Toronto Community Crisis Service

One-year outcome evaluation report

Toronto Community Crisis Service staff: Canadian Mental Health Association Toronto

Photo courtesy of the City of Toronto

September 2023

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Acknowledgments

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Evaluation team:

Ms. Emma Costello, Provincial System Support Program, CAMH
Ms. Priyanka Sharma, Provincial System Support Program, CAMH
Ms. Yara Janes, Shkaabe Makwa, CAMH
Dr. Nadine Reid, Provincial System Support Program, CAMH

Contact information:

Dr. Nadine Reid
Senior Consultant, Evaluation Science, Provincial System Support Program
Centre for Addiction and Mental Health
Email: nadine.reid@camh.ca

Ms. Jill Shakespeare
Senior Director, Provincial System Support Program
Centre for Addiction and Mental Health
Email: jill.shakespeare@camh.ca

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Executive summary

Launched on March 31, 2022, the Toronto Community Crisis Service (TCCS) is a pilot project offering a community-based crisis response service in four pilot regions within the City of Toronto. The TCCS is led by the City of Toronto in partnership with Findhelp 211 (211), Canadian Mental Health Association – Toronto (CMHA-TO), Gerstein Crisis Centre (GCC), TAIBU Community Health Centre (TAIBU), and 2-Spirited People of the 1st Nation (2-Spirits), and with the support of the Toronto Police Service (TPS).

Third-party evaluators from the Provincial System Support Program (PSSP) and Shkaabe Makwa at the Centre for Addiction and Mental Health (CAMH) completed a six-month implementation evaluation in January 2023 that would set the stage for a one-year outcome evaluation. From January 2023 through June 2023, evaluators engaged all TCCS partners in the collaborative design and execution of a revised, outcomes-focused evaluation framework that leveraged previous work while responding to lessons learned throughout implementation. This evaluation report reflects findings related to TCCS experiences and outcomes after 13 months of operation, from March 31, 2022 to April 30, 2023, and was guided by five key evaluation questions:

1. How did stakeholders experience the TCCS, and how did experiences vary within and across groups?
2. How have communities experienced the TCCS?
3. To what extent and how were non-emergency mental health and crisis-related calls to 911 and 211 responded to by the TCCS?
4. To what extent and how were direct crisis supports provided and connections made to appropriate community-based follow-up supports through the TCCS?
5. To what extent has the TCCS demonstrated its guiding principles?

A variety of methodological approaches were used to collect and analyze primary and secondary quantitative and qualitative data from three key participant groups: service users, service providers and community members. Data were then iteratively integrated and organized in response to the key evaluation questions, which, taken together, illustrate key stakeholder experiences and outcomes within the first year of TCCS operations.

Overall, results reinforce six-month evaluation findings that the service has been implemented with a high degree of success. Data show the TCCS is effectively and increasingly diverting mental and behavioural health crisis calls from police response; connecting service users to community-based follow-up supports; and leading to positive experiences for service users, service providers and the community at large. Also consistent with interim findings was the presence of clear opportunities for collective learning and quality improvement in collaboration and operational processes.

Key findings:

- The TCCS received a total of 6827 calls in its first 13 months, of which 93% were successfully completed. Most often, these calls were for “person in crisis” (47%) and “well-being check” events (24%). Call volumes differed between pilot regions, with the Downtown East receiving the most (39%), followed by the Northeast (25%), Downtown West (21%), and Northwest (12%).
- Call volumes are increasing over time and the intake source is changing. The number of calls received by 911 (54% overall) decreased over the period and stabilized in recent months, whereas the number of completed calls received directly by Findhelp 211 (34% overall) steadily increased from an average of 89 calls per month in the first six months to an average of 236 calls per month since October 2022.
- Of total calls received, 86% resulted in a TCCS Community Crisis Team (CCT) dispatch. Of these, 61% were completed, meaning CCTs met with service users and provided crisis care. Other dispatch dispositions (i.e., outcomes) include instances where service users were unable to be located upon CCT arrival (21%); service users declined service upon CCT arrival (8%); CCT support was no longer needed (6%); and CCTs provided support over the phone (4%).
- The overall diversion rate, defined as total calls received by 911 specifically that were subsequently transferred to the TCCS and completed by CCTs with no observed police on scene, was 78% over the 13-month period.

Executive summary

- The average total length of a TCCS call from receipt by Findhelp 211 has stabilized over time at 8 minutes 15 seconds. The median time for CCTs to arrive on scene increased slightly from 22 minutes to 25 minutes, while the median time from arrival on scene to completion of the event decreased from 53 minutes to 30 minutes.
- CCTs provided a wide range of crisis-related material resources, such as clothing and food; supports, such as resource-sharing and advocacy; and interventions, such as risk assessment, counselling, rapport building and safety planning. Referrals to shelter and crisis beds accounted for over half of all on-scene referrals made by CCTs.
- A total of 61% of service users agreed to receive follow-up support. Additionally, out of a total 1,160 service users who received follow-up support, over half (57%) of received support within the 90-day model of transitional care.
- For those receiving follow-up support, referrals were most commonly made for mental health and substance use referrals (26%), housing (16%), and case management (13%). A range of culturally relevant supports were provided to service users, of which 50% were Indigenous-specific supports such as traditional medicine and wholistic[1] family and kinship care; Afrocentric and West Indian/Caribbean-centric supports were next most commonly provided.
- TCCS service users reported generally positive experiences and an overall high level of satisfaction with the service, with 95% of service users surveyed indicating they were very satisfied or satisfied with support provided and that their overall experience was very good or good. Qualitatively, service users attributed their positive experiences to feeling respected, listened to, and meaningfully supported by non-judgmental and compassionate staff who took a person-centred approach and were able to provide holistic care that met individuals' wide-ranging and complex support needs.
- Sociodemographic data collected among service users receiving follow-up support from October 2022 to April 2023 suggest the majority of service users were between the ages of 30 and 64 years; race was most commonly reported as white (33%), Black (29%), Indigenous (9%), and South Asian or Indo-Caribbean (9%). Instances of gender identification were fairly evenly split between men (50%) and women (43%). In 85% of cases, service users indicated they had past month challenges meeting basic needs, and in 36% of cases, service users identified themselves as unstably housed. Of reporting service users, 59% indicated they live with a disability.
- TCCS service providers similarly reported positive experiences with the program, the nature of collaboration between partners, and the level of support provided to them. Specifically, 82% of frontline service providers are satisfied or very satisfied with their role and responsibilities in the service, and 93% indicated they would be likely or very likely to recommend the service to someone they know who is in need of help. However, opportunities for improvement in equitably supporting staff, refining operational processes and further enhancing communication and collaboration across partners were also identified.
- At the community level, public awareness has increased over time but is generally lacking, which is contributing to challenges with engagement in the broader service community and amongst the public. Ongoing awareness building, outreach and engagement is required to build capacity and trust in the TCCS. Impacts of the TCCS on public perceptions of community safety and well-being are emerging but challenging to achieve in isolation and in the context of broader system capacity gaps in health and social services. Such long-term impacts are also challenging to meaningfully evaluate at this early stage.
- Overall, feedback from all participant groups indicate the TCCS has successfully been operating in close alignment with its guiding principles. This has been achieved through a variety of mechanisms, including principled leadership and administration by the City of Toronto; organizational values and leadership within each of the service partners; the composition of staff teams' identities, skills and values; and the health care and well-being practices being offered to the community.

[1] 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 [1,2] .

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Executive summary

Recommendations

Based on the findings of this evaluation, a series of recommendations are proposed to support ongoing successful operation and growth of the TCCS:

1. Expand geographical eligibility to be city-wide to support equity, accessibility and overall program efficiency.
2. Consider implementing implied consent at 911 intake source only if/when geographic eligibility is city-wide.
3. Continue to regularly review and audit 911 calls in order to further expand and refine TCCS eligibility criteria.
4. Establish clear response processes for non-standard crisis support calls including a) callers requesting status updates; and b) repeat callers requesting follow-up support that does not meet crisis criteria.
5. Continue inter-partner engagement to build trust, relationships and capacities.
6. Continue engagement and awareness-building with TPS to promote a holistic understanding of crisis response and build awareness of each responder's roles and responsibilities.
7. Increase staffing at each stage of the TCCS service pathway are required to a) respond to increasing direct calls to Findhelp 211, untapped potential 911 calls suitable for diversion, and proposed boundary expansions; and b) to improve staff and service user experience.
8. Ensure robust and equitable health and well-being supports are available to all staff, including part-time and relief staff, across organizations.
9. Implement centrally coordinated and administered co-designed opportunities to engage in training on an ongoing or rolling basis.
10. Implement a TCCS Community of Practice to support standardization, quality improvement, professional development and relationship-building across sites.
11. Continue to monitor and evaluate use of radios.
12. Explore the feasibility of procuring and implementing a centralized data system.
13. Engage and collaborate with local payphone providers to ensure calls to Findhelp 211 from public payphones throughout the City of Toronto are free to callers.
14. Increase the frequency and scope of public awareness and education campaigns.
15. Continue to fund dedicated staffing positions or sufficient staffing levels to allow for dedicated time and capacity for TCCS staff to participate in community outreach.
16. Develop a strategic service provider engagement plan to support TCCS staff outreach.
17. Continue dedicated resourcing for community anchor agencies to access counselling and post-crisis support.
18. Advocate to increase funding and address system-level gaps in healthcare and housing.
19. Continue program monitoring to support ongoing service planning, quality improvement, and accountability; and plan for long-term evaluation to better understand impacts over time.
20. Continue co-design and respond to stakeholder needs in monitoring and evaluation to support engagement, trust and evaluation capacity across TCCS partners.
21. Prioritize service user engagement in future evaluations.

CAMH has appreciated the opportunity to support the evaluation of the TCCS in its inaugural year of operation and looks forward to supporting ongoing monitoring and evaluation as this unique, important, and impactful service continues to evolve to better meet the needs of historically underserved populations across the City of Toronto.

Background & context

Despite more than 80% of mental health-related 911 calls in Ontario being non-violent in nature [3], underinvestment in mental health services over several decades has caused acute care institutions such as police services to become the default first responders for those experiencing crisis [4]. In the City of Toronto, the TPS responds to approximately 33 000 mental health-related calls annually [5], which has increased by approximately 30% over the past five years [6]. However, evidence has demonstrated that law enforcement agencies are not the most appropriate responders for mental health and substance use crises, particularly among Black, Indigenous and other equity-deserving communities who experience disproportionate use of force, surveillance, invasive searches and interactions with the criminal legal system [6,7]. Having police-led responses to mental health-related crises also diverts substantial police resources away from responding to crime [4].

As such, the City of Toronto was called on to reimagine a new, non-police led crisis model that alleviates system pressures and prioritizes a proactive health approach. Non-police led, community-based crisis response models have been gaining traction across Canada and the United States, with approximately 107 programs operating as of August 1, 2023 [3, 8]. Evidence from these models show that the vast majority of mental health crisis calls do not pose safety risks to civilian crisis team staff, but rather create opportunities to connect service users with client-centred, trauma-informed resources [3]. These models are associated with positive individual-, community- and systems-level outcomes, including decreased mental health stigma, injury rates and unnecessary hospitalizations, as well as increased resources to respond to crime, and increased referral rates for follow-up supports [3,7].

Following extensive community consultation and research, Toronto City Council unanimously approved a pilot of the Toronto Community Crisis Service (TCCS), a non-police-led community-based crisis response service for non-emergency crisis calls and wellness checks.

Approved in February of 2021 and launched on March 31, 2022, the TCCS service model is the first of its kind in Canada. To monitor TCCS success and sustainability throughout the pilot implementation, the City has retained third-party evaluators from the PSSP and Shkaabe Makwa at the CAMH. In October of 2022, an interim six-month implementation evaluation report [9] was published (available here), highlighting key implementation processes, facilitators and barriers. Following the findings of the implementation evaluation, this current report presents findings from an outcome-focused evaluation of the TCCS, 13-months post-implementation.

Intervention description

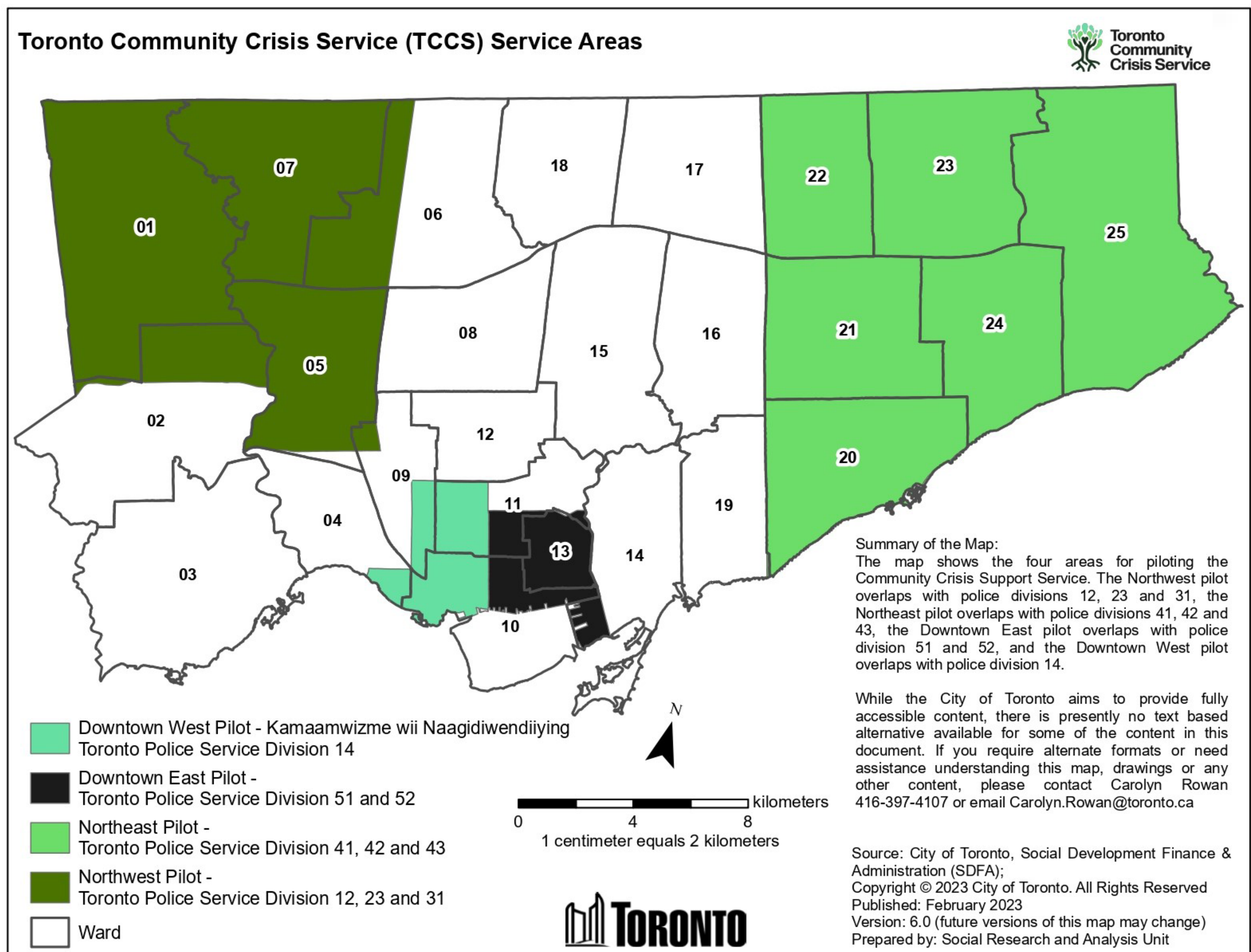
The TCCS is an approach to responding to mental health crises that focuses on health, prevention and well-being. An alternative to traditional police-led models, the TCCS is a community-based service with multidisciplinary CCTs who respond to non-emergency crisis calls and well-being checks. CCTs meet with consenting service users on scene and provide a wide range of services, including crisis stabilization, provision of resources to meet basic needs, and referrals to other needed person-centred, culturally relevant services. In addition to providing direct and immediate crisis care, the teams connect consenting service users to case managers or similar follow-up support to further assess their needs, develop a care plan and facilitate access to appropriate community-based follow-up supports. The TCCS is grounded in five guiding principles of care:

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.

Background & context

The TCCS is currently being piloted in four intentional geographical areas of the City of Toronto: Downtown East, Downtown West, Northeast, and Northwest (**Figure 1**). Pilot site selection took several factors into account, including geographic equity, the current landscape of available mental health and supportive services, concentrations of mental health-related 911 calls, and consideration of Neighbourhood Improvement Areas in the proposed locations. The TCCS received its first call on March 31st, 2022 and was gradually launched as a 24/7 service across all four pilot regions.

Figure 1. TCCS pilot regions



Background & context

TCCS partners

The TCCS is a collaborative initiative, with key partnerships between the City of Toronto, TPS, Findhelp 211 (211), and lead community-based health organizations anchored within each pilot region (“anchor partners”).

The four anchor partners currently participating in the TCCS are the Canadian Mental Health Association – Toronto (CMHA-TO), Gerstein Crisis Centre (GCC), TAIBU Community Health Centre (TAIBU), and 2-Spirited People of the 1st Nations (2-Spirits), which is leading an Indigenous-led pilot (“Kamaamwizme wii Naagidiwendiiying”). The mandates and values of each site differ according to where they are situated within the City of Toronto and the intended populations they aim to serve. As such, each anchor partner independently operates their own CCT and follow-up support, with staff specifically recruited and trained to respond to the unique characteristics and needs of their respective pilot region. Staffing complements vary for each site, but include roles such as trained crisis workers, harm reduction workers, case managers, peer support workers and engagement staff. Each anchor partner has also established a community service network of partnering organizations within their pilot region to facilitate access to the range of community-based follow-up supports they feel would best meet their respective communities’ needs. Summaries of the four pilot regions and anchor partners are provided in **Table 1**, as well as in the Site Profiles in **Appendix A**.

Table 1. Community anchors participating in the TCCS pilot

Pilot region	Police division	Community anchor partner	Launch date	Community service network
Downtown East	51, 52	Gerstein Crisis Centre (GCC)	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
Downtown West (Kamaamwizme wii Naagidiwendiiying)	14	2-Spirited People of the 1st Nations (2-Spirits)	July 11th, 2022	ENAGB Indigenous Youth Agency, Niiwin Wendaanimak/Four Winds Indigenous Health and Wellness Program (based out of Parkdale Queen West Community Health Centre)
Northeast	41, 42 & 43	TAIBU Community Health Centre (TAIBU)	April 4th, 2022	Scarborough Health Network, Canadian Mental Health Association - Toronto, CAMH, Scarborough Centre for Healthier Communities, Hong Fook Mental Health Association, Black Health Alliance, Strides Toronto
Northwest	12, 23 & 31	Canadian Mental Health Association–Toronto (CMHA-TO)	July 18th, 2022	Addiction Services of York Region, Black Creek Community Health Centre, Black Health Alliance, Caribbean African Canadian Social Services, Jane and Finch Community and Family Centre, Rexdale Community Health Centre, Yorktown Family Services

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Background & context

Call pathway

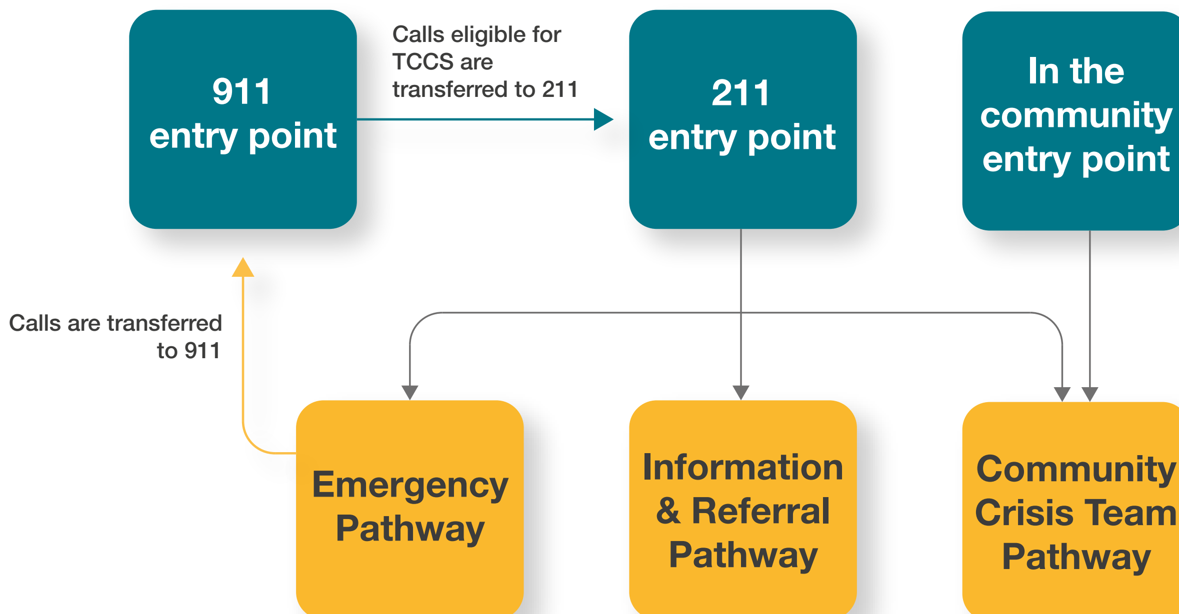
In accordance with the TCCS' guiding principle of enabling multiple coordinated pathways for accessing crisis and support services, there are three entry points through which the TCCS can receive calls: 211, 911 and directly through community anchor partners (i.e., "in the community"). While the primary intake source by design is 211, the majority of calls are currently coming in through 911.

When 911 serves as an entry point, calls are received by 911 Call Operators and are assessed for TCCS eligibility. If the call fits the eligibility criteria and the caller consents to being transferred to the TCCS, the call is then transferred to 211 via a "warm transfer". From there, 211 Service Navigators conduct a secondary safety assessment. Depending on its nature, the call is then routed to one of three general pathways:

1. Community Crisis Team: There is an identified urgent need for CCTs to be dispatched and respond to a person in crisis on scene.
2. Information and Referral (I&R): The call is less urgent in nature, such that caller needs can be met by 211's in-house information and referral services; CCT dispatch is not required.
3. Emergency: There is an identified need for emergency services (e.g., police, fire, ambulance) to be involved due to there being an imminent safety risk; the call is transferred back to 911.[2]

When 211 serves as the entry point, the same outlined steps are followed, with the only distinction being that individuals call 211 directly with no initial involvement of 911. When the community serves as the entry point, anchor partners receive calls directly to dispatch their CCT. Examples of calls that would generate this dispatch pathway include calls made to an anchor partner's direct referral line[3] or calls made during an outreach in the community. A simplified overview of the TCCS call pathway is illustrated in **Figure 2**.

Figure 2. Overview of the TCCS call pathways



[2] There are other, less common reasons that may require a call to be re-routed back into the emergency pathway (e.g., a mobile crisis team is not available, a call outside of the pilot region was sent in error, etc.).

[3] Only Gerstein and 2-Spirits are operating a direct referral line at the time of this evaluation. Gerstein had a pre-existing direct crisis line prior to TCCS implementation. The 2-Spirits direct referral line was launched on May 1, 2023.

Background & context

Eligibility criteria

Calls are eligible for the TCCS if they are located within one of the four geographical pilot regions, do not present a perceived or real risk of violence, and fall into one of six eligible TCCS call categories: *Thoughts of Suicide/Self-Harm, Person in Crisis, Well-Being Check, Distressing/Disorderly Behaviour, Dispute* and *Advised.*[4] These TCCS call categories are similar but not identical to the TPS event types received by 911. A seventh TCCS call category, *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 call categories. It can also be used in cases where a call ended prematurely. Individuals must be aged 16 years or older and must consent to receive TCCS services. Eligibility criteria and definitions of TCCS call categories are described in **Appendix B.**

Supporting infrastructure

The TCCS is supported by both internal and external infrastructure. As previously described, each anchor partner is independently responsible for operating their multidisciplinary crisis team and establishing a community service network to support community-based follow-up care. Administrative support and leadership is provided by the City of Toronto, as well as dedicated leaders and human resources within TCCS partners. Data capacity and information sharing is facilitated by dedicated data systems (e.g., administrative records and client management software) and technology (e.g., two-way radios), which aids in care coordination in the TCCS service pathway and informs quality improvement efforts. To assist with community engagement and awareness of the TCCS, education and outreach activities are embedded in the program delivery. Finally, the TCCS has a robust community engagement and accountability structure to support evidence-informed decision-making and adherence to the TCCS' guiding principles and values. This structure includes engagement from Community Advisory Groups for each partner and the TCCS as a whole, as well as third-party monitoring and evaluation embedded throughout implementation.

Theory of change

As previously described in the six-month evaluation report, the TCCS theory of change was co-designed by evaluators and TCCS partners to describe the intervention's inherent logic and the assumptions made about how or why the intervention is expected to yield its desired outcomes. 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-informed, trauma-informed, consent-based, culturally safe and person-centred, then service users will likely experience higher quality of care. This is by receiving (1) safety in their service interaction; (2) crisis stabilization; and (3) connection to follow-up supports. Over time, the increased diversion of calls from acute care institutions (e.g., police, hospitals) to appropriate community-based care should lead to positive system-level outcomes, ultimately improving community-level trust, safety, health and well-being.

There are two critical assumptions that are essential to achieve the overall success of the TCCS. The first assumption is that all TCCS partners have a baseline level of organizational readiness to change, such that partners are willing to respond to emergent programmatic and community needs. This readiness to change is essential for fostering trusting, successful partnerships among TCCS service providers and users. The second critical assumption is that the community-based follow-up supports, to which the TCCS aims to refer service users, have the capacity to accommodate and meet the needs of new service users in a timely manner. **Appendix C** provides a visual representation further articulating the TCCS theory of change.

[4] The category "Advised" was discontinued early in the pilot and is combined with "Unknown" for the purposes of the current analysis.

Background & context

Debaamjigewin Naagdobiigewin: Indigenous-specific evaluation framework

As previously outlined in the six-month evaluation report, in addition to the overarching theory of change, Debaamjigewin Naagdobiigewin, an Indigenous-specific evaluation framework was co-created by 2-Spirits program staff and partners, as well as members of the community and the 2-Spirits Advisory Group and supported by Shkaabe Makwa Evaluators. The framework 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 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. 2-Spirits Debaamjigewin Naagdobiigewin aided in the development of site-specific indicators and the creation of relevant and culturally safe methods of engagement. Development of this framework supported the evaluation team's understanding of 2-Spirits' unique context and considerations.

Principles and values of this framework were then used throughout the evaluation and across sites. For example, interview questions were modified for Indigenous participants and alternative data collection methods were explored (although ultimately not pursued in the current evaluation due to feasibility). Despite the current evaluation report not including site-specific indicators or alternative data collection methods, the process that was undertaken to co-create the 2-Spirits Debaamjigewin Naagdobiigewin was invaluable to the overall evaluation as it contributed strongly to the establishment of a supportive working relationship with and trust-building amongst 2-Spirits staff, partners and the evaluation team. Further, Debaamjigewin Naagdobiigewin can be used and/or adapted as needed to serve as a roadmap for ongoing assessments of the program. Please refer to the 2-Spirits' Debaamjigewin Naagdobiigewin visual in **Appendix D.**

Toronto Community Crisis Service staff: 2-Spirited People of the 1st Nations

Photo courtesy of the City of Toronto

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Evaluation overview

Evaluation objectives

From inception, the TCCS evaluation was designed to evaluate the implementation of the TCCS itself, as well as its outcomes over a one-year period. As previously mentioned, an interim six-month implementation evaluation was conducted in 2022 to determine the extent to which the TCCS was implemented as intended, as well as the key facilitators and barriers to implementation. Following from the findings of the implementation evaluation, an outcome-focused evaluation was conducted 13 months post-implementation. The outcome evaluation had the following objectives:

- to demonstrate strengths and weaknesses of a non-police led crisis response model
- to document and understand key program processes and outcomes
- to explore service user, service provider and community experiences of the program
- to identify opportunities to support quality improvement and sustainability.

Evaluation questions

Five key evaluation questions guided the one-year evaluation, which were as follows:

1. How did stakeholders experience the TCCS and how did experiences vary within and across groups?
2. How have communities experienced the TCCS?
3. To what extent and how were non-emergency mental health and crisis-related calls to 911 and 211 responded to by the TCCS?
4. To what extent and how were direct crisis supports provided and connections made to appropriate community-based follow-up supports through the TCCS?
5. To what extent has the TCCS demonstrated its guiding principles?

Each evaluation question includes a series of sub-questions that further guided inquiry (**Table 2**). Evaluation questions, evaluation sub-questions, and corresponding measurement details are further described in the following section and in the TCCS Outcome Evaluation Matrix (**Appendix E**).

Table 2. Key outcome evaluation questions

Evaluation question	Evaluation sub-questions
1. How did stakeholders experience the TCCS and how did experiences vary within and across groups?	a. How have service users experienced the TCCS? How did experiences vary by identity? b. How have service providers experienced the TCCS and how did experiences vary by identity?
2. How have communities experienced the TCCS?	a. What is the level of awareness within communities? b. To what extent has the TCCS supported service integration within communities? c. To what extent does the TCCS positively impact individuals' perception of community safety and well-being?
3. To what extent and how were non-emergency mental health and crisis-related calls to 911 and 211 responded to by the TCCS?	a. How did call volumes, characteristics and outcomes differ by pilot region?
4. To what extent and how were direct crisis supports provided and connections made to appropriate community-based follow-up supports through the TCCS?	a. What types of direct crisis supports were provided, to what extent and how? b. What types of follow-up supports were provided, to what extent, how and to whom? c. What facilitators supported crisis care and connection to follow-up support? d. What barriers hindered crisis care and connection to follow-up support?
5. To what extent has the TCCS demonstrated its guiding principles?	a. How accessible is the TCCS? b. To what extent and how are harm reduction principles and trauma-informed care demonstrated in the TCCS? c. To what extent do stakeholders believe the TCCS is consent-based, trustworthy and safe? d. To what extent is the TCCS person-centred and culturally safe?

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Evaluation design & methodology

Co-design and collaboration

The TCCS evaluation was co-designed to be evidence-based, useful, feasible, participatory and meaningfully inclusive and reflective of local community values and perspectives. Outcome 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 January 2023 to March 2023. To ensure the evaluation design was relevant and feasible for all TCCS partners, evaluators engaged in individual and collective consensus-based discussions to collect feedback on the six-month implementation evaluation report and evaluation processes, and to establish priorities specific to the one-year outcome evaluation. The preliminary outcome evaluation matrix, methodology and materials were drafted by the evaluators for partner review and refinement, which included revision by each partner's respective Community Advisory Groups. Following this process, the complete outcome evaluation plan was finalized and implemented at the beginning of April 2023.

Theoretical frameworks

As described in the six-month evaluation report, four literature-based evaluation frameworks were used as guidance to ensure the overall evaluation approach was designed in a credible, rigorous, and evidence-based manner: Realist Evaluation, Developmental Evaluation, Utilization-Focused Evaluation and Indigenous-Led Evaluation. These frameworks, described in **Table 3**, were selected based on the dynamic and complex nature of the TCCS and its implementation and were adapted for use in this context. Collectively, the frameworks emphasize stakeholder participation and co-design; context-specificity; flexibility; usefulness; cultural safety; and the use of mixed methods.

Table 3. Theoretical evaluation frameworks used to inform the TCCS evaluation

Evaluation framework	Relevance	Description
Realist	Focus on context	Prioritizes the understanding of how program mechanisms interact with implementation contexts to produce the expected outcomes [10]
Developmental	Focus on responsiveness	Anticipates the need to adapt and respond to expected and unexpected changes that occur during the course of implementation [11]
Utilization-focused	Focus on utility	Plans and facilitates the evaluation to enhance the likelihood of stakeholders using the findings and evaluation processes to inform decisions and improve performance [12]
Indigenous-led	Focus on Indigenous community-driven approach	Centres Indigenous ways of knowing in the design and implementation of the evaluation, by meaningfully incorporating the unique priorities, needs, and contributions of Indigenous communities and partners [13] The program values of 2-Spirits were weaved into the TCCS evaluation to be reflective of the 2-Spirits community and their voices, and to foster meaningful relationships. These values refer to the Seven Grandfather teachings: ***Love, Respect, Bravery, Truth, Honesty, Humility and Wisdom.***

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Evaluation design & methodology

Evaluation guiding principles

The aforementioned stakeholder consultation and theoretical frameworks informed a series of guiding principles that supported the operationalization of the TCCS evaluation design. These were co-determined by the City of Toronto and TCCS partners:

- 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.

Accordingly, this is an evidence-based, participatory, practical and mixed methods outcome evaluation of the TCCS, capturing data from a wide range of sources and stakeholders to inform decision-making for program success and sustainability. In addition, deliberate efforts were made to incorporate an equity-centred lens in the evaluation, by collecting sociodemographic information relevant to service users and the pilot regions where feasible, and using it to situate findings within the context of key variables such as place, race and gender. Data sources and measures used in this outcome evaluation are summarized in the following section.

Data sources

This outcome evaluation included a variety of primary and secondary data sources to capture robust and diverse perspectives from all relevant stakeholder groups (described in next section). Quantitative data on TCCS processes and outcomes, such as the volumes and types of calls received, how they were resolved and what immediate and post-crisis supports were provided, were abstracted from administrative records from the data systems of all partnered organizations participating in the delivery of the TCCS. The City of Toronto provided administrative data for the period of March 31, 2022 to April 30, 2023. Anchor partners supplied a secondary set of administrative data for the period of October 1, 2022 to April 30, 2023, which, where possible, was then merged with data for the period of March 31, 2022 to September 30, 2022 that had been previously collected as part of the six-month evaluation[5].

Primary mixed methods surveys relating to TCCS perceptions and outcomes were administered to each stakeholder group. Additionally, follow-up data from two validated survey tools measuring collaboration (Wilder Collaboration Factors Inventory [14]) and readiness to change (Organizational Readiness for Implementing Change (ORIC) [15]) was collected from each service provider organization for pre-post analysis; baseline data from these tools were collected in August and September 2022 during the implementation evaluation and reported in the six-month evaluation report.

Qualitative semi-structured interviews and focus groups were conducted with each stakeholder group to further explore experiences and perceptions of the TCCS, and took place over a three-month period from April 1, 2023 to June 30, 2023. Qualitative data was supplemented with an implementation tracker, which was completed and submitted on a quarterly basis by all service provider organizations. This tool was used to qualitatively document organizational-level longitudinal implementation experiences, including key activities, facilitators and barriers and lessons learned. Finally, Site Profiles were created for the four TCCS pilot regions to highlight defining characteristics of the anchor partner organizations and the communities they serve. Included in the Site Profiles are key sociodemographic characteristics of the respective pilot regions, obtained from the City of Toronto Open Data Portal, which enabled evaluators to situate the data collected through this evaluation within a broader equity-centred context.

Data collection took place intermittently over 11 months, from August 1, 2022 to June 30, 2023 but was overall reflective of a 13-month period where possible, from the date of the first call received by TCCS on March 31, 2022 to April 30, 2023. Data sources, frequency and timing of data collection activities are summarized in **Table 4** and described more fulsomely in the TCCS Outcome Evaluation Matrix (**Appendix E**).

[5] Note: Data collection periods varied for each pilot region, in accordance with their launch dates. The Northwest and Downtown West pilots were launched in July 2022, and therefore data collection for both of these sites began in July 2022.

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Table 4. Summary of TCCS outcome evaluation 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 service user records	Secondary quantitative data on service usage generated through routine administration of the service that is abstracted from existing organizational records and populated in a template	Call volumes, characteristics, and outcomes; crisis supports provided; referrals made; sociodemographics	Service providers (TPS, 211 via City of Toronto; anchor partners)	Retrospectively monthly; March 31, 2022–April 30, 2023. Where applicable, merged with previously collected data from April 2022 –September 2022 as part of the six-month evaluation
Mixed Methods	Surveys	Primary quantitative and qualitative data generated through Likert-style closed- and open-ended survey items assessing stakeholder experiences	Narrative experiences of receiving or providing care; perception of facilitators and barriers to care and connection; perception of TCCS guiding principles	Service users; service providers (TPS, 211, anchor partners); community	Cross-sectional; May 2023 – June 2023
	ORIC	Primary data generated through a validated 12-item tool that assesses determinants and consequences of readiness to change; collected at six months and one-year post-implementation	Commitment to change; confidence in implementation	Service providers (TPS, 211, anchor partners)	Pre-post; August–September 2022 vs. April–May 2023
	Wilder Collaboration Factors Inventory (Wilder)	Primary data generated through a 44-item tool that reflects experiences of 22 success factors for collaboration; collected at six months and one-year post-implementation	Mutual respect; favourable political and social climate	Service providers (TPS, 211, anchor partners)	Pre-post; August–September 2022 vs. April–May 2023
Qualitative	Semi-structured interviews and focus groups	Primary qualitative data generated through semi-structured individual or group dialogue assessing stakeholder experiences	Narrative experiences of receiving or providing care; perception of facilitators and barriers to care and connection; perception of TCCS guiding principles	Service users; service providers (all); community (Community Advisories)	Cross-sectional; April-June 2023
	Implementation tracker	Primary qualitative data reported by organizations in a template reflecting organizational-level longitudinal implementation experiences	Perception of call pathway, processes and outcomes; perception of facilitators and barriers to care and connection	Service providers (all)	Quarterly from October, 2022 – May 2023; merged with monthly trackers collected from April 2022–September 2022 as part of the six-month evaluation
	Site profiles	Primary qualitative data reported by organizations in a template through semi-structured inquiry reflecting organizational-level defining characteristics	Description of types of services and supports offered; organizational mandate and values; sociodemographics of pilot region	Service providers (anchor partners)	Cross-sectional; June 2023

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Evaluation design & methodology

Participants and recruitment

Evaluation data was collected from three key stakeholder groups:

1. service users
2. service providers
3. community.

Service users are individuals who have had direct interactions with the TCCS. This includes two sub-groups:

1. individuals in crisis who received support from the TCCS
2. individuals who identify as a support person (e.g., family member, caregiver, kinship relation) who were present during a TCCS CCT visit and were involved in supporting an individual who received services from the TCCS.

Service providers include two sub-groups of individuals:

1. staff in leadership roles, including management and senior or executive leadership
2. frontline staff who are involved in providing direct care to TCCS service users.

For this evaluation, frontline staff at TPS included Civilian Communication Services (911) Call Operators and Operations Supervisors, uniformed Constables and Inspectors from the Primary Response Unit (PRU), as well as uniformed officers from TPS' Mobile Crisis Intervention Team (MCIT). Frontline staff at 211 included Service Navigators and I&R Coordinators. Frontline staff at the four anchor partners included members of their respective CCTs, and case managers or staff who similarly provide follow-up support. The City of Toronto was also included in the service provider group, given their role in program administration. Frontline staff from the City included Policy Development Officers.

Community refers to three sub-groups in the context of the current evaluation:

1. members of each of the four anchor partners' respective Community Advisories, who advise on the TCCS from the perspective of each organizations' community
2. non-profit community agencies, who are organizations associated with 211 included on their non-profit listserv
3. community members at large, who are who are generally self-identified residents of the City of Toronto.

Recruitment and primary data collection through surveys, semi-structured interviews and focus groups occurred from April to June 2023. Participants were recruited using purposive and convenience sampling and were offered several options for engagement according to preference and availability. In total, 312 unique individuals engaged in primary data collection activities, which includes 53 interviews or focus group participants and 259 survey respondents. The distribution of participants across stakeholder groups was as follows: 135 service providers, 25 service users and 152 community members. Participants and sample sizes from each stakeholder group and primary data collection activity are summarized in **Table 5**.

It is important to acknowledge that this sample is not equally representative either within or across stakeholder groups. Participants were recruited based on availability to and willingness to participate at a cross-sectional point in time; a more in-depth reflection on recruitment limitations can be found in the ***Challenges, Limitations and Lessons Learned*** section. Despite a relatively smaller sample size, evaluators aimed to centre TCCS service users' voices and balance presentation of data in a way that supported representativeness and the current report's focus on diverse experiences and outcomes.

Toronto Community Crisis Service staff: TAIBU Community Health Centre

Photo courtesy of the City of Toronto

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Table 5. Participant groups and sample sizes participating in cross-sectional interviews, focus groups and surveys

Stakeholder group	Partner	Participant level	Sample size (N)		
			Focus group or interview	Survey	Total
Service users	First person service users (individuals having experienced a crisis)		3	16	25
	Support persons		2	4	
Service providers	City of Toronto	Leadership/Management	2	N/A[a]	135
		Frontline staff: *Policy Development Officers*	4		
	TPS	Leadership/Management	3	N/A	
		Frontline staff: *Staff supervisors*	4	16	
		Frontline staff: *Police Constables*	3	26	
		Frontline staff: *911 Call Operators*	5	10	
	Findhelp 211 (211)	Leadership/Management	2	N/A	
		Frontline staff: *Service Navigators and I&R Coordinators*	5	13	
	Anchor partners (2-Spirits, CMHA-TO, GCC, TAIBU)	Leadership/Management	7	N/A	
		Frontline staff: CCT staff	8	27	
Community	Community Advisory members [b]		5	N/A	152
	Non-profit community agencies		N/A	74	
	Community at large		N/A	73	
Total number of unique participants			53	259	312

[a] N/A indicates that the data source was not applicable to the participant group.
[b] Only members from CMHA-TO and TAIBU's Community Advisories participated in this evaluation.

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Privacy, consent and compensation

Participation in this evaluation was entirely voluntary, and all information received from participants was de-identified and kept confidential. All individuals provided informed consent to participate in this evaluation. Each interview and focus group participant received an information package detailing the evaluation as well as the data collection process, purposes, risks and benefits. Evaluators reviewed this information with each individual, ensured comprehension and acquired 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 was used: 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 trusting relationships 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 to access the survey. Before completing and submitting the survey, individuals were informed that submitting the survey implied their consent to participate in the evaluation.

Service users and Community Advisory members were offered monetary compensation for their time and contribution.

Reporting and analysis

Data from all sources were collectively analyzed and organized in response to each of the key evaluation questions. Quantitative data from administrative records and surveys was cleaned and organized in Microsoft Excel where analysis was conducted primarily using descriptive statistics, including frequencies, measures of central tendency and proportions. Where applicable, data was evaluated at both a monthly level and as aggregated over the data collection period. Additional disaggregation was performed by pilot region and/or call type, where possible and relevant.

Qualitative data for the current report resulted from interviews, focus groups, open-ended survey questions and implementation trackers. As noted, all interviews and focus groups were recorded and transcribed in full. Transcripts, implementation tracker data and open-ended survey content were analyzed using inductive thematic analysis and grounded theory, whereby data was reviewed both with pre-supposed codes and themes derived from the literature, stakeholder consultations and previous findings from the six-month evaluation report, while also maintaining space for codes and themes to emerge organically. All 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. Evaluators then conducted qualitative data analysis using either Microsoft Excel or NVivo qualitative analysis software. Quantitative and qualitative data were integrated to generate a robust and nuanced understanding of TCCS processes and outcomes.

As previously mentioned, an equity-centred lens was used in all analyses, with an aim to explore differences in experiences and outcomes according to key sociodemographic variables such as place, race and gender, as well as their intersectionality.

Results: Evaluation Question 1

Evaluation Question 1: How did stakeholders experience the TCCS and how did experiences vary within and across groups?

1a. How have service users experienced the TCCS and how did experiences vary by identity?

As noted above, service users are individuals who have had direct interactions with the TCCS. This includes two sub-groups: individuals in crisis who received support from the TCCS and individuals who identify as a support person (e.g., family member, caregiver, kinship relation) who were on scene during a TCCS CCT visit and were involved in supporting an individual who received services from the TCCS. A total of 25 service users and support persons participated in a survey and one-on-one interviews: 16 service users and four support persons participated in the survey, and three service users and two support persons engaged in one-on-one interviews to share their experiences with the TCCS.

The two support persons who engaged in interviews had unique relationships with individuals they supported while experiencing crisis, one being a family member of a service user and the other a staff member in a community agency where a community member was in crisis. One of the two support persons who engaged in an interview self-identified as Indigenous First Nations and one of the three service users self-identified as Black. Despite the small sample sizes of service users and support persons in both the survey (n=20) and interviews (n=5), the stories participants shared were profound and heartfelt, providing the evaluation team with a glimpse of if and how the TCCS is supporting community members with varied identities and complex contexts to better manage mental and behavioural health crises. As previously described, the limitations of the evaluation methods used to engage with service users and support persons can be found in the ***Challenges, Limitations and Lessons Learned section.***

Participants' stories, experiences and overall perspectives

It was clear during one-on-one interviews with service users and support persons that all participants shared different, and yet similar stories with significant elements of personal grit and strength. A majority of respondents had been navigating complex, stressful, and challenging life situations while taking care of themselves and/or their families, and were still open to engaging in the evaluation to share very personal and potentially triggering experiences at a time where many were still receiving TCCS services. This clearly demonstrates the extraordinary resiliency of participants. All service users and one of the two support persons interviewed shared multifaceted experiences with grief, institutional trauma, housing insecurity and complex medical needs. Experiences with grief were described by some participants as losing relatives or support persons (e.g., death of loved ones) within the last few years. A service user elaborated on the effect of grief following the death of multiple family members, sharing, "I am a single mother. My [parent] died a few years ago…it really hurt me big time. My [parent] died because my sibling was murdered…There is a lot of pressure…I have to take care of myself and my children" (TCCS service user). The same service user described the significance of the TCCS supports in supporting her to manage this experience; "the grief was weighing quite heavily on me at the time… it's hard to explain when you have no one and somebody steps up, even though it's a stranger, it really makes a difference," and when asked what was the most helpful aspect of the TCCS for them, the service user shared, "basically - be there for me" (TCCS service user).

Another service user shared their experience with grief and personal medical challenges during their interview. The participant, who described themselves as being in late-adulthood and self-identified as Caucasian, reflected on having lost her husband unexpectedly and being informed second-hand: "I was in the hospital, I got out… [my husband] was able to bring me home, then about a week later is when he passed away…his friend informed me over the phone that he had died" (TCCS service user). The participant then described their first interaction with TCCS, noting the caring initial interaction they had with the CCT:

> [Building] security contacted the crisis team and they came and spoke with me for a little while that day and the next day after they were done, and they made sure that I was okay to continue on my own and I wouldn't hurt myself or anything. (TCCS service user)

Results: Evaluation Question 1

Some participants described past experiences that have led them to lack of trust in institutions, which contributed to how they experienced the TCCS. Most noticeably, service users and support persons who self-identified as Black or Indigenous described having had negative experiences with institutions such as child welfare, police services and hospitals. The mistrust of institutions described by Indigenous TCCS service users and support persons who participated in the evaluation is multifaceted and may stem from both more recent experiences Indigenous communities have with these institutions, as well as from harmful past practices that these institutions were associated with (e.g., enforcement of residential school attendance by police, forced and coerced sterilization of Indigenous women in Canada Indian hospitals, etc.) [16,17]. As an example of how past experiences contribute to how the TCCS may be perceived and experienced, one Indigenous support person who participated in a survey reflected on how they feel there is an opportunity for the TCCS to reduce over-policing and the harmful effects of this practice in the community:

> Good work so far…there is a lot of potential to substitute police with these mental health crisis teams. Especially for Indigenous people, police in black suits who carry guns breaking down the doors of a person who is experiencing mental health difficulties to involuntarily hospitalize them is absolutely unacceptable. As well, whenever an Indigenous child is involved in a police call, [child welfare and child protective services] immediately becomes involved and shows up without any consent… It is extremely invasive and clearly they do not understand how harmful it is to walk into an Indigenous person's home to report on whether they are healthy enough to be a parent. It is important to keep Indigenous families together and supported with no police or child welfare involvement. Supporting rather than judging which the [TCCS] team did amazingly. (TCCS service user)

Another Indigenous support person who was interviewed described how their family had to navigate difficult situations in the past when feeling they had no other choice but to involve the police and subsequently the child welfare system when their sibling was experiencing mental health challenges. This was an experience that was reported by other TCCS service users and support persons who self-identified as Black and Indigenous as well. According to this participant, such situations can lead to stressful experiences for the entire family:

> We've had situations in the past when, against all of our wishes and my sibling's wishes, we've had no choice but to involve the police, and this is ultimately why my sibling is so averse to child welfare services, and with really good reason. The challenging part was [the impact] on our interpersonal dynamics between my sibling and I, the trust element in our relationship was at stake. (TCCS support person)

In comparison to previous experiences seeking care, the TCCS was described in stark contrast insofar as their ability to offer trauma-informed and consent-based support to this person and their family:

> What I found that was helpful [with TCCS] is that I could have a contact person [TCCS staff] to help and step in to support my sibling and us, so we were not seen by my sibling as family members who contacted police and child and family services against their wishes. So not having to report them to these services [police, child welfare], while being able to connect them with supports that are trauma-informed. (TCCS support person)

Toronto Community Crisis Service staff: 2-Spirited People of the 1st Nations

Photo courtesy of the City of Toronto

Results: Evaluation Question 1

For participants who self-identified as Black, mistrust was specifically described as mistrust of the police. According to a report released by Statistics Canada in 2022, Black individuals were more likely than non-Black individuals to report discrimination by the police in varied public environments such as stores, banks, and restaurants [17]; and to have encountered a serious problem or dispute related to discrimination by the police [18]. Again, TCCS stood out in contrast to past experiences as a different and welcomed approach, with one Black TCCS service user sharing that they were feeling hopeful to have a different service in the community to respond to mental health crises with providers who are better trained to respond to such needs:

> This [TCCS] is a life saver. I keep on saying that, and this gives the community hope. This gives the community hope because the community…we don't necessarily trust the police. Not all police are good but not all police are bad either. So with 211 Toronto [the TCCS], I feel like they fix that. So it's like "We're not the police. We can [respond to] your emergency depending on the situation and we can give you the support that you need." Because the police, when they come…this is what I know because I've been going through it, they're trained [to respond to] crime and that's that…they're not trained for the mental health piece of it. (TCCS service user)

This participant also reflected similarly to the Indigenous support person on the TCCS' model being one that can support families to maintain positive interpersonal dynamics even during the stressful experience of seeking crisis care: "The fact that I am calling the police on my child…it [the TCCS]'ll give you another option. [Calling the police] really beat up our relationship big time because it was like, 'Oh, she's gonna call the police' you know?" (TCCS service user).

As noted earlier, many service users and support persons who participated in the evaluation were experiencing complex challenges, which also included housing arrangements. The housing status of survey participants was disaggregated by ethnicity and Indigenous identity (**Table 6**). All survey participants who self-Identified as Indigenous (n=3) described their housing status as "unstable" (100%), and 20% of survey respondents who self-Identified as Black (n=5) reported their housing status as "unstable" while 80% of Black respondents noted having stable housing arrangements. All individuals who self-identified as "White" (n=4) reported having stable housing. While it is a principle of this evaluation to centre equity in analysis, small counts warrant awareness and caution should be taken in interpreting and drawing conclusions from these proportions.

Table 6. Housing status of service user participants disaggregated by ethnicity (n=20)

	Ethnicity				
Housing status	Black	Indigenous	Other racialized groups	White	Total
I have stable housing arrangements	4	0	6	4	14
I have unstable housing arrangements	1	3	1	0	5
Refused to answer	0	0	1	0	1
Grand total	**5**	**3**	**8**	**4**	**20**

Results: Evaluation Question 1

Overall satisfaction and validation among service users and support persons is high despite some identified gaps

Service users and support persons were overall satisfied with the service they received through the TCCS, with a majority of individuals who participated in one-on-one interviews describing having an overall positive experience with the TCCS; 95% of survey respondents indicated they were "very satisfied" or "satisfied" with the support provided by TCCS CCTs, and 95% reported their overall experience with the TCCS as "very good" or "good."

The overall high satisfaction of service users and support persons with the TCCS can be mostly attributed to participants feeling respected, heard and meaningfully supported by TCCS staff, who themselves were described by many as being non-judgmental and compassionate. As one interview participant shared; "I did [feel they respected my opinions]…they didn't do anything I didn't want them to do. They were definitely there for me" (TCCS service user). Another survey respondent elaborated on their satisfaction with the service received:

> I'm just very grateful I got to work with your staff. Everyone was patient. Accommodating. Emotionally present. Emotionally aware. Empathetic. Sincere. Genuine. Caring. If you didn't have a family. They could seriously be considered such with the amount of support. I'm beyond grateful. Thank you so much for everything! (TCCS service user)

In alignment with the overall high satisfaction with the program, a majority of service users and support persons who participated in the interview shared that they would or had already shared information about the TCCS with others in their community. As one service user noted:

> I would [share about the TCCS with others] in a heartbeat. I would let them know that people going through this are not alone and that there is this group of people who can help them through the worst of what they're going through and help connect them with other people who can do more…and just let them know that there are individuals out there that actually care, that they actually give a damn…because these people actually do. You can see that they're not in it for the money, that they're in it because this is what they want to do. This is their purpose in life, that they want to help people…I had never experienced anything like it before. (TCCS service user)

Another service user shared:

> Oh, I already did [share information about the TCCS]… everybody can use them. I just sent them a young girl [22 years old] in the community…I said to her…"I'm going to give you this number, 211 Toronto. They're going to help you and just explain to them and they will give you numbers and tell you what to do." (TCCS service user)

A third service user described their satisfaction with the TCCS and specifically the ability of staff to be good listeners and meet them where they were at: "They were supportive and understanding of my needs. Sometimes when I get nervous I get non-verbal. I don't like dealing with males and they respected that and listened to me" (TCCS service user). In addition, all survey respondents who self-identified as Indigenous (n=3) also reported being satisfied or very satisfied with the TCCS. As one Indigenous service user shared, "I loved my experience and I learned a lot about myself from reaching out for this help" (TCCS service user). **Table 7** shows the satisfaction rate of service users and support persons by ethnicity.

Table 7. Satisfaction rate of service users and support persons by ethnicity (n=20)

	Ethnicity				
Level of satisfaction	Black	Indigenous	Other racialized groups	White	Total
Dissatisfied	0	0	1	0	1
Satisfied	0	1	0	1	2
Very satisfied	5	2	7	3	17
Grand total	**5**	**3**	**8**	**4**	**20**

Results: Evaluation Question 1

Despite the high satisfaction with the TCCS, some participants shared that the program could still improve. For example, a support person shared that there are gaps in service delivery that should be addressed. These gaps include a lack of community awareness and knowledge of the program in the community (further discussed in ***Evaluation Question 2a***), as well as communication gaps in the call pathway, such as the unknown estimated time of arrival of the CCT on the crisis scene as a barrier effective use of and trust in the service as a whole. In this participant's experience, not having any communication around lead time led their agency to call 911 in addition to having called the TCCS in order to ensure the community member experiencing crisis and community members in the facility would have someone there responding for the person in crisis as soon as possible. However, this service duplication is resource-intensive and inefficient, in addition to creating unnecessary exposure to police. The participant reflected on their experience as follows:

> Not knowing how long it's going to take [to arrive on crisis scene] is a barrier, because we just can't wait…like do I say if the crisis team would've gotten there before the police, I'm confident they could've handled it, but I think the concern is maybe we/they haven't built up that trust because it's so new. And also because it's so new, maybe that's why there's not enough resources to be able to get there fast enough. Maybe the police are better resourced at this point to be getting there faster, even though they may not be the right person. I feel like if the crisis people got there first, they would've been able to handle it as well, if not better than the police. Police didn't need to be there, it's just that we needed someone then, and we didn't know, you know, how it would escalate. Even though there's no weapon, you know, but I think anytime there's children involved, parents picking up their kids, you want to make sure you have your bases covered. (TCCS support person)

However, another support person described feeling "impressed" by the 2-Spirits CCT's "prompt response" to their call, suggesting variability may exist case-to-case or site-by-site, which is similarly reflected in the data on call times reported in ***Evaluation Question 3.*** While this second support person was satisfied with their initial crisis response time, they also shared that from their perspective, the follow-up and case management are program components requiring some attention as they had experienced some challenges later in the service pathway:

> I was very impressed by the prompt response and how quickly they [2-Spirits CCT] came to the scene. The only thing that [I think it could improve] is the service continuity piece, where I felt there were some issues from our first call to our second call. I was saying my sibling's name and my name and the date that we first called and everything, but they did not have any information recorded so I had to tell the story again. The other part was my other family member [not the individual in crisis] was waiting for someone to connect with them to receive case management as well. Finally, they got in touch yesterday. I'm sure that case management is in high demand. So I'm sure there's a reason for the little bit of gap in service time. (TCCS support person)

Quality improvement processes and responsiveness to feedback are included in the TCCS' guiding principles, further discussed in ***Evaluation Question 5.*** Feedback from 2-Spirits staff indicated that they are aware of the follow-up challenges experienced by their service users; and that they have since made modifications in their service pathway to better capture service users' stories during intake so they do not have to repeat information during follow-up that they previously provided during their initial crisis encounter.

Toronto Community Crisis Service staff: 2-Spirited People of the 1st Nations

Photo courtesy of the City of Toronto

Results: Evaluation Question 1

Services and supports provided were described by service users and support persons with varied identities as being relevant, appropriate and beneficial to their overall sense of safety and well-being

A majority of service users and support persons who engaged in interviews shared that the TCCS is relevant, as its services are in direct alignment with the needs of their respective communities. As one service user identifying as Black shared, "I'm so happy you guys are here because people need this, people need this in the community. People need this in the Black community. This is an option. This actually works" (TCCS service user). Further, many participants who self-identified as Indigenous or Black in the survey and interviews highlighted the appropriateness of the TCCS by describing the CCTs' responses to be helpful and beneficial as they could culturally identify with staff on the crisis scene. For example, an Indigenous service user shared that "Yes, the Indigenous mobile crisis team led by other Indigenous women was helpful [because of] common understanding of cultural life experience" (TCCS service user). A support person who self-identified as First Nations during an interview shared that their experience with 2-Spirits is grounded on a long-standing relationship they have with the organization. The participant shared that when they reached out to the TCCS and were connected with 2-Spirits by the 211 dispatcher, they trusted that any support offered to them and their loved ones would be culturally appropriate and non-judgmental based on previous experiences they had with the organization. At the time of the interview, three family members were receiving various supports from 2-Spirits, including case management, which was being offered to the family member who was experiencing a crisis. A young member of the family was also receiving TCCS supports. The types of wholistic supports being received by the family according to the participant included exploring different services that the service user would consent to, with the TCCS team acting as a liaison in the building where the family member experiencing crisis lives in order to support security related challenges that may arise, and attending appointments with the service user to provide advocacy and support. According to this participant, having someone outside of the family supporting them was very helpful. The TCCS team was further helping the family to access psychiatric assessment while recognizing and respecting potential challenges in doing so that related to another sibling having experienced trauma with psychiatric supports they received from a mainstream service provider in the past: "They [the TCCS] are trying to address other areas to further support my family member, to help them to unpack past traumas with institutions. I think that this type of support is really important for our family" (TCCS support person).

Service users also reflected on how the TCCS was able to meet their individualized needs and consider their individual contexts in generating appropriate supports. One service user noted the positive effects of the holistic supports provided by the TAIBU TCCS team to their son, who was experiencing mental health challenges that had become a barrier to his ability to engage in and plan for his future: "My son has a forklift licence now and this is all from 211 Toronto [the TCCS]…when [my son] came home with the forklift licence, he was so happy. I called them [the TCCS], I said 'I got my son back. Thank you guys'" (TCCS service user). The same service user shared feeling surprised when they learned from the TAIBU TCCS team that they could also connect them with services to support their own individual needs:

> [The TCCS] talked to me. I told them that I called 211 for my son, not for me, I didn't call for help for me… But they were like, "No, we help you too." There's help for me too?! [The TCCS] talked to me and they talked to my son and they talked to us all and I'm still used to people saying, "We're gonna do X Y and Z" and then nothing really happens, but oh my gosh, they went above and beyond. (TCCS service user)

Similarly to the perspective shared by an Indigenous service user, a participant who self-identified as Black and engaged in the interview described how they were able to meaningfully connect with TCCS staff and how they felt understood as they have similar cultural backgrounds. These testimonies provided by service users indicate the importance of TCCS staff being culturally representative of the communities they are supporting, a guiding principle of the service that the TCCS has strived to implement since the program's inception. For example, one service user shared that:

> A lot of things come from our cultural background…so like [TAIBU TCCS staff] being Caribbean, I don't have to explain myself too much because they understood because of the culture and just the way all the people do things, right? It's what we grow up on and it's like less of a culture shock, if I could say it like that. I've never felt like this ever before…40 years…I never felt like this and

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> I have actually been a constant cry for help. I didn't have to explain as much because it's a cultural thing…I have old fashioned Jamaican parents, so they understood that. (TCCS service user)

Other service users reflected on the overall person-centredness and holistic approach with which support was delivered, describing having received a wide range of services addressing a variety of their health and well-being domains that ultimately set them on a positive path forward:

> I've been hooked up with the right medical people, so I'm getting my doctor's appointments. I now have Meals on Wheels [meal support]. I have somebody to help me with a shower and another one to help me with laundry, and this is all because they got the ball rolling. So they arranged all those supports through the Gerstein Centre and then through [Crisis Outreach for Seniors], they are a senior crisis unit that works from WoodGreen [Community Services], and they were able to set up all these supports for me so that I could carry forward. (TCCS service user)

Another support person who self-identified as First Nations described their own and their family's feeling of personal safety being positively impacted by the TCCS:

> I think that it has impacted my and my family's feeling of safety in a very positive way in the sense that we are [support person and family of the person in crisis] still treating this situation with a lot of care because every day can be different from the previous day…But it's so comforting to know that we have that [TCCS] number right at our disposal, and just to be able to access the 2-Spirits dispatch team because they offer 24-hour service. It's just such a feeling of comfort, and with that the element of safety is present, knowing that the service is there and it is safe. (TCCS service user)

Overall, the majority of service users and support persons shared deep gratitude for the program as a whole, sharing sentiments such as "These people [TCCS staff] are helping so much" (TCCS service user) and "Thank you. I appreciate everything you are doing to help the community and myself!" (TCCS service user). Participants appeared to very much appreciate the various supports they had received through the TCCS, noting an overall positive effect the program and teams had on them individually and also on their perception of health and well-being. As described, the supports provided to service users and support persons were often holistic and specific to their own and/or their loved ones' needs, which helped with their overall sense of well-being:

> I don't know what else to say, I really don't, other than, you know, that they [TCCS staff] were the best things that ever walked into my life when they did. If they hadn't when they did, I don't know what I would have done, I really don't, with all of the mess that my apartment was in, with the way I was feeling. I don't know, I would have given up and maybe gone and just left everything behind instead of sticking it out and putting my life back together and getting the help that I needed here. (TCCS service user)

As another service user concluded their survey feedback, "They helped me understand that I'm worthy and they wanted to see me go forward. They uplifted me and made me feel like I'm worthy" (TCCS service user).

Participants voiced their hope for program continuity and expansion

A majority of service users and support persons who participated in interviews and in the survey voiced their hope for program continuity and expansion as many highlighted the need in communities across Toronto for TCCS services:

> You guys [the TCCS] are amazing. They told me it was a three year project…No, I'm so happy you guys are here because people need this, people need this in the community. People need this in the Black community. This is an option. This actually works. "It's a wonderful thing that you guys [City of Toronto] have, and I really hope that you guys [City of Toronto] don't take it away. I was so upset when I heard it was just a three year project. What do we need to do to continue this to go on? This is a need. (TCCS service user)

Another participant echoed:

> If there is any way that this comment can get back to the program funders, I just want to stress that the [TCCS] is such an integral service. And I understand that it is a pilot right now, but I would like to stress that it should be a permanent service. It's just so important for community members [Indigenous community members] to be able to access this service. (TCCS support person).

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1b. How have service providers experienced the TCCS and how did experiences vary by identity?

Overall, and consistent with findings reported in the six-month implementation evaluation, service providers from across TCCS partner organizations continue to report positive experiences with the program. These included feeling as though sufficient supports were in place for service providers to successfully enact their respective roles and responsibilities; service providers from across partner organizations working positively and collaboratively as a collective; and service providers experiencing overall high levels of satisfaction and validation as a result of their roles in the TCCS, and contribution of the TCCS to the broader service system. However, service providers also articulated clear opportunities for improvements in these areas, such as increasing the robustness and equity of available staff supports; refining communication and operational processes both within and between organizations at all points in the call pathway; and continuing to advance understanding and appreciation for each organization's roles, responsibilities, capabilities and limitations.

Staff support is strong, although opportunities to improve exist and should be acted upon to support care quality and prevent staff burnout

Across organizations, service providers in leadership roles described being purposeful in their efforts to support staff through training, employment benefits and mental health and well-being supports. For example, one member of the leadership team at CMHA-TO described being "really focused on doing a lot of the internal trainings in order to get the team feeling really prepared about the complexities that they're dealing with in the community" (CMHA-TO service provider) while another described having "tried to be very intentional about providing debriefing services, about peer support within the team, as well as clinical supervision…we are very attuned to the potential for trauma impact on our staff and hope we have things in place that will help" (CMHA-TO service provider). Leadership at TAIBU echoed that staff support is paramount as "they're the ones doing the work" and described efforts such as recruiting for therapists who can do counselling and therapy for the crisis workers, making workout equipment available at the office, and ensuring scheduling of frontline staff shifts "always leave room for people to unwind from a call because it is very strenuous. Health and well-being is very important to us" (TAIBU service provider). For 2-Spirits, implementation tracker data suggested that bringing on a mental health support team has been particularly beneficial for staff health and well-being. In interviews, 2-Spirits leadership described taking a wholistic approach toward supporting staff because "that is who we are as an agency… supporting individuals' physical, mental, emotional and spiritual health…not just for community who we are responding to but also for our team members" (2-Spirits service provider); and indicated that prioritizing culturally appropriate supports has been key:

> [An Elder] came in three or four weeks ago now and did a bear skin ceremony with the team around renewal in spring and letting go of what the last year brought and only carrying the things we need because this work can be really cumbersome and emotional labour. Having connection to these resources for the team, from what I've heard, has been really beneficial to walk them through. (2-Spirits service provider)

At 211, leadership reported offering benefits that include sufficient sick days, vacation and counselling services. Implementation tracker data also showed concerted efforts by leadership to follow up on recommendations made in the six-month evaluation to invest in frontline staff training in operational processes and trauma-informed care, and in supporting overall staff capacity and reducing workload through increased hiring. As one member of their leadership team shared, and particularly because they are trying to recruit individuals with lived experience:

> We have to recognize that we need to create a safe, supportive environment for our teams or we're perpetuating everything we're trying to work against within our own organization…ultimately, we just want our staff to feel and to know that we care and that they are also a priority. (211 service provider)

Correspondingly, service providers in frontline staff roles tended to agree they felt supported by their leadership, with 15 individuals from across organizations speaking positively about the supports they receive. For example, 80% of service provider survey respondents (n=82) agreed or strongly agreed with the statement, "My organization is mindful of and/or supports my mental health and well-being in my role with TCCS" and service providers in frontline staff roles who participated in focus groups

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similarly reported feeling they were generally well-supported and empowered to carry out their roles. As one CMHA-TO frontline staff described, “management really leads a great team because of all the training…the police reform training, the safety training, the suicide training, we had situation training, CPR, mental health CPR” (CMHA-TO service provider) and another who completed a survey similarly commented that their management team is “very supportive. They are always available to meet with staff, they are always present and involved with the day-to-day operations, and they provide the team with information, materials, resources and trainings related to the job and our performance” (CMHA-TO service provider). Frontline staff from 2-Spirits echoed its leadership’s emphasis on wholistic supports, commenting that their “agency has provided some holistic supports to aid in my mental health and well-being” (2-Spirits service provider). 211 frontline staff reflected upon improvements in their supports, particularly in “well-being and mental health regarding rotation of shifts (i.e., now working an overnight and then having one day off)” (211 service provider) and in “personally feel[ing] a lot more confident on the line” (211 service provider). A third 211 staff echoed that overall, “the TCCS has been an exceptional project and experience, very supportive to staff” (211 service provider).

Despite overall positive reflections, leaders reflected on the challenges their staff face working in this space: “there have been some really traumatically impactful calls that have had at least short-term negative impacts on staff” (CMHA-TO service provider). Particularly for the 2-Spirits team in providing Indigenous support by Indigenous people with lived experience, leadership described it being:

> so, so, so hard working in the community…it is difficult showing up as a person who has trauma, intergenerational trauma, trauma from the systems that we are working alongside, has experienced police violence or substance use or homelessness or any of the number of things that we see… to show up on a call and respond to somebody else dealing with that…I think something that I hear a lot from the team is carrying that can be very heavy at times. (2-Spirits service provider)

The need to always improve training and health and well-being supports were acknowledged. Leaders described supporting staff as a learning experience, given this is a new initiative and emotionally burdensome work. CMHA-TO leadership reflected, “we hope we have things in place that will help but I think we’ve got to be realistic that this [trauma impact] is a risk of doing this intensity of work on a full-time basis” (CMHA-TO service provider) and 211 leadership noted that while they “build in all kinds of stuff – engagement, reflection, self-care – it’s never going to be enough” (211 service provider).

From their perspective, service providers in frontline staff positions identified concrete opportunities to improve both training and mental health and well-being supports. Across organizations, when prompted to comment on suggestions for improvements in both surveys and interviews, staff indicated that cultural safety training should be a priority. As some participants suggested, “absolutely training staff with the cultural sensitivity care” (CMHA-TO service provider) is needed, particularly given the nature of the program:

> As there are various marginalized communities within this project, it would be beneficial to have culturally-sensitive training and supports to help navigate through an individual’s crisis. These could include things like navigating through supports for those with a visual or hearing disability, or understanding the impact of mental health and Indigenous history. (211 service provider)

Staff also indicated that further training in providing clinical care for particular mental health diagnoses, such as “more training around psychosis (e.g., how to engage)” (2-Spirits service provider) and “more selective training for diagnoses such as BPD [borderline personality disorder] and schizophrenia” (TAIBU service provider), and would support them in carrying out their roles.

Frontline staff noted that while they “believe the program is great, there is always room to grow. More supports around mental health for staff would be great as this role can be a lot on people” (2-Spirits service provider). Suggestions for improved health and well-being supports included ensuring all benefit packages across organizations are equitable in areas such as “therapist and counselling services coverage” (TAIBU service provider), “staff wellness days for our mental health” (CMHA-TO service provider), and “more immediate supports and counselling for difficult calls” (2-Spirits service provider). Ensuring supports are available to all staff, regardless of their role, is also important, with some participants describing less accessible support for those in part-time positions - “support to staff is specific to full-time and less supportive for part-time staff” (CMHA-TO service provider).

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Service provider interaction and collaboration has been a positive experience for most but could be further enhanced by increasing awareness of partners' respective roles and responsibilities; and addressing persisting communication and process challenges, particularly between TCCS and TPS.

Overall, service providers reported feeling as though they are working positively and collaboratively as a TCCS collective. Data from the Wilder Collaboration Factors Inventory (Wilder), a quantitative measure of collaboration between organizations taken at six and 12 months, show that mean scores on two-thirds (66%) of statements improved or stayed the same, indicating consistently sustained high levels of collaboration, with an overall mean of 4.0 out of 5.0 (see **Appendix F** for the complete pre-post Wilder results). As one TPS leader remarked when asked how TPS and the TCCS is working together specifically:

> I think we're doing that on an enormous level. Historically, you call 911 and you're getting the police. Now, you're getting anchor partners, you're getting the TCCS, we're all working together…I think our integration is amazing…that is the best part of this whole thing. (TPS service provider)

TPS frontline staff generally echoed their leadership and were overall the most likely participants to speak positively to the collaboration within the TCCS. TPS service providers indicated they have "had several positive experiences with the TCCS" (TPS service provider) and aim to work collaboratively: "If we're both on the same call…I'm not trying to take the lead from them, and they're not trying to take the lead from us, we just listen to each other's questions" (TPS service provider). Division 14, where 2-Spirits operates, was described as having "an open door policy…the Two-Spirited people can always give us a call and talk to us…if they have concerns, they do have a direct line to our Inspector or our Superintendent" and that "over time, they'll improve…as we get to have a more personal relationship" (TPS service provider). Another police constable reflected upon their experience as follows:

> [TCCS] Staff's approach toward clients is professional and successfully encourages dialogue with clients. As a uniformed officer, I have only been contacted for instances when TCCS intervention was unsuccessful or a determination was made that hospitalization was appropriate. Each time I attended, TCCS workers gave relevant briefs/information prior to me entering the situation and interacting with the client. Overall, a positive experience. (TPS service provider)

Toronto Community Crisis Service staff: TAIBU Community Health Centre

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Results: Evaluation Question 1

Crisis workers from CMHA-TO, who administrative data indicate were the site most frequently in contact with TPS on scene, also reflected positively on their experiences working together with TPS. As one individual described, "the majority of police I've dealt with – very warm transfer with us. They let us take the lead. Their biggest thing is just safety for us, that's all" (CMHA-TO service provider); and their colleague expanded upon the impact working together is having:

> I think a really important thing is that we're kind of shifting the police culture…I've interacted with a few police officers and I've noticed what I expected was not what I saw. They actually met the service user were they were at…and were trying to talk to them…so I'm starting to see - surely, slowly - changes like that. They're actually calling us more, they're saying 'This is a mental health call and TCCS can handle it' so they're transferring those calls to us, and I've noticed that a lot more now. (CMHA-TO service provider)

Data provided by TPS indicate that over the pilot period, there were 406 events in which TPS frontline officers requested CCTs' attendance; in another three cases, TPS frontline officers were familiar with the person in crisis and voluntarily co-responded with CCTs.

At the intake end of the pathway, 911 and 211 staff similarly reflected positively upon their experiences working together and appreciating "having the option for TCCS…I know a lot of us find that very, very helpful" (911 service provider), noting their "experience has been mostly positive…there sure seem like a lot of hands in the work, which can at times make it overwhelming or redundant, but overall really good idea and service." (211 service provider)

While many positive experiences were described, some clear opportunities for improvement also emerged. Service providers from across organizations spoke to the need to improve communication and processes both within and between organizations. For example, staff from one anchor agency indicated the need for "clearer expectations to staff and more understanding of staff's varying capacities" (CMHA-TO service provider), with another suggesting that "setting basic ground rules, and clear procedures…will help to have structure" (2-Spirits service provider). Some service provider feedback suggests the need to continue to build awareness of each other's roles and responsibilities and implement strategies for working effectively together. A service navigator from 211 suggested "establishing a meeting or communication between anchor agencies, police and navigators that are initiating the dispatches and calls. It would help each other understand more of the roles and responsibilities of each person" (211 service provider); and an anchor agency staff member suggested that the "TCCS could help set a team guideline or structure to use as an example of how to run a large team of people working together in such an important and highly needed field" (2-Spirits service provider). TPS frontline staff echoed the need for "more side-by-side training. For example, meeting with the TCCS team in the division and getting to know them" (TPS service provider).

TPS participants were most likely to express desire for improved communication, interaction and understanding of roles, and in surveys, scored lowest on overall satisfaction with the TCCS at 73% and likelihood to recommend (84% vs. 100% of all other service provider organizations). For example, several TPS frontline staff commented on the need for improved communication, particularly regarding on-scene attendance and hand-off of calls where there is often a disconnect insofar as TPS knowing whether has attended a call before or after TPS arrives: "More communication between the teams and frontline officers" (TPS service provider), "follow-up to know if clients accepted help after or before police attend" (TPS service provider) and "improvement on safety issues and communications with TPS regarding attending calls" (TPS service provider) are examples of the types of comments made in response to prompts for how the service could be improved from their perspective. Other TPS participants expressed needing "training on what actual roles/responsibilities and resources are available" through the TCCS and reported feeling a lack of understanding of each other's roles that prevents them from effectively working together:

> Overall, I believe it [the TCCS] is a good service, I just wish there was a better working relationship between the two [TPS and the TCCS] and that there was a better understanding of the workings between the two. (TPS service provider)

Most often, this was related to people in crisis presenting in dynamic situations and the possibility of safety concerns for both responders and those being responded to. As one TPS frontline staff described, "we don't want

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to create a situation that could put the whole program in legal jeopardy or us in legal jeopardy, and we don't want to argue, obviously, with their staff" (TPS service provider). Service providers at 911 echoed this sentiment, suggesting that the definition of crisis is:

> very grey…the definition and what TCCS has the power to help with might be a little lost, and it's probably very difficult to define, but for me, sometimes I think that's difficult and that's where the difference between what TCCS can do and how it conflicts with our policy and procedure and our mandate comes into play. (911 service provider)

Another 911 call operator expressed a similar sentiment:

> I feel like on the other end, they lack an understanding of what our obligations are as a service…it would be really nice if they knew what exempting factors don't allow us to send calls to them, because we want to, but then there are all these other things at play that create a situation where we cannot make that referral despite best intentions. (911 service provider)

This has contributed to ongoing perceptions of potential liability concerns for both TPS and 911 frontline staff. Although these concerns have not been substantiated, perceptions persist among staff, with one 911 call operator describing how they "really want to make this work, and I really do make efforts wherever I can to try to do those referrals…but I think we all really keep in mind the liability piece. That is still very present among my peers" (911 service provider). A TPS frontline staff similarly remarked:

> I don't know what training they [TCCS staff] get in terms of what the police do and how we do it, or if they attend our call centre to see the training that we do so that they're exposed to it and know a little bit about…the standards and the accountability that we have to face. Our legal indemnity will only cover us if we're in lawful execution of our duties, so if we go outside of that, we could be financially destroyed, and obviously, you could be charged. (TPS service provider)

Such deeply entrenched differences in organizational cultures and beliefs are likely to take time, education and significant change management efforts to overcome. This was further reflected in readiness-to-change data, collected through the ORIC tool, which, like the Wilder, was administered at six- and 12 months. Scores on the ORIC (**Appendix G)** showed that the mean score among TCCS partners did not significantly change and remained high at approximately 90%, suggesting collectively persistent readiness to change. However, when specific constructs within the tool were examined, consistent improvement on mean scores related to "change commitment" (i.e., shared resolve to implement change) contrasted with less consistent improvement on constructs related to "change efficacy" (i.e., shared belief in capacity to implement change), suggesting that perhaps, overall, service providers feel more confident in the commitment to implement the TCCS but less confident in the likelihood of being able to effectively do so. And while results from the Wilder were positive overall, 7% of statements were evaluated as "areas of concern that should be addressed," with one of the two factors of concern being "ability to compromise" in response to the statement, "People involved in our collaboration are willing to compromise on important aspects of our project." The second concern related to having "sufficient funds, staff, materials and time," which is discussed throughout this report but particularly in ***Evaluation Question 4d,*** with corresponding recommendations presented in the **Recommendations** section.

Overall satisfaction and validation among service providers is high

Despite the aforementioned challenges and opportunities for improvement, service providers from across TCCS partner organizations reported feeling rewarded by and highly satisfied with their TCCS experiences. In interviews and focus groups, participants were prompted to comment on their overall satisfaction and what they felt most proud of. Leaders and frontline staff across organizations were generally effusive: "Here to now, it just has been all things difficult and wonderful…and what I am most proud of is that we just keep showing up and doing it because it's very hard and it's very rewarding" (2-Spirits service provider). Other leaders similarly remarked upon their own sentiments – "I'm hopeful…being able to have the dialogue around human rights and dignity and choice and autonomy and building systems that can actually respect that is really helpful for me" (GCC service provider) – and the sentiments of their staff, describing that they have "heard team members talk a lot about how proud they are to be part of this response, especially at the ground floor of it. And that it's really aligned with their values" (CMHA-TO service provider). They went on to say that they:

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> heard really positive things from our team, that it is very meaningful work. And now that they can actually see sometimes what the outcome is for people. It's incredibly validating, and very rewarding. So I think it's actually been really, really helpful for staff morale…this has just been a very, very validating service for people to be a part of. So definitely high reward for people, they feel like they're doing really meaningful work. (211 service provider)

Indeed, frontline staff agreed. Survey data indicate that overall, 82% of frontline service providers (n=82) are satisfied or very satisfied with their role and responsibilities in the service; and 93% (n=78) indicated they would be likely or very likely to recommend the service to someone they know who is in need of help. As CMHA-TO staff described, "I just really love what I do, that's the bottom line. It's not about helping people, it's about empowering them…having a team like us is long overdue" (CMHA-TO service provider); and "I also really love, love, love my job…we are really targeted over-policed, underprivileged areas, people that are racialized, and it's just so empowering" (CMHA-TO service provider). At the intake end of the pathway, 911 and 211 staff described similar feelings, noting they "think this is a very valuable program and I'm really proud to be a part of it. I think it is filling a very real void in resources" (911 service provider) and that they are "so grateful for this service and cannot wait until it becomes City-wide" (211 service provider).

Toronto Community Crisis Service staff: TAIBU Community Health Centre

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Results: Evaluation Question 2

Evaluation Question 2: How have communities experienced the TCCS?

This evaluation question examines the extent to which the TCCS is having community-level impacts. Four key community elements are discussed in this section – ***awareness, service integration, community safety and community well-being*** – which reflect several of the higher-order, longer-term goals of the TCCS as a new non-police led, community-based crisis response service. Mixed methods data in response to this evaluation question were collected from survey responses, implementation trackers, and interview and focus group transcripts, and included perspectives from all key stakeholder groups (i.e., service users, service providers and community members).

2a. What is the level of awareness of the TCCS within communities?

Overall public awareness is low but gradually increasing over time

Public awareness of the TCCS is integral for service user acceptance and uptake alongside general public support of the model. However, evaluation data revealed an overall persistent lack of awareness among the general public, community agencies, and City of Toronto institutions such as the Toronto Transit Commission (TTC) and the Toronto Community Housing Corporation (TCHC). Participants from all three stakeholder groups (i.e., service providers, community, and service users) perceived awareness to be inadequate. When asked directly, "Based on your overall interactions with service users and/or the community, how many people do you think know about the service?", the majority of service provider survey respondents (n=78) suggested overall awareness within the community remains relatively low, with 86% of respondents suggesting that only "some" (51%) or "few" (35%) people are aware of the TCCS. Similarly, a total of 68% of community survey respondents (n=147) reported knowing about the TCCS, but many shared qualitative sentiments suggesting they believe overall public awareness is low, such as: "It's essential and necessary but I don't think many people know about this [the TCCS]" (community member). Most notably, only 29% of service user interview and survey participants (n=24) reported knowing about the TCCS beforehand. When asked about their perceived level of community awareness, one service user shared that "a lot of people don't know about these resources that are there for them. For me, due to the fact that I have support, I was able to learn about it, but a lot of people aren't aware" (TCCS service user).

Lacking public awareness is contributing to challenges with community engagement and missed opportunities to build community trust and safety, particularly among some priority populations. One 2-Spirits leader shared how limited knowledge of the TCCS and a historic mistrust of government programs has caused a delayed acceptance of the TCCS among Indigenous communities in particular:

> I think a lot of trepidation that we've seen from [the Indigenous] community has been…"Is this going to last? Who is the face of this? What is it? Are police there? Are you just acting as police but without the uniform?" And it's because all of these systems have caused so much harm to our [Indigenous] community, that, even with us leading it, there is a mistrust and a cautiousness of, "What's going on over there? I'm going to keep my eye on it." (2-Spirits service provider)

Similar sentiments were shared about low engagement within the youth population in the Northwest pilot region. As one Community Advisory member from CMHA-TO suggested:

> A lot of them [youth] are a little bit unsure; they might have heard about it, but the whole parameters and the outreach strategies, I think it just needs to be more if we're trying to engage more youth. It needs to be youth-geared. (TCCS community advisory member)

Accordingly, participants urged the need for more accessible, population-specific outreach to increase community awareness, engagement and trust, as "the more accessible and more people see you [the TCCS], the more people are going to come and talk to you and be willing to accept the service" (TCCS community advisory member).

In addition to low awareness of the TCCS' existence and engagement, participants also spoke to specific confusion around its scope and capabilities. One support person, who also works in the social service sector, shared the following:

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> How is it that, you know, in social services, nobody knows about it?...And there's also certain circumstances as well, like…who do we call, 211 or 911? And what's safe and what's not safe? Like, we don't know, you know what I mean? It needs to be a real education campaign about when we should be calling them and when it's too risky, and I feel like that's something we're still learning about. (TCCS support person).

Low awareness around the purpose and scope of the TCCS, is a particular barrier to efficient and effective delivery of the service. From a service provider perspective, 911 and 211 continue to report that while some improvement has been noted since the outset of the program, in general, time spent educating callers on the nature of the TCCS and gaining consent to provide the service remains high and burdensome for both staff and people in the queue for emergency services. Implementation tracker data indicate that the lack of public awareness is contributing to perceptions of stress among some 911 Call Operators receiving TCCS calls, who describe "feeling as though they are responsible for this education piece, which can take several minutes. Increased talk time impacts our ability to answer 911 calls for service" (911 implementation tracker excerpt). Despite perceived impacts, TCCS calls represent a small proportion of total calls handled by the centre and the degree to which these calls are impacting overall service efficiency is currently unclear. To better understand the TCCS dispatch process, the City of Toronto has engaged a third-party consultant to review the overall process and identify ways for it to be improved.

Despite overall public awareness not being as high as may have been expected or as desired, participants did acknowledge that awareness is gradually increasing as the program becomes established and as partners continue to engage in public education and outreach in communities. When asked about the extent to which awareness of the TCCS has increased among 911 callers, one participant shared:

> I'm also seeing an increase in people who have some general knowledge or, like, have some sense of what they're looking for…I mean, even my Starbucks right below my building has a TCCS poster in it, which is really great; I'm starting to see it out in public more. (911 service provider)

Greater, ongoing efforts in awareness-building, outreach and engagement are required

In terms of awareness-building and outreach efforts to date, many participants felt that opportunity for improvement exists and that "the promotion of TCCS hasn't really taken off yet, in a big way" (GCC service provider). While a public awareness campaign by the City of Toronto and 211 was launched in January 2023, it was point-in-time. Anchor partners were predominantly charged with on-the-ground public education and outreach efforts, which they reported engaging in but simultaneously noted significant challenges associated with the time and capacity to participate in these activities on top of their operational roles in responding to calls. Participants from all four anchor partners described sharing information and familiarizing the public with their services via distributing fliers and posters, and attending various events in their communities such as Pride, powwows, church events and workshops. Participants from CMHA-TO described a particularly robust effort from their staff, Community Advisory group and network of community agencies. This includes creating a dedicated Engagement Coordinator role to facilitate community outreach, and ensuring "that we find solutions where we are marketing this program in a way that is able to reach individuals whether they have various ways of communicating" (CMHA-TO Community Advisory member).

As the TCCS continues to grow, participants emphasized the necessity for the City of Toronto to lead more extensive public advertising, a sentiment with which City of Toronto participants agreed: "Once we have the actual approval for the City-wide expansion…one of the key things will be to have a larger public awareness campaign to introduce the service to all of Toronto" (City of Toronto staff). TCCS partners have also indicated their commitment to engaging in meaningful, repeated outreach with both members of their communities, as well as with other service providers such as healthcare providers, community agencies, and other first responders (e.g., paramedics and firefighters). These efforts will help instill sustained awareness and trust of the TCCS, and stronger partnerships for a seamless, collaborative service.

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2b. To what extent has the TCCS supported service integration within communities?

Service integration is gradually developing but requires time, capacity and resourcing

The creation of a more cohesive, comprehensive, and collaborative network of community health and social service organizations will help ensure that TCCS service users have timely access to appropriate follow-up supports. As stated by a 211 service provider, "if there's not parallel work and engaging community organizations that are on-the-ground working with the populations that are prioritized for this work, we're going to lose the trust of those community organizations and we're going to lose the opportunity to do really meaningful work" (211 service provider).

Qualitative perspectives expressed by service providers and Community Advisory members in surveys and interviews or focus groups were primarily used to explore the extent to which the TCCS has supported service integration at the community and system level. Overall, 89% of service provider survey respondents (n=78) agreed that the TCCS supports service integration within communities (26% strongly agree; 63% agree). City of Toronto participants felt service integration is progressing, with one staff member noting that "there's been a lot of work on integration…it's gone surprisingly well in terms of going from inception to being a present force" (City of Toronto staff).

Participants spoke to how the overall TCCS service model, which requires each community anchor partner to develop its own network of community service providers and referral pathways to support access to follow-up care, is a mechanism that has been particularly effective in supporting service integration, particularly in a field that has traditionally experienced a "divide or kind of gatekeeping in a sense" (CMHA-TO Community Advisory member). CMHA-TO, GCC, and TAIBU have allocated funding to and/or hired staff from other community agencies in their pilot regions, developing coalitions of service providers that they expressed has facilitated faster access to a wide range of follow-up supports for its clients. One CMHA-TO participant described how, as a result of their service model, they have:

> access to not only those services that are funded by the TCCS, but we've ended up getting access to all of the services in each of the organizations, which has been very beneficial. So that's worked, for the most part, very, very well and that's kind of the first piece of service integration. (CMHA service provider)

CMHA-TO also described more practical choices related to how they deliver crisis care that can simultaneously support service integration, such as the decision to use the same risk assessment tool as triage nurses in hospital emergency departments. According to CMHA-TO, by using the same tool, "when our teams go into emergency rooms, they can speak the language that the nurses know, and so I think translating from community into acute care…has helped with continuity of care and getting better access to care" (CMHA-TO service provider).

While progress has been made, the overall consensus on TCCS' impact on service integration was that this is a system-level process that will take time, resourcing, and capacity; and that the service is too early in its implementation and operation to be able to impact or observe impacts at this level. As one community anchor partner reflected, "I think we've [the TCCS] got a long way to go in this area…this is a good beginning, but we're nowhere near that" (GCC service provider). When discussing the TCCS' progress on service integration, another participant similarly shared:

> I don't think we've yet got to the place of better integration. First was just getting a handle on what is out there, what we can help people access. I have hope that as the program gets more established, that we'll be able to use the data to identify what gaps are actually in the community, and what we're going to do about it. (CMHA-TO service provider)

Similar to community awareness, TCCS partners shared that they need to continue engaging and building relationships with their networks of crisis and health service to support service integration. However, various barriers to service integration were identified, which require dedicated time and resourcing to overcome. First, there are inherent culture and practical differences between organizations. City of Toronto noted that "what it takes to have different systems work together, fundamentally different cultures, to try to actually pull this off in a way that's seamless to the service user, takes way more time than anybody realizes" (City of Toronto staff). Second, under-resourcing across the system was noted to hinder everyone's capacity to integrate; while service providers who are aware or become aware of the TCCS appear to be supportive of the concept, "underinvestment in community

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doesn't contribute to community cohesion, it contributes to community divisiveness" (GCC service provider). Participants from all TCCS partner organizations spoke to system-level capacity gaps that prevent community agencies from effectively engaging in integrative service partnerships and accepting TCCS service users into their caseload in a timely manner. This was acknowledged by the City of Toronto as well:

> There are organizations that want to work with us [TCCS] and do work with us, but because funding is sparse and waiting lists and those kinds of barriers happen…it's not like the community doesn't want to support, it's like "You can come and get services but, unfortunately, there's going to be a waitlist"… and I think that's one of the things that causes some barriers for us to have a better relationship. (City of Toronto staff)

As such, more partnerships and resourcing will be essential to address these system-level gaps and facilitate access to supports across the City of Toronto, particularly for services experiencing the longest wait times for TCCS service users, including primary care, mental health and addictions services (and especially concurrent disorder services), and crisis, housing and detox beds. To ensure that "people don't end up down one stream and never see the other" (GCC service provider), participants additionally spoke to expanding collaborations to include other key intersecting institutions and community-based services such as the TTC, TCHC, hospital emergency departments, immigration services and schools, as well as "peer-based communities…that allow people to begin to build their own networks of support within a community" (GCC service provider).

2c. To what extent does the TCCS positively impact perceptions of community safety and well-being?

In the context of the TCCS, community safety and well-being are collectively defined as the ideal state of a sustainable community where everyone is safe, has a sense of belonging and opportunities to participate, and where individuals and families are able to meet their needs for education, health care, food, housing, income and social and cultural expression. Through surveys, interviews and focus groups, participants from all three stakeholder groups were asked directly, "Overall, to what extent does this service have a positive impact on your perception of community safety?" and "Overall, to what extent does this service have a positive impact on your perception of community well-being?" Mixed methods data from these questions revealed varied perspectives. Quantitatively, service users had the most positive responses, with 90% of survey respondents (n=20) indicating that the TCCS "very positively" or "positively" impacts their perception of both community safety and well-being. Community members followed, with 83% of survey respondents (n=109) indicating the TCCS positively impacts their perceptions of community safety and 81% indicating it positively impacts perception of community well-being. Lastly, among service provider survey respondents (n=78), 73% reporting feeling that the TCCS positively impacts their perceptions of community safety and 77% reported that the service positively impacts community well-being. The latter two stakeholder groups (community members and service providers) had comparatively higher proportions of the response option, "somewhat positively", than did service users themselves, demonstrating more moderate perceptions related to community safety and well-being in these two groups.

The TCCS appears to be contributing to community safety and well-being in a small but meaningful way, as an opportunity to access an innovative, non-police-led model of crisis care

Community member and service user participants spoke, to a large extent, about how it is:

> safer for TCCS crisis teams, who are trained to support people in crisis, to perform wellness checks, etc. than for TPS to do so…If a neighbour in crisis receives help, then my community will be safer, and TCCS is the best option for providing this support. (community member)

One aspect by which the TCCS may contribute toward positive perceptions of community safety, in contrast to traditional police-led responses, is the way in which CCTs identify themselves. As service users described in ***Evaluation Question 1a***, the appearance of uniformed police constables can be intimidating or triggering for some population groups. Comparatively, the TCCS model was deliberately designed in contrast, with staff wearing casual clothing and driving vehicles with minimal identification; communities were also engaged in designing the TCCS logo itself. Service user and community member survey respondents (n=61) were asked to indicate their preference for how TCCS CCTs

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identify themselves when responding on scene. Data, presented in **Figure 3**, revealed mixed perspectives, with almost equal proportions of respondents who prefer identifying markers (28%), no identifying markers (31%), and who are indifferent to how CCTs are identified (30%). Open-ended "Other" (11%) responses provided some context to the differing preferences. Participants tended to agree that certain identifiers "could feel triggering to those experiencing a mental health crisis, but some sort of identification would be useful" (community member).

Preliminary analyses also suggest that these preferences may vary by ethnicity (**Table 8**), which would align with qualitative feedback presented around the ongoing impacts that previous experiences of trauma and oppression have for some populations. For example, data suggest that Indigenous individuals in particular may prefer having minimal or no identifying markers; however, conclusions could not be drawn due to a limited sample size[6]. Perspectives should be further explored to ascertain the most appropriate identification for TCCS crisis workers and how different forms of identification impact perceived safety within and across different communities.

Figure 3. Service user and community member (n=61) preferences for identifying TCCS CCTs on scene

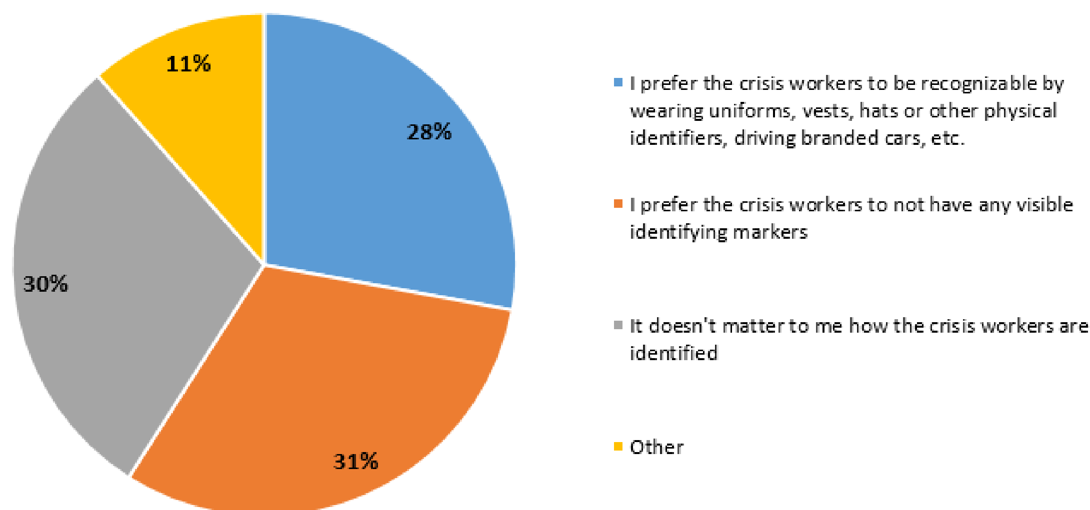

Table 8. Service user preferences, by ethnicity, for identifying TCCS CCTs on scene (n=20)

	Ethnicity				
Survey response option	Black	Indigenous	Other racialized groups	White	Total
I prefer the crisis workers to be recognizable by wearing uniforms, vests, hats or other physical identifiers, driving branded cars, etc.	1	0	1	1	3
I prefer the crisis workers to not have any visible identifying markers (e.g., uniforms, vests, hats, branded cars).	1	2	3	1	7
It doesn't matter to me how the crisis workers are identified.	3	0	4	2	9
Other – minimal identification	0	1	0	0	1
Grand total	**5**	**3**	**8**	**4**	**20**

[6] Sociodemographic characteristics were not collected from community survey respondents and therefore these responses could not be disaggregated by ethnicity.

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In addition to how CCTs self-identify, many participants felt that the TCCS can reduce the risk of harm or criminalization during a crisis event, and that the service being consent-based "is a big part of that safety piece", as service users "don't have to worry about…being forced or coerced into something that they didn't want to be a part of" (CMHA-TO Community Advisory member). By removing these risks, participants felt that the TCCS may allow more individuals to feel safe in seeking crisis support:

> A lot of my fellow community members have fear or distrust of traditional police and would not call 911 because of it. This alternative to traditional policing [the TCCS] will allow more people to ask for help instead of doing nothing and being at risk. (community member)

Furthermore, participants noted that the proactive approach of providing wrap-around follow-up supports and case management is "not just a Band-Aid to a single crisis situation" (community member), but can "contribute to helping people learn new healthy ways to cope and begin to feel part of the community" (community member).

Cultural safety plays an important role in contributing to perceptions of community safety and well-being

As similarly described in ***Evaluation Question 1a***, embedding cultural safety into the TCCS was also identified as important in impacting perceptions of community safety and well-being, particularly among priority populations such as Black, Indigenous, and 2SLGBTQIA+ communities. All four anchor partners were praised by the City of Toronto for their conscious efforts to ensure diverse identities are represented in their crisis teams and trainings, with one participant reflecting that "it's been really helpful that some of their staff are peers with lived experience and they're guiding and have the most experience working through this very difficult system…I think this builds trust with community and safety" (City of Toronto staff). This is also in alignment with the TCCS' overarching guiding principles, which are discussed more fulsomely in ***Evaluation Question 5***.

Leadership from TAIBU shared similar sentiments about how having a diverse crisis team contributes to community safety and well-being in the Northeast pilot region:

> When we have staff that is reflective of the community that we're serving, there is a certain level of comfort that comes immediately…They feel comfortable to speak in a way knowing that they will be understood…and they know that, you know there's no judgment that's going to come from it, because most likely we're coming from that same background. So those are the things that really mean safety to us (TAIBU service provider).

Indeed, this participant from TAIBU identified that "being able to speak about their mental health freely, you know, without judgment…is well-being for our [the Black] community, because it's not really something that we get to do." Similar sentiments were shared from a support person who identifies as Indigenous:

> [I] trusted that I could speak openly and honestly about the situation at hand without that information being used against [my] loved one. And that there were Indigenous women on the team who understand the impacts of colonial violence and the harms of child welfare. (TCCS service user)

Leadership from 2-Spirits similarly described how "it was really important for us to weave capacity-building initiatives into just the pilot, generally. And I think that really contributes to community wellness." One such example was intentionally hiring Indigenous staff members, which "for a lot of people on our team, they didn't have previous job experience" (2-Spirits service provider). The participant took pride in 2-Spirits' ability to create opportunities for Indigenous community members, reflecting that:

> I think there are so many community members on our team who would just say, "whether I'm here, next week, next month, next year or not, I gained a lot of skills… in this role. And I, like, made myself proud for being able to do this type of work, because it's really hard. And I showed myself and my family and my community that, like, we can all do these types of things." And I think that alone really contributes to something great in community. (2-Spirits service provider)

Continued change management is required to overcome deeply entrenched beliefs and system-level barriers

While many positive perceptions were described, the TCCS works "in some ways a little bit ahead of the current wave and public and political understanding of the need for mental health supports" (City of Toronto staff). In turn, a small proportion of community survey respondents did share some skepticism of the TCCS in terms of impacting community safety and well-being, with some indicating they would feel "A LOT more safe if a police officer is responding

to calls involving people with mental health issues than a community worker" (community member). Indeed, perhaps due to decades of being the de facto crisis responders, TPS Uniformed Officers (n=32) also had the lowest proportion of service providers who felt that the TCCS positively impacts their perceptions of community safety (53%) and well-being (63%), compared to survey respondents from all other partner organizations. In addition to the safety-related concerns discussed in ***Evaluation Question 1b***, some TPS participants shared concerns related to the TCCS service model, particularly its harm reduction principles: "I think it's totally unacceptable that these workers are delivering safe drug injection kits…they should not be encouraging, condoning and assisting people with doing something that is dangerous to their health and against the law" (TPS service provider). The perception shared by the TPS service provider is not aligned with evidence generated from peer-reviewed sources that show how harm reduction approaches not only reduce harm for those engaging in risky health behaviour, but ultimately save lives [19]. Continued change management efforts, such as collaborative discussions, training and education on harm reduction as an evidence-based approach, will be required among TPS in particular and the general public alike to shift from the deeply entrenched status quo and improve public confidence in the TCCS' ability to impact community safety and well-being. Notably, one participant suggested a need to reframe the current dialogue around community safety to de-stigmatize mental health, because "we often see, in media at least, 'unsafe' alongside those living with mental health-related issues or experiencing a mental health crisis, and the stigma that comes with that really impacts those and deters people from buying into responses like this one [the TCCS]" (2-Spirits service provider).

In addition, much like service integration, community safety and well-being is a systems-level concept that takes significant time and resources to develop, and requires a systems-level perspective to understand and evaluate. Participants acknowledged that community safety and well-being exists within a broader, historical context – particularly one of chronic underfunding and structural marginalization – that needs to be addressed in order to effect true change. As shared by 2-Spirits:

> Our [Indigenous peoples] access to even the very basic of things in this country has been a source of trauma. And so I think in order to understand how we as a community can exist in an understanding of safety, we have to be able to acknowledge…why it has become unsafe. (2-Spirits service provider)

While the TCCS may offer a safer crisis response than the status quo, "what happens before people's lives are thrown into crisis, what happens after the escalation of crisis, has to be where we start to build in some real layers of support and community and infrastructure and compassion" (GCC service provider). True community safety and well-being requires a preventive approach that ensures basic needs such as income and housing are met, which will support individuals in maintaining their recovery from crisis states, and in attaining consistent health, meaning and belonging within their communities. Fortunately, TCCS administrators from the City of Toronto have indicated their willingness to address these gaps:

> These [gaps] are becoming evidenced through the crisis service, so they're kind of almost indicators that highlight where there needs to be improvements and better coordination. The hope is that [since] we have that information as the City, we can work together with other levels of government to start to use evidence to help inform policy making and funding going forward. (City of Toronto staff)

Community-level impacts are emerging, but challenging to achieve in isolation and in the context of broader system capacity gaps in health and social services

Altogether, this one-year outcome evaluation demonstrates that community-level impacts require significantly more time and resources, both at a micro- and macro-level, to develop. However, this evaluation data does show that the TCCS is making gradual positive impacts within the greater community of Toronto in its first year of operations, in terms of building awareness of the service as a non-police-led alternative for crisis care; establishing a collaborative network of health and social service providers to provide a more seamless service; and improving individuals' perceptions of community safety and well-being. Several areas of improvement were identified by evaluation participants, which were all largely associated with increasing resources to provide the TCCS the capacity it needs to challenge the status quo and effect sustainable, community-wide change. Moving forward, it will be crucial for TCCS administrators to use this evidence to inform quality improvements, and continue to monitor and evaluate the service to maximize benefits for service users and the broader community.

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Results: Evaluation Question 3

Evaluation Question 3: To what extent and how were non-emergency mental health and crisis-related calls to 911 and 211 responded to by the TCCS?

As noted previously, administrative data was collected from the City of Toronto for the period of March 31, 2022 to April 30, 2023 and represents the primary data source used in response to this evaluation question. Supplementary administrative data was provided by TPS on "mental health calls for service attended" for the same period to enhance analysis and interpretation. However, it is important to note that TPS indicator definitions sometimes differ from TCCS definitions; for example, TCCS and TPS report "police attendance" differently, the implications of which are described in more detail later in this section. Further, TPS data includes event types that are not within scope for the TCCS, including active suicide attempts, jumpers and elopes; it is considered more meaningful to consider a sample of in-scope events, specifically "person in crisis" and "threatening suicide" calls, as proxies when comparing outcomes between TCCS and TPS. While City of Toronto data remains the primary data source, both sources are referenced throughout this section in order to offer a more robust evaluation of the volumes and types of calls received by TCCS; the proportion of calls for which TCCS CCTs were successfully dispatched; the outcomes of those dispatches, including whether they were successfully completed on scene and diverted from further police attendance, or led to outcomes such as other emergency service attendance, emergency department visits, apprehensions or arrests; and overall response times.

Calls completed

Calls to the TCCS are assigned a range of statuses based on the outcome of the event. For the purposes of this analysis, these have been simplified into two broad categories: "service completed" and "service interrupted." "Completed" calls include all calls where 211 and the CCTs were able to receive, dispatch, and arrive at the scene of an event; or calls in which 211 received the call and provided I&R services over the phone, thus completing the entire service pathway as designed. While in some of these cases, a caller may still have eventually declined the service, no longer required the service, or left the scene by the time CCTs arrived, for the purpose of this analysis, the service is still considered to have been completed to the fullest extent possible. Calls that were "interrupted" include calls that were not carried through to completion due to technical issues (dropped callers, caller hung up), capacity issues (TCCS crisis team rejected the request due to lack of availability), eligibility issues (call was sent back to TPS due to an escalated or previously uncommunicated level of risk), or the caller changed their mind about needing the service and withdrew consent while on the phone with 211.

In the first 13 months of operation, the TCCS received a total of 6,827 calls. The majority of these calls were made by individuals requesting support for themselves (n=4187; 61%). Of total calls received, 6,351 (93%) were completed. For reasons described above, the remaining 476 (7%) were interrupted. Regarding interrupted calls (**Figure 4**), service refusal by the caller (n=166; 35%) and the call being sent back to TPS (n=161; 34%) were the two most common reasons, both of which trend downward over time, as did caller hang ups, which is favourable to the efficacy of diversion protocols. Dropped calls remained relatively steady over the period, whereas a slight uptick in CCTs rejecting the request due to capacity reasons is apparent beginning in 2023, which should be monitored closely, particularly as awareness of the service grows. Over the time period, overall tapering of interrupted calls is clear (**Figure 5**), suggesting an interruption rate of 5% may be an acceptable baseline for future comparison; while technical issues, capacity issues and eligibility criteria are likely to be addressed over time, it is reasonable to expect some continued level of service refusal and hang-ups by callers. However, further monitoring of service interruptions over time will allow the TCCS to decide on an appropriate quality benchmark. There were no discernible trends in completed versus interrupted calls by call category or pilot region.

Results: Evaluation Question 3

Figure 4. Reasons for service interruption over time

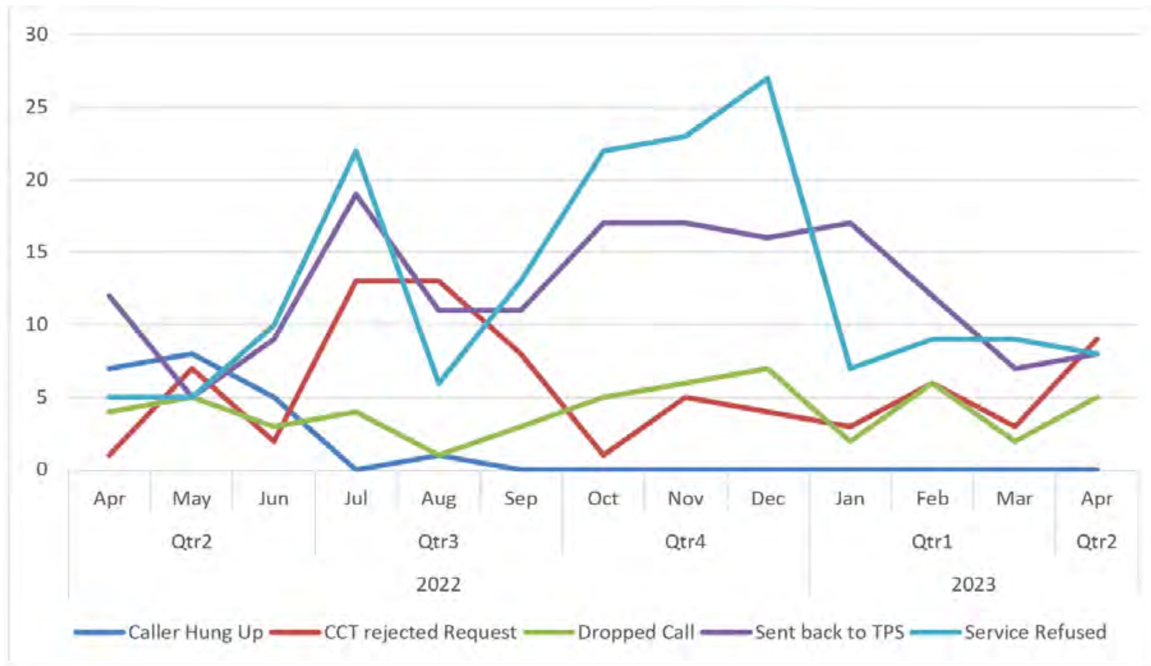
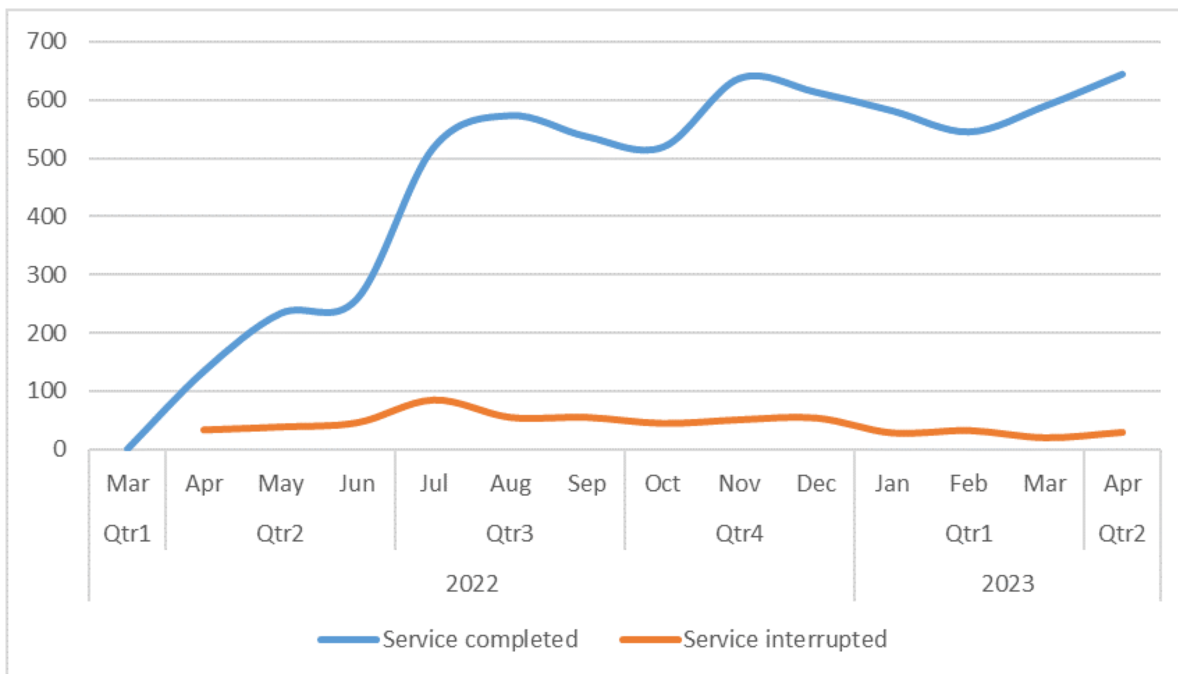


Figure 5. Calls in which the service was completed versus interrupted over time



Results: Evaluation Question 3

Calls completed by type and pilot region

Of the 6,351 completed calls, "person in crisis" calls were most common at 47% (n=2,961), followed by "well-being check" calls (n=1,519; 24%) and "distressing or disorderly behaviour" (n=881; 14%). However, incoming call categories were overall varied and no individual category represents a majority (**Table 9**). There were no noticeable trends in the categories of calls received over time; proportions of call categories remained consistent over time, by intake source and by pilot region.

Table 9. Total calls (%) completed by TCCS call category

TCCS call category	Total calls
Person in crisis	2,961 (47%)
Well-being check	1,519 (24%)
Distressing / disorderly behaviour	881 (14%)
Thoughts of suicide/self-harm	611 (10%)
Unknown[7]	226 (4%)
Dispute	67 (1%)
Grand total	**6,351**

Of the four pilot regions, GCC received the most calls over the period at 39% of total calls (n=2,466), with TAIBU (n=1,614; 25%) and 2-Spirits (n=1,342; 21%) receiving somewhat similar proportions and CMHA-TO receiving the fewest calls overall at 12% (n=765; **Table 10**).

Table 10. Total calls (%) completed by pilot region

TCCS pilot region	Total completed calls
2-Spirits (Downtown West)	1,342 (21%)
CMHA-TO (Northwest)	765 (12%)
GCC (Downtown East)	2,466 (39%)
TAIBU (Northeast)	1,614 (25%)
Unknown[7]	164 (3%)
Grand total	**6,351**

Toronto Community Crisis Service staff: Canadian Mental Health Association Toronto

Photo courtesy of the City of Toronto

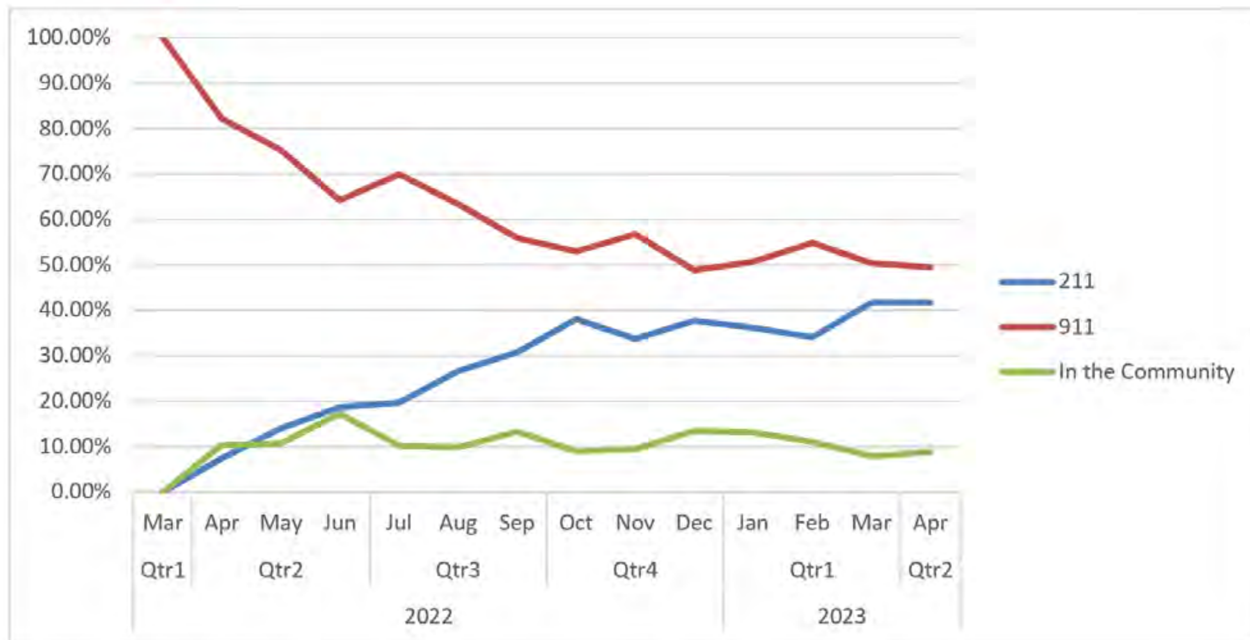
[7] Unknown calls include records in which the CCT was documented as 211 (n=2), as "not in a pilot region" (n=16), "unknown" (n=6), or in which the field was left blank (n=140). The majority of these calls are resolved through 211's Information & Referral service (n=155 of 164; 95%), for which event or dispatch type is not currently recorded.

Results: Evaluation Question 3

Calls completed by intake source: 911 vs. 211

In terms of call source, the majority of total completed calls were received by 911 (n=3,479; 54%), with 2,133 calls (34%) received by 211, and 739 calls (12%) received directly from community sources, such as GCC's direct crisis line or as part of CCT outreach in the community. However, as shown in **Figure 6**, clear time trends over the period emerged with calls received by 911 stabilizing while calls received directly by 211 steadily increased, indicating 211 may soon overtake 911 as the primary call source. The uptick in 911 call volumes in July 2022 coincides with the launch of the service at 2-Spirits and CMHA-TO; and the uptick in November 2022 coincides with the addition of new TPS Divisions (52 and 41) to the geographical scope. However, these peaks were not sustained over time, which may merit further investigation (**Figure 6**).

Figure 6. Total calls completed by intake source over time



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Results: Evaluation Question 3

This shift in call source over time was noted by evaluation participants qualitatively as well. From 211's perspective, leadership explained that:

> what's changed is that the general public is actually calling 211, as well as individuals in need. At the beginning of the pilot, there were more 911 calls that were diverted, but now that is quickly shifting…there's been more recognition of the TCCS pilot with promotion that's been happening within the four catchment areas…we're getting over 200 calls a month in terms of people looking for support. (211 service provider)

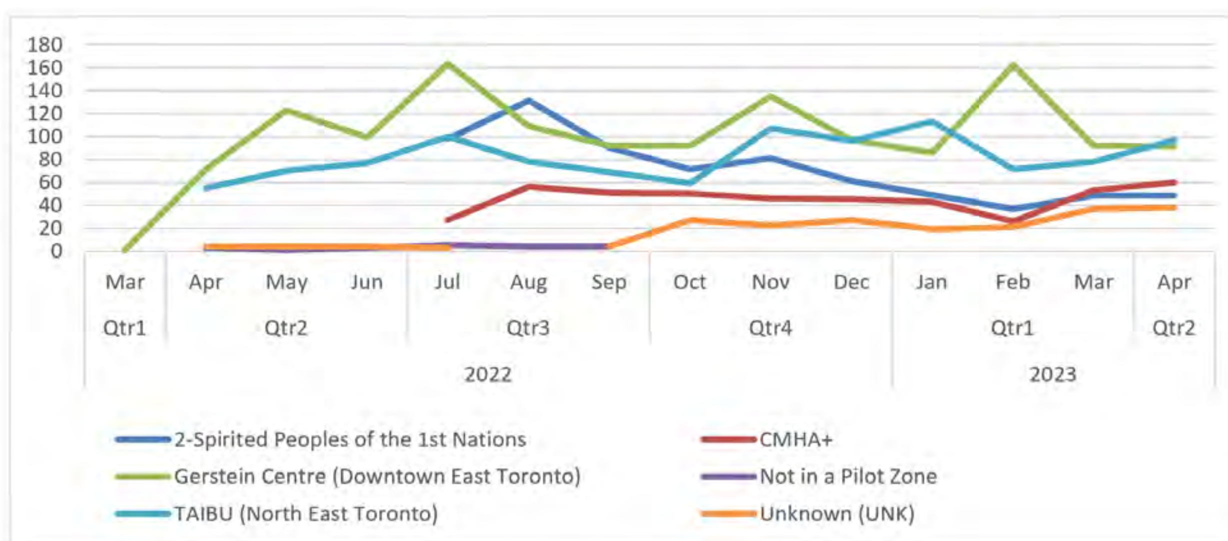
A participant from TPS echoed this experience: "I think they should be commended…the calls [to TPS and 911] are dropping, and I think over time, if things keep going the way they're going, they'll continue to increase" (TPS service provider).

Calls from in the community appear generally stable over time; however, for GCC, whose direct crisis line contributes to the total volume of calls received from in the community, documenting the impact of TCCS calls is challenging with no dedicated resourcing or capacity to respond to volume increases. Qualitatively, GCC noted that:

> we started very much with a very strong 911 connection, and even the way it was communicated out to the community was very much focused with 911 as access. We shifted to 211 as 211 was ready to take a little bit more. We also operate our own telephone crisis line and we've seen some increased traffic there. (GCC service provider)

As noted previously, no noticeable trends exist in 911 diverting certain categories of calls; and 911 and 211 received nearly the same proportions of call categories. However, trends exist in intake source by pilot region. Data indicate that 211 receives relatively more calls for 2-Spirits at 29% of total calls, whereas 2-Spirits makes up only 18% of total 911 transfers (it is unknown how many calls are received within the Division 14 pilot region but not transferred, which may warrant additional investigation). When looking at calls transferred from 911 by pilot region over time (**Figure 7**), it can be noted that 911 received a significant number of calls from the 2-Spirits pilot region in July and August 2022 immediately post-launch, but these transfers then taper sharply in subsequent months. This finding contrasts noticeably with trends in other pilot regions which show volumes generally increasing in lockstep with 911-211 diversion practice and also warrants further investigation.

Figure 7. Total calls transferred from 911 by pilot region over time



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Whereas calls transferred from 911 to 2-Spirits have decreased over time, **Figure 8** shows calls to 211 over time by pilot region and indicates that the demand for service in 2-Spirits' pilot region has generally been sustained; at this point in time, 211 is now the primary call source for 2-Spirits.

Calls resolved over the phone through 211 I&R

The total volume of calls resolved over the phone through 211's I&R pathway was low overall at 261 calls over the 13-month period, which represents only 4% of total completed calls. The number of I&R calls remained relatively stable over time (**Figure 9**). As noted above, most I&R calls are missing data reflecting the call category (80% unknown), but from what data does exist, "person in crisis" and "well-being check" calls still appear to be the most common category whereas "thought of suicide or self-harm" calls are less commonly resolved through I&R.

Figure 8. Total calls to 211 by pilot region over time

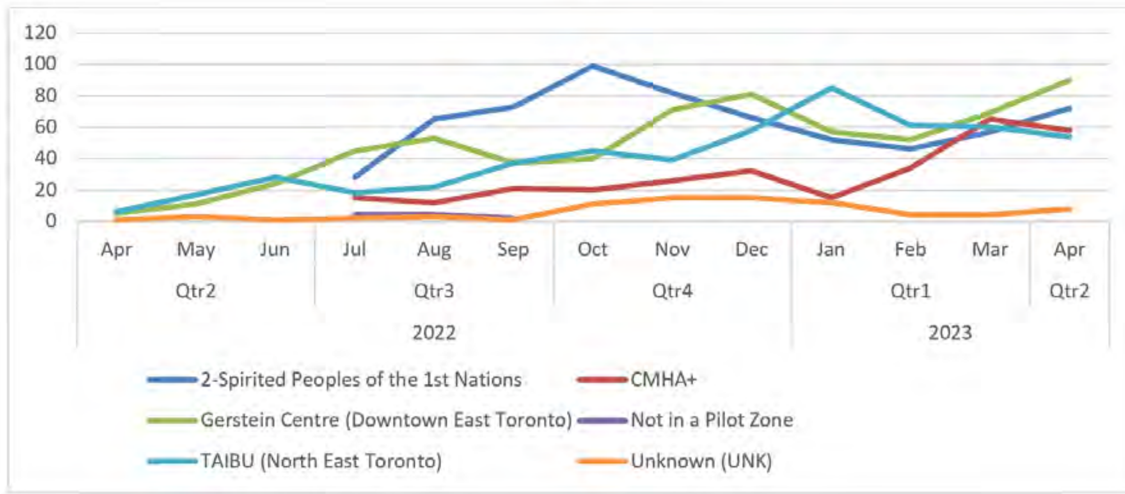

Figure 9. Calls completed through 211 I&R over time

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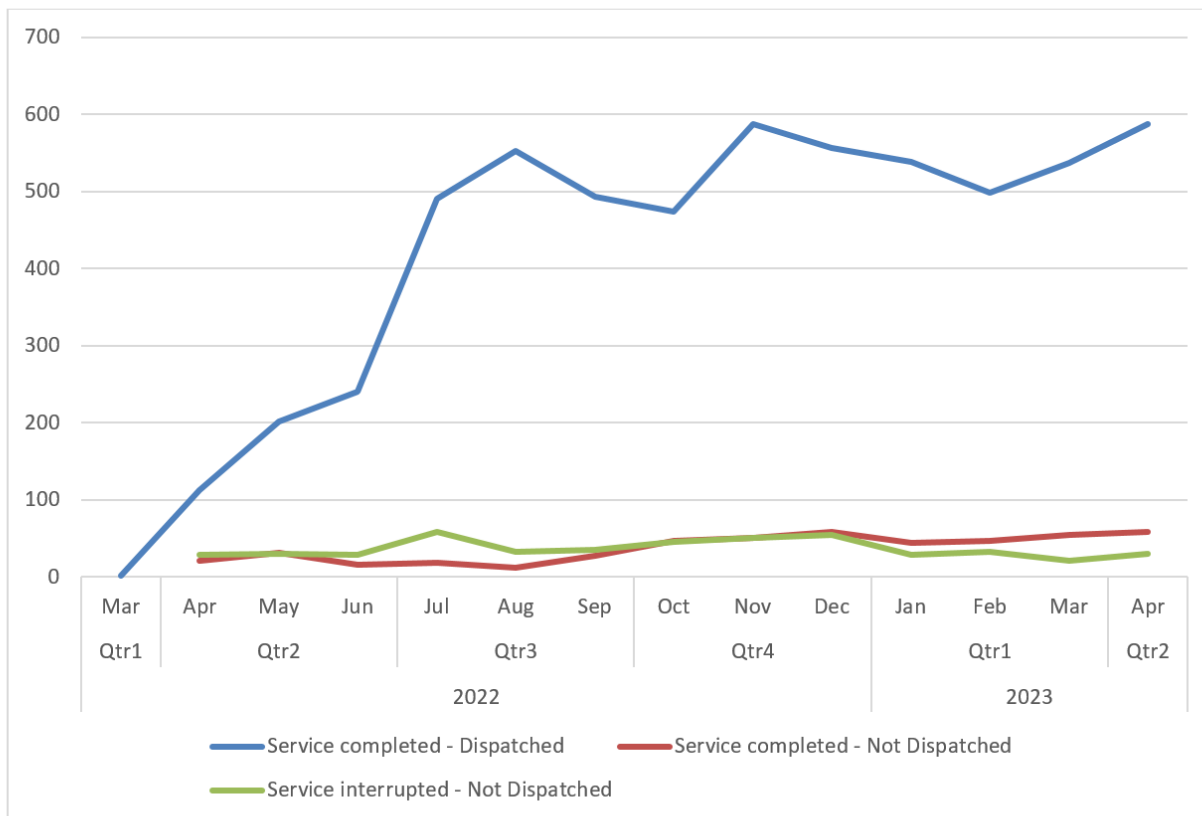
Results: Evaluation Question 3

Calls resulting in a CCT dispatch

Eighty-six percent (86%) of total calls received over the period resulted in a CCT dispatch (n=5,868 of 6,827). The remaining 14% of total calls (n=959) were either completed but not dispatched (n=483; 7% of total calls), most often because they were resolved through I&R (n=261; 54% of completed but not dispatched calls and 4% of total calls) or because CCT services were no longer required for a reason separate from refusal (e.g., a third-party caller indicating the subject of a call left the facility or location they were calling from; n=222; 46.0% of completed but not dispatched calls and 3.2% of total calls); or they were not dispatched due to service interruption (n=476; 7% of total calls). **Figure 10** depicts the total volume of calls dispatched over time. There were no discernible trends in whether a call from one source or another is or is not dispatched over time; trends follow overall call volumes whereby 911 calls resulting in dispatch stabilize over time and calls to 211 resulting in dispatch increase over time but in both cases, dispatch rates are proportional.

Figure 10. Total calls resulting in a CCT dispatch over time



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With the exception of unknown calls, which were primarily completed through I&R, there were no apparent trends in certain call categories requiring greater or fewer dispatches than another (**Table 11**); or in any particular pilot region requiring greater or fewer dispatches than another, with dispatch volumes at each site coinciding with their overall call volumes (**Table 12**).

Table 11. Total calls (%) resulting in a CCT dispatch by call category

Call category	Service completed		Service interrupted
	Dispatched (% call category)	Not dispatched (% call category)	Not dispatched (% call category)
Dispute	62 (90%)	5 (7%)	2 (3%)
Distressing / disorderly behaviour	853 (93%)	28 (3%)	35 (4%)
Person in crisis	2820 (92%)	141 (5%)	108 (4%)
Thoughts of suicide / self-harm	575 (90%)	36 (6%)	27 (4%)
Well-being check	1,470 (94%)	49 (3%)	48 (3%)
Unknown	88 (16%)	224 (39%)	256 (45%)
Grand total (% total calls)	**5,868 (86%)**	**483 (7%)**	**476 (7%)**

Table 12. Total calls (%) resulting in a CCT dispatch by pilot region

TCCS pilot region	Service completed		Service interrupted
	Dispatched	Not dispatched	Not dispatched
2-Spirits (Downtown West)	1,271 (91%)	71 (5%)	50 (4%)
CMHA-TO (Northwest)	718 (89%)	47 (6%)	46 (6%)
GCC (Downtown East)	2,356 (91%)	110 (4%)	120 (5%)
TAIBU (Northeast)	1,521 (89%)	93 (5%)	87 (5%)
Unknown	2 (1%)	146 (49%)	153 (51%)
Grand total (% total calls)	**5,868 (86%)**	**467 (7%)**	**456 (7%)**

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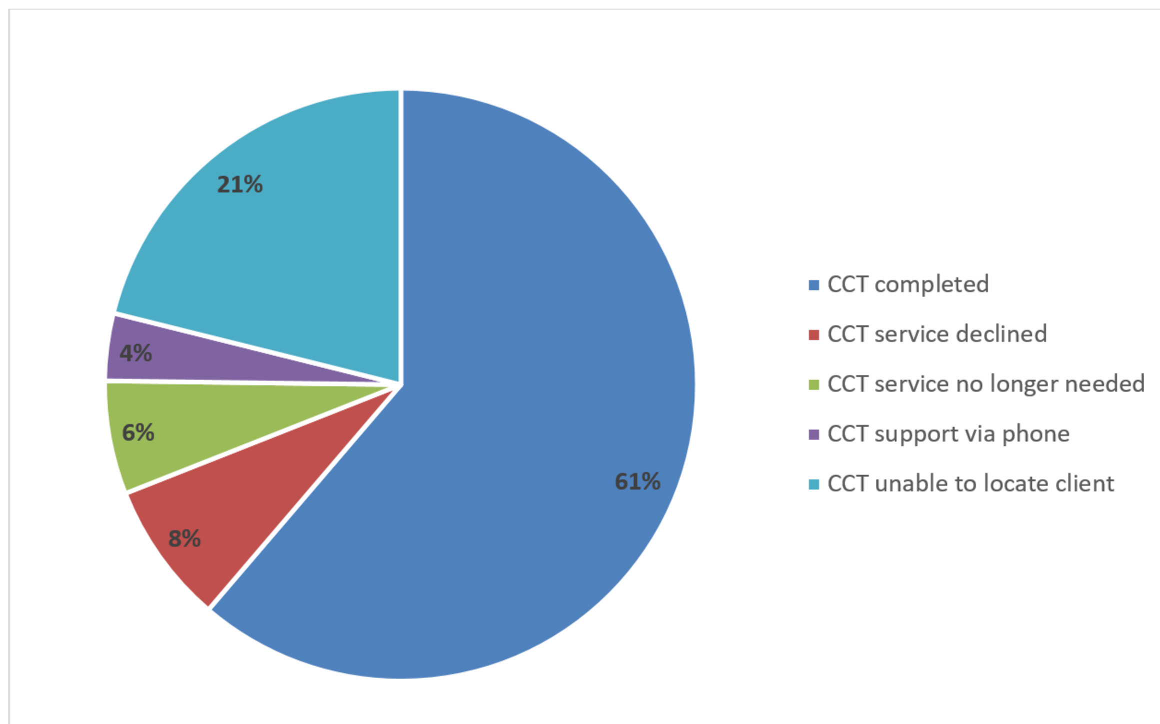
Results: Evaluation Question 3

Dispatch dispositions

Dispatch disposition refers to the outcome of a call when a CCT is dispatched. Of the 5,868 calls that were dispatched, the majority of calls (n=3,595; 61%) were "completed" by CCTs, which means CCTs met with service users and completed a crisis care interaction on scene; the next most common disposition was that CCTs were unable to locate the service user (n=1,239; 21%) (**Figure 11**). Other reported dispositions include the service being declined by the service user upon CCT arrival (n=455; 8%); CCT support no longer being needed (n= 363; 6%); or CCTs providing support by phone (n=216; 4%). Phone support might occur when CCTs call a service user to obtain more information after receiving an official dispatch request from 211 and upon call-back, are able to meet the service user's needs instead of meeting in person. Alternatively, phone support sometimes occurs when a CCT has provided in-person support to a service user earlier in time and follows up by phone if a follow-up dispatch related to the same service user is received at a later time or date.

These outcomes appear to be stable over time with no noticeable trends across the pilot period; dispatches completed increase over time in line with the overall increase in call and dispatch volumes (refer to **Figure 7**). There are also no noticeable trends in disposition by category of call. However, pilot region differences do emerge, specifically in relation to CCTs' ability to locate service users, with this disposition being noticeably higher for GCC (51% of "unable to locate" cases) and 2-Spirits (28%) than for TAIBU (15%) and CMHA-TO (6%). This difference may potentially be due to the Downtown Toronto environment. Unfortunately, data reflecting call setting currently does not capture whether CCTs are responding to a private residence or a service user on the street/in public. That 21% of overall TCCS dispatches resulted in CCTs being unable to locate the service user appears high in relation to data from TPS on the proportion of "person in crisis" and "threatening suicide" calls in which the outcome was "gone on arrival;" within the pilot regions during the pilot period and same hours of operation, the "gone on arrival" rate for TPS-attended calls of these types was 7.7%.

Figure 11. Disposition of total dispatched calls (n=5,868)



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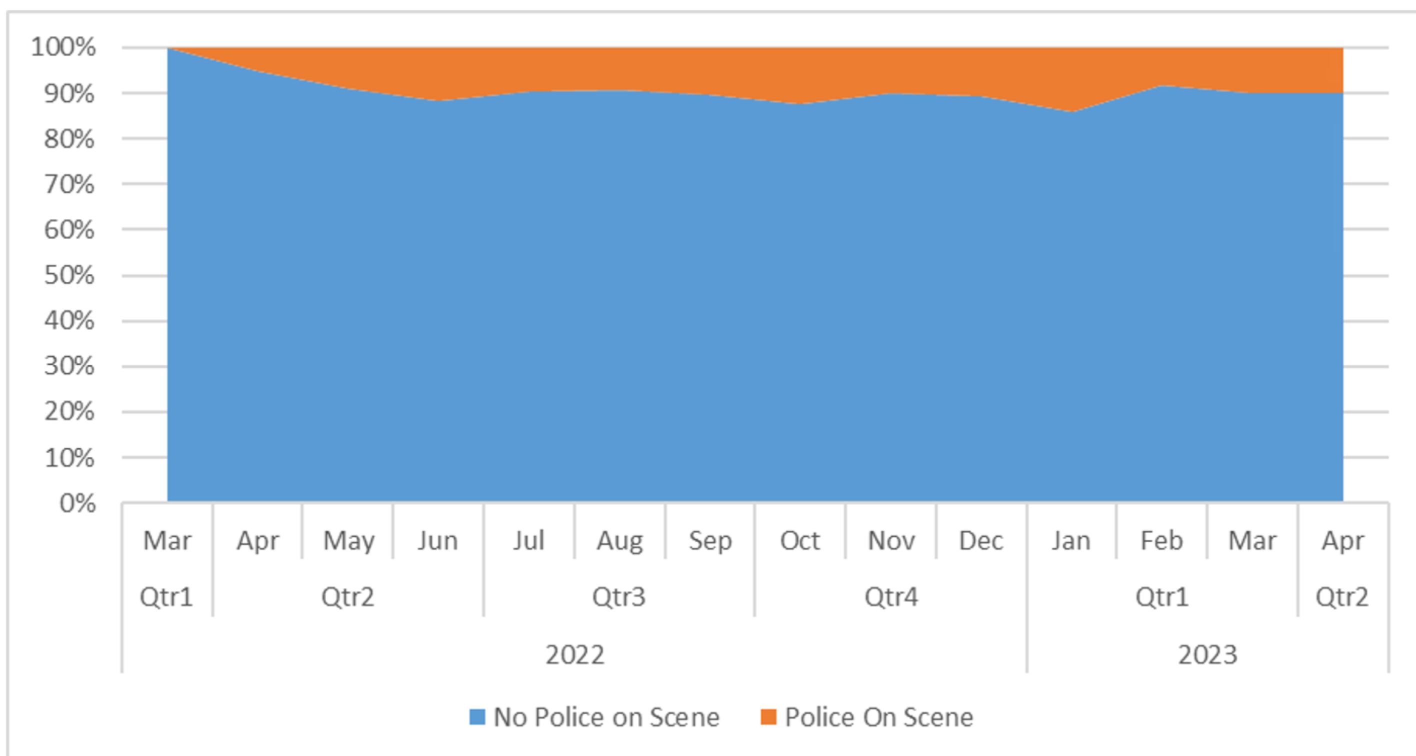
Results: Evaluation Question 3

CCT dispatches involving police on scene

As noted at the beginning of this section, the City of Toronto and TPS sometimes differ in how they define specific indicators. Regarding police attendance specifically, it is important to note that City of Toronto TCCS data, which is the primary data source informing this evaluation, only reflect instances in which police were observed by CCTs as being on scene; there are additional instances in which police may arrive either before a CCT arrives or after CCTs depart that are not accounted for in TCCS data. As such, TCCS data is not a definitive accounting of police attendance.

TCCS data indicate that of the 5,868 calls that were received from all sources and resulted in dispatch of a CCT, police attendance was requested by CCTs in only 2% (n=131) of dispatches. Furthermore, 90% of dispatches (n=5,262) had no police observed by CCTs on scene. This proportion has been steady over time (**Figure 12**). There does appear to be a difference depending on call source, with 911 calls being approximately 10% more likely to be associated with observed police presence: 85% of 911 calls (n=2,678) resulting in a dispatch had no police observed on scene versus 95% of calls to 211 (n=1,887) and 95% of calls from in the community (n=697). Data provided by TPS indicate that police were on scene for 1,007 events during the same period, which represents 28.0% of all events that were transferred by 911 to TCCS (i.e., 72.0% of events transferred to TCCS were resolved without the need for police).

Figure 12. Proportion of total dispatched calls (n=5,868) where police were also on scene as observed by CCTs



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Results: Evaluation Question 3

As with overall dispatches, there are no noticeable trends in police being observed on scene for any particular category of call. However, whereas there were no site-level trends in overall likelihood of dispatch, there do appear to be notable differences by pilot region in the proportion of dispatched calls where police were observed also on scene, with CMHA-TO being most likely to have police on scene at 16% of total dispatches, and TAIBU being slightly more likely at 13%; GCC CCTs were least likely to have police on scene (8%; **Table 13**). Reasons for site-level differences are unclear and warrant further investigation, however it appears that differences may be due to correspondingly more frequent CCT requests for police attendance (**Table 13**). Further investigation as to why CCTs are requesting police more frequently in these areas is warranted.

CCT dispatches with other emergency services on scene

Calls resulting in CCT dispatches that were also attended by other emergency services could include police, ambulance, fire and/or MCIT services. Despite an overall emergency services request rate by CCTs of 4% (n=231 of 5,868 dispatches), one or more of these emergency services were on scene in 13% of total dispatches (n=778). This proportion is higher for 911-sourced calls (19%) than it is for 211-sourced (7%) or calls or those in the community (7%). Of the four pilot regions, CMHA-TO was most likely to have other emergency services on scene at 21% (n=148), despite requesting other services in only 8% of their dispatches. It is unclear whether this is a data quality issue or whether there is another reason for the higher proportion at this particular site. At other pilot sites, on-scene attendance by other emergency services was lower, with TAIBU at 15% (n=225), 2-Spirits at 11% (n=145), and GCC at 11% (n=260).

Table 13. Total dispatched calls (n=5,868) where police were also observed on scene by pilot region

TCCS pilot region	No police observed on scene (% pilot region dispatches)	Police observed on scene (% pilot region dispatches)	Police requested by CCT (% pilot region dispatches)
2-Spirits (Downtown West)	1,154 (91%)	117 (9%)	19 (1%)
CMHA-TO (Northwest)	603 (84%)	115 (16%)	35 (5%)
GCC (Downtown East)	2,178 (92%)	178 (8%)	33 (1%)
TAIBU (Northeast)	1,325 (87%)	196 (13%)	44 (3%)
Unknown	2 (100%)	0 (0%)	0 (0%)
Grand total	**5,262 (90%)**	**606 (10%)**	**131 (2%)**

Table 14. Total calls diverted from 911 over time (N; %)

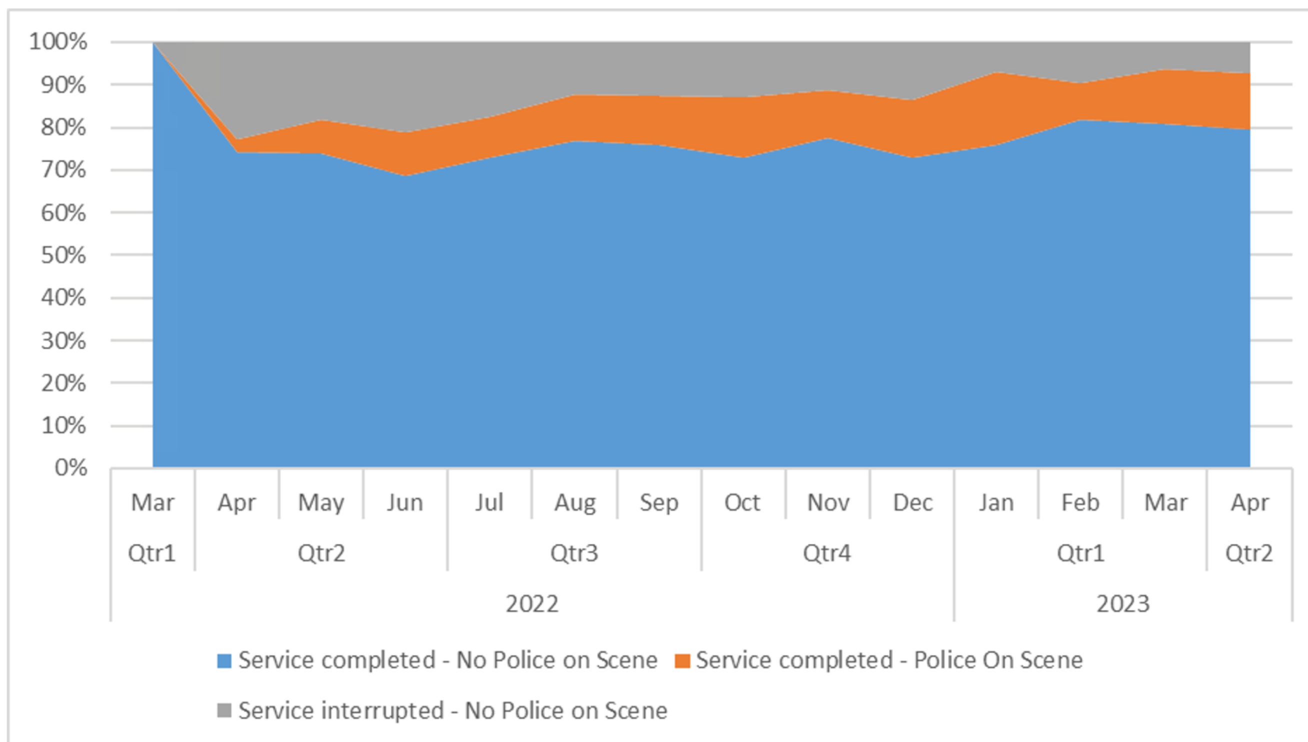
Time period	Service completed		Service interrupted
	No police observed on scene	Police observed on scene	
Q1 2022 (Mar)	1 (100.0%)	0 (0%)	0 (0%)
Q2 2022	392 (76%)	41 (8%)	82 (16%)
Q3 2022	856 (79%)	127 (12%)	101 (9%)
Q4 2022	759 (75%)	130 (13%)	127 (13%)
Q1 2023	743 (80%)	120 (13%)	72 (8%)
Q2 2024 (Apr)	266 (80%)	44 (13%)	24 (7%)
Grand total	**3,017 (78%)**	**462 (12%)**	**406 (11%)**

Results: Evaluation Question 3

Total calls diverted

"Diversion rate" is currently defined by the TCCS as the proportion of total calls received by 911 (n=3,885) that were subsequently completed without observed police involvement. This value includes calls successfully resolved through I&R and other criteria meeting the definition of a completed call, as detailed at the beginning of this section (e.g., service refusal once CCTs arrive on scene, or CCTs being unable to locate the client). This value does not include calls in which service was interrupted, and it does not include calls in which police may have been on scene either before or after CCTs. Using this definition of diversion, the TCCS dataset indicates the overall diversion rate for the 13-month pilot period is 78% (i.e., n=3,017 completed calls with no observed police involvement of 3,885 total calls received by 911). Unsuccessfully diverted calls (22%) include completed events in which police were observed on scene (n=462; 12% of total calls received by 911) and events in which service was interrupted (n=406; 11% of total calls received by 911). Performance appears to be improving slightly over time and particularly in the last six months of the period, increasing from 75% in Q4 2022 to 80% in the month of April 2023. This improvement is most likely due to a decrease over time in service interruption in calls sourced from 911 as the proportion of completed calls in which police were observed on scene is relatively stable (**Figure 13**).

Figure 13. Proportion of total calls to 911 diverted over time (n=3,885)



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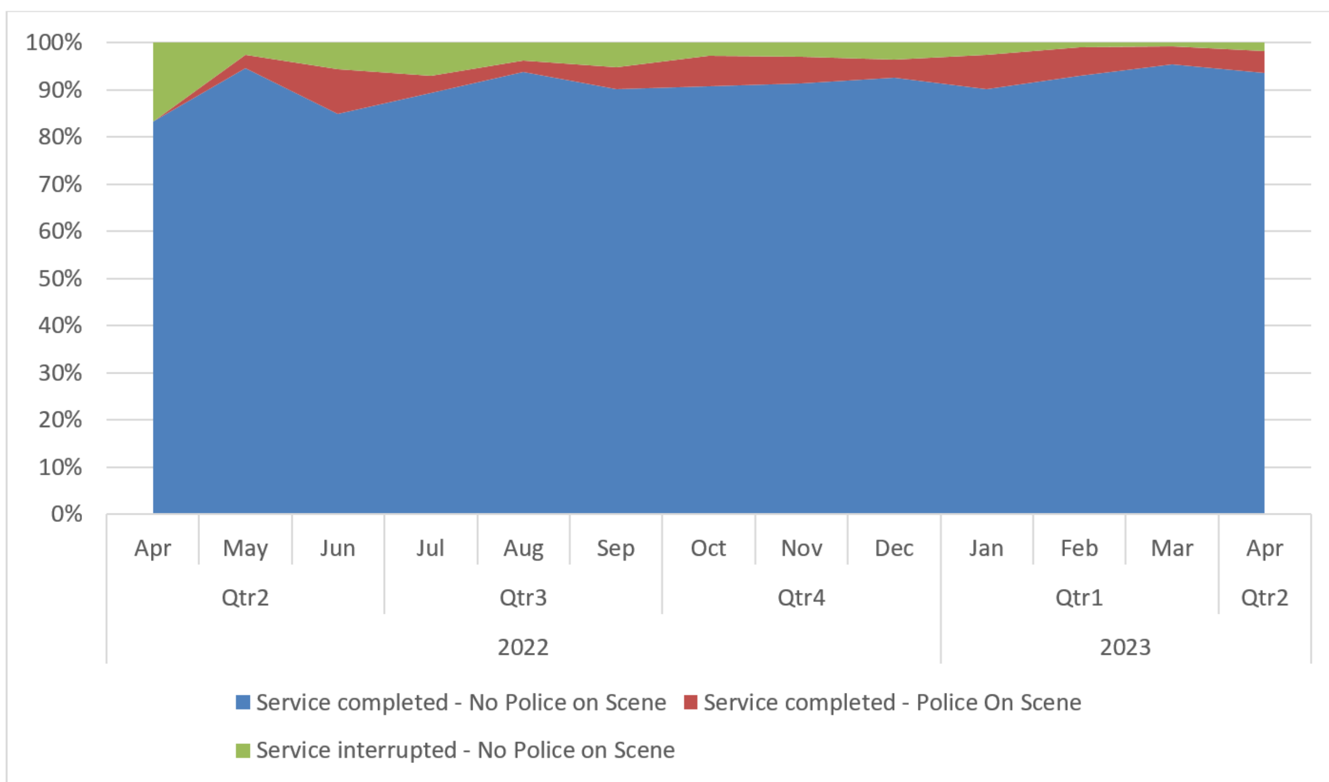
If the definition of diversion is expanded to include completed calls from all sources where no observed police were involved, which is based on an assumption that calls received directly by 211 and from sources in the community would have otherwise gone to 911 if the TCCS were not in place, then the overall diversion rate for the pilot period is 84% (n=5,745 completed calls with no observed police on scene of 6,827 total calls), with police observed on scene for 9% of total calls (n=606) and the remaining 7% of calls having been interrupted (n=476). When looking at calls to 211 alone (n=2,199), the diversion rate for the period is 92% (n=2,023), with police observed on scene for only 5% of calls (n=110) (**Figure 14**). The reason that calls to 211 are over 50% less likely to result in police on scene (5% vs. 12%) is unknown at this time and would require further investigation; postulations include that calls to 211 have innately lower risk levels and are therefore less likely to require police on scene, or that 911 is less likely to dispatch police to events they are unaware of. Calls sourced from 211 alone also have a lower rate of service interruptions than calls sourced from 911 (3% vs. 11%), which is likely due to the transfer process having one less step and thus being inherently less complicated.

Figure 14. Proportion of total calls to 211 diverted over time (n=2,199)



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Results: Evaluation Question 3

TPS data: calls diverted

While TCCS records remain the primary data source informing this evaluation, for comparative purposes, a binary variable indicating police attendance (yes/no) based on automated retrieval by TPS data systems was used by evaluators to calculate a diversion rate from January 1, 2023 to April 30, 2023 that would account for instances in which TPS recorded police attendance in their data; this count of police attendance by TPS includes events in which police arrived before or after CCTs and were thus not observed by TCCS and not included in TCCS counts of police attendance. For example, TCCS data indicate there were 220 records between January and April 2023 in which TPS recorded police attendance but CCTs did not observe police on scene.

Using the same definition of diversion insofar as the proportion of total TCCS calls from 911 that did not result in police attendance alongside TPS records of police attendance yields a diversion rate of 71% (n=828 of 1,173 total calls received by 911 between January 1, 2023 and April 30, 2023). This rate is lower than the 78% reported above based on TCCS observance of police attendance and similar to the discrepancy between diversion rates reported between the two organizations in the six-month evaluation report, in which the TCCS reported a 78% diversion rate and TPS reported 70%. Again, this discrepancy is to be expected as TCCS and its CCTs can only record whether TPS is on scene at the same time as their team and do not always know if TPS has responded previously. It is also favourable that this discrepancy has remained relatively stable over the pilot period.

A data summary independently conducted and provided by TPS for the purposes of this evaluation indicates that over the 13-month evaluation period, there were 5,860 events in which 911 callers were offered TCCS services. Of these, 39% of callers refused to be transferred (n=2,264), while 3,596 (61%) were transferred with consent to the TCCS. Of those transferred, 72% did not include any further police response and were considered successfully diverted (n=2,589), while 28% of those calls transferred with consent to TCCS still required a police presence (n=1,007). As noted earlier, in 406 events, TPS requested TCCS on scene.

TPS data indicate a number of reasons for why police attendance may have occurred for the remaining 28% of calls (n=1,007), including instances in which a TCCS service navigator requested police to attend (n=100) or in which the event was deemed unsuitable for diversion by the TCCS service navigator after transfer (n=140). There were also instances in which:

- the 911 caller requested both police and TCCS (n=249)
- multiple people called 911 about the same event with some requesting police and others requesting TCCS (n=41)
- Toronto Paramedic Services were on scene and requested police attendance (n=232 events)
- police were dispatched prematurely or prior to offering TCCS support (n=106)
- 911 callers refused diversion after being transferred to TCCS (n=67)
- there was no TCCS capacity to respond because no units were available, the event was outside of a pilot region, or outside of operating hours (n=38 events prior to the service expanding 24/7 across pilot regions).

The full range of reasons for why police attended events transferred to the TCCS is presented in **Appendix H**.

TPS data: diversion potential

TPS data reported for the purposes of this evaluation also identify "events for potential diversion," which represent "person in crisis" and "threatening suicide" events that were a) attended by police in the pilot regions during the pilot period and operating hours; b) for which there was no apprehension either under Section 17 of the Mental Health Act or due to a form; and c) do not include instances in which the service was offered but declined by the caller. This data indicate that of 11,517 "person in crisis" and "threatening suicide" events attended by police, 7,416 or 64% of these events did not result in an apprehension[8] (**Table 15**). In theory, if there was no apparent need for police to apprehend, this suggests that the person in crisis may not have been a threat or immediate risk to themselves or others, and therefore, had TPS Communications Operators referred the call to 211 instead, it is likely that the TCCS could have responded to the call instead of police.

[8] It is important to note that a limitation of this data is that there are limited contextual details provided at this time for the 36% of calls that did require apprehension (e.g. Of the number of TPS involved apprehensions, how many were documented on a form in the hospital? etc.).

Such data indicate significant untapped potential for the TCCS to further contribute toward diverting mental and behavioural health crisis calls from police response. While it is unlikely all 7,416 aforementioned events could have been diverted to the TCCS at the point of the initial call to 911, it should be reiterated that the TCCS received a total of 6,827 calls over the 13-month period. Receiving even a fraction of these non-diverted events would have represented a significant increase in overall call volume. Moreover, this comparative analysis only includes “person in crisis” and “threatening suicide” calls, and does not factor in other sources of untapped potential such as wellness checks, disputes, or distress/disorderly behaviour that are also currently eligible for TCCS diversion. Lastly, TPS data also indicate that 911 callers declined the TCCS at a rate of 39%, with the service offered on 5,860 but refused in 2,264 instances over the pilot period; however, for “person in crisis” and “threatening suicide” calls specifically, the decline rate is less than 10%, which may indicate that TPS Communications Operators should focus on offering the TCCS more to these event types specifically, where they may be more likely to receive consent for transfer of calls they assess as appropriate for TCCS.

CCT dispatches resulting in emergency department visits

The proportion of CCT dispatches resulting in emergency department (ED) visits remained stable at 8% over the pilot period (n=462 of 5,868 dispatches). Notably, there are no differences in the likelihood of an ED visit when comparing intake source – calls from 911, calls directly to 211 and calls from in the community were all equally likely to result in an ED visit. Likely related to emergency service attendance, dispatches within CMHA-TO’s pilot region were most likely to result in an ED visit at 14%, compared to 9% of TAIBU’s dispatches, 7% of 2-Spirits dispatches, and 5% of GCC’s dispatches. From among categories of calls, those related to thoughts of suicide or self-harm were most likely to result in an ED visit at 15%. Most ED visits were voluntary (n=311; 67.3%), either as a result of the CCT’s recommendation and collaboration (n=160; 35%) or at the service user’s own request (n=151; 32%; **Figure 15**). In 13% of cases (n=61), there was a medical emergency resulting in the need for an ED visit; and in the remaining 19% of cases (n=90), CCTs observed service users leaving with police for transfer to the ED (or 2% of total dispatches).

Table 15. Person in Crisis (PIC) & Threatening Suicide (THSU) Calls for Service Attended (CFSA) by police with potential for diversion to TCCS

TPS division (TCCS pilot region)	# of PIC/THSU CFSA	# of events resulting in apprehension under Section 17 of the Mental Health Act (% of PIC/THSU CFSA)	# of events out of scope due to Form-type of Mental Health Act apprehension (% of PIC/THSU CFSA)	# events caller declined TCCS (% of PIC/THSU CFSA)	# events for potential diversion to the TCCS pilot (% of PIC/THSU CFSA)
14 Division (Downtown West; 2-Spirits)	2,277	492 (22%)	208 (9%)	146 (6%)	1,431 (63%)
12/23/31 Division (Northwest; CMHA-TO)	1,797	468 (26%)	141 (8%)	97 (5%)	1,091 (61%)
51/52 Division (Downtown East; GCC)	3,805	454 (12%)	362 (10%)	317 (8%)	2,672 (70%)
41/42/43 Division (Northeast; TAIBU)	3,638	788 (22%)	324 (9%)	304 (8%)	2,222 (61%)
Grand total	11,517	2,202 (19%)	1,035 (9%)	864 (8%)	**7,416 (64%)**

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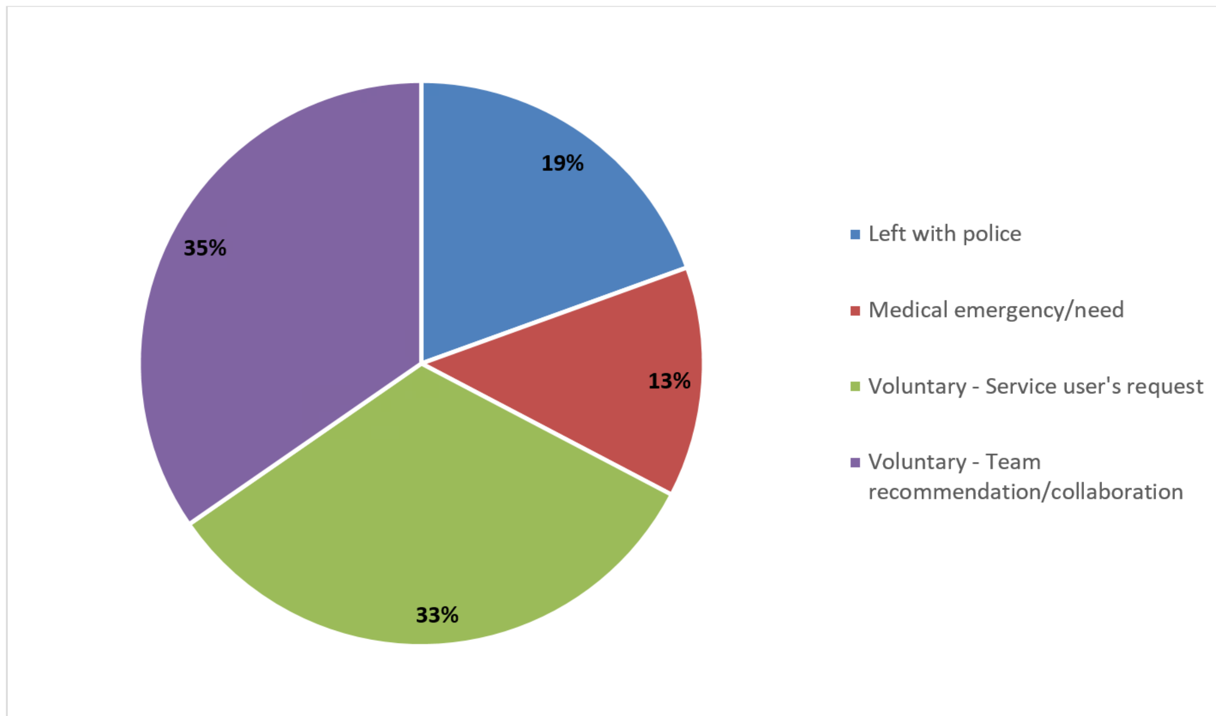
Figure 15. Consent and reason for ED visit (n=462)



TPS data: Mental Health Act apprehensions and arrests

TPS data show that for "person in crisis" and "threatening suicide" events alone attended by police in the TCCS pilot regions during the same time period and hours of operation, the average apprehension rate under Section 17 of the Mental Health Act, which allows police to apprehend an individual without a form and on their own authority, was 19% (**Table 15**). This rate was noticeably lower in 51/52 Division (Downtown East; GCC's pilot region) at 12% compared to values between 22% and 26% in the other three pilot regions, with 12/23/41 Division (North West Toronto; CMHA-TO's pilot region) having the highest rate. Total apprehensions related to all mental health calls for service in the TCCS pilot regions during the same time period and hours of operation averaged 26%, again ranging from a low of 19% in GCC's pilot region to a peak of 35% in CMHA-TO's pilot region. As noted at the beginning of this section, however, total mental health calls for service attended include several event types that are not in scope for the TCCS, thus outcomes for "person in crisis" and "threatening suicide" events make for a more meaningful comparison. The population of calls where 211 was offered to a 911 caller but refused (n=2,264 of 5,860 calls to 911 during the pilot period) may represent the most comparable group of "TCCS-eligible" calls when comparing such outcomes. TPS data indicate that 8% of this group who had the service offered to them but declined it were subsequently apprehended; and 2% were subsequently arrested. Of all "person in crisis" and "threatening suicide" events attended by police in the TCCS pilot regions during the pilot period, the arrest rate was 3%.

CCT repeat visits

Data collected by anchor partners from October 2022 to March 2023 revealed that CCTs made a total of 805 repeat visits within 30 days of an index crisis call. Of these, 49% of repeat visits were reported by 2-Spirits, 39% were reported by GCC, and 12% were reported by TAIBU. Additionally, CCTs responded to a total of 274 repeat service users within 30 days of an index call. Of these, 39% of repeat service users were reported by Gerstein, 38% reported by 2-Spirits, and 24% were reported by TAIBU.[9]

[9] Data for CMHA was not collected for repeat visits or repeat service users, given that this was a newer indicator collected in the last 6 months of the intervention. See limitations for more information on overall data quality challenges

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Results: Evaluation Question 3

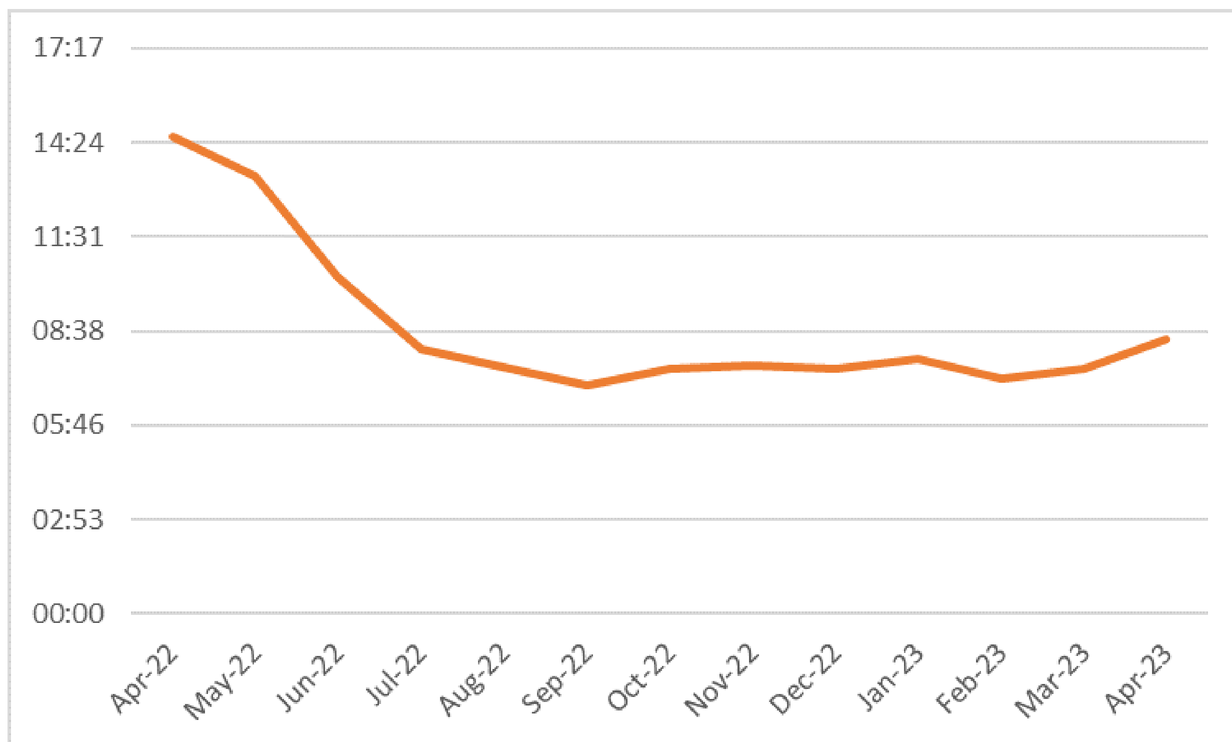
Call times for TCCS calls and dispatches

The average total length of a TCCS call, which includes both wait time and active call time, has decreased over the pilot period, with a 13-month average of 8 minutes 15 seconds. Call times were highest in the first quarter of operations (April – June 2022) but have since stabilized (**Figure 16**).

Qualitative feedback from 911 participants add context to these data, who shared that the time it takes them to explain the program to callers and obtain their consent to be transferred has improved due to both practice on their part and public awareness. As 911 leadership explained, "some callers are more aware of the program now…so that consent piece flows a little bit easier and the call takers don't have to explain each piece of it…it's still cumbersome but it's there and has to be done" (911 service provider).

Overall, however, call times qualitatively remain a reported challenge for TPS and 911 staff. As leadership from TPS expressed, "our challenge is the seven minutes it's adding to our already overtaxed call-takers" (TPS service provider). Frontline 911 staff participants correspondingly indicated that "the only negative I can ever say is hold times" (911 service provider) and described "undue stress while watching the 911 queue board go up while waiting for the TCCS to answer" (911 service provider). Although data presented in the April 2023 TPS Board Report [3] indicates calls transferred to TCCS take an additional 7 minutes 36 seconds on average, this reported data point is based primarily on the first three months of operation and not likely to be a reliable representation of the entire pilot period. More consistent and high-quality quantitative data on the time spent by 911 call operators on TCCS calls specifically would further enhance understanding of the burden on staff.

Figure 16. Average total TCCS call length ([minutes]:[seconds]) over time



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Results: Evaluation Question 3

More noticeable trends exist in TCCS dispatch times, which include dispatches of calls received from 911 and 211 but not dispatches sourced from in the community. Overall, time for CCTs to arrive on scene increased from a six-month median of 22 minutes to a 13-month median of 25 minutes; the 90th percentile increased from one hour 18 minutes to one hour 26 minutes. Some discernible differences exist across pilot regions, with the Downtown Toronto sites (GCC and 2-Spirits) times comparatively lower than TAIBU and CMHA-TO, which span much larger geographical regions. Here too, qualitative data suggest that time to arrive on scene should be continually monitored for quality assurance. As additional TPS staff reflected, “waiting for the team to arrive on scene is way too long” (911 service provider), and that TCCS CCTs are “very helpful once on scene [but have] very long response times with little or no updates” (TPS service provider). However, service users may have different expectations or experiences, as one support person reported being “impressed by the prompt response of the 2-Spirits mobile team” (TCCS support person). It should be noted that the often marked differences between the average and median values are indicative of significant variability call-by-call. It is also important to note that TCCS calls are inherently non-emergent; all TCCS callers are screened for risk level and are asked whether they are safe and have a safety plan to enable them to wait for support prior to being determined eligible for transfer to the service.

In terms of on scene interactions, CCTs appear to be completing calls in a noticeably shorter time, with median time from arrival to completion decreasing from 53 minutes at six months to 30 minutes at 13 months; the 90th percentile also decreased, from two hours 28 minutes to two hours five minutes. Here too, differences exist across pilot regions with Downtown Toronto sites reporting comparatively lower times. For instances in which CCTs were unable to locate the client or in which CCTs arrived on scene but service was subsequently declined or no longer required, call times remained stable at a median of 15 minutes; 90th percentile decreased slightly from 39 minutes to 35 minutes. Dispatch times are summarized in **Table 16**.

Table 16. CCT dispatch times by pilot region

TCCS pilot region		**Time to arrive on scene ([hours]:[minutes])**		**Time from arrival to completion ([hours]:[minutes])**	
		Average	*Median*	*Average*	*Median*
Downtown West (2-Spirits)	Six-month	0:21	0:22	1:22	0:50
	13-month	0:33	0:28	1:05	0:30
Northwest (CMHA-TO)	Six-month	0:15	0:25	1:40	1:02
	13-month	0:37	0:28	1:33	0:52
Downtown East (GCC)	Six-month	0:15	0:16	1:09	0:41
	13-month	0:31	0:18	0:59	0:21
Northeast (TAIBU)	Six-month	0:32	0:23	1:31	1:00
	13-month	0:38	0:26	1:25	0:45
Total	**Six-month**	**0:22**	**0:22**	**1:23**	**0:53**
	13-month	**0:34**	**0:25**	**1:13**	**0:30**

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Results: Evaluation Question 4

Evaluation Question 4: To what extent were service user connections made to appropriate community-based follow-up supports through the TCCS?

This evaluation question explores the extent to which the TCCS is able to connect service users to appropriate community-based follow-up supports. Four key elements are discussed in this section including the types of services and supports provided to service users a) on scene by the CCTs, and b) during follow-up, as well as the c) facilitators and d) barriers to crisis care and connection to follow-up supports. Mixed methods data in response to this evaluation question were collected from administrative data from anchor partner templates[10], service provider interview and focus group transcripts, and service user surveys.

4a. What types of direct crisis supports were provided, to what extent and how?

The TCCS CCTs offer a wide range of crisis care and support, as well as community-based referrals to service users in crisis. This subsection is divided into four main categories: resources provided, supports provided, the intervention used and referrals made.[11]

Survey data from service users (n=16) suggested that service users had overall positive experiences of the crisis care provided, with 95% of respondents indicating they were very satisfied or satisfied with the level of help they received by the CCT; only 5% of respondents reported that they were dissatisfied. Qualitative findings from the survey similarly suggested that service users had positive experiences when receiving support from the CCTs. One service user shared their CCT experience as follows:

Toronto Community Crisis Service staff: Gerstein Crisis Centre

Photo courtesy of the City of Toronto

[10] Note: data period reported for most variables from the anchor partner templates are from: October 2022-April 2023. Data collection template and disaggregation categories were revised since the six-month evaluation report, and therefore most indicators were not comparable to the first six months' of data collected. Indicators that were aggregated across April 2022-April 2023 include: number of culturally relevant supports provided, number of referrals made at follow-up, and sociodemographic data. See the Limitations section for more detail.

[11] Multiple resources, supports and interventions, and referrals can be used/made during one crisis visit.

Results: Evaluation Question 4

> They sat with me in the car for 30 minutes and talked me down and I felt much better. They gave me all of the distress lines to call (e.g., Gerstein, so many lines for shelters, 24/7 lines, connect Ontario). They gave me space to respect my privacy because I prefer to not be in-person. If I needed them to stay longer, they offered to stay. (TCCS service user)

Resources provided

Resources include tangible supplies provided to service users to meet basic health, hygiene and subsistence needs. Most commonly, CCTs provided service users with clothing (46%), blankets/sleeping bags (12%), harm reduction supplies (10%), and medicine bundles (10%). All sites were similar in being most likely to provide clothing; and that clothing was most common may reflect data having been collected over the winter months. Some minor site differences emerged in other types of resources provided, with GCC, for example, being more likely than other sites to have provided harm reduction supplies; and 2S being more likely to provide medicine bundles. Whereas other sites reported shelter beds as the most urgent type of resource or support required on scene that was unavailable, CMHA-TO reported that sufficient harm reduction supplies were most frequently required by their team but not available on scene at the time. See **Appendix I** for a total breakdown of all resources provided.

Supports provided

Supports include a variety of material and non-material social supports provided to service users during the course of a crisis care interaction, which might include physical or practical assistance, informational support and resource-sharing and emotional and physiological assistance. Across all support types, the most commonly provided included resources and information sharing (37%), advocacy during a crisis visit (37%), referrals (11%), practical supports such as making a phone call or packing up belongings (4%), and transportation in crisis vehicles to the hospital (3%). Again, there were no noticeable differences between sites in the two most common types of supports provided as all sites were equally likely to have provided advocacy and resources or information; however, GCC appeared noticeably more likely to provide referrals on the scene of an initial crisis versus other sites. See **Appendix I** for a total breakdown of all supports provided.

Interventions used

The most common types of clinical skills or crisis care interventions employed by TCCS CCTs with service users included risk assessment (18%), crisis counselling (17%), rapport building (14%), crisis and safety planning (13%), and crisis de-escalation (11%). See **Appendix I** for a total breakdown of all interventions used.

Referrals made on scene

The CCTs made a total of 411 outbound referrals for service users on scene between October 2022 and April 2023. Of these, the top five referrals made include shelter beds (35%), crisis stabilization supports[12] (20%), crisis beds (16%), EMS services (11%), and culturally relevant supports (10%). Despite the City of Toronto setting up access to shelter beds for all partners, referrals made to shelter and crisis beds still account for over half of all referrals made by CCTs and were consistently the most commonly made referral across sites. With the exception of CMHA-TO, who has priority access for TCCS clients to shelter beds they operate themselves, shelter beds were also reported as the top urgent support that was needed during a crisis visit but not available at the time. This finding aligns with qualitative data from surveys where service users reported that housing and shelter supports were among the most common supports offered or referred that they found helpful. See **Appendix J f**or a total breakdown of all outbound referrals made on scene.

4b. What types of follow-up supports were provided, to what extent, how and to whom?

After a crisis visit, consenting service users are asked if they would want to receive a follow-up visit or contact in which they would be provided with options to connect to follow-up supports and services, either through the community anchor partner's case management services or by making referrals to follow-up services within the community during the initial follow-up visit. Follow-up can vary in length and type of support depending on service user preference, and can be provided by the CCTs or case management staff.

[12] "Crisis stabilization supports" include food security, family support, housing, mental health and substance use supports, wellness and recovery, extreme cleaning, youth services, appointment support, consulate support, crisis lines for 2SLGBTQ+.

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Results: Evaluation Question 4

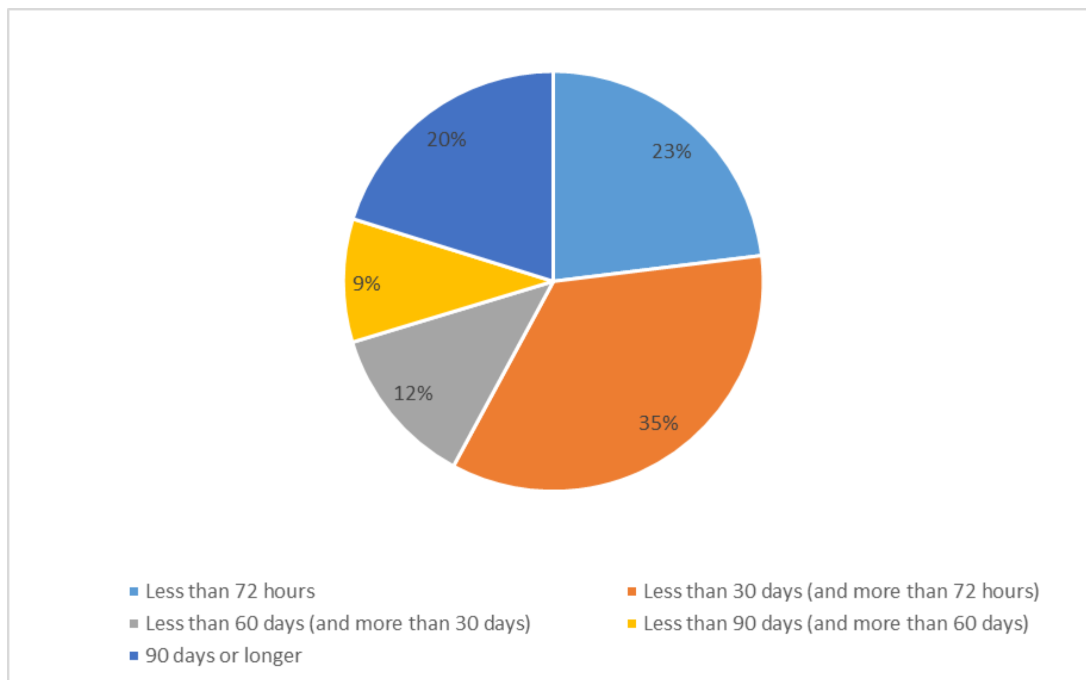
Follow-up attempts and duration

A total of 2,936 initial follow-up communication attempts were made to service users post-crisis visit between October 2022 and April 2023. Most often, service users agreed to receiving follow-up support (61%); however, in over one-quarter (26%) of cases, service users could not be contacted or located, and 13% of service users declined follow-up support[13]. Additionally, out of the total 1,160 service users who received follow-up support, over half (57%) received support within the 90-day model of transitional care. A total of 23% of service users received follow-up support within 72 hours, and 20% of service users received follow-up support for longer than the intended 90-day period. The latter is anecdotally related to system-level capacity gaps and waitlists associated with accessing supports to which service users are referred. **Figure 17** below provides a breakdown of the duration of follow-up support provided to service users.

Culturally relevant supports provided

As one of the few indicators that could be aggregated over the 13-month data collection period, data indicate that in the first year of TCCS operations, a total of 300 culturally relevant supports were provided to service users during follow-up. Of these, 50% were composed of Indigenous-specific supports. The most common types of Indigenous supports provided to service users include access to traditional medicine (32%), wholistic family and kinship care supports (28%), and culturally specific wellness programming[14] (27%). Other common types of culturally relevant supports provided to service users include Afrocentric and West Indian/Caribbean-centric supports (20%), and wholistic health supports (7%). Qualitative findings from surveys suggest that service users were satisfied with the culturally specific supports they received. One service user shared "I liked knowing I had the option" (TCCS service user) of receiving supports that were relevant to their culture and identity. See **Appendix K** for a total breakdown of all types of culturally relevant supports.

Figure 17. Duration of follow-up support provided to consenting service users (n=1,160)



[13] Reasons for declining follow-up support include needs were met during initial mobile crisis team visit (6%), no reason provided (6%), and already enrolled in another service (1%).

[14] Examples of culturally-specific wellness programming includes: beading, drumming, language, regalia-making, etc.

Results: Evaluation Question 4

Referrals to community-based follow-up supports

As described in the program model and detailed in Site Profiles, anchor agencies bring with them networks of community-based partner agencies to which they can refer TCCS service users for follow-up support. Data suggest anchor agencies are leveraging these networks for nearly half of all referrals made. Of referrals made by anchor agencies, 43% were external referrals made outside of network partner agencies, 42% were internal referrals made within network partner agencies, and 5% were inter-network referrals made across other pilot site regions.[15]

A total of 1,996 referrals were made for service users during follow-up in the first year of the intervention. The three most common types of referrals made include mental health and substance use referrals[16] (26%), housing referrals[17] (16%), and case management referrals (13%). See **Appendix L** for a total breakdown of all follow-up referrals provided. Consistent with the six-month implementation evaluation, data suggests that housing is one of the most common referrals made by both follow-up staff and CCTs on scene. This finding is in alignment with the challenges shared in interviews and focus groups around connecting service users to housing supports. One service provider shared that "the main thing is for sure housing shelters, we don't have enough and a lot of calls have to do with folks experiencing homelessness or displacement" (CMHA-TO service provider). This challenge, and others including system-level capacity gaps, staffing and resource capacity as well as infrastructure challenges are detailed in the barriers section.

Sociodemographic data shared during follow-up

Service user sociodemographic information was collected during follow-up from April 2022 to April 2023[18] on a monthly basis using anchor partner templates. Due to the lack of a shared data system across the intervention, a limitation to the collection of this data is that unique service users are unable to be tracked. To minimize the risk of double counting unique service users across each partner agency, data reported in this section is based on the number of times sociodemographic information was shared by service users during follow-up. This section provides an aggregate overview of the most commonly reported disaggregation variables for each sociodemographic data category across all pilot regions. A total of six categories are reported below: age, race and language preference, Indigenous identity, income and housing status, gender and sexual orientation and disability. See **Appendix M** for a breakdown of all sociodemographic data by anchor partner agency.

Age

In the first year of the intervention, age was reported by service users during follow-up a total of 1,593 times. Over half (54%) of the time, service users reported being between ages 30 to 64, while a quarter (25%) of the time they reported being between ages 20 to 29. It is important to note that the TCCS does not serve clients under the age of 16.

Race and language preference

Race was reported by service users a total of 1,012 times. Service users identified their race as White 33%, Black 29%, and South Asian or Indo-Caribbean 9% of the time during follow-up. Service users also shared their language preference a total of 773 times. English was reported 67% of the time, while other language preferences[19] were reported 16% of the time. Additionally, service users reported their language as 'Not listed' 13% of the time.

Indigenous identity

When asked about Indigenous identity during follow-up, service users identified as Indigenous 9% of the time. Indigenous identity was specified by service users a total of 132 times. Almost two-thirds of the time (65%) service users preferred not to answer and almost one-third of the time (31%) service users identified as First Nations.

Income and housing status

When service users were asked if they had challenges in the past month meeting basic needs, 85% of the time they said yes (n=142). Service users shared that they were receiving social assistance 81% of the time (n=89). Housing status was reported during follow-up a total of 972 times. Service users identified as being stably housed 59% of the time, while 36% of the time service users identified as having unstable housing arrangements.

[15] 10% of referrals were organizational (i.e., within the organization). This type of referral was specifically tracked by Gerstein Crisis Centre.
[16] Mental health and substance use support include data for crisis counseling and harm reduction services.
[17] Housing support includes data for shelter/hostel, and crisis bed supports.
[18] CMHA and 2-Spirits launched in July of 2022, therefore data for both these sites is recorded from July 2022-April 2023.
[19] Other languages include Arabic, Bengali, Chinese-Cantonese, Chinese-Mandarin, Farsi, French, Greek, Hindi, Hungarian, Indigenous-Mohawk, Italian, Korean, Polish, Portuguese, Punjabi, Romanian, Russian, Somali, Spanish, Tamil, Turkish, Ukrainian, and Urdu.

Results: Evaluation Question 4

Gender and sexual orientation

Service users identified their gender a total of 1,597 times during follow-up. The most commonly identified genders include man 50% of the time, woman 43% of the time, and other gender categories[20] 4%. Service users preferred not to identify their gender 3% of the time.

When sharing their sexual orientation, service users reported identifying as heterosexual or straight 48% of the time (n=368), bisexual 3% of the time (n=21), gay 3% of the time (n=22), and queer 3% of the time (n=22). Additionally, service users reported not knowing their sexual orientation 23% of the time (n=172) and preferred not to answer 18% of the time (n=136).

Disability (presence, type, barriers due to disability)

Service users reported the presence of a disability 59% of the time (n=684). The most common type of disability identified is mental health (63% of the time, n=621), followed by physical illness/pain (8% of the time, n=77) and developmental or cognitive disability (7% of the time, n=74). Service users preferred not to provide an answer about their type of disability 8% of the time. When identifying barriers due to a disability, overall uncomfortable environment was reported 18% of the time (n=77), attending an event or program in person 9% of the time (n=41), and communicating/interacting with staff 9% of the time (n=38). Service users preferred not to answer this question 31% of the time (n=134).

4c. What facilitators supported crisis care and connection to follow-up support?

Staffing and response model was appropriate for service user needs

When prompted to discuss facilitators in connecting service users to crisis care and follow-up supports, anchor partners spoke to inherently structuring their teams and response model to provide "a mental health response to a mental health need" (GCC service provider) rather than an enforcement response to a health need; "matching crisis type with crisis response, mental health crises with mental health responders, is something that's very important and part of the brilliance of the program" (CMHA-TO service provider).

All anchor partners have established processes for prioritizing calls and determining the immediate needs of service users. Consistent with their overall organizational identity, CMHA-TO, in particular, is intentional in taking a "really strong clinical approach" to their TCCS pilot, emphasizing that "without that clinical understanding or that comprehensiveness, you're not able to effectively mobilize the right support" (CMHA-TO service provider). In addition to having a triage process when receiving calls for service, CMHA-TO leadership noted that their CCTs use their clinical expertise and various adapted assessment tools – such as the Crisis Triage Rating Scale, Columbia Suicide Risk Assessment and a brief mental health screener – to guide decision-making when working with service users. TAIBU described doing "a lot of talk therapy" to "reframe their thinking and give more options and reference points to different ways to copy" (TAIBU service provider). Service providers from GCC echoed that being skilled in crisis assessment is essential to "be able to quickly get underneath what a person would benefit from and everything that's entailed in their situation, and then going from there and being able to collaborate and think together with that person about what might be helpful" (GCC service provider).

Participants from all anchor partners also noted that having a diverse team with different areas of expertise is helpful in effectively responding to the various needs of service users. Data from interview and focus group transcripts and Site Profiles (**Appendix A**) demonstrated that each anchor partner has a diverse complement of staffing positions, such as peer support workers, harm reduction workers, youth specialists, concurrent specialists, cultural specialists and that staff are reflective of the communities they serve, allowing for service user needs to be met in a culturally responsive manner (described more fulsomely in ***Evaluation Question 5d***).

Relationship and rapport building supported service user engagement

In addition to the technical aspects of the TCCS, anchor partners consistently reported that rapport building and "kindness, empathy, and support" (TAIBU service provider) are key to engaging service users through different stages along the TCCS service pathway. In terms of accepting services initially, one CMHA-TO service provider noted that "once they [service users] start to see how we're

[20] Other gender categories that service providers selected from include trans woman (1%), trans man (1%), gender non-binary (1%), Two-Spirit (0.4%), and other (0.4%).

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communicating with them, they usually end up feeling a lot better and more trusting, and then we can use our professional skills to meet the individual where they're at and support them through crisis." In fact, another CMHA-TO service provider echoed that consistent rapport building and reassurance has helped increase TCCS uptake among those who initially declined services, explaining that they may "see a service user for a crisis call numerous times, and sometimes it takes the first two times for them to build trust with us to want to consent."

Frontline staff shared that being relational and empathetic is beneficial in supporting service users through the CCT visit and follow-up response as well. One participant from TAIBU described that the CCTs "spend a lot of time listening to people and understanding and reiterating what they've told us, and then giving them…more options and reference points, different ways to cope" (TAIBU service provider). The same participant shared an example of resolving a call for a perceived disturbance simply through "the way we approached her, in the compassion and in the, just friendly banter…we didn't even have to convince her, we just told her the truth and she responded and 'end of story' we're done." Frontline staff at GCC shared a similar idea, noting that "some of the most effective follow-ups that we've done with folks have just been ongoing check-ins, like regular check-is, wellness checks, where we just kind of process things that have been going on for them and making them feel important and heard" (GCC service provider).

Partnerships with community organizations facilitated access to needed supports

As described earlier in the report, developing networks of service providers in each pilot region has been key in connecting TCCS service users to various community-based follow-up supports. TAIBU, for example, described that:

> developing those relationships has been huge, especially with hospital wait times – having the head of psychiatry at SHN [Scarborough Health Network] sitting on our advisory table, him giving us tips as to, 'When you go to the emergency room, do this…' So our community partnerships are really helping us to make the right connections and get clients what they need. (TAIBU service provider)

Both CMHA-TO and GCC also shared similar sentiments about how forming coalitions with other community agencies has enabled more effective service delivery insofar. One participant from CMHA-TO reported that:

> the way that we've subcontracted out funding to various organizations in order to get rapid access to certain services, I think that model has worked really well for our case management team. So if someone is wanting addiction services or a mental health therapist, we're able to connect them directly to our partners without them having to go through the regular system. (CMHA-TO service provider)

In similar fashion, service providers from GCC described that "when you've been doing crisis services for a long time, you've developed quite a network…we know where there are gaps, where people have difficulty accessing services. We really use partnership and collaboration as a tool to really hopefully strengthen our abilities in those areas to meet the needs of the people." GCC participants particularly noted their dedicated partnerships with two community agencies in their pilot region, WoodGreen Community Services and Family Services Toronto, which has facilitated rapid access to short-term counselling services for their TCCS clients. When reflecting on their ability to provide this connection, one participant shared:

> that's [counselling services] always been a challenge of mine while working in the field and feeling as though clients' need for counselling and their ability to process certain traumas isn't being addressed because there's little access to it. So it's nice to at least be able to offer a short period of time where they can access that. (GCC service provider)

4d. What barriers hindered crisis care and connection to follow-up support?

System-level capacity gaps preclude timely access to needed care and resources

On the other hand, while community networks have provided some direct connections to follow-up supports, anchor partners spoke to how they can only go so far, and how a significant barrier continues to be system-level capacity gaps that are causing long waitlists or an outright lack of availability for certain services. For example, a service provider from CMHA-TO described how:

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> not all of our services that we have access to are all the services that we need, there's still lots of gaps…We do what we can do, but when we need access to the natural or regular system, we still face those barriers. Our case management services are only up to six months, but a lot of times, trying to connect people to long-term supports before we discharge them can take longer than the six months. (CMHA-TO service provider)

GCC shared similar concerns, as some of their partnerships "only allows us to get an application done faster, it doesn't actually give us any kind of extra access. So these folks are still sitting on waitlists forever" (GCC service provider). As a result, many frontline staff reported feeling like "there isn't anything to pull on sometimes, which is the more frustrating part, that you can't pull on it in the crisis, or even you can't pull on it afterwards, which then creates even more of a barrier to delivering services" (TAIBU service provider). As mentioned previously, participants from all four anchor partners identified supportive housing and shelter space as the follow-up support with the greatest barriers. In fact, aggregated administrative data from the anchor partners showed that shelter beds and crisis beds together comprised 62% (n=149) of the "number of urgent supports needed during crisis visits but not available on scene."[21] Leadership from TAIBU shared that:

> It's very, very difficult to find them, whether it's a safe bed or just a shelter, or even actually getting them into housing. The housing list is a 12-year wait right now, so it's not workable, it's not humane and you end up having to leave people in their situation. We try our best to improve, but nothing beats having a safe roof over your head. So I think housing has been our biggest barrier challenge. (TAIBU service provider)

Apart from housing, service users and anchor partners identified capacity gaps in accessing primary care, psychiatry and addictions services. For example, frontline staff from TAIBU described how primary care referrals are needed for access to psychiatric services, but "we're saying to them, 'Go to your family doctor, get a referral', and they come back and say 'I can't get an appointment to my doctor for another three months'…so definitely the waitlists are a challenge" (TAIBU service provider). In terms of addictions services, aggregated administrative data from all anchor partners showed that harm reduction supplies were the third most common type of urgent support needed during crisis visits but were not available on scene (22%; n=53). A participant from GCC similarly commented on the difficulty in accessing community-based addictions services:

> If we can get someone a detox bed, that's great, but just the total gap and waiting period in terms of actually getting into a treatment centre or something like that, it's just too long, it's not viable. So if people are really experiencing substance use issues, it can be hard to actually effectively intervene around that. (GCC service provider)

These system-level capacity gaps are challenging effective service delivery for the TCCS, as it "makes it hard to effectively intervene and set people up for something better [and] get some momentum" (GCC service provider). When asked how crisis workers support service users during this waiting period, one participant shared that "I find a lot of times, those are the cases that I engage a lot more coping strategies for trying to put those in place within the environment they're in" (TAIBU service provider). These gaps are also contributing to issues of low engagement among some service users. As shared by a GCC crisis worker:

> For the folks that have had a lot of successful connections, it's the folks that have the means and capacity to actually enable them to follow through on those things, such as having a phone and basic needs met…we aren't housing providers, community case managers…we provide people with resources, fill out applications, but at the end of the day, once we do the referral, it's kind of up to them to maintain it. And that does make it really difficult if folks don't have phones or access to computers for email, or various other issues, that they're not housed. (GCC service provider)

Notably, these negative impacts are not only experienced by service users; 2-Spirits shared how these systemic barriers are impacting job satisfaction among crisis workers, describing how, for example:

> getting a call from somebody who is in crisis pretty well solely because they don't have a place to live or call home or have a space of their own, and then not being able to provide that to an individual, it's really frustrating.

[21] See **Appendix N** for a breakdown of all urgent supports needed but not available on scene.

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> And it also contributes to the burnout that our team experiences. It's really hard for our team to go out to be in these roles where they feel like they're enacting change and supporting folks, and then go out and run into these barriers and not have answers. (2-Spirits service provider)

The same participant urged that:

> more funds and access to resources needs to work in line with these pilots or else all of this is just a Band-Aid for the mental health crisis…I think we really need to look at creating systemic change that enacts, like, long lasting and meaningful change for generations to come. (2-Spirits service provider)

TCCS staffing and resource capacity should be monitored to ensure it keeps pace with growing demand

As discussed throughout this report, in addition to broader system-level capacity gaps, all TCCS partners raised concerns of whether the TCCS itself currently has the resources and capacity to respond to service users' needs, especially as the service continues to gain traction and demand increases. A financial analysis was outside the scope of the current evaluation as was projected demand; however, qualitative data presented in this report suggests further exploration and systematic analysis of the specific resource and staffing complements needed to match projected demand may be helpful.

At intake, participants from both 211 and 911 report that the level of staffing at both organizations challenges staff ability to respond efficiently to the rising number of calls. For 911, this is likely related to overall organizational pressures that pre-dated TCCS, as documented in the 2022 Toronto Auditor General's report that reviewed TPS' 911 operations [2]. For 211, however, data presented in ***Evaluation Question 3*** support staff perceptions of increasing demand by TCCS callers and a consequent need for greater capacity to meet rising call volumes.

Anchor partners also shared that limited capacity is hindering their ability to meet the needs of their follow-up and case management clients. For example, one participant from GCC described how, during follow-up, "if we can't get a hold of people via phone, we will go and do a mobile visit at their homes whenever possible, but sometimes staffing levels makes that difficult" (GCC service provider). CMHA-TO shared similar challenges, with two separate participants indicating that "as our call volumes have increased dramatically, we're running into issues around capacity on our follow-up team" (CMHA-TO service provider). However, with the TCCS model being one that allows each anchor partner to structure and organize their services uniquely, further exploration of staffing complements and average caseloads across organizations is needed to better determine whether reported concerns are due to organizational-level issues or reflective of larger programmatic capacity issues. If it is the latter, inadequate capacity has the potential to hinder the TCCS' ability to provide quality care, in addition to fulfilling its previously described untapped potential.

Lack of standardization in infrastructure and operational processes is hindering efficiency

Finally, consistent with findings from the six-month implementation evaluation, participants identified certain challenges with TCCS infrastructure and operational processes that continue to create inefficiencies in the overall service.

Similar to findings from the six-month implementation evaluation, one commonly reported barrier is the incompatibility of data systems used by the different TCCS partners. As described in the six-month report, each TCCS partner uses a different combination of data systems and data collection and reporting processes. Whereas 911 collects and reports data using a computer-aided dispatch system, 211 collects and reports data using both a helpline software (iCarol) that was modified for TCCS use, and a dispatch database and portal (TCCS Dispatch Portal) that was newly and specifically designed for the TCCS. Anchor partners have access to the TCCS Dispatch Portal and also have their own individual electronic medical record or charting systems in which they collect service user data, which are not necessarily aligned with the data TCCS intended to collect. For example, GCC and 2-Spirits use Pirouette Case Management Software, TAIBU uses PS Suite and CMHA-TO uses Input Health. Accordingly, service providers continue to suggest that a centralized TCCS database accessible to all partners would be helpful, especially if the service were to expand to the entire City of Toronto. As indicated by CMHA-TO leadership, this would not only alleviate the burden on staff who experiencing concerns of burnout, and free up more time for crisis teams to respond to calls for service, but it would also help facilitate higher quality, continuous and person-centred care:

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> I think the reality is, once we go city-wide, we're going to need that database…Our borders are going to cross, there are going to be clients that we're sharing…so it would be really helpful to know that this person has been supported by TCCS before; we can look up the file and see what was offered to them. And that will also make us more trauma informed so we're not retriggering people asking the same questions. It just allows all of us to be more informed and synchronized. (CMHA-TO service provider)

At the same time, different data systems and service sectors (i.e., enforcement and health) have different standards of retention and there are significant privacy and legal implications associated with data sharing that present potentially insurmountable barriers to implementation of a centralized data system. A more fulsome analysis of the feasibility of centralized data collection and sharing was outside the scope of the current evaluation. However, similar to the financial feasibility of implementing direct access points across all anchor partners and better understanding projected demand and corresponding capacity requirements, qualitative data presented here suggest further exploration of this issue may be warranted.

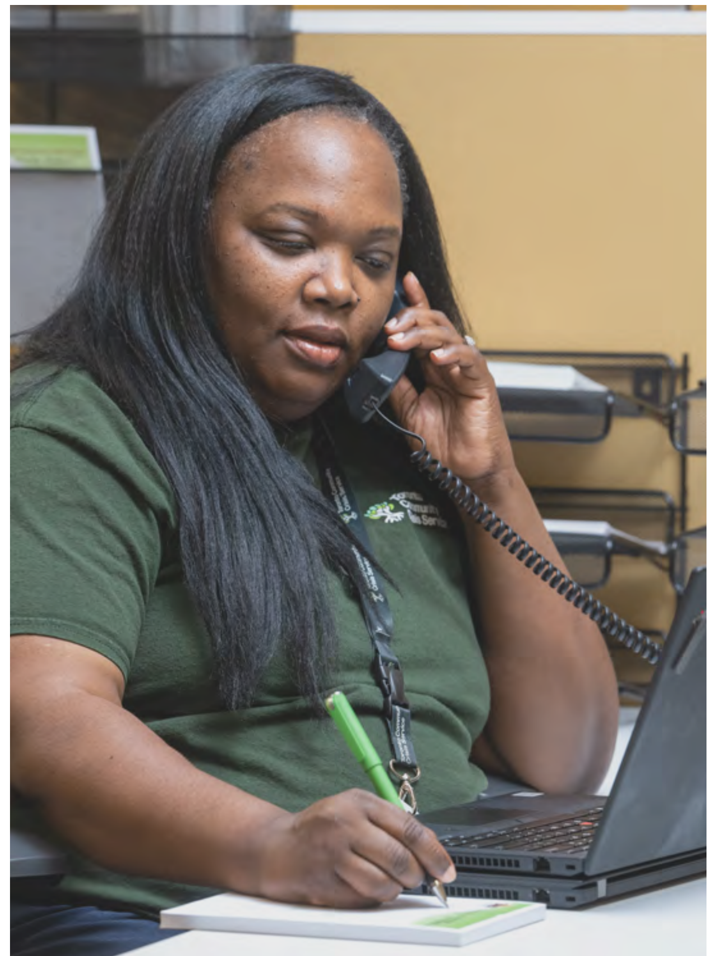
A final persistent technological barrier identified by TCCS partners is the use of two-way radios for the purposes of dispatching CCTs and communicating. Staff at 211 continue to report that challenges —such as being distracted by radio chatter while managing phone calls, and the fact that radios are used inconsistently and unreliably across anchor partners—are hindering their ability to dispatch CCTS for service. As one 211 service navigator explained, "radio monitoring is quite challenging when service navigators are on the phone with callers. Communication through radio is not as effective as through phone" (211 service provider). While radios are not the primary dispatch mechanism, the crux of the issue appears to be having a single staff role be responsible for simultaneous management of both phone calls and radios. Separating these responsibilities may alleviate the perceived burden reported by staff. As another 211 service provider echoed, "it would be nice to have someone just to monitor the radio. With all the other stuff that we have to do, sometimes that can be challenging" (211 service provider).

Altogether, in the face of these barriers, participants still shared optimism for the TCCS in the future, with one individual reflecting on how:

> we're working with a new program, we're working with a system that hasn't worked to some extent…but facing that head on and saying 'Okay, what can we do to fix this? What can we do to move forward?' And sometimes there isn't that magical solution, but if we're continuing this conversation, we're not letting it be silenced so that those who are really affected by it aren't feeling silenced themselves. (TAIBU service provider)

Participants from the City of Toronto similarly acknowledged that while "things were created like it was a pilot", they feel that:

> now we have a year or so under our belts. We can give a good idea of what is needed to take us to the next level and absorb an even larger number of calls that will likely come when the service expands. (City of Toronto staff).



Toronto Community Crisis Service staff — Photo courtesy of the City of Toronto

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Results: Evaluation Question 5

Evaluation Question 5: To what extent has the TCCS demonstrated its guiding principles?

As noted earlier in the report, five guiding principles were developed by the TCCS in collaboration with the communities it serves to support accountable implementation and operation. These guiding principles were then mapped to key concepts, which were collaboratively defined and operationalized alongside TCCS partners in a workshop facilitated by evaluators in March 2023 (**Table 17**; co-designed definitions for each concept are detailed in **Appendix O**). These key concepts and overall demonstration of the guiding principles were subsequently evaluated using a variety of data sources - including Site Profiles, implementation tracking, surveys, interviews and focus groups – collected from a variety of stakeholders.

Table 17. Guiding principles for the TCCS and corresponding key concepts for evaluation

Guiding principle	Key concepts
1. Enable multiple coordinated pathways for service users to access crisis and support services.	*Accessibility*
2. Ensure harm reduction principles and a trauma-informed approach are incorporated in all aspects of crisis response.	*Harm reduction; trauma-informed care*
3. Ensure a transparent and consent-based service.	*Trust; safety; participation, choice, rights*
4. Establish clear pathways for complaints, issues and data transparency.	
5. Ground the service in the needs of the service user, while providing adaptive and culturally relevant individual support needs.	*Person-centred care; cultural safety*

This evaluation indicates that the TCCS has meaningfully demonstrated and effectively enacted its guiding principles through a variety of mechanisms:

- principled leadership and administration by the City of Toronto
- organizational values and leadership within each of the service partners
- composition of staff teams' identities, skills and values
- health care and well-being practices being offered to the community.

In a focus group with City of Toronto staff who have supported implementation and operations over the past two years, their team reflected that the guiding principles "really guided everything that we've tried to do and to have a high degree of fidelity to them is what we want out of the service…we've done that to a good degree" (City of Toronto staff) and that they have "set it up in such a way that it's our North Star…it will continue to get better as we use these principles as a way of improving the service" (City of Toronto staff). TCCS service partners tended to agree that the City of Toronto has provided strong leadership in this respect, with one organization noting:

> I give an enormous amount of credit to the City of Toronto for this. They grounded this pilot in really strong principles. They picked partners that were committed to the principles. But they've also lived by the principles…I've never seen that. I have been doing community work for many years and I have never seen this before. I have never come across a funder-partner relationship like this before where they embody those principles. (211 service provider)

As 211 suggests in the above quote, TCCS partner organizations have also strongly demonstrated these guiding principles from the outset. Site profiles (**Appendix A**) depict how overall organizational mandates and values align closely with both the overall TCCS guiding principles and how the service partnerships and practices available are tailored to the unique needs of their respective communities. Selecting partners who were previously established in practising such values have supported the TCCS to be accountable to guiding principles it set out:

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> The anchor partners hold us accountable to these principles…and the learnings are constant because they're on-the-ground. Whenever they notice things that are either in conflict or in alignment with the guiding principles, they notify us and let us know what they're experiencing and suggestions on how things could be improved. (City of Toronto staff)

Survey data from staff across all partner organizations (N=92) indicate an overall high level of agreement that guiding principles have been demonstrated from their perspectives. Anchor partners were overall more familiar with the guiding principles than TPS and 211 respondents, who had comparatively higher proportions of "I don't know" responses when asked whether the TCCS has demonstrated its guiding principles in practice. When "I don't know" was excluded from the analysis, the proportion of those who agreed or strongly agreed with the statement ranged from 77% on accessibility to over 85% on all other principles. Service user survey data was similarly supportive, with service users and support persons reporting 85% to 95% agreement across principles. The level of agreement, taken as the summed percentage of the survey responses "Strongly agree" and "Agree", on each of the guiding principles is summarized in **Table 18** below (see **Appendix P** for the complete results, including sample sizes). Each of the guiding principles and their specific key concepts are evaluated in turn in the sub-sections that follow.

Toronto Community Crisis Service staff: 2-Spirited Peoples of the 1st Nations

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Table 18. Summarized survey responses, by % agreement, on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Key concept	Survey measure	% agreement by stakeholder group	
		Service users	**Service providers**
Accessibility	When someone is in need of help, the TCCS is readily available.	N/A[a]	77%
	Connecting with the TCCS is easy for service users.	95%	80%
Harm reduction; trauma-informed care	TCCS staff are compassionate when service users are feeling stressed or overwhelmed.	94%	96%
	The TCCS acknowledges service users' unique identity, personal strengths and life experiences.	95%	93%
	The TCCS enables service users to share things about their life and needs on their own terms and at their own pace.	95%	96%
	TCCS staff recognize that some groups or people ensure discrimination, violence, abuse and other hardships than others do.	N/A	96%
Trust; safety; participation; choice; rights	TCCS staff explain the types of supports that can be offered to service users in a way that they can understand.	N/A	95%
	The TCCS enables service users to feel confident in asking questions about the supports they were offered.	95%	95%
	The TCCS is supportive of service users in deciding the types of supports they want.	95%	96%
	The TCCS advocates for service users' best interests.	N/A	94%
	TCCS staff genuinely want to help service users.	100%	94%
	The TCCS promotes emotional safety while service users are receiving support.	95%	98%
	The TCCS promotes physical safety while service users are receiving support.	100%	86%
	The TCCS enables service users in sharing feedback about their experience if they had a complaint or compliment.	100%	90%
	The TCCS ensures that service users know what their personal information is being used for.	N/A	93%
	The TCCS ensures that service users know who to ask if they had questions about their personal information.	89%	86%
Person-centred care; cultural safety	Overall, the TCCS is welcoming and non-judgmental toward service users.	100%	94%
	Overall, the TCCS treats service users with dignity and respect.		95%
	The TCCS provides service users with options for supports that are relevant to their culture and identity.	93%	98%
	The TCCS promotes cultural safety training and practices in order to meet the needs of service users.	N/A	92%
	The TCCS recognizes and accommodates service users' disability-related needs.	100%	94%

[a] N/A indicates that the survey question was not asked of service users. Primarily, this was because service user surveys were intentionally designed to be shorter with the goal of being less burdensome for service user participants to complete. A structured, consensus-based decision-making process was undertaken in collaboration with anchor partners to determine which survey questions should be prioritized.

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Results: Evaluation Question 5

5a. How accessible is the TCCS?

The first guiding principle relates to providing multiple, coordinated pathways for service users to access crisis and support services, which is related to the concept of accessibility. The notion of accessibility considers several dimensions including whether care is easy to connect with, available in a timely manner to the extent required, and accommodating of differences in preferences or abilities. In the context of the TCCS, the co-created definition of accessibility is being readily and easily available to individuals when needed through a variety of low-barrier access points (e.g., at any time of day, through multiple communication channels, in multiple languages) and will respond to service requests in a culturally safe and appropriate way. Data suggest that this guiding principle has been demonstrated in large part by successfully having implemented a coordinated pathway from 911 to 211; an alternative pathway directly through 211 to which calls are successfully being (re)directed; and several access points from in the community, including direct phone lines to two of the four anchor agencies and the ability to intake calls from crisis teams while they are doing outreach in the community. As one city staff member reflected:

> We really heard community that calling for mental health services through one number like 911 wasn't always successful, so now we have a different pathway where we can build trust and people can feel safe. And I think that's really shown in the number of calls that have come through. (City of Toronto staff) [211]

Survey data indicate that 77% of service providers agreed or strongly agreed that the TCCS is readily available when someone is in need of help and 80% were similarly in agreement that the mechanism of connecting with the TCCS (i.e., phoning 911 or 211) is easy for service users. Service users themselves reflected this perception, with 95% of those surveyed (n=20) agreeing that connecting with the TCCS was easy for them (60% strongly agreed; 35% agreed).

That said, of all the guiding principles, service provider ratings were lowest for accessibility, and qualitative data indicate that this particular principle was the most challenging to demonstrate and was the only principle in which obstacles to demonstration emerged. Throughout the evaluation, participants reflected on several barriers that exist to providing multiple, coordinated pathways that meet the accessibility needs of all City of Toronto service users.

Staff capacity to intake calls is lagging behind demand for service, reducing access to timely and appropriate care

While qualitative data and data collected through their implementation tracker indicate 211 have hired more staff to accommodate the calls, as noted throughout this report, staffing capacity remains inadequate. Frontline staff from both 911 and 211 repeatedly noted the need for greater 211 staff capacity to respond to the increasing volume of calls coming to the organization. From 911's perspective, the program "definitely needs more staff on the 211 line" (911 service provider) as "it would be beneficial to have more [211] operators working with TCCS so that when the TPS 911 Communicators transfer a call, the caller and [911] operator are not waiting on hold for too long" (911 service provider). As a 211 service navigator taking calls after hours expressed:

> This very important initiative is embedded in the 211 call centre where multiple lines, provinces and programs are also happening at the same time. Many of our calls can be long in length and complicated, stressful. We are two staff on overnights with all of these lines and it's not sustainable in the current arrangement. There should likely be a dedicated team for this service going forward. (211 service provider)

The need for increased organizational capacity and a TCCS-specific team was acknowledged by 211 leadership alongside the tension with the TCCS being in a pilot stage:

> In an ideal world, we would just have a designated team for TCCS…[this] has been identified as the priority because there will be better service but we're in this awkward phase where the service is not big enough to justify the cost of a 24/7 designated team. (211 service provider)

Anchor partners expressed their experience of "bottlenecks" within the intake pathway due to lack of capacity. As one anchor organization described, "the sense of our team is that there's a bottleneck at 911 and that will need constant attention" (CMHA-TO service provider); and another organization reflected:

> 911 was the first promoted pathway and it still is a bottleneck…we find that most people do not end up with an alternate response other than a 911 emergency response. 211 is doing their best but they are not set

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> up as a purpose-built response to this either, so they are managing multiple calls for multiple reasons across multiple sectors, so it's a bottleneck of a different nature. (GCC service provider)

Lack of staff capacity to respond to the number of calls being received in an attentive and timely manner was noted to have negative impacts on staff workload and well-being for both 211 and 911. Frontline staff at 211 reflected on how not having a dedicated team and instead having to manage multiple lines from across the province, in addition to navigating dispatch responsibilities, is especially challenging:

> As a call taker, we have to manage people in crisis or concerned third parties and their expectations. … Far too often it does feel like there's just too much going on outside my role as call taker with the TCCS to be properly ready both professionally and mentally to handle these types of calls properly…I can't help but feel like it's almost gambling with people's lives…I don't know the solution outside of having some form of TCCS-only type role. (211 service provider)

As previously discussed, particularly in the context of organizational-wide pressure predating implementation of TCCS, increased perceptions of stress were experienced among staff at 911, with leadership noting that their organization:

> was tasked with education and procedure changes that increased workload on staff without further funding or staffing to support this worthy program. It had a negative effect on the mental health of staff trying to juggle further responsibilities and duties without increasing staffing to meet those demands. (911 service provider)

Frontline staff agreed, with one 911 call operator explaining that with already overwhelming demand on the 911 lines, TCCS calls "just increase undue stress, watching the 911 queue board go up while waiting for the TCCS to answer" (911 service provider). Despite the individual experiences captured in the current evaluation, TCCS calls continue to represent a very small proportion of total calls received by 911. The overall magnitude of TCCS' impact on 911 operations may warrant further investigation.

Overall, qualitative data taken together with administrative data showing consistently increasing call volumes through 211 over the course of this pilot period indicate 211 staffing increases are warranted.

Expanding TCCS to be City-wide would increase equitable access to the service

Expansion of the boundaries to be city-wide would present several opportunities to improve operational efficiency and overall accessibility of the service.

As one TPS service provider suggested, expanding the TCCS boundaries could "reduce call times as they [call operators] would not have to determine if the caller is within the pilot area" (911 service provider), which data suggest is burdensome for staff despite extensive change management activities documented in the latter six months of the pilot period. Boundary expansion also introduces the possibility of implementing an implied consent process, which could even more significantly reduce call times and staff burden:

> I'm very excited about it going city-wide and that's the goal…that can't happen soon enough … In our end state, if our communications operators can pick up and say, "police, fire, ambulance or mental health," — and by that we can skip the consent — I think that would be a huge game changer for us and that would alleviate several minutes just in that step … We can't [currently ask that] because we don't know where you're calling from. (TPS service provider)

From the perspective of being equitably accessible and available to meet the needs of service users across the City of Toronto when and where needed, boundary expansion also makes sense. As one community anchor partner explained, the current geographic restrictions challenge accessibility:

> We do our best to play within the rules of responding within our catchment while still meeting community needs outside of our catchment. But sometimes, that means not being able to respond to everyone, especially Indigenous folks in other divisions across the City [of Toronto] who don't have access to any of the pilots. And so I just hear time and time again that these [pilots] need to expand. (2-Spirits service provider)

TPS echoed this perspective as well, describing the challenge of adhering to a guiding principle of accessibility and multiple, coordinated access points and doing public awareness campaigns in support of the service: "it's hard to do when it's not everywhere. You can't advertise something and then when the person calls, say 'I'm

sorry, you happen to live in [ineligible division]' so I think everything City-wide is huge" (TPS service provider). City of Toronto staff acknowledged challenges with geographic restriction in this pilot stage: "because it is a pilot and we have these pilot areas, there are challenges around understanding 'When I can actually use the pilot?'…once we hit city-wide expansion, a lot of that gets eliminated" (City staff). The process of implementing implied consent, however, would need to be introduced in close consultation with both TPS' and City of Toronto's Legal Services and Privacy units.

Direct lines to anchor partners are an important low-barrier access point

Data suggest that implementing direct phone lines to anchor partners would be another meaningful way to build upon the guiding principle of having multiple, coordinated access points – that is, access points beyond just 911 and 211. As one anchor agency commented, "In enabling multiple access points, I think that there's work for us to be able to do more in that regard" (GCC service provider). City of Toronto staff agreed, indicating that:

> One thing we've been working on and trying to figure out is recognizing that there could be so many new entry points…it's 100% beneficial to have 211 on board but…there are other ways that people will also try to access the services and how do we think through the linkages to the pre-existing pathways. (City of Toronto staff)

In both surveys and interviews/focus groups, service providers from across organizations spoke to the need to have direct lines to the anchor partners for several reasons. From the call intake perspective, 911 and 211 participants spoke to the likelihood of service users having the option to contact anchor partners directly reducing overall burden and increasing efficiency for 911 and 211. This was particularly the case for repeat callers or individuals (service providers and users alike) requesting follow-up information on the status of dispatches. When prompted for what would improve the service, one participant commented: "A contact phone number and dispatcher for each of the anchor partners [would improve the service]…each organization should have a 24/7 contact for the teams" (911 service provider).

At this point in time, only two of the four agencies – GCC and 2-Spirits – have direct crisis lines. Data collected directly from the anchor partners indicates that GCC receives an average of 5,010 calls to their direct crisis line per month, with approximately 1.0% leading to a TCCS CCT dispatch. Data indicating specifically how many TCCS calls are handled on their direct line is not available at this time, in part due to challenges determining how best to document these instances, as callers may specifically request TCCS if they are aware of it but are more often calling for general crisis support and then being introduced to the option of TCCS services if they are eligible and if the GCC CCT is available. Even with an improved documentation process, the proportion of these calls that have the potential to be eligible for TCCS services is likely to be significantly underestimated simply due to lack of capacity to answer the lines:

> We've seen some increased traffic there but it's hard to measure that because we only have so much capacity to answer calls. It doesn't necessarily change the data in terms of calls handled but it does in terms of the calls coming in, so we'd love to see increased capacity for that access point. (GCC service provider)

A service user participant commented on the capacity available to support GCC's crisis line as well, noting long wait times that can feel impractical during a time of crisis. The participant felt that "they need more people, more phones, more lines…this is one area where they could expand" (TCCS service user).

At 2-Spirits, having an Indigenous-specific line has "expanded another entry for people to get services and it's also culturally specific and respectful and knowledgeable" (City staff). However, their crisis line was only implemented in May 2023 and administrative data was not available at the time of this evaluation. Anecdotally, 2-Spirits leadership reflected at the time of data collection that "we've had some fairly consistent callers calling in…it's only been operational for 18 days thus far so I don't know that that gives a great snapshot, but I think it's just going to continue growing and growing" (2-Spirits service provider). In principle, however, they explained that:

> with something like the [direct] crisis line, it really opens things up for folks to contact us directly and have a direct access point to community members who they know, to an agency who they've already built trust with. I think that is really important. (2-Spirits service provider)

For the two agencies without existing direct lines, data indicate that again, interest in better alignment with the

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guiding principle of multiple, coordinated access points and the willingness to implement a direct line is evident. However, dedicated capacity to support sustainable implementation of these access points is essential:

> We are marketing multiple, coordinated pathways for service users but we also risk confusing the public because we've created a system where people can call 211, they can call 911—which is great and that makes sense—but the next layer of it is that some people want to directly access us, they want to call us directly, and… We would love for people to call us directly, but the reality is, we don't have a position funded for someone to sit there and receive calls all day, especially when the team is busy attending calls all day. (CMHA-TO service provider)

From an administration perspective, however, funding direct access points to all partners may be financially prohibitive and administratively challenging. Further exploration of the financial feasibility and value added would enhance evidence-informed decision-making around implementation of direct lines. It is also worth noting that a national suicide and crisis lifeline, 988, is launching in November 2023 and how that line will impact and integrate with TCCS from an access point perspective is still to be determined.

5b. To what extent and how are harm reduction principles and trauma-informed care demonstrated in the TCCS?

Data indicate that the TCCS has strongly demonstrated the guiding principle around embedding harm reduction and trauma-informed care principles in all aspects of the service. In large part, enactment is driven by having chosen anchor organizations in which these care values are deeply embedded in both organizational identity and practice. City of Toronto staff reflected on their choice of partnerships in relation to this principle as follows:

> The principle around harm reduction and a trauma-informed approach has really been led by the [community anchor] organizations. We have partners that are so deeply enmeshed and embedded in that work and have been leading that work forever, or before any of this came to light, so I think that was a successful partnership and our ability to make that principle come to fruition. (City of Toronto staff)

Of all principles, this was one of the two most highly rated by service providers and service users alike. Over 90% of service providers from across organizations agreed or strongly agreed that the TCCS has successfully demonstrated a service grounded in harm reduction and trauma-informed care approaches, and 94% of service user respondents agreed or strongly agreed that TCCS staff with statements reflecting these principles, such as feeling that "TCCS staff were compassionate when I was feeling stressed or overwhelmed" and that they "were able to share things about my life and needs on my own terms and at my own pace" (95% agreement).

Trauma-informed care results from actively acknowledging the impacts of systems of oppression

Trauma-informed care means the TCCS understands the ways in which existing and past traumas, both individual and systemic, impact individual experiences, choices and outcomes; and actively responds to this understanding by promoting self-determination, respecting individuals' choice and privacy, and providing care that is culturally safe and inclusive. Trauma-informed care, for example, was demonstrated in practice by providing accessible information and education to staff and clients about the impacts of trauma and the role trauma plays in how care should be delivered and how it might be received and responded to. As a crisis worker from TAIBU described:

> The trauma-informed approach is really, really important to help people reframe. We give them the information, because often they don't know how the brain works and how trauma works in the body, so it's an educational piece. It's a constant reframing and seeing the same thing in different ways so they actually understand and make the connections in the body of what we're saying. (TAIBU service provider)

Another organization echoed the importance of this type of education for those who deliver care as well:

> We have a lot of internalized trainings around trauma, it's a two-part mandatory training that staff have to take when they're onboarded. The first part is understanding the basics of trauma and trauma symptoms, what that can look like and how that shows up for people. The second part is around us staff…how do we manage our own traumas… Our approach is always with understanding. (CMHA-TO service provider)

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Understanding and actively acknowledging prior experiences within the system that have caused trauma is another way in which the TCCS works to provide trauma-informed care. Among service providers, 96% of survey respondents agreed with the statement that "TCCS staff recognize that some people or groups endure more discrimination, violence, abuse and other hardships than others do." As 2-Spirits indicated:

> It was really just ensuring that our approach isn't expanding on the trauma that community members have felt in the systems that they tried to navigate before, whether that be policing or healthcare or judicial systems, housing, all these systems that cause a lot of trouble to our communities. (2-Spirits service provider)

In working with service users in crisis, crisis workers described spending time in conversation with individuals regarding their prior experiences and its impact on service users' willingness to engage. The goal, for TCCS staff, is often to balance, recognize and validate previous trauma while explaining that the TCCS is aiming to do things differently. As a TAIBU crisis worker reflected:

> I've had a lot of conversations with individuals to try and find a common ground…it's acknowledging the fact that individuals who have maybe been involved in the system are more hesitant to engage because there is an association with emergency service and a lack of ability to make their own decisions or to have their rights taken away. (TAIBU service provider)

Harm reduction is achieved through evidence-based practices and partnership

In terms of harm reduction, this was defined as the TCCS meeting individuals where they are at, providing care that is non-judgmental and centred on understanding and supporting their individual needs, strengths and preferences. This requires a flexible and holistic approach to care that aims to minimize harm through use of skillful, informed and culturally safe staff- and peer-led intervention. Service providers also highlighted the variety of ways in which harm reduction has been demonstrated, primarily in clinical practice but also in a broader sense, by being anti-racist and anti-oppressive, for example, and by working toward reducing exposure to police:

> This pilot is very solidly embedded in our work to move toward becoming an antiracist and anti-oppressive organization, and so by providing this service, our hope is that we will reduce over-policing of Indigenous and other people who are racialized and thereby reduce harm that's associated with over-policing… I see that as included in harm reduction. (CMHA-TO service provider)

In clinical practice, harm reduction is demonstrated in several ways. First, from a staffing perspective, TCCS teams were described as deliberately including harm reduction workers and addiction counsellors. At 2-Spirits, for example, there are "five specific harm reduction workers who have lived or living experience with substance use and in harm reduction, who know how to work with folks and apply harm reduction approaches, specifically Indigenous harm reduction approaches" (2-Spirits service provider). In terms of equipment and care practices, frontline staff from multiple anchor partners described having harm reduction and safe sex kits in vehicles, and Naloxone and Naloxone-trained staff available on every call they attend. Teams also have the ability to provide education that meets service users' preferences:

> If they're choosing to use substances, then we engage in conversations about the safest type of use and how to reduce potential harms related to them, but it's not our place to judge or say "don't," it's our place to reduce that. (CMHA-TO service provider)

For follow-up supports, TCCS service providers also described having partnerships and pathways with addiction supports like rapid access addiction medicine services and addiction counselling. Although, as described earlier in this report (Evaluation Question 4d), system-level gaps in substance use services remain a barrier faced by TCCS service providers alongside others in the system. Lastly, sites described having policies and procedures in place to review cases and protocols for contacting institutions and agencies that are associated with harm in some communities, such as Children's Aid Society (CAS). For example, when a service user crisis involves children and the team is unsure of whether or not to inform police or CAS, protocol directs frontline staff to call the on-call manager to review the situation prior to making any decisions that could potentially result in harm as a result.

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5c. To what extent do stakeholders believe the TCCS is consent-based, trustworthy and safe?

This sub-question relates to two TCCS guiding principles: ensuring a transparent and consent-based service, and establishing clear pathways for complaints, issues and data transparency. Key concepts evaluated include trust, safety and participation, choice and rights. Trust within the TCCS is characterized by the assurance of transparency and accountability throughout the care process, with rapport developing over time as the TCCS follows through on the commitment made to its service users to be accessible, to reduce harm, to be trauma-informed, to be person-centred, to be safe and culturally safe, and to prioritize their participation and right to choose. Safety within the TCCS means ensuring security, both physically through processes such as environmental and individual risk assessments and harm reduction-based risk interventions; and emotionally, by creating a calm, non-judgmental and respectful space in which service users can comfortably express their needs and preferences. Finally, participation, choice and rights within the context of the TCCS refers to the consent-based nature of the program and the processes required to support informed consent, which include the provision of transparent and accessible information on the range of service opportunities and outcomes, and service user-led collaborative decision-making.

Survey data from both service providers and service users similarly indicate an overall high level of agreement on statements reflecting demonstration of this guiding principle. Service providers agreed or strongly agreed with seven of the 10 related statements at rates over 90%. For example, 96% of service providers agreed or strongly agreed that the TCCS is supportive of service users in deciding the types of supports and 98% agreed or strongly agreed that the TCCS promotes emotional safety while service users are receiving support. Service users' perceptions were similarly very positive, with 95% agreeing or strongly agreeing they decided what types of supports they wanted; and 95% agreeing or strongly agreeing they felt emotionally safe. Among service providers, lowest ranking of the 10 statements, still at 86% agreement, related to physical safety (“the TCCS promotes physical safety while service users are receiving support”) and knowing who to ask if service users have questions about their personal information (“the TCCS ensures that service users know who to ask if they had questions about their personal information”). Service users responded relatively more favourably to the former, with 100% agreeing they felt physically safe while receiving support and similarly to the latter, with 89% agreeing they knew who to ask if they had questions about their personal information.

Self-determination and consent is embedded in organizational identity and practice

Qualitatively, service providers spoke to a variety of ways in which they aim to demonstrate these guiding principles. With regard to ensuring a consent-based service, anchor partners reflected on their histories of supporting self-determination and respecting decisions to engage or not as part of their organizational identities. As 211 noted, “we embody the client-centred approach, it’s a consent-based service…we always ensure that whoever’s getting the support is getting the support they actually want to be receiving” (211 service provider). GCC echoed that their organization has “a long history of putting people with lived experiences’ voice at the centre of everything we do and upholding those voices as voices that have strength and capacity, and taking a rights-based approach to mental health wherever we can” (GCC service provider). This includes communicating this perspective and role to third-party service users, as 2-Spirits described:

> We have gotten called to a number of shelters within the City asking for us to help remove people from the shelters. We've made it very clear to those systems that that's not our role. Our role is to meet with this individual, talk to them, de-escalate them if they are escalated, bring them to safe spaces if they need that, but not to force a relationship where they don't want one. (2-Spirits service provider)

TCCS teams described being deliberate in obtaining consent when they arrive on scene and throughout the care process. For example, CMHA-TO described “always asking people for consent as we arrive on scene, even if it’s explicitly stated in the dispatch” (CMHA-TO service provider) and explaining “that they need consent every step of the way, whether it’s for a referral to another organization or if our team assesses that the person needs to go to the hospital” (CMHA-TO service provider). TAIBU indicated that in addition to having service users sign consent forms when they first receive support on scene, when providing follow-up care:

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> We have the rule of "you do three attempts at follow-up and then you respect the fact that the person is not engaging and try to move forward…" It is that understanding that even if someone in crisis says they'd like a follow-up, if afterwards they don't respond, that is enough… We have to respect that because it is a consent-based service. (TAIBU service provider)

Service users' qualitative feedback was supportive of service providers' assertions, with one service user noting that the crisis staff "didn't do anything I didn't want them to do" (TCCS service user). A support person also reflected that they "trusted that I could speak openly and honestly about the situation at hand without that information being used against [my] loved one" (TCCS support person).

Managing expectations and creating accessible avenues to provide feedback supports transparency and trust

Service providers also described working to gain trust of service users by engaging in transparency, particularly in terms of acknowledging service limitations and managing expectations; and in being accessible to receive and respond to feedback. For example, CMHA-TO explained the importance of "being transparent, letting them know that obviously there are wait times…they are aware, there's that transparency, we're keeping things realistic and at the same time, we're connecting them to what we can immediately" (CMHA-TO service provider). Teams reflected on service users' appreciation of such transparency, with 2-Spirits, for example, describing having "had individuals complain about certain aspects of the process" but at the same time, "we've also heard that our process in addressing those complaints is really direct, really honest with people. We let folks know what we can and can't do" (2-Spirits service provider). Specifically enabling service users' access to leadership has been a particularly important aspect of promoting trust and transparency. As GCC reflected:

> We have very direct avenues for people if someone wants to talk to [Director] or [Executive Director]…we're accessible and we have those conversations and we call people back and speak to family members and spend time with them… Sometimes there's no great opportunity and it's just about having that opportunity to feel heard…and there's something about talking to who's in charge sometimes that can just feel like it has a different feeling to it. (GCC service provider)

Toronto Community Crisis Service staff: Gerstein Crisis Centre

Photo courtesy of the City of Toronto

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5d. To what extent is the TCCS person-centred and culturally safe?

Alongside demonstrating crisis care centred in trauma-informed and harm reduction principles, the guiding principle of grounding the TCCS in the needs of the service user and providing culturally relevant and culturally safe care emerged as the most evident. Across all survey questions related to this principle, over 90% of both service providers and service users indicated they agreed or strongly agreed. For example, 95% of service users agreed or strongly agreed that "TCCS staff acknowledged my unique identity, personal strengths and life experiences;" and 93% of service providers agreed or strongly agreed that "the TCCS provides service users with options for supports that are relevant to their culture and identity."

Responding to individuals' unique and changing needs reflects person-centredness

Person-centred care means the TCCS prioritizes autonomy and individuals' right to self-determine and self-direct care and care planning based on their perceived needs and preferences. The TCCS aims to support and advocate for person-centred care by ensuring individuals are offered accessible, comprehensive information about and a diverse array of, holistic and culturally safe service options and outcomes. Data suggest that the TCCS demonstrated person-centredness first by ensuring a holistic approach to care and needs that considered all wellness domains, including social determinants of health, was taken. As one service user summarized, "they helped me in many, many, many areas" (TCCS service user). Service providers described "definitely looking at the whole thing as a picture with intersectionality, social determinants of health…all these things" (CMHA-TO service provider); and aiming to:

> try and see the whole person, not just the diagnosis or the symptom. We understand that, but we also understand the social determinants of health that include poverty and food and oppression and trauma and racism and colonialism, and try to meet the person where they're at in the context in which they're living. (GCC service provider)

A second component of being person-centred and responsive to individual needs is recognizing the importance of providing care that adapts to individuals' changing needs and contexts. GCC reflected on the importance of ensuring that "whatever crisis plan is developed is fluid and flexible and continues to be shaped and reshaped as their needs and ideas change" (GCC service provider); and 2-Spirits described how, for their organization, what:

> was really important was flexible approaches to care. So ensuring that it isn't a one-size-fits-all model for us, that everyone who calls in doesn't get the same response, everyone who calls in doesn't get the same services… because that's just not how it works. Everyone gets the same level of care and approach to care, but not necessarily the exact same cookie cutter response. It's dependent on what that person needs. (2-Spirits service provider)

Third, being person-centred means actively considering an individual's cultural identity in the provision of care and incorporating relevant suggestions and approaches. As TAIBU explained, "we try to make sure that the things we provide are culturally relevant. We don't make general referrals, we do try to send people to things that would speak to their culture specifically" (TAIBU service provider). For TAIBU noted particularly helpful referrals such as referring Tamil service users to Tamil resources, such as Tamil physicians and referring Black service users to Scarborough Food Box, a faith-based food box program that provides foods from Africa and the Caribbean so the food service users receive is familiar to them and more easily used. A service user reflected on the meaningfulness of having received such supports: "I didn't know that you guys [TAIBU] have Black physicians…I never knew that, that's awesome…it gives people options. I love it. It's like, 'Hey, you guys, we have something for Tamil, or for Chinese…we have something too.' I love it" (TCCS service user).

Cultural safety is enabled by staff identities, skills and organizational culture

Cultural safety within the TCCS refers to the assurance of anti-racist and anti-oppressive competencies and practices and to the cultural humility required to understand, respect, advocate and adopt a variety of adaptive practices in order to prioritize representation and inclusivity in care. Data suggest that the TCCS has demonstrated provision of culturally safe and appropriate services through two primary mechanisms.

First, the TCCS has ensured that hiring practices and staffing compositions include a diversity of cultures, skills and lived experiences so that relatable and informed

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staff are accessible to diverse service users. Site profiles (**Appendix A**) outline the variety of positions each community anchor partner has on staff. Qualitatively, all TCCS partners described having been deliberate in forming diverse teams. For example, GCC reported that their board is made up of at least 30% with lived or living experience of mental health and substance use challenges; that 65% of staff self-identify as having lived experience of mental health and substance use challenges or trauma, including 50% of the leadership team; and over 60% of staff who identify as Black, Indigenous or racialized. For 2-Spirits, in serving the Indigenous community in particular, they:

> wanted to ensure that our pilot and our approach was really culturally grounded…we've done that just in the fact of who we've hired, it started with that…29 out of our 36 team members are Indigenous and those who aren't identify as being part of the 2S+ [2-Spirited] community. (2-Spirits service provider)

CMHA-TO leaders also described being "very intentional with recruitment and explicit about the purpose of the program" (CMHA-TO service provider), which, as discussed earlier in the report, contributes to overall experiences of cultural safety within the community:

> Our team is quite diverse, we have a lot of identities — faiths, languages, cultural identities, queer identities — Each of them has been tasked with looking at their own identities and social positions and how to effectively provide education to each other, to engage the team and the crisis work using that cultural approach…bringing that cultural awareness to increase safety, because once you're aware, you're more likely to perform in a safer way when you're interacting with people that identify that way. (CMHA-TO service provider)

Leadership from TAIBU similarly explained how having culturally reflective staff has positive impacts on service users:

> When we have staff that is reflective of the community that we're serving, there is a certain level of comfort that comes immediately. When people speak a different language or in a different dialect…when they see somebody that looks like them, they feel comfortable to speak in that way, knowing they will be understood. Whether it's culture, religion – they know there's no judgment because we're coming from the same background. (TAIBU service provider)

Again, service users reflected back the importance of this approach from their perspective, with one individual who received services from TAIBU having noted that with the crisis team and "them being Caribbean, I don't have to explain myself too much because they understood because of the culture" (TCCS service user); and another individual who received services from 2-Spirits noting that "there were Indigenous women on the team who understand the impacts of colonial violence and the harms of child welfare" (TCCS service user).

The second mechanism by which the TCCS is demonstrating cultural safety is related to the previously mentioned decision to partner with organizations in which these principles, including cultural safety, are embedded in overall organizational culture and training. As with trauma-informed care, harm reduction approaches and person-centredness, culturally grounded approaches are entrenched in TCCS partners' identities and strategic directions. As 2-Spirits reflected, "[the Indigenous approach] is just kind of ingrained in the fabric of how we, as a community, understand community care and collective care and how we take care of one another and how we operate" (2-Spirits service provider).

For 211, "if you look at the history of 211 and why it was even developed, it was with priority populations in mind, that's always been the focus" (211 service provider). However, they also noted the importance of ongoing work in this space, and that they:

> are on a learning journey…we're working really hard as an organization right now to decolonize…in building a very strong EDI [equity, diversity, and inclusion] and reconciliation framework for the organization…but it's a lifelong commitment and it's something that we need to build into the DNA of the organization and into the heart and soul of everything that we do… This has to be integral to who we are. (211 service provider)

Partners also described deliberate training efforts to enhance their capacity to provide culturally safe and appropriate care. For example, at GCC, "everybody has gone through training and had a variety of different culturally responsive and culturally safe trainings and anti-oppression trainings" (GCC service provider). At CMHA-TO, they described making cultural safety training mandatory for all TCCS staff and putting accountability mechanisms in place, such as deadlines to complete training and attendance at group discussions to review materials. Lastly, TAIBU reported that:

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> Training is ongoing, it never stops. Recently, we did an Indigenous wellness training program…there was training on how to work with families that are dealing with children with autism, caregivers that have children with autism, just various things around the communities and the issues they may be dealing with. We try to make sure our staff is very well versed on the various things they may come up against, whether it's cultural or developmental or mental health training. It's really, really important for us. A lot of training around things from an anti-Black racism perspective. Mental health is really important; we have Mental Health First Aid but then we wanted it tweaked specifically for the Black community, specifically for the Indigenous community, because it looks different for each population. So we're trying to seek specialized training to make sure it's relevant to the work we're doing, and that's ongoing." (TAIBU service provider)

Altogether, data indicate the TCCS has demonstrated proficiency in ability to deliver crisis care throughout the service pathway in a person-centred and culturally safe manner.

Toronto Community Crisis Service staff: Canadian Mental Health Association Toronto

Photo courtesy of the City of Toronto

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Challenges, limitations & lessons learned

Several limitations in overall data quality and challenges experienced during the evaluation process are important to reflect upon.

Regarding administrative data quality collected by the City of Toronto, which includes data reflecting call intake and dispatch records from 211 and TPS, overall completeness and quality of the 13-month dataset is very good. Five percent of total call records (5%; n=340 records)[22] submitted to evaluators were incomplete and could not be included in the current analysis. An additional 212 records[18] (3% of total calls) were missing both a pilot region and call category but still included in the analysis; many (40%) were resolved through I&R. Evaluators used two key proxy variables to enhance completeness of the dataset: 1) where dispatch type was missing, the TPS Event Type was used as a proxy; and 2) where the CCT was missing, either the TPS Division or postal code FSA was proxy. Overall, an incomplete record rate of 5% is a notable reduction from the 17% incomplete record rate reported in the six-month evaluation report and reflects the extensive and successful efforts put forth by the City of Toronto, 211 and TPS to engage in collaborative quality improvement in data management. An example of these efforts, which followed from recommendations presented to the City of Toronto in the six-month evaluation and also align strongly with the Toronto Auditor General's recommendations to TPS, includes the City of Toronto's undertaking of a separate Data Process Evaluation that was completed by PSSP in June 2023 and aimed to refine documentation, data-sharing, and reporting processes between the City of Toronto, 211 and TPS. Recommendations from this evaluation are currently being implemented, including automation of certain reporting processes within 211 and TPS data systems, refinements to data-sharing practices between organizations, and shifting of responsibilities around reporting, data quality monitoring and reconciliation. Still, there remain ongoing opportunities for quality improvement within the City of Toronto's dataset to reduce the rate of incomplete data and to improve the effectiveness and efficiency of data review and reconciliation processes with 211 and TPS. For this evaluation, the City of Toronto's data was used as the primary data source. However, from a system integration perspective of system, ongoing collaborative efforts to align TCCS and TPS documentation and reporting processes, including singular definitions for key TCCS indicators of success like diversion rate, would further improve ability to evaluate and draw robust conclusions on the system-level effectiveness and impact of the TCCS.

Within the City of Toronto's administrative data, there are also opportunities to improve its meaningfulness and utility. For example, as discussed when reflecting on CCT follow-ups and referrals on in ***Evaluation Question 3***, there is some misuse of the category "N/A" throughout the dataset and some indicators were not reported in this analysis due to high proportions of this category that cannot be meaningfully interpreted. For example, in 13% of total calls, the type of caller was identified as "N/A," which is likely better coded as and combined with the existing "Unknown" category as all callers are some type of caller. Further, a field exists to collect the "call setting," which was not reported here due to poor completeness, with 19% of calls "N/A" (again, it is more appropriate to have these coded as "Unknown," as all calls have a setting) and 55% of calls were "Other." More meaningful analysis could be supported by updating these categories to better reflect calls currently being categorized as "N/A" or "Other," which likely include settings such as "private residence" and "street/public area." Call setting in particular is an important data element that bears relevance to existing operational challenges like the high proportion of calls in which CCTs were unable to locate the client and their subsequent success in being able to provide services. It is also difficult to assess differences in performance between dispatch teams if it is unknown whether one team responds to more calls at private residences compared to the street/public areas. Elaboration of call categories and subsequent completeness may be a worthwhile quality improvement process that could support overall data quality in future monitoring and evaluation efforts.

Regarding administrative data collected from anchor partners, which reflects services provided by CCTs on scene and in follow-up care, the most significant limitation is related to this intervention having been in a pilot stage and the evaluation correspondingly having taken a developmental approach. With ongoing quality improvement-related changes to data collection templates and processes throughout the one-year period, including significant revisions made in response to the results of the six-month implementation evaluation, consensus

[22] Incomplete records are currently under review; this rate will be updated in September 2023.

Challenges, limitations & lessons learned

was not reached on a revised data collection template until April 2023. As administrative data collection for this evaluation occurred retrospectively, many of the revised fields in the template were for data that had not been purposefully collected earlier in time. The revised templates certainly position anchor partners well to be able to collect a meaningful, comprehensive and consistent dataset going forward in Year 2. However, this developmental process made reconciliation and aggregation of the data from anchor partners over the time period challenging as many fields were either unavailable for the full period, or data from the first half of the period was unable to be merged with the last half due to revisions resulting in data incompatibility. Accordingly, evaluators' ability to draw meaningful conclusions regarding trends over time was limited. In addition, there continue to be organizational-level differences in how each anchor partner interprets, documents and reports indicators, which make meaningful comparisons between sites difficult. Continued refinements to documentation processes and collaborative quality improvement efforts to reconcile data across sites may help to further improve the quality of administrative data on the direct crisis services and follow-up support provided by TCCS. A Data Process Evaluation similar to the one undertaken by the City of Toronto, 211 and TPS may be helpful to pursue with anchor partners to further standardize data collection and reporting processes, improve overall data quality and to determine key performance indicators for ongoing monitoring and reporting.

It was noted in the six-month evaluation report that sociodemographic data was challenging to collect and resulting data quality was very poor. In the current report, improvements in the overall availability and quality of sociodemographic data are present; and efforts were made to present the data in a more meaningful way (i.e., by basing the analysis on the number of times data was reported by service users). Still, sociodemographic data remains very challenging to collect from service users. Under the City of Toronto's Data for Equity Strategy and TCCS principles, sociodemographic data collection must be voluntary and non-burdensome. With service users who are in crisis, sociodemographic data collection cannot occur at the initial point of contact with TCCS. Instead, this data is collected during follow-up with a fraction of overall service users and with the primary goal of informing service planning. However, some service users may still be in crisis at the time of follow-up and data collection may not be clinically appropriate. Even when it is appropriate, reporting remains voluntary and based on service users' discretion and comfort level, both in the context of administrative data collection and during other data collection processes such as survey completion and participation in interviews; not all service users are comfortable disclosing this information, and this is particularly true of equity-deserving populations. As a result, at points throughout this report, readers should note that counts are small and reported proportions should therefore be interpreted cautiously.

In terms of engaging participants in primary data collection, several challenges and limitations are noted, which may be useful in informing future evaluation opportunities. It was noted earlier in the report that representation within and across all stakeholders was not equal. Primary data was collected cross-sectionally within a short time period in order to meet required reporting deadlines, which challenged evaluators' ability to reach desired sample sizes within and across all participant groups. For example, Indigenous service users are underrepresented relative to other service users in the current evaluation, in part because a culturally appropriate, arts-based data collection activity was not feasible within the short timeframe. While both qualitative and quantitative data was successfully collected from service users through interviews and surveys to address a limitation of the six-month evaluation report and efforts were made to centre service users' voices in reporting, the overall service user sample size in the current report is relatively small and underrepresented when compared to the sample of service providers. People in crisis are a challenging population to engage for a variety of reasons, including clinical appropriateness, willingness, capacity and availability. In the current evaluation, service users were primarily recruited through anchor partners, who collected consent to be contacted by the evaluation team from eligible individuals. However, it was often the case that upon reaching out to service users who had consented to be contacted by our team, they were either unable to be reached or no longer willing to participate.

Among service providers, representation was also unequal, with some service provider roles and organizations better represented than others due to reasons such as individual- and organizational-level responsiveness, availability and capacity to engage, and preferences in methods of engagement. For example,

Challenges, limitations & lessons learned

some service providers preferred to participate in anonymous surveys rather than interviews or focus groups, which yields important quantitative data at the expense of the opportunity to generate more detailed and nuanced qualitative reflections on experiences and outcomes. However, since a principle of the TCCS evaluation is that data collection not be burdensome to staff, there exists a need to balance desired sample sizes and expectations of representativeness with feasibility and responsiveness to individuals' needs and preferences.

In future evaluations, a significantly longer data collection period or rolling data collection strategy would be an important first step to maximizing recruitment success. An extended time period would also support inclusion of both a) a variety of recruitment methods, such as public advertisements in addition to recruitment through anchor partners, and b) a variety of data collection methods beyond surveys and interviews (e.g., focus groups, Sharing Circles, or arts-based methodologies like photovoice, art-journaling or ripple effects mapping). This would also enhance successful recruitment and meaningful engagement of both service users and service providers.

Toronto Community Crisis Service staff: TAIBU Community Health Centre

Photo courtesy of the City of Toronto

Recommendations

The data and analyses presented in this report lead to a series of recommendations to support ongoing successful operation and growth of the TCCS. Recommendations fall into several categories: operations and processes to support service quality, sustainability and scaling; staffing capacity and staff supports; infrastructure; community awareness, engagement and service integration; community safety and well-being; and monitoring and evaluation. Each recommendation is accompanied by rationale and identifies who should be responsible for acting on the recommendation. Recommendations are detailed below and summarized in **Table 19**.

Operations and processes to support service quality, sustainability and scaling

1. **Expand geographical eligibility to be City-wide to support equity, accessibility and overall program efficiency.**

Preliminary evaluation findings in Year 1 support expansion of the service city-wide to support equitable access for all potential service users; to reduce staff burden associated with time, training and change management challenges related to needing to determine case-by-case geographic eligibility, thereby improving overall organizational-level efficiency; to build public awareness, engagement, and trust in the TCCS as a reliable and accessible crisis service; and to increase opportunity to contribute further to establishing a sense of community safety and well-being across the City of Toronto.

Responsibility: City of Toronto

2. **Consider implementing implied consent at 911 intake source only if/when geographic eligibility is city-wide.**

Offering 911 callers a fourth emergency service option (i.e., "Police, Fire, Ambulance or Mental Health") and accepting implied consent to be transferred to TCCS by callers indicating they require a mental health response is likely to both improve service user experience by reducing call time; and significantly improve organizational efficiency and alleviate burden on 911 staff by reducing workload, talk time and perceived liability concerns. Should this process be implemented, service users who indicate "mental health" would still be screened for TCCS eligibility; eligible calls would then be automatically transferred to 211 without 911 call operators having to explain the service and obtain consent to make the transfer and share information. Implementing this process will also reinforce existing messaging positioning the TCCS as Toronto's fourth emergency service and support broader culture change and buy-in across TPS and the public at large.

Responsibility: TPS in collaboration with City of Toronto

3. **Continue to regularly review and audit 911 calls in order to further expand and refine TCCS eligibility criteria.**

Ongoing monitoring and analysis of TPS event types for calls received by 911 that were and were not transferred to the TCCS, alongside their corresponding outcomes, will increase understanding of and confidence in criteria of suitable calls for diversion and will inform quality improvement and long-term service planning as the TCCS expands.

Data prepared by TPS for their Board in April 2023 and for the purposes of this evaluation report indicate that notable potential to divert significantly more calls to TCCS exists. Specifically, police responded to 11,517 "person in crisis" and "threatening suicide" events within catchment during the year-long pilot period. 7,416 (64%) of these events did not require police to apprehend the subject of the call. If there was no apparent need for police to apprehend this entails that the person in crisis may not have been a threat or immediate risk to themselves or others, and therefore, it is likely a CCT could have handled the call and provided more appropriate services. These data supports the expansion of current diversion criteria to include refined definitions of violence and emergency thresholds that better capture events currently not being diverted. If these refinements are to be implemented, ongoing monitoring is essential to determining their success.

While it is unlikely that all 7,416 aforementioned events could have been diverted to the TCCS at the point of the initial call to emergency services, it should be noted that in total the TCCS received 6,827 calls over the year-long period. Receiving even a fraction of these non-diverted events would have represented a significant increase in overall call volume. Moreover, this comparative analysis only includes "person in crisis" and "threatening suicide" calls, and does not factor in other sources of untapped potential such as wellness checks, disputes, or distress/disorderly behaviour that are also currently eligible for TCCS diversion. Therefore, ongoing monitoring is also required to ensure that the refinement of diversion

protocols and the impacts on call volumes are well understood and can subsequently be planned for and accommodated by CCT response capacity.

Lastly, no single event/dispatch type represents the majority of calls diverted to the TCCS. If diversion protocols are to be amended or refined (for example, by seeking to increase the number of wellness checks deemed eligible for diversion), then the event/dispatch type must be continually monitored. However, moving toward a unified "TCCS event" category may be a desired future state to increase buy-in, normalization and efficiency at TPS. Given TCCS data indicates "person in crisis" calls are most common and TPS data suggests significant potential for diversion within this category, a possible change management exercise to explore the potential feasibility and utility of implementing "TCCS events" may be to use "person in crisis" calls as a test case whereby all incoming eligible calls in this particular category are relabeled as "TCCS event."

A separate review by PricewaterhouseCoopers is currently underway to project potential demand in a variety of policy-change circumstances; results of this review will be important in accurately anticipating volumes and determining the particular capacity increases that might be required in the future should changes around eligibility criteria and dispatch processes such as those suggested here be pursued.

Responsibility: City of Toronto in collaboration with TPS

4. **Establish clear response processes for non-standard crisis support calls including a) callers requesting status updates; and b) repeat callers requesting follow-up support that does not meet crisis criteria.**

To improve consistency and efficiency within the call pathway, 211 staff require clear instruction on consent limitations and protocols around how to communicate and manage expectations of callers requesting updates on wait times or the status of mobile dispatches and call outcomes by service providers, including TPS, third-party callers and service users. Each stakeholder group will require its own messaging and communication mechanism. Follow-up communication with TPS and other first responders during call attendance and hand-off, and on the outcome of calls, will help to support building TPS' trust in TCCS processes and outcomes. Particularly to manage expectations and support transparency and trust among service users, a mechanism to communicate wait times to service users should be continued, such as a direct phone or text line to anchor agencies or the CCTs themselves that 211 staff can communicate to service users upon dispatch. Receiving a call-back from an anchor agency or CCT staff, for example, could not only provide a mechanism for communicating wait times but could also introduce an opportunity to provide direct and more immediate crisis intervention and responses over the phone, thereby reducing wait time.

Clear protocols are also required for how to respond to repeat callers misrepresenting their crisis state in order to receive additional or faster follow-up support, creating inefficient and ineffective use of crisis response services. Monitoring to ensure service users receive follow-up within the intended 48-hour timeframe may be helpful. In addition, ensuring all service users who receive initial crisis support receive contact information to follow-up directly with anchor agencies rather than 211 staff may help to alleviate this reported challenge. A direct line or call-back mechanism may work well in this situation too as it would enable anchor agencies to provide intervention, support and referrals by phone without resulting in a CCT dispatch, as would occur when 211 is called. However, in both cases, ensuring anchor agencies are appropriately resourced and have capacity to receive additional incoming calls would be essential as current staffing levels do not account for the required level of responsiveness this process change would entail (see related Recommendation 7).

Responsibility: City of Toronto in collaboration with 211

5. **Continue inter-partner engagement to build trust, relationships and capacities.**

Ongoing engagement activities between TCCS partners that create opportunities to share experiences, perspectives and lessons learned has contributed significantly to relationship-building and capacity-building throughout the program. Site tours and job shadowing, regular opportunities to come together as a group to reflect on experiences, and regular communication regarding the outcomes of TCCS dispatches to 211 are recommended as effective ways of building trust and improving working relationships across the TCCS.

Responsibility: City of Toronto in collaboration with all TCCS partners

Recommendations

6. **Continue engagement with and education of TPS to promote a holistic understanding of crisis response and build awareness of each responder's roles and responsibilities.**

While progress has been made, gaps in a clear and consistent understanding of the new ecosystem of crisis response and how all emergency services involved can work together persist. Ongoing education for traditional emergency services, including police, fire and ambulance, regarding the roles, capabilities and limitations of the TCCS would support understanding and improve efficient and effective collaboration between TPS and the TCCS. While anchor partner attendance at TPS parades has been effective, and collaborative simulation training with TCCS staff and police has also recently been implemented with some success, demand on CCTs' time will become less feasible with program expansion. Should the program expand City-wide, a more feasible mechanism to provide widespread education and maximize exposure throughout the TPS workforce may be to embed a co-designed TCCS curriculum within the Toronto Police College's mandatory three-day In Service Training Program. Given the hierarchical structure and governance of TPS, clear direction from all levels of leadership within TPS would help to distribute and sustain awareness and education throughout the service. Mechanisms to specifically introduce the TCCS to TPS' Mobile Crisis Intervention Teams, Toronto Fire Services and Toronto Paramedic Services workforces should also be considered.

Responsibility: TPS with support from City of Toronto to co-design opportunities and content

Staffing capacity and supports

7. **Increase staffing at each stage of the TCCS service pathway are required to a) respond to increasing direct calls to 211, untapped potential 911 calls suitable for diversion, and proposed boundary expansions and b) to improve staff and service user experience.**

Intake:

a. While calls transferred from 911 to 211 have stabilized over time, completed calls received directly by 211 have increased markedly since the beginning of the pilot, from an average of 89 calls per month in the first six months to an average of 236 calls per month since October 2022. Total call volumes are even higher as this number does not include calls in which the service was interrupted, for which staff and time are still required. With increasing call volumes at 211 and potential boundary expansion, a dedicated 211-TCCS team is recommended to increase capacity to respond to direct calls, alleviate wait times in calls transferred from 911, and alleviate burden on 211 staff associated with having to manage multiple lines alongside TCCS and radio dispatch.

b. Qualitative feedback from participants suggest direct crisis lines at each anchor agency are an important way to support equitable accessibility to the service and specifically to enact the guiding principle of ensuring multiple, coordinated access points, particularly in the face of increasing demand and untapped potential. However, with 2-Spirits' line launching in May 2023, after the data collection period for the current evaluation, administrative data is not yet available to support an evidence-informed decision regarding whether implementation of these lines across sites is warranted. Monitoring of data reflecting call volumes received through direct crisis lines at the two agencies who currently have such access points in place (GCC and 2-Spirits) over a longer time period will better inform demand and financial feasibility of implementing this access point.

Mobile response:

c. Increasing the number of crisis staff at each anchor agency will improve capacity to respond consistently to increasing calls to 211 and untapped potential 911 calls suitable for diversion (see Recommendation 3). Specific efforts to ensure each anchor agency has a sufficient pool of relief staff will additionally support service providers' health and well-being by reducing work burden and enabling scheduling that allows for wellness breaks and work-life balance.

Follow up:

d. Increasing the number of staff dedicated to supporting follow-up service provision (e.g., case managers, access facilitators) will enable anchor agencies to consistently provide follow-up support within 48 hours, thereby improving service user experience; and support staff health and well-being by ensuring manageable caseloads.

Responsibility: City of Toronto

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Recommendations

8. **Ensure robust and equitable health and well-being supports are available to all staff, including part-time and relief staff, across organizations.**

While significant and successful efforts to support staff across partner organizations were reported, inequities exist and opportunities to prevent potential burnout were identified. Recommended supports include equitable access across sites to individualized supports including one-to-one counselling and a mental health support team, culturally appropriate wellness supports such as access to Elders for Indigenous staff, and consistent managerial or leadership support processes across sites such as regular team case reviews and debriefing opportunities.

Responsibility: All TCCS partners

9. **Implement centrally coordinated and administered co-designed opportunities to engage in training on an ongoing or rolling basis.**

While some sites are leveraging existing organizational training, this is financially and administratively challenging for sites to administer. Training should be centrally coordinated by the City of Toronto to ensure clear expectations and a consistent baseline for knowledge and skills across sites. Onboarding training should be scheduled regularly to accommodate new staff associated with program growth and staff turnover, and ensure access for staff working irregular hours due to part-time, overnight and/or weekend shifts. In addition, a rolling maintenance or refresher training curriculum should also be delivered to ensure all TCCS staff are continually supported in ongoing professional development. A maintenance or refresher training curriculum should be responsive to lessons learned about emerging service provider and service user needs over time and consist of broad crisis response and cultural safety skills. Training should also be related to specific culturally appropriate approaches to care and care for specific mental health diagnoses or needs so service users across sites have equitable opportunities to receive culturally safe and clinically appropriate services. All training materials should be preserved (e.g., through recording or documentation) and housed in a centrally accessible location (e.g., an online shared platform) for staff who are unable to attend and/or who would benefit from ongoing access to materials to sustain learning.

Responsibility: City of Toronto with support from all TCCS partners to co-design opportunities and content

10. **Implement a TCCS Community of Practice to support standardization, quality improvement, professional development and relationship-building across sites.**

Related to Recommendation 5, dedicated collective space and ongoing opportunities for TCCS staff across partner organizations to share experiences, challenges, and wise practices from within their unique contexts would create meaningful opportunities for TCCS staff to learn from each other, engage in collective problem-solving, innovate within their own services, build more robust skills and capacities, develop relationships, and identify opportunities for standardization to support consistent and quality care across sites. To support accountability, a reporting or feedback mechanism should be included to share back collective lessons learned and subsequent recommendations to the City of Toronto. Incorporating a mechanism by which to receive and review service user feedback within the Community of Practice would also support quality improvement across the program.

Responsibility: City of Toronto with support from all TCCS partners to co-design opportunities and content

Infrastructure

11. **Continue to monitor and evaluate use of radios.**

211 staff continue to report challenges associated with using radio technology, including that radio chatter while managing phone calls is distracting; and that radios are used inconsistently and unreliably across community anchor partner sites. Disentangling responsibility for responding to phone lines from responding to radio may be helpful; for example, a coordinator might be assigned radio monitoring and response alongside other administrative work aligned with the TCCS so Service Navigators can dedicate their time and attention to managing incoming calls.

Responsibility: City of Toronto in collaboration with 211

12. **Explore the feasibility of procuring and implementing a centralized data system.**

With increasing volumes and boundary expansion likely to result in shared care across TCCS sites, a centrally accessible and integrated data system for TCCS anchor agencies will significantly improve efficiency by reducing

duplication of efforts; reducing burden on frontline crisis staff by alleviating time spent on administration and documentation; and most importantly, improve service quality by allowing crisis teams to access to coordinated and comprehensive service user data that can inform more efficient and effective crisis response and service planning, resulting in improved service user experience of care quality, care continuity and person-centredness.

However, implementation of a centralized system that includes sharing of personal information or personal health information between health information custodians (i.e., the anchor agencies) introduces significant administrative complexities under PHIPA that would need to be explored further to better understand feasibility and implications. Introduction of additional information technology infrastructure that may or may not interface with anchor agencies' existing infrastructure could create additional complexities and challenges in meeting organizational-level monitoring and reporting requirements.

Exploration, procurement and implementation would be a time-consuming process. In the interim, additional considerations to reduce burden on frontline staff include additional funding for further staffing dedicated to administration and documentation; and refinement or reconsideration of what a "minimum dataset" for anchor partners entails for the purposes of program monitoring versus evaluation.

Responsibility: City of Toronto

13. Engage and collaborate with local pay phone providers to ensure calls to 211 from public payphones throughout the City of Toronto are free to callers.

Stakeholders report that calling 211 from public payphones in the City of Toronto to access TCCS services costs callers, whereas calling 911 is free. While 211 is toll-free as required by the Canadian Radio-television and Telecommunications Commission (CRTC), there is no requirement of public payphone providers specifically to provide toll-free access. There are currently nine public payphone providers in Ontario; in the City of Toronto, Bell Media is one of the largest providers. Advocacy to change local pay phone providers' practice in leveraging charges for callers dialling 211 in the City of Toronto is needed to support equitable access to TCCS. This will likely require support from the City of Toronto, in addition to United Way Centraide (the 211 trademark licence holder with CRTC), and others. Particularly if the program expands City-wide, ensuring there is no financial barrier to calling 211 (or incentive to call 911) is an important component of behaviour change management.

Responsibility: City of Toronto in collaboration with 211 and others

Community awareness, engagement and service integration

14. Increase the frequency and scope of public awareness and education campaigns.

Ongoing campaigning using a variety of platforms and methods tailored to stakeholder groups and settings are recommended to consistently build awareness of the TCCS and its intended use in terms of what types of situations are appropriate for the TCCS and when to call 211 versus 911. Examples of recommended awareness-building materials and methods include ongoing social media posts; posters in TTC stations and bus shelters; posters and/or pamphlets on bulletin boards in TCHC buildings; informational pamphlets in health care settings, including hospital waiting rooms, primary care offices, and community health centres; and youth-friendly posters, pamphlets and events at schools and youth agencies. Information should be communicated in a variety of ways using language that is accessible to varying levels of literacy and ability to speak English.

Responsibility: City of Toronto

15. Continue to fund dedicated staffing positions or sufficient staffing levels to allow for dedicated time and capacity for TCCS staff to participate in community outreach.

TCCS staff across organizations report that engaging in outreach is important but time-consuming. Continue to ensure that sufficient capacity exists to engage in such work, either through dedicated positions, such as CMHA-TO's Engagement Coordinator role, or by ensuring frontline staffing levels and scheduling protocols allow for capacity to meaningfully engage in community outreach without compromising frontline service delivery.

Responsibility: City of Toronto in collaboration with anchor partners

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Recommendations

16. Develop a strategic service provider engagement plan to support TCCS staff outreach.

A variety of institutional and community-based service providers with potential to refer to and engage with the TCCS were identified, each of which will require targeted engagement strategies beyond awareness and engagement conducted by the City of Toronto. Engagement appears most effective when it is conducted by frontline staff, for frontline staff, who are more likely to be referral sources and relationship-builders within the community. These include TCCS staff outreach at community-based mental health and addiction services; community-based social service agencies and networks, such as immigration services and the Indigenous Housing, Health and Social Service Network; primary care settings; hospital emergency departments; City of Toronto institutions including TTC and TCHC; and youth settings including youth service agencies and schools. Multiple visits per site are also likely to be required to reinforce messaging and reach different shifts of service providers, sustaining awareness and engagement.

Responsibility: City of Toronto in collaboration with anchor partners

17. Continue dedicated resourcing for community anchor agencies to access post-crisis supports.

To facilitate timely access to follow-up support and support TCCS integration within the broader community of crisis and health service providers, anchor agencies' networks require dedicated resourcing to meaningfully participate in referral pathways. Particularly if the TCCS expands city-wide, more partnerships will be required to facilitate access to post-crisis supports across City of Toronto communities, and resourcing will be required to build their capacity to accept TCCS clients. From the community anchor partner perspective, agencies should continue to engage in purchasing services to secure access for TCCS service users. In particular, purchasing services or resourcing partnerships that could support streamlined access to dedicated crisis, shelter and detox beds, addictions services and primary care for TCCS service users should be prioritized. From the City of Toronto's perspective, their Strengthening the Community Crisis System grant for $1 million, which will require successful organizations to dedicate access to post-crisis supports for TCCS service users, is a notable example of a mechanism by which to meaningfully support service integration. The City of Toronto may also consider advocating to Ontario Health for adequate capacity for and access to community-based mental health, addictions and primary care, particularly given the potential of TCCS to divert service users away from costly hospital-based care.

Responsibility: City of Toronto and anchor partners

Community safety and well-being

18. Advocate to increase funding and address system-level gaps in healthcare and housing.

The TCCS is operating within a broader housing and healthcare crisis that impedes the TCCS' potential to meaningfully impact community safety and well-being. Advocating for system-level increases in access to primary and specialist medical care, and to shelter beds, supportive housing units, and Housing First principles, are essential to enabling the TCCS to meaningfully address crises and support sustained recovery, safety and well-being of communities in the long-term.

Responsibility: City of Toronto

Monitoring and evaluation

19. Continue program monitoring to support ongoing service planning, quality improvement, and accountability; and plan for long-term evaluation to better understand impacts over time.

With staggered pilot start dates and ongoing revision and refinement of data collection measures and processes across anchor agencies throughout implementation and Year 1 of operations, establishment of a consistent and complete 12-month dataset for all sites was not possible. Ongoing monitoring over an additional 12-month period will yield a more reliable dataset to inform service planning from which to draw conclusions on program effectiveness and implications. Ongoing monitoring is also important in supporting ongoing quality improvement and accountability, particularly if the service scales up. In terms of subsequent evaluations, in initial evaluation consultations, stakeholders identified program goals such as impacts on service integration and community safety and well-being, which are long-term outcomes that cannot be meaningfully evaluated at this early stage. Ongoing program monitoring in Year 2 would position the TCCS well for longitudinal Year 3 and Year 5 impact evaluations.

Responsibility: City of Toronto

Recommendations

20. Continue co-design and respond to stakeholder needs in monitoring and evaluation to support engagement, trust and evaluation capacity across TCCS partners.

PSSP and Shkaabe Makwa have employed a developmental and utilization-focused approach to monitoring and evaluation that has contributed significantly to trusting relationships, engagement and increased capacity to participate in data collection and analysis. Continuing to ensure an approach to monitoring and evaluation that is highly contextualized and responsive to emerging stakeholder needs will contribute to the production of meaningful and useful data to drive decision-making. In particular, inclusion of case study methodology may be a valuable opportunity to evaluate and disseminate learnings regarding site-level wise practices and the contexts in which they might become best practices.

Responsibility: City of Toronto in collaboration with CAMH Evaluators

21. Prioritize service user engagement in future evaluations.

Future evaluations should reflect upon lessons learned in this first year regarding how to ensure diverse service user voices are included in evaluation. The populations who are or could potentially be served by the TCCS includes communities who have historically experienced the greatest degrees of marginalization, coercion, and biased practices (e.g., newcomers with or without status, Black, Indigenous and other racialized youth), making them least likely to reach out to and trust in offered supports. Continuing to explore how to effectively and appropriately engage these populations is essential. Opportunities to increase service user engagement include ensuring data collection opportunities are continuousto capture different perspectives along the service pathway and that any designated data collection periods are sufficiently flexible and long enough to engage desired sample sizes. Recruitment should use a variety of methods, including recruitment of service users both directly from anchor agencies and from the general public; promoting engagement and making participation possible in a variety of community-based spaces, such as in the Toronto Public Library or in local community centres, where community members might feel more comfortable exploring and speaking to mental health support. A variety of data collection methods should also be available to service user participants across sites, including the opportunity to participate in cultural and art-based methods such as photovoice, digital storytelling and Sharing Circles. To further support positive service user experiences and capacity to participate in evaluation, consider contracting peers or people with lived/living experience to conduct or support data collection. Lastly, ensure that all interviewers receive training in conducting data collection with people who have experienced crises in a culturally safe manner and that both interviewers and interviewees have opportunities to debrief and/or receive mental health and wellness supports as reflecting upon crisis experiences can be traumatic, (re)triggering, and/or emotionally challenging for everyone involved.

Responsibility: City of Toronto in collaboration with CAMH Evaluators

Toronto Community Crisis Service staff: Canadian Mental Health Association

Photo courtesy of the City of Toronto

Recommendations

Table 19. Year 1 recommendations for the Toronto Community Crisis Service

Operations and processes to support service quality, sustainability and scaling		
Recommendation	***Rationale***	***Responsibility***
1. Expand geographical eligibility to be City-wide to support equity, accessibility and overall program efficiency.	Preliminary evaluation findings in Year 1 support expansion of the service City-wide to: • support equitable access for all potential service users reduce staff burden associated with time, training and change management challenges related to needing to determine case-by-case geographic eligibility, thereby improving overall organizational-level efficiency • build public awareness, engagement, and trust in the TCCS as a reliable and accessible crisis service • increase opportunity to contribute further to establishing a sense of community safety	City of Toronto
2. Consider implementing implied consent at 911 intake source only if/when geographic eligibility is City-wide.	Offering 911 callers a fourth emergency service option (i.e., "Police, Fire, Ambulance or Mental Health") and accepting implied consent to be transferred to TCCS by callers indicating they require a mental health response is likely to both improve service user experience by reducing call time; and significantly improve organizational efficiency and alleviate burden on 911 staff by reducing workload, talk time and perceived liability concerns. Should this process be implemented, service users who indicate "mental health" would still be screened for TCCS eligibility; eligible calls would then be automatically transferred to 211 without 911 call operators having to explain the service and obtain consent to make the transfer and share information. Implementing this process will also reinforce existing messaging positioning the TCCS as Toronto's fourth emergency service and support broader culture change and buy-in across TPS and the public at large.	Toronto Police Service in collaboration with City of Toronto
3. Continue to regularly review and audit 911 calls in order to further expand and refine TCCS eligibility criteria.	Ongoing monitoring and analysis of TPS event types for calls received by 911 that were and were not transferred to the TCCS, alongside their corresponding outcomes, will increase understanding of and confidence in criteria of suitable calls for diversion and will inform quality improvement and long-term service planning as the TCCS expands. Data prepared by TPS for their Board in April 2023 and for the purposes of this evaluation report indicate that notable potential to divert significantly more calls to TCCS exists. Specifically, police responded to 11,517 "person in crisis" and "threatening suicide" events within catchment during the year-long pilot period. 7,416 (64%) of these events did not require police to apprehend the subject of the call. If there was no apparent need for police to apprehend this entails that the person in crisis may not have been a threat or immediate risk to themselves or others, and therefore, it is likely a CCT could have handled the call and provided more appropriate services. This data supports the expansion of current diversion criteria to include refined definitions of violence and emergency thresholds that better capture events currently not being diverted. If these refinements are to be implemented, ongoing monitoring is essential to determining their success. While it is unlikely that all 7,416 aforementioned events could have been diverted to the TCCS at the point of the initial call to emergency services, it should be noted that in total the TCCS received 6,827 calls over the year-long period. Receiving even a fraction of these non-diverted events would have represented a significant increase in overall call volume. Moreover, this comparative analysis only includes "person in crisis" and "threatening suicide" calls, and does not factor in other sources of untapped potential such as wellness checks, disputes, or distress/disorderly behaviour that are also currently eligible for TCCS diversion. Therefore, ongoing monitoring is also required to ensure that the refinement of diversion protocols and the impacts on call volumes are well understood and can subsequently be planned for and accommodated by CCT response capacity. Lastly, no single event/dispatch type represents the majority of calls diverted to the TCCS. If diversion protocols are to be amended or refined (for example, by seeking to increase the number of wellness checks deemed eligible for diversion), then the event/dispatch type must be continually monitored. However, moving toward a unified "TCCS event" category may be a desired future state to increase buy-in, normalization and efficiency at TPS. Given TCCS data indicates "person in crisis" calls are most common and TPS data suggests significant potential for diversion within this category, a possible change management exercise to explore the potential feasibility and utility of implementing "TCCS events" may be to use "person in crisis" calls as a test case whereby all incoming eligible calls in this particular category are relabeled as "TCCS event." A separate review by PricewaterhouseCoopers is currently underway to project potential demand in a variety of policy-change circumstances; results of this review will be important in accurately anticipating volumes and determining the particular capacity increases that might be required in the future should changes around eligibility criteria and dispatch processes such as those suggested here be pursued.	City of Toronto in collaboration with TPS

Recommendations

Table 19. Year 1 recommendations for the Toronto Community Crisis Service

Operations and processes to support service quality, sustainability and scaling		
Recommendation	***Rationale***	***Responsibility***
4. Establish clear response processes for non-standard crisis support calls including a) callers requesting status updates; and b) repeat callers requesting follow-up support that does not meet crisis criteria.	To improve consistency and efficiency within the call pathway, 211 staff require clear instruction on consent limitations and protocols around how to communicate and manage expectations of callers requesting updates on wait times or the status of mobile dispatches and call outcomes by service providers, including TPS; third-party callers; and service users. Each stakeholder group will require its own messaging and communication mechanism. Follow-up communication with TPS and other first responders during call attendance and hand-off, and on the outcome of calls, will help to support building TPS' trust in TCCS processes and outcomes. Particularly to manage expectations and support transparency and trust among service users, a mechanism to communicate wait times to service users should be continued, such as a direct phone or text line to anchor agencies or the CCTs themselves that 211 staff can communicate to service users upon dispatch. Receiving a call-back from an anchor agency or CCT staff, for example, could not only provide a mechanism for communicating wait times but could also introduce an opportunity to provide direct and more immediate crisis intervention and responses over the phone, thereby reducing wait time. Clear protocols are also required for how to respond to repeat callers misrepresenting their crisis state in order to receive additional or faster follow-up support, creating inefficient and ineffective use of crisis response services. Monitoring to ensure service users receive follow-up within the intended 48-hour timeframe may be helpful. In addition, ensuring all service users who receive initial crisis support receive contact information to follow-up directly with anchor agencies rather than 211 staff may help to alleviate this reported challenge. A direct line or call-back mechanism may work well in this situation too as it would enable anchor agencies to provide intervention, support and referrals by phone without resulting in a CCT dispatch, as would occur when 211 is called. However, in both cases, ensuring anchor agencies are appropriately resourced and have capacity to receive additional incoming calls would be essential as current staffing levels do not account for the required level of responsiveness this process change would entail (see related Recommendation 7).	City of Toronto in collaboration with 211
5. Continue inter-partner engagement to build trust, relationships and capacities.	Ongoing engagement activities between TCCS partners that create opportunities to share experiences, perspectives and lessons learned has contributed significantly to relationship-building and capacity-building throughout the program. Site tours and job shadowing, regular opportunities to come together as a group to reflect on experiences, and regular communication regarding the outcomes of TCCS dispatches to 211 are recommended as effective ways of building trust and improving working relationships across the TCCS.	City of Toronto in collaboration with all TCCS partners
6. Continue engagement with and education of TPS to promote a holistic understanding of crisis response and build awareness of each responder's roles and responsibilities.	While progress has been made, gaps in a clear and consistent understanding of the new ecosystem of crisis response and how all emergency services involved can work together persist. Ongoing education for traditional emergency services, including police, fire and ambulance, regarding the roles, capabilities and limitations of the TCCS would support understanding and improve efficient and effective collaboration between TPS and the TCCS. While anchor partner attendance at TPS parades has been effective, and collaborative simulation training with TCCS staff and police has also recently been implemented with some success, demand on CCTs' time will become less feasible with program expansion. Should the program expand City-wide, a more feasible mechanism to provide widespread education and maximize exposure throughout the TPS workforce may be to embed a co-designed TCCS curriculum within the Toronto Police College's mandatory three-day In Service Training Program. Given the hierarchical structure and governance of TPS, clear direction from all levels of leadership within TPS would help to distribute and sustain awareness and education throughout the service. Mechanisms to specifically introduce the TCCS to TPS' Mobile Crisis Intervention Teams, Toronto Fire Services and Toronto Paramedic Services workforces should also be considered.	Toronto Police Service with support from City of Toronto to co-design opportunities and content

Recommendations

Table 19. Year 1 recommendations for the Toronto Community Crisis Service

Staffing capacity and staff supports		
Recommendation	***Rationale***	***Responsibility***
7. Increase staffing at each stage of the TCCS service pathway are required to a) respond to increasing direct calls to 211, untapped potential 911 calls suitable for diversion, and proposed boundary expansions; and b) to improve staff and service user experience.	Intake: a. While calls transferred from 911 to 211 have stabilized over time, completed calls received directly by 211 have increased markedly since the beginning of the pilot, from an average of 89 calls per month in the first six months to an average of 236 calls per month since October 2022. Total call volumes are even higher as this number does not include calls in which the service was interrupted, for which staff and time are still required. With increasing call volumes at 211 and potential boundary expansion, a dedicated 211-TCCS team is recommended to increase capacity to respond to direct calls, alleviate wait times in calls transferred from 911, and alleviate burden on 211 staff associated with having to manage multiple lines alongside TCCS and radio dispatch. b. Qualitative feedback from participants suggest direct crisis lines at each anchor agency are an important way to support equitable accessibility to the service and specifically to enact the guiding principle of ensuring multiple, coordinated access points, particularly in the face of increasing demand and untapped potential. However, with 2-Spirits' line launching in May 2023, after the data collection period for the current evaluation, administrative data is not yet available to support an evidence-informed decision regarding whether implementation of these lines across sites is warranted. Monitoring of data reflecting call volumes received through direct crisis lines at the two agencies who currently have such access points in place (GCC and 2-Spirits) over a longer time period will better inform demand and financial feasibility of implementing this access point. Mobile response: c. Increasing the number of crisis staff at each anchor agency will improve capacity to respond consistently to increasing calls to 211 and untapped potential 911 calls suitable for diversion (see Recommendation 3). Specific efforts to ensure each anchor agency has a sufficient pool of relief staff will additionally support service providers' health and well-being by reducing work burden and enabling scheduling that allows for wellness breaks and work-life balance. Follow up: d. Increasing the number of staff dedicated to supporting follow-up service provision (e.g., case managers, access facilitators) will enable anchor agencies to consistently provide follow-up support within 48 hours, thereby improving service user experience; and support staff health and well-being by ensuring manageable caseloads.	City of Toronto
8. Ensure robust and equitable health and well-being supports are available to all staff, including part-time and relief staff, across organizations.	While significant and successful efforts to support staff across partner organizations were reported, inequities exist and opportunities to prevent potential burnout were identified. Recommended supports include equitable access across sites to individualized supports including one-to-one counselling and a mental health support team, and culturally appropriate wellness supports like access to Elders for Indigenous staff; and consistent managerial or leadership support processes across sites such as regular team case reviews and debriefing opportunities.	All TCCS partners
9. Implement centrally coordinated and administered co-designed opportunities to engage in training on an ongoing or rolling basis.	While some sites are leveraging existing organizational training, this is financially and administratively challenging for sites to administer. Training should be centrally coordinated by the City of Toronto to ensure clear expectations and a consistent baseline for knowledge and skills across sites. Onboarding training should be scheduled regularly to accommodate new staff associated with program growth and staff turnover, and ensure access for staff working irregular hours due to part-time, overnight and/or weekend shifts. In addition, a rolling maintenance or refresher training curriculum should also be delivered to ensure all TCCS staff are continually supported in ongoing professional development. A maintenance or refresher training curriculum should be responsive to lessons learned about emerging service provider and service user needs over time and consist of broad crisis response and cultural safety skills, as well as training related to specific culturally appropriate approaches to care and care for specific mental health diagnoses or needs so service users across sites have equitable opportunities to receive culturally safe and clinically appropriate services. All training materials should be preserved (e.g., through recording or documentation) and housed in a centrally accessible location (e.g., an online shared platform) for staff who are unable to attend and/or who would benefit from ongoing access to materials to sustain learning.	City of Toronto with support from all TCCS partners to co-design opportunities and content

Recommendations

Table 19. Year 1 recommendations for the Toronto Community Crisis Service

Staffing capacity and staff supports		
Recommendation	***Rationale***	***Responsibility***
10. Implement a TCCS Community of Practice to support standardization, quality improvement, professional development and relationship-building across sites.	Related to Recommendation 5, dedicated collective space and ongoing opportunities for TCCS staff across partner organizations to share experiences, challenges, and wise practices from within their unique contexts would create meaningful opportunities for TCCS staff to learn from each other, engage in collective problem-solving, innovate within their own services, build more robust skills and capacities, develop relationships and identify opportunities for standardization to support consistent and quality care across sites. To support accountability, a reporting or feedback mechanism should be included to share back collective lessons learned and subsequent recommendations to the City of Toronto. Incorporating a mechanism by which to receive and review service user feedback within the Community of Practice would also support quality improvement across the program.	City of Toronto with support from all TCCS partners to co-design opportunities and content
Infrastructure		
Recommendation	***Rationale***	***Responsibility***
11. Continue to monitor and evaluate use of radios.	211 staff continue to report challenges associated with using radio technology, including that radio chatter while managing phone calls is distracting; and that radios are used inconsistently and unreliably across community anchor partner sites. Disentangling responsibility for responding to phone lines from responding to radio may be helpful; for example, a Coordinator might be assigned radio monitoring and response alongside other administrative work aligned with the TCCS so Service Navigators can dedicate their time and attention to managing incoming calls.	City of Toronto in collaboration with 211
12. Explore the feasibility of procuring and implementing a centralized data system.	With increasing volumes and boundary expansion likely to result in shared care across TCCS sites, a centrally accessible and integrated data system for TCCS anchor agencies will significantly improve efficiency by reducing duplication of efforts; reducing burden on frontline crisis staff by alleviating time spent on administration and documentation; and most importantly, improve service quality by allowing crisis teams to access to coordinated and comprehensive service user data that can inform more efficient and effective crisis response and service planning, resulting in improved service user experience of care quality, care continuity and person-centredness. However, implementation of a centralized system that includes sharing of personal information or personal health information between health information custodians (i.e., the anchor agencies) introduces significant administrative complexities under PHIPA that would need to be specifically and fulsomely explored to better understand feasibility and implications. Introduction of additional information technology infrastructure that may or may not interface with anchor agencies' existing infrastructure could create additional complexities and challenges in meeting organizational-level monitoring and reporting requirements. Exploration, procurement and implementation would be a time-consuming process. In the interim, additional considerations to reduce burden on frontline staff include additional funding for further staffing dedicated to administration and documentation; and refinement or reconsideration of what a "minimum dataset" for anchor partners entails for the purposes of program monitoring versus evaluation.	City of Toronto
13. Engage and collaborate with local payphone providers to ensure calls to 211 from public payphones throughout the City of Toronto are free to callers.	Stakeholders report that calling 211 from public payphones in the City of Toronto to access TCCS services costs callers whereas calling 911 is free. While 211 is toll-free as required by the CRTC, there is no requirement of public payphone providers specifically to provide toll-free access. There are currently nine public payphone providers in Ontario; in the City of Toronto, Bell Media is one of the largest providers. Advocacy to change local pay phone providers' practice in leveraging charges for callers dialling 211 in the City of Toronto is needed to support equitable access to TCCS. This will likely require support from the City of Toronto, in addition to United Way Centraide (the 211 trademark licence holder with CRTC), and others. Particularly if the program expands City-wide, ensuring there is no financial barrier to calling 211 (or incentive to call 911) is an important component of behaviour change management.	City of Toronto in collaboration with 211 and others

Recommendations

Table 19. Year 1 recommendations for the Toronto Community Crisis Service

Community awareness, engagement and service integration		
Recommendation	***Rationale***	***Responsibility***
14. Increase the frequency and scope of public awareness and education campaigns.	Ongoing campaigning using a variety of platforms and methods tailored to stakeholder groups and settings are recommended to consistently build awareness of the TCCS and its intended use in terms of what types of situations are appropriate for the TCCS and when to call 211 vs. 911. Examples of recommended awareness-building materials and methods include ongoing social media posts; posters in TTC stations and bus shelters; posters and/or pamphlets on bulletin boards in TCHC buildings; informational pamphlets in health care settings, including hospital waiting rooms, primary care offices, and community health centres; and youth-friendly posters, pamphlets and events at schools and youth agencies. Information should be communicated in a variety of ways using language that is accessible to varying levels of literacy and ability to speak English.	City of Toronto
15. Continue to fund dedicated staffing positions or sufficient staffing levels to allow for dedicated time and capacity for TCCS staff to participate in community outreach.	TCCS staff across organizations report that engaging in outreach is important but time-consuming. Continue to ensure that sufficient capacity exists to engage in such work, either through dedicated positions, such as CMHA-TO's Engagement Coordinator role, or by ensuring frontline staffing levels and scheduling protocols allow for capacity to meaningfully engage in community outreach without compromising frontline service delivery.	City of Toronto in collaboration with anchor partners
16. Develop a strategic service provider engagement plan to support TCCS staff outreach.	A variety of institutional and community-based service providers with potential to refer to and engage with the TCCS were identified, each of which will require targeted engagement strategies beyond awareness and engagement conducted by the City of Toronto. Engagement appears most effective when it is conducted by frontline staff, for frontline staff, who are more likely to be referral sources and relationship-builders within the community. These include TCCS staff outreach at community-based mental health and addiction services; community-based social service agencies and networks, such as immigration services and the Indigenous Housing, Health and Social Service Network; primary care settings; hospital emergency departments; City of Toronto institutions including TTC and TCHC; and youth settings including youth service agencies and schools. Multiple visits per site are also likely to be required to reinforce messaging and reach different shifts of service providers, sustaining awareness and engagement.	City of Toronto in collaboration with anchor partners
17. Continue dedicated resourcing for community anchor agencies to access counselling and post-crisis supports.	To facilitate timely access to follow-up support and support TCCS integration within the broader community of crisis and health service providers, anchor agencies' networks require dedicated resourcing to meaningfully participate in referral pathways. Particularly if the TCCS expands City-wide, more partnerships will be required to facilitate access to post-crisis supports across City of Toronto communities, and resourcing will be required to build their capacity to accept TCCS clients. From the community anchor partner perspective, agencies should continue to engage in purchasing services to secure access for TCCS service users. In particular, purchasing services or resourcing partnerships that could support streamlined access to dedicated crisis, shelter and detox beds, addictions services and primary care for TCCS service users should be prioritized. From the City of Toronto's perspective, their Strengthening the Community Crisis System grant for $1 million, which will require successful organizations to dedicate access to post-crisis supports for TCCS service users, is a notable example of a mechanism by which to meaningfully support service integration. The City of Toronto may also consider advocating to Ontario Health for adequate capacity for and access to community-based mental health, addictions and primary care, particularly given the potential of TCCS to divert service users away from costly hospital-based care.	City of Toronto and anchor partners

Recommendations

Table 19. Year 1 recommendations for the Toronto Community Crisis Service

Community safety and well-being		
Recommendation	***Rationale***	***Responsibility***
18. Advocate to increase funding and address system-level gaps in healthcare and housing.	The TCCS is operating within a broader housing and healthcare crisis that impedes the TCCS' potential to meaningfully impact community safety and well-being. Advocating for system-level increases in access to primary and specialist medical care, and to shelter beds, supportive housing units and Housing First principles, are essential to enabling the TCCS to meaningfully address crises and support sustained recovery, safety and well-being of communities in the long-term.	City of Toronto
Monitoring and evaluation		
Recommendation	***Rationale***	***Responsibility***
19. Continue program monitoring to support ongoing service planning, quality improvement and accountability; and plan for long-term evaluation to better understand impacts over time.	With staggered pilot start dates and ongoing revision and refinement of data collection measures and processes across anchor agencies throughout implementation and Year 1 of operations, establishment of a consistent and complete 12-month dataset for all sites was not possible. Ongoing monitoring over an additional 12-month period will yield a more reliable dataset to inform service planning from which to draw conclusions on program effectiveness and implications. Ongoing monitoring is also important in supporting ongoing quality improvement and accountability, particularly if the service scales up. In terms of subsequent evaluations, in initial evaluation consultations, stakeholders identified program goals such as impacts on service integration and community safety and well-being, which are long-term outcomes that cannot be meaningfully evaluated at this early stage. Ongoing program monitoring in Year 2 would position the TCCS well for longitudinal Year 3 and Year 5 impact evaluations.	City of Toronto
20. Continue co-design and respond to stakeholder needs in monitoring and evaluation to support engagement, trust and evaluation capacity across TCCS partners.	PSSP and Shkaabe Makwa have employed a developmental and utilization-focused approach to monitoring and evaluation that has contributed significantly to trusting relationships, engagement and increased capacity to participate in data collection and analysis. Continuing to ensure an approach to monitoring and evaluation that is highly contextualized and responsive to emerging stakeholder needs will contribute to the production of meaningful and useful data to drive decision-making. In particular, inclusion of case study methodology may be a valuable opportunity to evaluate and disseminate learnings regarding site-level wise practices and the contexts in which they might become best practices.	City of Toronto in collaboration with CAMH evaluators
21. Prioritize service user engagement in future evaluations.	Future evaluations should reflect upon lessons learned in this first year regarding how to ensure diverse service user voices are included in evaluation. The populations who are or could potentially be served by the TCCS includes communities who have historically experienced the greatest degrees of marginalization, coercion and biased practices (e.g., newcomers with or without status, Black, Indigenous and other racialized youth), making them least likely to reach out to and trust in offered supports. Continuing to explore how to effectively and appropriately engage these populations is essential. Opportunities to increase service user engagement include ensuring data collection opportunities are rolling to capture different perspectives along the service pathway and that any designated data collection periods are sufficiently flexible and long enough to engage desired sample sizes; ensuring a variety of recruitment methods are employed, including recruitment of service users both directly from anchor agencies and from the general public; promoting engagement and making participation possible in a variety of community-based spaces, such as in the Toronto Public Library or in local community centres, where community members might feel more comfortable exploring and speaking to mental health support; and ensuring a variety of data collection methods are available to service user participants across sites, including the opportunity to participate in cultural and art-based methods such as photovoice, digital storytelling and Sharing Circles. To further support positive service user experiences and capacity to participate in evaluation, consider contracting peers or people with lived/living experience to conduct or support data collection. Lastly, ensure that all interviewers receive training in conducting data collection with people who have experienced crises in a culturally safe manner and that both interviewers and interviewees have opportunities to debrief and/or receive mental health and wellness supports as reflecting upon crisis experiences can be traumatic, (re)triggering and/or emotionally challenging for everyone involved.	City of Toronto in collaboration with CAMH evaluators

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Conclusions and next steps

This report has presented findings resulting from an ongoing and iterative evaluation of the TCCS' implementation and first year of operation. A large, complex dataset indicative of the experiences and outcomes of TCCS service users, service providers and the community at large reflect positively on the program. Evaluation results suggest the TCCS has been successful overall in its implementation and ongoing operation insofar as achieving its objective of providing a non-police-led, community-based alternative crisis response service that a) effectively diverts people experiencing mental and behavioural health crises away from police-led interventions and b) instead offers a by community, for community intervention that is accessible based in trauma-informed and harm reduction principles, safe, transparent, trustworthy, person-centred and culturally responsive. However, significant opportunities for quality improvement were also identified. Uptake of the recommendations offered in this report will be critical to supporting the ongoing success and sustainability of the TCCS. As evaluators, we have greatly appreciated the opportunity to support the TCCS in its pilot phase and look forward to continuing to support its evolution through ongoing monitoring and evaluation in the years ahead.

Toronto Community Crisis Service vehicle

Photo courtesy of the City of Toronto

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Appendices

Appendix A. Site Profiles of the four TCCS pilot regions

Pilot Area Profiles

Downtown West Pilot: 2-Spirited People of the 1st Nations Kamaamwizme wii Naagidiwendiiying

Vision

We see a strong, healthy, and self-determining 2-Spirit community in Ontario where 2-Spirit peoples live with pride in their Indigenous heritages, values and roles in our communities. We see 2-Spirit peoples as continuing to celebrate our strengths and supporting community members to live with physical, emotional, mental, and spiritual well-being.

Program pillars

Providing culturally grounded support;

Applying flexible approaches to care (not a one-size-fits-all model);

Providing wholistic health and wellness supports;

Providing accessible, trauma-informed care services;

Ensuring that individuals in crisis have self-determination and are empowered in their care response plans;

Community participation and by-in throughout each phase of the pilot;

Continuous quality improvement of our supports and services.

TCCS staff

Crisis response specialists provide leadership and coordination of the mobile response. Harm reduction workers provide an important lens around substance use and sex work. Peer support workers help build trust with community members, walk alongside them in the care response, and provide follow-up.

87% of employees identify as Indigenous and of those who are Indigenous, 60% identify as being Two-spirit. 100% of staff who are non-Indigenous identify as queer. The majority of staff have lived/living experience of mental health, substance use, intergenerational trauma, houselessness, police violence, child welfare systems, neurodivergence, disabilities, and/or HIV.

An advisory committee of 15 Indigenous community members supports community engagement and advises management on community issues/ concerns about the pilot.

8 crisis response specialists

6 (+5 part-time) peer & crisis support

5 harm reduction & crisis support

2 nurses

2 case managers

1 supervisor, 1 manager

1 data specialist

1 community resource specialist

1 director

Services available on site

System navigation, cultural programming, case management, referral coordination, HIV-specific programming, harm reduction services, rapid access to in-house mental health supports (for Indigenous service users), FOCUS table case management support, and food support programs.

Partnerships

- Parkdale Queen West Community Health Centre - *primary care, harm reduction, safe consumption*
- ENAGB Indigenous Youth Agency - *children & family services, outdoor space for sweat lodges and ceremonies*

Geographic area

Police Division 14

Parkdale-High Park

Davenport

Spadina-Fort York

University-Rosedale

Demographics[1,2]

41% visible minority

5% Black

2% Indigenous ancestry[3]

36 median age

Household size: 1.9

Median household income: $83,900

Contact information:

2spirits.org/

145 Front Street East, Suite 105
Toronto, ON M5A 1E3

(416) 944-9300

1. Data was computed by the Social Development, Finance & Administration Division of the City of Toronto using Statistics Canada's 2021 Census.
2. Calculated as an average of all the Neighbourhood Census profiles in the pilot area. Note that some neighbourhoods are included in more than one pilot region due to boundary overlap.
3. Includes both persons who have First Nations (North American Indian), Métis, and/or Inuit ancestry only, as well as persons who have First Nations, Métis, and/or Inuit ancestry and non-Indigenous ancestry. There are limitations with the Statistics Canada Census data pertaining to the size of the Indigenous population in Toronto. These limitations may result in the undercounting of Indigenous peoples [20].

Pilot Area Profiles

Northwest Pilot: CMHA-TO

Vision

Our vision is for mentally healthy people in a healthy society. We are on a mission to improve the mental health of all with services, advocacy and leadership that create belonging and hope.

Values

Integrity: We value honesty and ethical behaviour.

Diversity & Equity: We respect all individuals and value their differences.

Recovery & Well-being: We value hope, self-determination, social inclusion and well-being.

Safety & Privacy: We value people's privacy and work to create safe environments that promote recovery and well-being.

Partnership: We value partnership and teamwork with the people who use our services, their families, significant others, service providers and communities.

Accessibility: We value equitable access to integrated services and the social determinants of health - housing, income and employment.

Quality: We value providing effective, evidence-based services and supports.

TCCS staff

The clinical lead has experience with clinical assessment, standardized tools, relevant modalities and approaches to care. The community engagement lead has significant experience working with Black, Indigenous, and racialized populations through multiple languages.

Crisis response team members have experience in community mental health, crisis intervention, case management, suicide risk assessments, and crisis prevention interventions. They receive additional training in crisis assessment and intervention, harm reduction, anti-oppressive practice, client-centred and recovery-oriented care, trauma-informed care, and culturally competent care. They are a diverse team with various languages, religions and cultures, and personal experience of mental health and substance use challenges.

18 mobile crisis service ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●

6 follow-up team ● ● ● ● ● ●

1 clinical lead ●

1 program manager ●

1 community engagement lead ●

Partnerships and services offered

- Addiction Services of York Region - *addictions counselling, peer support, pharmacotherapy, housing services, court support*
- Black Creek Community Health Centre - *primary care, allied health*
- Black Health Alliance - *community engagement, system planning*
- Caribbean African Canadian Social Services - *counselling, case management, employment, youth mentorship and outreach*
- Jane/Finch Community and Family Centre - *mental health, youth programs, seniors programs, settlement services*
- Rexdale Community Health Centre - *primary care, health promotion, counselling, outreach*
- Yorktown Family Services - *Latin-speaking, Somali, Black population-based services, peer-based youth groups, mobile therapy, trauma treatment*

Geographic area

Police Divisions 12, 23, 31

Etobicoke North

Etobicoke Centre

York South-Weston

York Centre

Humber River-Black Creek

Davenport

Demographics[1,2]

60% visible minority

20% Black

1% Indigenous ancestry[3]

40 median age

Household size: 2.7

Median household income: $80,000

Contact information:

https://cmha.ca/

700 Lawrence Ave W, Suite 480, Toronto, ON M6A 3B4

(416) 646-5557

1. Data was computed by the Social Development, Finance & Administration Division of the City of Toronto using Statistics Canada's 2021 Census.
2. Calculated as an average of all the Neighbourhood Census profiles in the pilot area. Note that some neighbourhoods are included in more than one pilot region due to boundary overlap.
3. Includes both persons who have First Nations (North American Indian), Métis, and/or Inuit ancestry only, as well as persons who have First Nations, Métis, and/or Inuit ancestry and non-Indigenous ancestry. There are limitations with the Statistics Canada Census data pertaining to the size of the Indigenous population in Toronto. These limitations may result in the undercounting of Indigenous peoples [20].

Pilot Area Profiles

Northeast Pilot: TAIBU

Vision

Achieving and maintaining health through community development, knowledge exchange, empowerment and the elimination of systemic racism and other forms of prejudice and discrimination in healthcare

Values

Leadership: Leadership of Black communities is essential to provide sustained and equitable access to high quality primary healthcare.

Community Driven: We strive to be transparent and accountable to the communities we serve.

Africentricity: We recognize the rights of people of African descent to strive for self determination.

Quality: Our programs and services are evidence informed and reflect a high standard of quality.

TCCS staff

Mobile crisis workers and post-crisis case managers are integral to supporting community. In addition to their lived experience, the team has up to 100 years of professional experience in the crisis field amongst them. Multiple languages are spoken on team (e.g. French, Urdu etc.) and the LGBTQ2S+ community is represented. 90% of staff are culturally reflective of the communities served.

12 mobile crisis service ● ● ● ● ● ● ● ● ● ● ● ●

2 post-crisis management service ● ●

2 community outreach, engagement, early intervention ● ●

1 communication/coordination ●

1 administrative support ●

Services available on site

Primary care doctors, nurse practitioners, chiropactic care, diabetes team (nurse, dietician), Aya Circle of Care-HIV team (nurse navigator, NP, social worker), Plug Project (support for youth with issues in school), counselling services, Black Social Prescribing, seniors exercise program, francophone services (NP, RN), Scarborough Perinatal Support Program, IMARA Generation Project, L.E.A.R.N mentorship program, Kaya Project (CAST joint project), and From School to Success Pipeline.

Partnerships

- The Scarborough Health Network (SHN) - *psychiatrist*
- The Canadian Mental Health Association of Toronto (CMHA) - *safe bed*
- The Scarborough Centre for Healthier Communities (SCHC) - *fast-tracking primary care referrals*
- The Centre for Addiction and Mental Health (CAMH)
- Hong Fook Mental Health Association
- The Black Health Alliance (BHA) - *policy writing*
- Strides Toronto - *youth programming*

Geographic area

Police Divisions 41, 42, 43

Scarborough Southwest

Scarborough Centre

Scarborough-Agincourt

Scarborough North

Scarborough-Guildwood

Scarborough-Rouge Park

Demographics[1,2]

75% visible minority

11% Black

1% Indigenous ancestry[3]

42 median age

Household size: 2.9

Median household income: $85,700

Contact information:

taibuchc.ca/en/

27 Tapscott Rd unit 1, Scarborough, ON M1B 4Y7

(416) 644-3536

1. Data was computed by the Social Development, Finance & Administration Division of the City of Toronto using Statistics Canada's 2021 Census.
2. Calculated as an average of all the Neighbourhood Census profiles in the pilot area. Note that some neighbourhoods are included in more than one pilot region due to boundary overlap.
3. Includes both persons who have First Nations (North American Indian), Métis, and/or Inuit ancestry only, as well as persons who have First Nations, Métis, and/or Inuit ancestry and non-Indigenous ancestry. There are limitations with the Statistics Canada Census data pertaining to the size of the Indigenous population in Toronto. These limitations may result in the undercounting of Indigenous peoples [20].

Pilot Area Profiles

Downtown East Pilot: Gerstein Crisis Centre

Vision

People are connected to communities where they feel included and valued and have the resources they need and want to live safe, secure, and self-defined lives that are free of stigma and discrimination.

Values

Respect, autonomy, dignity, diversity, social justice, equity, collaboration, and accountability are at the core of all we do.

We value the whole person and acknowledge and respect their needs and wishes for recovery.

TCCS staff

Gerstein Crisis Centre staff are trained in crisis intervention, suicide intervention, harm reduction, anti-racism/anti-oppression, and work from a trauma-informed perspective. At least five years of experience working in community mental health or crisis intervention is required. Staff work collaboratively with community supports across the city and adapt interventions to ensure equity and access for a diverse client group.

Over 50% of staff identify as a part of the LGBTQ2S+ community, 70% of staff identify as BIPOC, and 75% of staff have lived/living experience with one or more of the following: mental health, neurodiversity, substance use, intergenerational trauma, justice system, immigration/newcomer.

Diversity of languages spoken amongst the TCCS team and across Gerstein Crisis Centre includes Farsi, Tamil, Arabic, Spanish, Bengali, Amharic, Hindi, Somali, and Punjabi.

18 (+1 p/t) community crisis intervention workers

4 access facilitators

1 manager of community crisis response

1 director municipal and community partnerships

Services offered on site

Downtown East FOCUS table crisis management support

Partnerships and services offered:

- Strides Toronto
- Toronto North Support Services & The Access Point - *coordinated intake and assessment*
- Unity Health Toronto - *addiction medicine, urgent psychiatry*
- Regent Park Community Health Centre - *harm reduction, community programming*
- WoodGreen Community Services - *walk-in counselling*
- Health Access St. James Town - *primary care, case management*
- Inner City Health Associates - *primary care, mental health*
- Family Services Toronto - *short-term solution-focused psychotherapy*

Geographic area

Police Divisions 51, 52

Spadina-Fort York

University-Rosedale

Toronto Centre

Toronto-Danforth

Demographics[1,2]

56% visible minority

8% Black

2% Indigenous ancestry[3]

35 median age

Household size: 1.8

Median household income: $73,700

Contact information:

gersteincentre.org/

100 Charles St E, Toronto, ON M4Y 1V3

(416) 929-5200

1. Data was computed by the Social Development, Finance & Administration Division of the City of Toronto using Statistics Canada's 2021 Census.
2. Calculated as an average of all the Neighbourhood Census profiles in the pilot area. Note that some neighbourhoods are included in more than one pilot region due to boundary overlap.
3. Includes both persons who have First Nations (North American Indian), Métis, and/or Inuit ancestry only, as well as persons who have First Nations, Métis, and/or Inuit ancestry and non-Indigenous ancestry. There are limitations with the Statistics Canada Census data pertaining to the size of the Indigenous population in Toronto. These limitations may result in the undercounting of Indigenous peoples [20].

Appendices

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

Table B1

Call category	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
Well-being 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	Behaviour that appears to be erratic with no clear objective or meaning
Disputes	Verbal disagreements
Advised	The caller who 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	Used by 211 in cases where calls generally fit the eligibility criteria for the TCCS but do not quite fit the exact definition of any of the other six call categories; it can also be used in cases where a call ended prematurely

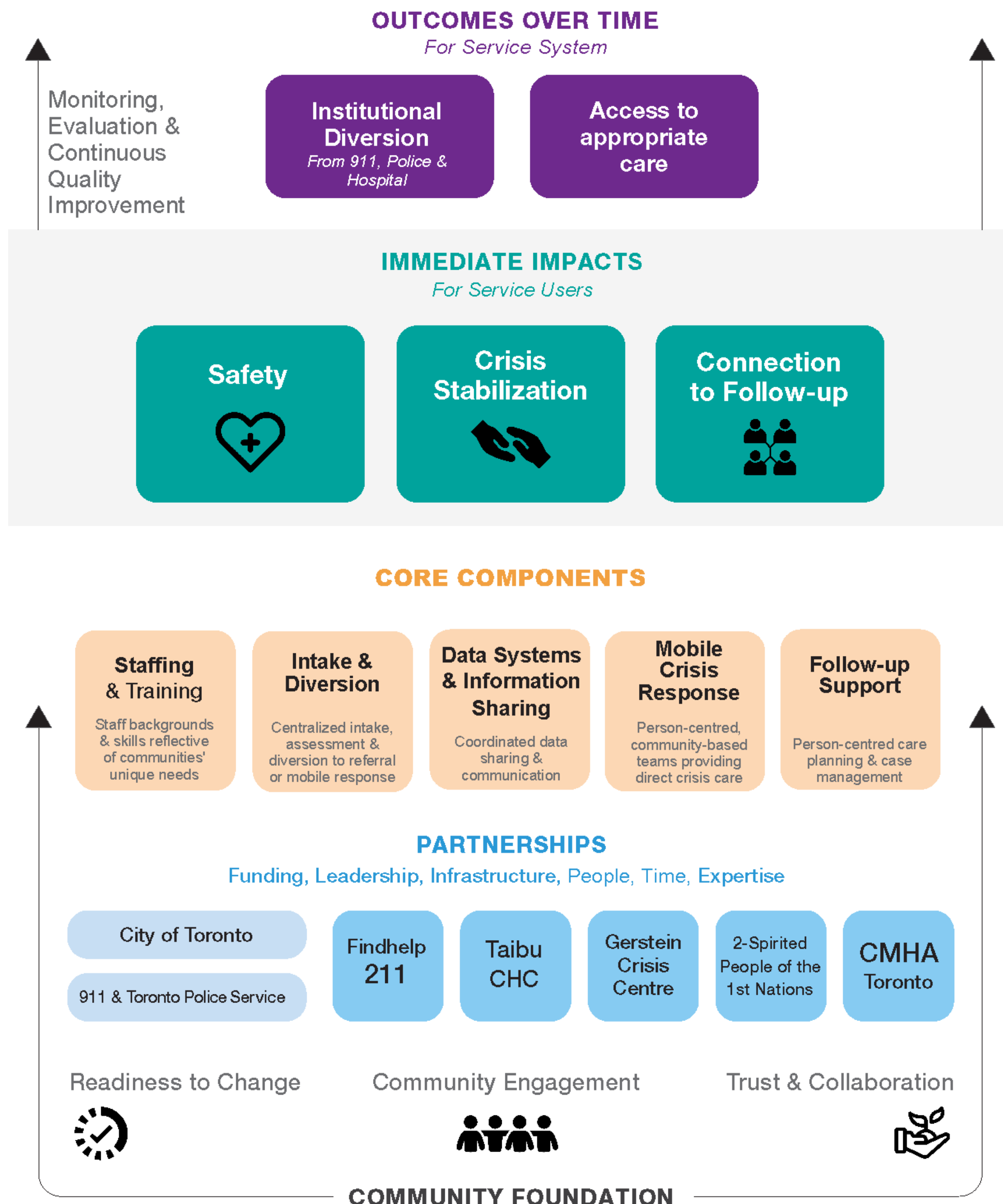
Call Diversion Criteria:

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 MCIT (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

Appendices

Appendix C. Toronto Community Crisis Service Theory of Change

Figure C1



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Appendices

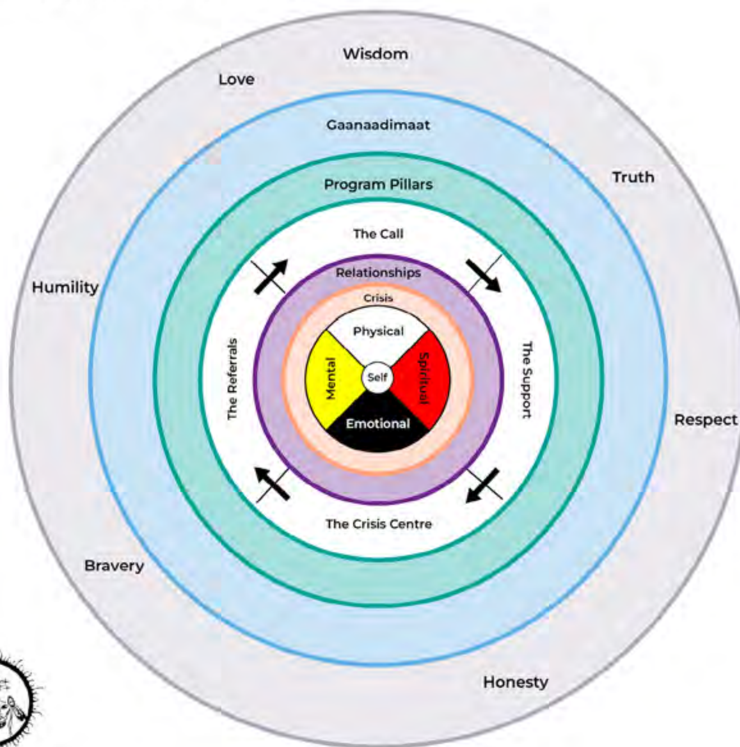
Appendix D. Debaamjigewin Naagdobiigewin: 2-Spirited People of the 1st Nations evaluation framework

Figure D1

Kamaamwizme wii Naagidiwendiiying

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

Debaamjigewin Naagdobiigewin



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

Appendices

Appendix E. TCCS outcome evaluation matrix

Table E1

Data type	Data source	Description of data	Evaluation question	Examples of data measures	Collected from	Frequency of data collection
Quantitative	Administrative service users records	Secondary quantitative data on service usage generated through routine administration of the service that is abstracted from existing organizational records and populated in a template	1	Call volumes; characteristics; and outcomes (e.g., diversion, apprehension and hospital transfer rates)	Service providers (TPS, 211 via City of Toronto)	Retrospectively monthly; March 31, 2022 – April 30, 2023
			2	Crisis supports provided; referrals made; service user sociodemographics	Service providers (anchor partners)	Retrospectively monthly; October - April 2023; merged with previously collected data from April 2022 –September 2022 as part of the six-month evaluation
Mixed methods	Surveys	Primary quantitative and qualitative data generated through Likert-style closed- and open-ended survey items assessing stakeholder experiences Separate versions created for each stakeholder group: (1) service users, (2) service providers, and (3) community	2	Crisis supports provided; perception of facilitators and barriers to care and connection	Service users	Cross-sectional; May 2023 – June 2023
			3	Rating and perception of accessibility, harm reduction, trauma-informed care, trust, safety, participation/choice, person-centredness and cultural safety	Service users; service providers (TPS, 211, anchor partners)	
			4	Narrative experiences of receiving or providing care; impact on health and well-being; demographics	Service users; service providers (TPS, 211, anchor partners)	
			5	Rating of awareness; rating of likelihood to engage; perception of service integration; perception of impact on community safety and well-being	Service users; service providers (TPS, 211, anchor partners); community (non-profit agencies and at large)	
	ORIC	Primary data generated through a validated 12-item tool that assesses determinants and consequences of readiness to change; collected at six months and one-year post-implementation	4	Commitment to change; confidence in implementation	Service providers (TPS, 211, anchor partners)	Pre-post; August–September 2022 vs. April–May 2023
	Wilder Collaboration Factors Inventory (Wilder)	Primary data generated through a 44-item tool that reflects experiences of 22 success factors for collaboration; collected at six months and one-year post-implementation	4	Mutual respect; favourable political and social climate	Service providers (TPS, 211, anchor partners)	Pre-post; August–September 2022 vs. April–May 2023
Qualitative	Semi-structured interviews and focus groups	Primary qualitative data generated through semi-structured individual or group dialogue assessing stakeholder experiences	1	Perception of call pathway, processes and outcomes	Service providers (TPS, 211, City of Toronto)	Cross-sectional; April–June 2023
			2	Crisis supports provided; perception of facilitators and barriers to care and connection	Service users; service providers (all)	
			3	Perception of accessibility, harm reduction, trauma-informed care, trust, safety, participation/choice, person-centredness and cultural safety	Service users; service providers (all)	
			4	Narrative experiences of receiving or providing care	Service users; service providers (TPS, 211, anchor partners)	
			5	Awareness, perception of service integration; perception of impact on community safety and well-being	Service users; service providers (all); community (Community Advisories)	

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Appendix E. TCCS outcome evaluation matrix

Table E1. Continued

Data type	Data source	Description of data	Evaluation question	Examples of data measures	Collected from	Frequency of data collection
Qualitative	Implementation tracker	Primary qualitative data reported by organizations in a template reflecting organizational-level longitudinal implementation experiences	1	Perception of call pathway, processes and outcomes, with the focus being on lessons learned	Service providers (TPS, 211, City of Toronto)	Quarterly from October 2022 – May 2023; merged with monthly trackers collected from April 2022–September 2022 as part of the six-month evaluation.
			2	Perception of facilitators and barriers to care and connection, with the focus being on lessons learned	Service providers (all)	
			4	Narrative experiences of providing care	Service providers (TPS, 211, anchor partners)	
	Site profiles	Primary qualitative data reported by organizations in a template through semi-structured inquiry reflecting organizational-level defining characteristics	2	Description of types of services and supports offered; training; sociodemographics	Service providers (anchor partners)	Cross-sectional; June 2023
			3	Organizational mandate and values; description of staff characteristics and composition; internal training initiatives		

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Appendix F. Pre-post means across the Wilder Collaboration Factors Inventory (Wilder)

Table F1

Wilder factors	Pre-test mean	Post-test mean
Agencies in our community have a history of working together.	3.83	4.17
Trying to solve problems through collaboration has been common in this community. It has been done a lot before.	3.83	4.33
Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	4.50	4.50
Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	4.33	4.50
The political and social climate seems to be "right" for starting a collaborative project like this one.	4.17	4.67
The time is right for this collaborative project.	4.83	5.00
People involved in our collaboration trust one another.	3.83	3.83
I have a lot of respect for the other people involved in this collaboration.	4.83	4.50
The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	4.50	4.50
All the organizations that we need to be members of this collaborative group have become members of the group.	3.33	3.33
My organization will benefit from being involved in this collaboration.	4.67	4.83
People involved in our collaboration are willing to compromise on important aspects of our project.	3.67	2.83
The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	4.00	4.00
Everyone who is a member of our collaborative group wants this project to succeed.	5.00	4.67
The level of commitment among the collaboration participants is high.	4.67	4.17
When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	3.33	3.33
Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	3.83	4
There is a lot of flexibility when decisions are made; people are open to discussing different options.	3.83	3.67
People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	4.33	4.17
People in this collaborative group have a clear sense of their roles and responsibilities.	4.33	4.5
There is a clear process for making decisions among the partners in this collaboration.	3.33	3.5
This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate or change in leadership.	3.50	3.33
This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	4.17	4
This collaborative group has been careful to take on the right amount of work at the right pace.	3.67	3.33
This group is currently able to keep up with the work necessary to coordinate all the people, organizations and activities related to this collaborative project.	4	3.33
A system exists to monitor and report the activities and/or services of our collaboration.	4	3.17

Appendix F. Pre-post means across the Wilder Collaboration Factors Inventory (Wilder)

Table F1. Continued

Wilder factors	Pre-test mean	Post-test mean
We measure and report the outcomes of our collaboration.	4.33	4.17
Information about our activities, services and outcomes is used by members of the collaborative group to improve our joint work.	3.83	3.83
People in this collaboration communicate openly with one another.	3.83	3.83
I am informed as often as I should be about what is going on in the collaboration.	3.5	3.83
The people who lead this collaborative group communicate well with the members.	3.67	4.17
Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	3.83	4.33
I personally have informal conversations about the project with others who are involved in this collaborative group.	3.83	4.33
I have a clear understanding of what our collaboration is trying to accomplish.	4.67	5.00
People in our collaborative group know and understand our goals.	4.50	4.67
People in our collaborative group have established reasonable goals.	4.50	4.33
The people in this collaborative group are dedicated to the idea that we can make this project work.	4.50	4.83
My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	4.00	3.83
What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	5.00	4.83
No other organization in the community is trying to do exactly what we are trying to do.	3.83	3.83
Our collaborative group has adequate funds to do what it wants to accomplish.	1.33	1.83
Our collaborative group has adequate “people power” to do what it wants to accomplish.	2.00	2.33
The people in leadership positions for this collaboration have good skills for working with other people and organizations.	4.33	4.33
Our collaborative group engages other stakeholders, outside of the group, as much as we should.	3.50	3.83
Overall mean	**3.98**	**4.01**

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Appendix G. Pre-post results across the Organizational Readiness for Implementing Change (ORIC) survey

Table G1. Pre-post ORIC scores among TCCS partners (n=6)

TCCS partner	Pre-test ORIC score (/60)	Post-test ORIC score (/60)
Findhelp 211 (211)	42 (70%)	56 (93%)
TPS	49 (82%)	47 (78%)
2-Spirits	53 (88%)	53 (88%)
CMHA-TO	59 (98%)	55 (92%)
GCC	57 (95%)	56 (93%)
TAIBU	59 (98%)	56 (93%)
Mean score	**53.17 (89%)**	**53.83 (90%)**

Table G2. Pre-post means for each ORIC survey item

Measure	ORIC survey item	Pre-test mean	Post-test mean
Change commitment	People who work here are motivated to implement this change initiative.	4.67	4.83
	People who work here are determined to implement this change initiative.	4.67	4.83
	People who work here want to implement this change initiative.	4.67	5.00
	People who work here will do whatever it takes to implement this change.	4.33	4.17
	People who work here are committed to implementing this change initiative.	4.50	5.00
Change efficacy	People who work here feel confident that the organization can get people invested in implementing this change initiative.	4.33	4.67
	People who work here feel confident that they can keep track of progress in implementing this change initiative.	4.17	4.33
	People who work here feel confident that the organization can support people as they adjust to this change initiative.	4.50	4.67
	People who work here feel confident that they can keep the momentum going in implementing this change initiative.	4.67	4.67
	People who work here feel confident that they can handle the challenges that might arise in implementing this change initiative.	4.33	4.33
	People who work here feel confident that they can coordinate tasks so that implementation goes smoothly.	4.33	3.67
	People who work here feel confident that they can manage the politics of implementing this change initiative.	4.00	3.67
Overall mean		**4.43**	**4.49**

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Appendix H. TPS reasons for police attendance at events transferred to the TCCS

Table H1

Reason	Number of events attended
Toronto Paramedic Services on scene requested police attendance	232
Toronto Fire Services on scene requested police attendance	1
911 caller requested both police and TCCS	249
Multiple 911 callers about the same event, with some requesting TPS and others the TCCS	41
TCCS service navigator requested police attendance	100
TPS officers were dispatched prematurely, or prior to offering the TCCS to the caller	106
TPS MCIT/PRU unit was familiar with the person in crisis and/or volunteered to co-respond with the TCCS	3
911 caller refused diversion after transfer to 211	67
No TCCS CCTs were available to respond	16
Event was not within TCCS catchment area or occurred outside the hours of TCCS operations	22
TCCS Service Navigator deemed the circumstances of the event were not suitable for diversion and not within the scope of the TCCS	140
911 Call Operator deemed the circumstances of the event were not suitable for diversion and not within the scope of the TCCS	3
Unknown reason	27
Grand total	**1007**

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Appendix I. Number of direct crisis supports provided by CCTs to service users on scene

Table I1

Resources provided		
Type of resources provided	**Number of resources provided**	**Percent breakdown[23]**
Food	48	5%
Clothing	423	46%
Blankets/sleeping bags	112	12%
Hygiene supplies	20	2%
Naloxone	33	4%
Harm reduction supplies	91	10%
Medicine bundles	92	10%
Other (please specify in Comments section)	98	11%
Grand total	**917**	**100%**

Table I2

Supports provided		
Type of supports provided	**Number of supports provided**	**Percent breakdown**
Transportation fare (ex: TTC token, taxi chit, etc...)	103	3%
Transportation in crisis vehicle to hospital	111	3%
Transportation in crisis vehicle elsewhere	80	2%
Advocacy during crisis visit	1199	37%
Resources/Information	1228	37%
Referrals (e.g., Streets to Homes, Health Bus)	358	11%
Practical supports (e.g., making a phone call, packing up belongings)	119	4%
Nursing	28	1%
Other	56	2%
Grand total	**3,282**	**100%**

[23] Total percentage for some tables in the Appendix may be off slightly due to rounding errors in Excel (i.e., floating point error).

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Appendix I. Number of direct crisis supports provided by CCTs to service users on scene

Table I3

Intervention used		
Type of intervention used	**Number of interventions used**	**Percent breakdown**
Crisis de-escalation	1291	11%
Suicide risk assessment	438	4%
Suicide intervention (please specify in Comments section - ASIST, Suicide Talk, etc.)	226	2%
Risk assessment	2125	18%
Crisis planning/safety planning	1540	13%
Rapport building	1686	14%
Crisis counselling	2031	17%
Needs assessment (Information gathering, goal setting, care planning)	1202	10%
Well-being check	945	8%
Family/kinship support	139	1%
Other	14	0%
Grand total	**11,637**	**100%**

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Appendix J. Number of outbound referrals made by CCTs on scene

Table J1

Type of referral	Number of referred support	Percent breakdown
Shelter bed	145	35%
Crisis bed	67	16%
Streets to Homes	11	3%
Health Bus	1	0%
EMS/emergency medical services	45	11%
Detox bed	8	2%
SCOUT/street-based health care/nursing	6	1%
Public health-related referrals	3	1%
Culturally relevant supports	43	10%
Crisis stabilization supports	82	20%
Grand total	**411**	**100%**

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Appendix K. Number of culturally relevant supports provided during follow-up

Table K1

Type of support	Number of supports	Percent breakdown
Afrocentric and West Indian/Caribbean-centric support	61	41%
Diabetes prevention education	7	5%
Mental health supports (e.g., counselling, social work, etc.)	17	11%
Francophone services	1	1%
HIV/Hep C testing	3	2%
Holistic health supports	22	15%
Settlement/Immigration	13	9%
Other	26	17%
Access to ceremony	3	2%
Grand total	**150**	**100%**
Indigenous-specific supports		
Elder/Knowledge Keeper support and teachings	8	5%
Access to medicine	48	32%
Wholistic family and kinship care supports	42	28%
Harm reduction with Indigenous lens	6	4%
Indigenous-specific supports	2	1%
Culturally specific wellness programming (e.g., beading, drumming, language, regalia making)	41	27%
Grand total	**150**	**100%**

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Appendix L. Number of referrals made during follow-up

Table L1

Type of referral	Number of referred support	Percent breakdown
Case management	258	13%
Chronic disease management	24	1%
Crisis bed	73	4%
Crisis counselling and support	120	6%
Culturally relevant supports	60	3%
Education	13	1%
Employment support	83	4%
Family support	20	1%
Financial support	45	2%
Food support	87	4%
Geriatric support	50	3%
Harm reduction services	15	1%
Hospital/emergency support	58	3%
Housing	116	6%
Legal supports	51	3%
Mental health supports (e.g., counselling)	270	14%
Peer support	40	2%
Primary care	67	3%
Psychiatric supports	77	4%
Rehabilitation services	13	1%
Self-help/support groups	14	1%
Shelter/hostel	137	7%
Social/recreational supports	55	3%
Substance use supports	122	6%
Wellness/recovery supports	58	3%
Other	70	4%
Grand total	**1,996**	**100%**

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Appendix M. Sociodemographic data shared by service users during follow-up

Table M1

Category	Disaggregation	TAIBU	GCC	CMHA-TO	2-Spirits	Total	Percent total
Language preference	English	38	316	5	159	518	67%
	Albanian	0	0	0	0	0	0%
	American Sign Language (ASL)	0	0	0	0	0	0%
	Amharic	0	0	0	0	0	0%
	Arabic	5	2	6	0	13	2%
	Armenian	0	0	0	0	0	0%
	Assyrian Neo-Aramaic	0	0	0	0	0	0%
	Bengali	4	0	0	0	4	1%
	Chinese-Cantonese	0	2	3	0	5	1%
	Chinese-Mandarin	2	1	0	1	4	1%
	Chinese-Other Dialects	0	0	0	0	0	0%
	Farsi	0	0	2	0	2	0.3%
	French	2	3	0	2	7	1%
	Greek	0	0	2	0	2	0.3%
	Gujarati	0	0	0	0	0	0%
	Hindi	0	0	6	1	7	1%
	Hungarian	0	0	1	1	2	0.3%
	Indigenous-Cree	0	0	0	0	0	0%
	Indigenous-Mohawk	0	0	0	1	1	0.1%
	Indigenous-Ojibway	0	0	0	0	0	0%
	Indigenous-Oji-Cree	0	0	0	0	0	0%
	Indigenous-Other	0	0	0	0	0	0%
	Italian	0	0	3	1	4	1%
	Korean	0	1	0	0	1	0.1%
	Polish	0	0	5	0	5	1%
	Portuguese	0	1	3	0	4	1%
	Punjabi	0	1	3	0	4	1%
	Romanian	0	0	2	0	2	0.3%
	Russian	6	0	0	0	6	1%
	Serbian	0	0	0	0	0	0%
	Somali	0	0	10	0	10	1%
	Spanish	0	5	10	1	16	2%
	Tagalog	1	0	1	0	2	0.3%
	Tamil	14	1	0	0	15	2%
	Tibetan	0	0	0	0	0	0%
	Turkish	0	0	1	0	1	0.1%
	Ukrainian	0	0	1	0	1	0.1%
	Urdu	0	0	2	0	2	0.3%
	Vietnamese	0	1	1	0	2	0.3%
	Not listed	20	0	84	0	104	13%
	Prefer not to answer	0	1	27	1	29	4%

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Appendix M. Sociodemographic data shared by service users during follow-up

Table M1. Continued

Category	Disaggregation	TAIBU	GCC	CMHA-TO	2-Spirits	Total	Percent total
Indigenous identity	Yes	3	16	8	53	80	9%
	No	11	172	485	23	691	81%
	Prefer not to answer	0	0	83	1	84	10%
Indigenous Identity - specified	First Nations	0	16	5	20	41	31%
	Inuit	0	0	0	1	1	1%
	Métis	0	0	0	2	2	2%
	Mixed Indigenous identity (e.g., Métis and First Nations, Inuit and Métis)	0	0	0	2	2	2%
	Prefer not to answer	0	0	85	1	86	65%
Race	Arab, Middle Eastern or West Asian	8	11	23	1	43	4%
	Black	91	37	141	21	290	29%
	East Asian	6	5	33	1	45	4%
	First Nations (status or non-status), Inuit, Métis	0	16	4	22	42	4%
	Latin American	1	9	16	2	28	3%
	South Asian or Indo-Caribbean	38	22	33	2	95	9%
	Southeast Asian	7	12	17	3	39	4%
	White	65	98	127	44	334	33%
	More than one race category or mixed race	7	17	1	1	26	3%
	Not listed	14	0	15	1	30	3%
	Prefer not to answer	1	15	24	0	40	4%
Mixed race (if identified)	Arab, Middle Eastern or West Asian	0	0	15	0	15	7%
	Black	0	0	45	0	45	21%
	East Asian	0	0	10	0	10	5%
	First Nations (status or non-status), Inuit, Métis	0	0	0	1	1	0.5%
	Latin American	0	0	4	0	4	2%
	South Asian or Indo-Caribbean	0	0	13	0	13	6%
	Southeast Asian	0	0	12	0	12	6%
	White	0	0	63	0	63	30%
	Not listed	0	0	15	0	15	7%
	Prefer not to answer	0	0	35	0	35	16%
Presence of disability	Yes	117	272	183	112	684	59%
	No	8	20	233	6	267	23%
	Don't know	7	9	108	7	131	11%
	Prefer not to answer	5	0	64	1	70	6%

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Appendix M. Sociodemographic data shared by service users during follow-up

Table M1. Continued

Category	Disaggregation	TAIBU	GCC	CMHA-TO	2-Spirits	Total	Percent total
Type of disability identified	Blindness or low vision	2	2	12	0	16	2%
	Deaf, deafened or hard of hearing	0	1	5	1	7	1%
	Developmental or cognitive disability	22	20	25	7	74	7%
	Learning disability	16	2	15	1	34	3%
	Mental health disability	95	249	190	87	621	63%
	Physical, coordination, manual dexterity or strength	3	14	41	6	64	6%
	Physical illness and/or pain	6	22	43	6	77	8%
	Speech and language disability	0	0	4	0	4	0%
	Not listed	1	0	12	0	13	1%
	Prefer not to answer	2	4	75	1	82	8%
Barriers identified due to disability	Accessing counter services	0	0	11	0	11	3%
	Attending an event or program in person	0	5	35	1	41	9%
	Communicating and interacting with staff	0	15	23	0	38	9%
	Completing forms or instructions	0	4	28	0	32	7%
	Difficulty trusting others	0	0	0	0	0	0%
	Difficulties with communication	0	0	0	0	0	0%
	Entering or navigating a building	0	2	26	0	28	6%
	Experiences of stigma and discrimination	0	0	0	0	0	0%
	Fearful of others and/or surroundings	0	0	0	0	0	0%
	Financial/economic	0	0	0	0	0	0%
	Finding, accessing or understanding print or online information	0	1	12	0	13	3%
	Overall uncomfortable environment	0	31	46	0	77	18%
	Other	0	31	30	0	61	14%
	Prefer not to answer	0	0	134	0	134	31%
Gender	Woman	127	138	292	137	694	43%
	Man	86	163	424	118	791	50%
	Trans woman	0	11	7	2	20	1%
	Trans man	4	5	3	1	13	1%
	Gender non-binary	0	15	1	7	23	1%
	Two-Spirit	0	2	1	3	6	0.4%
	Other	5	0	1	0	6	0.4%
	Prefer not to answer	0	0	41	3	44	3%

Appendix M. Sociodemographic data shared by service users during follow-up

Table M1. Continued

Category	Disaggregation	TAIBU	GCC	CMHA-TO	2-Spirits	Total	Percent total
Sexual orientation	Heterosexual or straight	81	52	224	11	368	48%
	Asexual	0	0	0	0	0	0%
	Bisexual	4	4	5	8	21	3%
	Gay	0	16	3	3	22	3%
	Lesbian	2	0	2	2	6	1%
	Pansexual	0	0	0	0	0	0%
	Queer	9	8	2	3	22	3%
	Questioning	0	0	0	0	0	0%
	Two-Spirit	0	0	0	3	3	0%
	Don't know	49	41	81	1	172	23%
	Not listed	0	3	5	2	10	1%
	Prefer not to answer	12	1	122	1	136	18%
Income security (past month challenges meeting basic needs)	Yes	0	130	0	12	142	85%
	No	0	9	0	9	18	11%
	Don't know	0	8	0	0	8	5%
	Prefer not to answer	0	0	0	0	0	0%
Income source: Social assistance	Yes	0	75	0	14	89	81%
	No	0	14	0	5	19	17%
	Prefer not to answer	0	0	0	2	2	2%
Housing status	Housed (individuals who identify as stably housed)	126	123	264	60	573	59%
	Unhoused (individuals who identify as having unstable housing arrangements)	37	87	133	91	348	36%
	Prefer not to answer	0	0	5	46	51	5%
Age	0-9 years	0	0	0	0	0	0%
	10-15 years	1	0	2	0	3	0%
	16-19 years	21	16	31	10	78	5%
	20-29 years	127	67	119	78	391	25%
	30-64 years	264	202	339	63	868	54%
	65 years and older	81	24	52	14	171	11%
	Prefer not to answer	0	0	81	1	82	5%

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Appendix N. Urgent supports needed during crisis visits but not available on scene

Table N1

Type of supports	Number of supports	Percent breakdown
Clothing	2	1%
Sleeping bags	10	4%
Hygiene supplies	5	2%
Shelter bed	122	51%
Detox bed	6	3%
Crisis bed	27	11%
Harm reduction supplies	53	22%
Referral (please specify in Comments section)	2	1%
Other	12	5%
Grand total	**239**	**100%**

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Appendix O. Definitions of key concepts

Key concepts were defined collaboratively by all TCCS partners, with the goal of balancing individual agency contexts and priorities with overall group consensus.

Table O1

Concept	Definition
Accessibility	The TCCS is readily and easily available to individuals when needed through a variety of low-barrier access points (e.g., at any time of day, through multiple communication channels, in multiple languages) and will respond to service requests in a culturally safe and appropriate way.
Harm reduction	The TCCS meets individuals where they are at, providing care that is non-judgmental and centred on understanding and supporting their individual needs, strengths and preferences. This requires a flexible and holistic approach to care that aims to minimize harm through use of skillful, informed and culturally safe staff- and peer-led intervention.
Trauma-informed care	The TCCS understands the ways in which existing and past traumas, both individual and systemic, impact individual experiences, choices and outcomes; and actively responds to this understanding by promoting self-determination, respecting individuals' choice and privacy, and providing care that is culturally safe and inclusive.
Person-centred care	The TCCS prioritizes autonomy and individuals' right to self-determine and self-direct care and care planning based on their perceived needs and preferences. The TCCS supports and advocates for person-centred care by ensuring individuals are offered accessible, comprehensive information about and a diverse array of, holistic and culturally safe service options and outcomes.
Safety	The TCCS ensures security, both physically through processes such as environmental and individual risk assessments and harm reduction-based risk interventions; and emotionally, by creating a calm, non-judgmental and respectful space in which service users can comfortably express their needs and preferences.
Cultural safety	The assurance of anti-racist and anti-oppressive competencies and practices and to the cultural humility required to understand, respect, advocate and adopt a variety of adaptive practices in order to prioritize representation and inclusivity in care.
Participation, choice and rights	Refers to the consent-based nature of the program and the processes required to support informed consent, which include the provision of transparent and accessible information on the range of service opportunities and outcomes, and service user-led collaborative decision-making.
Trust	Characterized by the assurance of transparency and accountability throughout the care process, with rapport developing over time as the TCCS follows through on the commitment made to its service users to be accessible, to reduce harm, to be trauma-informed, to be person-centred, to be safe and culturally safe, and to prioritize their participation and right to choose.

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Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1

Key Concept	Survey measure [a]	Scale	Responses and % agreement among stakeholder group: Service users (N=20) n (%)	Responses and % agreement among stakeholder group: Service providers (N=92) n (%)
Accessibility	When someone is in need of help, the TCCS is readily available.	Strongly agree	**N/A** [b]	22 (26%)
		Agree		42 (51%)
		Disagree		15 (18%)
		Strongly disagree		4 (5%)
		Total Answered		83
		Missing [c]		9
		% Agreement [d]		**77%**
	Connecting with the TCCS is easy for service users.	Strongly agree	12 (60%)	22 (27%)
		Agree	7 (35%)	42 (53%)
		Disagree	1 (5%)	12 (15%)
		Strongly disagree	0 (0%)	4 (5%)
		Total Answered	20	80
		Missing	0	12
		% Agreement	**95%**	**80%**
Harm reduction; trauma-informed care	TCCS staff are compassionate when service users are feeling stressed or overwhelmed.	Strongly agree	15 (83%)	37 (50%)
		Agree	2 (11%)	34 (46%)
		Disagree	1 (6%)	1 (1%)
		Strongly disagree	0 (0%)	2 (3%)
		Total Answered	18	74
		Missing	2	18
		% Agreement	**94%**	**96%**

[a] The wording and perspectives of the survey questions were adapted for each stakeholder group.
[b] N/A indicates that the survey question was not asked to that stakeholder group. Primarily, this was because service user surveys were intentionally designed to be shorter with the goal of being less burdensome for service user participants to complete. A structured, consensus-based decision-making process was undertaken in collaboration with anchor partners to determine which survey questions should be prioritized
[c] For the purposes of this analysis, missing data includes the responses "I don't know" and "Not applicable."
[d] % agreement was calculated as the sum of "Strongly agree" and "Agree" responses for each survey measure.

Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1. Continued

Key Concept	Survey measure	Scale	Responses and % agreement among stakeholder group	
			Service users (N=20) n (%)	Service providers (N=92) n (%)
Harm reduction; trauma-informed care	The TCCS acknowledges service users' unique identity, personal strengths and life experiences.	Strongly agree	16 (84%)	36 (52%)
		Agree	2 (11%)	28 (41%)
		Disagree	1 (5%)	3 (4%)
		Strongly disagree	0 (0%)	2 (3%)
		Total Answered	19	69
		Missing	1	23
		% Agreement	**95%**	**93%**
	The TCCS enables service users to share things about their life and needs on their own terms and at their own pace.	Strongly agree	14 (78%)	37 (57%)
		Agree	3 (17%)	25 (39%)
		Disagree	0 (0%)	1 (2%)
		Strongly disagree	1 (5%)	1 (2%)
		Total Answered	18	64
		Missing	2	28
		% Agreement	**95%**	**96%**
	TCCS staff recognize that some people or groups endure more discrimination, violence, abuse and other hardships than others do.	Strongly agree	**N/A**	40 (60%)
		Agree		24 (36%)
		Disagree		1 (1%)
		Strongly disagree		2 (3%)
		Total Answered		67
		Missing		25
		% Agreement		**96%**

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Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1. Continued

Key Concept	Survey measure	Scale	Responses and % agreement among stakeholder group	
			Service users (N=20) n (%)	Service providers (N=92) n (%)
Trust; safety; participation/ choice/rights	TCCS staff explain the types of supports that can be offered to service users in a way that they can understand.	Strongly agree	**N/A**	34 (49%)
		Agree		32 (46%)
		Disagree		3 (4%)
		Strongly disagree		1 (1%)
		Total Answered		70
		Missing		22
		% Agreement		**95%**
	The TCCS enables service users to feel confident in asking questions about the supports they were offered.	Strongly agree	15 (79%)	30 (43%)
		Agree	3 (16%)	36 (52%)
		Disagree	1 (5%)	3 (4%)
		Strongly disagree	0 (0%)	1 (1%)
		Total Answered	19	70
		Missing	1	22
		% Agreement	**95%**	**95%**
	The TCCS is supportive of service users in deciding the types of supports they want.	Strongly agree	12 (67%)	32 (46%)
		Agree	5 (28%)	35 (50%)
		Disagree	1 (5%)	2 (3%)
		Strongly disagree	0 (0%)	1 (1%)
		Total Answered	18	70
		Missing	2	22
		% Agreement	**95%**	**96%**

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Appendices

Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1. Continued

Key Concept	Survey measure	Scale	Responses and % agreement among stakeholder group: Service users (N=20) n (%)	Service providers (N=92) n (%)
Trust; safety; participation/ choice/rights	The TCCS advocates for service users' best interests.	Strongly agree	N/A	36 (52%)
		Agree		29 (42%)
		Disagree		2 (3%)
		Strongly disagree		2 (3%)
		Total Answered		69
		Missing		23
		% Agreement		**94%**
	TCCS staff genuinely want to help service users.	Strongly agree	15 (83%)	46 (58%)
		Agree	3 (17%)	28 (36%)
		Disagree	0 (0%)	4 (5%)
		Strongly disagree	0 (0%)	1 (1%)
		Total Answered	18	79
		Missing	2	13
		% Agreement	**100%**	**94%**
	The TCCS promotes emotional safety while service users are receiving support.	Strongly agree	15 (79%)	36 (51%)
		Agree	3 (16%)	33 (47%)
		Disagree	0 (0%)	1 (1%)
		Strongly disagree	1 (5%)	1 (1%)
		Total Answered	19	71
		Missing	1	21
		% Agreement	**95%**	**98%**

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Appendices

Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1. Continued

Key Concept	Survey measure	Scale	Responses and % agreement among stakeholder group	
			Service users (N=20) n (%)	Service providers (N=92) n (%)
Trust; safety; participation/ choice/rights	The TCCS promotes physical safety while service users are receiving support.	Strongly agree	17 (89%)	33 (47%)
		Agree	2 (11%)	27 (39%)
		Disagree	0 (0%)	7 (10%)
		Strongly disagree	0 (0%)	3 (4%)
		Total Answered	19	70
		Missing	1	22
		% Agreement	**100%**	**86%**
	The TCCS enables service users in sharing feedback about their experience if they had a complaint or compliment.	Strongly agree	13 (68%)	25 (46%)
		Agree	6 (32%)	24 (44%)
		Disagree	0 (0%)	3 (5%)
		Strongly disagree	0 (0%)	3 (5%)
		Total Answered	19	55
		Missing	1	37
		% Agreement	**100%**	**90%**
	The TCCS ensures that service users know what their personal information is being used for.	Strongly agree	**N/A**	25 (42%)
		Agree		30 (51%)
		Disagree		3 (5%)
		Strongly disagree		1 (2%)
		Total Answered		59
		Missing		33
		% Agreement		**93%**

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Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1. Continued

Key Concept	Survey measure	Scale	Responses and % agreement among stakeholder group	
			Service users (N=20) **n (%)**	**Service providers (N=92)** **n (%)**
Trust; safety; participation/ choice/rights	The TCCS ensures that service users know who to ask if they had questions about their personal information.	Strongly agree	8 (45%)	23 (40%)
		Agree	8 (44%)	26 (46%)
		Disagree	2 (11%)	5 (9%)
		Strongly disagree	0 (0%)	3 (5%)
		Total Answered	18	57
		Missing	2	35
		% Agreement	**89%**	**86%**
Person-centred care; cultural safety	Overall, the TCCS is welcoming and non-judgmental toward service users.[e]	Strongly agree	15 (79%)	41 (53%)
		Agree	4 (21%)	32 (41%)
		Disagree	0 (0%)	2 (3%)
		Strongly disagree	0 (0%)	2 (3%)
		Total Answered	19	77
		Missing	1	15
		% Agreement	**100%**	**94%**
	Overall, the TCCS treats service users with dignity and respect.	Strongly agree	**N/A**	44 (56%)
		Agree		30 (39%)
		Disagree		1 (1%)
		Strongly disagree		3 (4%)
		Total Answered		78
		Missing		14
		% Agreement		**95%**

[e] For service users, this statement and the statement above were combined into one survey question, "Overall, TCCS were non-judgmental and treated me with dignity and respect."

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Appendix P. Survey responses on the extent to which the TCCS has demonstrated that it enacted its guiding principles

Table P1. Continued

Key Concept	Survey measure	Scale	Responses and % agreement among stakeholder group	
			Service users (N=20) **n (%)**	**Service providers (N=92)** **n (%)**
Person-centred care; cultural safety	The TCCS provides service users with options for supports that are relevant to their culture and identity.	Strongly agree	10 (72%)	36 (54%)
		Agree	3 (21%)	29 (44%)
		Disagree	0 (0%)	1 (1%)
		Strongly disagree	1 (7%)	1 (1%)
		Total Answered	14	67
		Missing	6	25
		% Agreement	**93%**	**98%**
	The TCCS promotes cultural safety training and practices in order to meet the needs of service users.	Strongly agree	**N/A**	31 (49%)
		Agree		27 (43%)
		Disagree		4 (6%)
		Strongly disagree		1 (2%)
		Total Answered		63
		Missing		29
		% Agreement		**92%**
	The TCCS recognizes and accommodates service users' disability-related needs.	Strongly agree	9 (75%)	31 (48%)
		Agree	3 (25%)	30 (46%)
		Disagree	0 (0%)	3 (5%)
		Strongly disagree	0 (0%)	1 (1%)
		Total Answered	12	65
		Missing	8	27
		% Agreement	**100%**	**94%**

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Thank you

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