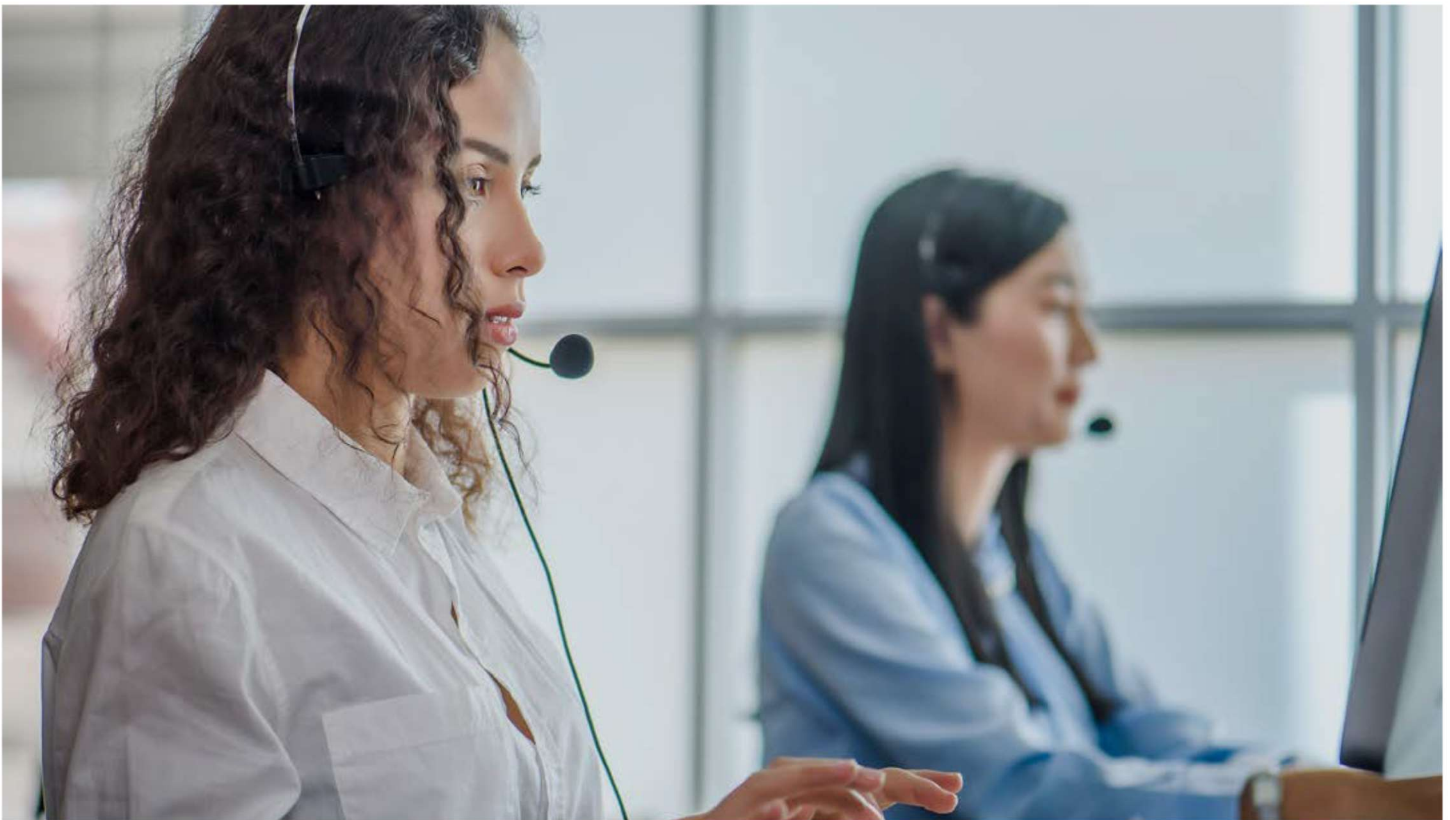
Sections of this report have been redacted to protect the anonymity of the focus group participants.

Meeting Non-Emergent Mental Health-Related Crisis Needs through Alternative Responses

Findings from an evaluation of the 911 Crisis Call Diversion Pilot Program



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Authors

Emma Costello, MPH
Nelson Pang, MSW
Stefanie Stuart-Williams, MPH
Hamer Bastidas-Bilbao, PhD

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Contact Information

Laura Gibbs
Manager, Evaluation – Clinical Programs and Community Initiatives
Provincial System Support Program, CAMH
Email: laura.gibbs@camh.ca

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Executive Summary

Background and Methods

This report presents the findings of the evaluation of the 911 Crisis Call Diversion Pilot Program (911 CCDPP). This program was developed by the Toronto Police Service (TPS) and the Gerstein Crisis Centre (GCC). It aims to divert non-emergent mental health-related calls from a police response by offering eligible callers the option to be transferred to a crisis worker co-located at the 911 Communications Services Call Centre. The GCC crisis worker can provide de-escalation interventions, follow-up, referrals to community-based services, or de-escalation support while police are en route. The 911 CCDPP was also conceived with the aim to alleviate the strain these calls can cause on TPS resourcing, in particular, response times to all incoming 911 calls and overall resourcing for on-site responses.

This program was first introduced in 2021 and later expanded to a 24/7 city-wide operation in 2022. The Centre for Addiction and Mental Health (CAMH) was engaged by TPS to conduct an evaluation. The evaluation findings will be used to decide whether the program should continue, and if it does, how it could be improved. Therefore, this evaluation was built upon the Utilization-Focused Evaluation (UFE) framework, including approaches and practices to ensure the participation of all relevant stakeholders, along with equity principles throughout the evaluation design. By adopting the UFE framework, this evaluation aimed to enhance uptake of its findings and recommendations. Furthermore, it was also necessary to adopt multiple methodological approaches to investigate the logic and assumptions (program theory) underlying the 911 CCDPP, its achieved and yet-to-be-achieved outcomes, relevant factors explaining the program's successes and challenges, and potential future improvements.

This evaluation analyzed multiple sources of data including: TPS administrative data from the first 27 months of program operations; program planning documents; questionnaire data; focus groups; interviews; and a validated tool assessing collaboration with members of frontline teams, management, and leadership from both organizations. Quantitative data were analyzed descriptively and qualitative data were analyzed using a modified version of Iterative Thematic Inquiry. A brief program-level assessment of equity and accessibility was also conducted.

Results

Our findings were grouped into three key takeaways, described below:

Key Takeaway 1: The program is meeting an established need in new ways

We found that the program does meet an established need for callers who may not have access to, or awareness of, other relevant services or supports during mental health-related crisis situations. Notably, service user participants who were referred by the 911 CCDPP to community-based supports reported being satisfied with such process and the overall service experience. The program has also become increasingly successful at diverting non-emergent mental health-related crises from police resources with 51% (n=1951) of eligible calls being successfully diverted. This was observed along with downward trends of declined diversions and incomplete diversions of eligible calls. However, the volume of all mental-health related events TPS responded to remained substantial. Although not every single mental-health related event can be considered eligible for diversion, these contrasts shed light on how the 911 CCDPP has made a meaningful yet comparatively small quantitative impact, and how there may be untapped potential for increased diversion opportunities.

Key Takeaway 2: Key operations are not connected despite expectations and some positive collaboration experiences

Despite initial expectations and evidence of positive collaboration experiences, the key operations of the program—crisis call screening, diversion, and co-response—lack integration. This lack of integration was described by stakeholders as a contributing factor associated with inconsistent numbers of calls transferred by TPS communications operators (COs) to the GCC crisis workers, and variable involvement of crisis workers in co-response events. The program's service delivery flow was also found to be negatively impacted by caller education and consent discussions, which must be completed by COs before an eligible call is transferred to a crisis worker. Staffing of the crisis desk was also identified as a factor contributing to inconsistent service availability and delivery. All these aspects were identified in a context where the 911 CCDPP, its aims, people, and outcomes, were perceived as having only modest internal and external visibility.

Executive Summary

Key Takeaway 3: There are partnership challenges

We found that underlying the challenges faced by the program is a lack of trust between the partner organizations. This lack of trust is illustrated by perceptions of low skill and competence between members of the TPS communications team and the GCC crisis team, and in divergent perceptions of commitment shared by members of both TPS and GCC leadership teams. The future of the program was perceived as uncertain, which further underscored the highly contrasting experiences lived by the stakeholders involved with the implementation of the 911 CCDPP.

Recommendations

The 911 CCDPP can benefit from strengthening the engagement between partner teams during critical processes such as planning, staff onboarding, quality monitoring, and others. Collaboratively revisiting and agreeing upon the program's assumptions and its overall conceptualization, together with the establishment of clear, standardized processes for call screening, diversion, co-response, and data collection and analysis, are all crucial steps for creating improvement opportunities. Further strengthening of equity and accessibility within the program design and implementation can also contribute to a better response to the needs of Toronto's diverse population. Lastly, as the program is immersed in broader mental health and social service systems, it can also benefit from developing and/or strengthening any awareness and advocacy endeavors aimed at decreasing barriers and improving system-level investments to ensure that individuals and communities across Toronto can equitably access and benefit from mental health supports when most in need. These recommendations are summarized below:

1. Strengthen the partnership by implementing opportunities for ongoing inter-partner engagement
2. Collaboratively review the program theory and objectives to develop attainable and well-defined goals, key operations, resources, and outcomes
3. Improve operational challenges by establishing clear, standardized processes for call screening, intake, co-response, and data collection and analysis processes
4. Encourage diversion by developing public education and awareness campaigns on available community-based crisis supports and their intended uses
5. Encourage diversion by continuing to advocate for increased investment into the broader mental health and social service systems

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Abbreviations

911 CCDPP: 911 Crisis Call Diversion Pilot program

CAMH: Centre for Addiction and Mental Health

CO: Communications Operator from TPS Communication Services

GCC: Gerstein Crisis Centre

MCIT: Toronto Police Service Mobile Crisis Intervention Team

MHAAP: Toronto Police Service Mental Health and Addictions Advisory Panel

PSSP: Provincial System Support Program

TCCS: Toronto Community Crisis Service

TPS: Toronto Police Service

UO: Uniformed Officer from the TPS Primary Response Unit

UOEA: Unintended Outcomes Evaluation Approach

Background and Context

In Ontario, over 80% of mental health-related 911 calls are non-violent in nature (Bromberg, n.d.), yet institutions, such as police services, have become the default first responders for people in mental health-related crisis (Balfour, 2021; Romeo-Beehler, 2022). In Toronto, the Toronto Police Service (TPS) annually handles approximately 33,000 mental health-related calls, a number that has grown by approximately 30% in recent years (Murray, 2021). However, academic researchers and mental health advocates have called for alternatives to the traditional police response to mental health crises. It has been argued that this is particularly important for historically marginalized communities who experience disproportionate use of force, invasive searches, and criminal legal system interactions (Marcus & Stergiopoulos, 2022; Murray, 2021). By design, the immediate intervention by police, or the short-term medical attention that people in mental health-related crisis receive in hospital emergency departments, is not enough to prevent repeated crisis incidents. Moreover, police-led responses to mental health-related calls also diverts police resources away from responding to crime (Romeo-Beehler, 2022).

In alignment with the TPS Board's 81 recommendations on police reform (Hart, 2020) and TPS's 2019 Mental Health and Addictions Strategy (Toronto Police Service, 2019), TPS developed the 911 Crisis Call Diversion Pilot Program (911 CCDPP) in collaboration with the Gerstein Crisis Centre (GCC). It was envisioned as an alternative, innovative, and collaborative model of mental health crisis response. This program was designed to achieve the following objectives:

1. divert mental and behavioural health crisis calls received by TPS communications operators (COs) to GCC crisis workers, reducing both demand on TPS COs and the need for a subsequent police response;
2. improve stakeholder and community experiences of crisis response; and
3. improve service users' connection to community-based follow-up support services.

Launched as a one-year pilot in October 2021, the program initially provided service 20 hours a day, seven days a week in TPS Divisions 14, 51, and 52 (GCC's service area). After a 6-month internal evaluation report (Carter, 2022) demonstrated preliminary success, the pilot was extended for another year in October 2022 as a 24/7, city-wide service. The extension of the program also offered an opportunity for conducting a more fulsome evaluation. The pilot has since received a second extension, set to end on September 30, 2024. During this pilot period, the City of Toronto also piloted and expanded the Toronto Community Crisis Service (TCCS), a separate non-police-led, community-based initiative to provide response services in mental health- and substance use-related crisis situations (City of Toronto, 2023).[1] Similar to the 911 CCDPP, TCCS can also be pathway to divert service users away from a police-led response when the initial contact is made through 911. In light of the evolution of the 911 CCDPP and the changing landscape of community-based supports for non-emergent mental health-related crises, TPS contracted the Provincial System Support Program (PSSP) at CAMH to evaluate the 911 CCDPP and gather information to inform decisions on the program's future.

Program Description

As described by Carter (2022), the 911 CCDPP provides a new response option for non-emergent mental and behavioral health-related 911 calls. This program aims to connect people in crisis, where there is no imminent risk, with community-based supports rather than a police response by identifying and diverting appropriate calls to trained GCC crisis workers co-located in the 911 Communications Services Call Centre.

TPS communications operators (COs) screen incoming calls based on specific risk criteria, and then offer eligible callers the opportunity to speak to a crisis worker, instead of police attending their location to respond to the situation; this response pathway is referred to as **"diversion."** With consent from the caller, the TPS CO then transfers the call to a GCC crisis worker.

Through an independent and confidential telephone system, the GCC crisis worker assesses callers for risk and provides immediate crisis support and de-escalation services. The discussions between a caller and a crisis worker are protected under the *Personal Health Information Protection Act (2004)* and are not recorded by TPS.

[1] The TCCS began operations in March 2022, with staggered launch dates across four geographical pilot regions in Toronto. It is set to expand city-wide by the end of 2024 (City of Toronto, 2023).

Background and Context

After the crisis worker determines that there are no imminent risks, they use empathy, respect, collaborative problem-solving and work from an equity-based approach to support the caller in developing a foundation of safety and strength referred to as a "Safety Plan" (Gerstein Crisis Centre, n.d.). The Safety Plan includes:

- identifying coping strategies;
- involving individuals who are a source of support in their lives;
- safeguarding the service user's environment by removing suicide means and other risk factors;
- highlighting the service user's reasons for living and what helps them stay safe;
- facilitating the creation of a safer environment (e.g., making agreements where callers agree to do certain things that maintain their safety, such as spending the day with a friend or family, or accepting a crisis, detox or shelter bed);
- identifying future supports, including scheduling follow-up calls, connecting with existing community supports or accepting linkages to new community supports; and/or
- planning ahead in case the service user experiences intense thoughts and feelings or is in imminent danger.

Crisis workers also provide crisis management and follow-up services for those who consent to receive further contact following the initial crisis. The role of crisis management and follow-up is to provide additional support and connection to services relevant to the needs expressed by the caller. As a whole, these additional supports and services could help identify, control, and reduce the factors that are likely to cause people to experience a future crisis (Gerstein Crisis Centre, n.d.), and may include:

- short-term supportive counselling;
- short-term service navigation;
- reconnection to existing supports; and
- connection to crisis services as an alternative to calling 911.

The 911 CCDPP also offers a **"co-response"** pathway for crisis calls that are not suitable for diversion from the police but could still benefit from de-escalation support provided by a crisis worker. In the co-response pathway, the crisis worker stays on the line with the caller until Uniformed Officers (UOs) arrive on scene. The crisis worker provides immediate crisis intervention and de-escalation to support the caller until the police arrive. The crisis worker also works collaboratively with caller to manage any expectations about police interactions; this aims to reduce harm and achieve safer outcomes (Carter, 2022). Callers who are supported through a co-response can also access crisis management and follow-up services after the initial call.

Program Eligibility Criteria

Calls are considered eligible for diversion through the 911 CCDPP if they meet any of the following 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, wherein a crisis worker can attempt to resolve with intervention and where there is no perceived or real risk of violence
3. a non-violent person requesting police presence 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 mental health crisis requesting TPS's Mobile Crisis Intervention Team (MCIT)
6. second-party callers concerned about the welfare of a non-violent person suffering a mental health crisis

Calls that are not suitable for diversion but may be eligible for co-response include those that involve:

- an imminent threat to life or property;
- violence or the threat of violence;
- violent tendencies;
- weapons;
- a criminal offence;
- attempted suicide;
- drug overdose;
- medical attention;
- a person under 16 years;
- public lewdness;
- domestic violence or incident; or
- a 911 call received from a crisis line, hospital, or emergency clinic.

Evaluation Purpose, Objectives, and Scope

The overall purpose of this evaluation was to inform a decision of whether the program should continue, and if it is decided that the program should continue, what changes should be adopted moving forward. This decision cannot be made without knowing what the program has achieved during its operation, what it is yet to achieve, what factors explain the program's successes and challenges, and what the future could look like. As such, the overall objectives of this evaluation were to:

1. understand the degree to which the program's objectives have been met and what outcomes – expected and unexpected – have been achieved to date;
2. describe contributing factors to the program's realized and unrealized (desired) outcomes; and
3. describe options for the program's future beyond the pilot period.

To ensure feasibility, this evaluation was limited to investigating calls that occurred within the first 27 months of program operation (i.e., October 4, 2021 to December 31, 2023), which comprised the origins of the program and its city-wide expansion. Service users, and staff from frontline, management, and leadership teams directly involved in the 911 CCDPP participated in this evaluation, as they were the most relevant stakeholders who represented both the program's implementation team and the program's target users.

Lastly, the need to decide on the program's future made it necessary to ensure that this evaluation, and its findings, can be used by all stakeholders. This required grounding the evaluation on a framework to ensure its utilization, together with the adoption of multiple methodologies tailored to capture an in-depth understanding of the program's resources, rhythms, and relationships. These approaches are described in more detail in the sections, Guiding the Evaluation: Co-Design, Equity and Engagement and Evaluation Approaches.

Evaluation Questions

In line with the evaluation purpose and objectives described above, this evaluation sought to answer three key questions and sub-questions:

1. **How successfully has the program met its objectives?**
    a. To what extent, and how, were mental and behavioral health crisis calls responded to by the 911 CCDPP?
    b. To what extent, and how, were direct crisis supports provided and connections made to appropriate community-based follow-up supports through the 911 CCDPP?
    c. How did stakeholders experience the 911 CCDPP, and how did access, experiences, and/or outcomes vary within and across groups?
    d. What unintended outcomes have emerged, if any?
2. **What factors of the 911 CCDPP are contributing to the program's realized and unrealized outcomes, as well as to accessibility and equity?**
    a. How is the program design affecting program delivery and outcomes?
    b. How are the financial, human, systemic, and/or physical (e.g., infrastructure, technology, etc.) factors facilitating or impeding the program in reaching its objectives?
    c. In what ways has the partnership between TPS and GCC affected the program outcomes?
3. **What are the opportunities for the future of the program?**
    a. What are the strengths and challenges with the current iteration of the program?
    b. What are opportunities and potential strategies for improvement?

Guiding the Evaluation: Co-Design, Equity and Engagement

This evaluation was guided by Patton's (2011) utilization-focused evaluation (UFE) framework. This framework emphasizes that evaluations should be designed and conducted with real-world use and learning in mind. Findings should be relevant and useful to their intended users (Patton, 2011). In line with the UFE framework, the intended primary users of the evaluation were identified as TPS and GCC. These partners were engaged from the onset of the project to understand their needs and expectations from the evaluation, including how they intended to use the evaluation process and its products (Patton, 2011).

In alignment with PSSP's approach, this evaluation also incorporated the following equity and engagement principles and practices:

1. **Inquiry:** Equity-centered language was embedded in the evaluation questions, objectives, and tools.
2. **Engagement:** A Project Committee consisting of individuals with the relevant "bundle of knowledge and skills"[2] needed to inform evaluation planning and reporting was convened for ongoing engagement with the evaluation team. Balance was sought to ensure representation from both TPS and GCC. Consultation was also sought from TPS's Mental Health and Addictions Advisory Panel (MHAAP), which includes individuals with "lived experience of mental health and addictions issues" (Toronto Police Service Board, 2024).
3. **Accessibility:** Accommodations were actively offered to participate in the evaluation, and multiple methods of participation were offered (e.g., verbally or in writing).
4. **Analysis:** A brief program-level equity analysis was conducted.

This evaluation uses the following definitions:

Equity: "Equity understands, acknowledges and removes barriers that prevent the participation of any individual or group, making fair treatment, access, opportunity, advancement and outcomes possible for all individuals." (City of Toronto, 2020)

Inequity: "[...] [I]nequities refer to unfair and avoidable differences in service access, experiences, impacts and outcomes." (City of Toronto, 2020)

This evaluation was co-designed to be useful, feasible, participatory, and grounded in evidence. Evaluation planning was facilitated by the PSSP evaluation team together with a consultation and co-design phase with project partners to ensure the evaluation was relevant and feasible to its intended users. The evaluation team also developed the preliminary evaluation matrix, methodology, and tools for partner review, refinement, and final approval. Appendix A contains more details on the evaluation governance structure, including the co-design and collaboration process behind this evaluation.

[2] The "bundle of knowledge and skills" included, but was not limited to: knowledge and experience developing and delivering mental health services to one or more priority populations; experience receiving crisis response services; lived experience of mental health and/or addictions challenges; lived experience of racism and other intersectional forms of oppression; knowledge of the 911 CCDPP from a service delivery and leadership perspective; experience providing leadership in the area of health equity; expertise in monitoring and evaluating equity-focused initiatives; expertise in information and telecommunications technology; and expertise in data and analytics.

Evaluation Approaches

As mentioned in the previous section, this evaluation was grounded on a UFE framework. This framework focuses on how evaluations and findings can be used; this is done by emphasizing principles, procedures and practices to bring all relevant 911 CCDPP stakeholders together around common evaluation goals, activities, and uptake of findings and corresponding recommendations.

We also adopted approaches to guide our methodological decisions regarding specific aspects of the program to be explored and the best ways for doing so. For this purpose, we adopted three approaches as follows:

1. theory-driven evaluation
2. unintended outcomes evaluation approach (UOEA)
3. mixed methods inquiry

Theory-driven evaluations (Chen, 1990) are guided by a "program theory", which outlines how the program works to achieve its intended outcomes. This is done by identifying assumptions and mechanisms that link together the program resources, activities, products, and outcomes. By focusing on program theory, the evaluation can test its validity and lead to an in-depth understanding of the program and the reasons for its effectiveness, if any.

Additionally, UOEA helped us explore whether the 911 CCDPP has produced any unintended outcomes, either extra benefits or negative impacts, in certain contexts (Jabeen, 2017). With UOEA, relevant findings can be used to capitalize on the positive unintended outcomes and reduce or remove any negative unintended outcomes. It follows a three-step process to study unintended outcomes:

1. **Outlining program intentions:** We used program documents, existing evidence, and stakeholder consultations to clarify what outcomes the program hopes to achieve.
2. **Anticipating likely unintended outcomes:** We reviewed existing evidence and consulted with stakeholders to identify unintended outcomes that may arise from the program's activities.
3. **Mapping the anticipated and understanding the unanticipated:** We collected data to identify and map any unintended outcomes that occurred, and used relevant literature to help explain the findings.

Finally, this evaluation adopted a mixed methods inquiry approach (Greene, 2005) to gather different data that responded to issues of concern not only to stakeholders with decision authority, but also to those who were part of the program frontlines. This required the simultaneous collection, analysis, and interpretation of quantitative and qualitative data representing quantifiable outcomes situated in a context rich in experiences, perspectives and meanings that, when taken together, shed light on how the program works and how it has responded to the needs voiced by its service users.

Methods

Informed by the evaluation approaches described in the previous section, this evaluation followed three iterative stages:

1. developing initial program theory.
2. exploring program delivery, experiences, and outcomes; and
3. exploring opportunities for improvement.

The following subsections will describe each stage and its methods for data collection, participant recruitment, and data analysis. As previously mentioned, we employed a variety of qualitative and quantitative data sources (primary and secondary) to capture robust, diverse perspectives from relevant stakeholder groups. The evaluation matrix in Appendix B summarizes the evaluation questions and data sources used to answer each.

Stage 1: Developing Initial Program Theory

The purpose of Stage 1 was to develop the initial program theory, which we depicted in a preliminary logic model (Appendix C). A logic model is a visual representation of the resources, activities, outputs, and outcomes of the program. The logic model presented was informed by three sources of data:

1. a review of key program documents provided by partners (e.g., pilot proposal, 6-month evaluation report, board reports, others);
2. routine consultations with the Project Committee; and
3. a review of existing evidence on crisis call diversion models (to foresee any unintended outcomes or program risks).

The evaluation team developed a preliminary logic model based on the resources then available. It was later reviewed and approved by the Project Committee. This stage took place from January to March 2024.

Stage 2: Exploring Program Delivery, Experiences, and Outcomes

Once the logic model was established, we collected data to “test the theory”, determining whether and how the program is achieving its intended outcomes, and whether any unintended outcomes have occurred. Primary data collection tools also offered space for participants to share views and experiences that could help identify potentially unintended outcomes. This stage took place from April to June 2024 and included a variety of data sources from diverse stakeholders.

Data Sources

Quantitative data on 911 CCDPP outputs 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 obtained from administrative records of TPS and GCC. Data was inclusive of the date of the first call received by the 911 CCDPP on October 4, 2021, to December 31, 2023.

Primary data collection was cross-sectional and took place between April and May 2024. We administered a questionnaire to service users in May 2024, exploring 911 CCDPP delivery, their experiences of the program, and potential outcomes. The questionnaire included Likert-type questions and open-text boxes to provide both quantitative and qualitative data about service users’ experiences.

We conducted qualitative focus groups with frontline staff and managers from TPS and GCC to explore their experiences and perceived outcomes of the 911 CCDPP. We conducted interviews with members of each organization’s executive leadership team. Focus groups and interviews took place from April to May 2024.

In addition, TPS and GCC staff members involved in the program could complete the Wilder Collaboration Factors Inventory (Wilder Inventory; Mattessich et al., 2001) from April to May 2024 to explore their perceptions of the partnership between the two organizations. The Wilder Inventory is a validated tool that measures factors of collaboration such as mutual respect, shared vision, and social climate (Mattessich et al., 2001). This inventory has 44 items grouped into 22 factors associated with successful collaboration. Unfortunately, due to a technological error, the source of the Inventory provided only half of the Inventory questions. As a result, we only measured 11 of the 22 factors. Participants from both organizations used a 5-point Likert-type scale to score each item.

Data sources and their frequency and timing are summarized in the evaluation matrix (Appendix B).

Methods

Participants and Recruitment

Two main participant groups were included in the evaluation: service users and service providers. Service user participants were individuals who called 911 and spoke to a GCC crisis worker as part of the 911 CCDPP. Crisis workers from GCC identified potential service user participants and invited them to complete an online questionnaire or connect with a CAMH evaluator to do the survey over the phone. We collected data from service users from May 14 to May 31, 2024.

Service providers included: (1) staff in leadership roles, including management, supervisors, and/or senior or executive leadership; and (2) frontline staff who are involved in providing services directly to 911 CCDPP users. Relevant frontline staff at TPS included COs and UOs. Frontline staff at GCC included co-located crisis workers. Eligible frontline staff that were directly involved with the program (as identified by the main contacts at each organization) were invited via email to attend a focus group. In total, five focus groups were offered, one for GCC crisis workers, one for GCC management, one for TPS COs, one for TPS UOs, and one for TPS management. After the first focus group for GCC crisis workers, we added a question to the focus group guide, soliciting opinions about the future of the program. Participants from that first focus group were then invited to an additional 30-minute discussion to gather data for this new question. Each focus group only included participants working in the same team, and at the same organizational level, to ensure that they could share candid thoughts.

The evaluation team endeavoured to provide a recruitment process and participation environment that was low-barrier, non-stigmatizing, and voluntary for participants. The evaluation team co-developed intentional engagement methods with the Project Committee, including offering multiple options for participation (e.g., completing the service user questionnaire online or over the phone), some accommodations for disability (e.g., text-to-speech or screen magnifiers for the online survey), abiding by informed consent practices, providing honoraria, and providing materials in advance. Sample sizes for each participant group and data collection method are summarized in Table 1.

Data Analysis and Interpretation

Quantitative data from administrative records and questionnaires were cleaned and organized in Microsoft Excel. We performed descriptive statistical analyses including frequencies, measures of central tendency, and proportions. Where possible and relevant, data was disaggregated by time period, event type, program function, and/or organization.

Table 1. Service users and staff from the Toronto Police Service (TPS) and Gerstein Crisis Centre (GCC) participated in this evaluation

Participant group	Organization	Participant level	Sample size*			
			Questionnaire	Wilder Inventory	Focus group	Total
Service users	N/A	N/A	13			13
Service providers	Toronto Police Service	Leadership		11	6	55
		Frontline staff (COs and UOs)		25	13	
	Gerstein Crisis Centre	Leadership		3	3	12
		Frontline staff (crisis workers)		3	3	

* These numbers may not represent the number of *unique* participants, as service providers were able to participate in both the Wilder Inventory and focus group/interview.

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Methods

For the Wilder Inventory, we calculated the average for all items representing each collaboration factor. Factor scores were also calculated for each organization (i.e., TPS and GCC) and compared against each other to identify organizational differences. The maximum score for each factor is 5.0. According to the Wilder Inventory developers, factors with average scores of 2.9 or lower reveal a concern and should be addressed; factors scoring between 3.0 and 3.9 are borderline and should be discussed by the group to see if they deserve attention; and factors scoring 4.0 or higher show a strength and likely do not need special attention (Mattessich & Johnson, 2016).

Interviews and focus groups were recorded and transcribed using Webex. We analyzed the transcripts using a modified version of Iterative Thematic Inquiry (ITI; Morgan & Nica, 2020). This deductive and reflexivity-centered approach systematically encourages analysts to identify the assumptions or preconceptions that they may develop during data collection activities. The analysts then openly conceptualize and describe their assumptions and use them as preliminary themes. Afterwards, evaluators iteratively code each data source and identify evidence for and against each preliminary theme. All themes are progressively refined until a cohesive narrative is obtained.

For the modified version of ITI (Morgan & Nica, 2020), three evaluators, actively involved during data collection activities, gathered to identify and describe a set of shared initial perceptions of the program that were used as preliminary themes. Afterwards, two evaluators coded each transcript, gathering evidence for and against each preliminary theme. They also discussed any insights or thematic refinements as they arose. Unlike the original ITI approach, the evaluators also proposed preliminary recommendations based on the analysis of each individual transcript. Once all transcripts were coded, the entire evaluation team (including the project lead and the health equity specialist) gathered and discussed a proposed narrative structure, encompassing qualitative and quantitative findings, that was used to organize the Results section. As previously mentioned, this structure was developed to ensure that no data was interpreted in isolation from the context of the program, its transformations over time, and the experiences of those involved.

In addition, program planning documents (e.g., pilot proposal and 6-month evaluation report), transcripts and audio recordings of focus groups and interviews, service user questionnaires and sociodemographic data practices were analyzed for a brief program-level assessment of equity and accessibility. To fill gaps in information, a short, focused discussion was facilitated with the Project Committee in June. The analysis included a search for equity and accessibility-related needs, program activities or functions, experiences, outcomes, expectations, strengths or challenges, and/or mention of priority populations. The assessment of sociodemographic data collection compiled 911 CCDPP's sociodemographic indicators, response rates compared to response rates when best practice is implemented, and any relevant qualitative data about the process.

Stage 3: Exploring Improvement Opportunities

The final stage aimed to answer evaluation question 3b, identifying areas and/or strategies for program improvement based on the findings from the first two stages using a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis (Appendix D). A SWOT analysis is an approach that maps internal (strengths and weaknesses) and external factors (opportunities and threats) that may help or harm the program, which can be used to develop strategies for improvement (Renault, 2017). The SWOT analysis was conducted by the PSSP evaluation team, with additional support from a Senior Health Policy Analyst and a Senior Innovation Specialist from PSSP in June 2024. The SWOT analysis, along with preliminary evaluation findings, were subsequently reviewed by the Project Committee, with the aim to improve the quality of data interpretation, have a clearer view of the context surrounding specific findings, facilitate dialogue across diverse perspectives, and build support for the use of the findings (Rogers, n.d.). Data from this stage informed the evaluation recommendations.

Ethical Considerations

This evaluation was guided by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2022), although we did not conduct an external ethics review.

Privacy, Consent, and Compensation

Taking part in this evaluation was voluntary and informed consent was secured from all participants. All information received from participants was kept confidential and any documents containing evaluation data were de-identified. All data was stored in CAMH password-protected servers, accessible only to internal evaluation team members.

Each participant joining any facilitated evaluation activity received an information package detailing the evaluation aims, as well as the data collection process, purposes, risks, and benefits. Evaluators reviewed this information during each focus group, ensured comprehension, answered any questions, and acquired verbal consent prior to commencing the focus group and audio recording the session. To ensure that both the participating individuals and the space of connection were safe, inclusive, and respectful, evaluators created continuous opportunities for checking-in, moments of reflection, and a reciprocal dialogue.

Online questionnaire participants received a link to a REDCap survey, which required them to review the same information package—including all details and the privacy considerations described above —shared with other participants and provided their informed consent before completing the questionnaire. Service users were offered an honorarium of $30, in the form of a choice of gift card, electronic funds transfer, or cheque, to show appreciation for their time and contribution to this evaluation. Frontline staff (UOs and COs) from TPS were compensated for their time by their employer following their own internal procedures and guidelines.

Results

The results of this evaluation are presented in the form of key takeaways, summarized in Figure 1, with supporting data provided below in detail. As mentioned in a previous section, qualitative data is essential to understand how the program has been experienced by different stakeholders, but also to contextualize metrics obtained from administrative data. We are mindful that narratives describing the experience of the program can be extensive and may have an impact on the overall readability of this report. For this reason, we are presenting only a limited number of direct quotations from evaluation participants to illustrate each takeaway, but more perspectives can be found in Appendix E. All illustrative quotes, including those in the appendix, have informed the evaluative findings and recommendations presented throughout this report.

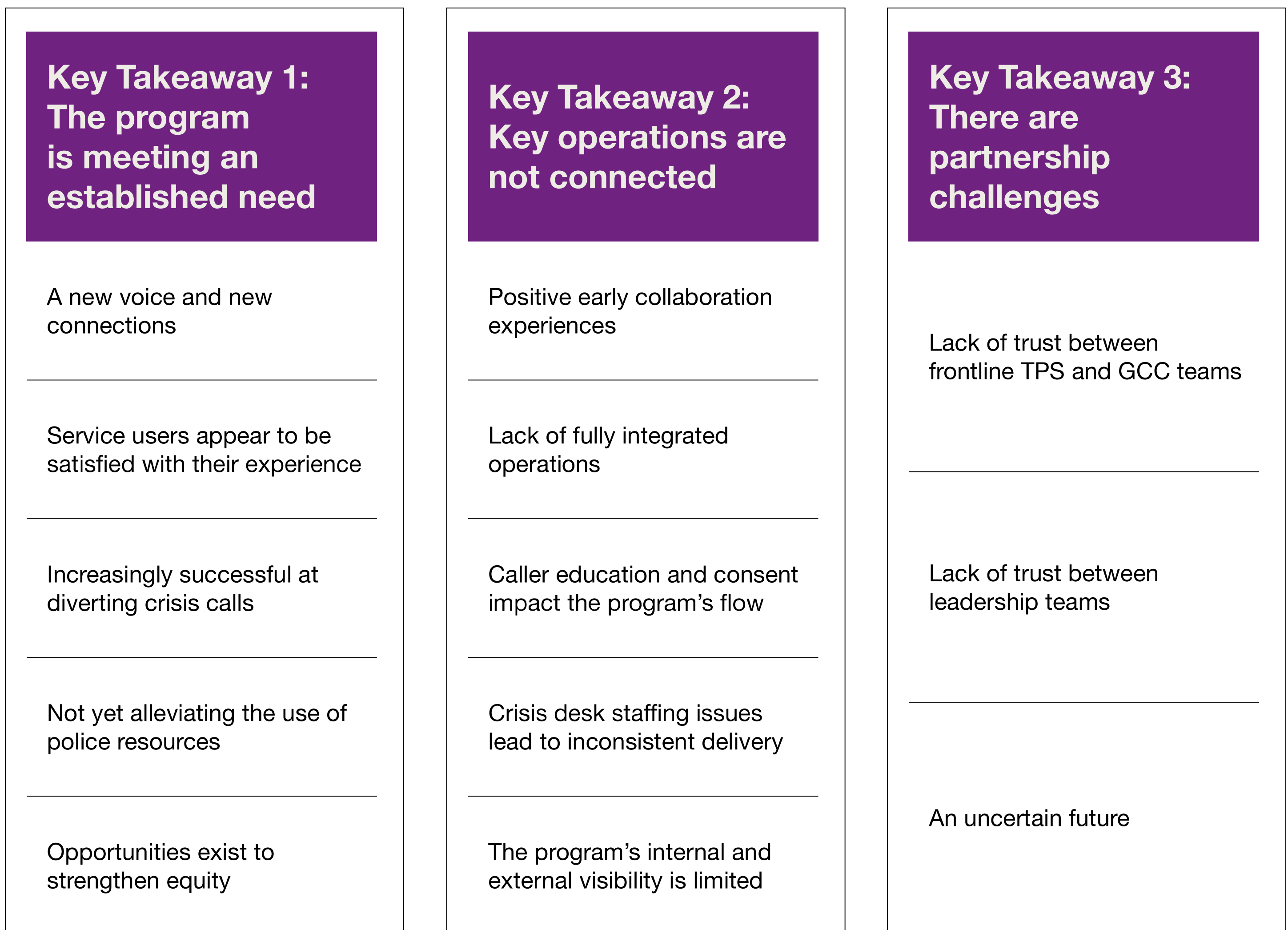

Figure 1. Summary of key takeaways

Results

Key Takeaway 1: The program is meeting an established need in new ways

1.1 The program provides a new voice and new connections

As described in the Background and Context section, people in non-emergent mental health-related crisis frequently choose to call 911, yet 911 was not originally conceived to meet the specific needs of these types of calls. As such, the 911 CCDPP was commended by many evaluation participants for its contributions towards a "paradigm shift", where the primary response is based on community resources. The 911 CCDPP was perceived to be bridging a gap in the current crisis response system, particularly for its ability to leverage a "huge access point we have at 911, to really make sure that it's strongly supported to be connected to mental health services" ( ). Service providers from both GCC and TPS acknowledged that this program can provide immediate support to people in crisis who do not necessarily need urgent in-person support or apprehensions, but may not know resources other than 911. This was thought to include populations such as immigrants or refugees, international students, seniors, and those who may not have access to means other than the phone. As shared :

> "There's always been a frustration for the events […] where an individual obviously needed support, but we recognize that the police were not the appropriate response. So the rollout of this program was, in my view, like an exciting opportunity for us to offer more appropriate supports to people away from the law enforcement system, and I think that it's a great program." ( )

As an alternative model that provides a "health and social response and move[s] away from a criminal justice response"), the 911 CCDPP was thought to improve experiences of receiving crisis support. Members of the team highlighted the benefits of having a program grounded in empathy, empowerment, and collaborative decision-making, which a traditional police response may not always be able to offer:

> "It takes the power away as well, you know, not somebody coming to tell me what to do. It's non-coercive […] for [callers] to choose what's best for them and offer that support, as opposed to the power over, 'This is what you're doing.' […] So, we find it was beneficial to kind of have that [alternative]." ( )

Co-located GCC crisis workers were praised for their ability to use a comprehensive, intersectional lens to support people in crisis with the various factors that may be contributing to crisis. Data from the service user questionnaire supported this finding, as participants indicated that the program supported them with various health and well-being dimensions, including overall mental health; social connectedness; healthy behaviors; coping skills; living conditions; suicidal thoughts/ideation; and well-being related to their unique culture and identity.

As previously described, the 911 CCDPP also provides callers with post-crisis follow-up and referrals to internal and external community-based supports, with the aim of reducing factors that are likely to cause a future crisis. This was perceived to be beneficial in comparison to a traditional 911 response, as:

> "[I]t just gives that opportunity to get connected, whereas [if] you call 911 or non-emergency, [callers] [may not] get a call back; there is no follow-up from that. So, it gives an opportunity […] to be able to have that one extra phone call to make sure they get connected" ( ).

emphasized how their organization's existing expertise and network are assets to ensure that the caller can stay connected post-crisis, with explaining how:

> "[GCC crisis workers] have quite a few tools […] at their fingertips to be able to help connect people to services […] And then of course, just regularly, the crisis workers are really knowledgeable about what's available within the system - systems knowledge." ( )

Between October 4, 2021, and December 31, 2023, GCC crisis workers offered a total of 3,840 referrals to GCC's internal crisis supports. Most commonly, service users were referred to GCC's direct crisis phone line (n=1994; 52%) which serves as an alternative to calling 911 for future crises, thereby contributing to efforts to divert non-emergent mental health-related calls from a police

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response and alleviate strain on police resources. Other common referrals included crisis management and follow-up (n=679; 18%), a mobile crisis visit by GCC's own mobile crisis team (n=467; 13%), and GCC's substance use crisis team (n=360; 9%). Table 2, shown below, provides a breakdown of the internal referrals provided. In addition, GCC has a strong network of external community-based agencies to which they can refer 911 CCDPP service users for support following their initial crisis. Appendix F provides a list of external organizations to which service users are commonly referred. This list is not comprehensive but illustrates the holistic nature of the service provided by the 911 CCDPP.

Table 2. The 911 CCDPP provided 3,840 internal referrals between October 4, 2021, and December 31, 2023

Internal support service	Total # of times provided	% (n=3840)
Crisis phone support	1994	52
Crisis management & follow-up	679	18
Mobile team visit	467	12
Substance use crisis team	350	9
Toronto Community Crisis Service (TCCS; internal)	190	5
Crisis bed	143	4
Finding Recovery Through Exercise Skills and Hope (F.R.E.S.H.)	16	0
DBT distress tolerance	1	0
Total	**3,840**	**100**

Data from the service user questionnaire indicate that 100% (n=5) of participants who were referred to community-based supports were either 'very satisfied' or 'satisfied' with the referral process. Additionally, 39% (n=5) of all service user participants felt that their access to community-based supports increased because of the 911 CCDPP. One survey participant shared that:

> "They stayed connected to me. They provided me with immediate help as well as kept working with me on my long-term goals. The incident happened a year ago and they still check up on me time-to-time." ( )

These findings indicate that the 911 CCDPP can not only address immediate crisis needs using a more person-centered approach, but also facilitate connections with longer-term support and utilization of appropriate mental health-related resources. As service providers noted, "the only hiccups really have to do with just all the things we can't control: waitlists and wait times and how long it takes to get connected" ( ). Therefore, continued success of this aspect of the program may depend on external factors, such as any changes in system-level healthcare investments that can make referrals accessible and sustainable over time.

The 911 CCDPP was also praised by evaluation participants for its co-response service, which was offered a total of 874 times in the first 27 months. This innovation illustrates how the integration of both organizations' expertise can improve the way in which a crisis response occurs. Service providers from TPS and GCC provided examples of how this service pathway contributes to a more efficient management of incoming calls, such as:

> "[I]t's helpful to have [a crisis worker] available in those moments because it allows you to continue with whatever is pending, but you're aware that [callers are] still getting the support they need to bring them down a little bit while officers are on their way so that the situation doesn't escalate further, especially for those people that are triggered by police or they are already concerned and worried that emergency services are coming." ( )

Evaluation participants also highlighted how the GCC crisis workers are able to improve the efficacy and safety of an in-person police response, by preparing and de-escalating the caller. For example, shared how a GCC crisis worker:

> "started to prime [the caller] to get them ready that the police are responding. Again, it was a rare instance but a great one. It was collecting information for us while de-escalating at the same time, with the specialty that a crisis worker has as opposed to just a dispatcher; sort of like a team effort." (

shared how service users have similarly shared positive feedback regarding the co-response service:

> "Clients as well, you know, talk about the benefits of this [co-response] […] Sometimes, when we do follow-up,

> [service users will say], 'Hey, you know, the response I received from the police was different this time.' And it was different because we have that connection […] So, [callers] find that the response is different; it's more respectful, feeling pretty unified, so it's beneficial for them." ( )

Lastly, in partnering with a community-based leader in crisis response and offering a more person-centered response, some evaluation participants perceived that the 911 CCDPP may have broader community-level impacts, including improving the relationship and trust between police and the community. As shared by :

> "I think it's the people in the community saying, 'Wow, Toronto Police might actually be thinking forward, thinking ahead and understanding that we're not the answer to everything and that there are other organizations they're willing to pay, they're willing to partner [with], they're willing to train there to be in the space.' So, I think for public trust, increasing public trust with the community.")

However, it is important to note that, due to feasibility, gathering data from the broader community (e.g., Toronto residents who did not access the service) and measurement of community-level outcomes were out of scope for this evaluation. Future evaluations could focus on these aspects.

1.2 Service users appear to be satisfied overall with their experience receiving support from the 911 CCDPP

The benefits of the 911 CCDPP were also reported by many service user participants as well. Data from the service user questionnaire showed that 77% (n=10) of participants were "very satisfied" or "satisfied" with the support received from the GCC crisis worker. Table 3 shows a high level of agreement—taken as the summed percentage of the survey responses "strongly agree" and "agree"—on various statements related to receiving empathetic and person-centered support from the co-located crisis worker.

Additionally, service users shared mostly positive experiences with the 911 CCDPP overall, with an overall satisfaction (e.g., "very satisfied" or "satisfied") rate of 77%. When asked to reflect on their experiences with the program and/or the impact it has had on their lives, some service users shared positive testimonials.

> "Getting connected to [the] Gerstein crisis worker changed my life for good that day, they went above and beyond to help me and to make sure I was safe. I will always be grateful to [redacted names of two GCC crisis workers]." ( )

> "I was in a crisis and didn't even realize how it was effecting [sic] my mental health. They helped me identify the severity of the situation and also helped me overcome my anxiety, provided me all the referrals and resources I needed. They inspire me to do more for community like what they did for me." ( )

Table 3. Service user participants were satisfied with the support received from a co-located crisis worker through the 911 CCDPP

Statement	% of participants that agreed with each statement (n=13)
I found the crisis worker understood and empathized with my needs when I was feeling stressed or overwhelmed	85%
I was able to share about my life and my needs on my own terms	92%
The crisis worker acknowledged my unique identity, personal strengths, and life experiences	85%
I found the crisis worker to be knowledgeable about supporting mental health needs and the resources available to me	69%
I got to decide what types of supports I wanted	85%
Overall, I didn't feel judged by the crisis worker and was treated with dignity and respect	85%

However, there were also negative experiences shared by some participants, including:

> "I think they need to be educated on how to deal with people with mental health issues and how to talk to people with issues."

> "Feel like talking to a psychologist who is just billing hours. Doesn't feel like they care. Ended up going private

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with care. I feel like there [sic] more concerned about checking billable hours. They're just watching a clock that we've been on the phone for a while and wants to move on." ([redacted]

"Some of the crisis workers minimize problems. Hate talking to certain crisis workers. [It] [d]epends on which crisis worker you get. Answer depends on which time. Gerstein needs to improve their service because people are in crisis. [It] [f]eels like they're giving resources that are not appropriate." ([redacted])

1.3 The 911 CCDPP is becoming increasingly successful at diverting non-emergent mental health-related crisis call away from police resources, albeit with a comparatively small quantitative impact

During the first 27 months of pilot operations, the 911 CCDPP offered services to 1,722 unique individuals, accounting for 4,724 events.[3] This included 3,850 offers for diversion (81%) and 874 offers for co-response (19%). Figure 2 provides an overview of the outcomes of 911 events received during this time period.

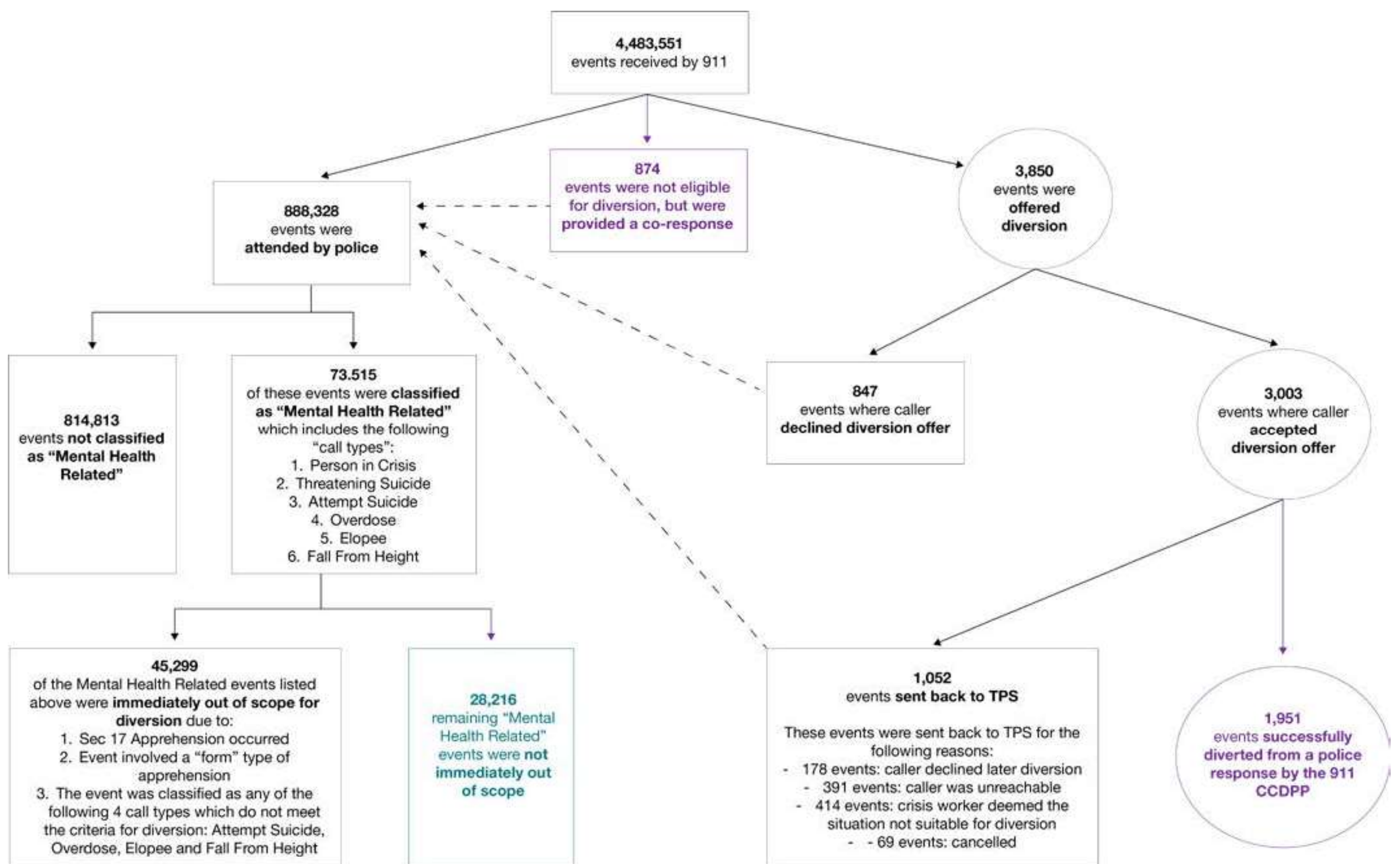

Figure 2. The 911 CCDPP supported 2,825 events during the pilot period and there were 28,216 events that may include more opportunities for diversion

[3] This section uses the term "event" in accordance with the data provided by TPS. An event number is created when an incident is reported to 911. In instances where multiple people call 911 regarding the same event, their information will be added to the same event number. As such, an event represents a unique incident regardless of how many phone calls from the public are received regarding it. Analysis of the data showed that, for this program, each caller was assigned a unique event number, suggesting a 1:1 ratio for calls and events. Therefore, these terms are used interchangeably in other sections of this report.

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1.3.1 Completed diversions

Of the 3,850 eligible events offered diversion, a total of 1,951 were successfully diverted from a police response, resulting in a "completion rate" of 51%. As illustrated in Figure 3 below, the completion rate has been increasing over time, suggesting that, while the program may not be increasing the number of diversion offers to 911 callers, it is becoming more effective at diverting the events they do receive. This finding could be attributed to various factors, including increased acceptance by callers which, in turn, could lead to future direct requests for diversion, an improved ability of 911 CCDPP service providers to correctly identify eligible events, or an improved ability of crisis workers to resolve diverted events.

1.3.2 Incomplete diversion events: Diversion declined

Events that were offered diversion were considered to be incomplete if the caller declined the offer or if the event had to be sent back to TPS after being transferred to the GCC crisis worker. Unlike other 911 offerings such as police, fire, and ambulance, callers must voluntarily consent to receive 911 CCDPP services, and are thus entitled to decline the offer and receive a traditional police response instead.

Approximately one-fifth (n=847; 22%) of callers declined diversion when offered. [redacted] who participated in the evaluation suggested various reasons that a caller may decline diversion. One participant reflected on implicit assumptions among communities, or within society, that may lead people to believe that a crisis situation can only be handled by the police, offering that callers in crisis "are just so upset or just believe that the only people that can respond appropriately are the police. Even when you explain about the GCC or Toronto Community Crisis Service (TCCS) response, the response is still, 'No, I want the police.'" ([redacted]). Another participant suggested that family members who may be calling on behalf of someone in crisis:

> "want the options removed. They want basically an action taken on how to address this matter […] When you provide [the option of] somebody who's not in a position to take somebody with or without force, it still lays options on the table to prolong the situation. Whereas when a police officer's there, you know that if they meet the criteria and need to go to the hospital, they're going." [redacted])

Finally, [redacted] explained how some callers may not recognize they are in crisis, "so when the idea of a mental health crisis worker to talk to [gets offered], they don't think they're having a mental health crisis, so they take offence to it, and they say 'No'. There's nothing else we can do about it." ([redacted])

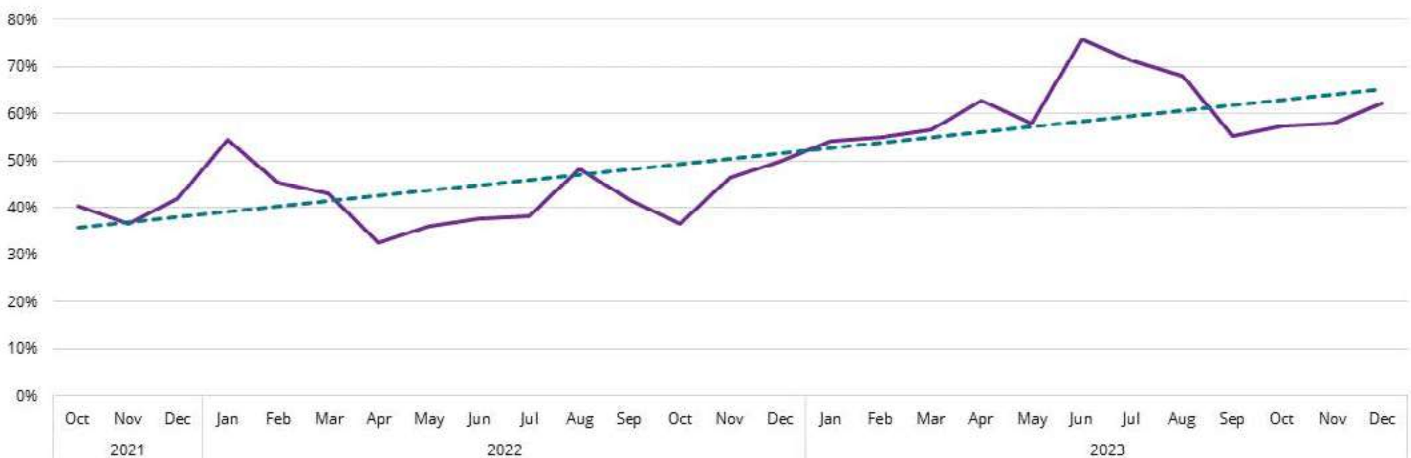

Figure 3. The program completion rate has increased over time (October 4, 2021, to December 31, 2023)

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Figure 4. The proportion of calls declining diversion has decreased over time (October 4, 2021, to December 31, 2023)

Notably, the dotted trend line shows that the proportion of events that declined diversion has been trending downward over time (Figure 4), despite increases in recent months. This suggests a potential increase in program buy-in among 911 callers. It is also reasonable to expect some continued level of service refusal by callers. Further monitoring of diversion refusals will allow program staff to gauge an appropriate benchmark.

1.3.3 Incomplete events: Diverted events sent back to TPS

The remaining incomplete events are those that were initially diverted to the 911 CCDPP but had to be sent back to TPS. This occurred in 1,052 events (35% of events sent to the 911 CCDPP for diversion), as illustrated below in Figure 5. There were various reasons for sending an event back to TPS, including:

- the event later being deemed unsuitable for diversion by the GCC crisis worker after they received more information (n=414; 39%);
- the caller being unreachable when the crisis worker attempted to contact them (n=391; 37%);
- the caller later declining diversion (n=178; 17%); and
- the diversion event being cancelled.

Similarly to diversion refusals, the proportion of events that are sent back to TPS has been trending downward over time. This finding provides evidence in favour of the effectiveness of the program's diversion efforts. It is important to ensure continued monitoring of incomplete events until a benchmark can be estimated.

Figure 5. The proportion of events sent back to TPS has decreased moderately over time (October 4, 2021, to December 31, 2023)

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1.4 However, overall expectations about alleviating the use of police resources for non-emergent mental health-related needs are yet to be achieved

As described in the Background and Context section, one desired objective of the 911 CCDPP was to divert police resources from responding to non-emergent mental health-related events, thus alleviating some of the strain on overall TPS resourcing. As shown in Figure 2 above, the 911 CCDPP successfully diverted 1,951 events from a police response, yet TPS still responded to 73,515 "Mental Health Related" events in 27 months. This suggests that the program is currently making a small, yet meaningful, impact on the number of events attended by TPS. Although the 911 CCDPP appears to be relatively small from a purely quantitative lens, the evaluation data shed light on various factors that may be contributing to the overall volume of mental health-related events responded to by 911.

1.4.1 A wave of mental health-related needs in the city of Toronto

Firstly, [redacted] reflected on the general increase in mental health-related events received by TPS, with participants perceiving that:

> "I feel like [call volume] stayed the same, but I don't know if that's because we're just getting more calls in general. We're just always slammed; it's never-ending. So, it's really hard to measure that." ([redacted])

> "For every one step that we take forward, I think we're taking two steps back just with the increased number of calls we have." ([redacted])

1.4.2 Possible reinforcement of calling 911

The 911 CCDPP was designed with the intention of helping callers connect with non-police resources. It was presumed that, should they experience a similar situation again, they would use these other resources instead of calling 911. During the first stages of data collection for this evaluation, this presumption was perceived to have materialized to some extent, as voiced by [redacted] [redacted]:

> "The crisis workers have been able to take on some of those regular callers and, in some cases, even reduce how many times they're calling, which is also, I think, huge in terms of diversion because it creates the space for people not to be calling 911 and getting their services in more appropriate places." ([redacted])

We also heard a complementary perspective, from [redacted] [redacted] emphasizing how diverting mental health-related events can also help redirect police resources to respond to events where they are most needed:

> "There were chronic callers […] where we would have to send like four officers and a sergeant or something. Now, because those [repeat] calls are being diverted to the [911 CCDPP] […] those [police] units can be used for other active or criminal calls instead of a wellbeing check or a mental health check." ([redacted])

However, other [redacted] perceived that the program is not decreasing the number of repeat calls to 911, but rather reinforcing callers to use 911 for non-emergent mental health-related needs. They offered hypotheses for why individuals may use the program multiple times, the first of which is the immediacy of getting connected to a crisis worker through the 911 CCDPP. [redacted] explained how calling 911 facilitates more rapid access to mental health support in comparison to other community-based crisis resources that operate within a mental health system that is stretched thin by high demand and under-resourcing and may have longer wait times as a result:

> "[redacted] regular callers aren't learning how to get their resources without calling 911 […] They're learning [that], if they call 911, they get the [crisis worker] immediately. If you call Gerstein['s direct crisis line] right now, you are going to wait 45 minutes to an hour and a half to speak to a crisis counselor. So, they're learning it's faster to come through 911." ([redacted])

Another [redacted] shared how "there are callers that are phoning 911 and immediately asking for, by name, the crisis worker", suggesting that callers may be reinforced to call 911 after developing a rapport with the co-located crisis workers. Furthermore, when asked what they would do if they experienced a similar situation again, [redacted] participant indicated that they would "call 911 but ask for crisis worker. [I] [t]hink that's what I'm supposed to do." These experiences and early data points might be suggestive of the need for enhanced public awareness and education on the various crisis services and access gateways available and their intended uses.

Results

After having engaged with different members of GCC and TPS teams, we proceeded to analyse administrative data to better understand this potential outcome of the 911 CCDPP. Data were not available to determine whether the overall number of calls to 911 has changed as a result of the 911 CCDPP. However, the available data showed preliminary evidence of repetitive program usage. Despite accounting for only 18% (n=316) of overall unique service users, repeat callers accounted for more than half (53%) of the diversion offers in the first 27 months pilot operations. Figure 6 provides a breakdown of the number of additional diversion offers to unique repeat callers, demonstrating that 80% of repeat callers re-called the service four or fewer times.

While the diversion completion rate for repeat callers has been improving over time, indicating that the program is becoming more effective at diverting their calls, the findings suggest that the 911 CCDPP is increasingly supporting a subset of repeat callers. A more fulsome investigation into repeat caller data, both within the context of the 911 CCDPP and 911 more broadly, is warranted to better understand the implications of these partial findings.

1.4.3 Diversion offers have grown modestly despite expansion of the program and an overall high volume of mental health-related calls

It is also important to acknowledge the context of the 73,515 mental health-related events attended by TPS. Of these events, 45,299 were deemed out of scope for diversion, for reasons such as a Section 17 apprehension; a "form" type of apprehension; or the event was classified as any of the following TPS call types that do not meet the criteria for diversion: Attempt Suicide, Overdose, Elopee, and Fall from Height. There remains 28,216 mental health related events which may involve critical factors like threat of violence, weapons, or a need for a criminal investigation. This does not necessarily mean that these events met diversion criteria, as all events were triaged by TPS COs to assess if they were appropriate for diversion,

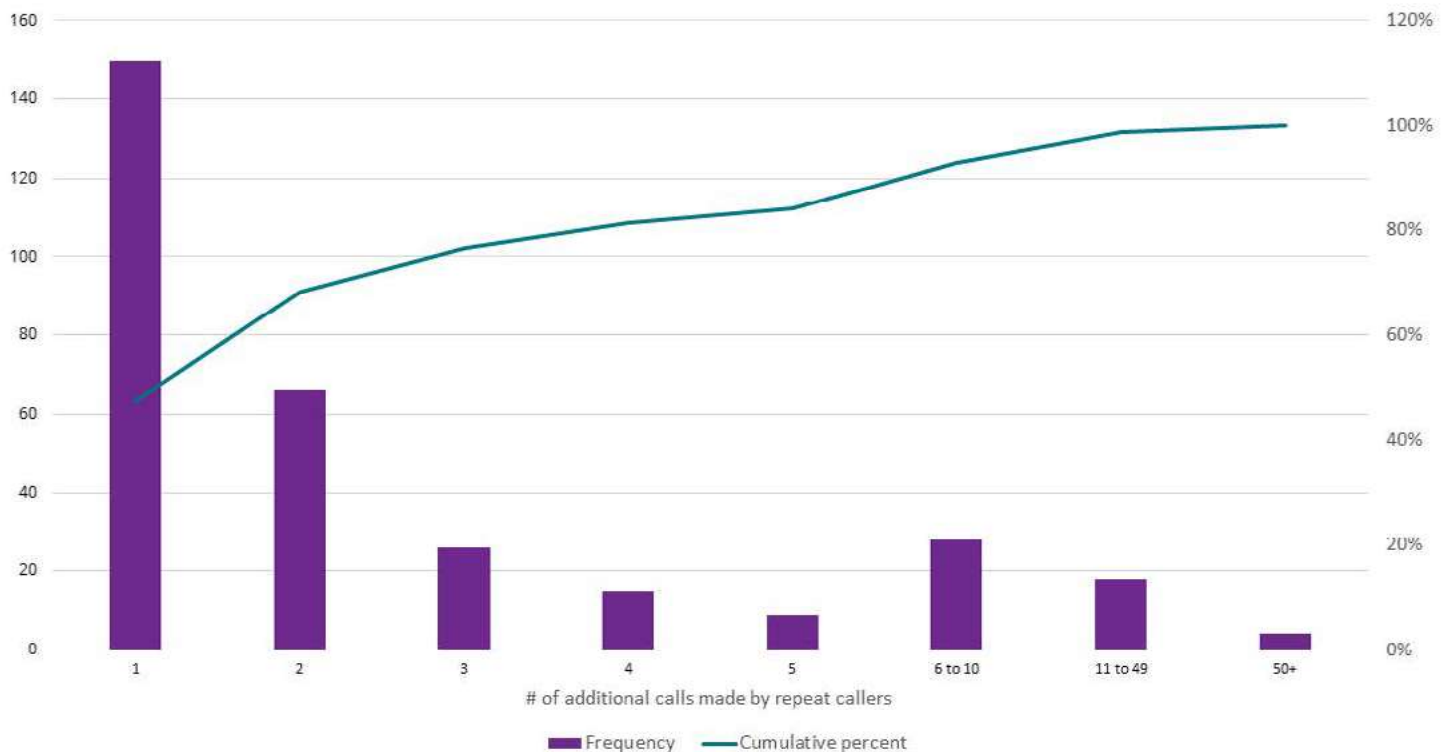

Figure 6. 80% of repeat callers made four or fewer additional calls to 911

nor does it mean that the most appropriate response pathway was the 911 CCDPP. However, due to a lack of standardized monitoring of diversion offers and our limited ability to analyze 911 data due to the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*, it was not possible to confirm whether any of these events were "missed opportunities" for diversion.

Considering that increases in the number of diversion offers do not appear to be sustained (Figure 7),[4] and that there remains a stark contrast between the number of events offered diversion (n=3,850) and not offered diversion through the 911 CCDPP (n=28,216),[5] more investigation into these events should be done to learn more about how the diversion criteria are being applied and/or could be revised to maximize utilization of the program. The findings within section 2.2 provide additional details on operational challenges that may be contributing to this contrast.

Ultimately, diversion is perceived as a favourable outcome that speaks to the effectiveness of the program but, most importantly, of callers being connected with more appropriate supports during a crisis situation. In this regard, we heard from [redacted] that "whenever that [diversion] happens, even if it's five times a year or a thousand times a year, those are a thousand people who got the best response that they needed when they were in crisis." Another [redacted] shared that, from their perspective:

> "Successful outcomes for me are someone getting the right type of services. It's not about saving police money because it's kind of negligible. If you look at the numbers of calls we attend and get, and the numbers that are diverted, it's negligible. So, it's not really a cost-savings or time-savings for police. It's just—the successful outcome is knowing that someone's getting that right call [crisis response]." ([redacted])

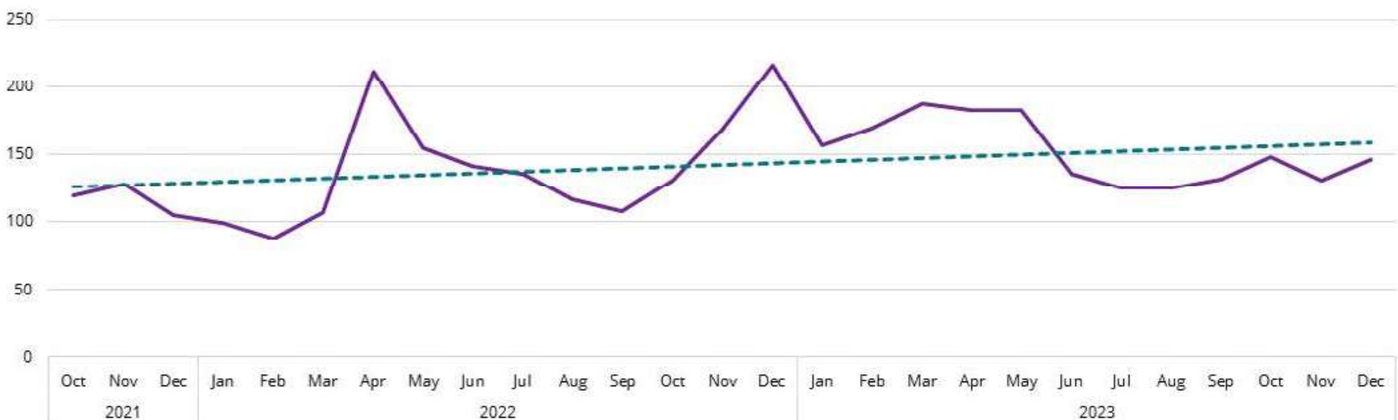

Figure 7. The number of events offered diversion through the 911 CCDPP program has grown modestly over time (October 4, 2021 to December 31, 2023)

[4] There were two temporary peaks in diversion offerings. A first peak occurred around March 2022. This coincided with the launch of the City of Toronto's TCCS, a parallel crisis response pilot offering in-person mobile crisis visits. A second peak occurred beginning in October 2022, which coincided with the expansion of the 911 CCDPP to a 24/7, city-wide service. It is possible that the staffing initiatives (e.g., training, hiring, call monitoring) and public awareness campaigns in preparation for these launches resulted in temporary increases in calls offered diversion. However, these increases do not appear to have been sustained.

[5] This number may include events that were offered diversion through the 911 CCDPP but were refused or sent back to TPS, or routed through other pathways, including competing programs (e.g., TCCS); however, this could not be confirmed due to the completeness and availability of data.

1.5 There are opportunities to strengthen equity and accessibility in the 911 CCDPP

Equity is inherent in the 911 CCDPP, in that it supports people experiencing mental health-related crises and offers an alternative to police response, which is of particular significance for historically marginalized communities who experience disproportionate use of force, invasive searches, and criminal legal system interactions (Marcus & Stergiopoulos, 2022; Murray, 2021). In addition, staff from both TPS and GCC described general organizational elements that may support the 911 CCDPP to provide accessible and inclusive crisis support. Some examples include, but are not limited to:

- the ability to provide empathetic and well-trained support through providing staff training on topics such as anti-racism, Indigenous cultural safety, trauma-informed care, accessibility, and gender diversity;
- the ability to provide service in the caller's language of choice due to the availability of interpretation services;
- the ability to provide 911 CCDPP service users with referrals to GCC's network of community partners that specialize in supporting diverse needs and identities (see Appendix F); and
- the inherent accessibility of 911 (e.g., 24/7 free calling services, text-to-911 service for the deaf or hearing impaired).

However, we identified some examples of program-level equity-related challenges. First, partners do not appear to be working from a place of shared understanding and prioritization of equity that emphasizes the need for specific activities, outcomes, and indicators to address equity in a consistent, program-wide manner. Second, many evaluation participants acknowledged that sociodemographic data cannot be easily captured during the regular provision of service due to the nature of crisis situations. Therefore, this type of data can only be collected during follow-up, which accounts for only a small fraction of all service users. However, even at the time of follow-up, some service users may still be in crisis, therefore making data collection not clinically appropriate, or they may not be comfortable with voluntarily disclosing this information, which may be particularly relevant for equity-deserving populations. These factors, compounded with inconsistent internal practices, such as different indicators being used by each partner organization and unclear plans on whether and how this data would inform program planning, create significant barriers to inform equity planning. Last, although Project Committee members reported that hiring practices at GCC aim to reflect the diversity and intersectionality of the community it serves, including hiring people with lived experience of mental health challenges, Project Committee members [redacted] reported that similar considerations are not currently part of the hiring practices for the role of TPS CO; they also described how the inclusion of criteria such as having lived experience could further reduce the pool of successful applicants. In turn, this would exacerbate the existing challenges the organization already faces when fulfilling this critical role.

Program planning is another area that could benefit from the adoption of an equity-informed lens. Initial planning for the 911 CCDPP included the following expectations for GCC crisis workers: providing crisis intervention that is equity based, working within an anti-Black racism, anti-Indigenous racism and anti-oppressive framework; utilizing a trauma informed and harm reduction framework; and providing a community based, non-coercive approach to crisis response. However, it is not known whether the use of these approaches has been tracked or evaluated. Still, findings from the [redacted] focus group demonstrated that they are encountering situations in which both program staff and service users would benefit from more intentional program-level equity planning. In addition to reiterating the challenges of collecting sociodemographic data often enough from service users to understand the profile of clients accessing the program, [redacted] spoke of various needs and challenges they had identified related to equity, such as racialized staff having difficult experiences of integration at the 911 Communications Services Call Centre; challenges conducting assessment and follow up with callers who are unable to read or write; and not having a clear sense of whether the public, and specific individuals and communities, are aware of the 911 CCDPP which, in turn, has implications for equitable access to its services.

> "[P]eople who are of the BIPOC [Black, Indigenous, People of Colour] community have difficult experiences of integration being at the call center for 911." ([redacted])

> "Yeah, [equity]'s difficult to assess as well because again, our crisis piece, we don't always check for demographic stats. So that's difficult. It's, it's a little easier to assess when you're standing in front of someone or when you're on the phone." ([redacted])

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Accommodation, acceptability, and inclusion are also untapped areas for potential improvement. There were mixed results from service user participants:

- Six out of nine (67%) service users agreed that their disability-related needs (e.g. mobility, hearing, vision, learning etc.) were recognized and accommodated by 911 CCDPP staff, two service users disagreed, and one person selected 'I don't know/Prefer not to answer'.
- Seven of 11 (64%) service users agreed that the crisis worker provided them with options for supports that were relevant to their culture and identity (e.g. ethnic background, race, gender expression, sexual orientation, religion etc.), 3 (33%) service users disagreed, and 1 selected 'I don't know/Prefer not to answer'.
- One service user reported experiencing discrimination on multiple grounds of their identity while accessing the program, with two others selecting 'I don't know/ Prefer not to answer'.

These findings should be interpreted with caution, as people who are the most marginalized experience greater barriers to participating in research and evaluation and are typically under-represented in evaluation findings (Feldman et al., 2014; Shea et al., 2022). As a result, these findings may overestimate accommodation for disabilities and underestimate experiences of discrimination. These considerations are further described in the Limitations section.

Overall, due to limitations in sociodemographic data collection, and significantly lower response rates than best practice, the evaluation was unable to conduct meaningful equity-related sub-analyses for service users. Thus, our ability to comprehensively understand if and how the program is meeting the needs of the full diversity of the community it serves, and the experiences of the diverse populations that the 911 CCDPP aims to serve, was limited. This aspect should be considered when interpreting the findings presented herein and making decisions for the program's future.

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Key Takeaway 2: Key operations are not connected despite expectations and some positive collaboration experiences

2.1 Positive expectations and collaboration experiences speak of the perceived potential of the program

The results from the Wilder Inventory (Appendix G) indicated high scores in areas such as "History of Collaboration", "Legitimacy", and "Favorable Political and Social Climate", which are foundations for an effective collaboration. Notably, GCC and its management team were consistently highly rated in historical collaboration and legitimacy, suggesting they have built strong community ties and are recognized leaders in their field.

We heard from members of [redacted] that the early stages of the program were characterized by positive expectations related to partnership and the co-location of the crisis workers.

> "[TPS] didn't just go ahead and hire themselves a crisis worker. There was a real desire for collaboration. That was another part of what was kind of the concept behind doing this kind of diversion. [It] wasn't [the] police on their own, but actually working in partnership with [the] community." ([redacted])

> "In the beginning, it was really advantageous. It allowed both sides to learn with the other and to create trust and, you know, to figure out what was possible between the two services." ([redacted])

[redacted] and [redacted] have seen how some of the initial expectations materialized and led to positive changes, as described by [redacted]:

> "[…] A couple of [redacted] have said 'I say things that you say now.' […] If they're open, if they're open in the slightest bit, they will give you that feedback, like 'oh, yeah, yeah, I tried that.' Right? And I think that that is one of the benefits, at least to helping to change a bit of the culture." ([redacted])

Similarly, [redacted] noted that:

> "Just talking like one-on-one with the [crisis] workers, and just kind of seeing what they're doing and, you know, their follow-up and things like that. I think it's a lot more encouraging all around. So, I'm definitely happy that this came into place for." ([redacted])

Co-location was also seen as an opportunity for providing an almost immediate response, setting the 911 CCDPP apart from other competing initiatives such as the TCCS. Members of both organizations also anticipated drawbacks without co-location.

> "If we were off-site, then there would be no personal kind of growth on [COs'] part of getting to know who we are and what we do and see how we work. I think – them seeing how we work, how we are with people." ([redacted])

> "They understand our systems. They're using our systems. It's easy to transfer back and forth. There's no loss of information. So, I think that is a huge benefit." ([redacted])

Lastly, an effective collaboration between the communications team and the crisis team was described as having the potential to alleviate some of the work burden, something that was perceived during the initial stages of the program as shared by [redacted]:

> "[W]hen [crisis workers] could do [call screening], the GCC would type in there 'we'll try calling complainant; diversion possible.' They would use their judgment based on what they can do in their policy to see if they could actually help us out. And then they diverted a couple of calls, so I think it makes an impact." ([redacted])

An unintended positive outcome was also identified: the program led to the provision of mental health support to [redacted] experiencing mental health concerns due to the nature of their work. In the voice of [redacted]:

> "[T]he crisis worker that was working was able to get connected to that [redacted] and support them in a way that was very quick, and in such a way that prevented them from having further mental health issues." ([redacted])

In summary, the Wilder Inventory, enriched with some experiences and perspectives of multiple members of TPS and GCC shared in focus groups, indicated that the partnership was established under favorable external conditions and perceived as being in the best interest of all parties involved. Members from different teams have

also had favorable experiences at different moments throughout the life of the program, as demonstrated by their first-hand accounts of successful collaborations that highlighted the overall positive potential of the 911 CCDPP.

2.2 There is a lack of fully integrated operations

As the program evolves, some of its key operations appear to be lacking in integration, which has resulted in challenges described by multiple members of both teams, at all organizational levels. Some challenges can be pinpointed, for example, impediments to call screening capabilities were discovered in the early stages of the 911 CCDPP due to privacy-related reasons; this required the introduction of changes to the program operations. However, not all challenges the program has faced can be situated in isolated moments of time, or attributed to any one particular internal or external cause. They represent an amalgamation of factors developed throughout the program's life that stakeholders can perceive and incorporate as part of their experience of the 911 CCDPP, and use them to inform their individual views on the program's improvement opportunities and future outlook.

Specifically, one of the challenges identified in this evaluation is an underlying lack of integration is impacting key program operations, namely, call screening and diversion, and co-response.

2.2.1 Call screening and diversion

Members ████████ described the contrasts they experienced over time in their call viewing and screening capabilities.

> "At the beginning of the project, for the first 4 months of the project […] at least we were able to see all of the calls that came into the Toronto police." (████████

This change was also acknowledged by some ████ who noted that those previous capabilities were positive, making it difficult to understand.

> "[W]hen they could do that, the GCC would say— they would type in there 'we'll try calling complainant; diversion possible.' They would use their judgment based on what they can do in their policy to see if they could actually help us out. And then they diverted a couple of calls, so I think it makes an impact." (████)

Communications operators are currently solely responsible for connecting with each individual caller and navigating their requests for emergency support. They have described using a combination of procedural criteria, safety judgements, and overall individual experience, to decide on transferring a call to a crisis worker. ████ ██ offered that:

> "[M]y own standard is, basically: if the caller, if anyone could potentially get hurt, whether it's self-inflicted on their end, or whether it's to responders, if somebody can get hurt, I don't make the referral [to a crisis worker]. I've sent police, ambulance, [and] fire, for over a decade. So, if there's potential for any physical harm on anybody's part, I don't make the referral." (████)

████████ described their preference for being able to connect eligible callers with a different service that can offer an in-person response:

> "I would way rather provide somebody in-person supports. Then, I think that they'd get that validation, that extra piece that they're not just talking to someone over the phone […]" (████

The immediate availability of crisis workers was also highlighted by ████████ as a factor impacting their decision-making:

> "I log on, take a call that fits the criteria to a 'T' and then I see the [crisis worker's desk] light's red, but I don't know what for. I don't know why it's red. So, I have to kind of figure that out during the call with the person [in the emergency situation]" (████)

Staffing of the crisis desk was repeatedly discussed by both TPS COs and crisis workers as it was perceived as impacting TPS COs' decision-making, as well as crisis workers' capabilities to consult on complex cases, do follow-ups, and decompress. Staffing challenges are discussed in detail in section 2.4.

The current status of call transfers illustrates how a lack of integration between teams and operations affect the overall performance of the 911 CCDPP, leading to an inconsistent number of calls transferred to the crisis team.

> "I don't even know if there is a screening process anymore […] Maybe there is, but it doesn't seem that way and it hasn't for a long time" (████████)

"I think that now we're stuck with very minimum of calls. I think that we [redacted]] dropped the number that a) we were giving them and b) we're able to give them, right? Again, it comes back to the whole thing that, because we're not collaborative, because we're not, like, sitting together. Um, there's that link. There's that bridge that's missing […]" ([redacted]

As highlighted in section 1.4, 28,216 calls were not immediately out of scope for diversion but were not diverted through the 911 CCDPP, as COs must consider factors such as potential for violence and weapons, the need for a criminal investigation, as well as other alternative response pathways (e.g., TCCS) that may be appropriate. This stands in sharp contrast with the total 3,850 calls for which diversion was offered. The number of calls not offered diversion does not necessarily represent calls that met diversion criteria, nor calls for which the most appropriate response pathway was only the 911 CCDPP. However, the administrative data that is currently available does not shed light on the potential reasons that could explain these metrics. Potential hypotheses, based on the experiences and perspectives we learned about throughout this evaluation, point to the role of each TPS CO's judgement and its underlying factors. It can also be hypothesized that initiating a police response could be perceived as the most appropriate response in most scenarios. Given that the current design of the 911 CCDPP places TPS COs in the role of being the only staff responsible for screening all incoming calls, these hypotheses require further investigation.

2.2.2 Co-response

Examining the implementation of the co-response also evidences an underlying lack of integration in terms of data generation and sharing, as well as decision-making. [redacted] noted that for on-site responses, there is no information regarding prior diversion attempts and outcomes. They also highlighted the value of having access to background data about the involvement of the crisis team, along with outcome data from each event. These data capabilities could contribute to fulfill a communication gap perceived between the GCC team and TPS [redacted]

"Rarely do I hear 'this call's being passed over to PRU (Primary Response Unit), [crisis worker] has done what they could, therefore – and the person on the line is saying they have access to a knife or whatnot, and can't de-escalate any further, therefore PRU needs to respond.' I don't hear the results of that interaction with [the crisis worker] and that person on the phone […]" [redacted])

In turn, [redacted] described that their assessment of the need for an on-site police response is not always taken into consideration. However, a counterpoint was offered by another member of the [redacted], along with a reflection on how each crisis worker can be experiencing the program in a very different way.

"Sometimes they will actually type in to just say, 'oh, we know this person, we'll just go.' So, it's kind of 'okay,' you know? There's no reason for us to be part of it if they're just automatically going to go cause they know them." [redacted])

"That's interesting, cause I haven't found that to be my experience, and this is what tells me about—we're so separate, right? Like, in some ways I have had them [the police] attend before, and there were situations that I could put [the police response] away, right?" ([redacted])

2.3. Caller education and consent discussions impact the program's service delivery flow

Navigating the callers' preconceptions on mental health services, incorporating their preferences for a police response despite the reported nature of the crisis situation, and guiding them through a consent discussion, are some of the unexpected obstacles encountered by TPS COs, which impact the 911 CDDPP service delivery.

As previously described, the 911 CCDPP is a consent-based service and therefore TPS COs must be successful in fulfilling the implicit responsibilities of educating callers about the appropriateness of the program and obtaining consent. However, in a high-volume, time-sensitive environment, achieving the goal of educating callers and gaining consent can lead to negative impacts to service delivery. This process, as perceived by [redacted] members, "is a significant amount of time to add to the workload." [redacted] had similar perceptions of an increased workload.

"Calls are coming in at the same time, while you're stuck trying to explain to this person, 'okay, these are the resources available.' And explaining a whole background

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to it, while the queue is going up because there is a big event in the city. Yeah, I think what it does is, that 911 aspect [of the 911 CCDPP], we get stuck as educating them, explaining the need for them to use [911 CCDPP], all of that.' ( )

The caller may also interpret some part of the consent and transfer processes negatively or decline the diversion altogether. :

"[I]f the [caller is] in crisis and they don't really accept it, or they don't understand it, they're worked up, then it's very hard to actually get the consent. Because the consent becomes more of 'you're attacking me,' or 'you're trying to find out information,' or 'you're trying to find out this information and use it against me,' kind of situation.")

also described that the scope of their work revolves around responding to life-or-death emergency situations, and thus raised concerns about navigating 911 CCDPP mental health-related calls [that may not be life-or-death]. shared that:

"I don't mind being a gateway, but I don't think we have the resources, the time, the numbers. And I think the role that we're playing in it right now, I think people could die as a result, because people are waiting on 911 with a baby not breathing, and they're waiting three minutes because we're dealing with this [education and consent piece.]" ( )

An analysis of the amount of time spent in each step taken when responding to a mental health-related crisis call can shed light on this issue and its impact on the overall emergency response times. Although this has not yet been done for the 911 CCDPP, data obtained from a relevant program, the TCCS, evidenced that during its first five months of operations, the call diversion process added an average of 7 minutes 36 seconds of 911 "talk time" (Demkiw, 2023). Similar analyses of 911 CCDPP calls can lead to a better understanding of the burden introduced by the additional tasks noted above, together with relevant impacts to the program's overall effectiveness.

2.4. Limited staffing of the crisis desk contributes to inconsistent service availability and delivery

In addition to the challenges that described facing during the screening and transfer operations, providers have also experienced challenges of their own which they described in relation to staffing of the crisis operation, as the program is currently limited to one crisis worker per shift. They spoke of the challenges they encounter when they need to consult with a colleague, during working hours, regarding a complex case. They also described some of the difficulties finding coverage for unplanned absences. The risk of vicarious trauma was also identified as a challenge.

"[I]f I'm reaching out to someone [for consultation], it's on their off time, so it really isn't fair to my coworker who's at home and trying to decompress to be like, 'hey, you know, I have this emergency situation and I don't know who to talk to.' So, that can be a drawback as well. Also, too, if we get sick or we're feeling unwell, or if I feel unwell partway throughout my shift, it's difficult to have someone else move from a different location, and then come here or split up the day. Or, if I do have to leave early or I can't make it into my shift that day, and they can't find anyone else to replace my position, then the [crisis desk] is empty." ( )

also described the desire for staffing more than one crisis worker at a time, to ensure a consistent service delivery.

"We need more than just one [crisis] staff cover the floor, whether it be, you know—they're humans, they have emergencies of their own, they get sick, all of that happens, but we need more, better coverage." ( )

Follow-up opportunities were also described as being impacted by having only one crisis worker at a time, which can result in difficulties reaching out to callers after the initial crisis situation.

"[I]t's hard to do both [crisis calls and follow-ups]. Right? So, I'm on days right now. And so I'll try to focus. However, I've been moved around—we get moved around a bunch [...] Other issue is that if you're on a follow-up call, and then you're watching calls on the board, right? And then you get a call on the board, so then you're like 'I got to go now,' [...] Hanging up on somebody and that's another call. Now we're calling them back again." ( )

Staffing has been identified as a factor impacting multiple program operations. Figure 8 illustrates the percentage of unfilled hours from Q4 2021 to Q4 2023. Initially, the

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percentage of unfilled hours remained relatively low and stable, around 3% throughout 2021 and early 2022. However, starting in Q4 of 2022, which coincided with the 24/7, city-wide expansion of the program, the percentage rose to 6%. This upward trend continued into 2023, with the proportion of unfilled hours reaching 10% in Q1 and peaking at 17% in Q4 2023.

This sharp rise in unstaffed hours highlights a growing issue that may be attributed to factors such as overall shortages of qualified staff, or inefficiencies in scheduling and resource allocation, including the availability of relief staff. Addressing this issue is crucial to ensuring that staffing needs are met and service delivery is not compromised.

Notably, despite the similarities among frontline staff's perceptions shown above, the [redacted] we spoke to do not agree with their counterparts from the other organization.

> "[T]wo [crisis workers] would be too many. We don't have the space for them and the call volume I don't believe is enough to keep two of them." ([redacted])

> "We're hearing that we are not seeing the numbers too for that to happen, but where are the numbers coming from? The numbers are not from us [redacted] the numbers are from them [redacted], they are controlling the numbers." [redacted])

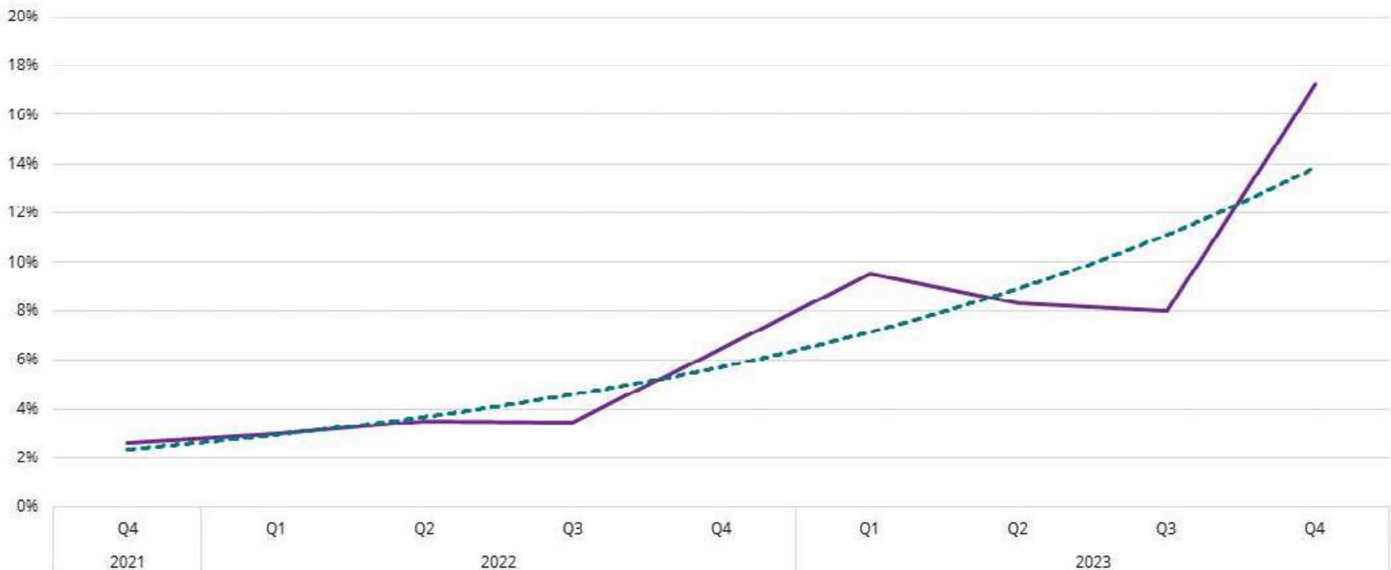

Figure 8. The proportion of unfilled staff hours of 911 CCDPP is increasing over time

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2.5 The program's internal and external visibility is limited

Members of TPS and GCC frontline teams, including crisis workers, COs, and UOs, shared that the program's internal and external visibility is not optimal. described how they learned about the program years ago, in its very early stages through mass emails, especially if they were connected to the program's pilot.

> "I have heard about this 911 diversion pilot project. I think it was done through a mass mailing, maybe what we call an e-update, maybe about a year or two years ago." ( )

Another shared how the program background, including how GCC was chosen as the best partner, were aspects unknown to them.

> "I think it was an e-blast. Yes, it was an e-blast, but not an in-person training session about it [the 911 CCDPP]. Or, even giving the background how we got here, why GCC was selected, why they're the best option, and what they can do to provide the frontlines with." ( )

The common sentiment among that they don't receive any critical information about the 911 CCDPP limits their ability to appreciate how the program has evolved and what it is achieving.

> "If something works well, officers will tend to go towards it, if it works well. It's just that we're not informed of it [the 911 CCDPP] and we don't know how well it's working."

emphasized the need for increased program visibility and offered suggestions and ideal scenarios describing the level of visibility they would like to see of co-located GCC crisis workers. They highlighted how not knowing about the program can be interpreted negatively, as it could convey that the program is not active, or ineffective despite being active, hence the need to share outcome data.

> "I'd like to see the GCC person have a call sign so they're on the dispatch board if like—almost as an additional person, so the rest can see that those calls are happening and have an idea that all this stuff is happening in the background. I think it would add to general credibility, the officers would feel like, 'oh, we're not going to these six person-in-crisis calls. They're happening, but we don't have to go to them,' which I think, right now, those could be happening and we just don't know about it. So then, of course, there's negative [perception], in the sense of 'it's not happening' or 'it's not effective'." ( )

Internal visibility challenges, related to outcome data and program updates, were also perceived by However, they noted that competing programs (e.g., TCCS) also compound the visibility challenges faced by the 911 CCDPP.

> "On parades we're read so many TCCS success stories – that they went and did this. But we never once have I heard [911 CDDPP]'s success stories and I'm sure there are multiple of them. They have spoken to our chronic callers so many times, but that hasn't been brought forward and is not really a knowledge that's been shared. So, even if it's working, we don't know about it because we don't have stats." ( )

Lastly, members of the described external visibility challenges regarding advertisement, public communications, and the internal strategies put into place to increase awareness of the 911 CCDPP.

> "I also don't think that]'re so mindful about cutting us 155%. However, we had all call viewing ability that then slowly got taken away. Then, we watched our call volume go down. We watch no advertisement for us. They were literally like, 'we will give you candy bars if you will give [calls] to TCCS, we need to get our numbers up' and I would say to them, 'hey, could you shout out about [911 CCDPP]?' Right? If you're going to do this with TCCS, you might as well shout out with [911 CCDPP] and I've been met with 'oh, no, I can't say that.'" ( )

The point raised by the members of the was also voiced among as follows:

> "[W]here's the CP24 ad? Where's the TTC ads? I think such a small aspect of the budget, as an advertisement, could make such a vast impact to our ability to connect with people and do public education and not having the burden fall to us as call takers [...]" ( )

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Key Takeaway 3: There are partnership challenges

The challenges faced by the program cannot be analyzed in isolation or attributed to any one particular cause. They reflect progressive transformations over time. Consequently, the wide array of views on the program, the partnership, and the future, illustrate how differently the program has been experienced by each party involved. Taken together, the following challenges describe how trust has been compromised across organizational levels.

3.1 There is a lack of trust between frontline TPS and GCC teams

Underlying the operational, staffing, and visibility challenges described above is a lack of trust between the partner organizations, which manifests itself in specific perceptions of skills and competence shared by members of both communications and crisis teams. Previous interactions or observations were also described as factors that could reinforce or dispel some perceptions. highlighted how all these factors can contribute to deciding against transferring a call to a crisis worker. They noted that:

> "[...] [I]f we] don't really know, or have talked to [crisis workers], or know that they're there, we might not feel as comfortable as well, either diverting calls to them. Maybe that's not the right thing, but that's how I feel personally." ( )

> "If officers are going and now I've transferred the call over [the 911 CCDPP] to calm [callers] down, what happens when that situation changes? [Crisis workers] are not trained like us, they have no idea what kind of questions we ask, what are we putting into the call, because they never sat with us, right?" (

Similarly, members of the also voiced perceptions regarding competence and skillset, and their perceived role in the stagnating volume of call transfers.

> "I actually don't believe that] have the skillset to actually identify when to offer us." (

> "[W]e're also hearing […] certain being incredibly contemptuous to callers, and in some ways – and then, we don't even get to the proper identification process. So this is where it's like it. That's where it eats me a little bit. Right? It's sort of like we're just here for show." ( )

3.2 There is a lack of trust between leadership teams

The results from the Wilder Inventory (Appendix G) align with perspectives from different team members who emphasized the need for improving collaboration between teams and harmonizing key program processes. Lower scores were reported by participants from GCC and TPS in areas such as "Mutual Respect" and "Appropriate Cross-section of Members". Scores are also indicative of challenges in "Flexibility" and "Multiple Layers of Participation". Partnership challenges were voiced by members of TPS and GCC teams, with a caveat offered by who added that "[…] from a higher level, organizationally, [and] corporate level, [the partnership] works well." . This perception of the partnership at a high organizational level was contrasted by the following leadership voices, who noted that:

> "As I said, it's more like a one-sided partnership where it's—that's how it feels where everything is, you know, it's what recommends or what they're doing." (

> "I saw a better partnership in the first year, and then once TCCS sort of developed, I saw our partnership—[911 CCDPP] was deprioritized and TCCS seemed to me like it was the priority ." ( )

These findings suggest a need for enhanced efforts to improve the partnership and the relationship between TPS and GCC as organizations. By addressing these areas, both organizations can work towards more effective and sustainable collaborative efforts, as summarized by one perspective offered by a member of the :

> "The idea of really building those environments where people can begin to build strong trusting relationships that allow them to maybe take a little more risk than they might otherwise. And then when that happens, people have this great opportunity to get more." ( )

3.3 An uncertain future

We heard contrasting views on the future of the program, particularly among COs and members of TPS leadership

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team. Among [redacted] it was noted that the program has potential for improvement, with emphasis on improving relationships and collaboration. However, an overlap with competing programs was acknowledged, along with hesitancy regarding a continued involvement in mental health-related crisis situations.

> "I think it's a good program. I think, you know, there's a lot of positives to it and getting people help is the greatest benefit. I just think [the 911 CCDPP]'s not a 911 service. 911 is [inaudible], someone's stabbed, someone's shot, life or death. It's not 'I need to talk.' Like I said earlier, ideally, we get removed from the equation as much as possible." ([redacted])

> "I hesitate to use the word redundant, but [TCCS and the 911 CCDPP]'re very similar." ([redacted])

> "I'd like to see more integration too, where [crisis workers] are there, and they're involved, and they know our procedures, and we meet them and all that, but they have more autonomy where they can look through calls to see if maybe we didn't divert something we could have, without us having to go through the referral. And them being able to call back without a consent piece – so that's just expected." ([redacted])

Highly contrasting views were offered by members of each organization's leadership team. The perception that the program should continue is not a shared and firm understanding, particularly, in light of the upcoming city-wide expansion of the TCCS.

> "We'll do it with [redacted] if they want to do it with us, but we'll have to see." ([redacted])

> "[…] [I]t's so obvious [911 CCDPP]'s a service already offered by the Toronto Community Crisis Service (TCCS). There's no way to better the current model to keep it because the ways in which you would better it, you'd be duplicating the TCCS model." ([redacted])

[redacted] shared views aligned with the continuation of the program, with emphasis on building and sharing outcome data as a critical input to informing perceptions on the program.

> "I agree that the program should continue, it's just—I think more than not, we need data just to kind of support how much has it been assisting us in diverting calls […]" ([redacted])

> "But for sure the program should continue. If it took five calls away from us in a day, that's a lot because those are very time-consuming calls." ([redacted])

In turn, members of the [redacted] emphasized the need to improve relationships and collaboration as a way to revitalize and realign the program's operations.

> "I think it would be lovely if we could be on the same page for how the tiered responses work, or how we respond to things." ([redacted])

> "I would love to see more harmony and us understanding what each other does, why we make the response, or why we choose the responses that we do." ([redacted])

Nonetheless, the multiplicity of perspectives across multiple levels of the partner organizations conveyed an overall sense of uncertainty regarding the future of the program that was succinctly summarized by [redacted] who noted:

> "At this point, is [CCDPP] still a pilot, or are we just like on a day-to-day basis? Some days I'm like, I don't even know if we're going to walk in one day and not going to have a [crisis] worker. We don't really know anything about that either." ([redacted])

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Discussion: The program needs a unified path forward

Altogether, evidence from administrative data, the Wilder Inventory, the service user questionnaire, and focus groups and interviews with members of TPS and GCC, suggests that the program is making strides towards improving stakeholder and community experiences of crisis response and improving service users' connection to community-based follow-up support services. The program has an identifiable and evidence-supported value for service users, primarily characterized by a quick connection to person-centered, non-coercive crisis support; access to referrals; and access to de-escalation support from a crisis worker when police are en route to an emergency call.

However, the program is not operating in a way that can directly lead to its main objective of reducing the operational demand on TPS COs and the subsequent need for a police response for non-emergent mental health-related crisis calls. We have highlighted both internal and external factors that might be impacting the program's efficiency, utilization, and equity. Internally, while there were identified benefits of the TPS-GCC partnership and the co-located nature of the program, we heard varying perspectives across teams within each organization that pointed to an overall disconnect between partners and key operations. Our findings also highlighted that stakeholders are experiencing the program in vastly different ways and have differing views regarding the focus of the program, its implementation, its understanding of necessary equity considerations, and its differentiating factors from competing or overlapping programs. This disconnect may have contributed to the operational challenges identified in relation to call screening and diversion, co-response, staffing, program visibility, data collection and analysis, and a lack of trust between partners. In turn, these challenges may be leading to an underutilization of the program, ultimately limiting opportunities for effective diversion on a larger scale. Taken together, all these factors may explain the highly contrasting views on the ideal future of the program and its position within the broader crisis response system in Toronto.

Additionally, from an external point of view, the embedded nature of the 911 CCDPP with all other 911 emergency services could be leading to a paradoxical increased use of 911. However, other external factors (e.g., health and social service system capacity gaps, the multifaceted nature of crisis situations, and the incidence and complexity of mental health challenges among the general population) can also be impacting the overall call volume and related demand for 911 services in non-emergent mental health-related situations. Given this combination of local, contextual, and systemic factors, it may be unlikely for some callers with mental health-related needs to shift away from 911 as their main source of support in crisis situations in the short term.

It remains essential to ensure that people in crisis can access other types of emergency crisis supports not led solely by uniformed police officers. This is especially crucial for the safety and dignity of people who face intersectional forms of discrimination and mistreatment. Regardless of the continuation of the 911 CCDPP in its current form, or in any other form, there is a need for a unified path forward that will not reintroduce gaps in crisis resources. For the most efficient and effective use of organizational resources and to best meet the need of people in crisis, program partners should reconcile this disconnection and reach a shared understanding of the resources, responsibilities, processes, outcomes, equity, and supporting data that should be in place, as well as revisit the theory of the program and its underlying assumptions.

Limitations

There were certain limitations to the evaluation which must be acknowledged, including engagement of service users in evaluation design, participant recruitment, and data quality and completeness.

The evaluation included a limited amount of meaningful integration of diverse perspectives of service users. Best practices consider it essential to involve those most affected or impacted by any particular issue, need, or intervention of interest. Involving service users can ensure that any planned solutions are relevant, appropriate, achievable and sustainable (Ontario Centre of Excellence in Child and Youth Mental Health, 2016), and that equity is infused throughout all stages of program development, including evaluation. The evaluation design did not include fulsome input from 911 CCDPP service users. However, we sought consultations with the TPS Board's MHAAP, which includes "people with lived experience of mental health and addictions issues" (Toronto Police Service Board, 2024). These consultation sessions were held to gather insights and reflect on potential unintended outcomes of the program, our service user recruitment strategies, and the service user questionnaire. Similarly, the preliminary evaluation results were shared with the Project Committee, which also included members with lived experience of mental health challenges. During this meeting, members of the Project Committee had the opportunity to offer any additional insights to help refine our understanding of the experiences, perspectives, and metrics we gathered for this evaluation.

There were limitations to participant recruitment for both service users and service providers. Due to the nature of the service offered by the 911 CCDPP, and time constraints due to a short project timeline, service user recruitment was limited and cautious. Engaging in evaluation activities with people who have experienced mental health-related crises requires considerations of clinical appropriateness to participate, in addition to the individuals' willingness, capacity, and availability (Dixon et al., 2016). As a result, we had a small sample size of 13 service user participants. We acknowledge that we were unable to capture the experiences of those who may have benefitted from the program but refused service or follow-up, and those who did not have the capacity or willingness to engage in this evaluation. These service users may include populations who have historically experienced the greatest degrees of marginalization, coercion, and biased practices. Although our findings are an insightful preliminary understanding of the 911 CCDPP service user experience, caution should be taken when interpreting and drawing conclusions. Further exploration into the experiences of a wide, diverse sample of service users is warranted to strengthen this knowledge base and make program improvements accordingly.

Service provider recruitment and participation was also limited primarily due to time constraints. These constraints narrowed the stakeholder groups that could be included in the evaluation. It narrowed our ability to do a more widespread recruitment of eligible participants and shortened the window for individuals to express their interest and complete data collection activities. It also limited our ability to offer additional participation opportunities to more members of TPS and GCC, along with different participation methods (e.g., survey or an interview) to accommodate for participant preferences for sharing the same type of information.

As such, we are mindful that the perspectives presented here may not be wholly representative of all groups and this is an aspect that must be taken into consideration when interpreting the findings reported herein. We are mindful that ensuring the inclusion of different experiences and views, through accessible forms of participation, is not a static goal but a continuous process. Time is only one of other key elements that are needed to ensure that relationships are genuinely built, and service users' and other equity-deserving stakeholders' needs are properly accommodated.

We also experienced limitations related to data quality and completeness. First, our analysis of administrative data was performed retrospectively based upon existing data collection practices, data completion, and data definitions from TPS and GCC. There were therefore limitations due to the availability of data as well as organizational-level differences in how each partner defines, documents, reports, and interprets indicators. Collaborative refinement of data documentation, validation, and reconciliation processes across TPS and GCC may be helpful at improving the quality of administrative data.

Finally, due to unforeseen technical problems with the source of the instrument, we were only able to collect half of the Wilder Inventory. As a result, our assessment was limited to 11 of the 22 factors that the Wilder Inventory is designed to measure. This partial data collection may have impacted the comprehensiveness of our analysis, potentially omitting critical insights into the collaborative dynamics we intended to evaluate. However, we were able to collect further insight and data on collaboration through the focus groups and interviews with TPS and GCC team members across all organizational levels.

Recommendations

Our recommendations provide actionable suggestions for a unified path forward. These recommendations were designed to address the challenges currently experienced by the program and create opportunities to strengthen its potential to support people in mental health-related crisis. All recommendations are meant to be collaboratively enacted by TPS leadership and GCC leadership, with active inclusion and participation from frontline teams and service users. Including perspectives from all relevant stakeholders is key to ensuring a shared and balanced vision.

Recommendation 1: Strengthen the partnership (e.g., trust, visibility, and capacity) by implementing opportunities for ongoing inter-partner engagement

Multiple members from both organizations voiced their candid perceptions and concerns regarding partner staff training, competence, and overall commitment to the program implementation and success. As mentioned previously, these issues cannot be properly understood without considering all the other challenges described throughout this report. We therefore recommend the adoption of collaborative practices to bring frontline and leadership teams, from both organizations, together. These practices are particularly relevant during critical stages such as program planning, onboarding, training, monitoring and feedback, and dissemination of program outcome data. In addition to strengthening collaboration, this approach can also help increase the visibility the program has within TPS, foster trust between teams, and nurture buy-in among all groups of stakeholders.

Recommendation 2: Collaboratively review the program theory and objectives to develop attainable and well-defined goals, key operations, resources, and outcomes

As previously described, various internal and external factors threaten the 911 CCDPP's ability to efficiently and sustainably achieve its intended objectives. There is a need for partners to come together and develop a unanimous, well-defined vision for the program's future: one that maximizes the use of its resources to fill a gap in Toronto's crisis response system, proactively plans for equity, and incorporates the perspectives of diverse service users. Program components, or the program itself, could then be redesigned to ensure it fulfills this shared vision, and that processes are integrated and driven by evidence.

Multiple paths can be followed to refine the program theory. For example, one option could be to move away from the overarching goal of diverting mental health-related calls from police resources, and instead leverage the "no wrong door" principle. The program could then be envisioned as an improvement to the overall 911 crisis response experience, including in-person police response, for those choosing this point of entry. This pathway would focus on maximizing the evidence-based positive outcomes identified throughout this evaluation and adopting indicators focused on the service user experience of crisis response services.

Another example of a refined program theory could involve reaffirming the goal to divert all mental health-related non-emergent calls from police resources and exploring whether an improved iteration of the program, or a substitute, could help achieve this goal. New, or supplementary, and wide-reaching initiatives aimed at educating the public on using non-911 alternatives will be needed as well, with particular attention to not aggravating gaps in or strains on existing crisis resources that may occur if the program changes or becomes unavailable.

Regardless of the path chosen for the refined program theory, we recommend that it includes specific activities, outcomes, and indicators that address equity as it represents an opportunity for the program to help respond to the mental health needs of populations for whom police involvement in mental health crisis response could cause additional harm (Marcus & Stergiopoulos, 2022; Murray, 2021). The inclusion of the components mentioned above as part of the program theory can help define what success could look like for the 911 CCDPP and how to best direct the investment of its resources.

Recommendations

Recommendation 3: Improve operational challenges by establishing clear, standardized processes for call screening, intake, co-response and data collection and analysis processes

Call Screening

As the number of calls offered diversion has only modestly grown throughout the life of the program, despite its expansion in coverage and operating hours, it is important to review current call screening processes. We first recommend performing a systematic retrospective review of calls that were both offered and not offered diversion, to strengthen the understanding of how the diversion criteria have been applied by TPS COs. This knowledge, combined with the perspectives of frontline staff described in this report, could then be used to identify more opportunities for diversion. A revision of call diversion criteria can also be useful to improve clarity and reduce overlap with other services. Other improvements can include iterative, joint training on call screening, and a revision of each role's responsibilities, scope of decision-making, and access to relevant data. Ongoing auditing of calls can also be adopted with continuous quality improvement purposes.

Intake

Communications operators from TPS described how educating callers about the appropriateness of the 911 CCDPP and obtaining informed consent can negatively impact workload and 911 service delivery for other emergency calls. Although TPS has noted impediments to call screening capabilities due to privacy issues, we recommend reviewing the consent process to identify potential opportunities for improved efficiency, including consultations with diverse service users to improve the accessibility, relevance, and clarity of the consent process and its language for people who are experiencing a crisis. Alternatively, as suggested by some evaluation participants, avenues for adopting a service approach based on implied consent can be explored. In this case, 911 callers could be offered a fourth emergency service option (e.g., police, fire, ambulance, or mental health), and callers that indicate a need for mental health-related services would be providing implied consent to be transferred to a relevant responder.

Co-response

Uniformed officers and members of the GCC crisis team described the value of the co-response operation, emphasizing how co-response can result in safer police operations for 911 callers and on-site responders alike. The need for seamless, data-driven communication was highlighted by TPS UOs, along with other strategies aimed at incorporating the expertise of crisis workers in the creation of resources to be consulted during mental health-related on-site operations. These suggested innovations and collaboration opportunities may contribute to further development and consolidation of the co-response as an additional service path available to callers in emergency situations with mental health-related components.

Data Collection and Analysis Processes

A review of data collection and analysis processes will strengthen the consistency and completion of data sets in both partner organizations. An inventory of all current data collected by the 911 CCDPP should be assessed to ensure the data captured are related to the revised program theory and facilitate future evaluation of that theory. With respect to equity, the inclusion of sociodemographic data remains critical to understand who the program's service users are and if any identifiable subgroups require adaptations and/or additional supports to access the 911 CCDPP, receive high quality services, and achieve positive outcomes.

We heard from that this can be best accomplished with service users who access follow-up supports. Therefore, we recommend ensuring that this process is aligned with best practices (e.g., content guidelines for sociodemographic questions) and supported by standardized training and materials (e.g., scripts to be used by all staff collecting equity-centred data). Special emphasis should be given to the adoption of plain language rationales for data collection to increase response rates, self-reporting from clients, and an ongoing use of equity data to continuously inform and strengthen program planning (Alliance for Healthier Communities, 2022; City of Toronto, 2020; Health Commons Solutions Lab, 2020; Tri-Hospital + Toronto Public Health, 2017).

Recommendations

Recommendation 4: Encourage diversion by developing public education and awareness campaigns on available community-based crisis supports and their intended uses

The evaluation data suggest that there is still an overall lack of public awareness of alternative crisis support services, which contributes to the inappropriate use of 911 as well as added workload burden on TPS COs, including increased process complexity (e.g., education and consent) and strain on TPS operational resourcing. Partners can therefore consider developing widespread public campaigns to build awareness of the available services (e.g., 911, 911 CCDPP, TCCS, 988) and their appropriate use. This should include intentional planning, informed by evidence and lived experiences, on how to reach diverse populations within Toronto who may experience greater barriers to accessing services and relevant information. Tailored education on the significance of diversion for historically marginalized communities who experience disproportionate use of force, invasive searches, and criminal legal system interactions should also be part of the strategy. Information can be offered in a variety of ways and using accessible language. Examples of campaign methods include social media posts, news releases, and posters in public settings (e.g., TTC stations, healthcare settings, social service settings).

Recommendation 5: Encourage diversion by continuing to advocate for increased investment into the broader mental health and social service systems

As previously described, the 911 CCDPP is currently operating within the context of an overall strained mental healthcare and social service system, which impedes the program's objective of diverting non-emergent mental health-related crises away from a police response. System-level investments, from all levels of government, are necessary to help reduce the need to call 911 by:

- strengthening other community-based crisis services;
- strengthening the 911 CCDPP's ability to reduce service users' risk of future crises by providing rapid connections to community-based short- and long-term follow-up resources; and
- promoting upstream crisis prevention by improving socio-economic conditions linked to the well-being of the population at-large.

Conclusion

This report presented findings from a complex dataset exploring the experiences and outcomes of 911 CCDPP service users and service providers. Our findings suggest that, as an innovative model for crisis response, the 911 CCDPP is meeting an established need for mental health crisis support in new ways. Furthermore, although the program has exhibited modest growth, stakeholder groups perceive that change is meaningful. Multiple relevant challenges have also been identified, including the lack of a unifying program view, operational inefficiencies, and partnership challenges, all of which, when taken together, threaten the success of the 911 CCDPP. Uptake of the recommendations provided in this report will be essential to inform decisions about the future of the program and help ensure that individuals and communities across the city of Toronto will be able to access timely and appropriate mental health supports when most in need.

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Appendix A: Project Governance

During the evaluation planning, a governance model was co-created by PSSP, TPS, and GCC leadership (Figure A). This model identified three levels of stakeholder collaboration with PSSP, which are described below:

- **Consulting:** PSSP engaged with subject matter experts, including TPS's MHAAP, on specific questions as needed.
- **Collaborating:** PSSP regularly engaged with the Project Committee in the development and review of the evaluation plan and key deliverables.
- **Confirming:** PSSP engaged with identified leaders from TPS and GCC, who provided final approval of major processes and deliverables to be submitted to the TPS Command.

Both partners (e.g., TPS and GCC) agreed to have equal input into decisions regarding the evaluation activities and products, with decisions made by consensus, where possible. Consensus was defined as the ability of each party to "live with" and actively support the decision going forward, even if they do not believe it is the "right" or "best" decision. If consensus could not be reached, it was determined that, as the funder, TPS retained the right to decide the format and scope of the final deliverables, as well as budget and allocation of funds and unanticipated expenses.

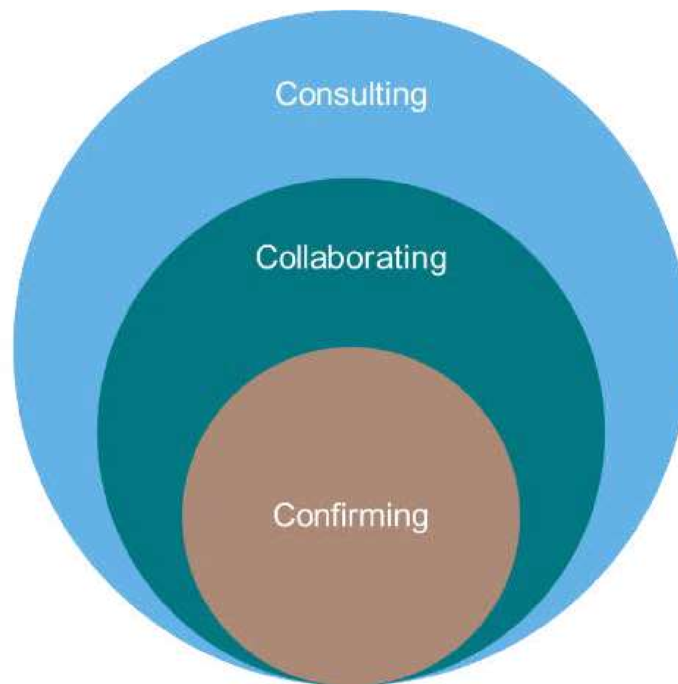

Figure A. Governance model

Appendix B: Evaluation Matrix

Evaluation question	Evaluation sub-question	Examples of data measures	Data sources	Timing
1. How successfully has the program met its objectives?	a. To what extent, and how, were mental and behavioural health crisis calls responded to by the 911 CCDPP?	Description of calls along call pathway (e.g., call volumes, dispositions, times)	TPS/GCC administrative data	Stage 2 Retrospective from October 4, 2021 - December 31, 2023
	b. To what extent, and how, were direct crisis supports provided and connections made to appropriate community-based follow-up supports through the 911 CCDPP?	Description of supports provided, referrals made	TPS/GCC administrative data	Stage 2 Retrospective from October 4, 2021 - December 31, 2023
	c. How did stakeholders experience the 911 CCDPP, and how did access, experiences, and/or outcomes vary within and across groups?	Description of service users (e.g., number of unique callers, demographics of follow-up users) Experiences receiving/ providing care (access/entry to services, crisis supports provided) Satisfaction with experience Impact on service user health and well-being	TPS/GCC administrative data Service user questionnaire Service provider focus groups	Stage 2 Cross-sectional; April - May 2024
	d. What unintended outcomes have emerged, if any?	N/A	Document review Service user questionnaire Service provider focus groups	Stage 2 Cross-sectional; April - May 2024
2. What factors of the 911 CCDPP are contributing to the program's realized and unrealized outcomes, as well as to accessibility and equity?	a. How is the program design affecting program delivery and outcomes?	Experiences with: • Call pathway/flow • Consent process • Wait times/transfer times	Service user questionnaire Service provider focus groups	Stage 2 Cross-sectional; April - May 2024
	b. How are the financial, human, organizational, and physical (e.g., infrastructure, technology, etc.) factors facilitating or impeding the program in reaching its objectives?	Experiences with: • Confidence/preparedness in decision making • Capacity/resourcing • Infrastructure	Service user questionnaire Service provider focus groups	Stage 2 Cross-sectional; April - May 2024
	c. In what ways has the partnership between TPS and GCC affected program outcomes?	Success factors for collaboration (e.g., favourable political and social climate; mutual respect, understanding, and trust; ability to compromise, etc.)	Wilder Collaboration Factors Inventory Service user questionnaire Service provider focus groups	Stage 2 Cross-sectional; April - May 2024

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Appendix B: Evaluation Matrix

Evaluation question	Evaluation sub-question	Examples of data measures	Data sources	Timing
3. What are the opportunities for the future of the program?	a. What are the strengths and challenges with the current iteration of the program?	Summary of findings from evaluation questions 1 and 2	TPS/GCC administrative data Service user questionnaire Service provider focus groups Wilder Collaboration Factors Inventory	Stage 2 Cross-sectional; April – May 2024
	b. What are opportunities and potential strategies for improvement?	Program challenges and successes; suggested opportunities	SWOT analysis	Stage 3 Cross-sectional; June 2024

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Appendix C: Preliminary Logic Model

Inputs		Outputs	Outcomes		
Stakeholders	**Resources**	**Activities**	**Short-term**	**Medium-term**	**Long-term**

• Toronto Police Service (TPS)
• Gerstein Crisis Centre (GCC)
	Tangible resources
	• Institutional infrastructure
	• Funding
	• Staffing
	• Information technology
	• Monitoring data
	• Crisis Worker Cheat Sheet
	  ◦ Eligibility criteria
	  ◦ Script
	  ◦ Text entries for CAD system
	• Crisis response decision criteria (TCCS vs. 911 CCD program)
	
	Intangible resources
	• Partnerships
	• Expertise
	• Leadership
	• Data and evaluation literacy
	• Policies, standards, and regulations
	• Time
		Trained and representative staff
		• Core and ongoing trainings
		
		Call intake
		• Triage and assessment
		• Transfer to GCC Crisis Workers for diversion or co-response
		
		Phone-based crisis response
		• De-escalation and crisis intervention
		• Safety plan development
		• Information and referrals
		• Transfer to mobile response (TPS or TCCS)
		
		Post-call crisis management and follow-up
		• Short-term/long-term supportive counselling
		• Short-term/long-term service navigation
		• Reconnection to existing supports
		• Facilitate connection to community-based services
			Provider-level outcomes
			• Increased knowledge and skills in providing person-centered crisis care
			
			Service user- and community-level outcomes
			• More service users' immediate needs are met
			• Improved experience of crisis response for individuals experiencing mental and behavioural health crises
			• Improved access to crisis management and follow-up
			• Improved access to appropriate community-based follow-up supports/referrals
			
			System-level outcomes
			• More eligible service users receive the most appropriate crisis intervention for their needs
			• Increased access points to the mental health and substance use sector
			• Proof-of-concept for a crisis call diversion model
			• Proof-of-concept for collaboration between police services and community-based organizations
				Provider-level outcomes
				• Increased staff empowerment
				• Improved staff satisfaction
				
				Service user outcomes/ Community-level outcomes
				• Improved community experience of mental health crisis response
				• Improved connection to community-based supports
				
				System-level outcomes
				• Reduced use of police resources for mental and behavioural health crises
					Service user outcomes
					• Improved service user well-being and quality of life
					
					Community-level outcomes
					• Increased community safety and well-being
					
					System-level outcomes
					• Reduced calls to 911 for mental and behavioural health crises
					• Improved intervention sustainability
					• Improved service integration for the mental health and substance use sector

Assumptions
• There is an assumed baseline level of organizational readiness to change across stakeholder groups, including a demonstrated commitment to police reform by TPS • Partnerships are assumed to generate the collaborative capacity to deliver the intervention effectively and in a manner consistent with its key values • Partners are assumed to have the organizational capacity to successfully deliver care that best meets the needs of the communities they serve • Community-based referral networks are assumed to have the capacity to meet the needs of new service users in a resource-strained health and social service sector

External factors and potential risks
• Time • Capacity vs. rising demand • Organizational cultures and readiness to change • Political climate • Community buy-in and trust

Appendix D: Summarized SWOT Analysis

After analyzing all qualitative and quantitative data, the evaluators, together with a Senior Innovation Specialist and Senior Policy Analyst from PSSP, identified the internal (strengths, weaknesses), and external (opportunities, threats) factors influencing the program's current and future success. The following lists describe those factors.

Strengths

- Co-location – benefits of proximity
- Meeting a need
- Indications of positive experiences of service users

Weaknesses

- Operational challenges leading to stagnant utilization of the program
- Under-theorization of the program, including issues of inclusion and access
- Lack of trust between organizations

Opportunities

- City-wide expansion of the TCCS
- Ongoing desire for a better response to mental health-related crises
- Ubiquity of 911

Threats

- "Competing" programs (e.g., TCCS, 988)
- Implicit assumptions to use 911 rather than community-based resources
- Fragmentation and low capacity of mental health and social service systems

Note: Due to the complexity and nuance of the program, we acknowledge that these categorizations are not static (e.g., a strength may have weaknesses components).

Appendix E. Additional Illustrative Quotations

Key takeaway and section	Quotation
1: The program is meeting an established need in new ways	
1.1 The program is providing a new voice and new connections	"In the past, if there's intimate threat, we're always going to be sending police out and whatever resources we need. But I have, in the past, had it where somebody was threatening suicide, and they were actively wanting to do it – And, I've seen that be very beneficial, especially because a lot of these GCC workers, they've got tools, courses, different things that we don't have."
	"But absolutely it [911 CCDPP]'s a better quality service [than traditional police responses for mental health-related calls]. They're getting the right person that can, can take care of their needs and address their needs. The person who's best qualified to deal with it is, is, is the person receiving those calls, for sure." ( )
	"We've done really, really excellent work. We fill a gap within service there. It isn't always the case that folks need in-person support and so for us to be able to offer this phone support really quickly and efficiently to those folks that get connected with us is incredibly important and important to the community." (
1.2 Service users appear to be satisfied overall with their experience receiving support from the 911 CCDPP	"They were respectful of my headspace and space. They gave me all available options to use should I ever face a problem. They were extremely patient." (
	"It was a very helpful experience and they [TPS COs] used their resources efficiently to provide me speedy assistance. They were calm and compassionate." ( )
	"I felt more supported in the moment. There was someone to talk to about the situation. It was less difficult to navigate my problems alone." ( )
1.5 There are opportunities to strengthen equity & accessibility	"...making sure that we are partnering with culturally competent or culturally specific service providers as well as part of our network of partners..." (
	" anyone should be able to call 911 from anywhere, right? It's free from a paid phone. It's free from your cell phone if you don't have minutes […] So I think we've tried to make that the most accessible phone number, right? So I think that increases access to everybody" ( )
	"... we also hire for people who've got lived experience [...] of mental health, lived experience of refugee or newcomer to Canada [...] lived in, in poverty or on assistance, you know, those kinds of backgrounds so that there's people who, who work at center who not only, you know, have empathy for people but really have deep empathy because they have lived that themselves. And then on top of that, we also hire for multiple languages and for people who look like the people we serve, trying to make sure that we have Black, Indigenous, racialized folks throughout the organization..."

Appendix E. Additional Illustrative Quotations

Key takeaway and section	Quotation
2: Key operations are not connected despite expectations and some positive collaboration experiences	
2.1 Positive expectations and collaboration experiences speak of the perceived potential of the program	“We wouldn't be able to work as collaboratively and there wouldn't be the same type of security that I think both the crisis worker and the call takers and dispatchers feel because everything's happening in real time. There's no gap in service because, again, we're able to update what's going on for that person that we're on the line with and they can see everything that's happening." ( )
2.2 There is a lack of fully integrated operations: Call screening and diversion.	“[…] they] literally took the calls away from us. The viewing of the calls. […] That was a huge piece and the rationale we were given for it didn't really make sense.” ( )
	“The told me they don’t have the capability of reviewing calls in the city anymore, so they can't do that anymore. Yeah, they used to, but then they said ‘because of privacy’ or something, which, that doesn't really make any sense considering they’re taking calls. We're giving them anyway.” (
	“It can be a bit arduous, especially, if I'm not sure if the call can go to , because I find I’d have to call them, ask them if they'd be willing to take this. And I don't—and they may be on a call already, or they may be marked unavailable for paperwork or something, so, I don't know—if they're on a bathroom break.” (
	“Um, there's times when we could take call after call at night, but we can actually sit there all day. Not received 1 call. And there's all sorts of calls happening that day I really think that needs to be reviewed on the , on what they sent over to us, or – what they just try to decide and to deal with them themselves, because it's easier.”
2.2 There is a lack of fully integrated operations: Co-response.	“If that diversion could put something in the call text, just so the frontlines who are going know what they've done already, but that's not done.” (
	“Sometimes, we'll say the situation doesn't need an officer and, sometimes, an officer will come by.” ( )
	“[T]he calls that come across our board, we don't know if there was an [diversion] attempt made or if it wasn't successful. (
2.3 Caller education and consent discussions impact the program’s service delivery flow	“That [explanation about being diverted to a crisis worker] throws [callers] off, and it takes definitely some explaining to them and then convincing them that ‘you are going through a crisis, I’m identifying certain things where you might benefit more [from].’” (

Appendix E. Additional Illustrative Quotations

Key takeaway and section	Quotation
2.4. Limited staffing of the crisis desk contributes to inconsistent service availability and delivery	"I have always wondered why there wasn't more efforts to have more of like a swing shift within it, not just one worker, because then it leaves a gap when they're not there." (
	"] can be hit or miss. If you have a busy [day] then it's difficult to do and then if you're not having a busy day, you're able to make some calls." ( )
	"Gerstein can't staff one desk. They would never be able to staff two. Yeah. Like it just wouldn't happen."
	"They say the numbers don't support more than one [crisis worker working per shift], but then, you know when […] don't have enough for it to really get flowing, so then the numbers won't support it. But, then, you get the right amount of resource in place and, you know, things can happen differently."
	"We are exposed to a lot of vicarious trauma and we don't really have a lot of the supports that the other folks who are in this space do." ( )
2.5 The program's internal and external visibility is limited	"I think it was when the pilot project was in its early stages, the first divisions that it was introduced in those areas, I think they had more knowledge about it because, and they would be telling me about GCC and we hadn't heard about it."
	"I think the [911 CCDPP's] efforts go unappreciated when we don't know how many calls are being diverted away, [or] when all we see is the work before us on the board versus what's being taken before we even get the chance to get on the board."
	"Personally, I would say a quarterly update by division [is needed] just to show how many calls are being taken, how many calls are being diverted away, just so that we can get a relative idea as to where and how effective it's been in a particular division over others."
	"It seems like the program is kind of stagnant now. Because now we have the new fancy TCCS thing, so I think—it feels like our focus is moving towards that, with the success stories, with the stats, those are being brought up Those are being delivered to us."
	"Also to it, [911 CCDPP]'s not like another crisis service where it's really advertised, right? I mean, the police service doesn't need to advertise that you need the police. So it's difficult to say."
	"[I]magine this, when I go to a call I'm gonna . I'm gonna read to get a background of what mental health problem they have and whatnot. [inaudible] or something, saying 'the subject had called TPS twelve times to the 911 CCDPP, and been de-escalated all twelve times,' but this is the only one now that was completed. That would be informative for sure."

Appendix E. Additional Illustrative Quotations

Key takeaway and section	Quotation
3: There are partnership challenges	
3.1 There is a lack of trust between the TPS communications and GCC crisis teams	"[...] things get hairy all of a sudden, they're asking questions,] don't have the best full control necessarily and they don't know what they should be asking—foreseeing safety, or like what direction it's about to be faced, that kind of thing. They wouldn't necessarily ask that question."
3.2 There is a lack of trust between leadership teams	"In our first year, whenever there was any changes to the pilot, we usually discussed them all together, GCC and TPS. And, in year two, there just, out of nowhere, came changes from the that actually has process impacts for stuff, with zero involvement or discussion with any of our managers at all." ( )
	"[It's] all about them] and what's convenient to them. It, doesn't feel collaborative and it feels more like a power over. That's how I'm feeling it."
3.3 An uncertain future	"[I]f we] work more collaboratively, it'll be more beneficial. Whether it's going to be with them either plugging in [for shadowing], or as new people come sit with them or versus—whatever the case might be. If there is an onboarding going on, if there's a training piece, send a], send , to have this conversation with to say, 'let them know what we do, so we can learn what they do.'"
	"I think the growth of the program and having a secondary crisis worker for contingency planning and ensuring adequate service would be the best case scenario moving forward for the future."
	"Right now it—we [are] the only real ones that can do it. So, until the other organizations, until every—all levels of government step up and step in, I think it might remain with us until someone says 'I can do this.'")
	"Frankly, we can't say whether or not the [911 CCDPP] program has taken an adequate measure towards diverting calls only because the calls , we don't know if there was an attempt made or if it wasn't successful."
	"I think that something that we can look to improve on is creating that harmonious relationship of a tiered response and working together. And trusting each other [...]")

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Appendix F. External Community-Based Organizations Commonly Referred to by the 911 CCDPP

- Assaulted Women's Helpline
- Barbra Schlifer Commemorative Clinic
- Bereaved Families of Ontario
- Black Legal Action Centre
- Breakaway Community Services
- Central Intake
- Centre for Addiction and Mental Health (CAMH)
- Canadian Mental Health Association
- Community Living Toronto
- COSTI Immigrant Services
- COTA Health
- Crisis Outreach Service for Seniors (COSS)
- Distress Centres of Greater Toronto
- Hassle Free Clinic
- Homes First Society
- Hong Fook Mental Health Association
- Humber River Hospital
- Landlord and Tenant Board
- Legal Aid Ontario
- LOFT Community Services
- Lumenus
- Office of the Public Guardian and Trustee
- Ombudsman Ontario
- Ontario Disability Support Program
- Ontario Student Assistance Program
- Ontario Works
- Parkdale Queen West Community Health Centre
- Partners for Access and Identification (PAID)
- Rainbow Health Network
- Rapid Access Addiction Medicine (RAAM) Clinics
- Reconnect Community Health Services
- Safe Bed Registry
- Sherbourne Health Centre
- Surrey Place
- The 519
- The Access Point
- Toronto Rape Crisis Centre
- Toronto Street to Homes Assessment and Referral Centre (129 Peter St)
- Toronto Withdrawal Management Services
- VHA Home HealthCare
- Victim Services Toronto
- Women's College Hospital
- WoodGreen Community Services
- YMCA of Greater Toronto
- 2-Spirited People of the 1st Nations

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Appendix G. Results from the Wilder Collaboration Factors Inventory

The maximum score for each factor is 5.0. According to the inventory developers, factors with average scores of 2.9 or lower reveal a **concern** and should be addressed, factors scoring between 3.0 and 3.9 are **borderline** and should be discussed by the group to see if they deserve attention and, lastly, factors scoring 4.0 or higher show a **strength** and probably don't need special attention (Mattessich & Johnson, 2016).

Collaboration Factor	GCC Mean Score (/5) (n=6)	TPS Mean Score (/5) (n=36)	Overall Mean Score (/5) (N=42)
Members see collaboration as in their self-interest	4.2	3.8	**4.3**
Favourable political and social climate	4.8	4.1	**4.2**
Mutual respect, understanding, and trust	3.4	3.7	**3.7**
Collaborative group seen as a legitimate leader in the community	4.3	3.6	**3.7**
History of collaboration or cooperation the community	4.3	3.4	**3.6**
Appropriate cross-section of members	3.5	3.5	**3.5**
Ability to compromise	3.2	3.4	**3.4**
Members share a stake in both process and outcome	3.0	3.5	**3.4**
Flexibility	2.5	3.1	**3.0**
Development of clear roles and policy guidelines	3.3	3.1	**3.1**
Multiple layers of participation	2.9	2.7	**2.8**

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