Reach Out
Response Network

REPORT ON

INTERNATIONAL

CRISIS RESPONSE

TEAM TRAININGS

July 5th, 2021

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Introduction

The City of Toronto is currently developing four geographically-based, non-police-led mobile crisis response team pilots that will respond to mental health crisis calls starting early 2022.

In advance of the rollout of these Community Crisis Support Services pilots, the City is consulting with local and international service agencies, community organizations, and other key stakeholders in its efforts to identify the core training curriculum that will be used in said pilots. To this end, they have contracted the Reach Out Response Network to liaise with eleven agencies that are experts in non-police-led crisis services, and to outline curriculums, best practices, as well as core competencies that currently exist across North America.

This report contains summaries of data and recommendations that are based off of a handful of supplementary materials in addition to interviews with representatives of the following organizations:

- *Baltimore (Here2Help)*
- *Denver (STAR)*
- *Edmonton (24/7 Crisis Diversion Teams)*
- *Portland (Street Response)*
- *New York City (B-HEARD)*
- *Olympia (CRU)*

- *Oregon (CAHOOTS)*
- *San Francisco (SCRT)*
- *Sacramento (Department of Community Response)*
- *Toronto (Strides Toronto)*
- *London (CMHA Middlesex's Reach Out)*

Essential Types of Training

There were twelve broad categories of training that crisis workers reportedly took part in:

1. Mental health-related (ex. Mental Health First Aid)
2. Substance use-related (ex. harm reduction training)
3. Working with specific marginalized populations (ex. street-involved individuals); equity/diversity
4. Clinical skills (ex. motivational interviewing training, trauma-informed care training, professional boundaries training)
5. Crisis de-escalation and suicide intervention (ex. ASIST)
6. Situational awareness/personal safety (ex. non-violent crisis intervention, self-defence training)
7. First aid and basic medical training (ex. CPR, tourniquet training, naloxone training)
8. Vehicle operations
9. Operational/logistics (ex. organizational policies, report writing, use of police radios)
10. Privacy (ex. Health Insurance Portability and Accountability Act compliance) and relevant legislation (ex. laws about involuntary commitment and duty to report)
11. Community resources (ex. learning about various resources; referrals) and field training
12. Other

Mental Health

The majority of teams provided mental health-related training to their staff. The most common example provided (by teams based in Baltimore, Edmonton, Portland, and London) was Mental Health First Aid (MHFA) training. It comprises introductory modules on common mental illnesses and how to identify as well as support individuals experiencing symptoms. There are several types, including MHFA for supporting adults and MHFA for supporting youth, and some teams receive multiple types. Sacramento's teams did not receive MHFA training because it is "very basic" and "not sufficient for the high level mental health needs and crises that [their] staff/teams may encounter." Some teams collaborated with community agencies to deliver other mental health-related training or provided this in-house.

Substance Use

All mobile crisis teams provided trainings on substance use disorders, symptoms, and withdrawal; harm reduction; medical detox; and/or how to work with people who may be experiencing diverse mental states caused by substance use. Many teams specifically taught their staff about harm reduction resources within their communities, such as safe injection sites and where to go for needle exchange. Edmonton provided training to their teams on relapse prevention, and Baltimore provided training to their teams on psychopharmacology. In Toronto, specific trainings are available through the Toronto Hostels Training Centre and through individual community workers on how to support people who are using substances, particularly those who may be using crystal meth. For example, Sanda Kazazic has provided these trainings in Toronto for our local and provincial Human Services and Justice Coordinating Committee (HSJCC).

Specific Marginalized Populations and Equity/Diversity

Teams provided various trainings to their staff on working with marginalized populations; for example, multiple teams provided training on how to work with individuals with dual diagnosis, autism, and personality disorders. After launching, Portland's team has added regular learning opportunities that hone in on diverse topics and communities' needs (see Appendix A). Its staff specifically recommended a training provided by Donna Beegle on understanding poverty as well as best practices for working and communicating with individuals experiencing poverty. Edmonton's team received a training on working with street-involved folks and those with "high-risk lifestyles," such as sex workers. Some teams also provided training on working with LGBTQ+ communities' members and in situations that involve domestic violence. Many of these trainings focused on de-stigmatizing the populations served and on language awareness; for example, saying "a person with borderline personality disorder" rather than "a borderline," or saying "a transgender person" rather than "a transgendered person." Lastly, the teams of therapists and police officers who are specific to Baltimore's Crisis Response Team (CRT) co-responder program get week-long trainings on how to approach crises that involve intellectual disabilities, behavioural health issues, as well as hearing and vision impairments.

Substantial equity/diversity training is provided by all teams (for more info, see "Trauma-Informed and Anti-Oppressive Trainings", page 9). Training on children/youth is also covered in a later section of this report.

Clinical Skills Training

Teams also provided substantial clinical skills training to their staff, including training on trauma-informed care. Some teams, including Denver and Olympia, provided training on professional boundaries and dual relationships, which can be particularly important in smaller communities where it is more likely that

clients and crisis workers know one another. Several teams provided training on motivational interviewing, and Denver's staff receive training on diagnostic criteria so that some assessments can be completed in the field (rather than having to refer or bring all clients who are in need of clinical assessments to clinics and hospitals).

Crisis De-Escalation and Suicide Intervention

Teams provided crisis intervention and specifically suicide intervention training to their staff. For example, New York City's B-HEARD (Behavioral Health Emergency Assistance Response Division) provided their staff with Crisis Intervention Team (CIT) training, and many teams provided in-house crisis de-escalation training. The team at Baltimore's Here2Help also receive "customer service training for behavioural health professionals," which covers how staff can act as welcoming as possible with clients, including when they're agitated or escalating conflict.

The most common suicide intervention training provided was Applied Suicide Intervention Skills Training (ASIST), which several teams, including Baltimore's and Edmonton's, provided. San Francisco's SCRT staff receives substantial in-house suicide intervention training, and Denver provided training based on the "Zero Suicide" model that was said to be popular across the state of Colorado. The most common crisis intervention/personal safety training provided to staff (specifically those of Baltimore, Denver, and Edmonton) was the Crisis Prevention Institute's Non-Violent Crisis Intervention Training.

Situational Awareness and Personal Safety

New York City's staff receive Partnering for Safety training, which "was provided by Health and Hospital staff and is typically put on by [their] NYS Office of Mental Health. It includes modules on planning for safety, verbal and nonverbal interventions, and defensive interventions." Meanwhile, Sacramento's team provides in-house personal safety training; Baltimore's receives a full-day training on working with aggressive clients; and San Francisco's is trained in working with agitation, violence, and violence/risk assessments.

Additionally, many teams, including those of STAR (Support Team Assisted Response) and CRU (Crisis Response Unit), provided their staff with substantial safety/scene awareness training to help their staff assess scenes for safety and risks and also to understand how to work collaboratively with police, fire, and EMS when necessary. Specifically, training was provided to help staff understand what police, fire, and EMS staff may be assessing when they arrive on scene and how they might act in order to help crisis team staff work effectively as partners (rather than getting in the way or hindering the efficacy of other emergency workers).

First Aid and Basic Medical Training

Most teams were provided with some types of first aid training, including CPR training, tourniquet training, and advanced life support techniques. Many teams were also provided with training on when and how to administer naloxone to someone who may have overdosed. Sacramento's team was also provided with infectious disease control training, and some teams with EMTs as staff were provided with additional medical training specific to EMS staff.

Vehicle Operations

Teams received training on defensive driving, vehicle maintenance, and driving the vehicles their team uses. They also received training on how to transport service users safely. Some staff received training on

avoiding parking tickets or parking-related concerns, and both Denver and Sacramento provided emergency vehicle operations training to their staff.

Operational and Logistics

Teams received substantial logistical and operational training, including training on how to use data management systems, record keeping and report writing, and how to use police radios. Staff received significant training on understanding 911 or other dispatch protocols. Some teams, like CRU's in Olympia, were provided with substantial training (about a month long) on police radio use in order to ensure staff developed adequate confidence and competence in this area. Staff also received training on organizational policies and processes, such as their responsibilities and benefits as city or agency staff as well as HR processes.

Privacy and Relevant Legislation

All teams received training on service users' privacy, confidentiality, and rights. This included training on Health Insurance Portability and Accountability Act (HIPAA) compliance in the United States and compliance with equivalent provincial legislation in Canada; legislation surrounding workers' duty to report and duty to warn; and any other legislation relevant to a team's work, including mental health and involuntary commitment-related legislation. Even if teams will not be doing the equivalent of Mental Health Act apprehensions themselves, they will still need relevant background knowledge to understand the criteria for such apprehensions. Lastly, Olympia has provided training on legislation surrounding public records, advocacy, and mental health/substance use, while some other teams received training on laws applicable in schools.

Community Resources and Field Training

Teams spent substantial amounts of time learning about resources in their communities, including what community services exist, what specific resources do, as well as how to access and refer people to them. For example, Olympia's team runs through quizzes with their staff on things like where they would refer a client who needs a free shower or coffee, and several teams mentioned that relevant contact information is programmed into staff members' cell phones (ex. phone numbers for community agencies).

During this part of their training, staff are also oriented to the geography of their city, which is particularly important if staff do not live in the community they serve. For example, Sacramento and Olympia provide a city orientation and tour to new hires. As well, many teams spend substantial amounts of time integrating their members into their communities: staff attend community meetings; visit libraries, parks, rotary clubs, and other community spaces to introduce themselves to locals and share information about their teams; go in person to community agencies to build relationships with their employees and learn more about services they provide; and build strong relationships with 911 dispatch staff, police, fire, EMS, and hospitals.

Additionally, teams spent significant amounts of time on field training. This includes ride-alongs and shadowing existing team members before later being shadowed by experienced team members. Substantial amounts of scenario and role-play-based learning are also incorporated into each team's training process.

Other

Some additional trainings were discussed. San Francisco, for example, provides substantial training on decision-making, team science, and team dynamics (ex. how members can understand each of their roles; best

work together collaboratively). This is particularly relevant for the SCRT because their teams each consist of a peer worker, a clinician, and a community paramedic. Additionally, Sacramento provides training on the use of OC spray (a.k.a. pepper spray) and animal control safety; Denver receives active shooter training; and New York City hosted a panel discussion that featured crisis workers from other cities who shared their experiences.

Baltimore's interviewee provided comprehensive lists of their teams' required trainings as of 2017 and 2020 (see Appendix B). They include many aforementioned as well as unique training module themes.

Standard Number of Hours and Distribution of Training

Key Recommendations

- *Provide substantial field training for staff (ideally three weeks or longer)*
- *Provide substantial time for becoming familiar with community resources and police radios*
- *Incorporate several weeks of job shadowing (shadowing a more experienced crisis worker and/or being shadowed by a more experienced crisis worker or supervisor)*
- *Incorporate team-building activities early on in training processes*
- *Partner with community agencies and people with lived experience to deliver trainings*

While the distribution and total number of hours of training varied, each team provided substantial field training to their staff. For many teams, the majority of training was field training. A breakdown of relevant information received can be found below:

- **Denver**: forty hours of training plus three weeks of onboarding, two of which involve new hires shadowing experienced staff members one of which involves managers shadowing new hires.
- **Edmonton**: approximately six days of classroom training plus a full-day staff retreat, which included at least half a day of training in addition to social opportunities.
- **London**: approximately half of onboarding at Reach Out (24/7 support and services line) is "knowledge building" training and half is "direct practice" training.
  - London's parallel Crisis Outreach and Support Team (COAST) program's training is two weeks long (for a sample training schedule, see Appendix B).
- **New York City**: five weeks of training for 7.5 hours a day.
- **Olympia**: three months of training, nearly all of which takes place in the field. This involves ride-alongs and building relationships with agency partners as well as community members; walking in the downtown core where the majority of crisis calls originate and simply introducing themselves and building relationships with potential service users.
- **San Francisco**: forty hours of classroom training; forty of field training (on the rig with a supervisor).
- **Sacramento**: four weeks of training total, half of which are classroom-based and half of which are field training. Afterwards, a new hire is partnered with an experienced crisis worker.

A majority of teams provide recurring trainings to their staff. For example, all staff within Denver's STAR program receive annual training on responding to mass shootings and on trauma-informed care. Olympia

has training days twice a month, and London provides educational opportunities at their monthly staff meetings. Additionally, Denver and London offer staff access to a large database of trainings that staff members can access individually based on their interests.

Managers recommended that substantial amounts of time be allotted for learning how to use police radios and practicing until workers were comfortable with using them. Additionally, New York City staff recommended that physical, outdoor trainings be provided earlier on to enhance team building, while Sacramento's representative noted that they have trained "ALL staff at the same levels", regardless of workers' roles and previous experience. Lastly, many teams recommended that the City of Toronto partner with community agencies as well as people with lived experience to facilitate trainings on their areas of expertise, with staff highlighting that they found hearing from people with lived experience particularly beneficial.

Supervisory/Managerial Training and Vicarious Trauma/Staff Debriefing

Key Recommendations

- *Provide mobile crisis team supervisors with training on performing a debrief following crisis calls; trauma-informed supervision; CISM (Critical Incidence and Stress Management)*
- *Ensure supervisors are able to effectively work with team members and service users of all backgrounds. To this end, provide trainings on topics that include anti-oppression, anti-bias, anti-racism, Indigenous cultural humility/competency/safety, domestic violence, as well as disabilities and homeless/unhoused populations. Also, cultivate understandings of how to support staff with lived experience of trauma and mental health challenges and/or addiction*
- *Allow for regular check-ins, debriefs, and accessing of Communities Practice*
- *Support supervisors with structured teaching and mentorship from other experienced crisis response professionals*
- *Clinical staff should be supervised by clinicians and peer supporters by peer workers*
- *Vicarious trauma training should be provided on an annual basis*
- *Manage staff schedules such that all members of a crisis team are afforded sufficient downtime*

Given the sensitivity of crisis response work, it is imperative that supervisors of crisis response teams are provided with the tools, knowledge, and perspective necessary to support their staff's performance and well-being. While much of what supervisors need in this vein is learned through on-the-job experience, leadership ought to also engage in ongoing education to ensure their effectiveness at managing crisis worker teams, and any training they receive must be trauma-informed, evidence-based, as well as culturally sensitive.

Sufficient financial resources should be allocated in order to ensure that staff can access necessary trainings and perform well in their roles while supporting their well-being. General training on how to manage employees and facilitate debriefings (individually and in teams) as well as on how to organize and facilitate meetings were also recommended for all supervisors. Furthermore, many interviewees expressed that specific training on how to support all populations that staff members will work with should be mandatory (ex. training on anti-Black racism; on Indigenous cultures, histories, and ways of being; etc.).

Teams are taught to expect that their members will likely be exposed to trauma. London's representative further clarified that their agency operates in accordance with the belief that every story Reach Out's workers hear has trauma embedded in it, either directly or indirectly.

In response to these conditions, teams recommended equipping all workers with the knowledge needed to identify job-related trauma and its impacts. They also often relied on supports such as:

- Supervision for both front-line workers and leadership;
- Structured coaching and mentorship for supervisors;
- Communities of Practice meetings between workers both within and across crisis support agencies (for more information on Communities of Practice, see "Considerations for Peer Workers", page 14).

As well, several teams reported that they hired clinical social workers for supervisor roles, and some staff suggested that peer support specialists were strong candidates for such roles. It was further suggested by some that clinical staff should be supervised by clinicians and peer supporters by peer workers.

The Edmonton team mentioned their requirement that their staff attend trainings that support resilience. They specifically recommended trainings from the TEND Academy, which offers both online and in-person training for helping professionals engaged in high-stress and trauma-exposed work. To support their staff, Denver's STAR team works with Healing Warriors Program, an organization that provides "non-narcotic" therapies to workers classified as first responders across Colorado. Meanwhile, Portland's front-line crisis response team have access to weekly meetings with team leaders and bi-weekly meetings with a therapist who leads staff through meditation and art therapy practices. Most teams recommended providing staff with vicarious trauma training on an annual basis.

Some teams noted a need for intentional scheduling and availability of vacation time. Specifically, Edmonton's team reported a need for "forced vacation time" during the pandemic. Their workers have increasingly saved up their days off at the same time that supervisors have begun to recognize greater cumulative impacts of vicarious trauma, as well as the intersections between this trauma and pre-existing/pandemic-specific traumas. Conversely, Olympia's staff highlighted a need to ensure that their crisis workers were allowed to take the vacation days as well as mid-shift breaks that they needed to take.

Multiple teams schedule workers such that they can avoid working three to four days each week. Denver and Olympia's teams both cited the scheduling of 12 hour shifts three times a week as being a key strategy for ensuring that their staff are supported and turnover is reduced. Edmonton's staff and some CRU workers use a similar "four on, four off" schedule. Lastly, all of the behavioural health clinicians and community paramedics in San Francisco's teams work 12 hour shifts (Sunday-Tuesday or Thursday-Saturday and every other Wednesday), while their peer workers either follow a similar schedule or work 6-8 hour shifts. Providing this flexibility is one of the ways in which their team supports workers who may be more likely to be triggered and to need additional supervision/support.

Trauma-Informed and Anti-Oppressive Trainings

Key Recommendations

- *Ensure that training facilitators and other key stakeholders reflect the diverse communities that the crisis response teams seek to serve; partner with community agencies, leaders, and people with lived experience when seeking facilitators*
- *Provide training on anti-oppression and trauma-informed practices that is mindful of the ways in which said training should be ongoing and can be triggering*
- *Strive to create shared baseline understandings of equity, diversity, and inclusion among service providers of varying professional and personal backgrounds*

As is also mentioned in points regarding hiring, multiple teams emphasized that anti-oppressive training and practices had to be preceded by equitable hiring. A best practice related to anti-oppression and training is ensuring that staff members, training facilitators, community members who are reached out to, and members of hiring panels all reflect the diverse communities that their respective crisis response teams seek to serve. Furthermore, many teams recommended that the City of Toronto partner with community agencies and leaders as well as people with lived experience in order to provide trainings relevant to their areas of expertise (ex. substance use; working with immigrant communities). Staff such as those in Toronto and Olympia highlighted that this was critical, and best done on regular bases. The team in London also recently requested that its peer workers design and facilitate a workshop on sanism and Mad studies.

Some teams recommended additional ways to fine-tune the delivery and development of trainings. One way in which Baltimore's team strives to increase the efficacy of its cultural humility trainings, for example, is by ensuring that they are done in-person. Edmonton partnered with Senator Patti LaBoucane-Benson, a noteworthy Indigenous leader, in order to develop and provide quality trainings on colonization and its history. Additionally, Edmonton's representatives acknowledged the importance of community partners speaking to and from their lived experience, as parts of crisis workers' trainings, and in ways that are trauma-informed.

While all teams stressed the importance of training on anti-oppression and trauma-informed practices, each team cited equity and trauma resources that others did not. For example, Portland's team recommended a textbook edited by Ranna Parekh titled "The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health", in addition to workshops on topics (ex. "harm reduction for sex workers") provided by local organizations working with specific marginalized populations. Olympia as well as Denver's teams shared that they are able to receive support with equity, diversity, and inclusion (EDI)-related training and questions from local city staff. Meanwhile, NYC's staff noted their attempts to remain mindful of the various ways in which trauma-informed practices come up in day-to-day operations (ex. through "statements cautioning that information may be disturbing or upsetting"; when possible, ensuring that breaks can be taken when the work is difficult and people need them). Additionally, San Francisco is in the process of implementing a survey that captures equity-related data and feedback across its teams, and their clinicians as well as their peers already track the demographics of the people who they successfully reach out to and connect with while providing follow-up support. Olympia uses worksheets as well as other resources surrounding trauma-informed best practices (see Appendix C), and lastly, London's team recommended relying on internal committees (ex. Professional Development Committee) that create educational events as well as other content

regarding topics like anti-racism. For example, their Trauma and Violence-Informed Care Committee creates tools that support London's staff and their "participants" (a.k.a. clients) in managing expectations surrounding their interactions with one another during crises.

Striving for trauma-informed and anti-oppressive practices can present material challenges. Most interviewees believed that there was room for improvement when it came to their teams' trainings on equity, anti-racism, anti-oppression, and Indigenous cultural humility/competency. Furthermore, two teams touched on how it can be both challenging and necessary to cultivate shared understandings of equity, diversity, and inclusion across service providers with different academic, professional, and lived backgrounds. EMTs in one team, for example, were said to be "less used to" relevant discussions and practices than other co-workers.

Special Considerations Regarding Children/Youth

Key Recommendations

- *Provide age-specific training and tools*
- *Ensure that service providers are well-equipped to work with family systems and engage youth alongside their families during crises*
- *Clarify how care and best practices related to trauma, mental illness, substance use, suicidality, abuse, and other topics differ between children/youth and adults*
- *Ensure adequate access to culturally and linguistically-appropriate services as well as providers*
- *Develop extensive background knowledge of youth-specific contexts, resources, laws (including those specific to schooling and students); workers' abilities to provide referrals and warm handoffs*

Responses to questions about children and youth varied greatly. One primary cause of these divergences had to do with differences in the target demographics of agencies: Baltimore and San Francisco's teams strictly serve adults (18 and older), while other teams work with all age groups. London's team has historically advertised itself as an agency that serves clients ages 16 and up, but they have not turned away community members below that age who requested help, and more recently, some of their workers have begun supporting children/youth consistently. This is due to the development of a partnership with a child and youth family crisis line in their region (for which the London team now handles after-hours calls).

Teams that were familiar with child and youth needs often received training and tools that are specific to age sub-categories. For example, Baltimore's team reported provision of extensive training on transition-aged youth needs and services. They support a disproportionate number of clients who are between the ages of 20 and 26, and who experience unique challenges related to service provision (ex. poor fits with existing mental and behavioural health services designed for children and older adults). Distinctions were also made between children ages 12 and older and children under the age of 8. The two Strides Toronto staff members interviewed noted that their areas of expertise did not include working with children below the age of 12, and that this was "very different" from working with youth above that threshold because the age of consent is 12. Many members of London's team attended an ASK (Assessing for Suicide in Kids) workshop, which is suicide assessment and prevention training specific to children. This uniquely helped staff understand how to better work with children below the age of 8, and up to age 14. In addition to this, all London staff received a workshop

on child and youth risk assessment, and they have access to age-specific tools like the National Institute of Mental Health (NIMH)'s Ask Suicide-Screening Questions (ASQ) suicide risk screening tool (see Appendix D).

All teams that work with children/youth stressed that this requires service providers to understand how to best work with family systems and how to engage youth in addition to their families during crises. They emphasized how, broadly speaking, their training needed to prepare them to understand how trauma and other mental health challenges present differently in children than they do in adults. Denver's staff added that trauma-informed best practices can differ when working with youth; they offered the example of ensuring that an adult does not remain in the same space that a child/youth is in if abuse of the latter is suspected.

Some teams emphasized the centrality of respect and client-centered care: how to make sure, for example, that children/youth are being reached out to, listened to, and learned from throughout an agency's trainings and beyond; that their expectations are being properly managed; and that they are engaged with in culturally- and age-appropriate ways (especially those "from backgrounds that tend to be more distrustful of authority figures"). Strides Toronto's representatives noted that cultural and language compatibility are among the factors considered when trying to match youth with service providers during their intake processes.

A few interviewees reported provision of training on youth and warm handoffs as well as referrals. One team hopes to use a greater amount of child- and youth-specific training content in the future. Sacramento's team reported receiving eight hours of training on the following themes as they relate to children and youth: mental health, suicide, and suicide interventions; substance use; trauma-informed care; mental health symptoms and de-escalation; as well as learning disabilities, school campuses, and laws applicable in school settings. Similarly, Denver's team receives training on local school systems, resources, and laws.

Hiring Practices

Key Recommendations

- *Hire staff who already have substantial experience doing crisis work*
- *Hire staff who are comfortable working with marginalized populations, who have experience working with people using substances, and who are comfortable working in all weathers*
- *Incorporate substantial amounts of scenario-based questions into application processes*
- *Consider a "blind" application process in which the names of candidates are redacted*
- *Prioritize hiring staff who reflect the communities they serve in terms of identities and familiarity; consider whether requirements for particular types of educational backgrounds (ex. having a master's degree) may impede recruitment of workers who are reflective in this way*
- *Ensure that hiring panels are diverse*

The majority of the teams we spoke to stressed the importance of hiring staff who already have substantial experience with doing crisis work and supporting marginalized populations. For example, several managers stated that they would not hire workers who were "fresh out of school" and lacked experience doing crisis work; they would instead prioritize applicants who had extensive experience in other crisis worker roles.

They provided several reasons for this preference. First, many of the agencies operating alternative crisis services provide predominantly crisis team-specific trainings, such as training on how to use police radios and training on appropriate community referrals. Most of these teams do not provide more introductory trainings such as "active listening" training or "mental health 101" training. Therefore, crisis workers are required to have received this kind of training or skill-building prior to being hired to work on the crisis teams.

Second, several managers stated that ensuring adequate experience and/or expectation management was essential for improving staff retention. They noted that experienced crisis workers already know what to expect in this role and are better able to gauge whether the role of a crisis worker is a good fit for them. Furthermore, San Francisco's SCRT (Street Crisis Response Team) program require potential hires to shadow existing team members prior to accepting a position regardless of their previous professional experience, so that potential hires can accurately assess the fit of the job for them while supervisors can observe how they can respond to scenarios in the field. Teams like Olympia's CRU team — which hire experienced crisis workers, provide competitive salaries and benefits, and create opportunities for career advancement within their roles — have substantially higher rates of staff retention than crisis teams that predominantly hire staff who are fresh out of school and fail to provide competitive salaries, benefits, or opportunities for advancement. Additionally, Olympia's CRU team stressed the importance of hiring staff who are comfortable working with marginalized populations, who have experience working with people using substances, and who are comfortable working outside in all weathers (particularly in cold, windy, or rainy conditions).

Some teams, such as Denver's STAR team, only hire master's-level clinicians to work on their teams. Other teams, such as Olympia's CRU team, allow for more flexibility and seek staff with equivalent requisite experience without mandating a particular degree. CRU's approach may be particularly beneficial in ensuring equity and in developing a team that genuinely reflects the community it serves, given disparities in opportunities for educational attainment among racial and socioeconomic groups. While most teams indicated a preference for substantial scenario-based questioning during the interview and hiring process, CRU's hiring process goes even further by prohibiting cover letters and resumes from being submitted during the application process. Instead, candidates must fill out a written application consisting primarily of scenario-based questions. The names on the applications are redacted so that hiring managers are not unconsciously influenced by gender or racial markers. This process ensures fairness and equity in hiring.

Many teams, particularly San Francisco's SCRT team and Olympia's CRU team, flagged the importance of ensuring that crisis teams reflect the diverse communities they serve and that crisis workers are familiar with and have developed trust with these communities. CRU also mentioned the importance of having a diverse hiring panel to evaluate applications.

Considerations for Peer Workers

Key Recommendations

- *Peer workers should be supported in accessing peer-specific training early on as well as ongoing training and check-ins (ex. Communities of Practice)*
- *Peers should ideally be supervised by other peers rather than by clinicians*

- *Training provided to peers should be based on the fundamental principles of peer support*
- *The ways in which peer workers are at times equivalent to other crisis workers (ex. in terms of their responsibilities or value) and are at times unique must be recognized, and by all team members. Flexibility, accessibility, role clarity, equitable pay, and open communication should be woven into peers' hiring, onboarding, training, and continued work when appropriate*

A number of key findings surrounding peer workers are summarized below. These were derived from both Reach Out Response Network's interviews as well as supplementary documentation made available by the Mental Health Commission of Canada (MHCC), the Centre for Innovation in Peer Support (the Centre), Addictions and Mental Health Ontario (AMHO), and the Canadian Mental Health Association (CMHA).

Training and Supervision

All sources stated that peers should receive both typical onboarding/crisis intervention training from the agency they work at as well as additional peer-specific training provided by a peer facilitator or a peer-led organization. For example, San Francisco's SCRT team contracts with an organization called RAMS (Richmond Area Multi-Services) which runs a Peer Specialist Mental Health Certificate Program that many SCRT peer workers previously graduated from (see Appendix E). In Ontario, a number of organizations — including the Centre, the Ontario Peer Development Institute, and Stella's Place — offer peer worker training courses, and Peer Support Canada offers certification for peer support specialists. In some cities, such as Baltimore and San Francisco, certification is also available (see Appendix E). Sources also agreed that training provided to peers should be based on the fundamental principles of peer support (for the MHCC's interpretation of these principles, see Appendix E).

Some sources highlighted how accessible and flexible trainings are essential to the success of peer workers. Their training should ideally include experiential elements, and must also be flexible so as to support each peer's needs (ex. peer workers may need to adjust the pace or in-class duration of training in order to work with disability and trauma-related needs or otherwise benefit the most from their training).

An effective supervisor of peer workers will need to have a nuanced understanding of the unique role of peers and be a strong advocate for peers throughout the organization. The best practice is to have a peer supervisor who is themselves a peer support specialist, and to ensure that all supervisors are able to:

- Provide space for shared as well as self-reflection;
- Support peers in identifying areas of growth and setting goals for professional growth;
- Involve discussion of boundaries, confidentiality, and dual relationships;
- Provide support with accommodations where appropriate; and
- Be aware of the distinction between supervision and therapy (as the goal of supervision should not be to monitor peers' emotional states or provide psychological treatment, but rather to support peer staff in maintaining wellness in the workplace and accessing accommodations).

Ongoing training and check-ins are integral for peers in order to support them in networking and collaborating with other peers, to promote self-care, and to provide additional skill-building as well as career advancement opportunities. Communities of Practice, where peers meet on a regular basis to share successes/challenges and support one another through them, can be particularly beneficial. Baltimore's peer workers have monthly Communities of Practice, and Toronto-based agencies such as Stella's Place and CAMH

provide similar opportunities for their peer workers. The Centre's Provincial Peer Network and Provincial Peer Supervisor Network are Communities of Practice that are open to all Ontario-based peer workers and supervisors/managers, respectively (See Appendix F).

Peer Worker Hiring and Integration

All sources who work with peer workers emphasized the importance of agency readiness when hiring and integrating said workers. One important aspect of agency readiness is creating an agency culture in which mental health challenges are de-stigmatized, openly discussed, and responded to with support by all employees, such that peers with specific lived experiences do not feel singled out. An added benefit of this is that non-peer crisis workers may also benefit from resources and accommodations created for peers.

San Francisco's staff as well as our supplementary sources discussed the importance of training non-peer staff in understanding the value of peer support and the role of peer workers. Said staff also mentioned the importance of hiring clinicians who are experienced with and comfortable working on multi-disciplinary teams. It may be particularly beneficial to hire clinical staff who have worked successfully with peers in the past, or who are former peer workers themselves. Additionally, organizational structures must be set up such that peers are valued and the integrity of peer work is promoted. Failure to do so can contribute to the creation of disproportionately clinical crisis response models that do not adequately centre peers and their lived experience. In this vein, all sources stated that it is best practice to compensate peer workers appropriately for their work, with pay equity (i.e. vis-à-vis other types of crisis workers/traditional first responders) being the gold standard. Where pay equity is not possible, salaries and benefits packages should at minimum be competitive vis-à-vis other service providers in one's region. Similarly, it would be advisable to avoid discrepancies between the full-time and part-time statuses of peer versus non-peer workers.

Effective integration of peer workers into an agency also requires a balance between role flexibility and role clarity. On the one hand, the peer's unique role must be clear to them as well as the staff they work with; a lack of detailed job descriptions, meaningful tasks, and/or active roles can, according to San Francisco's Street Crisis Response Team, increase the risk of peer workers being treated as "helpers" or "assistants". Simultaneously, peers may at times be in the best position to take the lead in an intervention, while a clinician may take the lead at other times. Sufficient flexibility, communication, and team cohesion must therefore exist within multi-disciplinary crisis teams if they are to succeed.

San Francisco recommended providing training in-person as much as possible to promote team-building. Their supervisors also organize regular debriefs and weekly meetings in order to ensure that they are discussing team dynamics and swiftly identifying any challenges as they emerge. Conversely, a different team has struggled to address tensions between peer and non-peer workers since their launch; they may eventually connect with an external organization that can help them define roles and leadership within their team.

Conclusion

Although many of the teams we spoke with had developed rigorous training protocols and standards for their staff, it is important to highlight that this field is an emerging field. Many of the teams we consulted had recently launched their programs, and some were still in the process of finishing developing and/or following their core training curriculums with soon-to-be-launched teams across North America. Additionally, there are dozens of teams across Canada and the United States currently developing alternative crisis response models and training programs for their staff. As such, findings in this report capture many of the best practices and recommendations of major players within a nascent field. To our knowledge, no such report on existing community responder training resources and best practices has been created on this scale, and no relevant body of literature exists.

As such initiatives continue to multiply and research begins to be compiled on these programs, it is the sincere hope of those at the Reach Out Response Network that best practices like those captured here will continue to be documented, evaluated, standardized, and implemented across jurisdictions, such that all communities will better co-create dignity, efficacy, and hope with people in crisis.

Appendix A: Presentation Slide on Cultural Competency Training Topics For First Responders (Portland)

Appendix B: Baltimore Crisis Response, Inc. (BCRI) Assigned Training

2020 Relias Assigned Training

Competency-based training is required of all BCRI staff both at hire, and annually thereafter. Training modules for the coming year in the Relias Online Learning system include:

- an online review of the most recent version of the BCRI Health & Safety Manual, which is reviewed annually and revised as necessary);
- an online review of an in-house document providing instruction on appropriate identification and reporting on critical incidents;
- the module referenced in 1H3 above, Preventing Slips, Trips, and Falls;
- a module addressing Defensive Driving;
- two modules addressing Infection Control and Prevention; and
- a module addressing Standard Precautions and Bloodborne Pathogens.

The BCRI Health and Safety Manual outlines those procedures that comprise the agency's health and safety practices, including emergency and evacuation procedures. All staff are required to complete CPR and First Aid certification, which is provided on-site quarterly, and must be renewed every two years. Courses from the Relias Online Learning System cover the identification of unsafe environmental factors, and reducing physical risks in the workplace.

Additional courses required annually in the Relias Online Learning System are assigned separately for staff according to their specific functions within BCRI and are chosen by the unit director to address skills most appropriate to their unit, and those needed by staff as identified in ongoing supervision. During the coming training year, these modules are being required:

Nursing Staff
 Reducing Medical & Treatment Errors in Behavioral Health
 Psychopharmacology
 Psychiatric Medications
 Safe Use of Prescription Medications, 2 modules
 Assisting with Self-Administration of Medications

Supervisors
 Effective Communication for Supervisors
 Sexual Harassment: What Supervisors Need to Know
 Analyzing Performance and Corrective Action Plans
 Workplace Harassment Prevention
 Workplace Discrimination: What Supervisors Need to Know
 Workplace Coaching and Mentoring

Residential Counselors
 Communication Essentials: Navigating Conversations

Basic Communication and Conflict Management Skills
Motivational Interviewing
Working with Difficult People
Learning to Love Groups

Peer Recovery Support
Peer Support: The Basics and Beyond
Intentional Peer Support: A Different Kind of Relationship
Peer Support Services in Substance Use Disorder Recovery
Effective Communication
Communication Essentials: The Effective Listener
Communication Essentials: Navigating Conversations
Supporting Individuals in Early Recovery
Trauma-Informed Care: Implications for Clinicians & Peer Support Specialists
Working with Difficult People
Self-Advocacy and Recovery

MH Counselors
Best Practice for Interviewing the Patient
Learning About People – Interviewing Techniques
Motivational Interviewing in Clinical Practice
De-escalating Hostile Clients
Behavioral Health Screening Tools
Safety in the Field

Hotline Staff
AIRS: An Introduction to Information & Referral
AIRS: Confidentiality in Information & Referral Services
AIRS: Information & Referral Customer Services
AIRS: Empowerment & Advocacy in Information & Referral
AIRS: Crisis Intervention within Information & Referral
Suicide Screening for Direct Care
Information & Referral: Serving People with Mental Health Disorders
Crisis Management Basics
Overview of the Behavioral Health System for Behavioral Health Interpreters
Ergonomics: Office
A Culture-Centered Approach to Recovery
Communication Essentials: Navigating Conversations

Addiction Counselors
Harm Reduction
Substance Use Treatment and the Stages of Change Model

2017 Relias Assigned Training

1. **2017 Cultural Competency: ALL STAFF**
A Culture-Centered Approach to Recovery (REL-HHS-CASRA-CCA) 8/1/17, 1 hour

2. **2017 Ethics and Confidentiality: ALL STAFF**
HIPAA Do's and Don'ts: Electronic Communication and Social Media (REL-ALL-0-HSOCM) 5/1/17, 0.5 hours

3. **2017 Health & Safety: ALL STAFF**
Workplace Emergencies and Natural Disasters: An Overview (REL-ALL-0-NDEP) 6/1/17, 1 hour

4. **2017 Identified Competencies: All Licensed Counselors**
Co-Occurring Disorders (REL-HHS-0-COOD): 9/1/17, 1 hour

5. **2017 Identified Competencies: All Supervisors**
Coaching and Mentoring in the Workplace (EL-CMWP-HR-0): 8/15/17, 1 hour
    AND
Documentation for Supervisors (REL-ALL-0-DOCSUP): 10/1/17, 1 hour

6. **2017 Identified Competencies: Case Managers**
Intro to Case Management Basics (REL-HHS-0-CMP): 5/1/17, 1 hour

7. **2017 Identified Competencies : Direct Service Staff**
(MCT, CRU, Detox, Targeted Case Management, ALI, LEAD, CIT):
Boundaries (REL-ALL-0-BOUND): 8/15/17, 0.5 hours
    AND
Bullying On The Job (REL-ALL-0-BOTJ): 6/15/17, 0.5 hours

8. **2017 Identified Competencies: Hotline Staff**
AIRS: Working with Challenging Clients (REL-WCC-IR-AIRS): 5/15/17, 1 hour
    AND
AIRS: The Information & Referral Process (REL-HHS-AIRS-IRP): 8/15/17, 1.5 hours

9. **2017 Identified Competencies: all RCs, CTs, and ACs**
Nutrition and Exercise for Clients in Behavioral Health (REL-HHS-0-NECBH): 10/1/17, 2 hours

10. **2017 Medications for Nursing Staff**

Overview of Psychiatric Medications for Paraprofessionals (REL-HHS-0-OPMPP): **10/1/17, 1.5 hours**

11.   2017 Substance Use Disorders: RCs, CTs, ACs, & Nurses
Overview of Substance Use Disorders, Part 2 (REL-HHS-0-OSUDPART 2): **11/1/17, 1.25 hours**

12.   2017 Universal Precautions: Direct Service Staff
(MCT, CRU, Detox, Targeted Case Management, ALI, LEAD, CIT):
Infection Control (REL-CV-0-IC) **7/1/17, 0.75 hours (45 minutes)**
          AND
Bloodborne Pathogens (REL-ALL-0-BBPATH) **4/15/17, 0.5 hours (30 minutes)**

13.   2017 Universal Precautions: Admin & Hotline Staff
Infection Control: The Basics (REL-ALL-0-BASIC) **7/1/17, 0.25 hours (15 minutes)**

14.   2017 Wellness and Recovery Management: Direct Service Staff
(MCT, CRU, Detox, Targeted Case Management, ALI, LEAD, CIT)
What Does Becoming Trauma-Informed Mean for Non-Clinical Staff (REL-HHS-0-TIC1): **5/15/17, 1 hour**

15.   2017 Workplace Threats and Violence: ALL STAFF
The Two Most Common Forms of Workplace Violence: Hostile Encounters and Domestic Violence (REL-ALL-0-W007): **7/15/16, 1 hour**

16.   BCRI Code of Ethics – ALL STAFF *
BCRI and Discipline-Specific Codes of Ethics: 1 hour, 90 days after hire date anniversary

17.   BCRI EP and Admin Discharge – MCT & CRU Staff *
EP and Administrative DC Process (BCRI-EP): 1 hour, due 30 days after hire date anniversary

18.   BCRI Health & Safety Manual: ALL STAFF *
BCRI Health & Safety Manual (BCRI-HS): **1 hour, due 60 days after hire date anniversary**

19.   BCRI Incident Report Form Training: ALL STAFF *
BCRI Incident Report Form Training (BCRI-INCREP): **1 hour, due annually on 5/15**

20.   BCRI Mandated Abuse Reporting: MHC's, RC's, Case Mngr's, & Care Coord's *
Reporting Child & Vulnerable Adult Abuse (BCRI-ABUSE): **1 hour, due 30 days after hire date anniversary**

21.   BCRI Personnel Policies: ALL STAFF *

*BCRI Personnel Policies (*BCRI-PP2015*):* **1 hour, due 30 days after hire date anniversary**

22.   Defensive Driving: All Drivers *

Defensive Driving: The Basics (REL-CV-0-DDTB): **6/15/17, 1 hour**

23.   Medications for Nursing: All New Nursing Hires (one time only)

Safe Use of Prescription Medications: Part 1 (REL-ALL-0-SUPD):   0.25 hours (15 minutes)
     AND
Safe Use of Prescription Medications: Part 2 (REL-ALL-0-SUPD2): 0.25 hours (15 minutes)

24.   Welcome to Relias: All New Hires (one time only)

25.   Welcome to Relias Supervisors: All Supervisory Staff (one time only)

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* Annual Recurring Trainings:

1. **Personnel Policies – ALL STAFF, 30 days after hire anniversary**
2. **EP & Admin DC – MCT & CRU Staff, 45 days after hire anniversary**
3. **Health & Safety Manual– ALL STAFF, 60 days after hire anniversary**
4. **Mandated Abuse Reporting – Licensed staff, AC's, RC's, MCT Nurses, 75 days after hire anniversary**
5. **Code of Ethics – ALL STAFF, 90 days after hire anniversary**
6. **Defensive Driving – All Drivers, 105 days after hire anniversary**
7. **Incident Report Form Training – ALL STAFF, annually on 5/15/17**

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Appendix C: Sample Schedule: COAST Training Program

COAST Training Schedule 2021: March 22nd to April 1st

Monday March 22nd	Tuesday March 23rd	Wednesday March 24th	Thursday March 25th	Friday March 26th
0800-0830 Housekeeping & Introductions (McGugan & D'Angelo) 0830-0930 COAST Background & Objectives (Bill Chantler) 0930-1100 Standards Operating Procedures (Marcy Harris & Yvonne Lammers) 1100-1200 Team Building Exercise (Yvonne & Lori Hassall)	0800-1200 ** Mental Health First Aid (Aleena Needham- CMHA)	0800-1200 Applied Suicide Intervention Skills Training (ASIST)	0800-1200 Applied Suicide Intervention Skills Training (ASIST)	0800-0930 Negotiation and De-escalation (Mark McGugan) 1000-1200 Compassion Fatigue (Amy Cooke- OPC)
Lunch 1200-1300				
1300-1430 CMHA Documentation** (Aleena Needham- CMHA) 1430-1600 CMHA Documentation (Online Modules)	1300-1600 Mental Health First Aid** (Aleena Needham- CMHA)	1300-1600 Applied Suicide Intervention Skills Training (ASIST)	1300-1600 Applied Suicide Intervention Skills Training (ASIST)	1300-1600 Columbia Suicide Severity Rating Scale- CSSRS** (Amy Van Berkum & Shauna Graf)

Monday March 29th	Tuesday March 30th	Wednesday March 31st	Thursday April 1st	Friday April 2nd
0800-0900 Addiction and Withdrawal Symptoms (Dr. Mehta) -Pending 0900-1000 Trauma & Violence Informed Care (Yvonne Lammers) 1000-1200 Crisis Communication Skills ** (Sabrina Andrews- CMHA)	0800-0900 Cultural Competency and Working with Indigenous Partners** (Bill Hill) 0900-0930 CMHA Virtual Tour 1000-1030 Mental Health Act** (Andrew Marlowe & Farnaz Michalski- St. Joes) 1030-1200 Community Treatment Orders and Form 47s** (Joe Skufca & Lisa Dinon)	0800-0830 ADSTV Services** (Pam Hill) 0830-0930 PEPP/Early Signs of Psychosis** (Julie Richards & Adam Gosney) 0930-1000 Connectivity Table** (Christine & Carl) 1000-1045 Homeless Prevention- Coordinated Access** (John & Deb) 1100-1200 Crisis Intake Team- Children and Youth Sector/Vanier**	0800-1200 Emergency Medical Management (Meagan Slack & Miranda Bothwell- MLPS)	HOLIDAY: Good Friday
Lunch 1200-1300				
1300-1330 CMHA Crisis Services (Yvonne Lammers & Lori Hassall) 1330-1430 Violence Threat Risk Assessment (Yvonne Lammers) 1500-1600 Veterans Affairs (PC Reid & Sgt Alexander) 1600-1800 Pending	1300-1430 Psychosocial Rehab Model** (Aleena Needham- CMHA) 1430-1600 Supporting Individuals with Chronic Suicidality: Borderline Personality Approach ** (Nancy Wardrop) 1600-1800 Pending	1300-1430 Behavioural Response Team** (Bonnie Purcell & Mychelle Blackwood- LHSC) 1430-1600 Chatham COAST (Ed & Christine) 1600-1800 Barriers to Care & Social Determinants of Health ** (Brandi Tapp & Sean Warren- London Intercommunity Health)	1300-1330 Safety and Scene Assessments (McGugan & D'Angelo) 1330-1430 Case studies 1430-1530 Lived Experience (Irnes) 1530-1600 Q&A Session	HOLIDAY: Good Friday

**Denotes virtual presentation

Appendix D: CRU's Trauma-Informed Practice Principles and Wellness Worksheets

TRAUMA INFORMED PRACTICE PRINCIPLES

Adapted by the Boston Public Health Commission from the American Psychological Association (2008); National Child Traumatic Stress Network (2012); National Center on Family Homelessness (2012); Hollywood Homeless Youth Partnership (2009) and the Substance Abuse and Mental Health Services Administration (N.D.)

In your group, expand on the answers below and complete the chart:

1. What does this "Principle" mean?   **2. What does this principle look like behaviorally, in action (get specific)?**

3. How are you already doing this?   **4. What more or different could you do?**
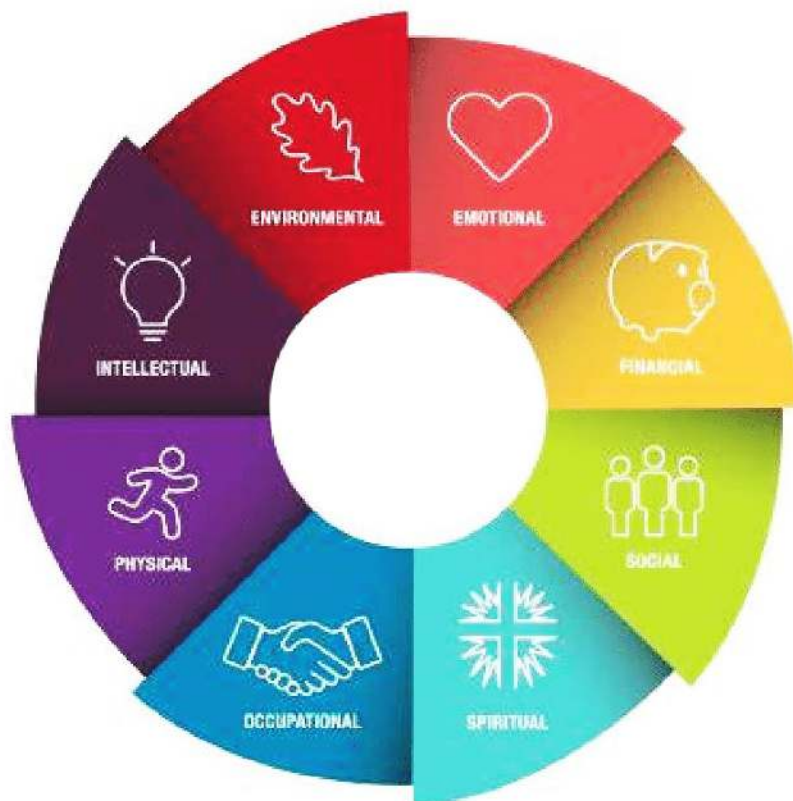
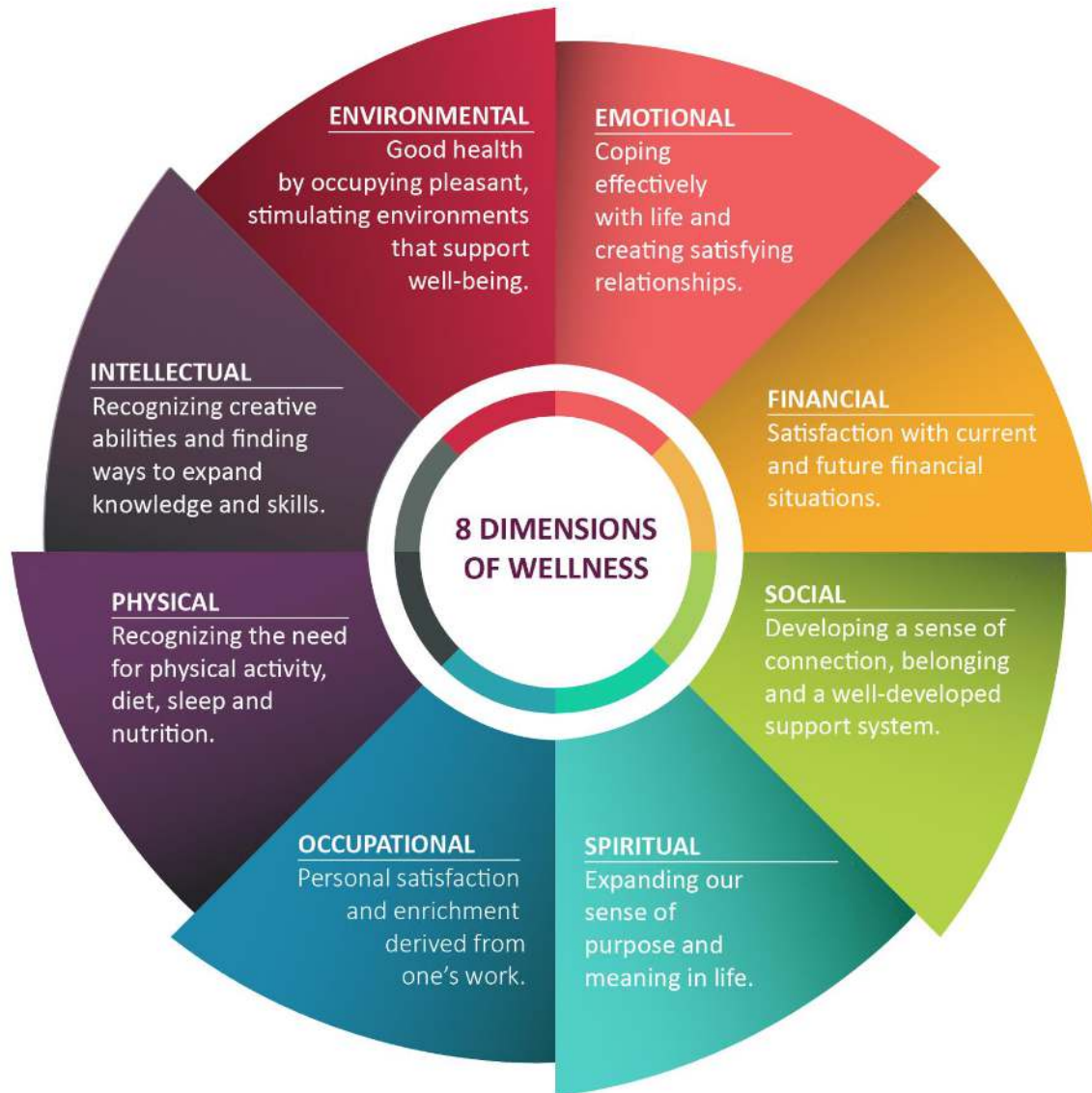| PRINCIPLE	WHY?	WHAT COULD IT LOOK LIKE BEHAVIORALLY, IN ACTION?	WHAT DO YOU ALREADY DO?	WHAT MORE OR DIFFERENT COULD YOU DO?
Positive Relationships	· Staff who have experienced trauma may have difficulty forming healthy relationships · Consistent, supportive relationships can support healing and growth	· Staff are consistent, reliable, empathetic · Take opportunities to recognize everyone's strengths · Build trusting relationships by being in frequent communication		
Understanding Trauma & Its Impact	· Trauma is widespread and can influence our thoughts, feelings, and behaviors · Understanding trauma and how it affects individuals and communities is the first step to putting knowledge into action	· Staff and management attend trainings · Trained staff and management share information on trauma with other staff, management and people they work with · Consider and discuss role of trauma in individual interactions		

Culture of Self-Care	· Working with people who have experienced trauma can cause secondary or vicarious trauma in providers · Working with people who have experienced trauma can remind us of our own trauma · Vicarious trauma harms staff and can limit the effectiveness of programming · A culture of self-care in the work place helps to minimize secondary trauma	· Seek out supervision when possible · Practice mindfulness (checking in with own feelings, deep breathing, taking a break) · Staff have self-care plans that are supported by the culture of the agency		
Promoting Safety	· People who have experienced trauma often have experienced chaos and unpredictability · Staff may expect bad things will happen to them and that others cannot be trusted · Trauma causes the brain to be overly sensitive to signals of danger. Reminders of trauma can trigger automatic "survival brain" reactions · Creating safety—routines, rituals, consistency, predictability, minimizing trauma reminders--allows everyone to relax and shift their energy from survival to healthy learning/development	· Have predictable, structured activities · Have secure entries, exits and restrooms · Staff interactions are consistent, and have clear expectations and boundaries		
Voice & Choice	· Trauma often involves a loss of control and feelings of helplessness · Staff may believe they are powerless or may constantly challenge limits and authority · Creating a space for staff to be heard and have a choice helps them regain a sense of control and to feel empowered	· Create opportunities for feedback and leadership · Provide opportunity for staff to contribute their experience and insights		
Access to Resources	· Staff may have multiple, interrelated needs (physical, emotional, spiritual) that are beyond the resources of one	· Offering a "menu" of options so staff can determine what works best for them		

	supervisor and need to be attended to by community · Staff can work together to suggest options and support ongoing, "wrap-around" services for each other	· Build relationships with service providers and make "warm referrals"		
Cultural Competence & Promotion of Equity	· Healing and healthy development is rooted in cultural identity. It is important to recognize resilience and foster cultural pride and community connectedness · Programs are more effective when staff are knowledgeable about everyone's cultural background (beliefs, history, language, social customs) and their own assumptions/biases	· Promote and hold activities that affirm positive cultural identity · Staff education on each other's cultural backgrounds and culturally-appropriate resources · Supervisor demonstrates cultural humility		

Dimensions of Wellness Assessment

- Rate your assessment of today's level of wellness from 0-5; 0 meaning "none" and five meaning "best it could ever be!"
- Offer one specific example of each type of wellness for YOU

ENVIRONMENTAL
Good health
by occupying pleasant,
stimulating environments
that support
well-being.

EMOTIONAL
Coping
effectively
with life and
creating satisfying
relationships.

INTELLECTUAL
Recognizing creative
abilities and finding
ways to expand
knowledge and skills.

FINANCIAL
Satisfaction with current
and future financial
situations.

**8 DIMENSIONS
OF WELLNESS**

PHYSICAL
Recognizing the need
for physical activity,
diet, sleep and
nutrition.

SOCIAL
Developing a sense of
connection, belonging
and a well-developed
support system.

OCCUPATIONAL
Personal satisfaction
and enrichment
derived from
one's work.

SPIRITUAL
Expanding our
sense of
purpose and
meaning in life.

Appendix E: Ask Suicide-Screening Questions (ASQ) Tool

NIMH TOOLKIT

asQ — Ask Suicide-Screening Questions

Suicide Risk **Screening Tool**

Ask the patient:

1. In the past few weeks, have you wished you were dead? ○ Yes ○ No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ○ Yes ○ No

3. In the past week, have you been having thoughts about killing yourself? ○ Yes ○ No

4. Have you ever tried to kill yourself? ○ Yes ○ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ○ Yes ○ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen*).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen.** Ask question #5 to assess acuity:
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit · NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) · NIH · 7/1/2020

Appendix F: Examples of Peer Support Training Programs

San Francisco RAMS

The RAMS Peer Specialist Mental Health Certificate Program provides extensive peer provider training opportunities and offers three main training opportunities:

1. Peer Counseling Entry Course: a 12 week course (96 hours of classroom instruction and 8 hours of shadow experience) in partnership with San Francisco State University. Curriculum includes topics such as:
   - Motivational Interviewing
   - Crisis prevention, intervention and de-escalation
   - Principles of Wellness & Recovery model
   - Principles of Trauma Informed Care
   - Building Counselor Resilience
   - Case Management & Community Mental Health Work
   - Principles of Harm Reduction and approach to care
   - Cultural Humility and responsiveness
     - Law & Ethics
     - Basics of Peer Counseling

2. Advanced Course: an 8 week advanced peer counseling class that is tailored for folks already doing work in the field as peers. Curriculum is based on deeper dive into some of the topics covered in the entry course as well as topics covering current trends in the field. Competitive entry requirements are required for selection of students into the Entry and Advanced Courses

3. Leadership Academy: a monthly, sign up, large seminar type training (2-3 hours) open to all peer providers in San Francisco for free. Topics are more general and cater to more entry level peers in this field.

Mental Health Commission of Canada

1. Fundamental principles of peer support

   - Lived experience, hope, and recovery
   - Self-determination and how to foster it
   - Peer support values, ethics, and principles of practice
   - Trauma-informed practice
   - Applying peer support principles in diverse environments

2. Historical context of peer support

   - Historical context of peer support
   - Prejudice, discrimination, and stigma

- Diversity and social inclusion
- Social determinants of health

3. Concepts and methods that promote peer-to-peer effectiveness

- Interpersonal communication principles and methods
- Building supportive relationships
- The process of recovery and change
- Building resilience through self-care and wellness plans
- Limits and boundaries
- Crisis situations and strategies
- Connecting with community resources
- Understanding medication use and side effects

Centre for Innovation in Peer Support

The Centre offers a 30-hour training with the following modules:

1. Recovery and Wellness

2. Foundations of Peer Support

3. The Peer Support Role

4. Communication Basics

5. Connecting Through Our Experiences

6. Peer Support Relationships

7. Ethics and Boundaries

8. Trauma-Informed Care Practices

9. Stigma and Discrimination

10. Culture, Diversity, and Worldview

11. Social Determinants of Health and Advocacy

12. Self-Determination and Stages of Change

13. Supporting Someone Experiencing Distress/Crisis

14. Wellness Planning

15. Resilience and Wrap-Up

The Centre also offers a one-day training for organizations seeking to employ peer workers, including modules on:

1. Current Spread and impact of peer work

2. Applying the values and ethics of Peer Support in actions

3. Negotiating the Values of Peer Support in different organizational settings

4. Being a change champion

5. Exploring the ethics and boundaries related to professional peer work

6. Tools and resources for providing Peer Support in organizational settings

Lastly, The Centre also offers a one-day training for supervisors of peer staff, including modules on:

1. The history of peer support

2. The definition of peer support

3. The core values of peer support

4. What peer support workers are trained on

Appendix G: The Centre for Innovation in Peer Support's Communities of Practice

COMMUNITIES of PRACTICE

Provincial Peer Network

The Provincial Peer Network provides ongoing professional development of peer support staff through intentional collaboration and reflexive practice in order to promote peer values in action in all service settings. Rotating schedules allow for focused conversations on the Values in Action, wellness, anti-oppressive practice and more. Membership is open to peer workers employed by an agency in the province of Ontario.

Provincial Peer Supervisor Network

The Provincial Peer Supervisor Network (PPSN) focuses on values-based practices and supporting organizations with the implementation and sustainability of formalized peer positions. Membership open to supervisors, leaders and/or managers in the province of Ontario who support peer positions.