# Toronto Community Crisis Service

## Six-month implementation evaluation report

January 13, 2023

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## Acknowledgments

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# Executive summary

The Toronto Community Crisis Service aims to provide a Toronto-wide, non-police-led, alternative crisis response service. Launched on March 31st, 2022 through partnerships between the City of Toronto, Toronto Police Service, Findhelp 211, and four community-based anchor partners – Gerstein Crisis Centre, TAIBU Community Health Centre, Canadian Mental Health Association – Toronto, and 2-Spirited People of the 1st Nation – this service model is the first of its kind in Canada. Third party Evaluators from the Provincial System Support Program and Shkaabe Makwa at the Centre for Addiction and Mental Health were retained to evaluate key implementation and service delivery processes and outcomes associated with the Toronto Community Crisis Service. From June 2021 to March 2022, evaluators engaged all project partners in the collaborative design of an evaluation framework that was grounded in the needs of the local context and communities of interest. The framework design focuses on yielding useful and relevant data; is responsive to changing needs and priorities over the course of implementation; and incorporates Indigenous-led evaluation principles throughout.

The current report reflects the findings of a six-month implementation evaluation, which details Toronto Community Crisis Service partner and staff perspectives and experiences regarding implementation of the program from March 31st, 2022 to September 30th, 2022.

**This implementation evaluation was guided by five key evaluation questions:**

1. **To what extent were non-emergency 911 mental health and crisis-related calls diverted to the Toronto Community Crisis Service?**
2. **To what extent were service user connections made to appropriate community-based follow-up supports through the Toronto Community Crisis Service?**
3. **How was the Toronto Community Crisis Service implemented?**
4. **How feasible was it to implement and deliver the Toronto Community Crisis Service?**
5. **How suitable is the Toronto Community Crisis Service for the system and setting in which it is operating?**

To answer these questions, a variety of primary and secondary mixed method data was collected from a range of sources including monthly administrative data, mixed method surveys, interviews and focus groups, and an implementation tracker. All Toronto Community Crisis Service partners participated across a range of leadership levels and staff positions. Mixed method data was iteratively integrated to generate a robust and nuanced analysis and narrative of the implementation of the Toronto Community Crisis Service to date.

The resulting large mixed-methods dataset reflecting a breadth of operational activities and diverse partner perspectives collectively suggests that ***overall, the Toronto Community Crisis Service has been successfully implemented to date.*** Alongside successes, this report details a diverse array of implementation challenges faced by partners, in hopes of informing opportunities for learning and quality improvement. Overall, the data reveals a dedicated and forward-thinking collaborative of partners working together toward implementing a highly complex intervention in a complex context, with data further demonstrating positive results to date. Key findings are presented below.

# Executive summary: Key findings

- Preliminary program data provided by the City of Toronto indicate the Toronto Community Crisis Service has met one of its primary objectives by successfully diverting 78% of calls received from 911. From March 31st, 2022 to September 30th, 2022, the Toronto Community Crisis Service received 2,489 unique calls, including 1,530 from 911. Of these, 1,198 mobile crisis team dispatches were successfully completed. Emergency services were requested by mobile crisis teams in 4% of events responded to.
- Toronto Community Crisis Service mobile crisis teams provided a wide range of on-site supports including risk assessments, direct crisis care, facilitating access to information and resources, safety planning, and meeting basic needs.
- Mobile crisis teams made over 700 referrals to community-based follow-up supports and enrolled over a quarter of service users (28%) in post-crisis case management.
- The cultural supports most commonly referred to included those for Africentric and West Indian/ Caribbean-centric supports and Indigenous-specific supports, which reflects and aligns with the previously identified underserved communities of interest.
- System-level capacity gaps in key support services such as housing, shelter and safe beds, and specific service subtypes like harm reduction and Indigenous-specific services have impeded mobile crisis teams' ability to successfully connect service users to needed follow-up supports.
- Toronto Community Crisis Service partners and staff showed a high level of individual and partner buy-in and willingness to collaborate, engagement in strong partnerships, and a collective commitment to continuous quality improvement.
- The Toronto Community Crisis Service core training curriculum emerged as a key implementation facilitator but one that was not equitably or sustainably implemented across partners. Expanding access across partners and revising core training content and processes that prioritize interpersonal interaction across intervention partners will support role clarity, trust, efficiency and effectiveness in service delivery, as well as reduce discrepancies in partner capacity and readiness.
- Adequate staff capacity and access to appropriate staff training and mental health supports are essential to promote workforce effectiveness and burnout prevention. Ensuring Toronto Community Crisis Service staff in all positions across partners have awareness of and access to ongoing training resources and workplace mental health supports will enable staff to successfully enact their respective roles for this intervention.
- Process improvements are required to increase role clarity, trust, efficiency and effectiveness in service delivery, particularly with regard to how Toronto Community Crisis Service staff and other first responders on site (police, fire and paramedic services) interact and work together with each other and with service users to meet service user needs.
- Existing technology and data system infrastructure is inadequate for the needs of the Toronto Community Crisis Service. Barriers include incompatible systems, duplicative processes, and differences in organizational capacity to meet data collection and reporting requirements. This context has increased the burden of data collection and reporting, impeding partners' overall capacity to participate in monitoring and evaluation; and negatively impacted the quality of resulting data. Quality improvement processes to improve the overall efficiency and quality of data collection and reporting have been identified and many are underway to mitigate challenges identified in this report.
- Race and disability data was missing at a rate of 96%. This critical data gap precludes determination of whether the Toronto Community Crisis Service is reaching its intended communities. Additional time and resources dedicated specifically toward quality improvement of sociodemographic data is essential to allow for evaluation of health equity and appropriateness across the intervention.
- Public awareness of the Toronto Community Crisis Service and community engagement activities have been limited to date; staff across partners report significant time spent explaining the intervention to service users in order to receive their consent. This, in turn, has increased burden on staff and created capacity pressures, particularly for 911 and Findhelp 211. While increased awareness is needed to reduce time spent by staff explaining the Toronto Community Crisis Service, increased awareness is also expected to yield an overall uptick in calls and sufficient staff capacity to manage this projected increase over time will be essential to sustainability.

# Executive summary: Recommendations

In considering the primary and program data, and the varied implementation experiences and outcomes described across Toronto Community Crisis Service partners and staff, PSSP and Shkaabe Makwa evaluators developed a series of recommendations critical to continued successful implementation and future sustainability and scaling potential of the intervention. The recommendations listed here include a series of sub-recommendations or specific actions, which are detailed in the report body. In addition, recommendations are subject to the design and data limitations noted at the end of this report.

1. **Commit more time and space to partnership and engagement activities within the intervention.**
2. **Streamline communication and transition protocols between partners, particularly other first responders.**
3. **Increase support for data system implementation and quality improvement in data collection and reporting.**
4. **Dedicate time and resourcing toward strengthening sociodemographic data collection processes.**
5. **Implement a co-designed, centralized and sustained ongoing training curriculum.**
6. **Build organizational capacity in Indigenous cultural safety amongst all partners to support recruitment and retention of Indigenous staff.**
7. **Design and implement a deliberate and robust community awareness and engagement campaign that targets strategies to community needs.**

Given the developmental and utilization-focused approach to the evaluation of the Toronto Community Crisis Service, immediate next steps include revising the intervention's evaluation framework to improve the quality and feasibility of existing indicators and data collection processes based on the results of the current report. Following this report, PSSP and Shkaabe Makwa look forward to leading the Toronto Community Crisis Service project partners through the co-design and implementation of a revised framework to reflect the outcomes and impacts of this intervention on the health, safety and wellbeing of service users and their communities, the service providers who serve them, and the health, social and justice systems in which they are embedded. These outcomes will be reported in a follow-up evaluation report in 2023.

# Background & context

In the City of Toronto, a growing demand for mental health and substance use services and a lack of community-based service capacity has led to an overwhelming reliance on acute care institutions, including 911, Toronto Police Service, and hospital emergency departments (1,2). In 2021, Toronto Police Service responded to 35,367 "Person in Crisis" calls made to 911 (3). Concurrently, emergency department visits for mental health and substance use-related needs have grown significantly across both the City of Toronto and province of Ontario as a whole in recent years (4, 5). Increasing access to appropriate, community-based mental health and substance use services is essential; evidence consistently indicates that by ensuring service users receive the right care, by the right service providers, in the right place, at the right time, will alleviate system pressures and improve service user experiences (2).

For the general population, calling 911 for crises or emergencies is considered to be the status quo; thus, a police-led response to mental health and substance use-related calls has remained the default service offering (1,2). From 2017 to 2021, mental health and substance use-related calls for service attended by police have increased by 23% in the City of Toronto (3). As such, there are more in-person interactions between police and individuals with mental health and substance use needs. However, evidence has consistently revealed that there is a lack of preparedness among police in appropriately responding to in-person mental health and substance use events and crises (1).

Maintenance of this status quo and continued endorsement of a police-led response to mental health and substance use events and crises has led to rising concerns related to quality of care, inequity, and distrust, particularly among Indigenous and other equity-deserving groups such as Black and 2-Spirited-LGBTQIA+ communities (2,7). Instead, there is growing evidence that non-police-led, community-based, mental health and substance use crisis response alternatives are needed (2). Community-based service models are associated with improved service user experiences and more positive service use outcomes, such as decreased injury rates, perceived stigmatization, emergency department visit rates, as well as increased referral rates to follow-up supports (2).

Following an extensive and evidence-informed community consultation process conducted in the fall of 2020. In February 2021, the City of Toronto approved the implementation and piloting of the Toronto Community Crisis Service: a non-police-led, community-based mental health and substance use crisis response service (7). Four geographical pilot regions were determined by analyzing Toronto Police Service crisis call volumes, as well as current mental health and supportive services needs and gaps across the City. The current report reflects the findings of an interim, six-month implementation evaluation conducted by third-party Evaluators from the Provincial System Support Program (PSSP) and Shkaabe Makwa at the Centre for Addiction and Mental Health (CAMH), who were retained by the City of Toronto to support and evaluate the program's implementation and impact.

# Background & context

## Intervention description

The Toronto Community Crisis Service (TCCS) received its first call on March 31st, 2022, with staggered launch dates across four geographical pilot regions across the City of Toronto: Downtown East, Downtown West, Northeast and Northwest (**Figure 1**).

The TCCS aims to provide an alternative to traditional, police-led models by responding to mental health and substance use-related calls through a non-police-led, community-based crisis response service. The TCCS is grounded in several guiding principles:

1. Enable multiple coordinated pathways for service-users to access crisis and support services
2. Ensure harm-reduction principles and a trauma-informed approach are incorporated in all aspects of crisis response
3. Ensure a transparent and consent-based service
4. Ground the service in the needs of the service-user, while providing adaptive and culturally relevant individual support needs;
5. Establish clear pathways for complaints, issues and data transparency

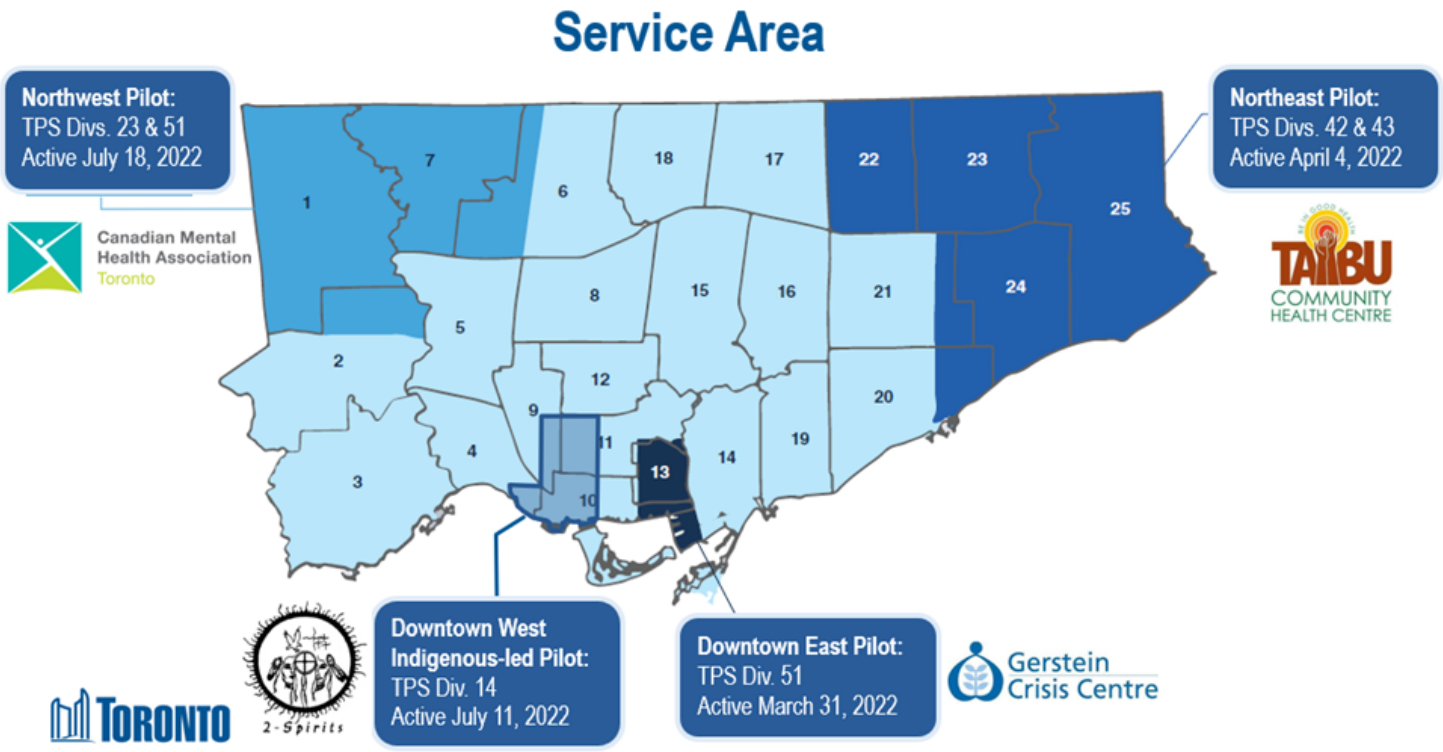


**Figure 1.** Toronto Community Crisis Service pilot regions

# Background & context

## Partnerships involved

In practice, the TCCS is characterized by collaborative partnerships between the City of Toronto, Toronto Police Service (TPS), Findhelp 211 (211), and lead community-based health organizations anchored within each geographical site ("anchor partners"), who have come together to establish a non-police-led, community-based service pathway for mental health and substance use-related emergency service calls received by 911, 211, or directly by anchor partners. The four community anchor partners currently participating in the TCCS include the Canadian Mental Health Association – Toronto (CMHA-TO), Gerstein Crisis Centre (Gerstein), TAIBU Community Health Centre (TAIBU), and 2-Spirited People of the 1st Nations (2-Spirits), which is leading an Indigenous-led pilot. Participating anchor partners and their community service network are summarized in **Table 1a**, along with their overlapping police divisions and launch dates. Additionally, **Table 1b** illustrates the hours of operation of each anchor partner, which has been modified over the course of implementation.

**Table 1a.** Anchor partners participating in TCCS

| Pilot region | Police division | Community anchor partner | Launch date | Community service network |
|---|---|---|---|---|
| Downtown East | 51 | Gerstein Crisis Centre (Gerstein) | March 31st, 2022 | Strides Toronto, Toronto North Support Services, Unity Health Toronto, WoodGreen Community Services, Health Access St.James Town, Inner City Health Associates, Regent Park Community Health Centre, Family Services Toronto |
| Northeast | 42 & 43 | TAIBU Community Health Centre (TAIBU) | April 4th, 2022 | Scarborough Health Network, Canadian Mental Health Association - Toronto, Centre for Addiction and Mental Health, Scarborough Centre for Healthier Communities, Hong Fook Mental Health Association, Black Health Alliance, Strides Toronto |
| Downtown West | 14 | 2-Spirited People of the 1st Nations (2-Spirits) | July 11th, 2022 | ENAGB Indigenous Youth Agency and Niiwin Wendaanimak / Four Winds Indigenous Health and Wellness Program, based out of Parkdale Queen West Community Health Centre |
| Northwest | 23 & 31 | Canadian Mental Health Association–Toronto (CMHA-TO) | July 18th, 2022 | Addiction Services of Central Ontario, Black Creek Community Health Centre, Black Health Alliance, Caribbean African Canadian Social Services, Jane and Finch Community and Family Centre, Rexdale Community Health Centre and Yorktown Family Services |

**Table 1b.** Hours of operation of anchor partners

| Pilot region | Police division | Community anchor partner | Hours of operation |
|---|---|---|---|
| Downtown East | 51 | Gerstein Crisis Centre (Gerstein) | March 31st - July 8th, 2022 for 24 hrs every day EXCEPT for Sat 7am until Sun 7am<br>July 9th - September 9th, 2022 for 24 hrs every day EXCEPT for Saturdays 7pm until Sun 7am<br>September 10th - September 30th, 2022 for 24 hrs every day |
| Northeast | 42 & 43 | TAIBU Community Health Centre (TAIBU) | April 3rd - July 8th 2022 for 24 hrs every day EXCEPT for Sat 7am until Sun 7am<br>July 9th - September 9th 2022 for 24 hrs every day EXCEPT for Saturdays 7pm until Sun 7am<br>September 10th - September 30th, 2022 for 24 hrs every day |
| Downtown West | 14 | 2-Spirited People of the 1st Nations (2-Spirits) | July 11th - September 30th, 2022 for 24 hrs every day<br>July 18th - September 30th, 2022 for 24 hrs every day EXCEPT for Saturdays 7am until Sun 7am |
| Northwest | 23 & 31 | Canadian Mental Health Association – Toronto (CMHA-TO) | July 18th - September 30th, 2022 for 24 hrs every day EXCEPT for Saturdays 7am until Sun 7am |

# Background & context

## Call pathway

There are three primary sources from which a call can enter the TCCS. The primary intake source at this time is via 911; secondary intake is via 211 and tertiary intake directly through a community anchor partner (i.e., "in the community"). When 911 serves as the entry source, calls are received by 911 Call Operators and are assessed for TCCS eligibility. If the call fits the TCCS' criteria and the caller consents to being transferred to the TCCS, calls are then transferred to 211. From there, 211 Service Navigators conduct a secondary safety assessment; depending on the nature of the call, the call is then routed to one of three general pathways:

1. Mobile Crisis Team: There is an identified and urgent need for mobile crisis teams to be dispatched and respond to a person in crisis on site.
2. Information and Referral (I&R): Caller needs can be met by 211's in-house information and referral services; mobile crisis team dispatch is not required.
3. Emergency: There is an identified need for emergency services (e.g., police, fire, paramedic) to be involved due to there being an imminent safety risk; the call is then transferred back to 911.[1]

When 211 serves as the entry source, the steps outlined above are also followed; the only difference with this entry source is the TCCS call pathway "starts" with 211. Individuals are calling 211 directly, with no initial involvement with 911. The third entry source is from the community directly to a community anchor partner. Occasionally, a dispatch is generated from either a call made to an anchor partner's direct referral line (only Gerstein is operating a direct line at this time), a call made during an outreach in the community, or a call transferred from a separate alternative response pilot led by TPS and Gerstein that is operating concurrently with the TCCS. **Figure 2** illustrates a simplified overview of the TCCS call pathway.

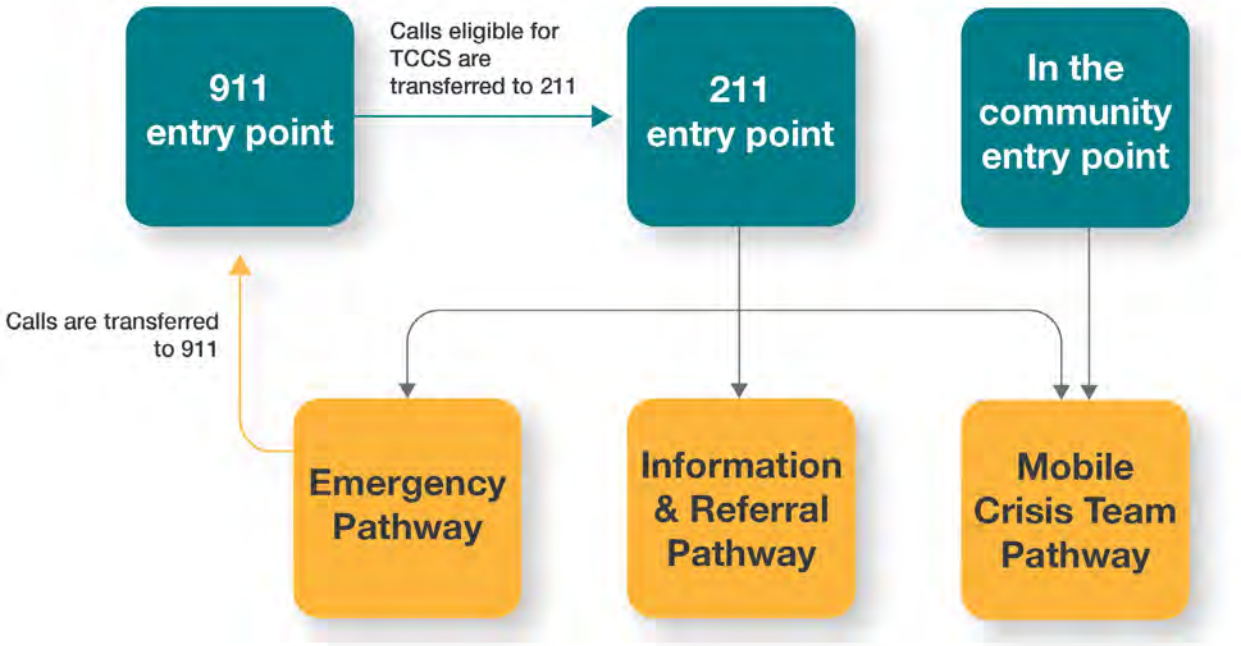


**Figure 2.** Overview of the TCCS call pathway

[1] There are other, lesser common reasons that may require a call to be routed into the emergency pathway. For example, a mobile crisis team is not available or a call outside of the pilot regions was sent in error.

# Background & context

## Eligibility criteria

Calls are considered in scope for TCCS if they are located within one of the four geographical pilot regions and fall into one of six eligible TCCS call categories (i.e., event types): *Thoughts of Suicide/Self-Harm, Person in Crisis, Wellbeing Check, Distressing/Disorderly Behaviour, Dispute, and Advised*. A seventh event type, *Unknown*, is used by 211 in cases where calls generally fit the eligibility criteria for TCCS but do not quite fit the exact definition of any of the other six event types; it can also be used in cases where a call ended prematurely. Calls are in scope only when there is no safety risk or violence identified. Individuals who are offered TCCS services must be 16 years of age or older and must consent to receiving the service. Eligibility criteria, as well as the definitions of event types, can be found in **Appendix A**.

## Infrastructure and resourcing

The TCCS' mobile crisis teams are independently operated by each anchor partner, with each multidisciplinary team specifically recruited and trained to respond to the unique characteristics and needs of their sites. Staffing complements include trained crisis workers, harm reduction workers, and peer support staff. The mobile crisis teams meet with consenting service users on site to assess and respond to crisis needs, providing a range of direct, person-centred, culturally relevant supports and services. In addition to providing immediate and direct crisis care, mobile crisis teams connect consenting service users to case managers or similar follow-up supports, who work with service users to further assess their needs, develop a care plan, and facilitate access to appropriate community-based follow-up supports. To bolster this process, each anchor partner has established community service networks of partnering organizations within their geographical boundaries.

Key infrastructure supporting the TCCS includes administrative support and leadership from the City of Toronto as well as dedicated leaders and human resources within TCCS partners. Dedicated data systems (e.g., administrative records and client management software) and technology (e.g., two-way radios) support data capacity and information sharing, which aids in care coordination in the TCCS service pathway in addition to informing quality improvement efforts. Education and outreach are embedded to assist with community engagement and awareness of this intervention. Finally, a robust community-based oversight and accountability structure, which includes advisory bodies for each partner and the intervention as a whole, supports adherence to the TCCS's guiding principles and values. Similarly, embedded third-party monitoring and evaluation aims to support evidence-based decision-making, quality of care, and accountability throughout implementation.

## Intervention overarching theory

The intervention overarching theory was co-designed with TCCS partners and describes how the TCCS is expected to achieve its goals. The TCCS theory of change posits that if calls from multiple coordinated access points can be successfully diverted to a community-based crisis response that is harm reduction- and trauma-informed, consent-based, culturally safe and person-centred, then service users will experience safety in their service interaction, crisis stabilization, and connection to follow-up supports. Over time, increased diversion of calls from institutions (e.g., 911, police, hospitals) to appropriate community-based care, would result in positive system-level outcomes, with long-term impacts on community trust, safety, health, and well-being. The TCCS theory of change is further articulated and depicted visually in **Appendix B**.

Two critical assumptions underlie this theory, which are essential for TCCS' successful implementation. The first is all TCCS partners have a baseline level of organizational readiness to change; a willingness to respond to emerging community needs will be essential for nurturing a trusting and successful partnership among involved service users and providers. The second key assumption is the community-based follow-up supports in which the TCCS aims to refer service users, actually have the capacity and availability to accommodate and meet the needs of new service users in a timely manner.

# Background & context

## Indigenous-led partner evaluation framework

In addition to the overarching Theory of Change, an Indigenous-specific evaluation framework was co-created by 2-Spirits program staff, partners, and 2-Spirits Advisory Group members, and is an example of a community-driven theory of change grounded in local context and Indigenous Worldviews. The 2-Spirits evaluation framework is directly aligned with both the overarching Theory of Change (and its assumptions), and the 2-Spirits program model. The 2-Spirits program model was co-created by 2-Spirits staff and partners, as well as members of the community and the 2-Spirits Advisory Group prior to the program implementation. The rationale for creating a different visual to depict the program theory from Indigenous perspectives was for 2-Spirits and its community to utilize language that was appropriate to their context, and to also acknowledge principles and values that guide the 2-Spirits TCCS program. Moreover, 2-Spirits staff and partners designed a framework image that is relational and accessible to their community as it is grounded in traditional teachings. Please refer to the 2-Spirits evaluation framework visual in **Appendix C**.

# Evaluation overview

## Goal of evaluation

As noted above, third party monitoring and evaluation is embedded in the Toronto Community Crisis Service (TCCS) to support implementation, operations, and sustainability. The TCCS evaluation was designed to evaluate the implementation of the TCCS itself as well as its outcomes over a 12-month period. More specifically, the TCCS evaluation has several aims:

- Demonstrate strengths and weaknesses of the model
- Document and articulate key processes and outcomes associated with implementation
- Explore service user, service provider, system and community experiences and outcomes
- Identify opportunities for iterative quality improvement
- Identify facilitators and barriers to implementation and sustainability

This interim report presents the preliminary results of a six-month implementation evaluation (March 31st, 2022 to September 30th, 2022). A final outcome evaluation report, 12 months post-implementation, will follow in 2023.

Development of the key domains for the implementation evaluation were guided by an evidence-based framework commonly employed in health services implementation research (8); the domains were adapted based on TCCS' context, priorities, and stakeholder feedback gathered to date. Operationalization of these domains was guided by the TCCS Theory of Change (**Appendix B**). These domains include the following:

- ***system integration***, or the extent to which TCCS has successfully engaged with existing institutions and systems of care;
- ***adoption***, or the extent and nature of initial uptake and utilization of TCCS across settings and stakeholders;
- ***appropriateness***, which speaks to the fit and relevance of TCCS for the City of Toronto in its current context; and,
- ***feasibility***, which reflects the extent to which TCCS is useful and can practically, be carried out as intended.

## Evaluation questions

The key evaluation questions specifically explored in this six-month implementation evaluation report are summarized below (**Table 2**). Each guiding question includes a series of sub-evaluation questions further guiding inquiry into each domain. Evaluation questions, sub-evaluation questions, and corresponding measurement details are further articulated in the TCCS Evaluation Matrix (**Appendix D**).

**Table 2.** Key implementation evaluation questions

| **Evaluation question** | **Implementation domain** |
|---|---|
| **1. To what extent were non-emergency 911 mental health and crisis-related calls diverted to the Toronto Community Crisis Service?** Example sub-questions: What were the call characteristics and volumes at each point of the service pathway? | System integration |
| **2. To what extent were service user connections made to appropriate community-based follow-up supports through the Toronto Community Crisis Service?** Example sub-questions: What proportion of calls resulted in a follow-up call? What proportion of calls resulted in a community-based service referral? | System integration |
| **3. How was the Toronto Community Crisis Service implemented?** Example sub-questions: How were partnerships and collaborations formed and leveraged? How were service providers trained? | Adoption |
| **4. How feasible was it to implement and deliver the Toronto Community Crisis Service?** Example sub-questions: What factors impeded or facilitated implementation? | Feasibility |
| **5. How suitable is the Toronto Community Crisis Service for the system and setting in which it is operating?** Example sub-questions: What is working well in service delivery, and not working well? What unintended consequences or opportunities emerged as a result of implementation? | Appropriateness |

# Evaluation design & methodology

## Co-design and collaboration

The Toronto Community Crisis Service (TCCS) evaluation was co-designed to be evidence-based, useful, feasible, participatory, and meaningfully inclusive and reflective of local community values and perspectives. Evaluation planning was facilitated by PSSP and Shkaabe Makwa evaluators and took place over an extended consultation and iterative co-design phase with project partners from June 2021 to March 2022. The preliminary evaluation matrix was first finalized shortly ahead of TCCS's launch on March 31st, 2022. To ensure the evaluation design was relevant and appropriate for all partners, Evaluators engaged in and facilitated ongoing individual and collective consensus-based discussions leading up to, and throughout the TCCS' implementation. Feedback loops via regular check-ins with individual partners and quarterly all-partner collaborative working meetings were used throughout the implementation process to endorse evaluation responsiveness to emerging needs and issues.

A series of guiding principles have supported the operationalization of this evaluation design. These were co-determined by the City of Toronto and TCCS partners in response to the community consultation conducted prior to implementation:

- Foster transparent and data-driven processes
- Incorporate culturally safe and culturally relevant methods
- Account for and engage diverse stakeholder perspectives including communities with lived and living experience
- Apply flexible and adaptable approaches to data monitoring
- Consider practicality and efficiency
- Foster reciprocity by sharing evaluation information with stakeholders
- Inform decision-making for ongoing programming

## Theoretical frameworks

The TCCS evaluation guiding principles were informed by several theoretical evaluation frameworks that have been adapted for use in the context of the TCCS. Because the TCCS is a unique model, implemented in a complex setting, the evaluation first draws on the practices of *Realist Evaluation* (9), which prioritizes the understanding of how program mechanisms interact with implementation contexts to produce the expected outcomes. Second, because the TCCS is a pilot project operating in a complex and dynamic environment subject to a wide range of internal and external influences, this evaluation takes a *Developmental Evaluation* approach, which anticipates the need to adapt and respond to expected and unexpected changes that occur during the course of implementation (10). Third, a *Utilization-Focused Evaluation* lens was used to define the scope of the evaluation according to the likelihood of utilizing the resulting data and evaluation processes by the TCCS partners and immediate stakeholders (11). Lastly, *Indigenous-Led Evaluation* principles are incorporated throughout the TCCS evaluation to meaningfully address the unique priorities, needs, and contributions of Indigenous communities and partners (12).

The role of an Indigenous lens in this process is to centre Indigenous ways of knowing in the design and implementation of the evaluation. The Indigenous-led evaluation approach includes weaving the 2-Spirits program model values, which refer to the Seven Grandfather teachings of ***Love, Respect, Bravery, Truth, Honesty, Humility & Wisdom*** into the evaluation process from the very beginning. These values supported the implementation of a community-driven approach that is practical, relevant, and reflective of the 2-Spirits community and their voices, as well as the fostering of meaningful relationships and connections.

These four frameworks share a collective focus on stakeholder participation and co-design, context-specificity, flexibility, usefulness, cultural safety, and use of mixed methods. Together, the frameworks have informed the overall design of the TCCS evaluation. As a result, the TCCS evaluation is a participatory, interactive mixed methods evaluation that includes both quantitative and qualitative data collected by different methods from a wide range of sources and stakeholders. Measures and data sources included in the current implementation evaluation are summarized in the following section.

# Evaluation design & methodology

## Data sources and collection

As noted above, a variety of primary and secondary mixed method data sources were included to ascertain that a robust and diverse perspective was included. For the purposes of this implementation evaluation, the primary quantitative data source includes secondary administrative records from the data systems of all partners participating in the delivery of the TCCS. Primary mixed methods surveys related to implementation experience and training, were administered in some stakeholder groups, yielding both quantitative and qualitative data. Finally, two validated quantitative survey tools measuring collaboration (Wilder Collaboration Factors Inventory (13)) and readiness to change (Organizational Readiness for Implementing Change (ORIC) (14)) were administered; baseline data from these tools is reported in the current report with the a follow-up analysis of change over time (six months), which will be analyzed and reported in the final outcome evaluation report.

To further complement and add nuance to the quantitative data, an implementation tracker was completed and submitted on a monthly basis by all TCCS partners and the City of Toronto. This tool was used to qualitatively document key implementation activities, facilitators and barriers from pre-launch or launch to the time of implementation evaluation. Lastly, qualitative semi-structured interviews and focus groups were conducted to explore stakeholder experiences related to the core components of implementation, including partnership development, training, data systems, unintended consequences and perceived implementation facilitators and barriers.

Data collection took place over six months throughout the course of implementation, from March 31st, 2022 to September 30th, 2022. Data sources, frequency and timing of data collection is summarized in **Table 3** below.

**Table 3.** Data types, sources, and collection timelines

| Data type | Data source | Description of data | Examples of data measures | Collected from | Frequency of data collection |
|---|---|---|---|---|---|
| Quantitative | Administrative records | Secondary administrative and chart data generated through routine administration of the service that is abstracted monthly from existing data systems | Call volumes, wait times, demographics | All TCCS partners | Monthly |
| | Organizational Readiness for Implementing Change (ORIC) tool (13) | Primary data generated through a 12-item tool that assesses determinants and consequences of readiness to change; collected at baseline and six months. | Commitment to change, confidence in implementation | All TCCS partners | Baseline (August-September 2022) and six months later |
| | Wilder Collaboration Factors Inventory (Wilder) (12) | Primary data generated through a 44-item tool that reflects experiences of 22 success factors for collaboration; collected at baseline and six months. | Mutual respect, favourable political and social climate | All TCCS partners | Baseline (August-September 2022) and six months later |
| Qualitative | Implementation tracker | Primary data reflecting longitudinal implementation experiences generated through monthly tracking | Implementation facilitators and barriers, risks and issues | All TCCS partners | Monthly |
| | Focus groups and/or individual interviews | Primary data generated from cross-sectional semi-structured conversations | Partnership formation, unintended consequences, service delivery facilitators and barriers | All TCCS partners | Cross-sectional; August-September 2022 |
| | Reflexive Circle and Art-based activity | Primary data generated from an Indigenous-led Reflexive Circle and the Anishnaabe Symbol-Based Reflection (art-based activity) | Partnership formation, unintended consequences, service delivery facilitators and barriers | 2-Spirits | Cross-sectional; August-September 2022 |
| Mixed Method | Service provider survey | Primary data reflecting implementation experience generated through cross-sectional, closed-ended survey items | Partnership formation, unintended consequences, service delivery facilitators and barriers | All TCCS partners | Cross-sectional;August-September 2022 |
| | TCCS Training survey | Primary data reflecting TCCS staff experience and outcomes of the TCCS training curriculum generated through closed- and open-ended survey items administered at two time points (pre- and post-training) for two staff cohorts | Change in confidence in skills and knowledge, satisfaction, demographics | Community anchor partners | Pre-post each of two training cohorts; February-March and May-June 2022 |

# Evaluation design & methodology

## Participants and recruitment

A range of stakeholder groups are represented in the TCCS evaluation. For the purposes of this report and its focus on implementation, primary participant groups included service providers, management and leadership from across TCCS partners including the City of Toronto, TPS, 211, and the four community anchor partners: Gerstein, 2-Spirits, TAIBU and, CMHA-TO. In addition, three service user testimonials were gathered ad-hoc and are included for interest and in anticipation of the outcome evaluation report to follow.

Participants were recruited using purposive, convenience and snowball sampling methods. A total of 20 focus groups, 14 individual semi-structured interviews and one Reflexive Circle in combination with the Anishnaabe Symbol-Based Reflection (15) (art-based activity) were conducted with a total of 71 individuals from across partners and staff levels. Participants were asked to reflect on their overall implementation experience and narrative. Interviews, focus groups and the Reflexive Circle were audio-recorded and transcribed verbatim. Another 43 individuals completed the mixed method service provider survey on the same broad topic. It is important to note that this sample is not equally representative of all participating partners or all staffing levels within a particular organization; participants were recruited from across partners based on availability and capacity to participate at a cross-sectional point in time; staff roles, organization size, stage of implementation, and data being collected in the summer months all influenced recruitment. Participants and sample sizes for each group are summarized in **Table 4** below.

**Table 4.** Participant groups and sample sizes participating in cross-sectional interviews, focus groups and survey

| Participants | Partner | Participant level | Sample size (N) | |
|---|---|---|---|---|
| | | | Focus group or interview | Service provider survey |
| **Funder/ Administrator** | City of Toronto | Senior leadership | n/a[a] | n/a |
| | | Project management | 5 | |
| **TCCS partners** | Toronto Police Services | Senior leadership | n/a | 23 |
| | | Project management | 6 | |
| | | Staff supervisors | 3 | |
| | | Direct care provider: *Police Officers* | 6 | |
| | | Direct care provider: *Mobile Crisis Intervention Team* | 2 | |
| | | Direct care provider: *911 Call Operators* | 6 | |
| | Findhelp 211 | Senior leadership | 3 | 8 |
| | | Project management | 2 | |
| | | Staff supervisors | 3 | |
| | | Direct care provider: *Service navigators* | 11 | |
| | Gerstein<br>2 Spirits<br>TAIBU<br>CMHA-TO | Senior leadership | 1 | 17 |
| | | Project management | 8 | |
| | | Direct care provider: *Crisis team staff* | 11[b] | |
| | | Direct care provider: *Case managers* | 6 | |
| **Service users** | First-person service users (people in crisis) | | 3[c] | n/a |
| | Third-party service users | | n/a | n/a |
| **Community** | | | n/a | n/a |
| **Total number of unique participants** | | | 71 | 43 |

[a] n/a refers to participant groups not included in the current report
[b] Includes reflexive circle participants
[c] n=3 service user testimonials were collected

# Evaluation design & methodology

In addition to the cross-sectional interviews, focus groups and/or the mixed method survey, 56 community anchor partner staff completed the pre-post TCCS training survey. The Implementation Tracker, Wilder and ORIC tools were collectively completed by each partner; and again, baseline data from the Wilder and ORIC are referred to descriptively only in the current report pending pre-post results. Finally, community anchor partner staff approached a convenience sample of service users to provide verbal testimonials during follow-up using several pre-determined prompts, which were transcribed and are reported verbatim (n=3).

## Informed consent

All individuals provided informed consent to participate in this evaluation. Each participant in either the interviews, focus groups or the Reflexive Circle received an information package detailing the evaluation as well as the data collection process, purposes, and risks and benefits for participants; Evaluators reviewed this information with each individual and collected verbal consent prior to commencing the interview or focus group and audio-recording the session. To ensure that both the participating individual and the space of connection were safe, inclusive, and respectful, an ongoing consent process occurred. In order to achieve this space, the Evaluators created continuous opportunities for checking-in, moments of reflection, and a conversational approach to connecting. These approaches created reciprocal dialogue and increased levels of comfort and relationality amongst all participating individuals.

Survey participants received an online link to an anonymous SurveyMonkey survey, which required individuals to review the same information package before allowing them access to the survey; by completing and submitting the survey, individuals were aware that this implied their consent to participate in the evaluation.

## Analysis

To support integration of findings, a range of analytical techniques were used. Quantitative data was cleaned and imported for analysis using primarily descriptive statistics, such as frequencies and proportions; where longitudinal data was available and sample sizes permitted, non-parametric inferential tests of difference between groups or time points were employed. Quantitative data analysis was conducted via Microsoft Excel and IBM SPSS.

Qualitative data was primarily analyzed using inductive thematic analysis (16), a process in which data are iteratively and hierarchically organized into key themes within and across groups. Grounded Theory (17) was also used, which allows for unanticipated themes to organically emerge from the data, which is relevant given the complex and fluid nature of this intervention. Qualitative data were coded by a team of four PSSP & Shkaabe Makwa Evaluators; all qualitative data was coded by a minimum of two Evaluators who reached consensus with each other prior to reviewing higher-order themes and reaching consensus across all four Evaluators. Qualitative data analysis was conducted via Microsoft Excel and NVivo.

# Results: Evaluation Question 1

The results of this evaluation are reported and organized sequentially according to the key evaluation questions detailed in **Table 2**. Results for the third and fourth evaluation questions are reported together as one fulsome section to support flow, in response to the interwoven themes that emerged from the data. Reporting of results was based on the collective analysis and interpretation of the range of primary and secondary mixed method data collected.

## Evaluation Question 1: To what extent were non-emergency 911 mental health and crisis-related calls diverted to the Toronto Community Crisis Service?

This evaluation question speaks to the overall call intake, triage and diversion process of the Toronto Community Crisis Service (TCCS). Data in response to this question primarily include administrative records from 911 and 211 data systems. In this section, the entry source of all TCCS calls are described first, followed by the outcomes of those calls from all sources in each of the main three pathways: Mobile Crisis Team pathway, Information and Referral (I&R) pathway, and Emergency pathway. The subsequent section details calls that specifically originate from 911, which depicts the extent of call diversion from 911. Call and dispatch times are then described, followed by a final section describing Toronto Police Service (TPS) Primary Response Unit (PRU) and Mobile Crisis Intervention Team (MCIT) data for added context in interpreting these results.

### Toronto Community Crisis Service calls originating from all sources

#### Origin of TCCS calls from all sources

Program data provided by the City of Toronto indicate that between March 31st, 2022 and September 30th, 2022, the TCCS successfully received 2,489 calls from all three primary sources. Of the successfully received calls, the majority were from 911 (1,530 calls; 62%), followed by 526 calls made directly to 211 (21%), and 284 calls that originated from the community (11%), which can include other crisis programs or TCCS partners' existing crisis lines (e.g., Gerstein has a direct crisis line that has established a process by which to transfer calls to TCCS). At the time of writing this report, the source of the remaining 149 calls (6%) are still to be determined (see **Limitations**). Counts and proportions of all 2,489 calls by origin are summarized below in **Table 5**.

In addition to the 2,489 calls that were eligible for TCCS, there were 412 incomplete records, meaning there is partially missing data that preclude their inclusion in the current analysis at this time; these records are currently under further review and verification (see **Limitations**). Another 123 calls involved individuals who were following up with 211 and/or 911 for an update on the status of an existing event; 85 of these repeat calls were from police (69%) and the other 38 calls were from the general public (31%). These records are also excluded from further analysis.

**Table 5.** Origin of TCCS calls from all sources[a, b]

| Source of TCCS call | Count (%) |
|---|---|
| 911 | 1,530 (62%) |
| 211 | 526 (21%) |
| In the community | 284 (11%) |
| To be determined[c] | 149 (6%) |
| **Total number of successfully received calls** | **2,489** |

[a] 412 incomplete records are excluded from the total count of 2,489 calls.
[b] 123 follow-up calls are excluded from the total count of 2,489 calls. 85 of these calls were from police (69%) and 38 of these calls were from the general public (31%).
[c] There are 149 calls where the source of the call has yet to be identified at the time of writing this report.

# Results: Evaluation Question 1

**Pathway of successfully received TCCS calls from all sources**

In reference to the successfully received calls (n = 2,489), 2,092 of those calls resulted in a dispatch of a TCCS mobile crisis team (84%). Another 121 calls (5%) were transferred to 911, while 103 were triaged to information and referral (4%). Outside of these three primary pathways, there were 117 call records (5%) in which the caller either refused the service and/or hung up. An additional 35 calls (1%) did not proceed due to technical issues (e.g., dropped calls); similarly, another 21 calls (1%) also experienced technical issues (e.g., dispatch requests being rejected, mostly due to error). **Figure 3** depicts the outcome pathway of TCCS calls from all sources. Further details with respect to the source and outcomes of TCCS calls in the mobile crisis team, I&R, and emergency pathways are outlined in the sections that follow.

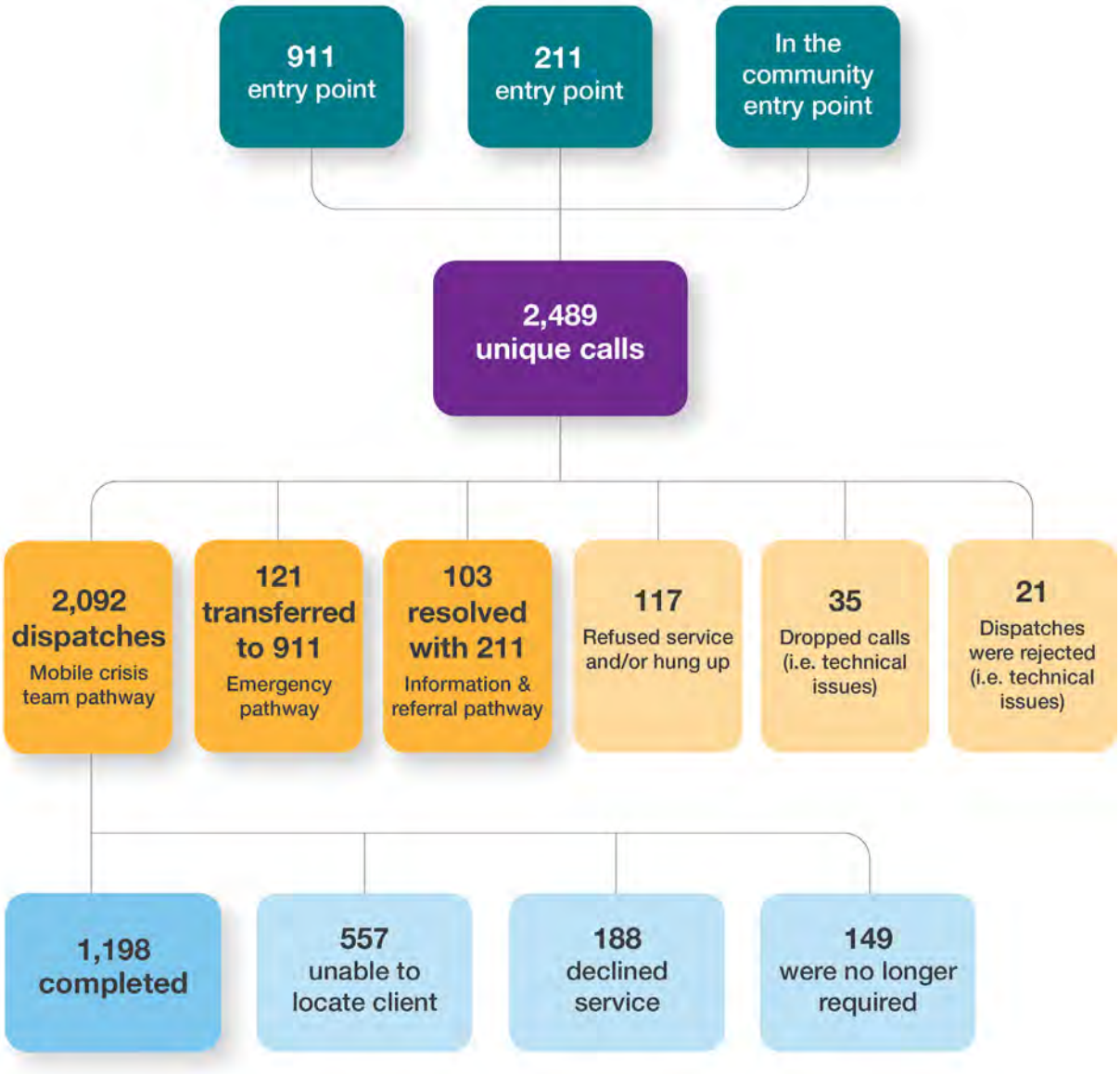


**Figure 3.** Outcome pathway of TCCS calls from all sources

# Results: Evaluation Question 1

**Mobile crisis team pathway: Origin and outcomes of calls**

### Origin of TCCS mobile crisis team dispatches

With respect to intake source, 1,324 dispatches (63%) originated from 911 callers, 486 dispatches (23%) originated from 211 callers, and 282 dispatches (13%) originated from callers in the community. Counts of all dispatch sources are summarized below in **Table 6**.

**Table 6.** Origin of mobile crisis team dispatches

| Source of mobile crisis team dispatch | Count (%) |
|---|---|
| 911 | 1,324 (63%) |
| 211 | 486 (23%) |
| In the community | 277 (13%) |
| **Total number of mobile crisis team dispatches** | **2,092** |

### Outcomes of TCCS mobile crisis team dispatches

From among the 2,092 dispatches, mobile crisis team successfully completed a majority (1,198 dispatches; 57%). The second most common dispatch outcome was when a client could not be located, which occurred in approximately a quarter of records (557 dispatches; 27%). An additional 188 dispatches (9%) resulted in the service being declined, while another 149 dispatches (7%) no longer required support from a mobile crisis team after the dispatch was made. Counts of all dispatch outcomes are summarized in **Table 7**.

**Table 7.** Outcomes of mobile crisis team dispatches

| Mobile crisis team dispatch outcome | Count (%) |
|---|---|
| Completed | 1,198 (57%) |
| Client cannot be located | 557 (27%) |
| Service declined | 188 (9%) |
| Service no longer required | 149 (7%) |
| **Total number of mobile crisis team dispatches** | **2,092** |

### Wrap-Up details

All dispatches contain wrap-up details to further describe any additional context of what happened during a dispatch, its outcome, and whether other emergency services were involved. Wrap-up details may also contain information around next steps for clients, such as emergency department visits, follow-ups, and/or referrals. The next few paragraphs highlight these wrap-up details.

*TCCS mobile crisis team involvement with other emergency services*

Emergency services were requested by mobile crisis teams in a relatively small number of records. Out of 2,092 total dispatches, only 90 dispatch records requested emergency services (4%). More specifically, 53 dispatches requested police for back up, 36 dispatches requested paramedic services, and one dispatch requested fire services. Similarly, there have been events where mobile crisis teams arrived on site and encountered other emergency services already on site before their arrival. Contrary to the previously described scenario, mobile crisis teams did not formally request emergency services in these cases. This was the relatively more common involvement with other emergency services (if any), with there being 262 dispatch records of this type of interaction (13%). Specifically, City of Toronto program data indicate that TCCS staff recorded 202 dispatches in which police were already on site (with MCIT co-attending 34 out of those 202 dispatches), 120 dispatches with paramedic services, and 17 dispatches with fire services in attendance. For any of these 262 dispatch records, there may be more than one emergency service on site at the same time, hence it is counted once. **Table 8** summarizes mobile crisis team involvement with other emergency services.

**Table 8.** Mobile crisis team involvement with other emergency services during a dispatch

| Involvement type with other emergency services | Count (%) |
|---|---|
| None | 1,740 (83%) |
| Emergency services already on site[a] | 262 (13%) |
| Mobile crisis team requested emergency services[b] | 90 (4%) |
| **Total number of mobile crisis team dispatches** | **2,092** |

[a] 202 dispatches had police (with MCIT co-attending 34 out of those 202 dispatches), 120 dispatches had paramedic services, and 17 dispatches had fire services. For any of these 262 dispatch records, there may be more than one emergency service on site at the same time.
[b] 53 dispatches requested police, 36 dispatches requested paramedic services, and 1 dispatch requested fire services.

# Results: Evaluation Question 1

*Visits to the emergency department*

A small number of dispatches resulted in an outcome of a visit to an emergency department (ED) (169 out of 2,092 dispatches; 8%). There were 62 dispatches (3%) where the client, in agreement with the mobile crisis team, visited an ED. Similarly, there were 55 dispatches (3%) where the client voluntarily requested the mobile crisis team to support their visit to an ED. Another 28 (1%) dispatches resulted in a visit to the ED due to there being an identified medical need. Twenty-four dispatches (1%) were transported by Toronto Police Services to hospital. At the time of writing this report, TPS has not validated whether or not these occurrences were under the Mental Health Act; quality improvement processes are underway to further validate and strengthen such reporting processes. The majority of dispatches (1,923 dispatches; 92%) did not result in an emergency visit (**Table 9**).

**Table 9.** Dispatches resulting in a visit to an emergency department

| Dispatches resulting in an emergency department visit | Count (%) |
|---|---|
| None | 1,923 (92%) |
| Voluntary; mobile crisis team recommendation/ collaboration with client | 62 (3%) |
| Voluntary; client's request | 55 (3%) |
| Emergency medical need | 28 (1%) |
| Transported by Toronto Police Service[a] | 24 (1%) |
| **Total number of mobile crisis team dispatches** | **2,092** |

[a] At the time of writing this report, TPS has not validated if these occurrences were under the Mental Health Act; quality improvement processes are underway to further validate and strengthen this reporting process.

*TCCS mobile crisis team follow-up and/or referrals*

Out of the 2,092 dispatches, there were 565 records (27%) in which mobile crisis teams offered follow-up and/or referrals to clients, post-crisis. There were 327 follow-ups requested by the client, 158 records with a client requesting both a follow-up and referral, and 80 records where only a referral was made.

**Emergency pathway: Origin of calls**

Of all 2,489 successfully received calls, there were 121 calls that were transferred to 911 due to a number of reasons (e.g., imminent safety risk, risk of harm, inability to connect with the caller, mobile crisis team is not available). Seventy-nine of these calls originally came from 911 (65%). Two calls sent to 911 originated from 211 (2%) while the original source of the remaining 40 calls (33%) are still to be determined. Counts of all emergency pathway call sources are visualized below in **Table 10**. Outcomes of calls routed through the emergency pathway were not captured at the time of this report (see **Limitations**).

**Table 10.** Origin of emergency pathway calls

| Source of emergency pathway calls | Count (%) |
|---|---|
| 911 | 79 (65%) |
| 211 | 2 (2%) |
| To be determined | 40 (33%) |
| **Total number of unique calls** | **121** |

**Information and referral pathway: Origin of calls**

Similar to the origin of dispatches (**Table 6**), a majority of I&R calls originated from 911 (41 calls; 40%). There were 19 calls (18%) that originated directly from 211, and one call (1%) that originated from in the community. The source of the remaining 42 calls (41%) are still to be determined. Counts of all I&R call sources are summarized below in **Table 11**. Further outcomes of all I&R calls can be found in Evaluation Question 2: To what extent were service user connections made to appropriate community-based follow-up supports through the Toronto Community Crisis Service?

**Table 11.** Origin of information and referral calls

| Source of information and referral calls | Count (%) |
|---|---|
| 911 | 41 (40%) |
| 211 | 19 (18%) |
| In the community[a] | 1 (1%) |
| To be determined | 42 (41%) |
| **Total number of unique calls** | **103** |

[a] Although in the community calls are normally routed to the mobile crisis team pathway (i.e., dispatch), the dispatch request may have been rejected and instead re-routed to the information and referral pathway.

# Results: Evaluation Question 1

## Toronto Community Crisis Service calls originating from 911

In the previous section, the source and outcome of all 2,489 TCCS calls were described. In this section, the outcomes of a subset of those calls, specifically originating from 911, are described. This highlights the extent of call diversion from 911 (depicted below in **Figure 4**).

As highlighted in **Table 5**, there were 1,530 TCCS calls that were originally from 911 and were transferred to 211.[2] Toronto Police Service data indicate that for the period between March 31st and September 30th, 2022, TPS Communications Operators identified an additional 1,043 calls made to 911 that met eligibility criteria for transfer to the TCCS, however the callers declined the offer for transfer. These calls are not included in the analysis. Collaborative quality improvement processes with PSSP, the City of Toronto and TPS are underway to determine how best to evaluate instances in which the TCCS is declined; future analyses will aim to include such data.

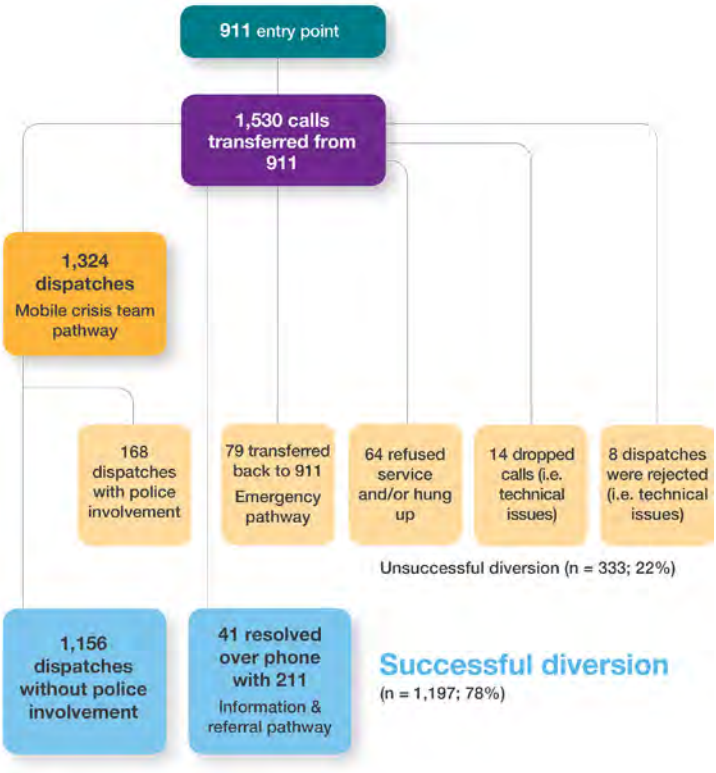


**Figure 4.** Outcomes of TCCS calls diverted from 911

The majority of successfully transferred calls (1,324 calls; 87%) resulted in a dispatch of the mobile crisis teams. Another 79 calls (5%) were transferred back to 911 while 41 calls (3%) were routed to information and referral. There were additional calls that did not route to the three, general pathways: after being transferred to 211, 64 calls (4%) refused service and/or hung up, 14 calls (1%) did not proceed further due to technical issues (e.g., dropped calls), and another 8 calls (1%) also experienced technical issues (e.g., mobile crisis team requests being rejected, mostly due to error).

A successful diversion in TCCS constitutes calls successfully transferred from 911 to 211, with no further police involvement recorded by TCCS staff.[3] Hence, this constitutes calls that resulted in information and referral (n = 41), and dispatches that did not have police involvement (n = 1,156). Thus, 1,197 calls (78%) transferred from 911 resulted in a successful diversion.

Conversely, an unsuccessful diversion in TCCS consists of transferred calls sent back to 911 via the emergency pathway (n = 79), where service was refused and/or the caller hung up (n = 64), and did not proceed further due to technical issues (dropped calls, n = 14; dispatch requested were rejected; n = 8). Unsuccessful diversion also consists of dispatches where police were involved (n = 168). Thus, 333 calls (22%) transferred from 911 resulted in an unsuccessful diversion at endpoint.

## Call times

Between the March 31st, 2022 and September 30th, 2022 data collection timeframe, the average total wait time for a caller to be connected with a 211 Service Navigator was 1 minute and 36 seconds. The average length of an active call, where a caller is actively speaking with a 211 Service Navigator, is 7 minutes and 30 seconds. Thus, the average total length of time a caller spends on a 211 call is 9 minutes and 6 seconds. This is depicted in **Table 12a** below.

[2] Toronto Police Service data indicate that for the period between March 31st and September 30th, 2022, TPS Communications Operators identified 2,673 calls made to 911 that met eligibility criteria, with these callers offered the option to be transferred to the TCCS. TPS records further indicate that 1,630 callers accepted the transfer. Due to data limitations attributable to business processes requiring manual data input, there is a slight discrepancy (approximately 100 calls) between the total number of recorded events transferred from 911 to 211 (1,630) and the total number of recorded events received by 211 from 911 (1,530). As business improvements and further data reviews are undertaken, this discrepancy will likely be resolved.

[3] Toronto Paramedic Services and Toronto Fire Services may still be present, separate from Toronto Police Service.

# Results: Evaluation Question 1

**Table 12a.** Length of call times with 211

| | **Average Time** |
|---|---|
| Total Prequeue seconds[a] | 37.97 |
| Total Inqueue seconds[b] | 58.35 |
| **Total Wait Time (Prequeue + Inqueue) (minutes: seconds)** | **01:36** |
| **Active Call Time (minutes: seconds)** | **07:30 (Median - 04:48)[c]** |
| **Total Length of a Call (minutes: seconds)** | **09:06** |

[a] Prequeue refers to the "Notice of Collection of Personal Information" message that is recorded and played before going into the call queue.
[b] Inqueue refers to the call queue before a call is answered.
[c] The median is included to aid in understanding the data set used for calculating the average and whether it is skewed. In this scenario, the average active call time is greater than the median active call time. This means that there are more records with a longer active call time than there are records with a shorter active call time.

The same indicators shown in **Table 12a** are further disaggregated by month in **Table 12b**. It is worth noting that although March is included in this table, it does not depict the entirety of the month; data collection began on March 31st, 2022, with only one anchor partner (Gerstein) having launched at that time. This explains the much lower length of call times compared to April through September. With regards to the average total wait time, there is a slight uptick from April into May, followed by a decrease in June, and then a moderate stabilization onwards until September. A somewhat similar trend is observed with respect to the average active call time and average total length of a call. The longest length of these call times is observed in April, which may be attributable to staff familiarizing themselves with TCCS processes. There is then a decline in the average active call times and average total length of a call in the subsequent months.

**Table 12b.** Length of call times with 211 disaggregated by month

| **Call time type** | **March[a]** | **April** | **May** | **June** | **July** | **August** | **September** |
|---|---|---|---|---|---|---|---|
| Average Total Prequeue Seconds (seconds) | 0 | 54.69 | 54.69 | 34.8 | 33.99 | 33.97 | 33.85 |
| Average Total Inqueue Seconds (seconds) | 12.5 | 39 | 64 | 57.1 | 60.79 | 63.86 | 53.47 |
| **Average Total Wait Time (Prequeue + Inqueue) (minutes: seconds)** | **00:12** | **01:34** | **01:59** | **01:32** | **01:35** | **01:38** | **01:27** |
| **Average Active Call Time (minutes : seconds)** | **01:12** | **13:00** | **11:23** | **08:46** | **06:31** | **05:55** | **05:30** |
| **Average Total Length of a Call (minutes: seconds)** | **01:25** | **14:34** | **13:22** | **10:18** | **08:06** | **07:33** | **06:58** |

[a] Gerstein was the only partner that launched on March 31st, 2022.

# Results: Evaluation Question 1

## Dispatch and on-site interactions

### Dispatch times

Dispatch times were captured at three time intervals: the amount of time it took for mobile crisis teams to arrive on site upon a dispatch approval, the amount of time it took for mobile crisis teams to complete a dispatch (with a completion status) upon arrival, and similarly, the amount of time it took for mobile crisis teams to complete a dispatch (with a non-completion status) upon arrival. The following sections describe each of these three time intervals.

### Time to arrive on site

The average amount of time it took for all mobile crisis teams (across all anchor partners) to arrive on site was 22 minutes. The median was also 22 minutes, meaning this estimate is relatively reliable as the distribution of the data set is not skewed (see **Table 13**). In this data set, the 90th percentile is 1 hour and 18 minutes, meaning that 90% of all dispatches take less than 1 hour and 18 minutes to arrive on site upon a dispatch. A key variable to consider in arrival time differences between sites is the geographic context of each pilot region, with teams in larger catchments having to travel greater distances as a result (see **Figure 1**).

**Table 13.** Time to arrive on site [a, b, c]

| Pilot region | Average time to arrive on site (hours : minutes) | Median time to arrive on site (hours : minutes) |
|---|---|---|
| Northeast (TAIBU) | 0:32 | 0:23 |
| Downtown West (2-Spirits) | 0:21 | 0:22 |
| Northwest (CMHA-TO) | 0:15 | 0:25 |
| Downtown East (Gerstein) | 0:15 | 0:16 |
| **Total** | **0:22** | **0:22** |

[a] Includes only dispatches with the following statuses: "Completed", "Service Declined", "Service No Longer Needed", "Unable to Locate Client". This does not include dispatches with the status, "Mobile Crisis Teams Rejected Request".
[b] Does not include dispatches from the source, "In the Community".
[c] Removed records where the total length was below 0 minutes (i.e., completed time started before the arrival time) and records with a value over 1000 minutes (i.e., error in citing AM/PM, or a timestamp is missing).

### Time from arrival on site to completion

A completed status is defined by dispatches where service users received services, and wrap-up actions have been performed by the mobile crisis teams. The average amount of time it took between teams arriving on site and completing a dispatch with a completed status was 1 hour and 23 minutes. The median time was 53 minutes, meaning there were more dispatches with a longer time to completion than there were dispatches with a shorter time to completion (see **Table 14**). In this data set, the 90th percentile time was 2 hours and 28 minutes, meaning 90% of records took less time than this to complete a dispatch with a completion status.

**Table 14.** Time from arrival on site to completion (with a completion status) [a, b, c]

| Pilot region | Total average time from arrival on site to completion (hours: minutes) | Total median time from arrival on site to completion (hours : minutes) |
|---|---|---|
| Northwest (CMHA-TO) | 1:40 | 1:02 |
| Northeast (TAIBU) | 1:31 | 1:00 |
| Downtown West (2-Spirits) | 1:22 | 0:50 |
| Downtown East (Gerstein) | 1:09 | 0:41 |
| **Total** | **1:23** | **0:53** |

[a] Includes only dispatches with the status, "Completed"
[b] Does not include dispatches from the source, "In the Community".
[c] Removed records where the total length was below 0 minutes (i.e., completed time started before the arrival time) and records with a value over 1000 minutes (i.e., error in citing AM/PM, or a timestamp is missing).

In contrast, a disposition status marked as “non-complete” resulted in one of the following scenarios: Unable to locate client, service declined, and service no longer needed. Although these dispatches were technically completed, no further engagement with a client actually takes place; this explains why the dispatch times for these scenarios were shorter in length. The average amount of time it took between teams arriving on site and completing a dispatch with a non-complete status was 36 minutes. The median time was 15 minutes, meaning there were more dispatches with a longer time to completion than there are dispatches with a shorter time to completion (see **Table 15**). In this data set, the 90th percentile time was 39 minutes, meaning that 90% of records took less time than this to complete a dispatch with a non-complete status.

# Results: Evaluation Question 1

**Table 15.** Time from arrival on site to completion when service users were unable to be located, declined the service, or no longer required the service [a, b, c]

| Pilot region | Total average time from arrival on site to non-completion (hours: minutes) | Total median time from arrival on site to non-completion (hours : minutes) |
|---|---|---|
| Downtown West (2-Spirits) | 0:37 | 0:15 |
| Downtown East (Gerstein) | 0:36 | 0:15 |
| Northeast (TAIBU) | 0:36 | 0:15 |
| Northwest (CMHA-TO) | 0:31 | 0:22 |
| **Total** | **0:36** | **0:15** |

[a] Includes only dispatches with the status, "Completed"
[b] Does not include dispatches from the source, "In the Community".
[c] Removed records where the total length was below 0 minutes (i.e., completed time started before the arrival time) and records with a value over 1000 minutes (i.e., error in citing AM/PM, or a timestamp is missing).

## Toronto Police Service (TPS): Primary Response Unit (PRU) and Mobile Crisis Intervention Team (MCIT) Data

Given that TCCS is presented as an alternative model to the status quo, exploring police and MCIT data can reveal a snapshot of how many mental health and substance use-related events occurred during the operational hours of the TCCS pilot. Police and MCIT data are presented within the TCCS implementation period (**Table 1a**) and within the service hours of all anchor partners (**Table 1b**). This section will report the counts of mental health calls for service attended by police, counts of mental health apprehensions by police, and counts of mental health calls for service attended by MCIT. Because of the significant differences in how data is counted and what is included, direct comparisons between TCCS and police data are not meaningful.

### Mental health calls for service attended by TPS

Mental health-related calls for service are attended by at least two police officers, and include the following six event types: a person in crisis, a person threatening suicide, a person attempting suicide, an elope, a jumper, and a person who has overdosed. Of these event type categories in the TPS mental health calls for service attended data (CFSA), only counts for person in crisis and threaten suicide event types would be within TCCS' scope if the minimum criteria were met for diversion: no weapons, not actively attempting suicide, no violence, and/or non-emergency.

Counts for a person attempting suicide, a jumper, and a person who has overdosed are out of scope and ineligible for TCCS due to there being an urgent, medical emergency, or in the case of the counts for an elope, a Form 9 request to apprehend under Section 28 of the Mental Health Act. It is important to note the TPS CFSA data does not include the event type, Wellbeing Check, as not all of these calls to 911 are mental health-related, whereas these event types are included in TCCS' count. **Appendix A** and **Appendix E** highlight TCCS' and TPS mental health CFSA's event types. Considering these limitations, the following results should be interpreted with caution.

Within the same timeframe, geography, and service hours of TCCS, police responded to a total of 4,157 mental health CFSA, with the highest attendance being in the divisions that overlap the TCCS pilot regions in TAIBU (42 and 43 division), followed by Gerstein (51 division) (see **Table 16**).

**Table 16.** Mental health CFSA across police divisions that overlap TCCS pilot regions

| Police division | Counts of mental health CFSA |
|---|---|
| 14 (Downtown West)[a] | 872 |
| 23 (Northwest)[b] | 268 |
| 31 (Northwest)[b] | 187 |
| 42 (Northeast)[c] | 853 |
| 43 (Northeast)[c] | 586 |
| 51 (Downtown East)[d] | 1,391 |
| **Total count of mental health CFSA across all divisions** | **4,157** |

[a] Overlapping pilot region: 2-Spirited People of the 1st Nations (2-Spirits).
[b] Overlapping pilot region: Canadian Mental Health Association – Toronto (CMHA-TO).
[c] Overlapping pilot region: TAIBU Community Health Centre (TAIBU).
[d] Overlapping pilot region: Gerstein Crisis Centre (Gerstein).

# Results: Evaluation Question 1

### Mental health apprehensions

During the course of mental health calls for service, police may apprehend individuals under the Mental Health Act. Within the same timeframe, geography, and service hours of TCCS, police executed a total of 1,864 mental health apprehensions, with the most apprehensions occurring in the divisions that overlap the TCCS pilot regions in TAIBU (42 and 43 division), followed by Gerstein (51 division) (see Table 17). Not all apprehensions made were classified with a mental health call for service event type; a total of 1,267 counts could be included and mental health apprehensions by TPS event types are highlighted in Appendix F. Furthermore, of the 1,864 mental health apprehensions, 1,439 were conducted by a police officer under Section 17 of the Mental Health Act (Police Officer's Power of Apprehension). The remaining 425 counts of apprehensions are 'form' type of apprehensions (Form 1, 2, 9 and 47 of the Mental Health Act) where police are formally directed by a doctor, a Justice of the Peace, or Judge to apprehend. Police are required to execute these forms and cannot transfer this responsibility to TCCS. In relation to the 4,157 mental health CFSA data, a total of 683 apprehensions (16%) by a police officer under Section 17 of the Mental Health Act belonged to the call type 'person in crisis' (320 counts) and 'threatening suicide' (343 counts).

**Table 17.** Mental health apprehensions across police divisions that overlap TCCS pilot regions

| Police division | Counts of mental health apprehensions |
|---|---|
| 14 (Downtown West)[a] | 366 |
| 23 (Northwest)[b] | 138 |
| 31 (Northwest)[b] | 133 |
| 42 (Northeast)[c] | 433 |
| 43 (Northeast)[c] | 303 |
| 51 (Downtown East)[d] | 491 |
| **Total count of mental health apprehensions across all divisions** | **1,864** |

[a] Overlapping pilot region: 2-Spirited People of the 1st Nations (2-Spirits).
[b] Overlapping pilot region: Canadian Mental Health Association – Toronto (CMHA-TO).
[c] Overlapping pilot region: TAIBU Community Health Centre (TAIBU).
[d] Overlapping pilot region: Gerstein Crisis Centre (Gerstein).

### Mobile crisis intervention team (MCIT) calls for service attended

The MCIT correspond with police from the PRU to mental health CFSA events and other events that do not fall within the definition of a mental health event type (see Appendix E) but are in scope for their mandate. MCIT teams consist of a specially trained uniformed officer and a registered nurse partnered to respond to incidents involving a person experiencing a mental, emotional and/or substance use crisis. Within the same timeframe, geography, and service hours of TCCS, MCIT responded to a total of 1,735 CFSA. Note that this total is a subset of the total number of mental health CFSA (n = 4,157). The most responses occurred in the divisions that overlap the TCCS pilot regions in Gerstein (51 division), followed by TAIBU (42 and 43 division) (see **Table 18**).

**Table 18.** MCIT CFSA across all police divisions that overlap TCCS pilot regions

| Police division | Counts of MCIT CFSA |
|---|---|
| 14 (Downtown West)[a] | 334 |
| 23 (Northwest)[b] | 80 |
| 31 (Northwest)[b] | 71 |
| 42 (Northeast)[c] | 280 |
| 43 (Northeast)[c] | 260 |
| 51 (Downtown East)[d] | 710 |
| **Total count of MCIT CFSA across all police divisions** | **1,735** |

[a] Overlapping pilot region: 2-Spirited People of the 1st Nations (2-Spirits).
[b] Overlapping pilot region: Canadian Mental Health Association – Toronto (CMHA-TO).
[c] Overlapping pilot region: TAIBU Community Health Centre (TAIBU).
[d] Overlapping pilot region: Gerstein Crisis Centre (Gerstein).

# Results: Evaluation Question 2

## Evaluation Question 2: To what extent were service user connections made to appropriate community-based follow-up supports through the Toronto Community Crisis Service?

This evaluation question examines the number and types of community-based follow up support referred and provided to service users and the number of service users accessing case management after receiving support from mobile crisis teams. Data in response to this evaluation question includes quantitative data from anchor partner templates, and I&R-specific call dispatch data. Five key elements of follow-up connection are discussed in alignment with the service pathway including: ***211 Information and Referral, TCCS mobile crisis team direct supports and referrals, follow-up connection and enrollment in case management, follow-up community supports and referrals across sites and specifically for 2-Spirits***.

### Referrals made by Findhelp 211

As mentioned earlier, 103 calls were resolved over the phone by staff providing Information and Referral (I&R) services. Of these, 52% (54 calls) required only information being provided,[4] while 29% of calls (30 calls) led to a referral, for whom a total of 35 referrals were made.[5] Of these 35 referrals, the top three referrals provided through I&R were for mental health and substance use supports (40%),[6] housing supports (31%)[7] and general healthcare supports (9%).[8] See **Appendix G** for a total breakdown of I&R referrals provided.

### Direct supports and referrals provided by Toronto Community Crisis Service mobile crisis teams

The TCCS mobile crisis teams provide direct crisis care and support, as well as community-based referrals to service users in crisis. The types of direct care and supports provided vary across the intervention. In the first six months of the TCCS intervention, mobile crisis teams across all pilot regions provided a total of 6,487 crisis care activities or supports[9] directly to service users on site. Of these, 1,521 (23%) involved an immediate risk assessment for the service user, including identification of harmful and protective factors in de-escalation; 1,361 (21%) were immediate crisis counseling, de-escalation and support; and 912 (14%) were information/resource specific supports. See **Figure 5** below for a breakdown of the top five direct supports provided by mobile crisis teams. See **Appendix H** for a total breakdown of direct supports categories.

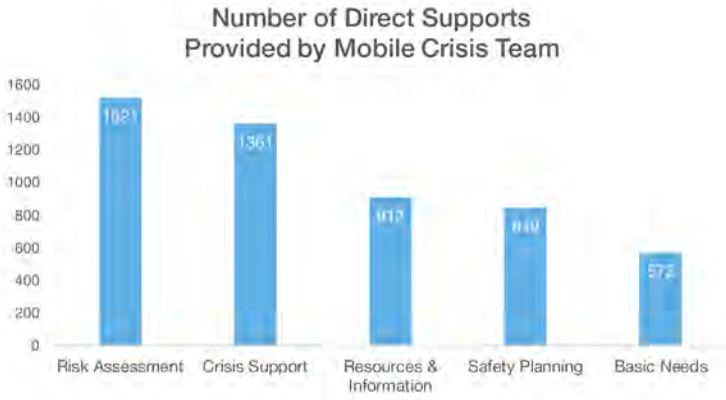


**Figure 5.** Top five direct supports provided by mobile crisis teams

The mobile crisis teams made a total of 700 referrals for service users on site. Of these, 391 (56%) were external referrals (outside of network partners), 176 (25%) were internal referrals (within network partners), 119 (17%) were organizational[10] (internally within the anchor partners), and 14 (2%) were inter-network referrals (across the pilot regions).

[4] Note: Examples of info provided includes: general information about the pilot and pilot service region, information about general health care support, information about labour rights, information on mental health organizations and walk-in clinics.
[5] Note: During the calls where referrals were provided, often one or more referrals were made.
[6] Mental Health and substance use I&R data includes the following supports: crisis line, detox services, elder abuse lines, Indigenous counseling, older 5 adult counseling, withdrawal management and youth mental health.
[7] Housing I&R data includes the following supports: housing complaint support, mental health disability housing support, shelter and tenant rights support.
[8] General healthcare I&R data includes the following supports: general health, health insurance and homecare.
[9] Note: It is possible that service users may have received more than one type of support on site.
[10] Data for organizational referrals is from July-September. Data for organizational referral was missing for Downtown East and Downtown West.

# Results: Evaluation Question 2

## Follow-up connection and enrollment in post-crisis case management

The mobile crisis teams connect consenting service users to case managers/follow-up support staff at each respective anchor partner to further assess needs and facilitate access to appropriate community-based follow-up supports. A total of 485 service users were offered a follow-up connection and accepted. Additionally, data reported by community anchor partners indicate a total of 362 service users declined the mobile crisis team's offer to be connected to post-crisis follow-up supports.[10]

Communication methods used to connect to service users post-crisis varied across the intervention. A total of 1,976 follow up attempts were made by case managers/follow-up support staff to connect to service users.[11] The most common type of follow-up communication attempt was via phone call (59%), followed by in-person attempts (20%).[12] See **Appendix I** for a total breakdown of communication attempt categories.

Service users connected to a case manager or equivalent follow-up support staff are defined as those who have received support from the mobile crisis teams and have had at least one follow-up appointment with a TCCS case manager/follow-up support staff. During the first six months, a total of 334 service users were connected to a case manager across the intervention. **Figure 6** below is an aggregate breakdown of newly enrolled service users, and previous enrollment, making up the total active enrollment across July-September.[13]

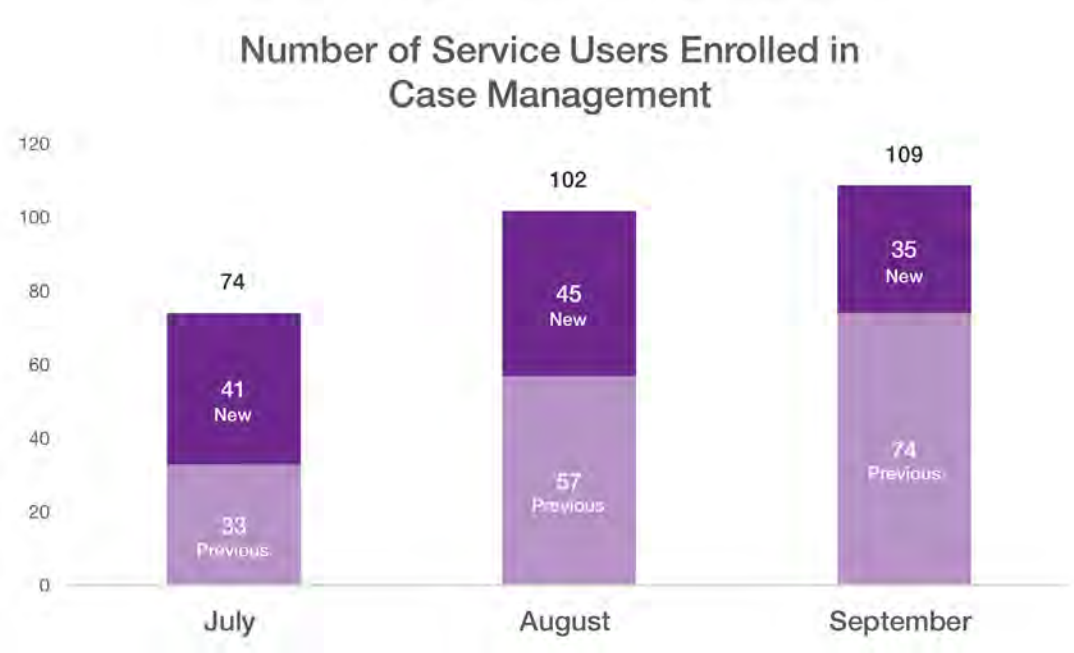


**Figure 6.** Active enrollment delineated by newly enrolled and previously enrolled service users

[11] Data for service users refusing follow-up supports is from July-September, and does not include counts for the number of dispatches where "no contact was made" with a person in crisis.
[12] Follow-up attempts does not equate to connection to the service user. This data point captures multiple follow-up attempts made to the same service users.
[13] This indicator was added as a data point in July. Pilot regions that launched in April (Downtown East and North East) do not have data reported for this indicator for the months of April-June.
[14] Note: Data collection for the breakdown of case management enrollment (i.e. new enrollment vs. total active enrollment) for all anchor partners began in July. Data for TAIBU and Gerstein for case management enrollment began in April, but the data was not disaggregated by new vs. total active enrollment. CMHA-TO's EMR does not have the capacity to collect enrollment in case management. Data from CMHA-TO for this indicator is reported only for September. New enrollment is defined as service users who are connected to a case manager in a respective month. Previous enrollment is defined as service users who have been enrolled in case management from previous months.

# Results: Evaluation Question 2

## Referrals to community-based follow-up supports

In the first six months of the intervention, 799 community-based referrals were made to service users during case management appointments. These included 231 (29%) referrals to mental health and substance use supports,[15] 185 (23%) referrals to housing supports,[16] and 101 (14%) referrals to general healthcare supports.[17] This data is in alignment with the top three referrals made during I&R calls (i.e. mental health and substance use, housing and general healthcare). See **Figure 7** below for a breakdown of the top five community-based referrals made to service users. See **Appendix J** for a total breakdown of community-based referrals.

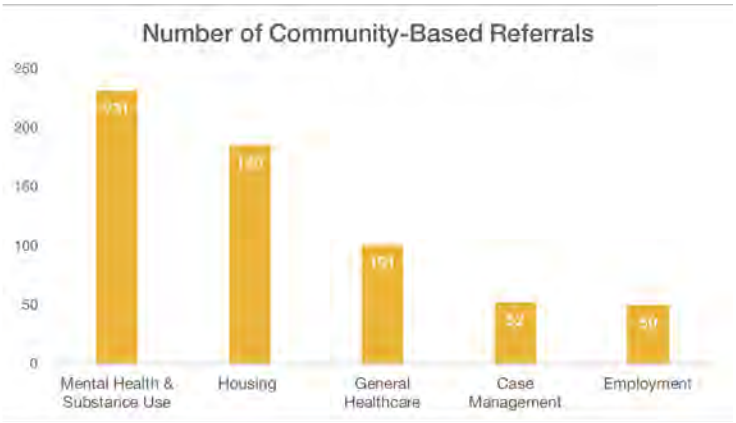


**Figure 7.** Top five community-based referrals made to service users

The total number of culturally relevant supports[18] requested by service users was 75. The most common types of supports requested by service users were Africentric and West Indian/Caribbean-centric supports and Indigenous-specific supports, which suggests the program is reaching at least some members of the populations it intends to serve. Africentric and West Indian/Caribbean-centric supports were requested a total of 26 times (35%); of these, 73% were made by service users connected to TAIBU, while the remaining 27% were made by service users connected to CMHA-TO. Indigenous-specific supports were requested across all pilot regions a total of 24 times (32%).[19] Requests for Indigenous-specific supports came from Gerstein (17%), CMHA-TO (13%), and 2-Spirits (71%).[20] See **Appendix K** for a total breakdown of culturally relevant supports requested. This data reveals the increased demand for culturally relevant supports for Black and Indigenous service users, population groups who are under-served in the Canadian mental health system (18, 19).

### 2-Spirits specific follow-up supports and referrals[21]

The total number of supports requested by service users enrolled in case management at 2-Spirits was 69. Over half of the requested supports were for housing (52%);[22] 40% (37 out of 93) of referrals made for service users at 2-Spirits were for housing supports. These figures are in alignment with the narrative provided by 2-Spirits staff during interviews which emphasized the need for more housing supports in the system overall and a more effective way(s) to connect their clients with the housing supports that may be available. For example, according to 2-Spirits staff, circumventing the housing central intake would potentially be a more efficient way to connect clients with much needed housing supports and in a timelier manner.

2-Spirits provide supports and referrals for family members. A total of 33 follow-up supports were provided for family members. The top three types of supports provided were for wholistic[23] (20, 21) family and kinship care (55%), access to medicines (28%), and education (15%). See **Appendix L** for a total breakdown of supports provided to family members. A total of 16 referrals were made for family members. The most common referrals made were to mental health supports (69%), shelter/hostel supports (25%) and psychiatric supports (6%). See **Appendix M** for a total breakdown of referrals made for family members.

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[15] Mental health and substance use support include data for crisis counseling and harm reduction services.
[16] Housing support includes data for shelter/hostel, and crisis bed supports.
[17] General Healthcare support data includes psychiatric, hospital/emergency supports, primary care and chronic disease management
[18] Culturally relevant supports are defined as supports and/or services that are relevant to a service users' culture and cultural practices
[19] Indigenous-specific support data includes access to medicine, elder/knowledge keeper support and teachings, and harm reduction services with an Indigenous lens, and culturally specific wellness programming (e.g., beading, drumming, language, regalia making, etc.).
[20] Data limitation: Do not have the number of referrals for specific types of culturally relevant supports. As per Appendix J, the total number of culturally relevant supports referred was 13 (2%) out of 799 total community-based referrals.
[21] Additional data points collected by 2-Spirits that are not collected by other anchor partners.
[22] Housing includes shelter/hostel supports, and crisis beds.
[23] Wholistic(ally): An Indigenous worldview that sees the whole person as being interconnected to "all my relations". The "w" is used intentionally in the Indigenous wholistic framework to reference the whole person, which includes the notion of Spirit. This wholistic lens is integral to many Indigenous teachings in North America (20, 21).

# Results: Evaluation Question 3 & 4

## Evaluation Questions 3 and 4: How was the Toronto Community Crisis Service implemented and how feasible was implementation?

The TCCS is a complex, newly implemented intervention that aims to support community members experiencing crisis through a non-coercive, harm-reducing, trauma-informed, culturally safe, and anti-racist lens. This broad evaluation question examines the overall implementation and adoption of the TCCS into existing organizational and system processes. Data in response to this evaluation question, which include meeting notes, interview and focus group transcripts, implementation tracker data, pre-post training survey data, quantitative data resulting from anchor partner templates, and the ORIC and Wilder tools, reflect TCCS partners' experiences implementing and adopting the program model.

Four key elements of program implementation are discussed in this section: ***partnership and collaboration, staffing and training, data systems and information-sharing, and community outreach and engagement.*** These four sub-sections reflect key components of implementation derived from the overarching program model and Theory of Change that provide an overarching, high-level picture of implementation. In each of these four sub-sections, key implementation processes and experiences are described. Reflecting critically on ongoing monitoring and assessment of implementation activities, experiences and outcomes from the program's inception to September 2022, critical components of program implementation emerged and were identified on the basis of their role in successful implementation. Program facilitators refer to factors or mechanisms that were crucial in aiding program implementation. In contrast, program barriers refer to the factors that hindered implementation and contributed to the challenges and overall difficulties experienced by the partners in implementing the program. In the current report, where implementation barriers are discussed, some opportunities for program improvement are also highlighted. Facilitators and barriers for each implementation component evaluated are summarized in **Table 19** below.

**Table 19.** Key implementation facilitators and barriers

| Implementation component | Facilitators | Barriers |
|---|---|---|
| **Partnership and collaboration** | Individual and collective buy-in | Organizational differences in readiness to change |
| | Inter-partner interaction and knowledge-sharing | Lack of role and process clarity |
| | | System-level capacity gaps |
| **Staffing and training** | Co-designed core training curriculum<br>Culturally safe approaches to staff wellness | Timeline, pace and variability in training implementation |
| | | Lack of staff capacity and resources |
| **Data systems and information-sharing** | Quality improvement approaches | Incompatible systems, technology, and duplication of efforts |
| | | Organizational differences in data collection capacity |
| **Community outreach and engagement** | Partnership and collaboration | Lack of staff capacity |

# Results: Evaluation Question 3 & 4

## Partnership and collaboration

**How was partnership and collaboration implemented?**

As the TCCS Theory of Change suggests, this program is rooted in partnership and collaboration within and across the many program partners and successful implementation of the program is tied to the quality of relationships and extent of collaboration. Overall, TCCS partners reported positive experiences of partnership and collaboration related to the intervention. Key facilitators of partnership and collaboration included a baseline level of willingness to collaborate and engage with each other; and ongoing inter-partner interactions and knowledge-sharing, particularly at the leadership level. Key barriers to partnership and collaboration included baseline organizational differences in culture and readiness for change; a lack of clarity and trust in roles and processes; and system-level capacity gaps that challenge the TCCS' ability to partner more broadly within the system.

When prompted to discuss their overall partnership and collaboration experiences, participants were first asked to define strong partnership. Across partners, there was clear alignment in their characterizations of strong partnerships. Participants agreed that strong partnerships are defined by alignment in understanding of and respect for each other's roles, goals and values: "Strong partnership is one where you understand one another's unique roles and how your roles complement each other" (211 participant). Participants also placed emphasis and value on open and honest communication in partnerships. For example, both 211 and 911 participants described examples transparency by 911 around the need for change management among their call operators in order to increase the number of calls diverted to 211; and by 211 regarding capacity to answer phones and radios, concluding that "more truth telling has led to better partnerships" (211 participant). This sentiment was echoed by 911:

> *Strong partnerships are what we're doing now - open, transparent, able to bring any issues or concerns forward knowing it will be taken in a good way, not defensively. We haven't had any issues yet; we acknowledge issues, everyone does their part. It's a really good collaboration, we enjoy the people we work with, it's a good environment for spitting ideas back and forth. We all have the common goal of wanting this pilot to succeed. **(911 participant)***

Participants in this evaluation generally described their TCCS partnerships with optimism and with continued growth potential. A police participant, for example, described that their "interactions with the [TCCS mobile crisis] teams have been positive, and a good relationship. And a potential to grow." This sentiment was particularly strong among participants from 911 and 211, partners whose interactions, often facilitated by the City of Toronto, were extensive. Qualitative data recorded in partners' monthly implementation trackers described frequent regular meetings throughout the first six months to establish, problem-solve and continuously refine operational call and dispatch processes. A 211 participant described it as being "fantastic working with partners" with a 911 participant agreeing that "overall, interactions have been pretty great minus miscommunications."

Community anchor partners were also positive in their assessments. Particularly given the early stage of implementation and staggered launch dates, community anchor partners were more likely to reflect on the nascency of their partnerships and collaboration experiences and it being "early days in a project so things are working well, but could we be doing more? Absolutely….down the road, I think things will look very different. [We have] so much to learn from each other" (Gerstein participant). Other community anchor partners spoke to their experiences partnering with their community service networks, with one partner noting how "working with a coalition has been great – such strong, critical thinkers. It's great to get different perspectives" (CMHA-TO participant) while simultaneously noting challenges with lengthy decision-making processes and having everyone work effectively together.

Participants went on to describe how their TCCS partnerships have evolved over the course of implementation. As one community anchor partner indicated, "partnerships aren't always linear. They require check-ins throughout to see where everyone is at, communication, trust. Not a linear thing, especially with Indigenous community, we're always working to build and rebuild" (2-Spirits participant). Another community anchor partner echoed how "a lot of people are coming into this work with a variety of experiences and goals. Learning to work with partners within the context of this intervention involves evolving and a learning curve" (Gerstein participant). Across partners, participants expressed a strong desire to better "see each other, get

# Results: Evaluation Question 3 & 4

to know one another" (911 participant) and understand each other's roles, responsibilities, and values: "better understanding the work each partner is doing and shifting the way we think about the pilot as being multiple agencies versus one unified system" (211). This collective sense of willingness to collaborate emerged as a key partnership facilitator, alongside the extensive inter-partner interactions and knowledge-sharing that emerged at the leadership level. These two facilitators are further described in the section below.

**Partnerships and collaboration: Key facilitators**

### Individual and collective buy-in

Essential for successful partnership and collaboration is a baseline level of willingness to collaborate with others and buy-in to the nature, goals and values of the intervention. Data resulting from this evaluation surfaced a collective sense of willingness to collaborate across all TCCS partners. For example, preliminary data resulting from the Wilder Collaboration Factors Inventory baseline assessment show that six of six responding partners "strongly agreed" with survey items reflecting consensus on the need for collaboration ("What we are trying to accomplish with this collaboration would be difficult for any one single organization") and collective buy-in ("Everyone who is a member of our collaborative group wants this project to succeed").

Across data sources, participants in this evaluation described feeling proud to be involved in this intervention and gratified by their work, despite the many challenges experienced throughout implementation to date. A 211 participant reflected that Service Navigators "feel it's a very good service, absolutely needed, proud to be a part of it. They feel good about the program itself and about being able to help."

On the TPS side, willingness was also generally present,[24] with participants describing how "it's wonderful to have groups like TCCS" and "we want their [TCCS'] help and need it. We can't do it all…Social problems, we need participation from social services and we want to work with them" (police participant). This was acknowledged by some community anchor partners, with TCCS crisis workers from TAIBU, for example, noting that "there's a willingness from police" and that it has been "great to work with police because we know they're needed."

Despite universal willingness to collaborate, data indicate that practically, readiness to change varied organizationally, which emerged as a parallel barrier in the implementation process. This barrier, and others including lack of clarity around roles and processes, and system-level capacity gaps that preclude partnership and collaboration, are detailed in **Partnerships and collaboration: Key barriers** below.

### Inter-partner interaction and knowledge-sharing

Building on baseline willingness to collaborate, data indicate that partnerships improved over time as a result of a second key facilitator: extensive inter-partner interactions and knowledge-sharing. Ongoing, responsive interaction and knowledge-sharing among people within and across partners aided partners in becoming more familiar with each other's respective roles, responsibilities, capabilities and ways of working. Implementation tracker data showed ongoing interaction between partners through activities ranging from weekly status and issue meetings and conversations to inter-partner presentations and having community anchor partners attend police and 911 "parades," which are akin to information-sharing sessions and/or presentations regularly delivered to staff throughout 911 and TPS. One 911 participant commented on how community anchor partner attendance at their parades helped with both understanding of and confidence in the intervention:

> *[Gerstein manager] coming and telling them [911 Call Operators] they've done this for years and have experience and skills and are knowledgeable with people in crisis, so we're not sending them into the fire to get burned. And they always have the backup to radio in for support. It's helpful for people on parade to know they weren't setting anyone up to get hurt.*

Community anchor partner participants described how "we keep talking, meeting, getting to know each other" (Gerstein participant) and that partnerships are "working. It's going to take time, but it's working" (TAIBU participant). Participants shared a long-term perspective and suggested such initial experiences could be expected as each partner is "learning to be a good partner" (211 participant); and it is particularly important to consider the pace at which these partnerships were formed, with a 911 participant remarking that "more established relationships may just come with time…I do think it comes from seeing

[24] According to Toronto Police Service data, Toronto Police Service frontline officers requested the TCCS to attend 96 events between March 31, 2022 and September 30, 2022.

# Results: Evaluation Question 3 & 4

the outcomes of our collaborative efforts and this is still very new." Overall, participants described notable progression in their TCCS partnerships over the course of implementation: "as we move forward, it's been so much better" (211 participant).

As the funder and administrative backbone of the TCCS, the City of Toronto has played a central role in supporting inter-partner interaction and engagement activities for the TCCS, which has resulted in improved collaboration and trust-building amongst project partners overall, and especially between community anchor partners (Gerstein, TAIBU, CMHA-TO and 2-Spirits) and other partners participating in the project (TPS, 911, and 211). Based on meeting notes, interviews, and implementation tracker data, it is clear this has been a significant undertaking for the City of Toronto, who have taken an active role in partnership development. Partnership and facilitation experiences by the City of Toronto were described positively in implementation tracker data month-to-month and in interviews and focus groups with participants, particularly by 211: "We have a very good foundation with the City, they were always our ally" (211 participant). City of Toronto participants reflected overall that the "collaborative nature of the work is very satisfying." As one participant offered: "Historically, when you think about the funder and the power dynamic…our team doesn't look at it like that and looks at it like a partnership and that we are co-developing something" (City of Toronto participant). Taking on this role was described as "constant work" (City of Toronto participant), responding to issues and risks promptly through regular communication, engagement and problem-solving with partners in order to "adjust processes and operations mainly to respond to situations on the ground" (City of Toronto participant):

> *We have active conversations officially and unofficially with partners, do check-ins and phone calls with partners, they email us with questions they might have. We're also able to follow up on questions they may have and that's how we try to foster healthy relationships. (City of Toronto participant).*

Facilitating TCCS partnerships has been "such a huge part of the work. Every day is about partnership and relationships and nurturing those" (City of Toronto participant).

**Partnerships and collaboration: Key barriers**

### Organizational differences in readiness to change

Necessary for partnership and collaboration and following from willingness to collaborate is adequate readiness to change within each TCCS partner. It was apparent throughout the evaluation that the unique organizational cultures each partner possesses and the unique approaches each partner has to support individuals, families and communities during a mental or behavioural health crisis has led to challenges in implementing the TCCS collaboratively. As one community anchor partner identified, "different politics and many different players makes for different types of partnerships" (Gerstein participant). Indeed, survey data indicated that organizational readiness to change at implementation outset varied across partners. Notably, ORIC scores were positively skewed overall (mean score across items=4.4 of 5; median=5), indicating an overall proclivity toward readiness to change. However, total scores differed by up to 28% between partners with community anchor partners scoring higher, on average, than TPS and 211. Unlike willingness to collaborate, no individual items were similarly agreed upon by all six partners participating in the survey.

Different levels of readiness to change led to some negative attitude surfacing in survey responses. These were most often between community anchor partners and institutions like TPS and the City of Toronto. While not representative of all police participants, one suggested the need to "drop the anti-police attitude" while another elaborated:

> *Several of these questions help me understand why our agencies do not get along. We cannot do crisis resolution together when our perspectives are completely opposite. I know that I have great success with my strategy. Stop telling me how to do my job.*

City of Toronto participants reflected how they themselves are beholden to institutional structure and policy. Since different divisions and offices within the City of Toronto - Shelter, Support and Housing Administration, for example - do not operate synchronously or necessarily share the same priorities and agenda, the City of Toronto project management team's scope of influence to respond to intervention and partner needs - greater access to housing supports, for example - is sometimes limited.

# Results: Evaluation Question 3 & 4

Community anchor partners acknowledged "there is a desire for change but also not to change. Folks are used to the way things have always been done" (Gerstein participant). When prompted to describe partnership and collaboration barriers, another community anchor partner offered:

> *Readiness to change at the system level…there is an engrained pushback and participation from police services in this pilot that were not discussed in the beginning. That should have been an open and frank conversation from before agencies applied to lead these pilots. (2-Spirits participant)*

On the ground, community anchor partners reported experiencing these readiness to change differences as well, including with other project partners including TPS and 211. Some participants from 211 noted during interviews that person-centred language is not always used by their staff and others on TCCS calls; for example, the description of a person in crisis is not communicated or documented in a culturally relevant way when information from the caller is collected or communicated between partners. Insofar as police, a TCCS crisis worker shared that "there are progressive police who say, 'We need you, and you need us' and they believe that this work is very important" while at the same time noting:

> *I don't want to sugarcoat it: there are still some police officers who have specific schools of thought and say 'We know what we are doing and we have been doing this for so long.' Due to this, people get thrown in jail who otherwise wouldn't have if they were not in crisis. (TAIBU participant)*

Notably, it was suggested early in the evaluation design phase by community anchor partners that in order to increase their trust in the overall system, the evaluation team should consider supporting all partners, but especially institutional partners to track their ability to adapt processes and attitudes over time to best respond to community mental health priorities utilizing the program's core principles. This was presented as an opportunity for trust-building amongst partners and communities being served by the TCCS, which includes a high proportion of structurally marginalized groups. It was also presented as an opportunity for capturing important learnings overtime in relation to if/how the entire system can work collaboratively and with shared respect using the program's core principles. The next phase of this evaluation will include six-month data from the Wilder and ORIC tools, which, together with the baseline assessment and follow-up qualitative data collection, will speak to change over time in attitude toward collaboration and readiness to change.

### Lack of role and process clarity

Lack of understanding of respective roles and processes was associated with a general lack of trust in each partner's ability to enact their roles across TCCS partnerships, particularly insofar as 211's ability and capacity to respond to crisis calls. As a 211 participant described, "I think there was a learning curve and questioning of 211's ability to do this work – this was apparent in meetings"; another 211 participant agreed "I think it has evolved for sure. There was a bit of mistrust, we were the non-experts coming into the system. I think there's still a little bit of mistrust." This was acknowledged by some community anchor partners, some of whom have been "doing this work for 30+ years, now having this middle person doing the dispatch. There was a lot of question as to, 'Why do we need this middle role?' At times, I questioned that too" (Gerstein participant).

Community anchor partners also experienced mistrust by other first responders, including police, mobile crisis intervention teams (MCIT), and paramedic services. Interview and focus group data indicated that community anchor partners, and specifically TCCS Crisis Workers, have had mixed experiences working with police or having MCIT services on site during a crisis call. Most often, these experiences were attributed to a lack of understanding and clarity around TCCS crisis workers' role, capabilities, responsibilities, and accountabilities. One participant described the need to

> *establish a better relationship between TCCS and MCIT/211/911 dispatch so that more calls that should be coming to us do come to us as the team is aware that many calls that should come to us go to MCIT or the police when they don't need to or could be sent to us with police by our side. (Gerstein participant)*

However, police participants indicated they were "not sure if TCCS has a good understanding of what the police role and MCIT role is, and what our authorities and limits are, and what we can and can't do" and how "TCCS, in terms of their role in determining who and what is apprehendable [sic], they lack understanding

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that there's little that can be done if the person doesn't consent." There is a clear opportunity to improve role clarity going forward. Community anchor partners echoed this sentiment: "There needs to be better understanding of everyone's respective roles, so folks can work together to make sure that the right people are going to the right types of care and service providers" (Gerstein participant).

Other challenging encounters were due to lack of clarity surrounding collaboration processes, often related to communication or handoff when on-site. For example, a TCCS crisis worker described how

> *police might see the dispatch be pushed over to 211 and might show up and be based on their past experience and say they're going to apprehend them, and we say "no you're not!" …But this can be hijacked by how TPS' protocols go. And then the client is confused and doesn't trust us and doesn't trust them and then we've torn apart something we've almost just put together.* ***[TAIBU participant]***

A police participant described similar process concerns:

> *If TCCS is not available for one hour, we should know that. We've had situations where they [TCCS] show up in 45 mins, and then there are seven people standing around the client - it's off-putting. If we could pick up the phones and ask them what time TCCS is coming, we can make better decisions. It's never a competition, it's about 'Let's figure out who's most appropriate and how to deliver that.' That piece is the real issue for me here.* ***(police participant)***

A particular challenge has been establishing a clear understanding of the violence threshold for when to involve (or re-involve) 911 and police in TCCS. The program emphasizes and prioritizes the safety and wellbeing of TCCS crisis workers and both 911 and 211 participants described concerns about personal liability should they make an eligibility determination that exposes TCCS staff and service users to risk of harm. Exposure to violence was a concern in some areas more than others, with police participants working in downtown Toronto noting how

> *given it's right downtown in 51 Division, we deal with a lot of unpredictable situations. We do get a lot of people who are quite violent. When they're considering sending TCCS, that's a huge component. Downtown violence is something we have to be very cognizant about.* ***(police participant)***

This barrier is associated with both a lack of role clarity (on TPS' part, in terms of what types of calls TCCS crisis workers are capable of responding to; and on TCCS' part, in terms of when police is required to attend) and process clarity (not having a clear definition of violence, for example; and how handoffs occur when TCCS calls become violent during the course of a TCCS interaction). A police participant offered their perspective on this topic:

> *What's the threshold, what they can or can't deal with in violent situations? My own opinion is throwing a fit, breaking something. I think they would be able to deal with that. When they start becoming physical, then yeah, that's not something suitable the mobile team should do. I'm not sure what point they decide. It literally just says non-violent behaviour, what you and I consider [violent] is two drastically different things.*

This was echoed by 911, with one participant reflecting how 911 Call Operators:

> *sometimes see a flag that this person has been violent… or has a noted address. The big thing is the violence threshold - sometimes we get calls about a person kicking out a window - that's violent but there's no weapons - what's the threshold for what the teams can respond to? And we're not sure what violence means.*

For effective collaboration to occur, especially between police and 911 and TCCS mobile crisis teams, there needs to be more time built into the intervention for partners to engage with one another, and learn about each other's respective roles, responsibilities, and protocols. The importance of police buy-in into the program to promote optimum outcomes for all parties involved is particularly essential. There exists an opportunity for police to become more aware of TCCS crisis workers' expertise and ability to de-escalate mental and behavioural health crises; and, there is an opportunity for community anchor partners, especially TCCS crisis workers, to understand that institutions such as police and MCIT are beholden to their own training, operational protocols and accountabilities. Understanding, respecting and appreciating the orientations and limitations of each role is essential for the intervention to succeed more broadly. One TCCS crisis worker, for example, recalled a TCCS event in which police arrived on site after the TCCS staff were already present. Arrival of police led the service user to feel triggered by their presence; in this situation, the participant shared they had asked police not to intervene because their client was

being re-triggered by their presence (2-Spirits participant). The participant mentioned that the police in this instance was very understanding and remained on site in case the TCCS staff needed support, but stayed away from the service user's view which allowed them to de-escalate the situation and provide the immediate supports the service user needed. According to the participant, the service-user was appreciative of their advocacy efforts:

> *The service-user really appreciated the fact that we did not let police engage with them when they specifically told us they did not want to interact with police. And I think that is a big part of our role- to make sure service users feel safe. (2-Spirits participant)*

### System-level capacity gaps

A final barrier in partnerships and collaboration is related to gaps that reflect a lack of system capacity in key resources and services needed to improve access to care and community representativeness within the TCCS. Participants described the need for greater partnership with groups and organizations to whom the TCCS can refer its service users as part of post-crisis follow-up care planning, particularly in subsectors known to lack capacity, such as housing, which was noted across all community anchor partners; harm reduction and substance use services; and Indigenous-led services. When asked who is missing from current partnerships, one community anchor partner explained:

> *What's missing is also housing. CMHA-TO has housing but is confined with the waitlist through the Access Point. To have a direct link to housing would be really helpful. We haven't had conversations with organizations that could provide this support, but it is an important step…to begin that communication. (CMHA-TO participant)*

Another community anchor partner echoed, "Housing partnerships are missing" (Gerstein participant). Even with partnerships, in place, however, capacity within those partnerships to provide access and services is limited. As TCCS's Indigenous-led community anchor partner reflected:

> *That's where we're finding a gap, in terms of capacity – a lot of folks are at capacity. And because we don't have funds to offer them…it's a difficult conversation to have sometimes…Referring to ENAGB [Indigenous community service partner] would be helpful, but they're also super busy. (2-Spirits participant)*

Indeed, the data reflect a level of frustration experienced by staff involved in the program who noted the ongoing challenges they have been facing to support clients in the short- and long-term and connecting clients to shelters, permanent housing and food security. A CMHA-TO participant reported it has been "a point of frustration for case managers when we aren't able to connect a client to a specific service so they keep bringing up gaps, etc. They also understand we work in this system."

As reported in Evaluation Question 2: To what extent were service user connections made to appropriate community-based follow-up supports through the Toronto Community Crisis Service?, 40% of total TCCS referrals made were to housing supports but waitlists for housing (supportive and non-supportive) in the City of Toronto are inordinately long and an absolute shortage of housing stock has persisted for years. In addition to housing capacity, a lack of hospital capacity, particularly ED wait times, has been a key barrier with TCCS crisis workers reportedly spending significant amounts of time waiting in EDs to hand off TCCS service users. TAIBU described their challenges initially taking service users to the ED because the team would be there for four to five hours: "There are often long wait times at the emergency room/hospitals, no expedited service" (TAIBU participant). Another TCCS crisis worker echoed that the "only area we can't bypass right now are hospitals and a lot of people have trauma with hospitals… we sit with them for however long the hospital time takes, if they want us there" (CMHA-TO participant). If another call comes in, "it will depend on priority and if the service user is able to stay in hospital on their own, then we will prioritize the call coming in" (CMHA-TO participant).

The City of Toronto has acknowledged this systemic context in facilitating successful partnership and collaboration within and outside the intervention, noting the decentralized model has been a challenge: "A lot of things are out of our hands. Some of the challenges and issues our partners face, we have to try to help them overcome" but there are contexts in which, "for various reasons like economic and other challenges, this has not yet happened" (City of Toronto participant). A community anchor partner countered:

> *While not intentional the city and the machine that the city is has positioned itself in between all of the stakeholders which can at times replicate a system that is very siloed. There needs to be a system-level adjustment to capacity. We aren't able to provide individuals with the support*

# Results: Evaluation Question 3 & 4

*they truly need when things like housing/shelter/food access etc are not accessible.* ***(2-Spirits participant)***

A TCCS crisis worker echoed this notion:

*We don't have enough modular housing. We don't have enough solutions. We need to petition and advocate. What's not working is that the old systems are there and we don't have enough space to have dialogue on solution-based conversations. We can continue to be mobile crisis and TCCS but if we don't start the dialogue to start the solutions of how we're going to change things… We have all these moving parts and all these managers having dialogues but we don't have solutions in front of us, and that's not working, and not going to work in the long term.* ***(TAIBU participant)***

This finding was not limited to community anchor partners; 211 participants also resonated with this sense of frustration: "often it feels like you're referring clients to a broken system because you don't know when they're actually going to get the help" (211 participant). While a more fulsome system-level analysis is outside the scope of this report, preliminary evidence gathered indicates multi-layered systemic barriers should be carefully assessed in future TCCS evaluation.

## Staffing and training

**How were staffing and training implemented?**

### Staffing

Staffing the TCCS, in terms of recruiting, training, supporting and retaining staff, was described overall as a significant and challenging component of implementation for all TCCS participants. TCCS staff were hired through the partners and each partner hired different complements of staff depending on their original program proposals. Still, all partners had a sentiment in common: "Staffing has been a challenge" (211 participant), as one TCCS partner stated. For example, City of Toronto program documentation shows that the four community anchor partners filled a total of 100.45 full-time equivalent (FTE) roles associated with TCCS in its first six months (March 31st, 2022 to September 30th, 2022). Of these, 85% were roles for frontline community crisis workers, case managers, peers, resource specialists, and access facilitators. At 211, funding allowed 7.0 FTE staff positions to be hired while also reallocating staff from other crisis lines.

In the context of post-COVID, sector-wide labour market shortages, candidates were sometimes limited and recruitment for TCCS roles often took longer than anticipated. As one community anchor partner described, "we are not getting a lot of responses to new positions" (2-Spirits participant). Another community anchor partner described how

*Hiring has been an ongoing process. A lot has changed since COVID in terms of how people do things - availability of childcare, for example - and as a mobile team, you have to work 12-hour shifts and on evenings and weekends - not as appealing to folks.* ***(TAIBU participant)***

Uniquely, CMHA-TO shared funding with their coalition of community service providers to increase likelihood of hiring. Still, they reported hiring delays and were not operating 24/7 at launch as expected; it was not until after the evaluation period, November 2022, that all four pilot regions were operating 24/7 as intended.[25] "Addictions Services haven't hired a therapist or nurse for the RAAM [Rapid Access Addiction Medicine] clinic and I don't have control over that as I am from CMHA-TO," as one CMHA-TO participant described. Only one partner (2-Spirits) had fully hired its team at the time of launch.

In part, this was associated with the intent to hire individuals with lived experience who reflect the communities they serve and ensure an appropriate fit. The TAIBU participant above went on to describe how they "wanted to ensure that a person's values are in line with what we do here. All team members here - it's their passion, and they are part of the community in some sort of way." Finding people who meet these criteria took time and came with unique challenges. TAIBU noted how securing driver's insurance has been a challenge, for example, with new hires not necessarily having driving history to be able to operate the TCCS mobile vehicles. Another partner, 2-Spirits, described:

*We wanted to hire folks who are Indigenous and 2-Spirits. With that comes challenges because we know Indigenous folks are lower on all social determinants of health, which impacts your job…Then, we hired a lot of folks that didn't have a lot of job experience, but that comes with challenges - the need for a lot more hands-on management. Even simple things to me were things we had to work on so that the team had those skills. We had to meet the community where they're at. But it's definitely worth it.* ***(2-Spirits participant)***

[25] CMHA-TO was the final of the four pilot sites to become operable 24/7 on November 12, 2022.

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## Training

In parallel to recruitment and staffing, training for the TCCS was implemented variably across partners. A core component of implementation has been its five-week core crisis training curriculum, which was co-designed by project partners (led by Gerstein) to provide training in key knowledge and skills domains of community-based crisis response. Training was administered to 56 unique TCCS staff from across the four community anchor partners in two cohorts aligned with the two staggered launch dates; 23 TCCS staff (primarily from Gerstein and TAIBU) were trained in February and March 2022, and a second cohort of 33 TCC staff were trained in May and June 2022 (primarily from 2-Spirits and CMHA-TO).

Of 56 trainees, 44 (79%) self-reported demographic data that indicate cohorts were demographically similar, with the exception of a greater proportion of participants identifying as Indigenous in the second cohort (55% vs. 9% of respective cohorts), which aligned with 2-Spirits' launch date. Training participants overall were most commonly middle-aged (30 to 54 years) but overall skewed younger with 45% under age 30 years. In terms of gender, half of participants identified as women (N=22; 50%) and over 20% identified as Two-Spirit (N=10). Participants varied in racial background with Indigenous identity (N=20; 46%) and mixed race identity (N=11; 25%) being the most commonly self-reported categories. Nearly half of participants (N=19; 44%) reported a disability, and of those identifying as disabled, many reported multiple disabilities (N=12; 63%). Most often, mental health and learning disabilities were cited. Relatedly, across both cohorts, there was a clear preference for kinesthetic learning (median score = 4) as compared to other learning types (visual median =3; auditory median = 3; reading/writing median = 2). Alignment of the demographics of this cohort with the overall reach of the program is discussed further in **Sociodemographic reach**.

Qualitative data from the pre-training survey indicated that for TCCS staff, training aspirations and goals ranged significantly, with many stating broad learning goals related to improving their overall ability to respond to crises in the community and understand more about mental health. For example, some participants described wanting to learn "how to support people in crisis" (TCCS training participant; training survey participants were anonymized), "mental health and harm reduction" (TCCS training participant X5), "basically everything" (TCCS training participant), which may relate to the overall level of experience of trainees, with average time in the sector ranging from two to five years and a quarter of participants reporting less than two years' experience. Other participants noted more specific learning objectives related to crisis skills like "intervention and de-escalation skills" (TCCS training participant), "conflict resolution" (TCCS training participant), and "skills on suicide prevention and recognizing signs of opioid overdose" (TCCS training participant). Many participants also described learning goals related to the ability to use crisis skills in culturally safe ways with diverse populations. For example, some participants wanted to learn "Indigenous harm reduction and understanding gender and sexual diversity and the way it affects those in crisis" (TCCS training participant), "ABR [anti-Black racism] and similar teachings" (TCCS training participant), and "how to assist neurodivergent people" (TCCS training). Lastly, participants expressed interest in effectively referring and connecting to the follow-up support community, including "resources that I can share with community members" (TCCS training participant), "how to connect with local stakeholders more effectively" (TCCS training participant), and "supports available within our community and specifically catchment area" (TCCS training participant).

Two training components in particular were consistently found to be most helpful: Applied Suicide Intervention Skills Training (ASIST) and scenario-based training. Participant described how, for example,

> *the ASIST training really breaks down the pieces involved in health communication with clients that I can and will use in all interactions with clients. It really helped show me how to listen to the client story more effectively and to avoid rushing to solutions and problem-solving-based responses. **(TCCS training participant)***

Another participant reflected on the scenario-based training:

> *I found our scenario training to be the most helpful as it was a much more personal approach to how our crisis response work will flow. It taught me to expect almost anything and to not interact with people like I'm reading a script. **(TCCS training participant)***

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As a result, TCCS trainees reported a greater level of preparedness post-training, with the proportion of trainees who felt very or completely prepared to enact their roles post-training increasing from 17.9% pre-training to 44.6% post-training. Furthermore, participants described a range of scenarios in which they intended to practically incorporate their training. Primarily, these reflected the training components they had indicated were most helpful – suicide intervention and scenario training. The two most common examples of intended change offered by participants were asking people in crisis whether they are experiencing suicidal thoughts; and using improved active listening and empathic communication skills in crisis situations in order to connect with and de-escalate individuals. TCCS trainees described intending to "be direct in asking about suicidal thoughts" (TCCS training participant), "pay very close attention to invitations from people in distress" (TCCS training participant), and "use active listening skills to connect and understand the needs of the person experiencing crisis" (TCCS training participant). Quantitative data from the survey indicated participants felt the highest level of confidence post-training in knowledge and skill areas related to consent, person-centred and culturally safe language, anti-racism and oppression, and privacy practices and laws (see **Appendix N** for pre-post median scores in each training domain). No noticeable cohort differences existed in training satisfaction or the resulting level of preparedness.

The length of the core training curriculum was the only noted area for improvement, with participants suggesting that "some trainings needed more time than others" (TCCS training participant) and that the overall training time was not right-sized to the amount of information, leading some participants to feel "rushed with a lot of information" (TCCS training participant. As one participant described, "While it was the most extensive training I have ever done, I felt that it could have been slightly longer so that some of the material would not have been as rushed" (TCCS training participant). However, overall, pre-post item responses from a training survey (n=41 valid responses) indicated that TCCS trainees were satisfied with the training (63% satisfied or very satisfied; median score 4 out of 5), with many commenting that "most" or "all" of the sessions were useful. For example, participants described the sessions as "very necessary for the work being done" (TCCS training participant), "very useful…all training touched almost all areas" (TCCS training participant), and "offered a number of practical approaches on how to assist and support in crisis" (TCCS training participant). One of the key factors facilitating TCCS staff satisfaction with the core training curriculum related to the design and implementation of the curriculum having been a highly collaborative and community-based process. This is elaborated upon in the next section detailing key implementation facilitators for TCCS staffing and training.

In addition to the core training curriculum, community anchor partners have offered additional training to staff to promote training equity. This included some topics offered during the five-week mandatory training, such as ASIST suicide intervention training, and net new training opportunities made available to staff across the partners. For 2-Spirits these included training on the following topics: *Group Dynamics, Case Management Software Training, Making your Own Bundle*; CMHA-TO provided additional training to TCCS staff in *Concur, AODA,* and the CMHA-TO *EMR System*; and Gerstein offered additional training to newly hired staff on *Data Recording*. This evaluation did not include formal evaluation of the additional training provided to TCCS staff across partner organizations; in the future, there is an opportunity to report on the efficacy of additional training provided.

**Staffing and training: Key facilitators**

### Co-designed core training curriculum

As noted above, the training curriculum development was led by Gerstein in close collaboration with community anchor partners. Individual training sessions were offered by content experts who were often directly affiliated with TCCS partners. According to community anchor partners, the participatory and engaging nature of the curriculum development efforts facilitated relationship-building between partners and strong understanding of each other's approaches. As one participant shared,

> *The best part of the trainings were us coming together as a team…my favourite trainings were the ones done by Gerstein, TAIBU and 2-Spirits. I really appreciate the effort that went into team-building. (TCCS training participant)*

It also facilitated the production of relevant and high-quality training materials. As a City of Toronto participant shared, "Partners were involved with the design; the wealth of knowledge to co-develop the curriculum was

really helpful." A participant from the lead training partner, Gerstein, agreed and shared during interviews that offering different ways for staff to engage with training content is critical to their learning. Such additional considerations regarding support for staff undertaking training (during and after) is especially critical for BIPOC staff and staff with lived and living experiences of mental health challenges; 38% of TCCS trainees shared they have multiple disabilities, most often learning and mental health-related, which further suggests that careful consideration and collaboration in designing and delivering training content is required.

TCCS partners shared during interviews that moving forward, responsibility of administering training (e.g. scheduling) and creating a platform for ongoing orientation should be led by the City of Toronto as the program's backbone support, however, training-related tasks should continue to be done in close collaboration with community anchor partners.

### Indigenous cultural safety approaches support Indigenous staff wellness

One of the concepts embedded throughout the TCCS is cultural safety. Cultural safety is directly associated with one of the core principles of the intervention - ***to ground the service in the needs of the service-user, while providing adaptive and culturally relevant individual support needs.*** This connection is imperative because culturally relevant supports exist in spaces where cultural safety is embedded in the guiding practices of organizations and institutions. Within the context of TCCS, 2-Spirits, partners, and advisory members have defined what Indigenous cultural safety as follows:

> *Indigenous cultural safety is specific to making space, services, and organizations equitable and considerate of the historical/colonial impacts and manifestations of racism and discrimination within institutions and other systems. Indigenous Peoples should be a priority.*

Following from this, participants also took the opportunity to explain what Indigenous cultural safety does not mean from their perspectives:

> *Indigenous cultural safety does not mean we exclude people that have other faith-based beliefs/values, or denomination and it is not a pan-Indigenous approach.*

The concept of a pan-Indigenous approach is an important one to be considered when discussing Indigenous cultural safety as a "one model fits all'' approach is often perpetuated by institutions and systems. In the context of the TCCS, 2-Spirits highlighted that Indigenous cultural safety takes into account that "safety or safe" may have different meanings depending on the Indigenous groups and individuals being engaged and supported. According to 2-Spirits' Advisory Group, Indigenous cultural safety approaches also acknowledge that not every Indigenous staff, service-user and/or their families will require "culture" to be part of the supports requested by them.

Cultural safety is a term that emerged from New Zealand in the 1990s and has since become broadly incorporated into healthcare training and practice worldwide, including in Canada (22). Broadly speaking, cultural safety is about power; this approach recognizes the barriers to service that are inherently connected to power imbalances between the person providing care and their client.

> *"…cultural safety seeks to achieve better care through being aware of difference, decolonizing, considering power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe." (22)*

Indigenous cultural safety invites individuals working with Indigenous peoples to practice ongoing self-reflection to meaningfully recognize their own cultural biases and prejudices toward Indigenous peoples, as well as the culture of the system(s) in which they operate, to understand how those may affect/influence their attitudes and the overall care they provide to their clients (22). Cultural safety is not about service providers learning the different cultures of the peoples they are supporting, it is about looking inwards to understand how one's culture, belief, and values may impact quality/safe services provided to Indigenous peoples;

> *"In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the 'exotic other' patient." (22)*

Overall, Indigenous cultural safety approaches that are meaningfully embedded across interventions help Indigenous staff to enact their roles within their organizations; and help to guide non-Indigenous staff and organizations to best support Indigenous peoples

experiencing mental health and substance use challenges using a reflexive, trauma-informed, anti-Indigenous racism lens (22). An important limitation pertaining to Indigenous cultural safety in this report is that the term itself was neither directly and collaboratively defined nor measured with all partners involved in delivering the program to date. However, based on the 2-Spirits findings pertaining to the concept of Indigenous cultural safety and that cultural safety is directly associated with one of the principles of the intervention, there is an opportunity for a future evaluation to include well-defined measures pertaining to Indigenous cultural safety across all partners. A key follow-up step will then be to extend and adapt the definition and measurement of cultural safety to other historically and structurally marginalized groups served by the TCCS, including people who identify as Black or racialized, 2SLGBTQ+, and/or as living with disability.

Data from this evaluation show that TCCS' Indigenous-led pilot region has meaningfully embedded culturally safe approaches to staff wellness throughout implementation, which emerged as a strong facilitator of overall Indigenous staff wellness and satisfaction within their organization. This began with training, as one 2-Spirits participant explained:

> *Ensuring staff feel represented in the training, ensuring staff are engaged in the training process as learning processes vary for individuals, and supporting staff that were being triggered around training topics were things we were actively doing…Having the additional staff supports in place, such as access to an Elder and medicines…were essential.*

Whereas the majority of respondents from other partners (65%) indicated they were either unsure or unaware of existing supports for Indigenous staff, that none existed, or that this was "not applicable" to them, only one of 12 2-Spirits participants did not provide a description of active strategies with 67% indicating that "access to culturally relevant support" was the top strategy in place in their organization to help Indigenous staff to feel empowered and safe in their roles.

Participants from 2-Spirits shared that they (uniquely) launched their program model with a full staffing complement, of whom 86% Identified as Indigenous; of those who did not, 100% identified as belonging to the 2-Spirits LGBTQIA+ community. Further, like other teams, 2-Spirits recruited many individuals with lived and living experience of disabilities, including mental health challenges. Many 2-Spirits participants, in turn, highlighted the benefits of having access to culturally relevant supports while working with the TCCS. The types of supports most meaningful to participants included traditional medicines, smudging, Elder supports, and peer help to feel safe and supported in their roles. According to 2-Spirits, these supports are critical for job satisfaction and overall well-being. Frontline workers from 2-Spirits shared that despite enjoying their roles, the work can be challenging and engaging in self-care is important to help staff feel rebalanced emotionally and spiritually. As one 2-Spirits participant described, "accessing culturally relevant self-care and peer support nurtures my Spirit," and another echoed, "access to an Elder really helps my spiritual and mental health."

Throughout the evaluation engagement process, 2-Spirits front-line workers noted the importance of working together as a team to support each other to respond to complex needs in the community. As one 2-Spirits participant indicated, "I have never worked in an agency where there is so much peer support." Another participant reflected:

Staff who participated in the art-based reflexive discussion mentioned that they feel like their work is part of a "cohesive circle" in which there is significant amount of peer support. This, in turn, helps them to provide meaningful care to community members in need of the service.

> *I really feel that we are supported, even in the little amount of time that I have been in this role. To have an Elder who we can actually speak to so that we can deal with stuff, not just from a Western lens is really nice. (2-Spirits participant)*

The overall high job satisfaction reported by 2-Spirits staff could potentially be attributed to the high staff retention rate reported by the partner, an average of 92% for full-time staff and 100% for part-time staff from July to September 2022. Unfortunately, at the time data were being analyzed to inform this report, there was no available data on the number of Indigenous TCCS staff hired within the non-Indigenous partners and their respective staff retention rates as this had not been identified as a core indicator at the time. Staff retention, if tracked across sites, could be used as a comparator to support further analysis. Given the developmental nature of this evaluation, there exists an opportunity to comprehensively measure overall and

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specifically BIPOC TCCS staff numbers and retention rate across all partners, and to qualitatively capture overall BIPOC staff satisfaction within their roles as the program evolves. Such metrics are essential to understand if and how the program continues to be in alignment with its core principles.

**Staffing and training: Key barriers**

While the qualitative data indicate staff are satisfied in their roles overall, and the training survey data indicate that the curriculum itself was well received by those who received it, qualitative data also reveals that implementation of staffing and training had its own challenges. Key barriers to successfully implementing staffing and training included the ***pace of implementation and organizational differences in the nature and type of training*** received across TCCS partners; and ***a lack of staff capacity and staff resources*** to support and retain staff once hired and trained.

### Timeline, pace, and variability in training implementation

For community anchor partners with staff attending the five-week training module, in both cohorts, timelines were cited as a particular challenge as participants reflected on "difficulties hiring staff while trainings were being offered" (Gerstein participant) and it being "expensive…and challenging to have everyone together at the same time because the services are offered 24/7" (TAIBU participant). Another community anchor partner expanded:

> *The timelines of how things rolled out, it was a difficult process…all the policies, while simultaneously hiring 32 people, while having those people in training full-time… That created a situation where folks didn't have a lot of access to us because they were in training for five weeks. Those early-on issues, questions around roles and policies, workplace environment, group dynamics – were affected by the timelines. There wasn't enough time to have things in place. They were hired, then they started the training. (2-Spirits participant)*

The City of Toronto also reflected on these challenges, which in itself reflects their overall level of responsiveness within this intervention: "One challenge is that the anchor partners didn't get to onboard the crisis workers; they went straight to training and didn't get a chance to see who they are working for and to help ground them there" (City of Toronto participant).

Other TCCS partners – 211 and 911 - received organizational-level training determined in collaboration with the City of Toronto. For these partners, both staff and leadership described feeling training implementation was hurried and decision-making was challenging for partners to keep up with. For example, a 911 participant recalled that insofar as training, "things were changing daily…but there were procedures we'd never seen before. That put the most confusion and stress on the call-takers – we'd get daily updates that things had to change." Staff from 211 described how "it was overwhelming with all the information, lots of handouts, different scenarios, didn't know what to expect" and how "it wasn't really explained to us, it was just thrown at us." At 911, 200 people were trained over nine weeks and so with the pace of change, those trained toward the end of the training period did not necessarily receive the same training as those trained at the beginning of the nine weeks. With both partners operating 24/7, it was also challenging to train overnight staff who were not scheduled to be on shift during the times training was offered.

Indeed, participants who did not receive the five-week core training also described concern about the comprehensiveness of the training they received and resulting level of preparedness leading up to the launch of the TCCS. Some staff who were hired after the training modules were delivered shared during interviews that they did not participate in the mandatory training and had limited or no access to the required module materials. In addition, some of the staff who did not participate in the core training shared that they had mainly received training information via staff who have had the opportunity to participate.

Police officers did not receive formal training but presentations were delivered by TPS senior leadership in March 2022 ahead of the TCCS' launch date to build awareness in each division. Police officers themselves described receiving minimal exposure to the intervention: "we didn't get a lot. We knew that a new program was being rolled out, and through our regular police channels, that a briefing would happen" (MCIT participant). Another police trainee suggested they had "needed more interaction to figure out whose role is what when on the call and the strengths of different people and how each group de-escalates." Several participants from 911 similarly described how "it would've helped if the actual training was "more in-depth" and "more extensive,"

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providing examples of how the "training skipped out on the part where we were trained to then be the people educating everyone else on the program" and "the part of training of when and how we can send."

A 211 participant reflected that "211 thought it was work we already do but there are differences on the TCCS line and we could have had better training supports." For example, 211 staff members reflected that "having more mock calls would've been good. Felt rushed to be honest. I didn't feel quite prepared." Another 211 participant shared they believe new hires need more training and coaching, as well as job shadowing, to be better prepared to respond to TCCS related calls and to ask the appropriate questions of service users. Training remotely was also described as a challenge, particularly for learning the dispatch processes and technology: "If the training is more interactive and engaging, it is easier to retain the information" (TCCS training participant). A 211 participant suggested: "We should've gotten training in a group setting, like with 911 – one, to get to know each other as colleagues; and two, that we would get the same training. It should be standardized, even with different organizational policies."

Despite the quick pace and evolving nature of how TCCS training was implemented, participants who received organizational-level training also described feeling increasingly more at ease over the course of implementation, with exposure to calls and practice. This was particularly true of 211, where "the majority of staff now feel confident, 'own' the radio and rarely now need any confirmation or push from management - they help each other and are saying that they feel way more confident" (211 participant), with another 211 participant summarizing: "More practice has yielded more confidence on the line." Success was attributed at least in part to their management team and the level of support provided to staff by direct supervisors. For example, one 211 participant described: "We have each other… we work well as our team and our managers" and another reflected, "managers are doing an amazing job to support when needed," while going on to importantly note "but their capacity to be live support might run out." In fact, this lack of staff capacity and staff supports emerged as the second key barrier to successful staffing and training for the TCCS.

### Lack of staff capacity and resources

Nearly all TCCS partners expressed concerns about the lack of "people power" - both in terms of having enough staff capacity and enough resources to support those staff to be successful and stay well within their roles. Particularly with early staffing challenges and the resource-intensity of implementation, the lack of staff capacity to respond to the current demand for the service, let alone its projected expansion emerged as a critical barrier to successfully staffing and sustaining this intervention. As a 911 participant summarized, "The numbers are manageable now, but if we scale up the project, it is not sustainable."

Participants from 211 described being concerned about their existing capacity to take on this quickly evolving and expanding intervention, going on to note how it will be important to ensure sufficient staff are in place to manage the projected increase in calls as awareness of the intervention builds and boundaries are potentially expanded. Management at 211 agreed that staff capacity was an issue in the first six months of operation, particularly earlier in implementation when they had only two Service Navigators on the overnight shifts. Overnight staffing has since increased. A 911 participant described an instance in which they "transferred where a caller definitely meets criteria and gets consent, and then finds out the team is not available and has to tell the caller that ok, guess I have to send the police anyways, which defeats the purpose" (911 participant). Another 911 participant reflected that

> *211 has staffing issues too though so quite often, we are waiting three minutes to get a Service navigator and then introduce the caller, give the information - would be nice if it was a more immediate transfer. That should shave off three minutes, which is huge in our world - another two callers we could've dealt with.*

While 911 participants expressed positive sentiments about the intervention overall, capacity pressures did emerge as a topic of concern in interviews and focus groups. As one participant described, "Every other agency has people solely assigned where we're still trying to wear multiple hats and we can't shortchange our other responsibilities." Participants emphasized their need for dedicated resourcing given they are currently the "the primary point of contact, spending five minutes explaining the program, increasing talk time, and putting others at

risk" and that they are "pulled in so many directions... wish I could dedicate more time or that there would be someone fully dedicated. But people cheer when they put a call through and I enjoy that."

Capacity was a barrier for community anchor partners too, from both 911 and 211's perspective, as well as the community partners themselves. As a 211 participant described,

> *sometimes there's a bottleneck too, only one van out at a time spending one hour with someone - sometimes it might be three to four hours before the van gets there so we can't guarantee an immediate response…still building capacity…a few times, 211 has received calls and the van has been off the road.*

Community anchor partners echoed the need for additional staff and went on to speak to the importance of having resources to support those staff. A CMHA-TO participant commented "more funding would be helpful. More staff - even in terms of staff retention." Another community anchor partner summarized that from the crisis worker perspective, "staff burnout will be on its way if staff are not hired" (TAIBU participant); and another echoed, "Service delivery should also consider the mental health and wellbeing of those delivering the service" (211 participant).

As noted earlier, 85% of the 100.45 FTE roles were filled by frontline staff. While both interview and survey data indicate staff are satisfied or very satisfied with their roles overall, a majority of the frontline staff attribute their high satisfaction to the sense of reward that follows their interactions with service users and those who support them. In addition, despite overall satisfaction, participants in this evaluation spoke to the need for increased staff supports. As a 211 participant expressed, "retaining newer staff has been tough. We train staff and spend all this time, etc., and then they quit. It's too much and they get stressed."

Data indicate additional resourcing is required to prevent staff burnout and increase support for community anchor partners to best support their communities. As one 211 participant reflected, "Our Service Navigators are the heartbeat of 211 and if that heart is hurt or bruised, it's going to ripple upwards and outwards." Participants from 211 at the management and leadership level shared they are "hearing that the calls are taking a toll on staff's mental health," particularly compared 211's other specialty lines, and that "staff feel they don't have the tools they need to do the work." The 211 Service Navigators themselves described how it can be

> *very jarring at times when you're dealing with TCCS calls - mental health issue, then you're looking for a food bank, then jumping to another crisis call - it can be very draining for us. Mentally, even emotionally. Some calls are really difficult. We need some time to gather ourselves, but there's like 11 calls waiting, and you feel you need to jump back in. I took a recent call, I'm not the type of person to cry, but that call made me really cry. I needed a five minute breather. (211 participant)*

Increased access to culturally safe staff supports, particularly for Indigenous staff across partners, was another identified resource gap. The majority of participants in interviews, focus groups and surveys shared that their respective organizations do not have a specific strategy or plan in place to support Indigenous staff, or were unsure and unaware of any specific resources and opportunities for Indigenous staff support, with participants from different partners indicating "Our agency has no current strategies in place for Indigenous staff" and "I'm Indigenous and I'm not aware of anything specific." As was seen with the impact of cultural safety and culturally safe resources, adequate staff supports, and awareness of those supports, across the TCCS workforce are critical and present a notable risk to the sustainability of the intervention.

## Data systems and information-sharing

**How were data systems and information-sharing implemented?**

A key part of the TCCS intervention is the way in which data is collected, stored, reported and shared at each partner level. Overall, TCCS partners reported challenges with data collection and information sharing processes due to the unique data platforms used across the intervention. That being said, quality improvement approaches to support these challenges have been a key facilitator in the implementation process. Key barriers of data systems and information sharing included incompatible systems and duplication of efforts, and organizational differences in data collection capacity.

Each TCCS partner brings to the intervention a different combination of data systems, data collection and

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reporting processes and electronic platforms. Whereas 911 collects and reports data using a computer-aided dispatch (CAD) system, 211 collects and reports data using both a helpline software (iCarol) that was uniquely modified to incorporate new fields for TCCS and a dispatch database and portal (TCCS Dispatch Portal) that was newly and specifically designed for the TCCS. Community anchor partners both have access to the dispatch database and have their own individual electronic medical record or charting systems in which they collect service user data using fields not necessarily aligned with the data TCCS intended to collect.

These different data systems have different functionalities. At 911, their CAD system's functionality is limited to call counts and basic call characteristics such as source, place, type and time. At 211, iCarol's functionality requires extensive manual entry, resulting in duplication of effort when used in conjunction with the TCCS Dispatch Portal as the two internal data systems are not connected. Data from 911's CAD system can be linked with 211's iCarol data using a TPS event number to produce a complete service user record from call intake to TCCS mobile crisis team completion on site, however, challenges have emerged when the TPS event numbers for relevant calls are not recorded or captured. Additionally, there is currently no process to link the data from 911 and 211 with community anchor partners' independent data systems.

**Data systems and information-sharing: Key facilitators**

### Quality improvement approaches

As mentioned, a key facilitator of this intervention is the quality improvement lens used by partners to support data system implementation and information-sharing challenges. From the backbone perspective, the City of Toronto acknowledged the complexities of data collection processes and data system implementation. A City of Toronto participant described the idiosyncrasy of the data as the most challenging aspect; data is entered by many different individuals with different systems and is often open-ended or text-based and situationally specific. This, in addition to the unpredictability of calls, has limited the ability to create efficient and standardized data collection processes such as checkboxes and drop-downs. The need to match data from one system to another has added further complexity; for example, in linking of 911 and 211 call data where

> *one identifier that links the calls is the event number from TPS and we can't match a record without this. This number is put in manually and if 911 doesn't provide this info to 211 [or it is not recorded by 211], then you cannot match the record. Hence so many missing data points. [This] requires a lot of manual verification. (City of Toronto participant)*

When asked about the management of data, the City of Toronto shared that they had not fully anticipated or known what data management processes would be required until implementation was already underway. Since then, however, the City of Toronto remarked that partners have come together with "a lot of great ideas and problem-solving" around data management. Examples to support quality improvement and streamlining have included the ongoing refinement of data fields; procuring software, such as Tableau, to merge data sources; and receiving support from the Safe TO analytics lab to streamline processes and make data collection and reporting more sustainable.

In addition to the City of Toronto, 211 approached data collection and reporting from a quality improvement perspective. Implementation tracker data shows 211's frequent activities associated with modifying data fields and processes within iCarol and the dispatch portal, particularly when community anchor partners have shared challenges associated with data system implementation on the ground. This was exemplified by community anchor partners sharing times they have arrived on site to police already present because of a situational change that had escalated to require their response. As a result, 211 was looking into a way the dispatch can be canceled on the dispatch portal by 211 so the crisis team does not duplicate service and create confusion for other first responders and the service user. Other forms of quality improvement processes taking place at 211 include meeting regularly with anchor partners to learn about their needs and hearing feedback on what works well and/or does not work well from a data system implementation perspective. A 211 participant shared that "practices have changed and become more complex but that's also a good thing so we get to dig down further." With the ongoing adaptations to implementation processes on the ground, 211 continues to make data system changes to support the improvement of data collection and reporting.

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Like 211, with time, community anchor partners reported adapting to data collection and reporting processes. TAIBU, for example, described the many hours spent pulling data from the dispatch portal and they "fell behind initially on the data piece because the EMR wasn't designed for it." Since then, TAIBU, like other partners, has dedicated data collection to a designated staff (as per the program model) and "now folks are getting better with checking off boxes in the EMR and writing specific things down in terms of the data points" (TAIBU participant).

**Data systems and information-sharing: Key barriers**

### Incompatible data systems, technology, and duplication of efforts

A common theme that emerged related to the incompatibility of the intended use of existing data systems and the data required by TCCS. For example, a 911 participant described "a level of frustration on this [data systems we are using]. They are not designed to collect information in the way we are collecting information for the TCCS" and that "reporting is completely different than the reporting we typically do," citing frustration with the inability to collect and report a greater level of call detail:

> *The data was the biggest nightmare on the tech side – people want numbers but we work with an emergency system meant to dispatch police. We couldn't speak to all the different data pieces that all the partners wanted. They wanted to know if it's decreasing calls, decreasing repeat callers, but the system's not set up for that – had to create a lot of extras which are now extra steps for the call-taker to do as well. Now they have to click this extra box, enter this message into text, introduces a lot of human error and lack of stats, lack of understanding. Very frustrating.*

While some new data points were created, like a notification checkbox for when a call is transferred outside the TPS system (i.e. to 211 for TCCS), for example, "the quality of the data for the new data points were not as high as we would like them to be" (911 participant).

Community anchor partners described similar sentiments as a variety of data system platforms are used at respective partners. For example, Gerstein and 2-Spirits use Pirouette Case Management Software, TAIBU uses PS Suite and CMHA-TO uses Input Health. With each partner implementing a unique system, there is a need to adapt to often incompatible processes. A CMHA-TO participant, for example, described having "to create our own manual form where staff are capturing data in there and then it's sent to the admin who puts it back in one place…it's not an ideal system that we have right now." A TAIBU participant echoed: "When we saw the data points that needed to be collected, we needed to redesign our whole process." Partners with later launch dates were also less far along in implementation of data systems and information-sharing, describing their experience as follows: "in the moment, it's quite tedious, but helpful. We started grabbing the data but we haven't finalized it to send it in" (2-Spirits participant).

These incompatible systems contributed significantly to the presence of redundancy and duplication of efforts in the data collection system used by 211. For example, when 211 Service Navigators receive and assess a call, iCarol is first used to collect information. In cases where a 211 Service Navigator determines a dispatch may be required, they must then replicate that same information into another system (i.e., TCCS Dispatch Portal), which is used to formally submit a dispatch request. A 211 participant shared the following:

> *The biggest bottleneck is the doubling of what we have to do. When we get a call, we do iCarol, we capture the event number. Once that's done, we have to copy that same darn info piece by piece to put it into a portal to submit it. Then log into the radio. I guess there is no stable solution to that? But that adds like 5 mins to that call.*

Another 211 participant agreed: "Sometimes you have someone in crisis so you wanna work as quickly/accurately as possible .. so when you're copy/pasting over and over it feels like a waste of time." Adding onto the above, more 211 participants shared their thinking around the purpose of the two systems (i.e., iCarol and the TCCS Dispatch Portal), and whether it may be worthwhile for mobile crisis teams to have direct access to iCarol. As one 211 participant explained,

> *Personally, all the information about the call - the anchor agencies should go to iCarol for the information and the TCCS Dispatch Portal is the trigger/new request prompting you to verify the call and confirm. When I use the two platforms, I think some of the info should be the same. As a call taker I spend extra time copy/pasting. That is something I think in terms of technical support they can do that. They can help us to make it easier.*

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Technology challenges with radios in particular have posed a barrier to implementation to date, especially for 211, whose participants universally described frustration and inefficiencies resulting from having to learn a new technology and then having technical issues. These included not being able to hear the mobile crisis team staff on the other end of the line; or in the early months of implementation, having to hear radio chatter in the background while attending to calls on the phone, which was distracting for staff. With a dedicated dispatch position, distraction by radio chatter is expected to subside.

Community anchor partners shared instances of process challenges and duplication as well, such as when mobile crisis teams and other emergency services are both involved in dispatches due to a lack of streamlined communication and information-sharing. For example, there was an event shared where a mobile crisis team was on site beforehand, departed, and then MCIT arrived. A police participant recounted:

> *One time, there were duplication efforts, TCCS was there before and then MCIT showed up. I had no idea that the team was there before. Another call, I requested. I understand the division is huge. Took an hour to get there. Which seems outlandish. When they did get there, it was proper, and it was good. We cannot leave, it's like an hour of us hanging out, keeping the narrative going.*

Although it was not clear why there was a duplicate dispatch of both TCCS and MCIT to the same event, it may imply a lack of information sharing between the two teams. This experience also revealed another complication: when police request a TCCS mobile crisis team to take over the event, whether or not police are required to remain on scene until TCCS arrives is determined by Road Sergeants on a case-by-case basis. Ultimately, incompatible systems and technology could result in a delay of police being relieved by mobile crisis teams and responding to other urgent events.

### Organizational differences in data collection capacity

Participants were asked to reflect on their experiences implementing and using their data systems to fulfill their respective roles in data collection, reporting and information-sharing, which collectively contribute toward the overall data collection and reporting for the TCCS. As one 911 participant reflected, "the data source we [911] are collecting is a very small piece of the puzzle." A common theme was how the addition of new fields and a new platform felt like a significant change for staff across partners and created "more pressure to fill in more information for TCCS because it affects other people at other agencies" (211 participant). Reviewing and revising data collection platforms and processes were the most commonly cited implementation activities for 211 in the first six months. As one 211 staff described, "TCCS allowed for a new template to be developed, which has been the biggest change," and another noted how there were "a lot of platforms to navigate that were sold as being easy but are not when you have a PIC [person in crisis]." 911 participants similarly described how "the burden has been placed on the call-takers and this is a big ask" and echoed that there was, for example:

> *a lot of confusion because we have many programs implemented – we have a canned dropdown but there are some for [another pilot program] plus TCCS plus other programs – a lot of confusion around what to click, 'Am I doing it right?' 'I'm not a bean counter.' That's been a big frustration for the call-takers.* ***(911 participant)***

Another 911 participant echoed that additional data points are challenging in the context of a crisis: "Typically, they [911 call operators] are just creating the response, not thinking about the data, that's not their function – their job is to analyze a situation and create a response. Adding the metrics is an extra challenge."

Frontline police officers have had a lesser role in data collection to date, due to their indirect role in TCCS and limited interactions with the TCCS mobile crisis teams to date. One police participant remarked they have "no box [to check], people may be putting it into their written reports," as another police participant indicated they have "no idea where the data goes. I was told to keep a log of how many calls, yes, no, didn't show – I wasn't told very much. I was told I was representing my group on the platoon and I should keep track of things."

Community anchor partners shared similar sentiments regarding data collection and reporting processes. With many changes to data collection processes within this intervention (i.e. addition and revision of indicators, and data changes to data collection tools), the current capacity for anchor partners to make these changes on the back-end of their data system is low. For example, in order to capture quantitative data and send it to the

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City of Toronto on a monthly basis, anchor partners have created separate excel spreadsheets to support the collection and reporting of some data points that their respective data systems do not have the capacity to collect. As mentioned above, this work requires hours of manual labour, accessing data from multiple sources, including case notes, in order to meet reporting requirements. The following quote was shared by a TCCS staff member regarding the challenges associated with data collection and reporting processes:

> *We need to review all data manually and extract the relevant information from multiple sources in order to input into the data collection template that goes to the City. This is very time consuming and creates opportunities for mishandling the data. (2-Spirits participant)*

Moving forward, several participants spoke to the need for a centralized, uniform system for all service providers involved in the TCCS. As one community anchor partner described, there are likely gaps here as well… all of our data isn't centralized. Everyone is operating within their own systems. We've had to integrate new systems because we weren't a crisis response so our data software didn't really apply with what we're doing now. Our data across the agency isn't really centralized. Even with the pilot [TCCS] too, because we're doing things like the implementation tracker, quarterly reporting on the same page, then quant[itative data] on another one, which we have to grab data from our case notes to put into there. Data is also coming from 211/iCarol. The data feels like it's coming from every direction. (2-Spirits participant). Another echoed, "Having a standardized system in the future would be a key part of this project" (TAIBU participant).

## Community outreach and engagement

**How was community outreach and engagement implemented?**

The majority of TCCS partners reported an overall low level of community outreach and engagement in the first six months of operation, with varying levels and types of community outreach and engagement activities throughout implementation.

Implementation tracker and qualitative data from interviews and focus groups detail collaborative, community-based launch events held in alignment with the staggered launch dates. Additionally, some participants described limited community outreach and engagement. From across partners, participants identified the need for greater partnership with groups and organizations that can or should be aware of and refer to the TCCS, such as the shelter system, Toronto Transit Commission, and large community organizations like the YMCA. Participants from 911 suggested there "could be a lot more public education and organizational education" and relayed "limited information went out through social media – a couple tweets and Facebook posts…don't do much with the community." A 211 participant echoed that they "haven't seen the community's voice since the first session."

Some TCCS participants went on to associate the lack of community outreach and engagement to date with operational challenges, including capacity challenges associated with the amount of time spent by 911 and 211 introducing and providing information on the service to service users. "A public campaign should have been done before the pilot started…so that call-takers would not need to share with callers what the project is about over and over again" (911 participant). The overall low level of awareness of the program within the broader community was also noted. One police participant remarked, "the community doesn't know you [TCCS]." A City of Toronto participant acknowledged "some areas are getting high volumes of calls, and some lower - this has to do with the education piece."

As a result, 911 "call operators are frustrated there's no public education piece and it's solely on them to explain the program" (911 participant). Another participant described feeling burdened by the need to fill the gap:

> *The burden of education has fallen on us; 99% of the time, 911 calls are not emergency. Usually, it's people looking for information, people asking for police when it's not needed. But the pilot is absolutely necessary, absolutely valuable. But our wait times are atrocious. And the time we have to spend explaining the program adds up and the queues keep growing… callers get frustrated that they've never heard of it and just say to send the*

> *police. Some people don't even want to understand the education part of it, they just want the police to come instead.* ***(911 participant)***

At the same time, 211 expressed concerns about capacity to carry out and respond to greater community outreach and engagement efforts if/when implemented more fulsomely: "In terms of wider promotion in the fall of 211 as an entryway into TCCS, 211 currently doesn't have the internal capacity to handle that" (211 participant).

Community anchor partners reported relatively more robust outreach and engagement than other TCCS partners, indicating outreach was generally embedded in their daily operations. When asked to comment on their community engagement, TAIBU, for example, described attending Children's Aid Society meetings as well as a community event they hosted at the end of August in which they brought food and community together to learn more about the TCCS. "If we don't let community know we are here, then we don't have a service" (TAIBU participant);

> *We do this on a regular basis. If the team is not too busy, we tell the team to go to areas like the Beaches and hand out flyers to ensure they know that this initiative exists…42 Division, letting them know that there different places to go…CAS [Children's Aid Society], go to their meetings…If we don't let community know we are here, then we don't have a service.* ***(TAIBU participant)***

A Gerstein participant similarly described reaching out to the community by having a table at the Toronto Pride Parade to share information about the TCCS, for example, and reported "the TCCS team does outreach all the time, staff meetings with other organizations." Other partners reflected on the outreach and engagement they had done with their community service networks. In particular, 2-Spirits reported a comparatively robust effort:

> *We did host info[rmation] sessions...we created posters and registration forms to share with those agencies [ENAGB and Parkdale Community Health Centre] to share with their community…presentations on the pilot and answering a Q&A at the end. We created a Facebook and Instagram media campaign, our community access us through Facebook…a newsletter as well. Beyond that, through our Community Advisory Committee, we have those folks that talk within communities.* ***(2-Spirits participant)***

TCCS staff at CMHA-TO described outreach efforts to date as "going to different organizations on their shift; going to shelters, hotel shelters, government organizations, going to the nearest McDonalds" (CMHA-TO participant). In this northwest pilot region, which was unique in developing a coalition of community service providers and distributing funds amongst the group, CMHA-TO reported having coalition member Caribbean African Canadian Social Services (CAFCAN) lead community engagement but this being limited to date given their relatively earlier stage of implementation: "The community engagement lead was hired by CAFCAN and they just started and they will be taking the lead to create a Community Advisory Group and do more community engagement events" (CMHA-TO participant).

# Results: Evaluation Question 3 & 4

### Community engagement and outreach: Key facilitators

#### Partnerships and collaboration

In the limited community engagement and outreach that occurred, the most apparent facilitator was partnerships and collaboration. For example, CMHA-TO noted their coalition model has particularly supported their ability to engage the community because "they've been working with communities for so long and it's helpful to get their insight" (CMHA-TO participant). Reflecting on their launch event as an example:

> *The Launch event would not have been possible without the partnerships we have. Jane and Finch set us up with a space and equipment all for free for the program; and other partnerships gave us vendors and discounted rates because those vendors have worked with these organizations for such a long period of time. (CMHA-TO participant)*

### Community engagement and outreach: Key barriers

#### Lack of staff capacity

Despite this being a key element of the TCCS theory of change, capacity to enact these activities was frequently limited by a lack of staff capacity as well as emerging and pressing operational needs associated with the launch and process improvements in the initial months of TCCS operation. This emerged as a cross-cutting barrier that has previously been described and is therefore not expanded upon further in the current section beyond to say that participants from across partners have previously identified significant capacity barriers to direct service delivery. If direct service delivery lacks capacity, certainly partners are unlikely to then have additional capacity to participate in robust, proactive community engagement and outreach.

# Results: Evaluation Question 5

## Evaluation Question 5: How suitable is the Toronto Community Crisis Service for the system and setting in which it is operating?

This final evaluation question reflects on the appropriateness of the intervention in terms of its perceived fit and relevance for communities across the City of Toronto. Data in response to this question were drawn from the range of mixed method data sources and include Toronto Community Crisis Service (TCCS) program partner and staff perceptions around overall suitability of the model for its intended communities and current context; reach to intended communities; and service user perspectives. The section concludes with a brief overarching assessment of suitability or appropriateness for the system.

### Partner and staff perceptions of service suitability

Preliminary data from a variety of sources indicate the TCCS is trending in the right direction in providing meaningful support to individuals and communities, despite the implementation challenges and system-level barriers described in previous sections. TCCS partners tended to agree with this overarching assessment, with 82% of survey participants from across TCCS (N=43)[26] responding favourably (49% strongly agreed; 33% agreed) when asked directly, ***"To what extent do you agree the Toronto Community Crisis Service is suitable for the system and setting in which it is operating?"*** In addition, when asked whether the intervention was working well overall, 75% of survey respondents indicated they strongly agreed or agreed. Results of the Wilder Collaboration Factors Inventory further showed that 100% of participating partners agreed (with five of six strongly agreeing) that ***"the time is right for this collaborative project."***

Overall, TCCS program partners and staff who participated in one-on-one interviews shared a degree of optimism in relation to the suitability of this program model across the four pilot regions, while continuing to note implementation challenges. A majority of TCCS partners and staff described reasons they believe the program is suitable and appropriate to the setting in which it is operating. As one individual described,

> *The TCCS program has come at a time when members of TPS Communications [911] are being asked to do more in their positions. As such, there has been a learning curve with this program but members do see the benefits of TCCS - not only for citizens who need it but for the TPS organization as well.* ***(police participant)***

TAIBU participants shared that "the system is geared to work in a certain way that works for a certain group that's very small - really, really small - compared to the communities who are experiencing these problems" and that it is the consent-based and compassionate approach their TCCS team have when supporting individuals in crisis helps to build community trust in the service:

> *Because the model is consent based and is so different from the way police work, this adds a level of trust within the community. For example, if a client asks to be left alone, crisis workers will leave, but may leave a bottle of water or food as basic needs supports.* ***(TAIBU participant)***

As another TAIBU participant shared:

> *Part of the reason this program is so successful is that we talk on their level and are able to explain what's happening. It isn't just a compartment. We need a solution for how to live with this diagnosis. How can we offer solutions when there's no avenue to take care of yourself and give to the world? That's really what heals people: contribution and belonging.*

Indeed, other participants shared learnings on how critical it is to be present for clients in the moment, to meet them where they are at on a human-level, to listen to their stories without judgment: "I'm going to walk into this call, I don't know what the situation is, I would make sure I have no judgment, no stigma, positive energy and energy to support that person in that moment of crisis." (2-Spirits participant).

Despite some implementation challenges and "steep learning curves" experienced by institutional partners, including the overall capacity of partners to implement the program, data and technology, and systems-level readiness to sustainably address major inequities to

[26] Note: Survey limitations include unequal representation across partners. Please see survey representation in Appendix O.

# Results: Evaluation Question 5

effectively support TCCS clients (e.g. mental health supports, housing and shelter, food security, and basic income), there are truly valuable and appropriate elements of the intervention in relation to the needs of the population it serves. Most importantly, the compassionate, trauma-informed, holistic support offered to service users during and after crises to address their immediate mental and physical health, as well as their basic needs for social care, is integral to effectively serving historically and structurally marginalized communities.

Immediate opportunities to enhance service appropriateness were discussed earlier and include increased collaboration and communication amongst partners, data and technology enhancements, and ongoing core and maintenance training, co-designed with and equitably available to all TCCS partners. One of the most significant opportunities to improve the overall intervention's suitability is the development and implementation of meaningful, Indigenous cultural safety practices within all partners, particularly when used in combination with better data systems and data training to support high quality demographic data collection and use. Successfully and meaningfully incorporating Indigenous cultural safety practices will take time and real commitment by all involved, but will purposefully facilitate the implementation of equity-focused approaches throughout the intervention pathway.

## Sociodemographic reach

A key consideration in the assessment of suitability is the intervention's reach or the degree to which the intervention was accessed by its intended structurally marginalized populations, including Black- and Indigenous-identifying people, people of colour, and members of the 2-Spirited LGBTQIA+ community. To evaluate this, demographic data was collected from TCCS service users at different points in the call pathway, where feasible, at this stage of implementation. Five key equity specific indicators were reported from follow-up during case management and from 211 I&R referral data: age, gender, disability, race, Indigenous identity and are presented below for comparative purposes. However, it is important to note that all TCCS partners shared notable challenges collecting demographic data during follow-up calls and visits, hence the proportion of missing data reported.

As mentioned previously, there were 103 calls resolved over the phone by 211 through I&R.[27] Of those 103 calls, 71% of callers were aged 16 years and over and thus eligible for the service; in 23% of age data was reported as "not applicable". Gender was identified by callers with 43% identifying as woman, 34% identifying as men, 3% reported no option listed for them to identify with and 1% preferred not to say. 19% of gender-specific data was reported as "not applicable". In terms of racial background, data was 96% incomplete and disability data was missing at a similar rate (96%). This critical gap in data precludes determination of whether the TCCS reached its intended populations.

Among community anchor partners, demographic data collected during follow-up visits and case management was of higher quality but still missing in notable proportions. Across site, this dataset indicates that TCCS service users who received follow-up care as part of the intervention were aged 16 years and older (63%; 28% missing); fairly evenly split between men (40%) and women (34%) with 2% identifying as transgender, another 2% gender non-binary, and 1% Indigenous; the remainder of data is missing. Similar trends were present for language, with approximately 40% of service users identifying as English-speaking. There were very small proportions of other categories such as French, Hindi and Somali, and the remainder missing (40%); and for disability, with 37% identifying as experiencing a disability, most often mental health (58%); physical illness or pain was the next most commonly identified disability at 8%), and the remainder of disability data either missing or participants were unaware or preferred not to answer.

Lastly, sociodemographic data was collected for training participants, as reported in the previous section (see **Training**). In part, this data was collected in order to evaluate whether TCCS staff backgrounds and experiences reflect the communities they intend to serve, a key tenet of the program model. While this data is not representative of all program staff, it does begin to suggest that the TCCS mobile crisis teams, in particular, are staffed by individuals with diverse gender and racial or ethnic backgrounds, as well as lived experiences of mental health disabilities.

As a whole, sociodemographic data quality, especially for service users, precludes conclusions at this time

[27] It is important to note the limitation of collecting I&R specific demographic data. Not all callers are comfortable disclosing demographic characteristics over the phone. Therefore, the data reported will consist of responses where "not applicable (N/A)" is reported.

# Results: Evaluation Question 5

beyond suggesting the intervention has successfully reached adults across the City of Toronto experiencing mental health challenges. The need for improved data systems and capacity to support collection, reporting and use of high quality demographic data collection has been identified previously in this report, and its impact on resultant data quality in the current report is worth highlighting.

## Overall assessment of suitability

The TCCS has successfully diverted a large majority of its calls from 911 (78%) with only 4% of events over six months attended by emergency services and 1% of events resulting in service users being transported by Toronto Police Service. In addition, TCCS mobile crisis teams made over 700 referrals to community-based follow-up supports and enrolled 334 service users (28% of mobile crisis team dispatches) in post-crisis case management. The most commonly referred cultural supports included those for Africentric and West Indian/Caribbean-centric supports and Indigenous-specific supports, which suggests reach to communities of interest. Preliminary program data such as these and several process indicators trending in positive directions, including increasing call volumes and decreasing total call time, suggest overall suitability of the TCCS for the City of Toronto. Further, given demonstrated collective willingness to collaborate and improve and the fact that a significant proportion of the implementation barriers identified were related to identifiable and actionable process improvements, many of which are currently being acted upon, the evaluation's overall assessment of the suitability of this intervention is positive.

To further improve appropriateness in the current intervention stage and system context, and given lessons learned to date, a series of recommendations are offered in the next section of this report, the implementation of which is expected to bring the TCCS even closer to meeting the needs of the communities it aims to serve.

## Service user testimonials

While service user experiences and outcomes were outside the scope of this evaluation, a short survey was developed upon ad-hoc request by the City of Toronto containing open-ended questions for community anchor partners to use with former TCCS service users to preliminarily inquire about their experiences of services received. A total of three former service users engaged in the survey across different pilot regions. The survey was administered verbally by TCCS staff who were known to the participants via the phone; or a survey link was shared with participants and TCCS staff supported them through the response process via phone. Based on the information gathered, the overall experience of these service users was very positive, with participants sharing they felt safe, supported, and respected while receiving support from the TCCS staff. One survey respondent shared they were able to access the support they needed through the program, while another survey respondent noted the "great care and compassion" they experienced while in the program.

Below are testimonials provided by the three service users broken down by the different survey prompts.

**What was your experience like getting help through TCCS? Did you feel safe? Did you feel supported? Were you able to access the supports/services you think you needed?**

> *"I felt very safe and supported. The support I received was way beyond what I expected." (TCCS Service User, 2022)*

> *"Yes, I feel safe and supported by [TCCS staff]. Yes I was able to access support." (TCCS Service User, 2022)*

> *"The service is so efficient and honest. I felt safe, I felt heard. There was no judgment. They helped me with no issue and made me feel like a person again. There were no lies and no promises that she didn't keep." (TCCS Service User, 2022)*

**In what ways has getting help through TCCS impacted you and/or your community? Examples: awareness of the services available, culturally relevant supports, sense of safety/belonging.**

> *"I felt very safe and respected in the services I received. Great care and compassion was given in the handling of my situation each and every time." (TCCS Service User, 2022)*

> *"I have a better sense of safety in my own home. And of what my rights are as a tenant/renter." (TCCS Service User, 2022)*

# Results: Evaluation Question 5

**If a friend/family member were in need of crisis support, would you recommend TCCS? Why?**

> *"Yes I would recommend it because it is good that someone is always checking on you." (TCCS Service User, 2022)*

> *"Absolutely 110% without a doubt." (TCCS Service User, 2022)*

**What has been different about TCCS compared to your past experiences in getting help?**

> *"The level of experience, knowledge, respect and care I received." (TCCS Service User, 2022)*

> *"The intervention has been very down to earth, fast, efficient. I have no complaints at all. Excellent service." (TCCS Service User, 2022)*

**Is there anything else you'd like to share?**

> *"The TCCS is an amazing and compassionate agency. I felt heard, seen and listened to. For me that was extremely important. The workers were non judgmental, kind and always available. Thank you very much!!" (TCCS Service User, 2022)*

# Limitations

## Evaluation design limitations

This evaluation was co-designed with Toronto Community Crisis Service (TCCS) partners and the evaluation scope, priorities and processes have evolved over the course of implementation. Given the early stage of implementation and the complexity of this intervention, scope of the current evaluation was limited to several key implementation processes and outcomes and the perspectives and experiences of TCCS partners and staff; that service user and community voices are not included in the current evaluation report is its most significant limitation. Particularly in light of limited staff capacity and data system capacity challenges, further refinement of the evaluation design is also required to reduce burden on staff and improve monitoring and evaluation efficiency and utility moving forward. This approach aligns closely with the developmental and utility-focused frameworks informing this evaluation.

## Data limitations and considerations

There are several limitations to the data presented in the current report. Of 3,024 total call records reported in the first six months of the TCCS, 412 (14%) were incomplete and could not be verified at the time of analysis; and of the 2,489 calls successfully received by TCCS, 149 (6%) require further verification to determine intake source before missing data rates can be further attributed to each partner with confidence. Missing data in individual partners' datasets had led to challenges reconciling datasets and verifying and/or completely documenting a TCCS call record. Incomplete records can result from a variety of circumstances. Most often, the Toronto Police Service (TPS) event number, on which dataset linkage is based, is missing due to miscommunication or misreporting during handoff between 911 call operators and 211 service navigators; or, a 211 call record is missing a corresponding TPS record or dispatch record, leading to an inability to verify a successful transfer.

With the TCCS being a pilot program in its first months of implementation, significant evolution in data quality was expected. Data reconciliation has been ongoing and quality improvement discussions and activity have occurred consistently throughout implementation; and responsive decision-making has led to continuous improvement in both data collection and reporting processes and the resulting data quality. Continued improvement in data quality is expected to continue with the automation of several key data sharing processes underway, including the automated transfer of TPS event numbers to 211, which is expected to significantly improve data quality and completeness.

The second limitation to note is with regard to the quality and completeness of sociodemographic data in this report. Demographics remain challenging data elements to collect and report across sites given different collection points and processes by different partners with different data systems. Across both sets of demographic data included in this report, the majority of data is missing, particularly for key equity indicators like race and disability, which are collected later in the call process and for a smaller proportion of eligible callers. Additional and ongoing refinement of demographic data collection processes through both data collection and reporting training and centralized data system infrastructure improvements are anticipated to contribute to improved data quality over time.

The third and final consideration is the qualitative data included in this report reflect the experiences and perspectives of a convenience sample of participants and may not generalize across partners or to the broader populations participating in and affected by this intervention. At the partner level, this sample includes significantly more participants from 211 and 911. In part, this was due to the scope of this implementation evaluation and the focus on call intake and diversion processes; in part due to organizational size; and in part due to the staggered launch dates, with two of four community anchor partners launching in month four of a six-month evaluation, which limited staff availability and capacity to participate. Most importantly, however, the voices and experiences of service users and communities are not represented in the current report due to scope and feasibility. As noted, a follow-up comprehensive outcome evaluation will take place in 2023, which will be co-designed with TCCS partners and service users to ensure service user and community experiences and outcomes are prioritized in this next evaluation phase.

# Recommendations & future considerations

A series of recommendations aligned with current analysis are presented below. Each recommendation includes several sub-recommendations or specific actions with an indication of who should be responsible for implementation. Recommendations are further categorized as relating to immediate implementation or for scaling considerations (also summarized in **Tables 20a** and **20b** below). Recommendations are also subject to change pending feedback from partners.

## Immediate recommendations for ongoing successful implementation of the Toronto Community Crisis Service:

### 1. Commit more time and space to partnership and engagement activities within the intervention.

a. Co-create regular opportunities for all partners at all levels to directly engage and share perspectives, experiences and lessons learned; and involve multiple staff levels in such sharing and planning spaces.

   Inter-partner interactions and collaborative activities have been a key facilitator of successful partnership and collaboration within the Toronto Community Crisis Service at the leadership level, ongoing opportunities for which are feasible and should be maintained. Involving more staff from frontline positions in these interactions is recommended to further increase buy-in, alignment and collaboration within and across Toronto Community Crisis Service partners.

   **Responsible actor(s):** City of Toronto (lead) with participation by all partners

b. Increase community anchor partner attendance at 911 Operations and Toronto Police Service parades across Divisions.

   Specifically to improve the working relationship between Toronto Community Crisis Service staff and Toronto Police Service, increased regular attendance by all four community anchor partners and Findhelp211 at 911 Operations and Toronto Police Service parades are recommended as a feasible and effective mechanism by which to increase awareness and understanding of the intervention and to increase trust and confidence in the intervention within the Toronto Police Service.

   **Responsible actor(s):** Community anchor partners, Findhelp 211, Toronto Police Service

c. Offer opportunities for job shadowing and/or ride-along exchanges between frontline staff across Toronto Community Crisis Service partners including Toronto Police Service.

   Frontline staff from across Toronto Community Crisis Service partners expressed a strong desire to better understand one another's roles and contributions to the service pathway. Offering opportunities for in-person experiential exchanges such as in-person site visits to 911 and 211 operations and ride-alongs with Toronto Community Crisis Service mobile teams, Toronto Police Service Primary Response Units, and Mobile Crisis Intervention Teams, are likely to build trust and support role clarity and collaboration.

   **Responsible actor(s):** Community anchor partners, Findhelp 211, Toronto Police Service

d. Regularly communicate examples of service user pathways and outcomes across partners to promote team-building, bolster buy-in and instill confidence in the intervention and role of each partner (e.g. via eBlasts, storytelling, or while on parades).

   It is recommended that a regular communication plan be implemented to report back tailored program data to Toronto Community Crisis Service partners and staff that demonstrates the impact of their individual and collective efforts. Understanding what is happening to service users who participate in the Toronto Community Crisis Service as a whole alongside demonstrated impacts on service users and partners, particularly insofar as diversion from 911 and Toronto Police Service, will support confidence and investment in this intervention.

   **Responsible actor(s):** Community anchor partners, Findhelp 211, Toronto Police Service

# Recommendations & future considerations

## 2. Streamline communication and transition protocols between partners, particularly other first responders.

a. Increase availability of shared information across partners on call and service user status to ensure a safe and timely response from most appropriate first responder, and to prevent service duplication

It is recommended that process improvements, in addition to infrastructure and technology improvements, be explored to better facilitate data-sharing and communication between Toronto Community Crisis Service partners and any collaborating first responders when attending to Toronto Community Crisis Service calls. Ensuring all individuals involved in responding to a call for service have access to the most up-to-date call and service user status is essential to safety and efficiency of all Toronto Community Crisis Service partners.

**Responsible actor(s):** City of Toronto (lead) with participation by all partners

b. Develop clear protocols, including violence thresholds, for warm transfer or handoff of service users and information between Toronto Community Crisis Service staff, Toronto Police Service, Mobile Crisis Intervention Teams and Toronto Paramedic Services when on site across possible scenarios (e.g. escalating violence).

It is recommended that process improvements be collaboratively undertaken by Toronto Community Crisis Service and Toronto Police Service to clarify principles and protocols for co-response and hand-off of cases in several scenarios including when violence is present or escalating to support safe, efficient and effective on-site collaboration and positive staff and service user experiences and outcomes.

**Responsible actor(s):** City of Toronto, Toronto Police Service, community anchor partners

c. Regularly convene partners to review audited calls with opportunities for improvement.

Bringing partners together to collectively review calls end-to-end, identify opportunities for quality improvement, and collaboratively problem-solve and plan how to implement solutions will contribute to a culture of quality improvement and will serve as a forum to facilitate partnership development and collaboration.

**Responsible actor(s):** City of Toronto (lead) with participation by all partners

d. Monitor and continue to examine use of radios as key communication technology.

Radios have been notably challenging for Toronto Community Crisis Service staff to implement due to both process and technology impediments. With process improvements actively underway, ongoing monitoring and examination of the impacts of continued radio use on staff effectiveness and experience is required to determine whether process improvements alone can alleviate staff burden and subsequently improve suitability of the technology; or whether use of the radio technology itself should be reconsidered altogether.

**Responsible actor(s):** City of Toronto (lead) with participation by Findhelp 211 and community anchor partners

## 3. Increase support for data system implementation and quality improvement in data collection and reporting.

a. Dedicate additional staff, training and/or technology to increase capacity for high quality and efficient data collection and reporting across partners.

Dedicated supports and resources are recommended with regard to data system implementation at several levels. Greater staff capacity allocated to data collection and reporting and coaching are recommended to minimize burnout and human error; process improvements in data collection, data management and data reporting are needed to improve data quality, minimize inefficiencies and opportunities for error, and reduce burden on staff. Explore automation processes where possible to reduce duplication and time spent by 911 Call Operators and Findhelp 211 Service Navigators. Additional time and resources committed to identifying opportunities for the collection and quality of sociodemographic data across partners is also essential to supporting evaluation of health equity.

**Responsible actor(s):** City of Toronto (lead) with participation by all partners

# Recommendations & future considerations

## 4. Dedicate time and resourcing toward strengthening sociodemographic data collection processes.

Dedicated time and resourcing is required to determine how best to increase sociodemographic data collection opportunities and strengthen processes to improve overall sociodemographic data quality. Bridging this critical data gap will support a more robust determination of intervention suitability and ultimate success in reaching the Toronto Community Crisis Service's intended communities of interest.

## 5. Implement a co-designed, centralized and sustained training curriculum.

a. Adapt and extend a core training curriculum to all Toronto Community Crisis Service partners including Findhelp 211 and Toronto Police Service.

   Differential access to training across Toronto Community Crisis Service partners was negatively associated with differences in staff and partner experiences and preparedness to successfully enact intervention roles. Extending an adapted version of the co-designed core training curriculum, which was well received by community anchor partners, to Findhelp 211, 911 Operations and Toronto Police Service, would result in a more equitable training experience and greater levels of the necessary knowledge, skills and confidence to succeed collectively as a collaborative.

   **Responsible actor(s):** City of Toronto

b. Revise structure to include a "big picture" introduction to the service pathway and project values, including use of people-centred language; and more time spent on in-person i) cross-partner team-building and ii) practical or scenario training.

   Training that brings together Toronto Community Crisis Service partners as one and emphasizes a system-level perspective and collective focus on intervention goals and values will help to create buy-in and support alignment and understanding across Toronto Community Crisis Service partners, particularly with regard to respective roles, contributions and collaborative processes.

   **Responsible actor(s):** City of Toronto

c. Offer semi-regular centralized core training with rolling enrolment for new and recent hires to prevent knowledge gaps.

   Ongoing access to centralized core training across Toronto Community Crisis Service partners is recommended to prevent significant knowledge gaps within and across partners, which is particularly important in this context of early implementation with recruitment and retention challenges and expected expansion of the program.

   **Responsible actor(s):** City of Toronto

d. Design and implement a centralized maintenance training curriculum for all staff (e.g. "refresher trainings").

   Ongoing access to co-designed centralized maintenance training is recommended to ensure staff across Toronto Community Crisis Service partners equitably receive continued support in preserving knowledge and skills and in adapting to the expected emergent process changes associated with early implementation of a complex intervention.

   **Responsible actor(s):** City of Toronto (lead) with participation by all community anchor partners and Findhelp 211 and the collaboration of Toronto Police Service

e. Create a centrally accessible Community of Practice with all training materials for new and existing staff to easily access on an ongoing basis.

   Creation of a collective space or platform to host the most current training, reference and other support materials and interactive educational opportunities in a central and accessible location would contribute toward a collective identity and promote ease of access to and awareness of a breadth of resources required to support Toronto Community Crisis Service partners to enact their roles.

   **Responsible actor(s):** City of Toronto

# Recommendations & future considerations

## 6. Build organizational capacity in Indigenous cultural safety amongst all partners to support recruitment and retention of Indigenous staff.

a. Develop an Indigenous recruitment and staffing strategy to implement across sites.

   Co-design of a Toronto Community Crisis Service-wide Indigenous recruitment and staffing strategy is recommended to increase the representativeness of Toronto Community Crisis Service staff across sites and the Toronto Community Crisis Service' capacity to meet the needs of Indigenous service users across the City of Toronto.

   **Responsible actor(s):** City of Toronto with participation by all community anchor partners and Findhelp 211

b. Increase awareness of cultural safety and accessibility of Indigenous and culturally relevant staff supports across sites.

   It is recommended that all Toronto Community Crisis Service partners consider organizational-level cultural safety assessment tools, and receive resources to offer culturally safe and relevant supports for Indigenous staff across the intervention. Better supporting Indigenous staff wellness will capacity to support Indigenous service users and communities.

   **Responsible actor(s):** All partners

c. Implement ongoing anti-Indigenous racism training as part of the maintenance training curriculum.

   Actively embedding ongoing anti-Indigenous racism training and organizational supports for anti-racist, anti-oppressive practices is in alignment with key program values and support ongoing development of cultural safety capacity within and across partners in the Toronto Community Crisis Service.

   **Responsible actor(s):** City of Toronto

d. Implement ongoing monitoring and assessment of anti-Indigenous racism and culturally safe approaches within and across partners.

   It is recommended that the City of Toronto, community anchor partners and Findhelp 211 work together, with the collaboration of Toronto Police Service, to support accountability in the ongoing implementation, monitoring and assessment of anti-Indigenous racism and cultural safety approaches within and across partners.

   **Responsible actor(s):** City of Toronto (lead) with participation by all partners

## 7. Design and implement a deliberate and robust community awareness and engagement campaign that targets strategies to community needs.

a. Increase awareness, education, partnership and engagement efforts among the broader community of service providers (e.g. shelters, YMCAs, hospitals), frequent intake sources (e.g. Toronto Transit Commission, large building security companies), and service users.

   Dedicated capacity and resources to raise awareness and understanding of the Toronto Community Crisis Service in communities across the City of Toronto is needed to immediately reduce the burden on Toronto Community Crisis Service partners (especially 911 Call Operators and Findhelp 211 Service Navigators) of time spent explaining the intervention to callers in order to obtain consent. Greater awareness and engagement within and across communities will also contribute toward collective confidence and trust that Toronto Community Crisis Service is a safe and effective alternative crisis response.

   **Responsible actor(s):** City of Toronto (lead) with participation by all partners

# Recommendations & future considerations

## Preliminary considerations for scaling and sustainability of the Toronto Community Crisis Service

### 1. Increased service capacity is required.

a. With parallel expansion of program operations and community awareness, increasing the number and 24/7 availability of Toronto Community Crisis Service mobile teams within each division should be considered in order to ensure a reliable, timely response and support trust-building with collaborating service providers within and outside the intervention and with service users.

b. Expanded geographical boundaries of the Toronto Community Crisis Service are suggested both to support equitable access to care and to improve process by reducing inconsistencies and miscommunication regarding geographical eligibility for the service.

c. Ensuring Findhelp 211 Service Navigators are sufficient in number so as to have capacity to support growing demand is required and it is suggested that staffing be organized so as to allow for dedicated 24/7 Dispatch personnel to minimize lag in response times and interference by radios when responding to calls.

d. Although outside the scope of influence for the Toronto Community Crisis Service, collaborating with Toronto Police Service should consider increasedto identify funding opportunities for 911 asmay be one mechanism by which to alleviate baseline 911 capacity pressures. Evaluation findings related to 911 capacity pressures and need for increased funding align with those reported in the Toronto Auditor General's recent Audit of 911 Operations, which presents several potential funding opportunities for Toronto Police Service to consider. While process improvements have been recommended to alleviate some of the burden (e.g. building community awareness of the intervention and other entry points to reduce 911 Call Operators' explanation time), it is possible some baseline capacity pressures will remain and continue to affect the organization and the Toronto Community Crisis Service as it grows.

### 2. Investment in data systems and a centralized data system infrastructure is essential.

a. Sourcing and implementing a single, centralized data platform for use across sites will support data standardization and enhance all Toronto Community Crisis Service partners' capacity to participate in monitoring, reporting and evaluation and to generate high-quality data that is meaningful and useful to all intervention participants and the broader community of those impacted by the service.

### 3. Explore innovative and unconventional partnerships to address system capacity gaps.

a. Broadening the scope of potential partnerships and resourcing opportunities to include corporate, non-corporate, academic and individual philanthropic entities dedicated to addressing upstream capacity gaps and who have potential to facilitate development of or access to housing (shelter beds, crisis beds, supportive housing), hospitals, primary care, and other types of support services where referral data indicate gaps exist (harm reduction services, Indigenous services).

### 4. Consider adaptations to the intake model.

a. Increasing the number of community-based access points, particularly within BIPOC communities, will further minimize involvement by Toronto Police Service and facilitate upstream diversion from 911.

b. Continuing to examine whether an intake process, whereby service users are connected with a crisis worker earlier in the service pathway will support ultimate determination of suitability; align and consider evaluation outcomes with outcomes of other local alternative collaborative response models where possible.

# Recommendations & future considerations

**Table 20a.** Recommendations for the Toronto Community Crisis Service

| **Implementation Recommendations** | | |
|---|---|---|
| **Recommendation** | **Sub-recommendations or specific actions** | **Responsible party** |
| 1. Commit more time and space to partnership and engagement activities within the intervention. | Co-create regular opportunities for all partners at all levels to directly engage and share perspectives, experiences and lessons learned; and involve multiple staff levels in such sharing and planning spaces. | City of Toronto (lead) with participation by all partners |
| | Increase community anchor partner attendance at 911 Operations and Toronto Police Service parades across Divisions. | Community anchor partners, Findhelp 211, Toronto Police Service |
| | Offer opportunities for job shadowing and/or ride-along exchanges between frontline staff across Toronto Community Crisis Service partners including Toronto Police Service. | Community anchor partners, Findhelp 211, Toronto Police Service |
| | Regularly communicate examples of service user pathways and outcomes across partners to promote team-building, bolster buy-in and instill confidence in the intervention and role of each partner (e.g. via eBlasts, storytelling, or while on parades). | Community anchor partners, Findhelp 211, Toronto Police Service |
| 2. Streamline communication and transition protocols between partners, and particularly, other first responders. | Increase availability of shared information across partners on call and service user status to ensure a safe and timely response from most appropriate first responder, and to prevent service duplication | City of Toronto (lead) with participation by all partners |
| | Develop clear protocols, including violence thresholds, for warm transfer or handoff of service users and information between Toronto Community Crisis Service staff, Toronto Police Service, Mobile Crisis Intervention Teams and Toronto Paramedic Services when on site across possible scenarios (e.g. escalating violence). | City of Toronto, Toronto Police Service, community anchor partners |
| | Regularly convene partners to review audited calls with opportunities for improvement. | City of Toronto (lead) with participation by all partners |
| | Monitor and continue to examine use of radios as key communication technology. | City of Toronto (lead) with participation by Findhelp 211 and community anchor partners |
| 3. Increase support for data system implementation and quality improvement in data collection and reporting. | Dedicate additional staff, training and/or technology to increase capacity for high quality and efficient data collection and reporting across partners. | City of Toronto (lead) with participation by all partners |
| 4. Dedicate time and resourcing toward strengthening socio-demographic data collection processes. | Dedicate additional time and resourcing toward increased opportunities to collect sociodemographic data on TCCS service users throughout the call pathway; and to improve the quality of such data. | City of Toronto (lead) with participation by all partners |
| 5. Implement a co-designed, centralized and sustained training curriculum. | Adapt and extend a core training curriculum to all Toronto Community Crisis Service partners including Findhelp 211, 911 and Toronto Police Service. | City of Toronto |
| | Revise structure to include a “big picture” introduction to the service pathway and project values, including use of people-centred language; and more time spent on in-person i) cross-partner team-building and ii) practical or scenario training. | City of Toronto |
| | Offer semi-regular centralized core training with rolling enrolment for new and recent hires to prevent knowledge gaps. | City of Toronto |
| | Design and implement a centralized maintenance training curriculum for all staff (e.g. “refresher trainings”). | City of Toronto (lead) with participation by all community anchor partners and Findhelp 211 and collaboration of TPS |
| 6. Build organizational capacity in Indigenous cultural safety among all partners to support recruitment and retention of Indigenous staff. | Develop an Indigenous recruitment and staffing strategy to implement across sites. | City of Toronto (lead) with participation by all partners |
| | Increase awareness of cultural safety and accessibility of Indigenous and culturally relevant staff supports across sites. | All partners |
| | Implement ongoing anti-Indigenous racism training as part of the maintenance training curriculum. | City of Toronto |
| | Implement ongoing monitoring and assessment of anti-racist and culturally safe approaches across partners. | City of Toronto |
| 6. Design and implement a community awareness and engagement campaign that targets strategies to community needs. | Increase awareness, education, partnership and engagement efforts among the broader community of service providers (e.g. shelters, YMCAs, hospitals), frequent intake sources (e.g. Toronto Transit Commission, large building security companies), and service users. | City of Toronto (lead) with participation by all partners |

# Recommendations & future considerations

**Table 20b.** Future considerations for scale and sustainability of the Toronto Community Crisis Service

| **Scale and Sustainability Considerations** | |
|---|---|
| **Considerations** | **Sub-considerations or specific actions** |
| 1. Increased service capacity is needed. | With parallel expansion of program operations and community awareness, increasing the number and 24/7 availability of Toronto Community Crisis Service mobile teams within each division should be considered in order to ensure a reliable, timely response and support trust-building with collaborating service providers within and outside the intervention and with service users. |
| | Expanded geographical boundaries of the Toronto Community Crisis Service are suggested both to support equitable access to care and to improve process by reducing inconsistencies and miscommunication regarding geographical eligibility for the service. |
| | Ensuring Findhelp 211 Service Navigators are sufficient in number so as to have capacity to support growing demand is required and it is suggested that staffing be organized so as to allow for dedicated 24/7 Dispatch personnel to minimize lag in response times and interference by radios when responding to calls. |
| | Although outside the scope of influence for the Toronto Community Crisis Service, Toronto Police Service should consider increased funding opportunities for 911 as one mechanism by which to alleviate baseline 911 capacity pressures. Evaluation findings related to 911 capacity pressures and need for increased funding align with those reported in the Toronto Auditor General's recent Audit of 911 Operations, which presents several potential funding opportunities for Toronto Police Service to consider. While process improvements have been recommended to alleviate some of the burden (e.g. building community awareness of the intervention and other entry points to reduce 911 Call Operators' explanation time), it is possible some baseline capacity pressures will remain and continue to affect the organization and the Toronto Community Crisis Service as it grows. |
| 2. Investment in data systems and a centralized data system infrastructure is essential. | Sourcing and implementing a single, centralized data platform for use across sites will support data standardization and enhance all Toronto Community Crisis Service partners' capacity to participate in monitoring, reporting and evaluation and to generate high-quality data that is meaningful and useful to all intervention participants and the broader community of those impacted by the service. |
| 3. Explore innovative and unconventional partnerships to address system capacity gaps. | Broadening the scope of potential partnerships and resourcing opportunities to include corporate, non-corporate, academic and individual philanthropic entities dedicated to addressing upstream capacity gaps and who have potential to facilitate development of or access to housing (shelter beds, crisis beds, supportive housing), hospitals, primary care, and other types of support services where referral data indicate gaps exist (harm reduction services, Indigenous services). |
| 4. Consider adaptations to the intake model insofar. | Increasing the number of community-based access points, particularly within BIPOC communities, will further minimize institutional exposure and facilitate upstream diversion from 911. |
| | Continuing to examine whether an intake process in which service users are connected with a crisis worker earlier in the service pathway will support ultimate determination of suitability; align and consider evaluation outcomes with outcomes of other local alternative collaborative response models where possible. |

# Conclusion and next steps

This report has presented the findings of an implementation evaluation of the Toronto Community Crisis Service's first six months of operation in four pilot regions of the City of Toronto. Taken together, a large mixed-methods dataset reflecting a breadth of operational activities and diverse partner perspectives collectively suggest the Toronto Community Crisis Service has, overall, been successfully implemented to date. That said, a range of specific and feasible recommendations have been presented that PSSP and Shkaabe Makwa evaluators believe will be critical to receive and act upon in order to sustain successful implementation and alignment with the Toronto Community Crisis Service's core values and guiding principles. Acting upon the recommendations presented in this report is expected to further build trust and capacity across the intervention.

Data reported here reflect the intervention partners' and staff's experiences and outcomes in several key implementation domains that are critical to evaluating and attributing the outcomes associated with this intervention. Particularly given the developmental and utilization-focused approach to the evaluation of the Toronto Community Crisis Service, immediate next steps include revising the intervention's evaluation framework to improve the quality and feasibility of existing indicators and data collection processes based on the results of the current report. Following this report, the Evaluators look forward to leading the Toronto Community Crisis Service project partners through the co-design and implementation of revised framework that expands to encompass the outcomes and impacts of this intervention on the health, safety and wellbeing of service users, their communities, the service providers who serve them, and the health, social and justice systems in which we are embedded. These outcomes and others will be reported in a follow-up report in 2023.

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# Appendices

## Appendix A. Toronto Community Crisis Service event types and call diversion criteria

| Call type | Description |
|---|---|
| Thoughts of Suicide/ Self-Harm | A person who is thinking about or expressing thoughts of suicide or self-harm. |
| Person in Crisis | A person who is feeling overwhelmed and unable to cope and/or is experiencing a mental, emotional or substance use crisis |
| Wellbeing Checks | Checking the condition of a person who has not been seen or heard from for a length of time or may be in need of support. |
| Distressed/distressing Behaviour | Behavior that appears to be erratic with no clear objective or meaning. |
| Disputes | Verbal disagreements. |
| Advised | The caller is asking for referral information, advice or service, or there is an agreement with the caller that they call back at their own convenience. |
| Unknown | Is used by 211 in cases where calls generally fit the eligibility criteria for TCCS but do not quite fit the exact definition of any of the other six event types; it can also be used in cases where a call ended prematurely. |

### Call Diversion Criteria:

1. A person in mental health crisis who is not actively attempting suicide or being physically violent;
2. A person involved in a verbal dispute or disturbance with a mental health component, where a City Dispatch Agent can attempt to resolve with intervention and where there is no perceived or real risk of violence;
3. A non-violent person requesting police due to psychosis or an altered mental state;
4. A non-violent repeat caller with a known mental health history;
5. A non-violent person in crisis requesting a Mobile Crisis Intervention Team (Note: Communications Operator will first offer to transfer the caller to a City Dispatch Agent; if the caller refuses to be transferred, the Communications Operator will create a call for service requesting the TPS' MCIT);
6. Second party callers concerned about the welfare of a non-violent person in crisis.

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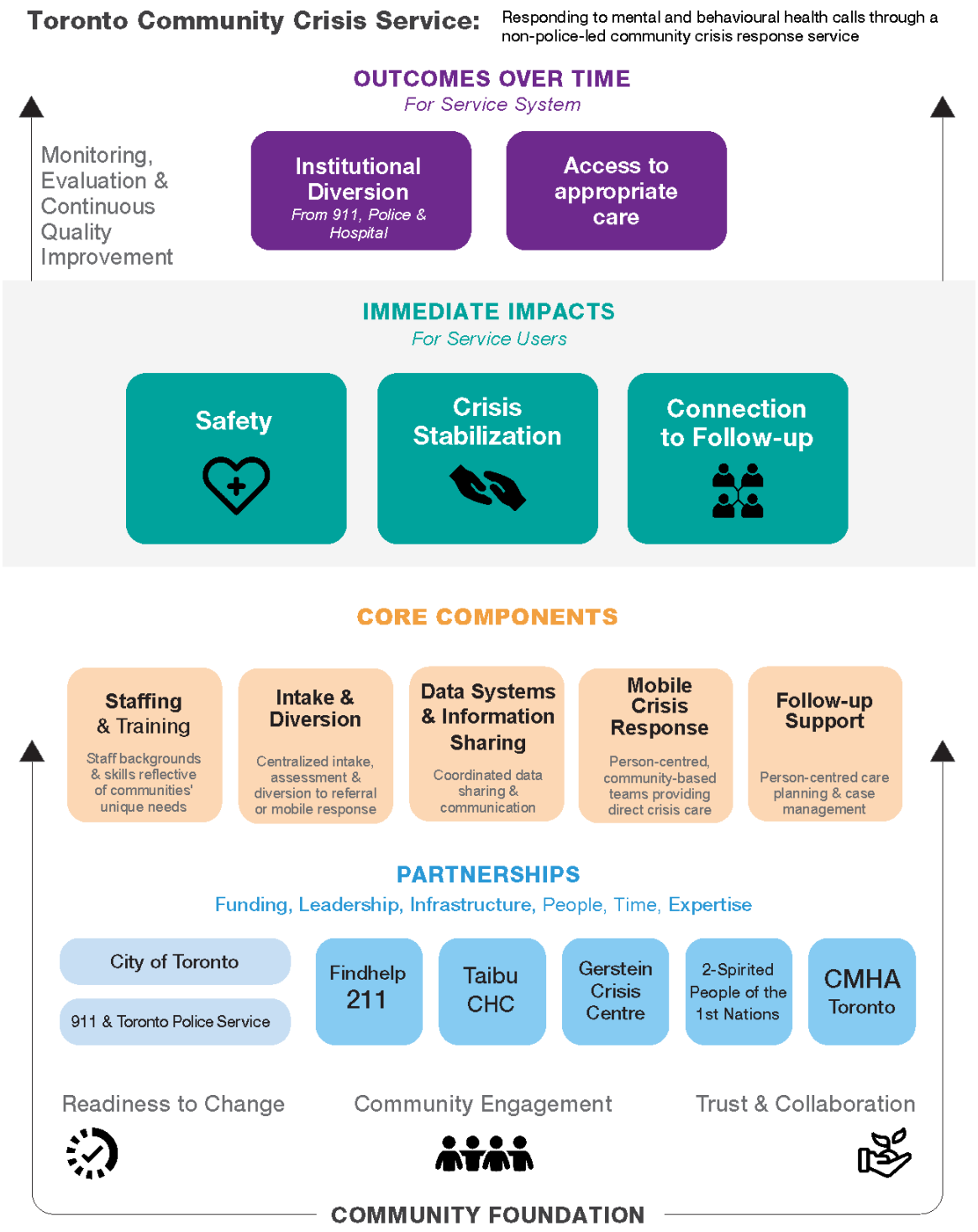
## Appendix B. Toronto Community Crisis Service Theory of Change



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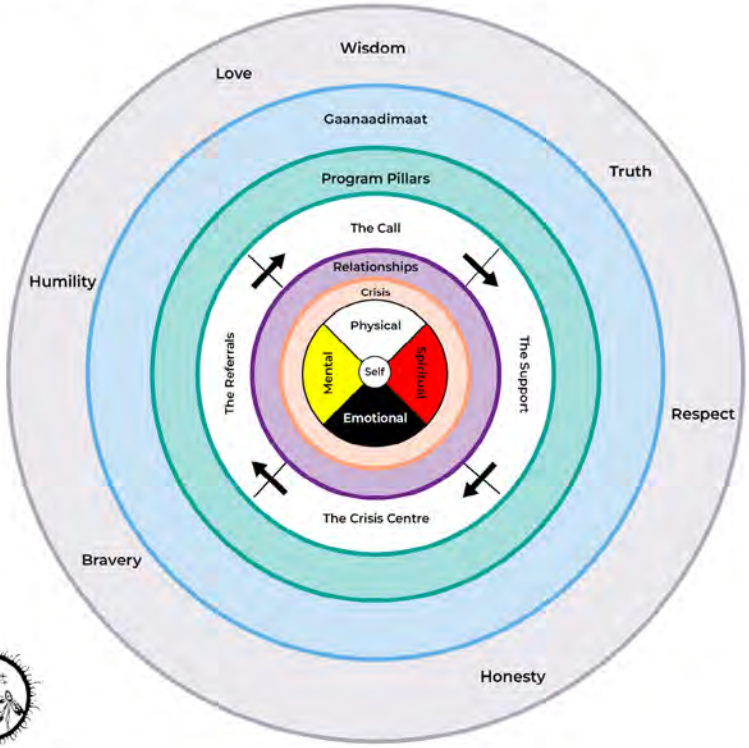
## Appendix C. 2-Spirited People of the 1st Nations Evaluation Framework

### Kamaamwizme wii Naagidiwendiiying

*Coming together to (heal or look after or to take care of) each other*

**Debaamjigewin Naagdobiigewin**




2-Spirits

***Relationships***

People with lived/living experience
Partnering Agencies
Community leaders/workers
2SLGBTQIA+ individuals
Aunties and Uncles program
Peer workers
Elders/Knowledge Keepers
City of Toronto

***Program Pillars***

Providing culturally grounded support
Applying flexible approaches to care (not a one size fits all model)
Providing wholistic health and wellness supports
Ensuring that individuals in crisis have self-determination and are empowered in their care
Response plans
Providing accessible, trauma-informed care services
Community participation and by-in throughout each phase of the pilot
Continuous quality improvement of our supports and services

***Gaanaadimaat (How it helped us?)***

Enhanced feeling of safety
Increased sense of wellness and belonging
Crisis stabilization
Increased access to appropriate care
Increased capacity
Decreased institutional involvement
Increased community well-being

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## Appendix D. Toronto Community Crisis Service Core Evaluation Framework

This evaluation matrix was developed by the PSSP Evaluation team, with input from all project partners. Where fields are blank, decisions remain to be made in collaboration with service partners. This evaluation adheres to developmental principles and as such, this is a living document in which the measures and data sources outlined are subject to change. This evaluation also places emphasis on and distinguishes implementation outcomes from service user, service provider, and service system outcomes. Key domains for implementation and outcome evaluation are guided by an evidence- based framework commonly employed in health services implementation research.[25] This framework has been adapted based on the current intervention context, priorities, and stakeholder feedback gathered to date.

To ensure an equity-focused evaluation, data will be disaggregated by equity-deserving populations (i.e., priority populations) throughout the pilot whenever data is available. According to the Ontario Public Health Standards (OPHS), priority populations are defined as "those groups that would benefit most from public health programs and service; that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level"[26]. The OPHS state that priority populations should be identified "by considering those with health inequities including: increased burden of illness; or increased risk for adverse health outcome(s); and/or those who may experience barriers in accessing public health or other health services or who would benefit from public health action."[25]

**In the context of the TCCS, the overarching definition of priority equity-deserving populations include people living with mental health and substance use needs and in particular, populations identifying as Black, Indigenous, People of Colour and/or 2SLGBTQ+.**

This core version includes those indicators all partners have agreed be considered core or critical to the evaluation of this service at this point in implementation. Indicators considered core are subject to change in line with changing needs and priorities within and outside the program. Indicators considered core by a particular site are indicated by colour as follows: **Funder/Administrator, 911/TPS,** 211, Gerstein, TAIBU, **CMHA-TO,** 2-Spirits.

| **Domain**<br>Implementation themes that guide the evaluation questions | **Evaluation questions**<br>What are the questions we want the evaluation to address? | **Sub-evaluation questions**<br>(if applicable) | **Measures**<br>What specific, observable and/or measurable information will address the evaluation question? | **Disaggregation**<br>(if applicable) How will we break down the data (i.e., sub-analysis)? | **Data sources**[27]<br>What tool(s) will we employ to collect the data? | **Frequency**<br>When and how often will we collect the data? | **Collected from**<br>Who are we collecting the data from? |
|---|---|---|---|---|---|---|---|
| **Implementation outcomes** (see following pages) | | | | | | | |

[28] Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76. doi:10.1007/s10488-010-0319-7.
[29] Lu, D., & Tyler, I. (2015). Focus on: A proportionate approach to priority populations. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Toronto, ON: Queen's Printer for Ontario.
[30] Time and capacity for administering surveys and conducting semi-structured interviews (and to whom) are still to be determined. In this current version, the data sources listed are in ideal circumstances. As such, this is subject to change. In cases where a semi-structured interview may not be feasible, a survey and/or focus group may be administered instead.

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## Appendix D. Toronto Community Crisis Service Core Evaluation Framework

| **Domain**<br>Implementation themes that guide the evaluation questions | **Evaluation questions**<br>What are the questions we want the evaluation to address? | **Sub-evaluation questions**<br>(if applicable) | **Measures**<br>What specific, observable and/or measurable information will address the evaluation question? | **Disaggregation**<br>(if applicable) How will we break down the data (i.e., sub-analysis)? | **Data sources**[27]<br>What tool(s) will we employ to collect the data? | **Frequency**<br>When and how often will we collect the data? | **Collected from**<br>Who are we collecting the data from? |
|---|---|---|---|---|---|---|---|
| **Implementation outcomes** | | | | | | | |
| **Adoption**<br><br>The act of using the program, where it is implemented, who is implementing it<br><br>(i.e., uptake, utilization, initial implementation, intention to try) | How was the program implemented? | To what extent have partnerships and collaborations been leveraged? | # of new partnerships formed<br>Description of how existing partnerships have evolved<br>Description of how partnerships and collaborations have been leveraged<br>Description f how new partnerships & collaborations have supported community buy-in and trust in the program<br>Description of organizations readiness to engage & overall capacity to provide supports | Type of partnership<br>Region (i.e. pilot site) | Implementation tracker<br>Social Network Analysis<br>Semi-structured interviews and/or focus group discussions | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |
| | | What community engagement mechanisms are being employed (i.e., promotion of TCCS)? | Description of community engagement mechanisms | Region (i.e. pilot site) | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |
| | | Across all stakeholders, what existing and/or new data-related practices are being used to support the program? | Description of existing, internal data monitoring and quality improvement practices | Region (i.e. pilot site) | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |
| | | What are, if any, the unintended positive and negative consequences of the program? | Perceived unintended positive consequences<br>Perceived unintended negative consequences | | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |
| | How were service providers trained to deliver the program? | To what degree did the training build competencies in person-centred[28] crisis care? | # of trainings delivered to staff<br>Change in service provider competencies<br>Intention to change rating | Type of trainings<br>Type of service provider(s) trained | Semi-structured interviews and/or focus groups<br>Surveys<br>Survey with service providers (pre- and post- training)<br>Daily survey with service providers | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |

[31] In the context of this intervention, person-centered care is respecting an individual's personal autonomy and choice, and treating the person receiving care and support with dignity, respect, and involving them in decisions about their situation.

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## Appendix D. Toronto Community Crisis Service Core Evaluation Framework

| **Domain**<br>Implementation themes that guide the evaluation questions | **Evaluation questions**<br>What are the questions we want the evaluation to address? | **Sub-evaluation questions**<br>(if applicable) | **Measures**<br>What specific, observable and/or measurable information will address the evaluation question? | **Disaggregation**<br>(if applicable) How will we break down the data (i.e., sub-analysis)? | **Data sources**[27]<br>What tool(s) will we employ to collect the data? | **Frequency**<br>When and how often will we collect the data? | **Collected from**<br>Who are we collecting the data from? |
|---|---|---|---|---|---|---|---|
| **Implementation outcomes** | | | | | | | |
| **Appropriateness**<br>Fit and relevance of the program for the setting and population<br>(i.e., perceived fit, relevance, compatibility, suitability, usefulness, practicability) | How suitable is TCCS for the system and setting in which it is being delivered? | With respect to service delivery and systems coordination, what is working well? What is not working well? | Barriers of delivering TCCS<br>Facilitators of delivering TCCS | | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |
| | | What gaps, innovations, and/or opportunities, if any, emerged as a result of program implementation? | Description of programmatic gaps, innovations, and/or opportunities | Type of stakeholder<br>Priority population<br>Region (i.e. pilot site) | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |
| | | | # of cultural and other types of contextual adaptations made to best respond to diverse community needs and priorities (sub-demographics being served in each pilot area) | Type of adaptation<br>Priority population<br>Region (i.e. pilot site) | Administrative data<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Service providers |
| | | | # of best and wise practices identified | Type of practice | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Service providers |
| **Feasibility**<br>Extent to which the program can be carried out<br>(i.e., actual fit or utility; suitability for everyday use; practicability) | Was it feasible to implement and deliver the program? | What factors impeded or facilitated program implementation? | Perceived implementation barriers of TCCS<br>Perceived implementation facilitators of TCCS | Partnering agencies' capacity to provide supports (e.g. housing) | Implementation tracker<br>Semi-structured interviews and/or focus groups<br>Surveys | Monthly<br>Quarterly | Funder & Administrator<br>Service providers |

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## Appendix D. Toronto Community Crisis Service Core Evaluation Framework

| **Domain**<br>Implementation themes that guide the evaluation questions | **Evaluation questions**<br>What are the questions we want the evaluation to address? | **Sub-evaluation questions**<br>(if applicable) | **Measures**<br>What specific, observable and/or measurable information will address the evaluation question? | **Disaggregation**<br>(if applicable) How will we break down the data (i.e., sub-analysis)? | **Data sources**[27]<br>What tool(s) will we employ to collect the data? | **Frequency**<br>When and how often will we collect the data? | **Collected from**<br>Who are we collecting the data from? |
|---|---|---|---|---|---|---|---|
| **Implementation outcomes** | | | | | | | |
| **System Integration**<br>Extent to which the program is integrated in the system<br>(i.e., level of institutionalization, spread, reach, service access) | To what extent is the program diverting calls from Toronto Emergency Services? | What are the participation rates/counts at each point of the service pathway (e.g., calls received, calls diverted)? | Total #/% mental health crisis calls received by 911 and 211<br>#/% of mental health, crisis calls received within pilot regions<br>#/% of calls received (2S direct phone crisis line)<br>#/% of calls received (GCC's existing phone crisis line)<br>#/% of calls received by 911-co-locatedcrisis worker<br>#/% of calls transferred from 211 | Type of call (i.e. event type)<br>Region (i.e. pilot site)<br>Priority population | Administrative data | Monthly | 911/TPS<br>211 |
| | | | #/% of calls transferred from 911 | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site)<br>Warm vs. cold transfer | Administrative data | Monthly | 911/TPS<br>211 |
| | | | #/% of calls requiring only information and/or referral (I&R) | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site) | Administrative data | Monthly | 211 |
| | | | #/% of calls transferred back to 911<br>Reason(s) for transfer back to 911 | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site) | Administrative data | Monthly | 911/TPS<br>211 |
| | | | #/% of repeat callers transferred to 211 (for the same event) | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site) | Administrative data | Monthly | 211 |
| | | | #/% of frequent callers | Type of call (i.e. event type)<br>To whom (911, direct line to community anchor partners)<br>Priority population<br>Region (i.e. pilot site) | Administrative data | Monthly | 911/TPS<br>211 |
| | | | #/% of calls where 211 is unavailable | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site) | Administrative data | Monthly | 211 |
| | | | #/% of calls not completed (e.g., called hung up, technical issues on caller or service provider end) | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site)<br>Reason(s) for uncompleted calls | Administrative data | Monthly | 911/TPS<br>211 |

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## Appendix D. Toronto Community Crisis Service Core Evaluation Framework

| **Domain**<br>Implementation themes that guide the evaluation questions | **Evaluation questions**<br>What are the questions we want the evaluation to address? | **Sub-evaluation questions**<br>(if applicable) | **Measures**<br>What specific, observable and/or measurable information will address the evaluation question? | **Disaggregation**<br>(if applicable) How will we break down the data (i.e., sub-analysis)? | **Data sources**[27]<br>What tool(s) will we employ to collect the data? | **Frequency**<br>When and how often will we collect the data? | **Collected from**<br>Who are we collecting the data from? |
|---|---|---|---|---|---|---|---|
| **Implementation outcomes** | | | | | | | |
| **System Integration**<br>Extent to which the program is integrated in the system<br>(i.e., level of institutionalization, spread, reach, service access) | To what extent is the program diverting calls from Toronto Emergency Services? | What are the participation rates/counts at each point of the service pathway (e.g., calls received, calls diverted)? | #/% of total calls where a mobile team is dispatched | Type of call (i.e. event type)<br>Priority population<br>Community anchor partner<br>Region (i.e. pilot site) | Administrative data | Monthly | Anchor partners |
| | | | #/% of calls rejected by mobile teams | Type of call (i.e. event type)<br>Community anchor partner | Administrative data | Monthly | 211 |
| | | | #/% of calls completed on the phone<br>#/% of calls completed on scene<br>Time that calls were made | Type of call (i.e. event type)<br>Type of call (i.e. event type)<br>Time of day (i.e. morning, afternoon, evening, night etc.) | Administrative data | Monthly | 911/TPS<br>211<br>Anchor partners |
| | | | # of calls that resulted in transport to ED | Type of call (i.e. event type) | Administrative data | Monthly | Anchor partners |
| | | | #/% of requests from mobile team requesting back-up (911's 3 streams: police, paramedics, fire) | Type of call (i.e. event type)<br>Type of emergency service used (e.g., police, MCIT or EMS)<br>Reasons for back-up<br>Region (i.e. pilot site) | Administrative data | Monthly | 911/TPS |
| | | | #/% of dispatches completed | Type of call (i.e. event type)<br>Priority population<br>Region (i.e. pilot site) | Administrative data | Monthly | Anchor partners |
| | | | #/% of complaints received | Type of call (i.e. event type)<br>Priority population<br>Community anchor partner | Administrative data | Monthly | Service providers |

# Appendices

## Appendix D. Toronto Community Crisis Service Core Evaluation Framework

| **Domain**<br>Implementation themes that guide the evaluation questions | **Evaluation questions**<br>What are the questions we want the evaluation to address? | **Sub-evaluation questions**<br>(if applicable) | **Measures**<br>What specific, observable and/or measurable information will address the evaluation question? | **Disaggregation**<br>(if applicable) How will we break down the data (i.e., sub-analysis)? | **Data sources**[27]<br>What tool(s) will we employ to collect the data? | **Frequency**<br>When and how often will we collect the data? | **Collected from**<br>Who are we collecting the data from? |
|---|---|---|---|---|---|---|---|
| **Implementation outcomes** | | | | | | | |
| **System Integration**<br>Extent to which the program is integrated in the system<br>(i.e., level of institutionalization, spread, reach, service access) | To what extent are service users being successfully connected with community-based follow-up supports? | | #/% of dispatches resulting in: (1) Referral(s) made, (2) Follow up requested, (3) Referral(s) made and follow up requested, (4) No referrals or follow up required | Type of call (i.e. event type)<br>Priority population<br>Type of follow-up support (e.g., harm reduction kits, substance use services, shelters, etc.)<br>Community anchor partner | Administrative data | Monthly | Anchor partners |
| | | | #/% of follow up calls made to service users<br>#/% of times a follow-up call resulted in connection to the service user | Type of call (i.e. event type)<br>Priority population<br>Service provider (211, anchor partners | Administrative data | Monthly | 211<br>Anchor partners |
| | | | #/% of follow up support provided directly by mobile team | Type of call (i.e. event type)<br>Priority population<br>Type of follow-up support (e.g., harm reduction kits, substance use services, shelters, etc.)<br>Service provider (211, anchor partners) | Administrative data | Monthly | Anchor partners |
| | | | #/% of follow-up supports referred | Type of call (i.e. event type)<br>Priority population<br>Type of referred supports<br>Service provider (211, anchor partners) | Administrative data | Monthly | 211<br>Anchor partners |
| | | | # times Indigenous service users from other pilot areas were referred to Indigenous organizations (including 2 Spirits) | Type of call (i.e. event type)<br>Priority population<br>Community anchor partner<br>Consented or declined | Administrative data | Monthly | Anchor partners |

# Appendices

## Appendix E. Definitions of event types used for mental health calls for service attended (CFSA)

The Toronto Police Service defines mental health calls as those categorized in one of six event types that are defined below:

| Call type | Description |
|---|---|
| Attempt Suicide | Call for service related to a person attempting to commit suicide. |
| Elopee | A person subject to detention in a mental health facility under authority of the Mental Health Act who is absent without leave from the facility. |
| Person in Crisis | Includes any person who appears to be in a state of crisis or any person who suffers from a mental disorder. |
| Jumper | Call for service relating to a person that has jumped (from a building, bridge, subway platform, etc.) in an effort to commit suicide. |
| Overdose | Call for service relating to a person that has overdosed on a drug. |
| Threaten Suicide | Call for service for a person threatening to commit suicide. |

# Appendices

## Appendix F. Toronto Police Service mental health apprehensions by TPS event type

| Event Type | Count |
|---|---|
| PERSON IN CRISIS | 682 |
| THREATENING SUICIDE | 376 |
| ATTEMPT SUICIDE | 151 |
| SEE AMBULANCE | 126 |
| UNKNOWN TROUBLE | 75 |
| OVERDOSE | 51 |
| VIOLENT BEHAVIOUR | 44 |
| PERSON WITH A KNIFE | 35 |
| CHECK ADDRESS | 28 |
| #N/A | 25 |
| ASSAULT JUST OCCURRED | 24 |
| UNWANTED GUEST | 24 |
| DOMESTIC | 22 |
| CHECK WELL-BEING | 20 |
| SUSPICIOUS INCIDENT | 13 |
| DISORDERLIES | 13 |
| INDECENT EXPOSURE JUST OCCURRED | 12 |
| HAZARD | 12 |
| ELOPEE | 12 |
| ASSAULT IN PROGRESS | 8 |
| DAMAGE IN PROGRESS | 8 |
| DOMEST ASSAULT | 8 |
| HOLDING LOST ELDERLY | 8 |
| ARREST | 6 |
| BREAK & ENTER IN PROGRESS | 5 |
| PERSON WITH A GUN | 5 |
| FIRE | 4 |
| THREATENING | 4 |
| DISPUTE | 4 |
| JUMPER | 4 |
| MISSING PERSON | 3 |
| SEE FIRE DEPT | 3 |
| DAMAGE JUST OCCURRED | 3 |
| ASSIST AMBULANCE | 3 |

| Event Type | Count |
|---|---|
| SEXUAL ASSAULT | 3 |
| WANTED PERSON | 2 |
| MISSING VULNERABLE PERSON | 2 |
| INDECENT EXPOSURE | 2 |
| ASSAULT | 2 |
| MEDICAL COMPLAINT | 2 |
| STABBING | 2 |
| HOLDING ONE WITH TROUBLE | 2 |
| FAIL TO REMAIN PROPERTY DAMAGE COLLISION | 2 |
| ECHO TIERED RESPONSE | 2 |
| ADVISED | 2 |
| WALK-IN STATION REPORT | 1 |
| TRESPASS | 1 |
| FAIL TO REMAIN PERSONAL INJURY COLLISION | 1 |
| MISSING ELDERLY LOCATED | 1 |
| IMPAIRED PERSON | 1 |
| MISSING JUVENILE | 1 |
| WOUNDING | 1 |
| BOMB THREAT | 1 |
| IMPAIRED DRIVER | 1 |
| MISSING PERSON LOCATED | 1 |
| MARINE RESCUE | 1 |
| FIGHT | 1 |
| PERSONAL INJURY COLLISION | 1 |
| SYSTEM-GENERATED ABANDONED CALL | 1 |
| PRIVATE PARKING COMPLAINT | 1 |
| THEFT IN PROGRESS | 1 |
| PROWLER ON LOCATION | 1 |
| THEFT JUST OCCURRED | 1 |
| LANDLORD & TENANT DISPUTE | 1 |
| **Total Apprehensions** | **1,864** |

# Appendices

## Appendix G. Number of referrals made by Findhelp 211

| Type of referral made | Number of referrals | Percentage breakdown |
|---|---|---|
| 311 Toronto | 1 | 3% |
| Case Management Autism Spectrum Disorder | 1 | 3% |
| Crisis Line | 8 | 23% |
| Detox Services | 1 | 3% |
| Disability Transportation | 1 | 3% |
| Elder Abuse Lines | 1 | 3% |
| Financial Supports | 1 | 3% |
| Food Supports | 2 | 6% |
| General Health Support | 1 | 3% |
| Health Insurance | 1 | 3% |
| Homecare | 1 | 3% |
| Housing Complaint support | 2 | 6% |
| Indigenous Counseling | 1 | 3% |
| Mental Health Disability Housing Support | 1 | 3% |
| Older Adult Counseling | 1 | 3% |
| Shelter | 7 | 20% |
| Street Outreach Programs | 1 | 3% |
| Tenant Rights Support | 1 | 3% |
| Withdrawal Management | 1 | 3% |
| Youth Mental Health | 1 | 3% |
| **Total** | **35** | **100%** |

# Appendices

## Appendix H. Number of direct supports provided by Toronto Community Crisis Service mobile crisis teams

| Type of support provided | Number of supports provided | Percentage breakdown |
|---|---|---|
| Risk assessment | 1,521 | 23% |
| Crisis counseling and support | 1,361 | 21% |
| Resources/Information | 912 | 14% |
| Safety planning | 849 | 13% |
| Basic needs (e.g., food, water, clothing) | 572 | 9% |
| Advocacy during crisis visit | 523 | 8% |
| Transportation in crisis vehicle | 197 | 3% |
| Care coordination | 125 | 2% |
| Transportation fare (Ex. TTC tokens, taxi chit) | 104 | 2% |
| Other | 77 | 1% |
| Family support | 60 | 1% |
| Needs Assessment/Goal-setting | 53 | 1% |
| Medicine bundles | 45 | 1% |
| Naloxone | 42 | 1% |
| Harm reduction supplies | 39 | 1% |
| Psychoeducation | 7 | 0.1% |
| **Total** | **6,487** | **100%** |

# Appendices

## Appendix I. Communication attempts made to service users

| Type of communication | Number of communication attempts | Percentage breakdown |
|---|---|---|
| Call | 1,159 | 59% |
| In person | 402 | 20% |
| Other | 158 | 8% |
| Unknown[a] | 135 | 7% |
| Text | 122 | 6% |
| **Total** | **1,976** | **100%** |

[a] TAIBU has a number of unknown types of communications that occurred during follow-up attempts in August 2022 and September 2022; there is no disaggregation for successful follow up attempts made.

# Appendices

## Appendix J. Number of community-based referrals made

| Type of community-based referral made | Number of referrals | Percentage breakdown |
|---|---|---|
| Shelter/Hostel | 100 | 13% |
| Mental health and Substance use supports | 85 | 11% |
| Substance use supports | 80 | 10% |
| Crisis counseling and support | 61 | 8% |
| Case management | 52 | 7% |
| Employment | 50 | 6% |
| Crisis bed | 44 | 6% |
| Housing | 41 | 5% |
| Psychiatric supports | 39 | 5% |
| Social/Recreation services | 31 | 4% |
| Primary care | 30 | 4% |
| Hospital/Emergency support | 22 | 3% |
| Court case Management | 21 | 3% |
| Family support | 20 | 3% |
| Food security | 19 | 2% |
| Geriatric supports | 17 | 2% |
| Wellness/Recovery supports | 15 | 2% |
| Other | 15 | 2% |
| Rehabilitation services | 13 | 2% |
| Culturally relevant supports | 13 | 2% |
| Chronic disease management | 10 | 1% |
| Harm reduction services | 5 | 1% |
| Financial support | 5 | 1% |
| Self-help/support groups | 5 | 1% |
| Peer support services | 4 | 1% |
| Education | 2 | 0.3% |
| **Total** | **799** | **100%** |

# Appendices

## Appendix K. Number of culturally relevant supports requested

| Type of culturally relevant support requested | Number of requests | Percentage breakdown |
|---|---|---|
| Africentric and West Indian/Caribbean-centric support | 26 | 35% |
| Indigenous-specific support (includes access to medicine, Elder/Knowledge Keeper support and teachings, harm Reduction services (with Indigenous lens), and Culturally specific wellness programming | 24 | 32% |
| Other | 21 | 28% |
| Settlement/Immigration | 1 | 1% |
| HIV/Hep C testing | 1 | 1% |
| Wholistic family and kinship care supports | 1 | 1% |
| Holistic health supports | 1 | 1% |
| **Total** | **75** | **100%** |

# Appendices

## Appendix L. Number of 2-Spirits-specific supports provided to family members

| 2-Spirits specific supports provided to family members | Number of supports provided | Percentage breakdown |
|---|---|---|
| Wholistic family and kinship care supports | 18 | 55% |
| Access to Medicines | 8 | 24% |
| Education | 5 | 15% |
| Harm Reduction services (with Indigenous lens) | 1 | 3% |
| Hospital/Emergency Support | 1 | 3% |
| **Total** | **33** | **100%** |

# Appendices

## Appendix M. Number of 2-Spirits-specific referrals made for family members

| 2-Spirits-specific referrals made for family members | Number of referrals | Percentage breakdown |
|---|---|---|
| Mental Health Supports (e.g. counselling) | 11 | 69% |
| Shelter/Hostel | 4 | 25% |
| Psychiatric Supports | 1 | 6% |
| **Total** | **16** | **100%** |

# Appendices

## Appendix N. Pre-post median scores across training domains

| Skills/Knowledge area | T1 mean | T2 mean |
|---|---|---|
| Trauma | 3.3 | 4.24 |
| Consent | 3.72 | 4.38 |
| Language | 4.02 | 4.44 |
| Oppression | 3.98 | 4.47 |
| Neurodiversity | 2.91 | 4.15 |
| Drug use | 3.7 | 4.21 |
| Cultural safety | 3.61 | 4.29 |
| Effective crisis response | 3.30 | 4.21 |
| Harmr eduction | 3.25 | 4.15 |
| Client-centred care | 3.11 | 4.12 |
| Communication | 3.52 | 4.18 |
| Crosscultural | 3.36 | 4.24 |
| Safety | 3.25 | 4.09 |
| Stress | 3.66 | 4.26 |
| First Aid | 3.16 | 3.94 |
| Overdose | 3.16 | 3.97 |
| Privacy | 3.45 | 4.41 |
| PHIPA | 2.93 | 4.15 |

# Appendices

## Appendix O. Partner representation in survey about service suitability

| Partner | Count | Percentage breakdown |
|---|---|---|
| Toronto Police Service (including 911) | 18 | 42% |
| 2-Spirited People of the 1st Nations | 12 | 28% |
| 211 | 8 | 19% |
| Gerstein Crisis Centre | 4 | 9% |
| Canadian Mental Health Association - Toronto | 1 | 2% |
| TAIBU Community Health Centre | 0 | 0% |

# Thank you

camh
mental health is health