicity, connections to sector supports are omitted as they are numerous. During engagement sessions, strategic advisors validated and clarified the levels within the diagram as well as the roles and responsibilities within each level. Diagram details are described below.

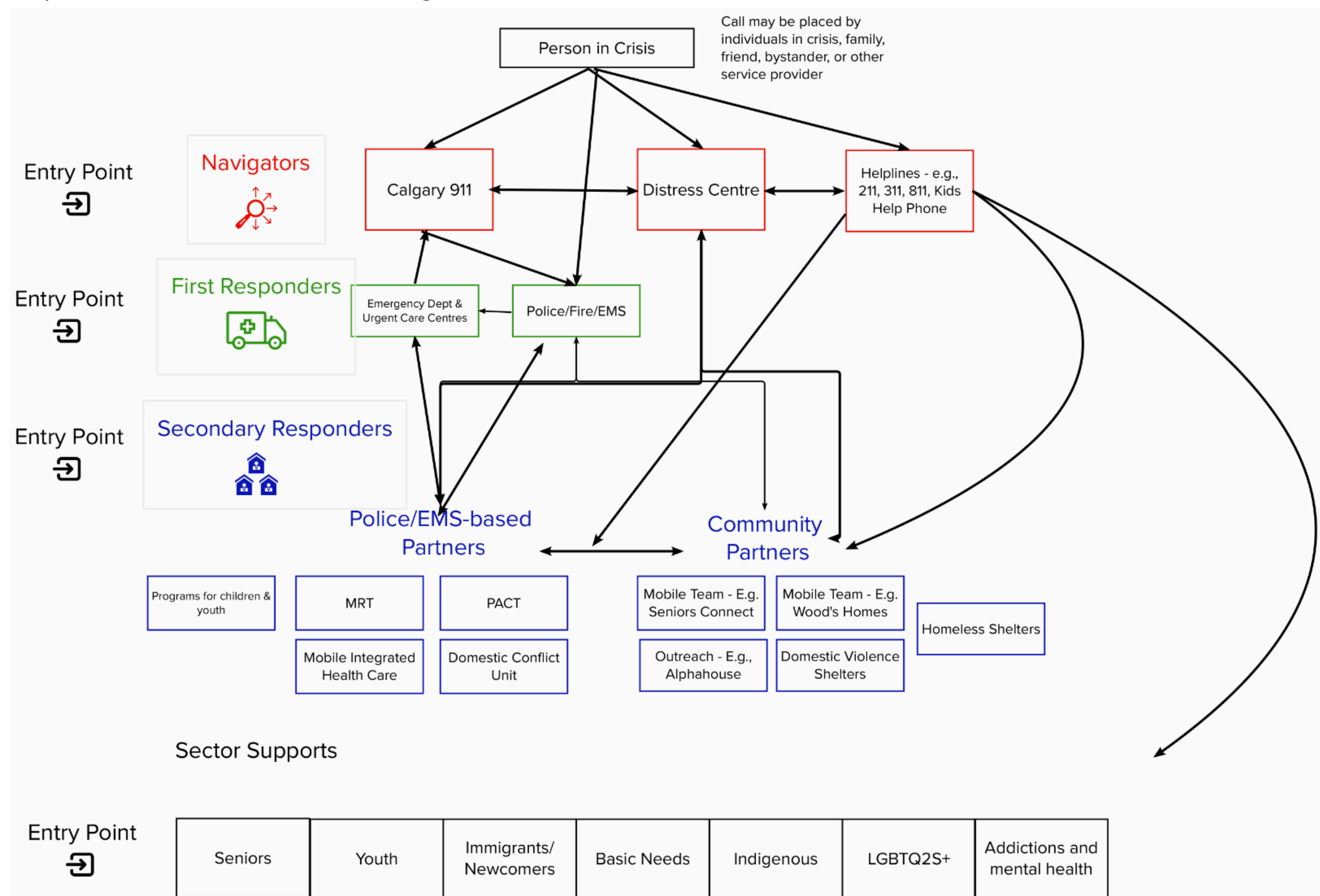


Figure 1. Overview of Calgary's Crisis Response System[2]

Entry points are defined as 'who' seeks out help during a crisis. Entry points vary, but usually begin with an individual (i.e., the person in crisis, a family member, friend, or service provider staff) connecting with a navigator usually via a direct phone call. Alternatively, some clients enter at the secondary responder level from self-referrals, phone calls from a loved one, or a referral from another service provider.

[2] See Glossary for definitions of MRT, PACT, LGBTQIA2+ in the figure.

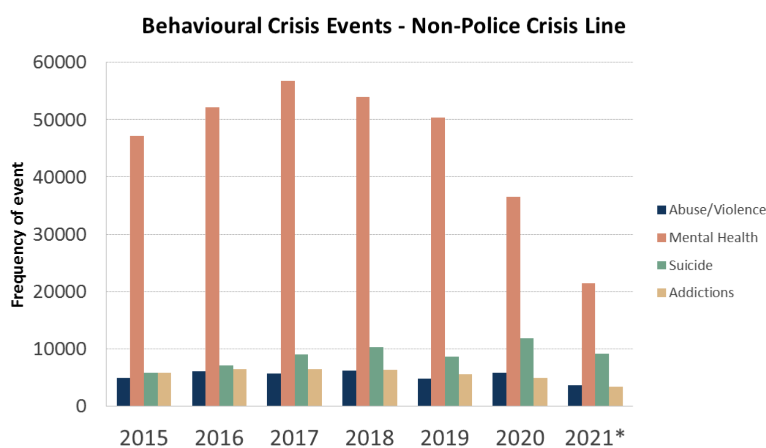
Navigators are service providers who receive calls and direct the course of action: either dispatching a responder or directing the service user to a community resource. Strategic advisors indicated that the pathways for a person in crisis differs depending on which of the two main navigator organizations is engaged. Note on the diagram the direct arrows from Distress Centre to secondary responders compared to the indirect arrows from Calgary 911 to secondary responders.

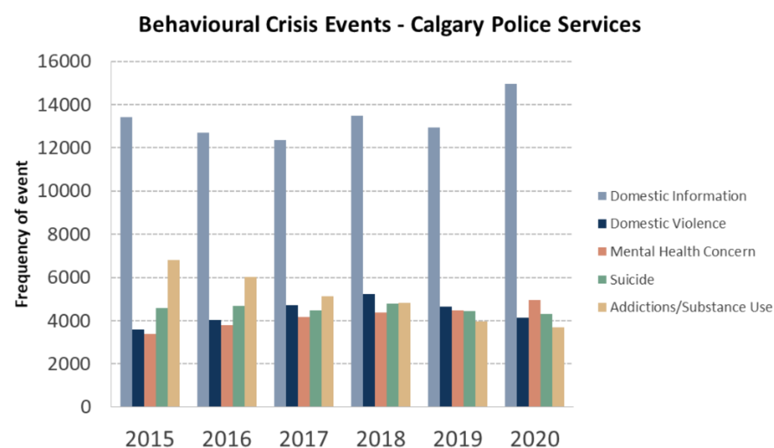
Responders are separated into two levels, first and secondary, based on the time frame in which they respond. Some crisis response teams emphasized that their services are not always available; there can be up to a 24-hour delay. These teams or organizations are considered **secondary responders.** In comparison, **first responders** attend a situation immediately and typically respond to situations of higher risk or with potential for violence. First responders are traditional 911-based responses (i.e., fire, police, EMS), whereas secondary responders involve more community-based organizations and partnerships with police and EMS. This includes mobile crisis teams and outreach.

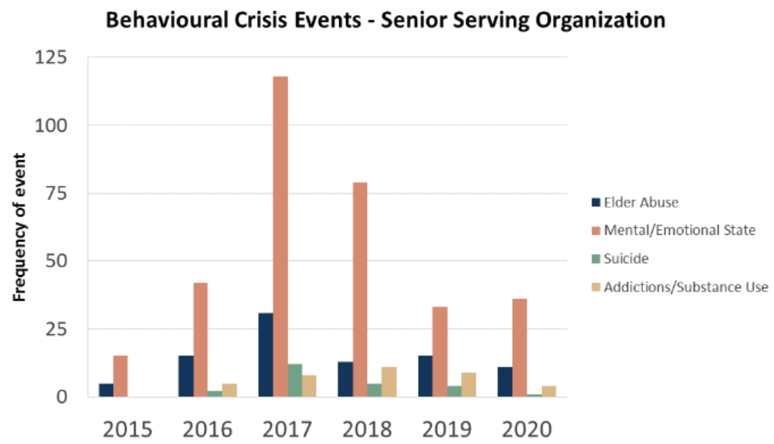
Sector supports capture the institutions, organizations, programs, and supports that provide continuing support for individuals or families in crisis. Examples include schools and community organizations that provide a range of services like short-term counselling, financial and basic needs support, and safe spaces for newcomers, LGBTQIA2S+ people, and Indigenous community members.

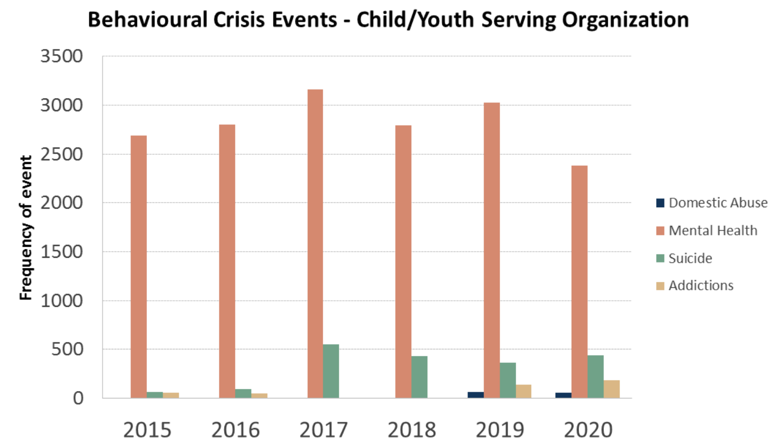
Illustrative Data from Calgary Organizations

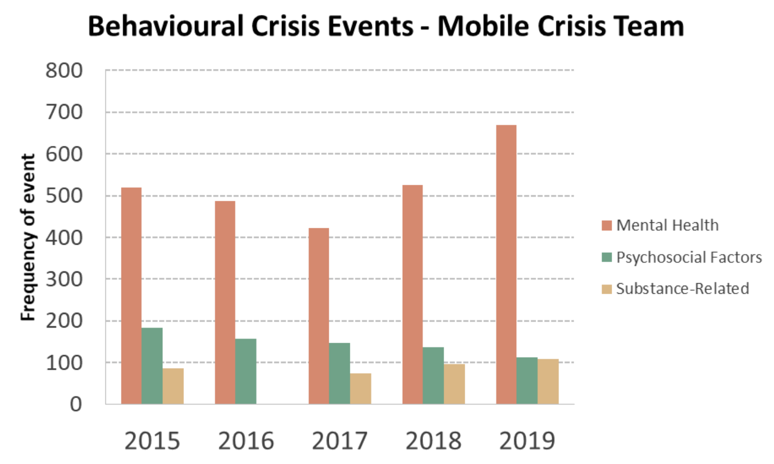
To further illustrate the types of crisis clients experience, administrative data was obtained from a sample of crisis response programs in Calgary (n=7). To further explore the **entry points** of the Calgary Crisis Response System, it was found that the most common categories of behavioural crisis across programs were: 1) domestic violence, 2) mental health, 3) suicide, and 4) addictions/substance use. The charts below indicate the volume of these types of crises across seven different programs (see Figure 2).

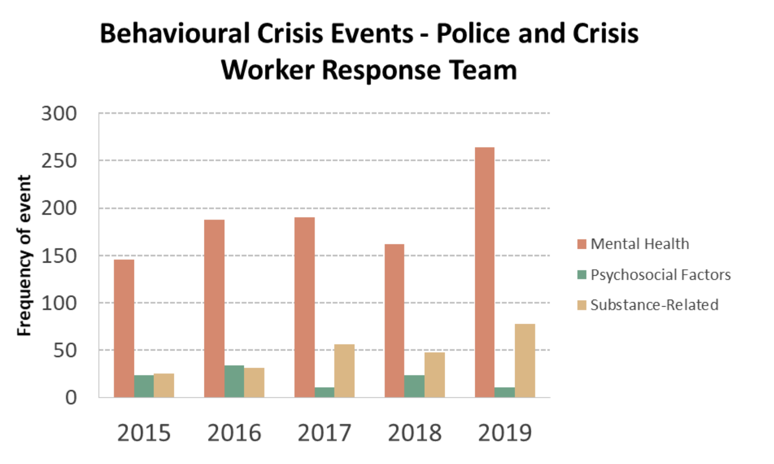












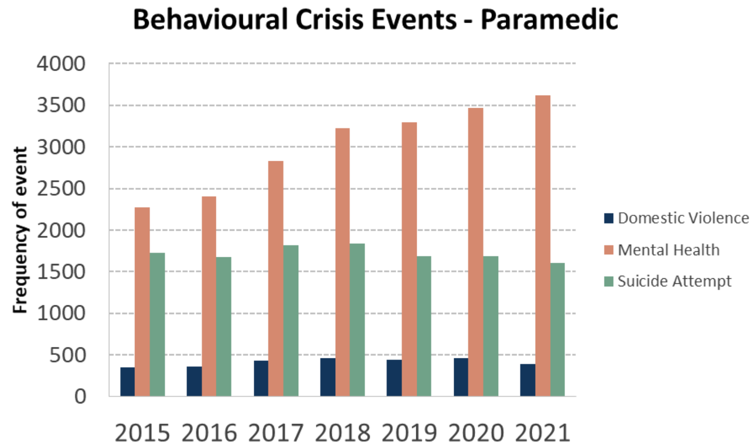


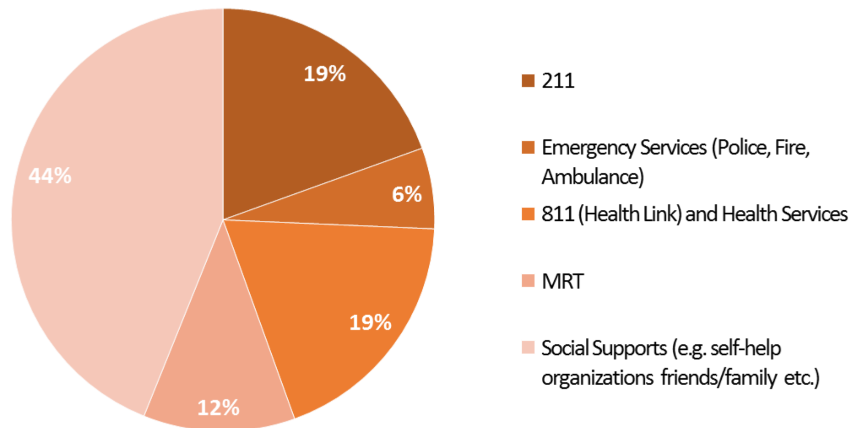
Figure 2. Data from Crisis Response Programs in Calgary[3,4]

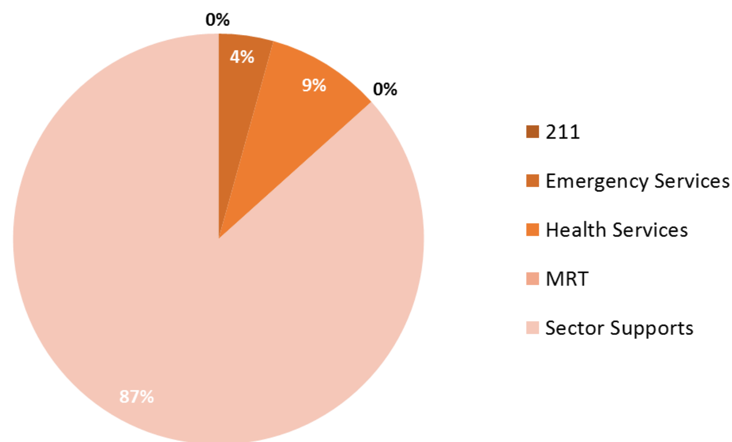
[3] Calgary Police Services definitions: 1) Domestic Information refers to calls that occur to obtain police support for safety issues related to child custody, relationship and parenting issues; 2) Domestic violence refers to calls due to abuse or threats within familial relationships.

[4] Mobile Crisis Team and Police and Crisis Worker Response Team definitions: 1) Mental Health refers to schizophrenia disorders, bipolar disorders, depressive disorders, anxiety disorders, trauma and stressor disorders, and personality disorders; 2) Psychosocial Factors refers to abuse and neglect, homelessness, parent-child

Navigator and **secondary responder** organizations reported mental health as the highest number of crisis events. The **first responder** organization reported domestic violence as the highest proportion of crisis events.

To further examine client pathways within Calgary's crisis response system, referral data was sampled from two organizations (n=2) and is illustrated in the charts below (see Figure 3).





relational problem, and uncomplicated bereavement; 3) Substance-Related Disorders refer to alcohol use disorder, cannabis use disorder, gambling disorder, and opioid use disorder.

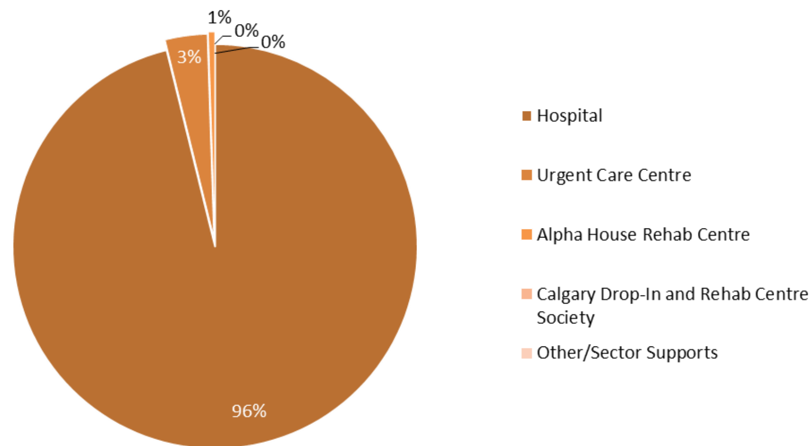


Figure 3. Referral Sources from Crisis Response Programs in Calgary

Sector supports are clearly the main source of referrals in two different Calgary organizations, indicating the importance of these resources for persons experiencing a behavioural crisis. The reliance on sector supports also suggest that often behavioural crises, such as mental health concerns, require additional support beyond addressing the immediate crisis.

Crisis Response Themes

A well-developed and sustainable crisis response system includes community-based crisis responders and alternative options to crisis response in addition to traditional responders like fire, police, and EMS. The system is an organized set of structures, processes, and services that are established to meet the spectrum of urgent and emergent mental health crisis needs in a community, effectively and efficiently (Group for the Advancement of Psychiatry, 2021). The following system-based themes have been identified as fundamental to transforming the crisis response system to better serve Calgarians. These themes, in turn, can drive the overarching structure, policies, protocols, and administration of the system.

System Themes

1. Accountability
2. Community-driven System Responsiveness
3. Values-based System

Additionally, Calgary service providers and individuals with lived experience identified several smaller themes that fall under the system themes and relate to operations. As such, the recommendations are separated into two categories: system and operational. Many of these smaller themes are rooted in gaps in Calgary's crisis response. Addressing these operational issues will improve crisis response service coordination and outcomes.

Operational Themes

- Accessibility
- Peer Support
- Cultural Representation
- Trauma-informed Care
- Training
- Transportation
- Client-information Sharing

The themes are not discrete, in practice they are interconnected. Addressing components of one theme is often contingent on the progress of another. Most notably, accountability is a fundamental concept on which many other themes rely. For the purpose of this report, however, themes are addressed separately.

The following sections outline the system themes and operational themes. Each theme is supported by findings from literature and exemplar models. Following the overview of each theme, implementation considerations are highlighted. Where possible, specific implementation considerations are provided based on engagement with Calgary-based crisis response services. It is important to acknowledge that because the recommendations themselves can look very different for each organization, implementation considerations especially for the operational recommendations will require individualized approaches.

System Themes

Accountability

Recommendation 1: Establish an accountable entity to oversee and monitor the crisis response system. This entity is dedicated to the coordination of service elements.

Regarding governance and accountability, numerous community service providers asked the question "who is overseeing the system and coordinating integration between service providers in Calgary?" It is apparent that service providers across the crisis response continuum are looking for leadership in the system, specifically a central entity that oversees and monitors the performance quality of the crisis response system. An example provided was the intentional collaboration between Alberta Health Services (AHS) and the City of Calgary during the 2013 flood. This joint leadership helped create an integrated system for service providers and ensured someone was handling the overall structure and protocols of the crisis response.

The Group for the Advancement of Psychiatry (2021) notes in their Roadmap to the Ideal Crisis System that there should be an entity **accountable for oversight and monitoring** as well as an **accountable provider dedicated to the coordination of all service elements.**

"Who is in charge of coordinating all of these pieces and aware of the community context"

Strong system leadership is key to improving coordination in the crisis response system. Leadership in this context refers to an entity or collaboration of organizations that manage the crisis response system. Accountability is often comprised of three main categories: financial, performance, and political/democratic accountability (Brinkerhoff, 2003). Financial includes tracking and reporting on allocation and utilization of funds, as well as auditing and budgeting. Performance focuses on services, outputs, and results related to system goals and objectives. Political/democratic relates to the organizations, procedures, and services to ensure government/the system is meeting societal needs and concerns. Having robust accountability in the sector contributes to the continued evaluation and improvement of crisis response services and supports by creating structure, integrating networks, setting standards, and measuring outcomes (Ontario Ministry of Health and Long-Term Care, 2005). Examples of outcomes include status (e.g. did the client perceive return of control), and stability (e.g. was the crisis stabilized).

It should be noted that best practices only indicate that an accountability entity be established, and not who or what organizations should be involved. The literature does not provide a specific recommendation because it is location and context dependent. Communities must consider what will work best based on existing structures, relationships, geographical considerations, and current gaps in the system. The accountable entity could be an individual organization such as a mental health department but could also be a formal collaborative structure. It is also possible that a single entity may be responsible for oversight and coordination, but additional organizations are involved in other aspects of accountability.

This theme combines several key components of successful crisis response including partnerships, system navigation, and funding. Each of these components are foundational to developing a system that is well-coordinated, well-structured, and easy to navigate for clients and service providers alike. While each of these could be a theme on their own, they are grouped under accountability because successful partnerships, system navigation, and funding require an accountability entity. It is assumed that prior to addressing each component, an accountability entity would be established and therefore leading the work. The following sections detail how an accountability entity can and should contribute to strengthening partnerships, system navigation, and funding, and highlights why each of these is critical to a strong crisis response system.

Implementation Considerations

- The overarching goal of the accountable entity is to ensure the crisis response system is: accessible, acceptable, appropriate, sustainable, responsive, safe, and accountable for all individuals.
- When forming the accountability entity, consider a collaborative governance structure that brings together key players involved in crisis response.
    - This model of governance differs from traditional forms of governance in that it involves "stakeholders in a collective decision-making process that is formal, consensus-oriented,

and deliberative and that aims to make or implement public policy or manage public programs or assets" (Ansell and Gash, 2008, p.544).

- These players may include, but are not limited to: City of Calgary, Calgary 911, Calgary Police Services, Calgary Fire Department, Alberta Health Services (various departments, e.g., Addiction and Mental Health, EMS), Alpha House/DOAP Team, Drop-in Centre, The Alex, and Distress Centre.
- Key functions include being accountable for system performance through monitoring and evaluation, coordinating funding sources to support the entire crisis continuum, and coordinating service elements (e.g. system navigation, partnerships, availability of crisis response teams/programs).
- The collaborative will require shared memoranda of understanding (or similar) and protocols, as well as formal staffing commitments.
- Membership should be position-based, not person-based. Consider what level of decision making and influence the positions require within an organization.
- The chair or co-chair position(s) could be for a limited term and rotate among participating organizations.
- The role and scope of the accountable entity, along with members, can evolve over time as it moves through different phases of system transformation.

PARTNERSHIPS

Recommendation 1a: The accountable entity works to build close relationships and formalized partnerships between first responders, dispatch centres, diverse community service providers, and crisis system coordinators in different geographic areas of the city.

Considering the complexity of mental health and other crises, and diversity of individuals experiencing crises, no one profession or service provider can adequately meet the needs of clients. Working in tandem with other service providers can produce positive outcomes for clients and professionals, and therefore improve the quality of service delivery (Winters et al., 2015). Partnerships can take on several different forms. It can refer to formal partnership teams of co-responders involving police or informal partnerships between a diversity of partners across the crisis care system. Strong partnerships bring a wider array of skills, training, subject matter expertise, and experience to the crisis response. This improves the likelihood of responding as early as possible, in the safest and least-restrictive setting as possible (Balfour et al., 2021).

"People who are in crisis are going through many different issues that are all inter-woven. One organization with one goal cannot resolve all of these issues. There needs to be collaboration to get this person the help and healing they need for the long term"

Crisis response partnerships with law enforcement, dispatching services, and emergency medical services are noted to be a core principle of best practice crisis care (Substance Abuse and Mental Health Services Administration, 2020). Many examples of these

formalized partnerships are captured under the category of co-responder crisis response models. Generally co-responder models involve law enforcement and mental health professionals working together in response to a person experiencing a mental health crisis (Krider et al., 2020). Co-responder models have been found to reduce the rate of police detention and hospitalization, create less distressing responses, and provide quicker access to mental health care (Puntis et al., 2018). Although the co-responder is its own model, many other responses involve aspects of co-responding with diverse service providers. For example, in Calgary, crisis intervention teams and mobile response teams like PACT, MRT, and DOAP rely heavily on partnerships and involvement from mental health service providers. Service providers in Calgary identified that these teams are critical to the crisis response system and heavily relied upon by individuals living on the street. There were multiple requests for increased partnerships and mobile teams comprised of multiple service providers. Most notably there were frequent calls to increase the capacity and availability of PACT.

Less formalized partnerships, including those among secondary responders and community support, are also vital to the crisis response system. Creating a system with well-developed networks and linkages is crucial to providing continuous, appropriate, and effective care (Group for the Advancement of Psychiatry, 2021). This includes ensuring there are seamless transitions between agencies, programs, and settings. Increasing communication between mobile teams, law enforcement, hospitals, and community service providers is important to ensure continuity of care (Flynn et al., 2021). Calgary service providers shared that the sector struggles with transitions and there is a real challenge to pass clients to the correct and next setting. Although warm hand-offs occur, they are often circumstantial and only a result of personal connections held by individual service providers. Therefore, many clients slip through the cracks and fail to end up at the most appropriate service or exit the system completely. Establishing an ongoing forum for crisis responders to meet, learn what other organizations are doing, and develop trusted relationships is one step towards strengthening informal partnerships.

Implementation Considerations

- Requires the accountable entity to make connections, develop formalized arrangements, and assist in developing and implementing shared protocols.
    - Partnerships need protocols to avoid inefficiencies when it comes to coordination of care.
- Begin with clarifying the roles and responsibilities of each organization in the accountable entity and subsequently the system.
- The goal is to work towards shared mission, vision, and values, establish mutual trust, and define role clarity for each organization within the system.
- Information sharing is a crucial component of moving beyond simply knowing other agencies and where to make referrals (see Client Information Sharing). Information sharing, as it pertains to the accountable entity is about addressing barriers (i.e., organizational policies) to facilitate timely and responsive sharing.

SYSTEM NAVIGATION

Recommendation 1b: Leadership from the accountable entity includes system navigation for partners including law enforcement, emergency departments, hospitals, primary care centres, behavioral health centres, and other community-based service providers.

Recommendation 1c: In collaboration with community members and service providers, define a crisis response protocol and resource it for adequate implementation.

Survey participants with lived experience: 62% reported that it is important or very important that an ideal crisis service has the ability to have connections to 911 and alternative crisis lines.

"For people not connected to the system, they don't know where to begin and are likely left with 911"

The Community Mental Health Action Plan (2018) reported that Albertans frequently express how difficult it is to navigate the mental health system. As a result, individuals and families are not receiving the appropriate supports they need, and this is heightened for those facing additional barriers (e.g., language, homelessness, and stigmatization). This was echoed by Calgary service providers, who see clients struggling with system navigation but also face challenges themselves to know who should be contacted and when. If you can navigate the system, there are great services available. However, the system can be quite overwhelming due to the number of players involved and lack of clear mapping, structure, and protocol. Several service providers explained that although an organization may acknowledge their deficits (e.g., language barriers, lack of culturally-affirming practices, treatment options) and want to turn to another organization with expertise, they may lack awareness of where to go or any means of coordination with the appropriate organization.

Navigation can be defined as "the act of linking and connecting individuals to trusted and relevant services and supports in a timely and trauma informed manner" (Community Mental Health Action Plan, 2018). System navigation is a challenge for all system partners, from individuals in crisis to service providers to communities. When it comes to emergency dispatch, call takers often have limited options, which are to send police, paramedics, or both. Although there are mobile teams with other service providers they are often not accessible via 911, or operate on limited hours (Watson et al., 2021). In addition to limitations about who can be dispatched and when, there are general concerns around crisis response protocols. A study into Ohio's urban crisis response system found that protocol confusion was a primary theme, there is general knowledge of what services agencies provide, but a lack of specific knowledge on the protocols or processes, or who should be contacted and in what order (Flynn et al., 2021). Although there is a wide range of options, there is often no clear plan of who to call and where to go. Difficulty

Crisis Response Protocol: Guidance and processes for responding to a crisis, including which agencies should be contacted and in what order.

navigating the system and inefficient points of entry result in barriers to accessing a range of crisis care, from preventative and routine care to adequate and timely crisis response (Group for the Advancement of Psychiatry, 2021).

It should be noted that certain parts of the crisis response continuum know how to navigate the system and have the infrastructure and databases in place to do so (e.g., Access Mental Health, Distress Centre, 211). For those without the right mechanisms in place, they are unaware of other options without a comprehensive database. This is touched on further in the information sharing section below. It was also noted that the Distress Centre is being utilized more to find the right resources for people in crisis, especially beyond traditional 911 responses. However, because there is no centralized database of crisis response protocol to follow, many people (i.e., clients and responders) end up calling 911. Increased awareness and education for clients, responders, and community members of the services available and alternative numbers to call in Calgary was identified as a strategy to address this. Additionally, many service providers highlighted the former Street Survival Guide and the importance of offering physical resources that do not rely on technology to use.

Implementation Considerations

- Accountable entity designs system navigation with the goal of always knowing where the individual in crisis is, that means never losing contact with the individual, and verifying the hand-off has occurred to the next service.
- Consider the “air-traffic controller” model adopted – ensure no individual gets ‘lost’ in the system.
    - Hub for effective deployment of mobile crisis and for ensuring timely, appropriate access to facility services (e.g. crisis stabilization, crisis respite, psychiatric hospitalization).
- System can provide electronic interconnectedness in the form of a secure and easy-to-navigate web-based interface and community partner portal to support communication between support agencies and more intensive service providers.
- Protocols to verify that they have been successfully connected with another agency or entity that will now have responsibility, or if they were referred to mobile crisis, law enforcement, or emergency department, ensure they were connected with care.

Implementation Considerations specific to Crisis Response Protocols

- At a minimum, the protocols should be inclusive and applicable to organizations in the accountable entity.
- The role and responses of key partners should be identified in the protocols.
- Situationally-based protocols should be developed for the most common types of crisis calls (e.g., domestic violence, mental health, substance use), acknowledging that each is unique and will require adaptability and flexibility (these protocols feedback into strengthening and formalizing partnerships).
- Consider reviewing 911 data and identify percentage of low-risk calls that potentially could be safely diverted over to 211 versus triggering dispatch of police, EMS, and fire.

- Ensure protocols capture shared system values and therefore include peer support, cultural competencies, and a trauma-informed lens.

FUNDING

Recommendation 1d: Make funding decisions in collaboration with partners to ensure the funding is directed to all aspects of the crisis response continuum overall. The accountable entity supports sustainable funding and avoids competitive funding processes.

Funding is a perpetual concern for service providers. It is inherently a competitive practice to seek funding, but this drives a wedge between some of the service providers trying to work together and goes against the vein of working collaboratively. Additionally, funding competition is occurring at different ends of the crisis continuum. What this means is that an organization providing preventative care may be competing for the same funds as an organization that provides follow-up care, when both are needed for continuity of care. Making funding decisions in collaboration with partners is important to ensure funding reaches across various components of the system rather than being limited to specific agencies. Calgary organizations also described the constraints of time-limited funding. Making significant service changes during a funding schedule is challenging. As a result, funding sets the timeframe to work within as opposed to supporting a true solution-based design. The accountable entity can work to support collaborative funding approaches that maximize resources, minimize competition, and reduce duplication.

The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes the importance of an integrated approach to providing and funding services to "address behavioural health crises, reduce the likelihood of future emergencies, and provide outcomes for those in need" (Substance Abuse and Mental Health Services Administration, 2014). Integrated approaches allow funds serving similar populations to be administered with greater flexibility and used to respond to multiple aspects along the care continuum (Association of Government Accountants, 2014). Two examples of integrated funding approaches identified in the *Ideal Roadmap to Crisis Response* are braided and blended funding, which aim to leverage money being spent on separate programs serving similar populations by combining two or more streams of funding (Group for the Advancement of Psychiatry, 2021).

Both braided and blended funding require an accountability entity or collaboration of organizations to coordinate and manage. Strong leadership for the crisis response sector will allow for collaborative strategies to ensure resources are utilized effectively and thus providing services to as many people as possible and addressing gaps in the sector. Often services are driven by the available funding, this can limit capacity, project timeframes, and the ability to engage in long-term proactive strategies. Coordinated funding approaches ensure that services are driven by the needs of the community (Clare, 2013). This is done by coordinating multiple funding sources to support the continuum as a whole as opposed to specific organizations (Group for the Advancement of Psychiatry, 2021). With a coordinated approach to funding that is overseen by an accountable entity, duplicate services are easier to identify and organization of care among agencies is improved (Substance Abuse and Mental Health Services Administration, 2014).

Implementation Considerations

- The accountable entity is responsible for developing a comprehensive budget for the crisis response continuum, the initial budget may be based on historical utilization of all components and players of crisis care and include projections based on future utilization under a transformed crisis response system.
- The accountable entity may consider completing a full funding review to understand each partner's funding stream (starting with organizations that form the accountable entity).
- Work towards shifting the sector to multi-year, rolling funding to offer increased certainty and sustainability, as well as the opportunity for long-term planning by organizations.
- Alternative to a full funding review, examine what are the programs and elements required in the crisis response system and map out who is doing what, and whether they are resourced to do so.
- There are two evidence informed funding approaches that may be considered, both funding concepts aim to increase stakeholder collaboration, enhance program outcomes, and maintain accountability to ensure program integrity (Association of Government Accountants, 2014).
    - Braided funding weaves funds together from multiple sources to support a common goal or idea, such that each individual funding source maintains its specific program identity.
    - Blended funding mixes together various sources to support a common goal or idea such that each individual funding sources loses program-specific identity (Butler et al., 2020).

Community-driven System Responsiveness

Recommendation 2: The crisis response system is community-driven. Ongoing community engagement informs the development, design, and implementation of crisis response.

An ideal crisis response system is responsive to the unique needs of its community, individuals, and families. By designing a responsive system, people will be served more effectively and efficiently (Group for the Advancement of Psychiatry, 2021; Ormerod et al., 2013). There is a need for the crisis continuum to provide program, service, and supports options that are in-tune with the full range of populations in need. This includes individuals across the lifespan, with different mobility levels, with various comorbidities (e.g., medical conditions, substance abuse disorders), with cultural and linguistic barriers, and who are members of the LGBTQIA2+ community (Group for the Advancement of Psychiatry, 2021). A significant piece of responsiveness is addressed through providing a value-based system (discussed in the proceeding theme). This includes providing care that is trauma-informed, culturally affirming, identity-affirming, and provides the individual with dignity and choice.

This theme solidly straddles the line between system-level theme and operational. Much of the action and change informed and driven by community will be visible at the operational level, however, it requires participation at the system level to evoke the desired changes. For clarity, this section focuses more on initiatives that ensure the system is informed by and engages with community. The operational implications of the system being responsive to community needs are discussed under the accessibility, transportation, and client information sharing themes in the operational section.

Implementation Considerations

- Design a crisis care continuum that meets the needs of the whole population served, emphasizing those that are more vulnerable and complex, as well as those with special needs or at risk of experiencing disparities in care.
- Create a community table for community-based organizations and members to inform the crisis response system and engage with the accountability entity.
    - Implement formalized communication channels between the community table and the accountable entity that is formalized.
    - Provide ongoing opportunities for community members and organizations to engage with the accountability entity and contribute to the transformation, implementation, and evaluation of the crisis response system.
- Community-driven representation needs to include Indigenous-led, Black-led, and other culturally diverse organizations, and be grounded in anti-racism and anti-oppression.
- Consult community members throughout the stages of transformation, including elements such as developing crisis response protocols, strengthening values, implementing peer support, and improving accessibility and transportation.
- Empower community members to inform others about the services and amplify public education campaigns.

Values-based System

Recommendation 3: The core values identified by Calgary service providers guide the design and operation of every aspect of the crisis response system. This includes the structure of the system, criteria to enter programs, guidelines and protocols for transitioning clients, and interventions with a person in crisis.

Values-based, in this context refers to services and systems that are designed in accordance with core values. This is not to be confused with values-based health care in which providers are paid based on patient health outcomes.

Calgary is a diverse city that continues to evolve, as such there are a wide range of populations accessing crisis response services. Community service providers identified several barriers that individuals and communities face in both accessing services and receiving inclusive, effective care. Additionally, first responders noted that vulnerable populations are overrepresented in the crisis response system. Service providers across the continuum of crisis care emphasized the importance of providing welcoming, affirming, and appropriate care for each individual. However, they also discussed many challenges across the system incorporating values-based practices that contribute to delivering this type of care. In order to provide welcoming, person-centered care to individuals experiencing crisis it is critical to operationalize values-based approaches throughout the crisis response system.

The core values identified by Calgary service providers across the crisis response continuum are highlighted in Figure 4. These core values arose out of reoccurring themes from conversations with a wide range of service providers along the crisis care continuum. Each value contributes to creating a more inclusive environment before, during, and after a crisis response. These values and principles focus on putting a client's safety and experience in the centre of the crisis response framework. This aligns with the notion that an ideal crisis system must be defined primarily by how individuals and families in need are served when in crisis (Group for the Advancement of Psychiatry, 2021). The health and well-being of first responders must also be considered. Calgary service providers noted that they are experiencing vicarious trauma, burnout, and mental health concerns that need to be addressed to ensure responders can provide safe, effective, and engaged care. These core values underpin every aspect of engagement with the crisis response system, from individual interventions to organization policies, to system navigation.

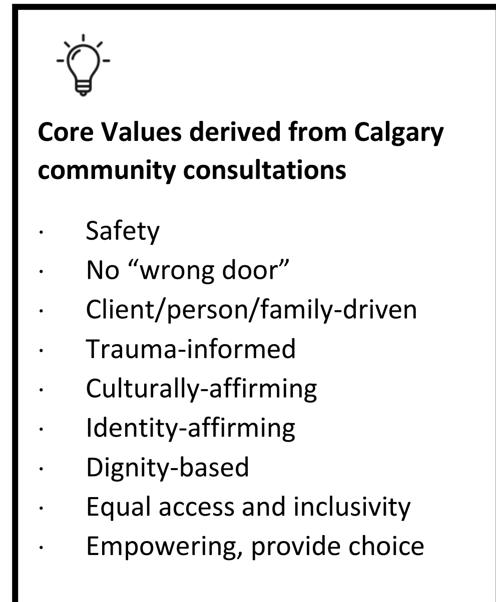


*Figure 4.*Core Values

Sackett et al., (2000) defines patient values as "the unique preferences, concerns, and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient" (Sackett et al., 2000, p.1). Values-based practices have been developed as the partner to the evidence-based approach, and aims to support shared decision-making between practitioners, clients, and their families on the basis of 'values' as well as 'facts' (Fulford, 2008; Petrova et al., 2006). Values-based practice aims to empower service users and providers to have more choice and access to diverse and individually-appropriate care (Ormerod et al., 2013). A crisis response system and crisis services that are rooted in these core values help create a positive and safe experience for responders, clients, and their families (Group for the Advancement of Psychiatry, 2021).

"We unintentionally create barriers, we have lost choice in the system because there is so much criteria-based services, [individuals] have no choice, so decisions are left in the hand of resources available. With patient-centered the patient has some choice into what their next step is."

Implementation Considerations

- Build core values into every aspect of the accountable entity. They are responsible for making sure values are maintained and incorporated into organizational processes.
- Encourage each organization to identify and re-evaluate their own values, and then map their values against other organizations.

- Define a standard set of values (collaboratively, with the accountability entity and community members and organizations). Confirm list of values and revise as the group deems necessary, possibly though the community table.
- Implement all components of the crisis response system (structure, protocols, standards, practices, and outcomes) according to the values; measure regularly to ensure continued progress.
- Maintain core system values and incorporate them into all organizational processes, including contracting, partnerships, data collection, quality improvement, and outcomes.

Operational Themes

Each of the operational themes presented below have loosely been categorized into one of the three system-level themes, although they can be cross-cutting. These are elements of crisis response that require system-level engagement or influence but result in impacts or actions that occur at an organizational level. Each recommendation is numbered according to the system-level theme under which it falls.

Accessibility

Recommendation 2a: Ensure the system provides diverse, barrier-free service options rooted in community needs.

All survey participants: 70% reported that it is important or very important that ideal crisis response services allow alternative crisis lines to be able to connect to other services, there is availability through local health centres, and that services should be offered 24/7. As well, 68% reported that mobile services were important or very important to ideal crisis response services.

It is important that crisis response systems offer a diverse, accessible array of service options to meet the needs of the population, including organizations that provide multiple service elements in one place. This approach is captured by the integrated care crisis model, which is noted to be a best practice in crisis response. This model advocates for fully integrated crisis response system that includes elements like a crisis call centre (someone to talk to), crisis mobile team response (someone to respond), and crisis receiving and stabilization facilities (somewhere to go) (Substance Abuse and Mental Health Services Administration, 2020). The Crisis Response Network exemplifies the integrated model in practice (the model is also known as the Crisis Now Model). In Maricopa County, Recovery Innovations (RI) began as a respite centre (providing crisis stabilization) as an alternative to hospital inpatient, jail, and emergency departments for those experiencing mental health crisis. It was successful but there was an acknowledgement that most people with acute cases were still being diverted to emergency departments and jails. A decision was made to adopt a policy of "never reject" to law enforcement drop-offs. A peer leader would greet the individual and law enforcement would not need to wait at the facility for a client to be assessed. The model uses police as transfer agents, and then frees them up to allocate their time to law enforcement duties. The Crisis Now model is a fully integrated and flexible crisis response system. Maricopa County's implementation shows that that the model is not restrictive to any one type of approach (i.e., non-police crisis intervention) or having an in-house crisis call center (Watson et al., 2019).

In the Calgary context, several key issues arose during community engagement, including: respite options, crisis call responders, need for services that address root causes, and availability of crisis response services (e.g. 24/7 services, service provided in local communities). A strong variety of services

is needed in one location, otherwise people may exit the system prematurely or continue in a revolving door situation as opposed to finding the appropriate resource.

Access to services may, unintentionally, be affected by the criteria required to use programs or facilities. As a result, an individual's choice for services may be limited and can result in a referral that is inappropriate for their needs. For example, strict shelter criteria can prevent access for an individual with a pet or force a youth into an environment that is not suited for them based on age cut-offs. As a result, individuals may not access care, in particular preventative care, which could mitigate future crises. Further, crisis response primarily focuses on dealing with the presenting problem. However, the crisis itself is often only one aspect of a larger set of issues or challenges the individual is facing. Service providers across the continuum of care emphasized the importance for the system to consider what is being done to address root problems and prevent future crises.

Indigenous survey participants: 69% reported that harm-reduction is important or very important to provide in crisis response.

When it comes to who is responding to crises, what interventions looks like, and where service users are being taken, preferences vary among populations and individuals with differing previous experiences. Based on the lived experience survey, those who identified as Indigenous preferred a crisis responder that did not involve police but rather a mental health professional or responder with lived experience. Almost 39% of Indigenous participants also identified harm-reduction to be a top priority in crisis response. Those who identified as gender-diverse almost never preferred police to respond in any crisis situation, instead they preferred a crisis worker to respond. These individuals also noted that referrals to housing, counselling, hospitals/specialists, and a safe place for recovery were important aspects of the crisis response system. It is important to be conscious and accommodating of these preferences and ensure there are diverse teams available to respond to calls. Hospitals were also a commonly discussed issue, as emergency departments are often where individuals in crisis land. Unfortunately, as noted earlier, those waiting in the emergency department with a mental health crisis are often there for an extended period of time. Health care professionals reiterated that the emergency department is often the worst place to be for individuals experiencing mental health concerns. Additionally, it is the role of hospitals to decide if a person in crisis is admitted to the hospital or not. Problems arise because hospitals are currently limited in their ability to connect an individual to another service or system, especially outside of traditional working hours.

Implementation Considerations

Note: Accessibility also includes providing service options that are culturally competent, anti-oppressive, anti-racist, and diverse. These elements are captured more thoroughly in the peer support, culturally competent, and trauma-informed themes. The considerations provided here speak more to the programs, services, and related logistics. It should also be noted that there is an endless list of accessibility details that could be provided here, the considerations below focus on addressing reoccurring issues identified by Calgary service providers.

- Consider crisis response options and services that meet the following goals:

  - All individuals feel safe, comfortable, and able to seek the support they need and want, when and where they need it.
  - Crisis response provides options that can avoid/minimize emergency room visits, institutionalization, and engagement with justice system.
- Provide more short-term sub-acute (i.e., somewhere between chronic and acute) crisis stabilization programs (e.g., respite centres, crisis beds, detox facilities, culturally specific healing centres, shelters).
  - Facilities are more home-like, and are staffed with a mix of professionals and paraprofessionals including peers as integral staff members.
  - Facilities provide more destination options for service user transport.
- Ensure there is a centrally deployed mobile crisis available on a 24/7 basis – mobile crisis response programs should include contractually required response times.
- Expand functions of mobile crisis services to include triage/screening, explicit screening for suicidality, assessment, de-escalation/resolution, peer support, coordination with medical and behavioural health services, and crisis planning and follow up (Crisis Now Task Force).
- Develop crisis response teams for mental health crises that do not involve police (in situations where there is no imminent risk of violence or weapons), staff should be multidisciplinary, reflect diversity of the community, and include peer support workers.
- Implement a case review process, where members from the accountability entity and community table have procedures for individual case review and root cause analysis to respond to adverse outcomes and recognize successes.

Peer Support

Recommendation 3a: Create a mechanism to incorporate lived experience into the crisis response system.

Calgary service providers discussed the importance of having a place for the peer support model in crisis response teams and programs, emphasizing the value of speaking to someone of the same level of hierarchy. It was noted that trained peers make it easier for people in crisis to connect because they are talking to someone who understands their experience. Additionally, it provides an opportunity to have a crisis responder reframe both the issue and resolutions in a way that resonates or aligns with the individual's experience, culture, and world views. To make peer support more readily available in Calgary, more opportunities with fewer barriers need to exist for people with lived experience to become engaged in the crisis response network. These opportunities need to include supports to reduce traumatization or trigger reactions for the peers.

"The Indigenous community is severely under-represented in these first responder organizations."

Peer mentorship and peer support are recognized as key components of crisis care, having demonstrated successful

outcomes which include reduced hospitalization, increased quality of life, greater improvement in symptom ratings, improved treatment satisfaction, and better physical health (Greenfield et al., 2008; Ormerod et al., 2013). Including peers as core members of the crisis team and in all elements of the crisis system recognises that individuals with lived experience could "take all of their experiences, regardless of the pain, and use them to transform their life into 'living hope' for others who want to recover (Ashcraft, Zeeb, & Martin, 2007). SAMHSA asserts that available peer support is a key principle to ensuring crisis intervention practice embody core values, and that mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness firsthand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences – an option that may heave particular relevance given feelings of isolation and fear that may accompany a mental health crisis" (Substance Abuse and Mental Health Services Administration, 2009, p.8).

An example of peer support in crisis response is the Recovery Coach Pilot Project in Montana, initiated by Montana's Peer Network. The project focused on prevention of mental health crisis calls in the community and involved peer supporters (i.e., recovery coaches) working with mobile crisis outreach. The program worked with law enforcement to help identify individuals at risk. Peer supporters would respond to an individual's home within 24 hours of a referral to offer support and resources, the peer supporters also disclosed to the individuals they were in recovery. The program also offered weekly one on one peer support to those who chose peer support as part of their recovery. Meetings looked different with each individual and were guided by what that individual was most comfortable with. A weekly peer support recovery group was also open to the community. The project was well received by law enforcement, the state, project participants, community organizations, and individuals. It has helped legitimize the peer support profession and demonstrate that community based peer support is effective (Montana's Peer Network, 2015).

Implementation Considerations

- Enlist peers not to duplicate the role of behavioral health practitioners but to establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis.
- Have community organizations identify roles and scope of peer support, what protocols are in place to allow peer support, and what potential barriers exist.
- Explore options for formalized training for peer support workers on how to use lived experience, implement a standardized training across organizations utilizing peer support.[5]
- Ensure peers are valued, treated equally, and provided a fair living wage when possible.
- Implement a careful selection process with slow onboarding.

[5] Guidelines for the Practice and Training of Peer Support (Mental Health Commission of Canada, 2013), Canadian Mental Health Association Calgary's School of Peer Support

- Learn from community organizations in Calgary with experience using peer support (e.g. Distress Centre, University of Calgary Student Wellness Centre, CMHA-Calgary, Women's Centre).

Cultural Representation

Recommendation 3b: The crisis response system reflects the cultural representation of Calgary's population including first responders and approaches to care.

Experiencing discrimination by a service provider and not having cultural background reflected in service provision were identified as the top two barriers to accessing crisis services across all survey participants in Calgary. Of Indigenous survey participants, 56% reported that not seeing their cultural background reflected in service provision negatively impacts access. There was a recognition that the sector has not done enough to connect with the Indigenous community, there is a lack of Indigenous oriented supports, access to culturally appropriate services, culture in general, and Indigenous peer supports. There is also a gap in both the availability of culturally appropriate services and the ability to connect individuals from mainstream services into more localized or niche service providers. For example, a service provider from a small ethnicity-specific crisis line explained the challenges they experience with making connection, publicity, advertising, and increasing familiarity with mainstream organizations. Increasing awareness of, and coordination with diverse service providers, specifically smaller organizations that lack mainstream visibility is an important step to address these concerns.

Indigenous survey participants: 56% reported that not seeing their cultural background reflected in service provision was a challenge to accessing services.

All survey participants: 65% reported that it is important or very important that crisis response services are offered in the language that they choose.

Accounting for specific insights and nuances of certain cultures when researching and engaging in community work was also identified as critical to ensuring health equity. This means that the wants and needs of communities are valued and not overshadowed by other approaches (i.e., traditional western approaches, or what is viewed as "best practice" by the sector). Finally, when it comes to language, services providers shared that receiving services in your own language is always preferable. The ability to communicate with someone in the language of their choice was identified by survey participants as a very important aspect of an ideal crisis response system, with 27% of participants overall endorsing this option. The crisis response system must be culturally responsive and competent such that beliefs, languages, interpersonal styles, and behaviours of individuals and families are honoured and respected. Cultural competence must also be recognized as a constantly evolving, developmental process that requires long term-commitment (Substance

"It is important to distinguish reconciliation from equity, diversity, and inclusion. Reconciliation has to stand alone."

Abuse and Mental Health Services Administration, 2014). Moving forward, the crisis response system needs to consider implementing less restrictive criteria for hiring (e.g., leniency around prior offences), and more job, internships, and practicum opportunities for racialized individuals to enter the crisis response sector.

Culture also plays a significant role in determining what crisis response should look like. Culture influences and contextualizes how individuals interpret the meaning of crisis, how they respond to interventions and mental health supports, and what type of threat or event is perceived as traumatic (Silva & Klotz, 2006). Ensuring cultural and historical consideration inform care is another principle of value-based care, and also contributes to practicing trauma-informed care (Substance Abuse and Mental Health Services Administration, 2020). This is particularly relevant for Indigenous communities, where there is the added lens of colonial impacts and experiences with authority figures. As noted by Hackett et al., (2018) the effects of historical and ongoing "socio-political impacts, including diminished self-determination, historical loss of traditional land, language, and culture as well as social exclusion, must be considered to understand changes in Indigenous Peoples' health" (Hackett et al., 2018, p.421). The viewpoints, worldviews, and epistemologies of Indigenous Peoples must be incorporated into their health and well-being care, particularly with culturally appropriate and specific practices.

"The crisis support system needs to do more to be culturally affirming. Language is only the first part – culture goes much further."

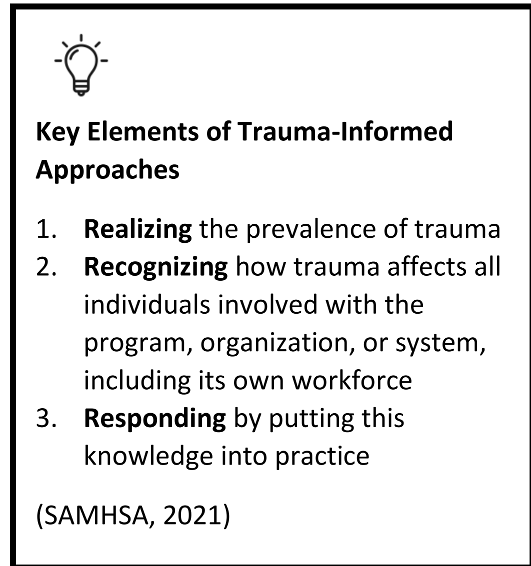
Implementation Considerations

- Employ staff members that speak the native languages of the people being served rather than exclusively relying on interpreters.
- Have crisis teams co-respond with local neighbourhood teams that have established trusting relationships in the community.
- Consider using terms that are more open and broad, that capture other cultures and avoid stigmas related to mental health.
- Incorporate culturally specific services and traditional health practices (e.g., Indigenous Elder partnering with a clinician and peer support worker).
- Build meaningful connections with existing culturally specific agencies and cultural institutions that are well-trusted by racialized individuals.
- Collect race-based data to measure service outcomes and critically examine the experiences and outcomes for people of colour, with the end goal of ensuring their crisis response experiences are not disproportionately inadequate.
- Consider cultural brokers to bridge the gap – individuals who not only know the language but are aware of the elements of culture that could be related to the way someone expresses a need, or demonstrates they are in crisis.

- Build trust between service providers and community (could be with formal partnerships).

Trauma-Informed Care

Recommendation 3c: Trauma-informed care and client-centered care is woven into all levels of strategy, practice, and policy in the crisis response system.



Key Elements of Trauma-Informed Approaches

1. **Realizing** the prevalence of trauma
2. **Recognizing** how trauma affects all individuals involved with the program, organization, or system, including its own workforce
3. **Responding** by putting this knowledge into practice

(SAMHSA, 2021)

*Figure 5.*Key Elements of Trauma-Informed Approaches

Trauma-informed approaches include an understanding of trauma and the awareness of the impact it can have on individuals, families, and communities across different settings (Substance Abuse and Mental Health Services Administration, 2014). Trauma-informed care is a service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010). Key elements of **trauma-informed approaches** are noted in Figure 5. There is a high degree of overlap between trauma-informed care and the values previously discussed, as they often contribute to addressing one another. This includes Calgary service providers across the crisis response continuum emphasized the importance of creating a sense of belonging for people in crisis. This includes avoiding turning people away, putting them on a waitlist, not calling back, or referring elsewhere with no warm hand-offs. Often such actions result in prolonged or worsened crisis, and failure of providing trauma-informed, client-centered care. Previous experiences with services should also be considered to offer trauma-informed care. Many racialized individuals have experienced negative interactions with law enforcement and other authority figures in their home country and/or in Canada, this creates a fear of calling the police and potential distrust in authority figures.

Service providers identified several means to strengthening trauma-informed care in Calgary. The most critical is ensuring trauma-informed care is not just a training, but rather a policy that is applied to all aspects of the crisis response system (i.e., planning, design, structure, protocols). It is also important to provide adequate choices to a client for their next step or options. Instead of overwhelming clients with a booklet or list of resources, provide culturally appropriate, identity-affirming options in the client's geographic areas of preference. Supporting a client's decision with help to access the service is also important (and discussed in further detail in the system responsiveness section). Finally, many service providers noted that although they do not receive funding for basic needs, offering clients

"Trauma-informed care is policy. Barriers get put up when trauma informed care is not there and can limit [an individual's] interest to access service."

access to basic needs is critical. Especially if a client must wait to access services, offering water, food, bathrooms, phone, internet is key to protecting client dignity.

Implementation Considerations

Note: Implementing trauma-informed care requires participation from all service providers, not solely crisis response. The entire system must be trauma informed. Therefore, implementation considerations will vary depending on the organization, its role, and the extent that their current practices are trauma-informed (e.g. trauma-informed organizations vs. building a trauma-informed workforce).

- Create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioural health.
- Consider the following steps to creating a trauma-informed organization as illustrated by SAMHSA (2014):
    - Commit to creating a trauma-informed agency.
    - Create an initial infrastructure to initiate, support, and guide changes.
    - Involve key stakeholders including clients who have history of trauma.
    - Assess whether and to what extent the organization's current policies, procedures, and operations either support trauma-informed care or interfere with the development of trauma-informed approaches.
    - Develop organizational plan to implement and support the delivery of trauma-informed care within the agency.
    - Implement plan and reassess the implementation of the plan and its ability to meet the needs of clients and provide consistent trauma-informed care on an ongoing basis.
    - Implement quality improvement measures as needs and problem areas are identified.
    - Institute practices that support sustainability such as ongoing training, clinical supervision, client participation and feedback, and resource allocation.
- Note: Comprehensive trauma-informed care also requires support for staff members who may have experienced trauma/vicarious trauma themselves.

Training

Recommendation 3d: First responder training requires both theory and practice with immersive and applied approaches. Training provided is ongoing with refreshers and in-depth learning.

A values-based system is anchored by a strong training framework that includes structure for advancement, refreshers, and practical training. Based on the core values, training should include trauma-informed care, intergeneration trauma, cultural supports, non-western approaches, Indigenous well-being mechanisms, and spiritual offers. A range of service providers noted that values-based and mental health training for first responders can be very basic and only occur as one-offs. As such there is

a need to move beyond the basics and engage in continuous practice-based training. This is particularly concerning for Indigenous-based trainings and awareness, which was referred to as the basic "101" training.

Implementation Considerations

- Examine organizations' current training inventories, minimum standards, and implementation considerations. The accountable entity can work to standardize training for different groups of responders.
- Employ rigorous training in anti-oppressive, anti-racist practice, and knowledge related to cultural safety (including cultural traditions about traditional knowledge and support practices of the communities they are serving).
- Ensure training goes beyond the basics. Indigenous training needs to include awareness and implementation of the relevant Truth and Reconciliation Commission calls to action and United Nations Declaration of Rights of Indigenous Peoples.
- Have police officers self-select for Crisis Intervention Team (CIT) training. Officers who volunteer to participate (rather than being assigned) report better outcomes with regards to key attitudes, skills, and behaviours (Compton et al., 2017).
- Pair first responders with other service providers to provide opportunities for them to understand the clientele being served. This approach has seen success, for example with Calgary police officers embedded at the Drop-in Centre as part of their training.

"Within any legal justice system there is systemic racism. Having some inter-cultural awareness training among all levels would be beneficial to mitigating systemic racism."

Gender diverse survey participants: 58% reported that they would prefer a crisis worker when in a situation that involved a mental health crisis, compared to 20% overall.

Transportation

Recommendation 2b: Explore solutions for addressing safe and reliable transportation of individuals to and from services.

Recommendation 2c: Allow EMS to transport patients to additional facilities for mental health care.

In Calgary, people struggle to get to the appropriate facilities or services due to limited transportation options. This includes transportation from the crisis centre to a confined program that the individual was attending; transportation from the hospital to a safe home/shelter; and individuals determining how to get to another resource/service when they are referred onwards. The survey results also indicate that transportation home or to a safe place is a top priority for Calgarians, with 28% indicating it to be very important.

Currently, EMS can only transport clients to hospitals, urgent care, Alpha House, and the Drop-In Centre. EMS would like AHS to approve more care options and appropriate facilities to transport to, or a single

facility that is dedicated to mental health. It was noted that more appropriate options would not only better serve clients but increase EMS availability and response times. This is because paramedics must remain on-site at hospitals while their client waits to be admitted to psychiatric care and wait times for these clients most often exceeds those with physical health concerns. A recent study found that the average length of stay in the emergency department for psychiatric patients in Calgary is 31 hours, and those who experienced an adverse event within the emergency department had a prolonged boarding time of 35 hours (Major et al., 2021).

Transportation is an essential service within the crisis response system because it provides the vital connection to the required service. SAMHSA notes that connecting individuals to facility-based care through warm hand-offs and coordination of transportation is a minimum expectation of operating a regional crisis call service or mobile crisis team (Substance Abuse and Mental Health Services Administration, 2020). Transportation services can be problematic or even a complete barrier to accessing appropriate services in a timely and safe manner. When people cannot get where they need to be it can worsen or prolong the crisis, or fail to address the root causes and therefore result in future crises (Group for the Advancement of Psychiatry, 2021). Therefore it is crucial that the crisis response system provides safe, welcoming, and supportive transportation.

All survey participants: 69% reported that it is important or very important that transport home or to a safe place is provided during a crisis.

Transportation begins with how an individual finds their way from community to the first point of in-person treatment and ends with how they are transported to their next destination (e.g., inpatient psychiatric unit, shelter, home, etc.). In Calgary however, many service providers feel the latter part of transportation is lacking. Most often, transportation concludes with the initial transfer to the first point of care. Additionally, the transportation experience itself can have a significant influence on how an individual perceives their crisis response care. For example, unnecessary restraint and force, or being transported in a marked law enforcement vehicle can result in trauma and reluctance to seek assistance in the future (Group for the Advancement of Psychiatry, 2021). The crisis response system requires a comprehensive transportation plan for individuals to the crisis centre, from the crisis centre, and to other locations in between along the continuum of crisis response.

"The current system is quite disjointed. Many individuals feel frustrated and overwhelmed when they are not being supported properly when being transferred between different organizations."

Implementation Considerations

Note: The issue of transportation is closely linked with accessibility in that service providers need appropriate facilities and programs to transfer individuals to.

- Map out the crisis response system with the lens of transportation, including who provides transportation, where they transport to, and where there are gaps or breakdowns in the transfer process.
- Review the several legislative elements impacted by broader transportation options, including the *Mental Health Act* and the *Emergency Health Services Act.*
- Consider the required funding support for organizations not governed under the *Emergency Health Services Act* to provide transportation.
- Consider the transportation of individuals transferred to secondary services (post-initial intervention), other services along the crisis care continuum, and to a safe place afterwards (e.g. home, shelter), because warm handoffs support successful outcomes.
- Consider innovative solutions like having designated crisis specialist present during transportation, they could provide support and treatment during transportation and begin identifying other issues (e.g., housing, substance use, family concerns, etc.)

Client Information Sharing

Recommendation 2d: Increase understanding of information sharing protocols and facilitate better information sharing.

Information sharing concerns focus on the disclosure of client information to other organizations. The Government of Alberta views *information sharing as important to the safety and well-being of Albertans* as highlighted in Figure 6. Robust information sharing can also help reveal gaps in care, which if addressed can help ensure continuity of care. Although there is a need to protect privacy, Calgary service providers noted that especially for those with complex needs, people can be served better with informed consent to allow information sharing.

Agencies and organizations in Calgary shared that there is lack of information sharing as well as information sharing protocols. This is a longstanding issue as organizations use different data management systems, operate under different policies, and often work in silos of information. Organizations indicated that they are unclear if they have the authority to share information, even if it is support of coordination of services and crisis response planning. Additionally, service providers noted that both responders and clients have hesitations and concerns around data collection. Service providers indicated that it can be uncomfortable to ask questions or collect personal information, there is also a fear of re-traumatizing

How does information sharing support the safety and well-being of Albertans?

- ✓ Sharing information appropriately results in increased communication and more informed decision-making.
- ✓ It allows organizations to share personal or health information for case planning to identify critical supports and services that meet the needs of Albertans and their family or caregivers.
- ✓ It enables risks to be managed properly by ensuring organizations are informed about urgent supports an Albertan may require. It also helps identify any health or safety risks the Albertan, staff, or others could experience.
- ✓ Information related to health and safety may be identified as necessary for providing ongoing supports. In these cases, the authority to share information is the same as for other areas of care and well-being.

(Government of Alberta, 2017)

Figure 6. Government of Alberta Information Sharing Guidelines.

individuals who have shared their story on multiple occasions. Clients can also be reluctant to share important information or concerned about how it will be used.

Historically, there was a vulnerable persons department and registry with the Calgary Police Service. With this service notes were kept on an individual's file about their history and physical or mental health. This was identified as a useful mechanism to prevent officers from treating situations as high risk and being more aggressive than necessary. The approach is similar to the flagging/linkage crisis response program. In this program, individuals give consent to share information, after which agencies can use various methods of flagging systems to alert officers about their unique needs when encountering that person (Watson et al., 2019). Calgary service providers emphasized that complete information needs to be available to providers who care for those in crisis (ex: specific details about de-escalation for a particular individual).

Information sharing can be done when it is primarily to "benefit the client", such as being identified as necessary for providing support to a person in crisis (Government of Alberta, 2017). Many organizations already share information across different programs and within sectors. For example, AHS data can be shared among AHS partners when necessary to provide care for a client in crisis that comes to the emergency room. The fact that AHS can share information within its programs is an example of how adherence to privacy laws is more seamless when programs fall under the same privacy law, compared to the perceived hurdle of sharing information with an organization that does not fall under the same privacy laws, such as an emergency food bank. Privacy laws in Alberta (e.g., FOIP, HIA, PIPA) guide the organizations under which they fall and protect users of these organizations by outlining the appropriate uses of their information (Office of the Information and Privacy Commissioner of Alberta, 2020).

As noted above, AHS provides a prime example of successful data management and information sharing. With the implementation of Connect Care in the spring of 2022, it is expected that information sharing will become more streamlined, and access will become easier. For clients that remain within the AHS system, data information sharing issues are less prevalent, but for organizations outside of AHS, information sharing is disjointed and more challenging. For example, EMS is limited in the information they can share with police and fire even if responding to the same crisis call. Assisting and facilitating the adoption of necessary agreements, infrastructure, and education around client information sharing is vital to addressing the current gaps faced by Calgary service providers. Furthermore, investing in a common platform to share information will streamline this process.

"Transitions are lacking, [we are] passing clients on to the next service but have no sense of where they are at, no information is shared, so when they call back it is challenging to serve them without the knowledge."

Implementation Considerations

- Map out which organizations in the system are governed under which information sharing Acts, identify areas of overlap where opportunities to share data are currently possible, note where there are differences and potential barriers.
- Move from an organization-based to a systems-based approach to crisis response, by:

- Informing clients during the consent process when and how their information could be shared to better the quality of their care while in crisis. Include this in a consent form and obtain consent from clients upon intake or through release of information forms (Office of the Information and Privacy Commissioner of Alberta, 2018).
    - Create information sharing agreements or use release of information forms between partnering organizations in crisis response. Disclose only the needed information. Ensure the information being shared aids in providing adequate and essential care for clients.
    - Continue to protect, monitor, and evaluate shared information to ensure the safe and most impactful use of information obtained from clients.
- Data sharing could also include:
    - the ability to schedule intake and outpatient appointment for individuals in crisis with other service providers;
    - shared bed inventory tracking; and
    - GPS-enabled technology to quickly and efficiently determine the closest available team, track response times, and ensure team safety.

Conclusion

This report provides system-level recommendations and specific operational recommendations for transforming Calgary's crisis response system. The recommendations and related implementation considerations are a starting point to guide the transformation. They address the key principles and elements crucial to equitable and effective crisis care. Additional research and considerations are required for all elements of crisis response discussed here, including a detailed analysis of the operations and data for each organization. Further engagement with the community (community members, crisis response service providers, sector support) is the necessary next step. Ongoing engagement is needed throughout the stages of transformation including implementation, evaluation, and modifications.

While all the recommendations hold value, developing the accountable entity and a community table is paramount. Establishing the accountable entity is a critical first step in addressing many of the other recommendations, in particular those in the system-level themes. The accountable entity is likely to evolve over time. Allowing room for it to adapt as the transformation process occurs will promote system sustainability. The community table is crucial to informing, guiding, and driving the crisis response system design and implementation. It is essential that the community table has a formalized role and mechanism to participate in the accountable entity.

Individual organizations will need time to review and consider the recommendations and their implementation. The diverse organizations along the crisis care continuum need to establish their own scope: where they will be involved, what is feasible for them, and how they can actively partner with others. As such, there is value in maintaining and further formalizing the steering committee (i.e., City of Calgary, Calgary Police Service, Fire, EMS, and add AHS) which can provide a table for promoting these conversations among the sector members.

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Appendix A: Client Stories

Crisis response system: Client stories

December 15, 2021

Overview

This section illustrates three stories that were heard during consultations with Calgary organizations.

The first and second are specific families' experiences in the Calgary crisis system. The third story is a composite of many similar stories that were heard. They are meant to give voice to Calgarians who have accessed the crisis response system and their experiences within it. Each story is its own; they are not necessarily generalizable to the greater priority population or even other families.

Each story is first described, then the response to the crisis is presented in 3 ways:

- What we expect to happen
- What did happen
- What could happen (this includes references to the recommendations outlined in this report)

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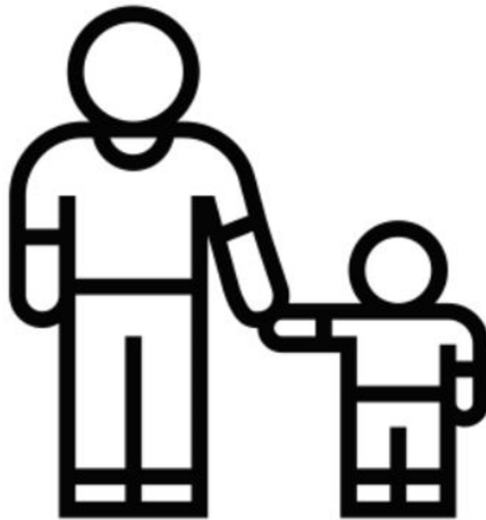
Meet the client, story #1



This story is a personal account of one Indigenous family's experience with police. It shows the importance of cultural connection.

- Indigenous parents with missing child
- Parents resistant to involving police
- Police are dispatched, with an Indigenous volunteer
- Parents interact with Indigenous volunteer; are hesitant with the officers due to negative past experiences

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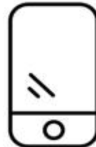
What we expect to happen

Client in crisis



Child goes missing

Parents call 9-1-1

Police dispatched

Parents provide statement to police

Police activate missing person protocols

AMBER Alert

Images courtesy of Eucalyp, Made x Made Icons, Oksana Latysheva, Rian Akbar, Adrian Coquet, Valeriy, and Fahmi Ramdani from Noun Project

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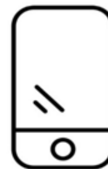
What did happen

Client in crisis

Child goes missing

Parents hesitant to call police



Parents exhaust options, call 9-1-1

Police dispatched with Indigenous community volunteer

Parents speak to Indigenous volunteer

Indigenous volunteer supports parents as they make their statement to police

Police supported by Indigenous volunteer as they interact with the family

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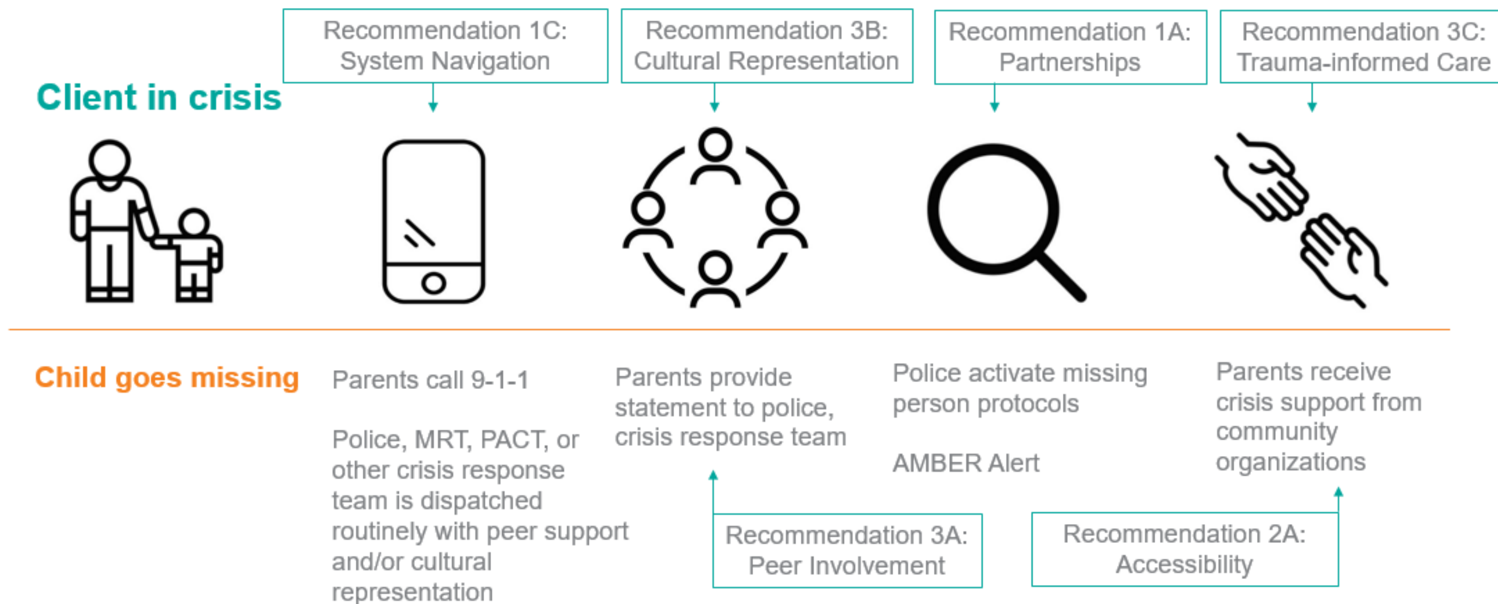
What could happen
Foundational recommendations: 1. Accountability 2. System Navigation 3. Value-Based System
Client in crisis
Recommendation 1C: System Navigation
Recommendation 3B: Cultural Representation
Recommendation 1A: Partnerships
Recommendation 3C: Trauma-informed Care
Child goes missing
Parents call 9-1-1
Police, MRT, PACT, or other crisis response team is dispatched routinely with peer support and/or cultural representation
Parents provide statement to police, crisis response team
Police activate missing person protocols
AMBER Alert
Parents receive crisis support from community organizations
Recommendation 3A: Peer Involvement
Recommendation 2A: Accessibility
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Meet the client, story #2

This story is a personal account of one Punjabi family's experience with police. It shows the importance of translation and interpretation services.

- Punjabi man who recently immigrated to Canada with his family
- Struggles with stress, anxiety, and depression
- Learning English

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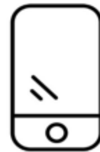
What we expect happens

Client in crisis

Stress, anxiety, and depression



Client calls 9-1-1

Police dispatched

Client taken to mental health community programming; receives adequate support

Client returns home or moves to longer-term supportive living

Images courtesy of Webtechops LLP, Made x Made Icons, Berkah Icon, Frey Wazza, Valeriy, Oksana Latysheva, Teewara Soontorn, and Atif Arshad from Noun Project

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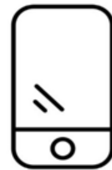
What did happen

Client in crisis

Stress, anxiety, and depression



Client calls 9-1-1 looking for help de-escalating his anxiety and for ongoing support

Police dispatched

Client describes his current state; he is misunderstood

Police perceive client to be dangerous rather than needing mental health support

Police place client in handcuffs, transport to holding cell

Client and family traumatized

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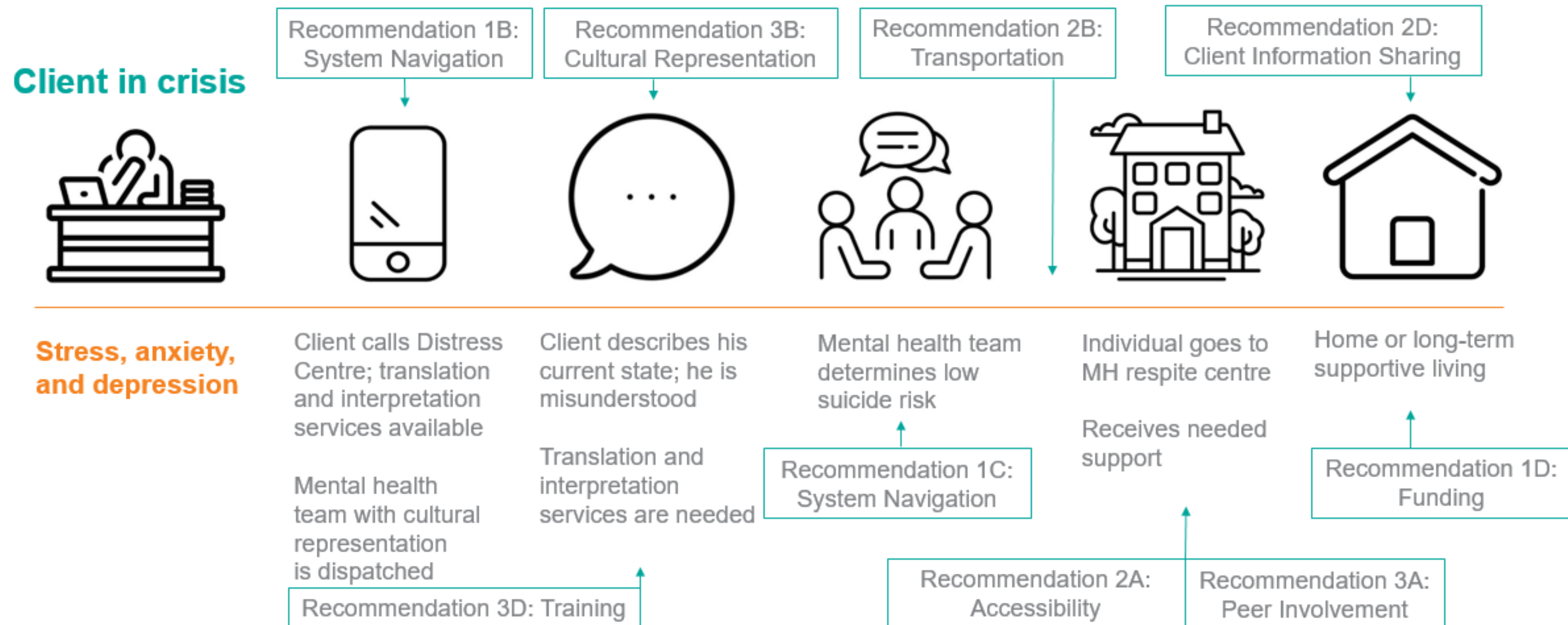
What could happen
Foundational recommendations: 1. Accountability 2. System Navigation 3. Value-Based System
Client in crisis
Recommendation 1B: System Navigation
Recommendation 3B: Cultural Representation
Recommendation 2B: Transportation
Recommendation 2D: Client Information Sharing
Stress, anxiety, and depression
Client calls Distress Centre; translation and interpretation services available
Mental health team with cultural representation is dispatched
Client describes his current state; he is misunderstood
Translation and interpretation services are needed
Mental health team determines low suicide risk
Individual goes to MH respite centre
Receives needed support
Home or long-term supportive living
Recommendation 3D: Training
Recommendation 1C: System Navigation
Recommendation 2A: Accessibility
Recommendation 3A: Peer Involvement
Recommendation 1D: Funding
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Meet the client, story #3

This story is a composite of many stories we heard. The stories have been overlayed to highlight their similar pattern.

- Person with Developmental Disabilities (PDD)
- Has an assigned caseworker
- Struggles with one of:
  - suicide ideation,
  - substance misuse, or
  - experiences intimate partner violence

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What we expect to happen

PDD Client in crisis

a) Pre suicide attempt b) Pre substance overdose c) Intimate partner violence	Caseworker calls 9-1-1 EMS dispatched	Receives medical care at hospital or transferred to community programming	Discharged to programming • CMHA Hamilton House (i.e. step-down unit) • Substance recovery centre • 2-stage women's shelter	Home or long-term supportive living

Images courtesy of Putu Kharismayadi, Bombasticon Studio, Fran Couto, Atif Arshad, Berkah Icon, Made X Made Icons, and Ben Davis from Noun Project

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What did happen

PDD Client in crisis

a) Pre suicide attempt
b) Pre overdose
c) Intimate partner violence

Caseworker calls 9-1-1

EMS dispatched

Receives medical care at hospital

Discharge to no specific supports or supports with long waitlists

Cycle repeats frequently

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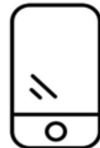
What could happen

Client in crisis



Client in crisis				
Pre suicide attempt	Calls Distress Centre	Sends mobile MH team	Goes to mental health respite care	Discharged to CMHA Hamilton House Re-establish case management
Pre substance overdose	Calls Distress Centre	Sends DOAP team	Detox	Discharged to community recovery program Re-establish case management
Intimate partner violence	Calls 911	Sends mobile MH team or PACT or police	Women's shelter or daytime respite centre (hours versus days)	Re-establish case management

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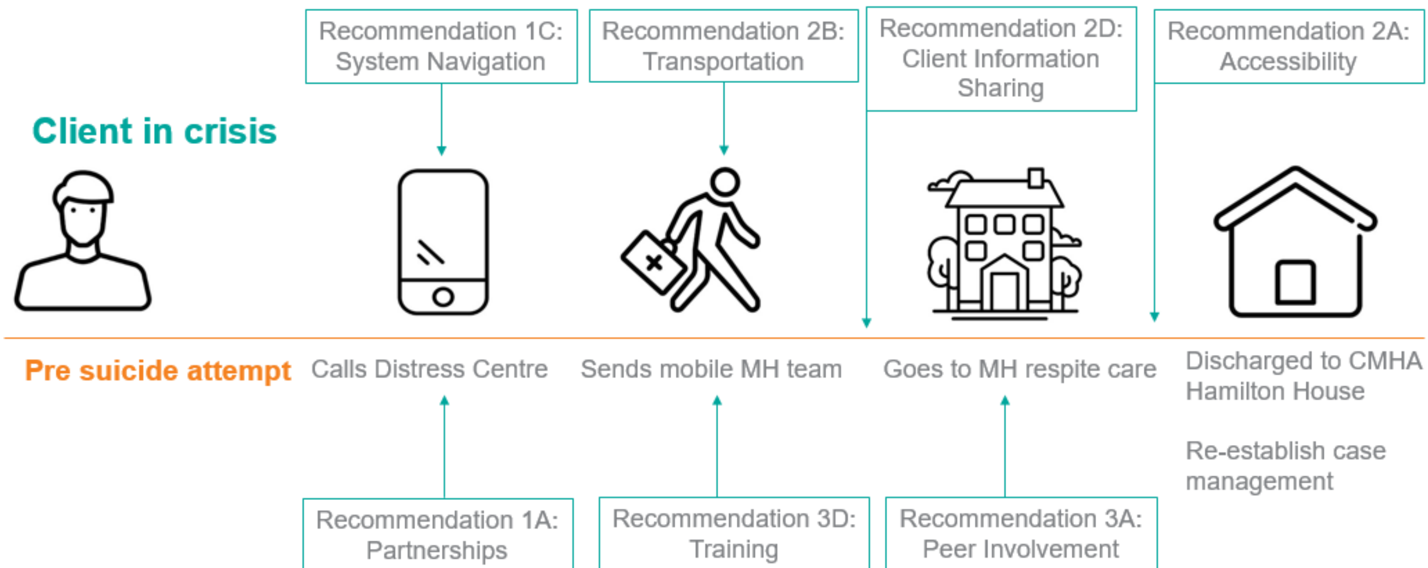
What could happen … Pre suicide attempt
Foundational recommendations: 1. Accountability 2. System Navigation 3. Value-Based System
Recommendation 1C: System Navigation
Recommendation 2B: Transportation
Recommendation 2D: Client Information Sharing
Recommendation 2A: Accessibility
Client in crisis
Pre suicide attempt
Calls Distress Centre
Sends mobile MH team
Goes to MH respite care
Discharged to CMHA Hamilton House
Re-establish case management
Recommendation 1A: Partnerships
Recommendation 3D: Training
Recommendation 3A: Peer Involvement
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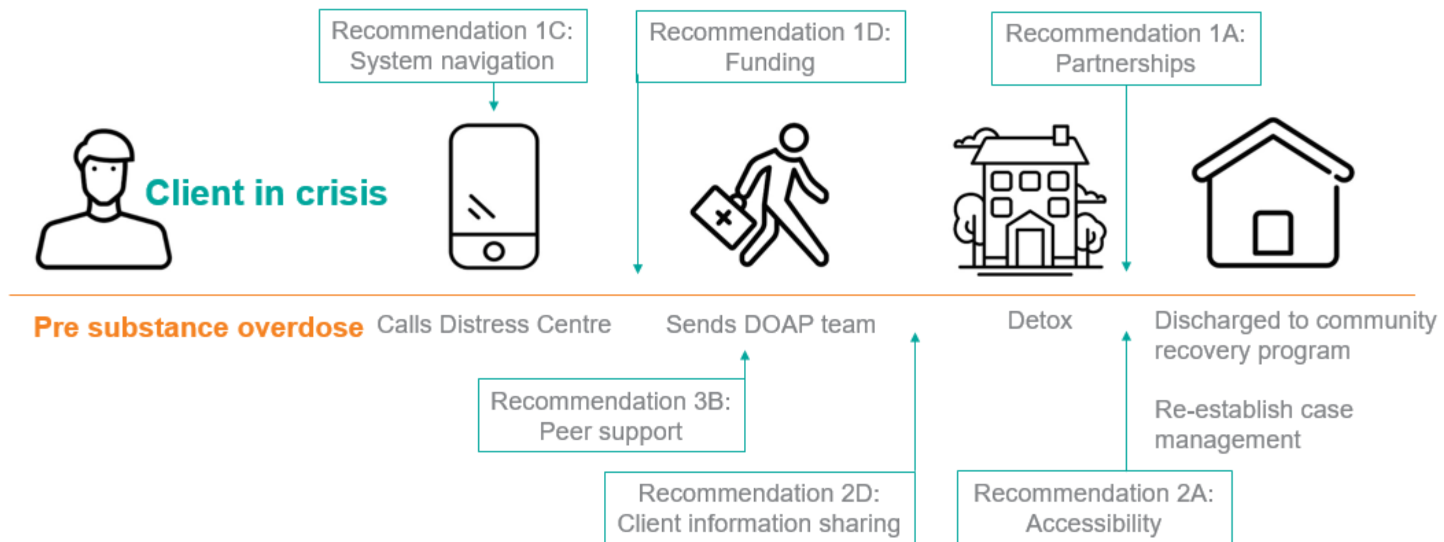
What could happen … Pre overdose

Foundational recommendations: 1. Accountability 2. System Navigation 3. Value-Based System



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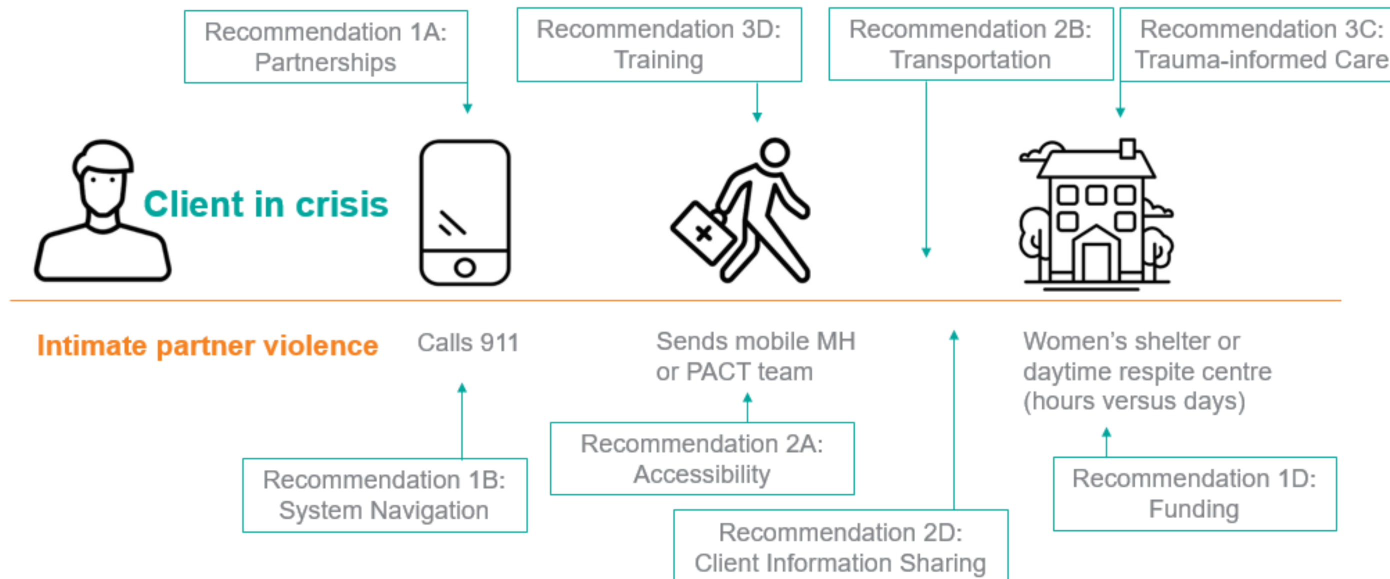
What could happen … Intimate partner violence
Foundational recommendations: 1. Accountability 2. System Navigation 3. Value-Based System
Recommendation 1A: Partnerships
Recommendation 3D: Training
Recommendation 2B: Transportation
Recommendation 3C: Trauma-informed Care
Client in crisis
Intimate partner violence
Calls 911
Sends mobile MH or PACT team
Women's shelter or daytime respite centre (hours versus days)
Recommendation 1B: System Navigation
Recommendation 2A: Accessibility
Recommendation 2D: Client Information Sharing
Recommendation 1D: Funding
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Appendix B: List of Contributing Organizations

A great number of individuals and organizations contributed their wisdom, experience, and perspectives to this project. Participating organizations are listed below. It is important to mention that several individuals from a single organization often participated in engagement sessions.

- 12 Community Safe Initiative
- Access Mental Health
- Action Dignity
- Alberta Health Services (Addiction & Mental Health, Calgary Zone)
- Alberta Health Services (EMS Operations, Calgary Zone)
- Alberta Health Services (Department of Emergency Medicine, Calgary Zone)
- Anti-Racism Action Committee (City of Calgary)
- Autism Calgary
- Aventa
- Bow Valley College
- Calgary 911
- Calgary Aboriginal Urban Affairs Committee
- Calgary Alpha House
- Calgary Downtown Association
- Calgary Fire Department
- Calgary Food Bank
- Calgary Homeless Foundation
- Calgary Immigrant Women's Association
- Calgary Legal Guidance
- Calgary Police Service
- Calgary Women's Emergency Shelter
- Centre for Newcomers
- Centre for Sexuality
- CMHA Calgary
- Community Living Alternatives Services

- Distress Centre
- Eastside Community Mental Health Services
- ECSSEN Career School
- Enviros
- Hull Services
- New Age Services
- Optional Rehabilitation Services Inc.
- Sagesse
- Senior Connect
- Sunrise Community Link Resource Centre
- Supported Lifestyles
- The Sinneave Foundation
- Trellis
- Universal Rehabilitation Service Agency
- Viewpoint Foundation
- Wood's Homes

Appendix C: Rapid Literature Review Search Strategy

The initial searches on the academic databases PsychInfo, MEDLINE, and Google Scholar were conducted using the following search strategies:

Mental health.mp AND cris*.mp AND response*.mp OR interven*.mp AND team*.mp OR program*.mp;

Mobile.mp OR communit*.mp AND mental health.mp OR psych*.mp AND cris*.mp AND team*.mp OR response*.mp OR program*.mp

Searches on Google were conducted using:

Mobile cris*is interven* plan

Mobile cris*s interven* model

Mobile cris*s respon* plan

Mobile cris*s respon* model

Non-police cris*s respons* team

Non-police cris*s interven* team

Non-police cris*s respons* model

Non-police cris*s interven* model

Appendix D: Jurisdictional Exemplars Interview Guide

Introduction and Consent

Thank you for agreeing to participate in this interview, we appreciate your time and feedback. PolicyWise for Children & Families is a provincial non-profit charitable organization in Alberta that exists to improve well-being by conducting evaluations and research for evidence-informed practice and policy.

Purpose: PolicyWise and the Centre for Suicide Prevention are working together to understand the current landscape of crisis response in Calgary and identify gaps and opportunities for improvement. In this project we are collecting and analyzing data from a range of service providers and conducting interviews to contextualize findings and gain deeper understanding of service provision, system organization, and lived experience.

Process and Confidentiality: We anticipate this interview will take approximately one hour. Your participation is voluntary, and you can end the conversation at any time or choose not to answer certain questions. With your permission, we would like to audio record the video call interview and transcribe the interview non-verbatim to support the data analysis process. All information collected during this interview will be kept confidential and used for project purposes only. The recording of the conversation will be kept on a secured server, stored for seven years from the end of the project, and no one outside of PolicyWise will have access to it. The anonymity of participants will be respected through presenting a summary of the findings in aggregate form so that no single person is identifiable.
Are you comfortable with the process outlined above? Do you have any questions before we get started?

Interview Questions

Context

*We've been conducting research on the various approaches to crisis response and categorizing them according to staffing and operations. For example, one category of crisis response approaches is **Standalone Community Crisis Response Centre,** which are staffed by mental health professionals such as social workers, counsellors, crisis response staff and operations include respite care for individuals in crisis. Another category is **Crisis Intervention Teams**, which is the more "traditional" response with staffing being police trained in crisis response and emergency services and operations being responding to crisis and helping individuals access the services they need. Other categories include: Mobile Crisis Teams, Co-responder, Integrated Crisis Care System, and Peer Navigation.*

1. What are the key programs/services that define your crisis response approach?
2. From our understanding your organization is a **Standalone Community Crisis Response Centre & Mobile Crisis Team** that provides 24/7 crisis response services for the community through mobile crisis response teams and short-term residential stays. The key partners you listed in the first interview were: police, emergency services, shelters, and 211. Can you confirm and provide further detail about your organizations approach to crisis response, including who you partner with.
3. How does your crisis model/approach fit into the traditional crisis responses (911, EMS, fire, police)?

   a. What does information sharing with 911 organizations look like?
   b. What level of contact does your organization have with 911?
   c. Can you speak to the referral process (both incoming and outgoing)
4. How does your crisis model/approach fit into the community-based crisis response?
   a. What does information sharing with community-based organizations look like?
   b. What level of contact does your organization have with other community-based organizations?
5. Can you share challenges and successes related to crisis response?
   a. Approaches
      i. Client journey, staffing, programs/services
   b. Partnership
      i. How were/are partnerships or collaborations with other organizations formed?

Appendix E: Lived Experience Survey

Calgary Crisis Response Survey

The City of Calgary has engaged Centre for Suicide Prevention and PolicyWise for Children & Families to examine Calgary's current crisis response system and envision how it can be transformed. We want to hear the voices of crisis response service users and frontline service providers to inform the future of crisis response services in Calgary.

Many organizations in Calgary provide crisis response programs and supports. We have asked these organizations to share this survey with participants who have accessed services through their organization as well as those who deliver the services.

This survey will take approximately 15 to 20 minutes to complete. At the end of the survey, there is an option to enter a draw for a $25 gift card.

Survey results will be viewed and analyzed solely by evaluators from PolicyWise for Children & Families and the Centre for Suicide Prevention who have been contracted to do the research necessary to develop recommendations. Any information you share is anonymous and no single person or organization will be identifiable. By participating in this survey, you will help inform the recommendations made to the City of Calgary about the future of crisis response programs.

If you have any problems accessing or completing this survey, please contact PolicyWise via email at data@policywise.com.

Reading about situations that involve a crisis can be distressing. If you need to talk to someone, contact the Distress Centre Calgary at 403-266-4357 or the National Crisis Line at 1-833-456-4566.

Demographics The following information is being collected to help us understand who is using services and programs, and the needs of service users. This information will help us make recommendations to provide better services to meet the diverse needs of Calgarians.

1. Please choose what best describes your interaction with crisis response in Calgary (select all that apply):	☐ I work as a service provider in crisis response ☐ I have personal knowledge or experience with crisis/crisis response
2. What ethnicity, or ethnicities, best describes you (select all that apply)?	☐ Black ☐ East Asian ☐ Indigenous ☐ Latin American ☐ Multiple ethnicities ☐ Southeast Asian ☐ South Asian ☐ West Asian ☐ White ☐ Another ethnicity or ethnicities not listed, please specify: ☐ Prefer not to answer
Please specify	________________________________
3. What is your gender?	○ Woman/girl ○ Man/boy ○ Gender diverse (e.g., non-binary, two-spirit) ○ Another gender not listed, please specify: ○ Prefer not to answer
Please specify	________________________________

4. What is your age?	◯ 0 - 17 ◯ 18 - 24 ◯ 25 - 34 ◯ 35 - 44 ◯ 45 - 54 ◯ 55 - 64 ◯ 65+ ◯ Prefer not to answer
Accessing Crisis Services The following questions are about how you currently access crisis services for either yourself or others.	
5. If you, a family member, or friend needed help with a crisis, who would you contact? Please choose all that apply.	☐ 911 ☐ Police non-emergency line ☐ 211 Alberta (information and service navigation ☐ 311 Calgary (city government information and non-emergency services) ☐ 811 (HealthLink) ☐ Mental health or distress line (e.g. Distress Centre) ☐ Community agency or organization where I receive service ☐ Local community health centre ☐ Family doctor or general practitioner ☐ My case worker ☐ Search online for resources ☐ I don't know ☐ I wouldn't reach out
6. If you saw someone you didn't know in crisis, who would you contact for help? Please choose all that apply.	☐ 911 ☐ Police non-emergency line ☐ 211 Alberta (information and service navigation ☐ 311 Calgary (city government information and non-emergency services) ☐ 811 (HealthLink) ☐ Mental health or distress line (e.g. Distress Centre) ☐ Community agency or organization that provides mental health services ☐ Local community health centre ☐ Search online for resources ☐ I don't know ☐ I wouldn't reach out
Feeling Safe The following questions ask about your feelings of safety when police are present in different situations.	
7. a) How safe does police presence make you feel in general?	◯ very unsafe ◯ somewhat unsafe ◯ unsure ◯ somewhat safe ◯ very safe
7. b) How safe does police presence make you feel if you were experiencing a crisis?	◯ very unsafe ◯ somewhat unsafe ◯ unsure ◯ somewhat safe ◯ very safe

7. c) How safe does police presence make you feel if friends or family were experiencing a crisis?	◯ very unsafe ◯ somewhat unsafe ◯ unsure ◯ somewhat safe ◯ very safe
7. d) How safe does a police presence make you feel if someone you don't know was experiencing a crisis?	◯ very unsafe ◯ somewhat unsafe ◯ unsure ◯ somewhat safe ◯ very safe
Crisis Situations The next few questions include situations that require crisis help. Please indicate what you would do in these situations.	
8. a) If you found yourself in the following situation and wanted to get help which of the following would you be most likely to do? Situation: You are experiencing harmful effects of substance use.	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Other (please specify):
Please specify	____
8. b) If you found yourself in the following situation and wanted to get help which of the following would you be most likely to do? Situation: You are in a mental health crisis and may harm yourself	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Other (please specify):
Please specify	____
8. c) If you found yourself in the following situation and wanted to get help which of the following would you be most likely to do? Situation: You are having mental health issues	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Other (please specify):
Please specify	____

8. d) If you found yourself in the following situation and wanted to get help which of the following would you be most likely to do? Situation: You are involved in a domestic dispute	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Other (please specify):
Please specify	________________________________
8. e) If you found yourself in the following situation and wanted to get help which of the following would you be most likely to do? Situation: You are walking in the cold and have nowhere to go	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Other (please specify):
Please specify	________________________________
9. a) If you were a bystander in the following situation and wanted to get help, which of the following would you be most likely to do? Bystander Situation: You see a person experiencing harmful effects of substance use.	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Do nothing and leave the person be ◯ Other (please specify):
Please specify	________________________________
9. b) If you were a bystander in the following situation and wanted to get help, which of the following would you be most likely to do? Bystander Situation: You see a person in a mental health crisis who may harm themselves.	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Do nothing and leave the person be ◯ Other (please specify):
Please specify	________________________________

9. c) If you were a bystander in the following situation and wanted to get help, which of the following would you be most likely to do? Bystander Situation: You see a person who appears to be having mental health issues	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Do nothing and leave the person be ◯ Other (please specify):
Please specify	______________________
9. d) If you were a bystander in the following situation and wanted to get help, which of the following would you be most likely to do? Bystander Situation: You witness a domestic dispute	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Do nothing and leave the person be ◯ Other (please specify):
Please specify	______________________
9. e) If you were a bystander in the following situation and wanted to get help, which of the following would you be most likely to do? Bystander Situation: You see a person walking in the cold without warm clothing and footwear	◯ Call 911 and ask for the police ◯ Call 911 and ask for an ambulance ◯ Call 911 and ask for the fire department ◯ Call 911 and ask for some other kind of help ◯ Call a number for crisis help that doesn't involve the police ◯ Don't know/unsure ◯ Do nothing and leave the person be ◯ Other (please specify):
Please specify	______________________
Priorities for Crisis Response The following questions ask you to consider what an ideal crisis response looks like and who should be involved.	
10. a) Which of the following do you feel would be the best type of person to be a first responder for the following situation? Please choose all that apply. Situation: A person experiencing harmful effects of substance use.	☐ Police ☐ Indigenous Elder, or self-identified Indigenous crisis support worker ☐ A crisis support worker who speaks the language of the person in crisis ☐ Someone who has personal experience with substan use challenges ☐ Licensed mental health professional ☐ A paramedic ☐ Trained volunteer from my community ☐ Other (please specify):
Please specify	______________________

10. b) Which of the following do you feel would be the best type of person to be a first responder for the following situation? Please choose all that apply. Situation: A person in a mental health crisis who may harm themselves	☐ Police ☐ Indigenous Elder, or self-identified Indigenous crisis support worker ☐ A crisis support worker who speaks the language of the person in crisis ☐ Someone who has personal experience with mental health challenges ☐ Licensed mental health professional ☐ A paramedic ☐ Trained volunteer from my community ☐ Other (please specify):
Please specify	______________________________
10. c) Which of the following do you feel would be the best type of person to be a first responder for the following situation? Please choose all that apply. Situation: A person who appears to be suffering from mental health issues	☐ Police ☐ Indigenous Elder, or self-identified Indigenous crisis support worker ☐ A crisis support worker who speaks the language of the person in crisis ☐ Someone who has personal experience with mental health challenges ☐ Licensed mental health professional ☐ A paramedic ☐ Trained volunteer from my community ☐ Other (please specify):
Please specify	______________________________
10. d) Which of the following do you feel would be the best type of person to be a first responder for the following situation? Please choose all that apply. Situation: A domestic dispute	☐ Police ☐ Indigenous Elder, or self-identified Indigenous crisis support worker ☐ A crisis support worker who speaks the language of the person in crisis ☐ Someone who has personal experience with domestic disputes ☐ Licensed mental health professional ☐ A paramedic ☐ Trained volunteer from my community ☐ Other (please specify):
Please specify	______________________________
10. e) Which of the following do you feel would be the best type of person to be a first responder for the following situation? Please choose all that apply. Situation: A person walking in the cold without warm clothing and footwear	☐ Police ☐ Indigenous Elder, or self-identified Indigenous crisis support worker ☐ A crisis support worker who speaks the language of the person in crisis ☐ Someone who has personal experience with walking in the cold without warm clothing and footwear ☐ Licensed mental health professional ☐ A paramedic ☐ Trained volunteer from my community ☐ Other (please specify):

11. How important is it that crisis response provides:	not important	less important	unsure	important	very important
a) Immediate supports like food, blankets, medicine etc.	○	○	○	○	○
b) A range of harm reduction supports, including supplies and counselling	○	○	○	○	○
c) Primary health care, such as basic emergency health services, prevention and treatment of common diseases and injuries	○	○	○	○	○
d) Referrals to hospital and specialist care	○	○	○	○	○
e) Referrals to other services such as housing, counselling, employment etc.	○	○	○	○	○
f) Transportation to primary health care services (e.g. family doctor, therapist)	○	○	○	○	○
g) Transportation to home or a safe place	○	○	○	○	○
h) Safe and supportive space for immediate recovery (up to 24 hours)	○	○	○	○	○
i) Safe and supportive space for short-term recovery (3 to 5 days)	○	○	○	○	○
j) Safe and supportive space for longer-term recovery (15 to 30 days)	○	○	○	○	○
k) Residential or in-home care and wellness checks	○	○	○	○	○

What else might be important to crisis response that was not already listed?

____

12. In a perfect world, if there was a new way to get help during crisis, how important is it that the new crisis response service include the following:	not important	less important	unsure	important	very important
a) A specific phone number where a person can contact the service directly	○	○	○	○	○
b) 911 connects to the new service	○	○	○	○	○
c) Other contact lines (e.g. 211, Distress Centre, 311, helplines) connect to the new services.	○	○	○	○	○
d) The ability to communicate with someone in the language of my choice	○	○	○	○	○
e) The service is available 24 hours a day, 7 days a week	○	○	○	○	○
k) The service is available through phone, text, and chat	○	○	○	○	○
f) The service is mobile and can meet me where I am	○	○	○	○	○
g) The service has outreach teams walking around the community	○	○	○	○	○
h) The service has a drop-in location in my community where I can talk to someone in person	○	○	○	○	○
i) The service is available at a location where I already get other services	○	○	○	○	○
j) The service is available through my local community health centre	○	○	○	○	○

What else might be important if there was a new way to get help during a crisis that was not already listed?

____

13. What are challenges to accessing crisis services and programs? Select anything that may prevent, delay or discourage you or someone you know from getting help.	☐ Have to provide too much information or I don't want to share personal information ☐ Cost of program/service ☐ My cultural or ethnic background was not reflected in the staff, programs, and services ☐ Didn't know how to reach the service ☐ Didn't know the service was available ☐ Unable to contact the service ☐ Experienced stigma and/or discrimination by the service provider ☐ Service required abstinence from drug use ☐ Hours of operation ☐ Location or transportation was an issue ☐ Other (please describe):
Please describe:	____________________________________
Thank you for your responses! If you are feeling distressed or need crisis assistance, please contact the Distress Centre or the community agency that sent you this survey. If you need to talk to someone, please contact the Distress Centre Calgary at 403-266-4357 or National Crisis Line at 1-833-456-4566. Thank you for completing this survey. If you're interested in entering a draw for a $25 gift card, please enter your email below:	
Email address (for gift card draw):	____________________________

Appendix F: Lived Experience Survey – Technical Report

Acknowledgments

PRIMARY CONTRIBUTORS

Saira John, Kiran Gurm, Shannon McInnes, and Naomi Parker: PolicyWise for Children & Families

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SHARING GUIDELINES

It is the hope of all those who contributed to this project that these findings are shared and used to benefit others and inform policy and practice to improve child, family, and community well-being. PolicyWise and the Centre for Suicide Prevention ask that the intent and quality of the work is retained and that PolicyWise for Children & Families and the Centre for Suicide Prevention be acknowledged.

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Project Overview

On behalf of the Calgary Police Services and City of Calgary, the Centre for Suicide Prevention (CSP) and PolicyWise for Children & Families engaged in a project to understand the landscape of crisis response in Calgary and identify gaps and opportunities for improvement. Survey data was a key element of the project as it helps to tell the story of Calgary's crisis response. Survey data was used to identify critical needs, gaps, and contextualization of individual experiences related to service provision and lived experience[6].

Purpose of the Lived Experience Survey

To better understand crisis response from the perspective of service providers[7] and individuals with lived experience, PolicyWise and Centre for Suicide Prevention were contracted by the City of Calgary to conduct a survey to assess the crisis services needs of service providers and individuals with lived experience. In particular, the survey assessed participant needs in four domains:

1. Experiences with crisis services (i.e., who do you call?)
2. Perceptions of safety of crisis responders (i.e., do police make you feel safe?)
3. Situational assessments of crisis response (i.e., when is it best to call police/fire/ambulance; when is best not to call police/fire/ambulance?)
4. Priorities of crisis response (i.e., what crisis services & programs are desired; what challenges exist?)

Methods

The online survey was delivered through RedCap, hosted by the University of Alberta. An overview of the methods used by PolicyWise and Centre for Suicide Prevention is provided below.

Data Collection and Analysis

An online survey was developed for service providers and individuals with lived experience to provide feedback on their experience of Calgary's crisis response system, including gaps and opportunities for improvement. The survey was adapted from the City of Toronto's (2021) survey that was used for a similar purpose. Scenarios were modified to reflect the Calgary crisis response system. The questions were developed by PolicyWise and Centre for Suicide Prevention and reviewed by service providers and staff not involved in the development of the survey for comprehension of the questions and appropriate length. The survey consisted of:

- Demographic questions (gender, ethnicity/race, age)
- Multiple selection questions about experiences with the current crisis services, responding to crisis situations
- Likert-scale questions about feelings of safety, most likely response to crisis situations, and importance of crisis services

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[6] Lived experience refers to an individual's experience of a behavioural crisis

[7] Service providers within crisis response services

The survey invitation was sent publicly and by invitation and was open to all residents of Calgary. The survey was open for three weeks, with a total of 660 responses.

Approaches used to recruit survey participants included: an email invitation and reminders distributed to all service providers already engaged in the project. To go beyond the existing contacts made in the project, the survey was sent out via tweets by the City of Calgary, Centre for Suicide Prevention and PolicyWise. Service providers were requested to send the survey link to participants of crisis response programs.

Before being analyzed, data were cleaned for duplicate responses (n=1), which could only be determined by examining repeat responses on all questions, as personal identifiers such as name and date of birth were not collected for the survey. Missing data was compiled per question, with the majority of questions containing less than 10% of answers missing overall. Means were calculated for questions that contained Likert-scales (n=5). Frequencies were obtained for all questions, and then obtained for specific categories within demographic questions (see Appendix A).

Key Messages

Below is a summary of the key messages related to participants' experiences with the crisis system in Calgary. A detailed description of the survey results and quotes from open ended questions are provided in the Findings section.

1	**Who do you call?**	Participants will mostly call 911 during a crisis. A larger proportion of Black, youth, and lived experience participants would call 911 compared to gender diverse, Indigenous, and multiple ethnicities participants.
2	**Do police make you feel safe?**	In terms of perceptions of overall safety with police, most participants *feel safe* in the presence of police. Gender diverse, multiple ethnicities, and Indigenous participants, *feel less safe* in the presence of police.
3	**When is it best to call police/fire/ambulance?** **When is it best not to call police/fire/ambulance?**	In certain situations such as substance abuse and domestic violence, participants preferred police/fire/ambulance to respond if they were in crisis or if a bystander was in crisis. In other situations, such as mental health crises and walking in the cold, participants preferred alternatives to police response.
4	**What crisis services & programs are desired?** **What challenges exist?**	Many of the existing crisis response programs, responders, and approaches are needed, but there is variation in *how much* and *when* these services are needed across different groups.

Challenges within the crisis response system were mainly on privacy, system navigation, and recognizing the importance of culture/ethnicity.

Survey Results by Demographics and Crisis Response Related Questions

This section presents demographics of participants followed by an overview of findings under each of the survey areas of interest:

1. Experiences with accessing crisis services
2. Perceptions of safety of crisis responders
3. Situational assessments of crisis response
4. Priorities of crisis response

Demographics

Four demographic questions were asked as part of the survey to better understand how specific groups may differ in responses to questions about crisis response. Where possible, Calgary census data was used to compare to the survey sample. All numbers reported on the City of Calgary are from the 2016 Census.

Crisis Experience

- Just over half of the participants had lived experience (54%), 38% were crisis response service providers, and some participants had both lived experience and were service providers (8%; see Figure 1).

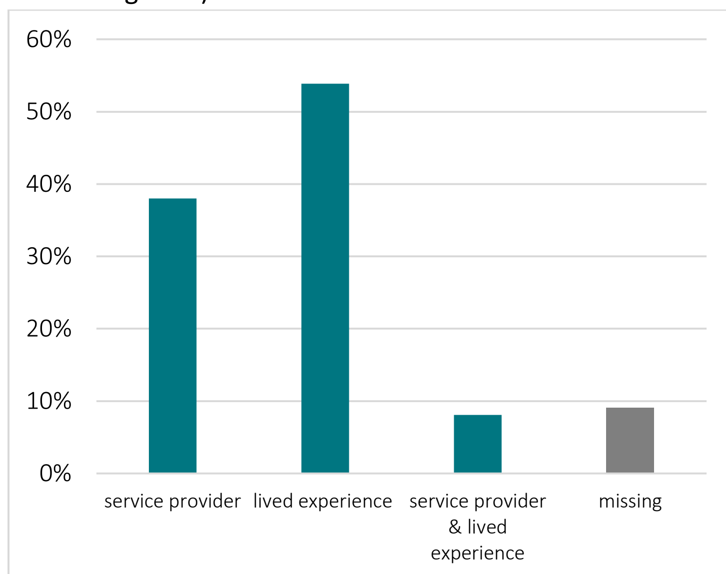

Figure 6. Proportion of Participants with Lived Experience, Service Provider Experience, or Both

Ethnicity/Race

- The majority of participants were white (64%) and less than a quarter of participants were Black (15%) and about 10% of participants were Indigenous (8%) and Latin American (7%; see Figure 2).
- According to the 2016 Census, in Calgary, the proportion of residents that identify as Aboriginal is 3% and the proportion who identify as visible minority is 36%.

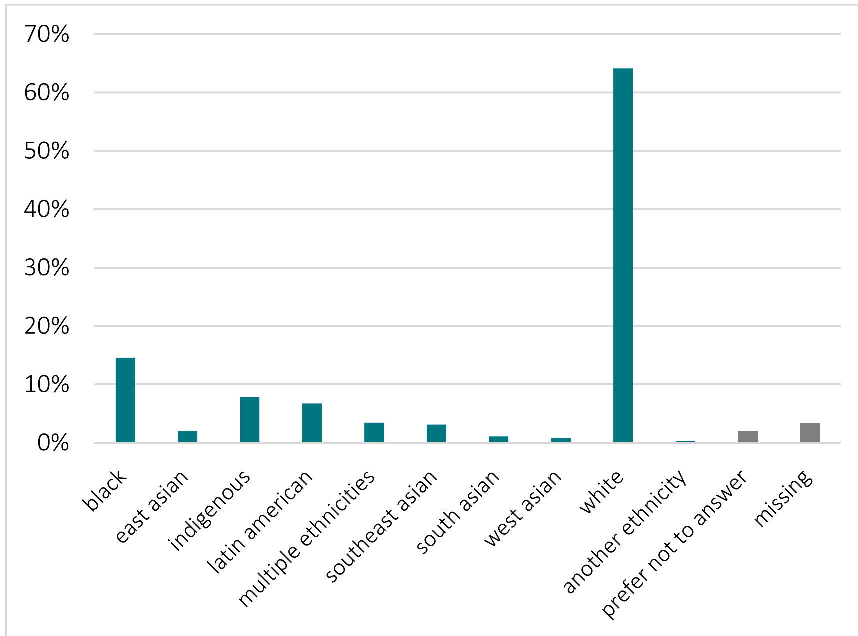

Figure 7. Ethnicity of Participants

- To aid in analysis, ethnicity was then collapsed into six categories[8]. Most participants identified as white (60%), followed by Black (13%), racialized[9] (11%), Indigenous (7%), and multiple ethnicities[10] (3%; see Figure 3)

[8] Categories were split based on relevance to crisis response. Black and Indigenous communities have had a history of experiencing racism by first responders and police during behavioural crisis, which is why they are categorized on their own (Stelkia, 2020).
[9] Racialized indicates participants who indicated the following ethnicities: East Asian, Latin American, Southeast Asian, South Asian, or West Asian.
[10] The category of multiple ethnicities was determined by participants who indicated "multiple ethnicities" as well as participants who chose two or more different ethnicities (e.g., Black and South Asian).

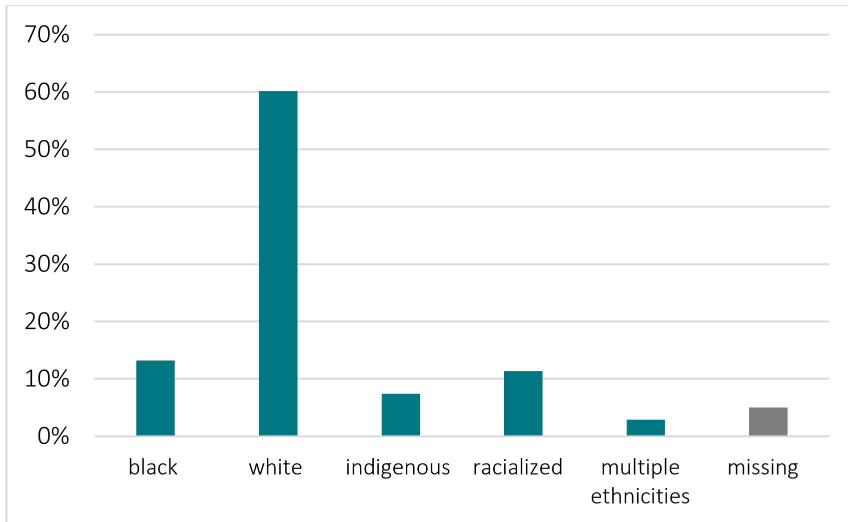

Figure 8. Ethnicity of Participant by Six Categories

Age

- The majority of participants were adults between the ages of 25-34 (50%) and 35-44 (26%; see Figure 4)
- According to the 2016 Census, in Calgary, the proportion of residents between the ages of 15-34 is 30% and the proportion of residents ages 35-64 is 42%.

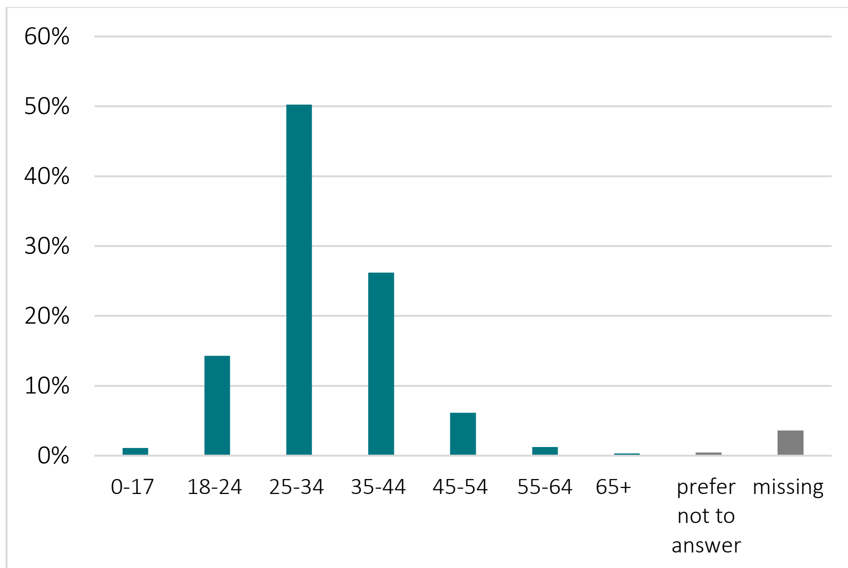

Figure 9. Age of Participants

Gender

- About half of participants identified as men (52%) and almost half identified as women (44%). A small amount of participants identified as gender diverse (2%) or another gender not specified (1%; see Figure 5).

- According to the 2016 Census, in Calgary, the population by sex was reported as 50% male and 50% female[11].

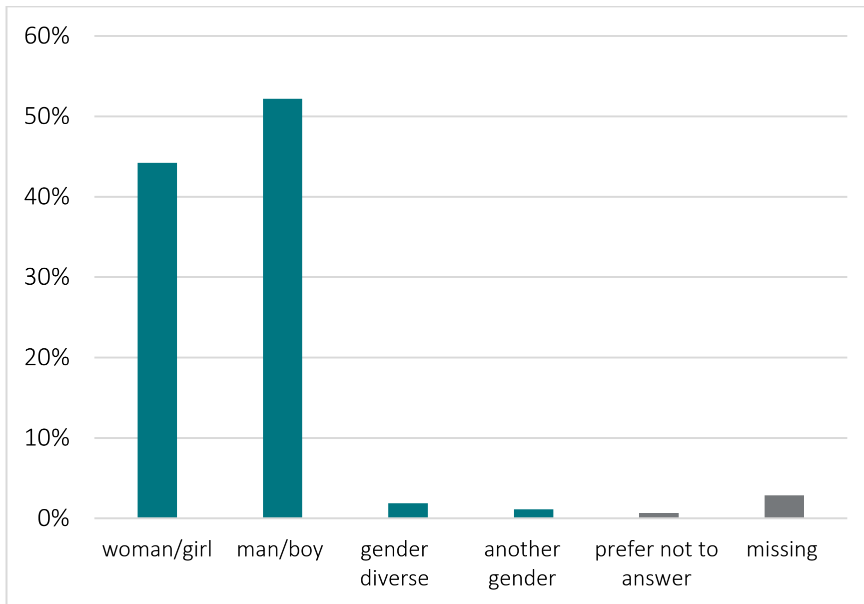

Figure 10. Gender of Participants

Crisis Response Related Questions

Accessing Crisis Services (i.e., who do you call?)

This section asked participants to identify who they would contact for help in a crisis that involved themselves or someone they did not know. See Appendix A for a breakdown of responses by group.

HIGHLIGHTS

- Overall, when thinking about themselves and when thinking about someone they didn't know, most participants would contact 911 for help during a crisis (77% and 73% respectively).
- Compared to overall frequencies, Black participants were more likely to call 911 for help during a crisis (77% vs 92%), but less likely to call the police non-emergency line (27% vs 15%; see Figure 11).

[11] The 2016 Census asked about sex (male or female).

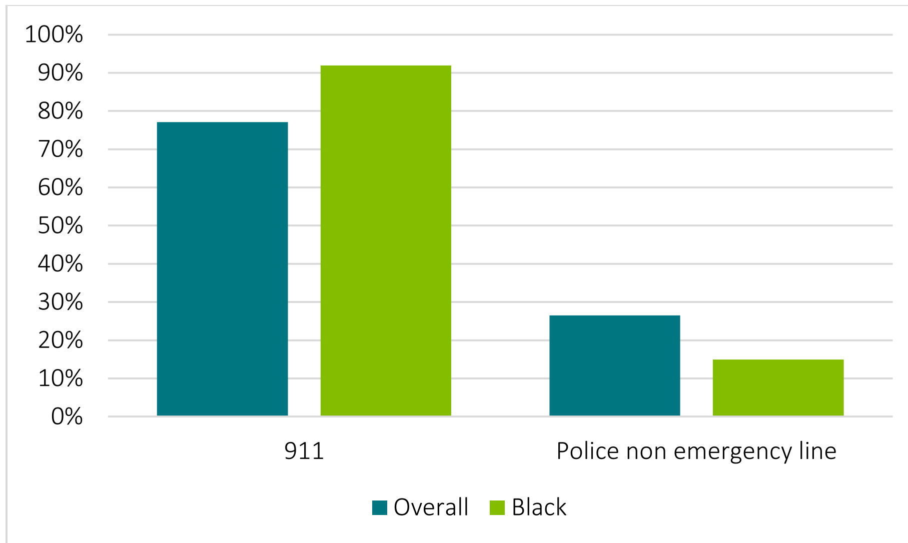

Figure 11. Proportion of Responses to Who to Call during a Crisis Overall, and by Black Participants

- Compared to overall frequencies (27%), youth (31%), gender diverse (42%), and Indigenous (35%) respondents were more likely to contact the police non-emergency line during a crisis about themselves (see Table 1)
- Compared to overall frequencies, Indigenous and gender diverse participants were more likely to call helplines like 211, 311, and 811 (see Table 1).
- Compared to overall frequencies, gender diverse participants were more likely to call the Distress Line (22% vs 25%) and search online for resources (7% vs 25%; see Table 1).

Table 1

Proportion of Who to Contact in a Crisis Overall and by Indigenous, Gender Diverse, and Youth Participants

Response Options	Overall	Indigenous	Gender Diverse	Youth (0-24)
Police non-emergency line	27%	**35%**	**42%**	**31%**
211	13%	**14%**	**42%**	4%
311	15%	**18%**	**33%**	5%
811	13%	**18%**	**17%**	4%
Distress line	22%	20%	**25%**	12%
Search online for resources	7%	6%	**25%**	5%
Total	660	49	12	98

Feeling Safe (i.e., does police presence make you feel safe?)

This section asked participants to rate on a five-point scale their feelings of safety when police are present in different situations. The four situations asked, “how safe does police presence make you feel”: 1) in general, 2) if you were experiencing a crisis, 3) If friends or family were experiencing a crisis, and 4) if someone you don’t know was experiencing a crisis. See Appendix A for a breakdown of responses by situation and by group.

HIGHLIGHTS

- Overall, most participants felt very safe or somewhat safe in the presence of police across all four situations (between 82% to 85%). Participants felt most safe with police when a friend or family was experiencing a crisis.
- Compared to overall responses, Black participants felt very safe or somewhat safe to a greater extent across all four situations (87% to 91%).
- On average, participants who identified as Indigenous, multiple ethnicity, having lived experience, or gender diverse rated their feelings of safety lower than the overall responses across all four scenarios.
    - For example, participants who identified as multiple ethnicities or gender diverse were less likely to view police presence as safe in general and if experiencing a crisis (see Figure 12).
    - Compared to overall responses, participants who identified as Indigenous or multiple ethnicities were less likely to view police presence as safe if a friend or family was in crisis and if a bystander was in crisis (see Figure 13).

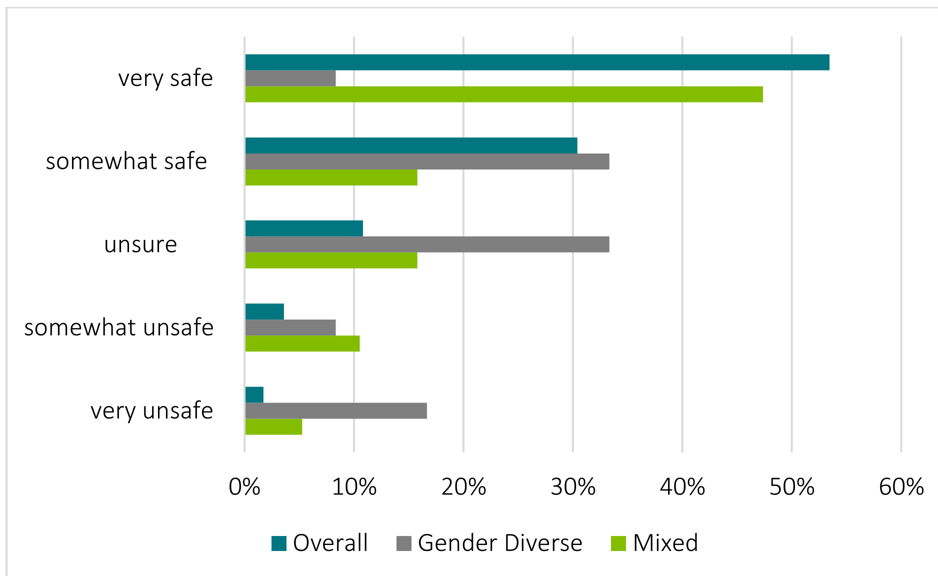

Figure 12. Perception of Safety of Police during a Crisis by Overall, Indigenous, and Multiple Ethnicities Participants

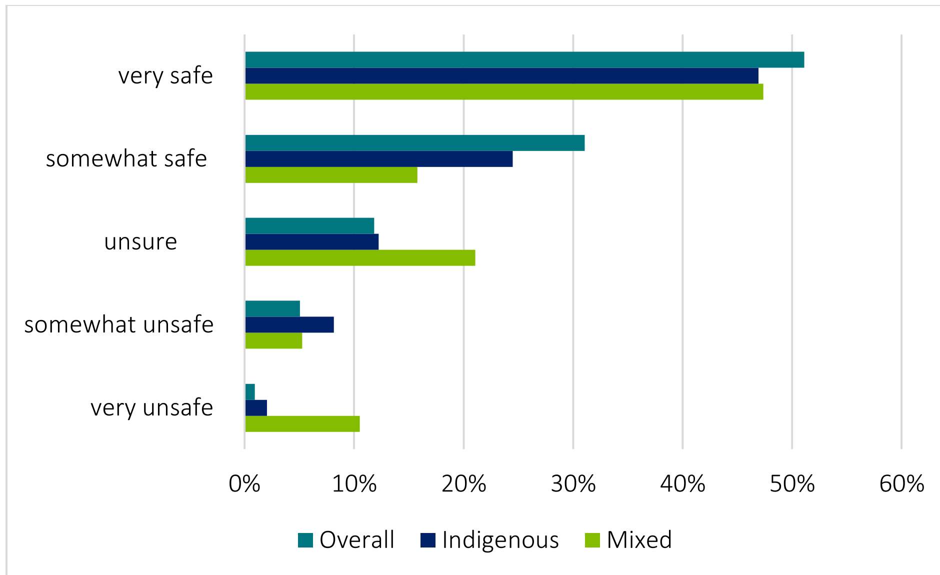

Figure 13. Perception of Safety of Police as Bystander by Overall, Indigenous, and Multiple Ethnicities Participants

Crisis Situations (i.e., when is it best to call police/fire/ambulance; when is best not to call police/fire/ambulance?)

This section asked participants to select their most likely response out of seven possible options when dealing with five behavioural crisis situations. The five situations were involved:

- You are experiencing harmful effects of substance use
- You are in a mental health crisis and may harm yourself
- You are having mental health issues
- You are involved in a domestic dispute
- You are walking in the cold and have nowhere to go

Participants were then asked to select their most probably response of the seven possible options when it was someone they didn't know in each of the five behavioural crisis situations. For full response results, see Appendix A.

HIGHLIGHTS

- Overall, participant responses differed somewhat depending on the situation, but did not differ as much when thinking about oneself compared to someone they didn't know.
- Overall, when considering situations involving oneself, participants showed slightly more preference for response options such as police, ambulance and fire when dealing with situations that involved substance use (76%), when in mental health crisis and may harm oneself (66%), and when involved in a domestic dispute (65%; see Figure 14).
- Overall, when considering situations involving oneself, participants were more likely to prefer alternate crisis response options[12] (i.e., a response that did not require police, ambulance and

[12] Choices consisted of "Call 911 and ask for other help" and "Call number for crisis that doesn't involve police"

fire) when in situations that involved mental health issues (50%) and walking in the cold with nowhere to go (49%; see Figure 14).

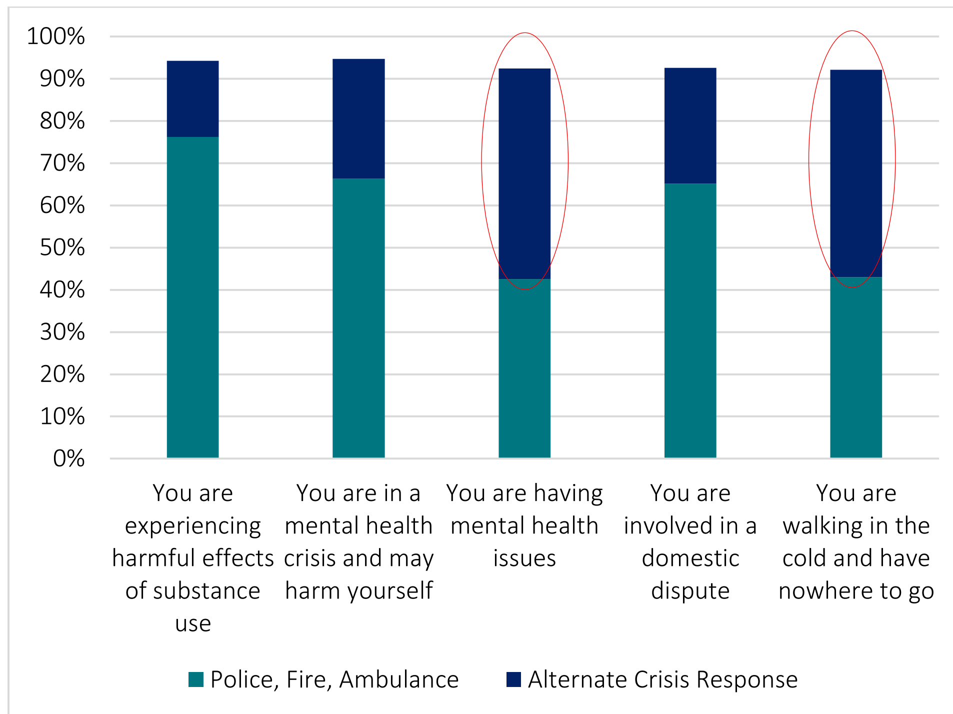

Figure 14 Preferences in Situational Responses to Crisis

- Gender diverse participants consistently preferred alternate crisis response options for themselves when experiencing a mental health crisis (50%) and walking in the cold with nowhere to go (58%; see Figure 15).

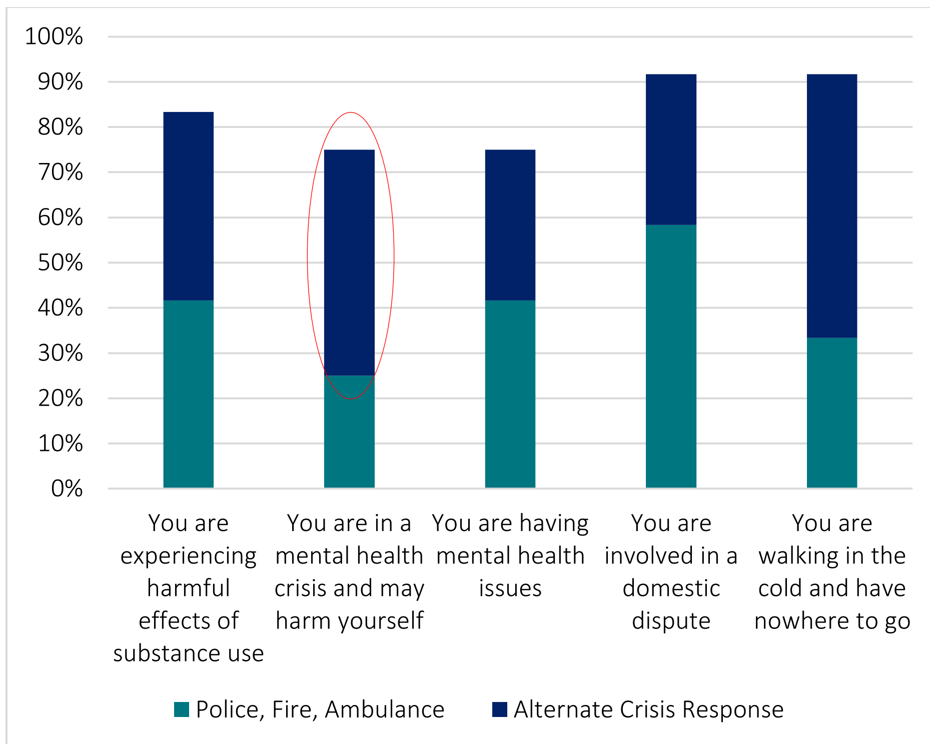

Figure 15 Preferences in Situational Responses to Crisis by Gender Diverse Participants

- Indigenous participants were more evenly split between police, fire, and ambulance (45%-47%) and alternate crisis response (43%-49%), when asked about a domestic dispute, mental health crisis, and walking in the cold with nowhere to go that crisis that involved themselves (see Figure 16).

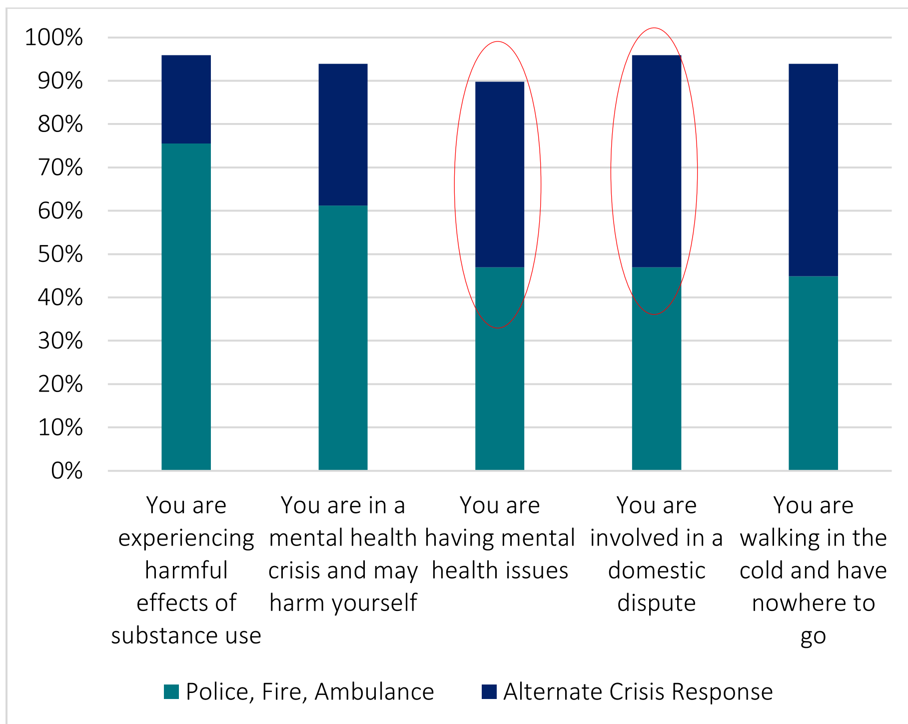

Figure 16 Preferences in Situational Responses to Crisis by Indigenous participants

- During crisis events that involved being a bystander, compared to overall responses, Black and youth participants showed more preference for police across all five situations (see Table 2).
- During crisis events that involved a bystander, compared to overall responses, individuals with lived experience showed more preference for police across three situations: substance use, mental health crisis in which someone may harm themselves, and domestic dispute (see Table 2).

Table 2
Frequency of Call 911 and ask for Police Responses in Bystander Crisis Situations Overall and by Black, Lived Experience, and Youth Participants

Response Options	Overall	Black	Lived Experience	Youth
Someone is experiencing harmful effects of substance use	38%	**40%**	**41%**	**46%**
Someone is in a mental health crisis and may harm themselves	41%	**49%**	**42%**	**47%**
Someone is having mental health issues	26%	**36%**	26%	**34%**
Someone is involved in a domestic dispute	52%	**69%**	**54%**	**56%**
Someone is walking in the cold and have nowhere to go	27%	**33%**	27%	**40%**

Priorities for Crisis Response (i.e., what crisis services & programs are desired; what challenges exist?)

In this section, participants were asked who the best person is to respond to crises situations that were the same as the previous section. They were also asked to indicate on a five-point scale how important specific elements of crisis services are during a crisis and which elements are important to an ideal crisis response system. Participants were also asked to indicate challenges to accessing crisis services and programs from a list provided. For full response frequencies see Appendix A.

HIGHLIGHTS

Who, specifically, is best to respond to crisis?

- Overall, many participants preferred **police** to respond across most situations, but especially during domestic dispute (63%) and substance use (56%) related crises (see Table 3).
- Overall, **mental health professionals** were preferred in situations that involved mental health crises (41 and 45%).
- Overall, individuals with **lived experience** and **trained volunteers** were also preferred in situations that involved walking in the cold with nowhere to go and mental health issues (see Table 3).

Table 3
Best responder for crisis situations.

	Police	Indigenous Elder	Crisis support worker	Lived experience	Mental health professional	Paramedic	Trained volunteer	Other
You are experiencing harmful effects of substance use	56%	14%	23%	28%	18%	18%	10%	1%
You are in a mental health crisis and may harm yourself	46%	13%	20%	32%	41%	16%	10%	1%
You are having mental health issues	41%	11%	22%	31%	45%	17%	13%	1%
You are involved in a domestic dispute	63%	17%	25%	18%	15%	8%	9%	1%
You are walking in the cold and have nowhere to go	41%	13%	19%	35%	17%	15%	25%	1%

- Compared to overall responses, Indigenous participants showed a preference for **Indigenous elders** (14% to 22%) **crisis support workers** (24% to 33%) and **lived experience** (33% to 49%) in their responses across the five situations (see Figure 17).

Figure 17 Best Responder for Crisis by Indigenous Participants

- Compared to overall responses, gender diverse participants showed a preference for **Indigenous elders** (17% to 42%) **crisis support workers** (42% to 67%) in their responses across the five situations. None of the gender diverse participants indicated preference for police in substance use and mental health crisis situations (see Figure 18).

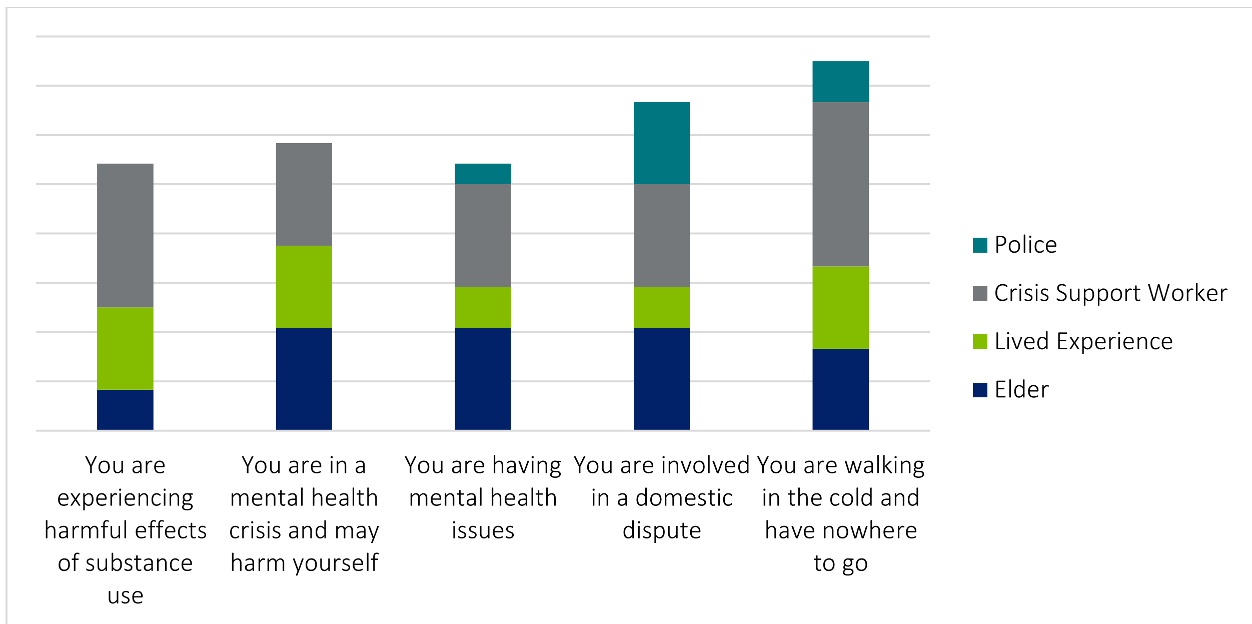

Figure 18 Best Responder for Crisis by Gender Diverse Participants

What are important elements of crisis response?

- Overall, participants rated highest on average immediate supports (such as food and blankets) as important or very important to crisis response. The other elements rated high on average were transportation to a safe place and referrals to hospital/specialist care (see Figure 19).
- Compared to overall responses, Indigenous participants rated highest on average immediate supports (such as food and blankets), followed by transportation to primary care services or to a safe place. Compared to overall responses, Indigenous participants indicated more preference for harm reduction supports, transportation to primary care and home, and home care and wellness checks (see Figure 19).
- Compared to overall responses, youth (0-24) reported importance as higher on average for immediate supports, a safe space for recovery for 15-30 days, and home care and wellness checks.

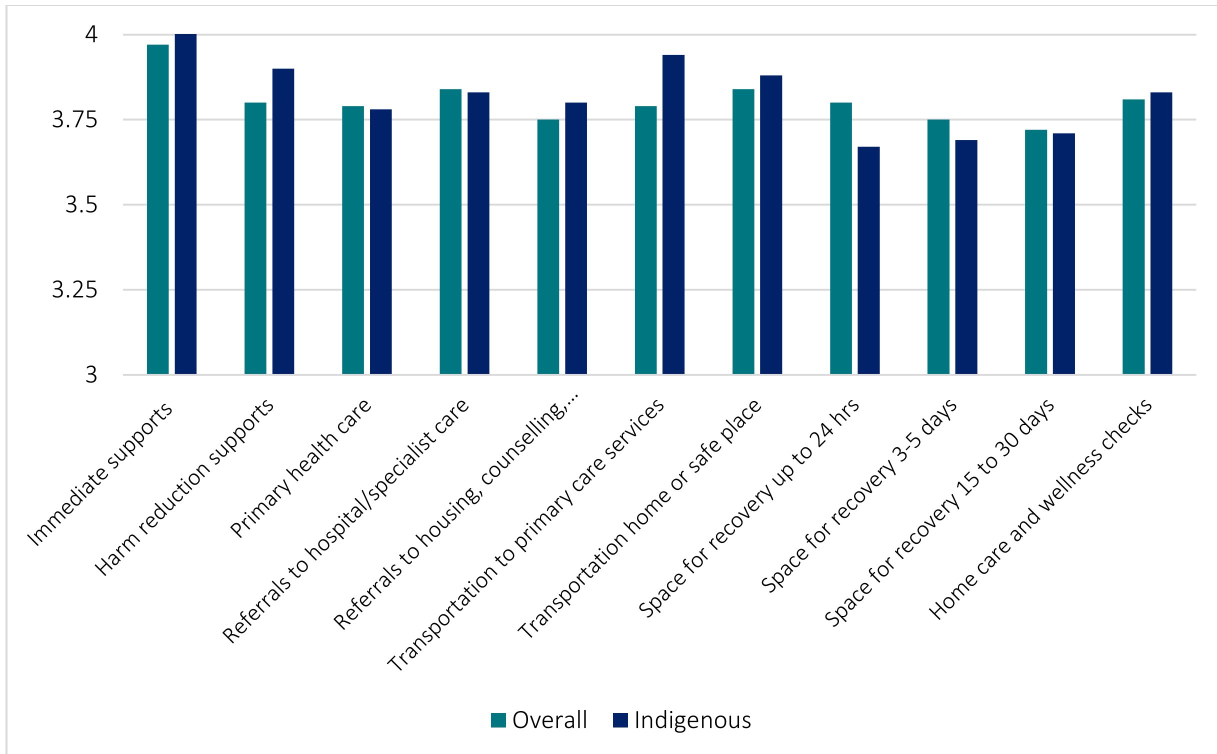

Figure 19 Important Elements of Crisis Response, Overall and by Indigenous Participants

- Additional elements of crisis response that participants shared in open-text responses can be found in Figure 255.

Open Text Responses Related to Elements Important to Crisis Response

- **A place to recover**
- Mental health follow up from first responders.
- Alternate staff to police when responding to crisis
- Going beyond referral to other services (e.g., booking an appointment for client).
- Trauma-informed service delivery

Figure 20 Additional Important Elements in Crisis Response

What belongs in an ideal crisis response system?

- Overall, participants reported importance higher on average for the following aspects of an ideal crisis response system (see below, and Figure 21):
  - *Other contact lines (e.g., 211, Distress Centre, 311, helplines) connect to the new services*
  - *Phone number where a person can contact the service directly*
  - *Service is available through local community health centre*
  - *Service available 24 hours a day, 7 days a week*
- Compared to overall responses, a service being available through chat, text and phone was rated higher on average by youth (see Figure 21).

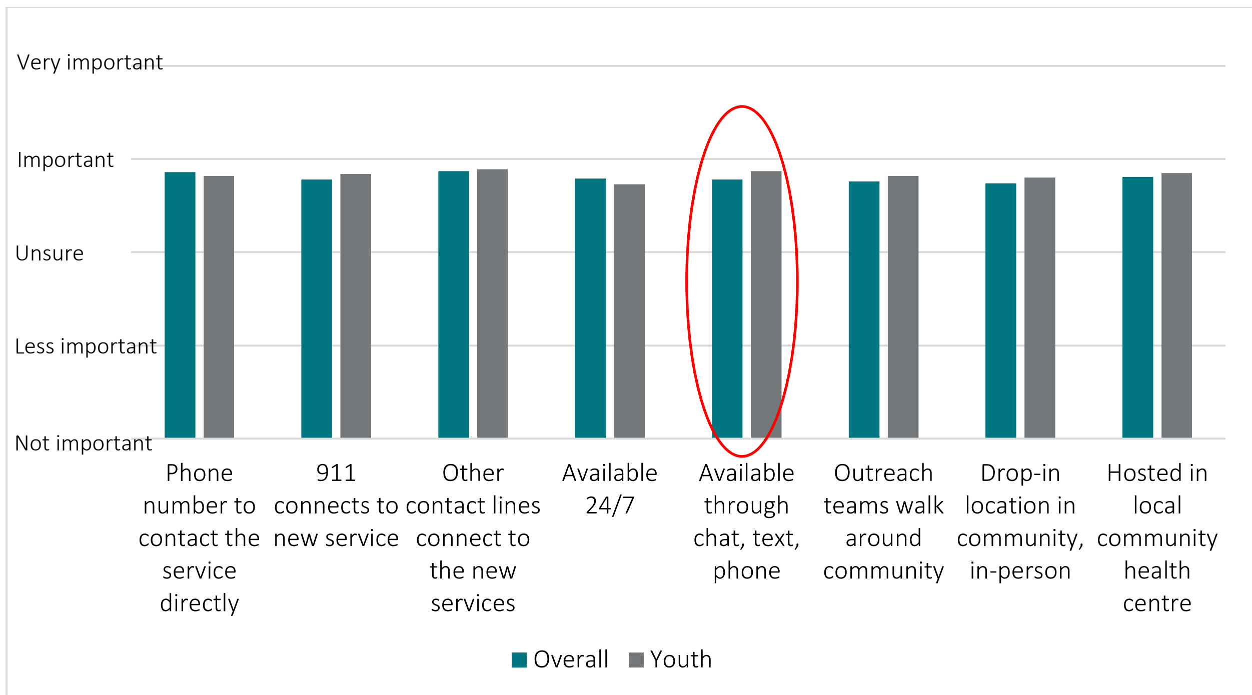

Figure 21 Challenges in Crisis Response, Overall and by Youth

- Compared to the overall responses, gender diverse participants reported slightly higher on average for *911 connects to the new service* and that the service is *available through chat, text, phone* (see Figure 22).
- On the other hand, compared to the overall responses, gender diverse participants reported lower on average for services such as the following (see Figure 22):
    - *Phone number where a person can contact the service directly*
    - *Outreach teams walk around community*
    - *Hosted in local community health centre*
    - *Drop-in location in community*

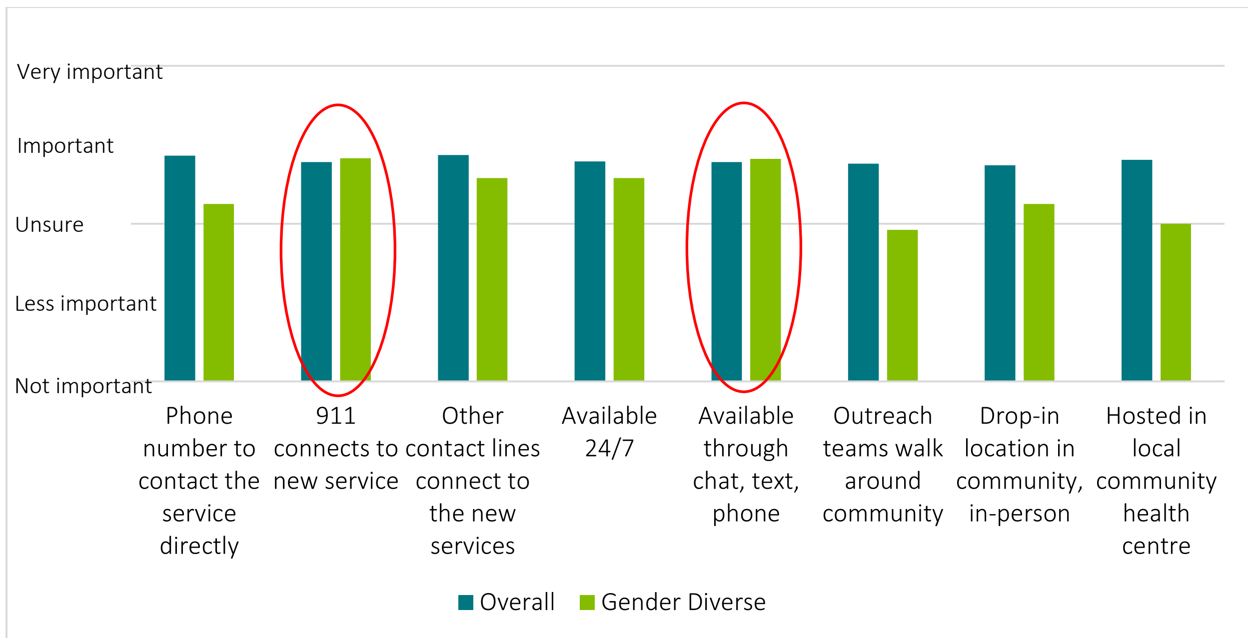

Figure 22 Challenges in Crisis Response, Overall and by Gender Diverse Participants

- Compared to the overall responses, Indigenous participants reported higher on average for the following service elements (see below, and Figure 23):
  - *Phone number where a person can contact the service directly*
  - *Available through chat, text, phone*
  - *Service has a drop-in location in the community and allows clients to talk to someone in person*
  - *Service is available through local community health centre*

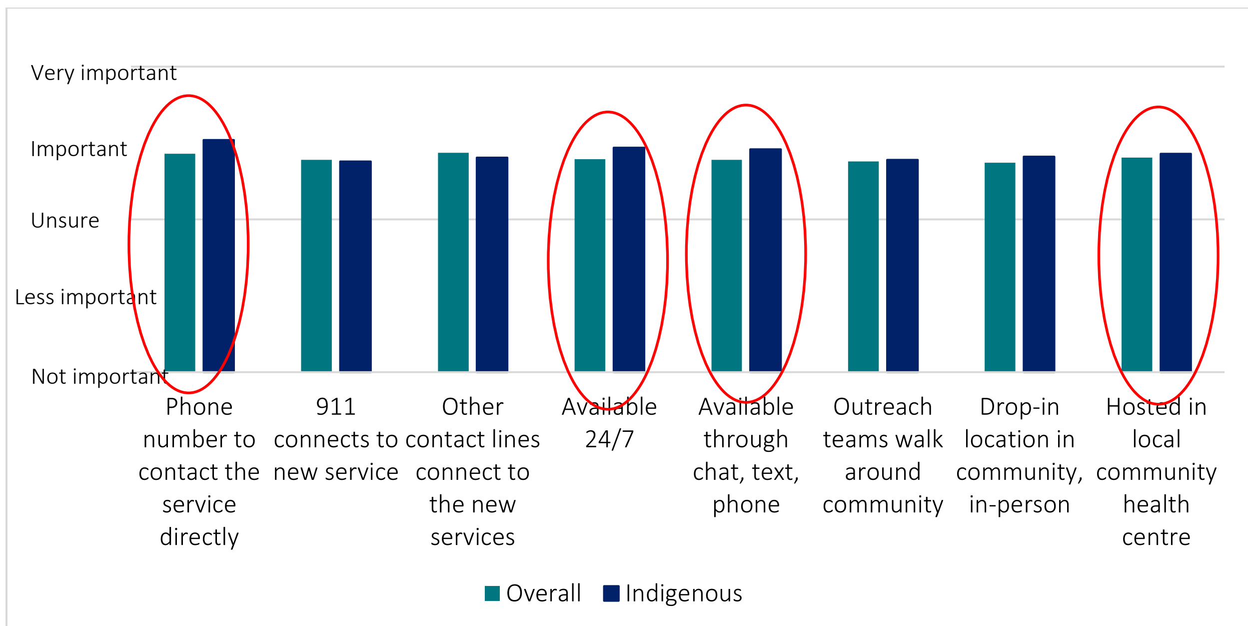

Figure 23 Challenges in Crisis Response, Overall and by Gender Diverse Participants

- Additional elements of an ideal crisis response system shared in open text responses by participants can be found in Figure 24.

Open Text Responses Related to Elements of an Ideal Crisis Response System

- **A place to manage crisis** (e.g., a bed, shower, someone to talk to).
- **Collaboration** between agencies.
- **Follow-ups** with the person in crisis.
- Having **Elders** assist in crisis response
- **Alternative numbers** to 911

Figure 24 Additional Ideal Elements of Crisis Response

What are challenges to accessing crisis services and programs?

- Overall, participants reported having to provide too much information and not wanting to share personal information (35%) as the top challenge to accessing crisis services, followed by cultural/ethnic background not being reflected in the staff, program, or service (33%) and navigating the system such as knowing who to call (28%) and the availability of that service (28%).
- For Indigenous and youth participants, cultural/ethnic background not being reflected in staff, programs, and services was the top challenge (50% and 32% respectively).
- Compared to overall responses, gender diverse participants reported having to provide too much information higher (35% vs 58%).
- Some additional challenges stated by participants in open text responses that can be found in Figure 25.

Open Text Responses Related to Challenges in Crisis Services & Programs

- **Literacy** (e.g., has trouble following instructions).
- Having to use **phone** instead of text.
- Previous **negative experiences** (e.g., harm) with crisis service.
- Concern that **police will make things worse**.
- Police & paramedics **don't put people first.**
- Extensive **waitlists.**
- **Worry** about others from community knowing

Figure 25 Challenges in Crisis Response

Conclusion

The lived experience survey of residents of Calgary indicates that several aspects of the crisis response system are satisfactory and other aspects are opportunities for growth and require system transformation.

The **satisfactory elements** of crisis response, according to the survey are that:

- Some participants use the available crisis response services,
- Some participants feel safe in the presence of police,
- During various crisis situations there are options available to help
- The fact that immediate needs can be met during crisis response is valued by participants

The **opportunities for growth** and targets for system transformation are as follows:

- Aspects of crisis response services are not perceived the same by participants who identify as Indigenous, multiple ethnicities, youth, or gender diverse. For example, for some, choice in responder during crisis situations most often indicated preference for alternate crisis response services.
- Participants want to see barriers overcome when accessing crisis system, such as lack of acknowledgement of culture and ethnicity, privacy concerns, and knowing who to call and when a service is available.

Appendix A: Frequencies by Question

The tables below are organized by question and by specific categories within demographic questions. Not all categories are represented within each demographic question (e.g., gender diverse is listed without woman and man categories). As a result, row totals will not add up to the overall total (second column). This type of representation was chosen to reduce the size of tables.

Question 1: If you or someone you know needed help with a crisis, who would you contact for help? Responses indicate % of respondents who said "yes" to any of the proposed response options.

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
a) 911	77%	92%	61%	68%	81%	25%	84%
b) Police non-emergency line	27%	15%	35%	26%	25%	42%	31%
c) 211	13%	8%	14%	16%	13%	42%	4%
d) 311	15%	8%	18%	5%	13%	33%	5%
e) 811	13%	8%	18%	11%	13%	17%	4%
f) Distress line	22%	13%	20%	16%	22%	25%	12%
g) Community agency	15%	9%	16%	5%	14%	0%	5%
h) Local health centre	12%	9%	12%	5%	16%	8%	8%
i) Family doctor	12%	6%	10%	11%	12%	17%	7%
j) Case worker	6%	6%	4%	0%	5%	8%	2%
k) Search online for resources	7%	3%	6%	0%	7%	25%	5%
l) I don't know	1%	1%	0%	0%	1%	8%	1%
m) I wouldn't reach out	1%	0%	0%	0%	1%	8%	0%
Total	660	87	49	19	326	12	98

Question 2: If you saw someone you didn't know in crisis, who would you contact for help? Responses indicate % of respondents who said "yes" to any of the proposed response options.

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
a) 911	73%	87%	69%	58%	73%	17%	81%
b) Police non-emergency line	30%	23%	27%	21%	30%	42%	29%
c) 211	11%	9%	8%	26%	9%	25%	7%
d) 311	11%	8%	18%	5%	12%	33%	3%
e) 811	11%	9%	6%	11%	10%	0%	3%
f) Distress line	14%	9%	8%	11%	16%	8%	10%
g) Community agency	15%	7%	12%	11%	13%	33%	7%
h) Local health centre	13%	8%	12%	11%	15%	0%	9%
i) Search online for resources	4%	3%	4%	0%	5%	8%	1%
j) I don't know	1%	0%	2%	0%	2%	17%	2%
k) I wouldn't reach out	2%	1%	0%	0%	2%	8%	1%
Total	660	87	49	19	326	12	98

Question 3: How safe does police presence make you feel **in general**?

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Very unsafe (1)	3%	3%	2%	11%	4%	8%	4%
Somewhat unsafe (2)	4%	2%	10%	11%	3%	33%	3%
Unsure (3)	10%	6%	8%	11%	13%	25%	8%
Somewhat safe (4)	34%	28%	31%	21%	36%	17%	18%
Very safe (5)	48%	60%	49%	47%	43%	17%	65%
Missing	3%	1%	2%	11%	1%	0%	1%
Mean	4.20	4.40	4.14	3.84	4.12	3.00	4.39
Total (n)	660	87	49	19	326	12	98

Question 4: How safe does police presence make you feel **if you were experiencing a crisis**?

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Very unsafe (1)	2%	2%	2%	5%	2%	17%	0%
Somewhat unsafe (2)	4%	2%	4%	11%	3%	8%	3%
Unsure (3)	11%	3%	8%	16%	13%	33%	12%
Somewhat safe (4)	30%	28%	35%	16%	30%	33%	15%
Very safe (5)	53%	62%	49%	47%	50%	8%	68%
Missing	3%	2%	2%	5%	2%	0%	1%
Mean	4.30	4.48	4.27	3.94	4.25	3.08	4.51
Total (n)	660	87	49	19	326	12	98

Question 5: How safe does police presence make you feel **if friends or family were experiencing a crisis**?

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Very unsafe (1)	1%	1%	2%	5%	1%	8%	0%
Somewhat unsafe (2)	3%	2%	10%	11%	3%	8%	3%
Unsure (3)	11%	6%	8%	11%	13%	25%	9%
Somewhat safe (4)	32%	24%	31%	21%	32%	42%	12%
Very safe (5)	53%	67%	47%	47%	49%	8%	70%
Missing	4%	0%	2%	5%	3%	8%	5%
Mean	4.33	4.53	4.13	4.00	4.28	3.36	4.58
Total (n)	660	87	49	19	326	12	98

Question 6: How safe does police presence make you feel if **someone you didn't know was experiencing a crisis?**

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Very unsafe (1)	1%	1%	2%	11%	1%	8%	0%
Somewhat unsafe (2)	5%	7%	8%	5%	5%	8%	4%
Unsure (3)	12%	1%	12%	21%	14%	8%	8%
Somewhat safe (4)	31%	23%	24%	16%	31%	50%	18%
Very safe (5)	51%	68%	47%	47%	48%	17%	66%
Missing	4%	1%	6%	0%	2%	8%	3%
Mean	4.26	4.49	4.13	3.84	4.22	3.64	4.52
Total (n)	660	87	49	19	326	12	98

Question 7: If you found yourself in the situations, what would you do? Responses indicate % of respondents who said "yes" to only one of the proposed response options.

a) *You are experiencing harmful effects of substance use*

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	43%	43%	51%	37%	48%	8%	60%
Call 911 and ask for ambulance	20%	14%	18%	16%	17%	25%	15%
Call 911 and ask for fire	14%	28%	6%	21%	15%	8%	12%
Call 911 and ask for other help	13%	11%	18%	11%	13%	17%	7%
Call number for crisis that doesn't involve police	5%	3%	2%	11%	4%	25%	1%
Don't know	2%	0%	2%	0%	1%	0%	3%
Other	1%	0%	2%	0%	1%	17%	0%
Missing	3%	1%	0%	5%	1%	0%	1%
Total (n)	660	87	49	19	326	12	98

b) *You are in a mental health crisis and may harm yourself*

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	35%	41%	39%	21%	35%	8%	46%
Call 911 and ask for ambulance	25%	26%	20%	21%	24%	8%	28%
Call 911 and ask for fire	6%	3%	2%	26%	6%	8%	7%
Call 911 and ask for other help	16%	9%	27%	11%	20%	25%	10%
Call number for crisis that doesn't involve police	12%	20%	6%	16%	13%	25%	6%
Don't know	1%	0%	0%	5%	1%	0%	2%
Other	2%	0%	6%	0%	1%	8%	1%
Missing	3%	0%	0%	0%	0%	17%	0%
Total (n)	660	87	49	19	326	12	98

d) You are having mental health issues

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	24%	25%	31%	21%	21%	8%	31%
Call 911 and ask for ambulance	13%	15%	12%	21%	12%	17%	14%
Call 911 and ask for fire	6%	2%	4%	16%	6%	17%	6%
Call 911 and ask for other help	29%	23%	29%	16%	33%	8%	28%
Call number for crisis that doesn't involve police	21%	30%	14%	16%	22%	25%	17%
Don't know	2%	0%	2%	0%	2%	0%	2%
Other	2%	0%	6%	5%	1%	17%	0%
Missing	4%	0%	2%	5%	2%	8%	2%
Total (n)	660	87	49	19	326	12	98

e) You are involved in a domestic dispute

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	51%	69%	41%	47%	55%	17%	51%
Call 911 and ask for ambulance	7%	5%	4%	5%	5%	25%	5%
Call 911 and ask for fire	8%	5%	2%	21%	6%	17%	9%
Call 911 and ask for other help	18%	11%	43%	16%	20%	17%	22%
Call number for crisis that doesn't involve police	9%	6%	6%	5%	10%	17%	6%
Don't know	3%	1%	2%	5%	2%	0%	2%
Other	1%	0%	2%	0%	1%	8%	0%
Missing	3%	3%	0%	0%	2%	0%	4%
Total (n)	660	87	49	19	326	12	98

f) You are walking in the cold and have nowhere to go

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	27%	33%	29%	26%	27%	8%	4%
Call 911 and ask for ambulance	10%	6%	12%	11%	6%	8%	1%
Call 911 and ask for fire	6%	2%	4%	5%	5%	17%	7%
Call 911 and ask for other help	32%	31%	37%	16%	38%	17%	29%
Call number for crisis that doesn't involve police	17%	26%	12%	32%	20%	42%	6%
Don't know	4%	0%	2%	11%	3%	0%	4%
Other	1%	0%	4%	0%	0%	8%	0%
Missing	3%	1%	0%	0%	2%	0%	3%
Total (n)	660	87	49	19	326	12	98

Question 8: If you were a bystander in the situations, what would you do? Responses indicate % of respondents who said “yes” to only one of the proposed response options.

a) Person experiencing harmful effects of substance use

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	38%	40%	41%	32%	41%	0%	46%
Call 911 and ask for ambulance	17%	10%	14%	11%	13%	0%	13%
Call 911 and ask for fire	13%	24%	12%	5%	14%	25%	11%
Call 911 and ask for other help	18%	13%	22%	21%	20%	17%	19%
Call number for crisis that doesn't involve police	7%	5%	6%	32%	6%	33%	7%
Don’t know	2%	0%	2%	0%	3%	0%	2%
Do nothing and leave the person be	1%	2%	0%	0%	1%	0%	1%
Other	1%	0%	2%	0%	1%	17%	0%
Missing	3%	6%	0%	0%	1%	8%	0%
Total (n)	660	87	49	19	326	12	98

b) Person in a mental health crisis and may harm yourself

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	41%	49%	20%	26%	42%	8%	47%
Call 911 and ask for ambulance	20%	31%	14%	11%	21%	0%	17%
Call 911 and ask for fire	6%	3%	6%	11%	6%	8%	5%
Call 911 and ask for other help	18%	3%	31%	32%	20%	50%	22%
Call number for crisis that doesn't involve police	8%	8%	10%	16%	8%	33%	2%
Don’t know	2%	1%	10%	5%	2%	0%	2%
Do nothing and leave the person be	1%	1%	4%	0%	2%	0%	2%
Other	1%	0%	2%	0%	0%	0%	0%
Missing	3%	2%	2%	0%	1%	0%	2%
Total (n)	660	87	49	19	326	12	98

c) Person having mental health issues

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	26%	36%	20%	21%	26%	8%	34%
Call 911 and ask for ambulance	10%	11%	14%	5%	8%	8%	12%
Call 911 and ask for fire	5%	3%	6%	5%	5%	8%	2%
Call 911 and ask for other help	30%	20%	31%	37%	34%	33%	29%
Call number for crisis that doesn't involve police	19%	23%	10%	16%	21%	25%	16%
Don’t know	4%	2%	10%	5%	4%	8%	2%
Do nothing and leave the person be	2%	3%	4%	0%	2%	0%	3%
Other	1%	0%	2%	0%	0%	0%	0%
Missing	2%	1%	2%	11%	1%	8%	2%
Total (n)	660	87	49	19	326	12	98

d) Person involved in a domestic dispute

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	52%	69%	47%	37%	54%	17%	56%
Call 911 and ask for ambulance	8%	8%	4%	5%	6%	33%	5%
Call 911 and ask for fire	4%	1%	2%	16%	4%	8%	5%
Call 911 and ask for other help	18%	5%	31%	26%	21%	17%	22%
Call number for crisis that doesn't involve police	8%	6%	8%	16%	7%	8%	4%
Don’t know	4%	2%	2%	0%	5%	8%	2%
Do nothing and leave the person be	3%	5%	2%	0%	2%	0%	3%
Other	1%	0%	2%	0%	0%	8%	0%
Missing	3%	5%	2%	0%	1%	0%	2%
Total (n)	660	87	49	19	326	12	98

e) Person walking in the cold and have nowhere to go

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Call 911 and ask for police	27%	33%	24%	32%	27%	8%	40%
Call 911 and ask for ambulance	12%	8%	14%	16%	8%	8%	12%
Call 911 and ask for fire	5%	5%	2%	16%	5%	17%	6%
Call 911 and ask for other help	29%	25%	27%	16%	33%	8%	29%
Call number for crisis that doesn't involve police	17%	23%	20%	16%	18%	42%	5%
Don't know	4%	1%	0%	0%	5%	8%	4%
Do nothing and leave the person be	3%	2%	6%	5%	2%	0%	1%
Other	1%	0%	4%	0%	1%	8%	0%
Missing	2%	2%	2%	0%	2%	0%	3%
Total (n)	660	87	49	19	326	12	98

Question 9: Who would be the best person to respond in the following situations? Responses indicate % of respondents who said "yes" to any of the proposed response options.

a) Person experiencing harmful effects of substance use

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Police	56%	77%	53%	26%	60%	0%	65%
Indigenous Elder	14%	6%	22%	32%	11%	42%	8%
Crisis support worker	23%	20%	24%	26%	15%	50%	20%
Lived experience	28%	16%	33%	21%	29%	25%	15%
Mental health professional	18%	9%	20%	16%	16%	33%	14%
Paramedic	18%	7%	16%	16%	17%	8%	8%
Trained volunteer	10%	3%	8%	5%	11%	17%	6%
Other	1%	0%	6%	0%	1%	8%	0%
Total	660	87	49	19	326	12	98

b) Person in a mental health crisis and may harm yourself

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Police	46%	59%	43%	26%	45%	0%	58%
Indigenous Elder	13%	10%	20%	26%	11%	17%	7%
Crisis support worker	20%	11%	27%	26%	18%	58%	11%
Lived experience	32%	23%	33%	21%	29%	33%	29%
Mental health professional	41%	45%	45%	37%	44%	25%	29%
Paramedic	16%	2%	8%	5%	16%	8%	11%
Trained volunteer	10%	5%	10%	11%	10%	25%	5%
Other	1%	0%	4%	0%	0%	8%	0%
Total	660	87	49	19	326	12	98

c) Person having mental health issues

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Police	41%	74%	27%	26%	42%	8%	55%
Indigenous Elder	11%	7%	14%	11%	9%	42%	3%
Crisis support worker	22%	9%	33%	26%	17%	42%	27%
Lived experience	31%	15%	49%	26%	28%	33%	24%
Mental health professional	45%	38%	53%	26%	45%	33%	32%
Paramedic	17%	9%	10%	11%	16%	8%	7%
Trained volunteer	13%	6%	14%	5%	12%	17%	9%
Other	1%	0%	4%	0%	0%	8%	0%
Total	660	87	49	19	326	12	98

d) Person involved in a domestic dispute

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Police	63%	89%	53%	53%	68%	33%	69%
Indigenous Elder	17%	11%	22%	26%	13%	42%	8%
Crisis support worker	25%	17%	33%	26%	22%	42%	13%
Lived experience	18%	6%	35%	5%	16%	17%	20%
Mental health professional	15%	7%	16%	11%	13%	17%	5%
Paramedic	8%	6%	8%	5%	7%	8%	6%
Trained volunteer	9%	10%	6%	11%	10%	8%	7%
Other	1%	0%	0%	0%	0%	0%	0%
Total	660	87	49	19	326	12	98

e) Person walking in the cold and have nowhere to go

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Police	41%	57%	24%	32%	42%	17%	59%
Indigenous Elder	13%	8%	18%	26%	13%	33%	7%
Crisis support worker	19%	13%	31%	32%	15%	67%	12%
Lived experience	35%	20%	43%	32%	32%	33%	28%
Mental health professional	17%	5%	33%	11%	17%	33%	3%
Paramedic	15%	10%	14%	11%	16%	8%	12%
Trained volunteer	25%	32%	31%	11%	28%	17%	15%
Other	1%	0%	2%	0%	0%	0%	0%
Total	660	87	49	19	326	12	98

Question 10: *How important is it that crisis response has:* Responses range from 1(not important) to 5 (very important). Means are reported, where anything above three would indicate "important" or "very important" and anything below three would be "less important" or "not important".

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Immediate supports like food, blankets, medicine, etc.	3.97	3.90	4.08	3.78	3.91	3.50	4.02
Harm reduction supports	3.80	3.44	3.90	3.26	3.73	3.33	3.76
Primary health care, such as basic emergency health services, prevention and treatment of common diseases and injuries	3.79	3.70	3.78	3.89	3.65	3.17	3.77
Referrals to hospital/specialist care	3.84	3.73	3.83	3.74	3.77	3.25	3.82
Referrals to housing, counselling, employment, etc.	3.75	3.67	3.80	3.84	3.65	3.17	3.74
Transportation to primary care services (e.g., family doctor, therapist)	3.79	3.75	3.94	3.58	3.73	3.25	3.73
Transportation home or safe place	3.84	3.72	3.88	3.47	3.74	3.33	3.85
Safe and supportive space for recovery up to 24 hrs	3.80	3.69	3.67	3.47	3.62	3.42	3.71
Safe and supportive space for recovery 3-5 days	3.75	3.59	3.69	3.44	3.67	3.08	3.57
Safe and supportive space for recovery 15 to 30 days	3.72	3.56	3.71	3.26	3.63	3.67	3.88
Residential or in home care and wellness checks	3.81	3.69	3.83	3.32	3.67	3.00	3.83
Total	660	87	49	19	326	12	98

Question 11: *In a perfect world, if there was a new way to get help during a crisis, how important is it that the new crisis response service includes*. Responses range from 1(not important) to 5 (very important). Means are reported, where anything above three would indicate "important" or "very important" and anything below three would be "less important" or "not important".

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Phone number where a person can contact the service directly	3.86	3.70	4.04	3.44	3.75	3.25	3.82
911 connects to new service	3.78	3.51	3.76	3.63	3.66	3.83	3.84
Other contact lines (e.g., 211, Distress Centre, 311, helplines) connect to the new services	3.87	3.70	3.81	3.89	3.74	3.58	3.89
Ability to communicate in language of choice	3.78	3.75	3.76	3.53	3.63	3.50	3.82
Service available 24 hours a day, 7 days a week	3.79	3.52	3.94	3.11	3.68	3.58	3.73
Available through chat, text, phone	3.78	3.47	3.92	3.61	3.73	3.82	3.87
Service is mobile and can meet me where I am	3.78	3.56	3.73	3.68	3.70	3.58	3.77
Service has outreach teams walking around the community	3.76	3.45	3.78	3.26	3.63	2.92	3.82
Service has a drop-in location in my community where I can talk to someone in person	3.74	3.33	3.82	3.39	3.63	3.25	3.80
Service is available at location I already get service	3.75	3.56	3.69	3.37	3.64	3.25	3.75
Service is available through my local community health centre	3.81	3.51	3.86	3.63	3.70	3.00	3.85
Total	660	87	49	19	326	12	98

Question 12: *What are challenges to accessing crisis services and programs?* Responses indicate % of respondents who said "yes" to any of the proposed response options.

Response Options	Overall	Black	Indigenous	Multiple Ethnicities	Lived Experience	Gender Diverse	Youth (0-24)
Have to provide too much info/don't want to share personal info	37%	41%	27%	42%	33%	58%	27%
Cost of program/service	28%	22%	24%	21%	28%	17%	19%
Cultural/ethnic background not reflected in staff/programs/services	33%	32%	55%	37%	31%	25%	32%
Didn't know how to reach the service	28%	28%	33%	32%	26%	33%	22%
Didn't know service was available	28%	18%	47%	16%	27%	25%	29%
Unable to contact service	24%	23%	29%	11%	24%	17%	19%
Experienced stigma and/or discrimination by service provider	20%	11%	18%	11%	21%	25%	11%
Service required abstinence from drug use	10%	2%	12%	5%	9%	8%	4%
Hours of operation	19%	8%	29%	26%	17%	25%	13%
Location/transportation was an issue	20%	8%	22%	16%	16%	25%	24%
Other	1%	0%	2%	0%	1%	17%	0%