Dear Members of the Toronto Police Services Board,

We are graduate students in the Department of Psychology at Ryerson University and we are writing to urge you to address the failures of the City of Toronto's current policing practices with regard to responding to mental health crises. It is neither feasible nor fair to expect police officers to be experts in mental health and crisis intervention. It is undeniably clear that this expectation is also ineffective and harmful. The recent deaths of D'Andre Campbell, Regis Korchinski-Paquet, Chantelle Moore, Rodney Levi, and Ejaz Choudry resulting from police encounters highlight the tragic and unacceptable consequences of current practices.

Although the Toronto Police Service (TPS) has begun to develop a more appropriate response to mental health calls using mobile crisis intervention teams (MCIT), their implementation remains woefully inadequate (Lamanna et al., 2015). For one, the MCIT act as secondary responders; armed police officers are still the first to arrive at the scene when a community member is experiencing a mental health emergency. Additionally, MCIT services are limited to the hours between 11am and 11pm (Toronto Police Service, n.d.) and involve the presence of a police officer in addition to a mental health nurse. Teams arrive in police vehicles, and police officers are in uniform and armed, with little distinguishing them from other TPS officers. Of the 30 000 mental health calls received annually by the TPS (Nasser, 2020), the MCIT responds to a mere 6000 of these calls (Szklarski, 2020). Given this inadequate response, as well as the fact that 70% of victims of lethal force are individuals with mental health issues (Nasser, 2020), there is an urgent need to transform current policing practices to *safely and responsibly* serve and protect the most vulnerable members of our community.

We also know that mental health difficulties intersect with, and are produced by, systems of oppression such as racism, sexism, and ableism. Organizations have recently called on the Ontario government to name anti-Black racism a public health crisis, especially as it relates to police violence (Alliance for Healthier Communities, 2020). A recent report by the Ontario Human Rights Commission (2018) found that a Black person in Toronto is 20 times more likely to be fatally shot by the TPS than a white person. Black individuals in Toronto are victims of disproportionate police violence, clearly demonstrating institutional racism within the TPS. Our Black community members report feeling fear, trauma, and humiliation as a result of these egregious actions (Ontario Human Rights Commission, 2018). Police interactions are associated with increased symptoms of anxiety, depression, posttraumatic stress, and psychological distress, as well as suicidal ideation/attempts and psychotic experiences in Black Americans (Herd, 2020; McLeod et al., 2019). Racial profiling by police has also been shown to be related to adverse mental health effects through direct (e.g., confrontation due to police language) and indirect (e.g., knowledge about an individual being racially profiled) pathways (Laurencin & Walker, 2020). By continuing to send police officers as first responders to mental health emergencies, TPS is re-victimizing Black communities and exacerbating mental health difficulties in already at-risk groups.

In cities around the world, non-police mental health first response services have been implemented successfully, decriminalizing mental illness and in turn, reducing stigma. For instance, the CAHOOTS program in Eugene, Oregon, which has been operating for over 20 years, deploys a team of medics and crisis workers as first responders to mental health crisis calls without a significant threat of violence (White Bird Clinic, n.d.). The program is funded

entirely by the police department, yet it retains public trust by ensuring that for those experiencing mental health crises, their first, and likely only, contact is with trained health care providers, not armed police officers. Leaders of the CAHOOTS program estimate that they respond to over 20 000 calls per year and that their program produces over $15 million in cost savings annually (Shapiro, 2020). Due to its success, similar programs are being implemented in larger American cities such as Denver, Colorado (STAR program), Austin, Texas (CHP program), and in the Bay Area, California (Continuum of Crisis Care). In addition, mental health ambulances have replaced police officers as first responders for mental health crisis calls in Stockholm, Sweden (Bouveng et al., 2017). With this mounting evidence, it is clear these programs are feasible, destigmatizing, and effective (Dempsey et al., 2020).

For those of us pursuing clinical psychology, our first practicum placement is with the Family Health Team at St. Michael's Hospital. Many of our patients will, at one time or another, experience a mental health crisis. We see Black and Indigenous patients, and patients who are struggling with housing and employment, who are most at risk of experiencing violence at the hands of the police (Dhillon, 2015; Ontario Human Rights Commission, 2018; Zakrison et al., 2018). As mental health care providers, protecting the confidentiality and privacy of our patients is of utmost importance, and confidentiality can only be broken if we believe it to be in our patients' best interest. One of the first lessons we are taught is to call 9-1-1 if we are concerned about someone's safety and their ability to get to a hospital. This system relies on our expectation of a proportional and empathetic response from first responders. Knowing the risks associated with the current first response, how can we confidently and in good faith purport to be acting in our patients' best interests? How can we expect vulnerable patients to trust us with their thoughts of self-harm, when they know that the first response can lead to tragedy?

We psychology students stand with other leading Canadian organizations in mental health (Centre for Addiction and Mental Health, 2020; Canadian Mental Health Association, 2020) in stating that we need a non-police crisis response for our patients and for our communities. Consistent with other successful initiatives for responding to mental health crises, this non-police response should be funded by diverting a portion of the funds allocated to the TPS, rather than through already underfunded community and social services (City of Toronto, 2019). It must also be developed in collaboration with mental health care providers and community stakeholders--including, but not limited to, racialized communities (especially Black and Indigenous communities most affected by systemic racism in policing), individuals with mental health and substance use problems, individuals dealing with housing/employment insecurity, individuals with disabilities, LGBTQ+ individuals, immigrants, sex workers, and other marginalized and overpoliced communities in Toronto. It is imperative that this non-police alternative remain an independent program separate from TPS and that it deploys counsellors, social workers, crisis workers, and/or paramedics that have ties to the communities they serve. Individuals experiencing mental health crises should not be criminalized due to our society's failure to provide adequate care.

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