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Toronto Mobile Crisis Intervention Team (MCIT) Program Implementation Evaluation Final Report

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Key Messages

The Toronto Mobile Crisis Intervention Team (MCIT) program implementation evaluation has highlighted a number of program strengths to be built upon and challenges to be addressed in order to improve implementation and service delivery across MCITs. Key recommendations for program improvement include:

- Improved police organizational support for the program by raising awareness of the program mandate among the Primary Response Unit (PRU). Raising awareness of the program mandate will also serve to improve capacity to respond appropriately to mental health issues and knowledge of resources in the community within divisional policing.
- Clear communication to program partners and the community on the mandate of the MCIT program is needed. This is necessary to address different perceptions of the purpose of the program, for example the types of calls to which the MCITs should be responding, in light of confusion among community members regarding whether MCITs should be involved in more volatile, potentially violent encounters between PRU and emotionally disturbed persons (EDPs)
- Clarification of certain team responsibilities and procedures is required:
    - It should be clarified whether primary response (without the PRU) by MCIT teams is ever appropriate, for example when teams have had previous contact with a consumer.
    - Clarification on whether follow-ups should be a program priority is needed. If teams will be conducting more consistent follow-up, it should also be considered whether they should follow-up with consumers in person or by phone. One possible suggestion would be to contract out phone follow-ups to a 3rd party agency.
    - Program management should clarify with program staff that they can use their discretion, based on the nature and safety of the call, on handcuffing consumers.
- Improved external and internal feedback mechanisms have been requested by a number of stakeholders.
- Resolution of debates on resource issues, such as team cars and uniforms is recommended. With respect to cars, some stakeholders have recommended that an unmarked SUV with a light pack would address challenges concerning vehicle comfort and potential stigma when transporting consumers to hospital.
- More comprehensive training for teams and PRU officers was recommended. It was suggested that teams receive more cross-over training in each other's areas of expertise for the purposes of bridging their different professional cultures. It was also recommended that PRU officers receive real-time training involving ride-alongs with MCITs to raise awareness of the program mandate and build capacity for positive engagement with program consumers.
- More opportunities for teams to meet and debrief were recommended as this was viewed by many as a valued activity – the same opportunities should be provided to PRU officers.
- The program is already exploring program expansion – it is recommended that this process involve the consideration of a more effective dispatch process whereby dispatch and MCITs are in more regular communication.

- The program is currently developing more standardized team protocols. In this process, it is recommended that a more streamlined process for data entry be developed to minimize the number of data entry points and data sources that require completion by staff.
- In order to avoid some of the limitations encountered by this study, future program evaluation design must incorporate realistic timelines to accommodate research ethics board approvals in all partnering organizations, and related participant recruitment delays. Moreover, early planning and development of partnerships, resources and timelines needs to be conducted in order to provide adequate support for the recruitment and representation of the consumer population in future evaluations.

Executive Summary

The City of Toronto Mobile Crisis Intervention Team (MCIT) Coordination Steering Committee recommended that the Centre for Research on Inner City Health (CRICH) conduct an implementation evaluation to further guide MCIT program development. MCITs comprise a hospital-based team involving a mental health nurse and a police officer team trained in crisis intervention who responds to individuals in crisis in the community. The purpose of this evaluation was to document and understand processes of MCIT service delivery, and identify facilitators and challenges in implementation. Furthermore, the evaluation sought to gain an understanding of levels of satisfaction with the program among stakeholders.

The evaluation study involved a series of qualitative interviews and focus groups with program stakeholders to learn more about program operations, facilitators and challenges. Purposive sampling was used to engage 57 stakeholders at health system, managerial, team and consumer-levels. Interviews and focus groups were conducted between November 2013 and February 2014. Interviews and focus groups lasted approximately 45 minutes to 2 hours. Administrative data (e.g., call volume) is also presented for descriptive purposes. The aggregate results of a police personnel survey on experience and awareness of the MCIT program are also presented. Ethics approval for the study was sought and received through research ethics boards (REBs) at the five participating hospitals with MCITs.

The implementation evaluation of the Toronto MCIT Program has yielded a number of important findings on the process of program implementation and service delivery. Overall, program stakeholders, including police, staff, community agencies, health system partners and consumers, feel that the program is meeting its key goals to respond to individuals in crisis, and treat them in the community with the goals of preventing unnecessary hospitalization and criminalization. Consumers interviewed expressed having positive experiences with the teams, and emphasized that these experiences were related to interactions whereby the teams were caring, made the consumer feel respected and heard, and gave them choice in the context of the interaction. Less positive interactions reflected a lack of these qualities and left consumers feeling criminalized. Administrative data illustrate that call volumes of the program have gradually been increasing over time, and awareness is relatively high in certain police service areas. However, in-depth data from interviews and focus groups have illustrated that greater awareness of the program mandate is needed within the police service, among hospital partners and in the community to further increase utilization of the program.

A number of facilitators and challenges to program implementation and optimal service delivery were identified through the study. With respect to facilitators, existing partnerships between the police and the health system, between the MCITs and emergency departments (EDs), and MCITs and community agencies are viewed as positive and instrumental to the functioning of this complex program. Furthermore, team members are proud and invested in the work that they do. In the area of team practice, teams are viewed as knowledgeable in how to engage with consumers in crisis, and to refer consumers to relevant community services. The knowledge and experience brought by the nurse is

highly valued by a variety of stakeholders in these interactions, as are team procedures for following up with consumers to prevent repeat crises.

Challenges to program implementation and service delivery reflect the complexity of the program. Despite the fact that partnerships between the various program stakeholders are viewed as positive, some of these relationships require more work in order to better support the program. Toronto Police and health system stakeholders feel removed from each other's cultures, and this is often reflected in a lack of awareness of the program mandate among the Primary Response Units (PRU) and a lack of buy-in for the program in some divisions. Also related to this cultural/organizational distance were issues of role clarity, whereby team members may step into each other's roles, and a desire by many team members to be more involved in program decision-making. Further relationship-building appears to be needed in some hospital EDs, as teams often report a lack of prioritization of consumer admission leading to long wait times and an inability for teams to attend other calls.

Mixed views on certain resources and team practices emerged in discussions with stakeholders. There appears to be a debate among program stakeholders as to whether police officers should be in uniform or in plain clothes, and the extent to which current uniforms distinguish the nurse from the police officer. Differing views also emerged on whether teams should be driving marked or unmarked cars, and concern that current vehicles are uncomfortable for consumers. A lack of clarity on certain team responsibilities, such as whether teams should always be secondary versus primary response, as well as whether and how teams should be conducting consumer follow-ups, also appear to hinder service delivery. There also appears to be some discomfort among teams with current handcuffing procedures. Challenges in communication between dispatchers and teams were discussed as negatively affecting team ability to attend EDP calls, and documentation procedures lack standardization and are viewed as onerous.

The evaluation study has highlighted a number of program strengths to be built upon and challenges to be addressed in order to improve implementation and service delivery across MCITs. Key recommendations for program improvement include:

- Improved police organizational support for the program by raising awareness of the program mandate among the Primary Response Unit (PRU). Raising awareness of the program mandate will also serve to improve capacity to respond appropriately to mental health issues and knowledge of resources in the community within divisional policing.
- Clear communication to program partners and community on the mandate of the MCIT program. This is necessary to address different perceptions of the purpose of the program, for example the types of calls to which the MCITs should be responding in light of confusion among community members regarding whether MCITs should be involved in more volatile, potentially violent encounters between PRU and EDPs
- Clarification of certain team responsibilities and procedures is required:
    - It should be clarified whether primary response (without the PRU) by teams is ever appropriate, for example when teams have had previous contact with a consumer.

    - Clarification on whether follow-ups should be a program priority is needed. If teams will be conducting more consistent follow-up, it should also be considered whether they should follow-up with consumers in person or by phone. One possible suggestion would be to contract out phone follow-ups to a 3rd party agency.
    - Program management should clarify with program staff that they can use their discretion, based on nature and safety of the call, on handcuffing consumers
- Improved external and internal feedback mechanisms have been requested by a number of stakeholders. In the area of external mechanisms, more communication and input from community stakeholders and consumers was recommended and could be addressed through the creation of a community advisory committee or linkage with an existing committee. With respect to internal feedback, greater inclusion of frontline staff in program-decision making should be considered.
- Resolution of debates on resource issues, such as team cars and uniforms is recommended. With respect to cars, some stakeholders have recommended that an unmarked SUV with a light pack would address challenges concerning vehicle comfort and potential stigma when transporting consumers to hospital.
- More comprehensive training for teams and PRU officers was recommended. It was recommended that teams receive more cross-over training in each other's areas of expertise for the purposes of bridging their different professional cultures (i.e., nursing/mental health and police cultures). For example, additional training in safety and the police system for nurses, and training in mental health de-escalation and the mental health system for police officers were viewed as helpful. It was also recommended that PRU officers receive real-time training involving ride-alongs with MCITs to raise awareness of the program mandate and build capacity for positive engagement with consumers. Furthermore, given the intensive work of the MCITs, more opportunities for teams to meet and debrief were recommended as this was viewed by many as a valued activity – the same opportunities should be provided to PRU officers.
- The program is already exploring program expansion – it is recommended that this process involve the consideration of a more effective dispatch process whereby dispatch and MCITs are in more regular communication. This will overcome challenges in ability for dispatch to locate the teams and increase capacity for teams to respond to calls. In the future, the program may want to consider a more centralized dispatch system to overcome current issues with dispatch and the impact of varying divisional support on service delivery.
- The program is also currently developing more standardized team protocols. In this process, it is recommended that a more streamlined process for data entry be developed to minimize the number of data entry points and data sources that require staff completion.
- In order to avoid some of the limitations encountered by this study, future program evaluation design must incorporate realistic timelines to accommodate research ethics board approvals in all partnering organizations, and related participant recruitment delays. Moreover, early planning and development of partnerships, resources and timelines needs to be conducted in order to provide adequate support for the recruitment and representation of the consumer population in future evaluations.

Introduction

Background

Police have typically been front-line responders to mental health emergencies in the community [1, 2]. For example, Toronto Police Service received and were dispatched to 19,454 calls related to Emotionally Disturbed Persons (EDPs) in crisis situations in 2011 [3]. However, police often experience a number of challenges when responding to EDPs in crisis situations [4]. These challenges can include perceived lack of training on how to effectively respond, and challenges in referring consumers to appropriate community services [5]. Mobile Crisis Intervention Teams (MCITs), comprising a mental health nurse and a police officer trained in crisis intervention who respond to EDPs in the community, have been established to address this issue [1].

A small body of evaluative literature exists on the MCIT program/police and mental health nurse co-response model, primarily from the United States. These studies are primarily focused on outcome evaluation and have identified that MCIT programs are cost-effective, and reduce the number of consumer hospitalizations, and officer time on scene [1, 6, 7]. High levels of consumer and officer satisfaction with programs have also been reported in some studies [1, 7, 8]. However, little is known about how these programs are implemented and the critical program ingredients that contribute to successful outcomes, as well as the contextual factors that affect program operations. Furthermore, despite the fact that a number of MCIT programs have been implemented in the province [9], few evaluations have examined how these programs have been implemented in the Ontario context [10].

Successful program implementation is required for achieving program outcomes[11]. Simply evaluating program impacts and outcomes without considering how a program has been implemented can lead to inaccurate findings regarding a program's effectiveness. Implementation evaluation verifies what the program *is* and whether or not it is being delivered as planned to the targeted recipients [11]. Furthermore, assessing whether a program has been implemented as intended can facilitate making linkages between programs and outcomes in an outcome evaluation [12]. The purpose of this evaluation was to document and understand processes of MCIT service delivery, and identify facilitators and challenges in implementation. Furthermore, the evaluation sought to gain an understanding of levels of satisfaction with the program among stakeholders. Findings from the implementation evaluation will inform improvements to service delivery, allocation of resources, program coverage, and ensure standardization of service provision across Toronto.

Review of the literature on implementation of the co-response model

A small body of literature has evaluated aspects of implementation of the police and mental health nurse mobile crisis intervention response model. Forchuk et al. [9] compared and evaluated three different co-response models of crisis service in three communities in Ontario: 1) police membership on

a specialized mental health team; 2) a mental health worker as part of a specialized police team; and 3) an informal relationship between police and a mental health crisis service. Through focus groups with stakeholders across the communities, Forchuk et al. identified a number of challenges and facilitators related to the models. They found that the services were highly valued in their communities, and that stakeholders, families and consumers were satisfied with the quality of the services, but not necessarily the scope of services. Challenges in service delivery emerged related to the need for greater training and education of police officers on mental health issues and addictions, long wait times for team staff and consumers due to delayed access to psychiatric beds at hospitals, and delays in team response time due to inadequate staffing during peak hours.

Scott [7] found positive ratings of satisfaction among consumers and police officers in an evaluation of a mobile crisis program in Georgia, USA. In an evaluation of an Integrated Mobile Crisis Response Team (IMCRT) in British Columbia, Baess [13] also found strong levels of satisfaction with the program among consumers, families, and community stakeholders. However, challenges in implementation of the IMCRT program were found related to inconsistent staffing of police officer team members, availability of appropriate vehicles, a lack of education on mental health issues among district police officers, and communication with dispatch staff. These challenges led to program recommendations including the need for increased capacity among police to regularly staff teams, adequate vehicles to transport consumers, greater training of district police officers on how to best respond to individuals experiencing a mental health crisis, and training of team nurses in police radio procedures to enhance communication of teams with the dispatch centre.

Toronto's MCIT Program

The Toronto Police Service and area hospitals developed an MCIT program to provide support to individuals experiencing mental health crises in the community. The MCIT program currently includes six hospital-based teams, each covering multiple police district divisions. The teams are based at St. Michael's Hospital, St. Joseph's Hospital, the Scarborough Hospital, Humber River Regional Hospital, the Toronto East General Hospital, and North York General Hospital. Recently, the program added a team through North York General Hospital (as of March 2014), however this program was not included in the evaluation study as this team had not yet been implemented during the data collection period. Each MCIT program consists of nurses who are trained in crisis intervention, police officers, and a team manager.

The aims of Toronto's MCIT program are to: 1) provide prompt assessment and support to EDPs; 2) link EDPs to appropriate community services if follow-up treatment is recommended; 3) avert escalation and injury to both police and individuals in crisis; 4) reduce pressure on the justice system (e.g. by decreasing encounters with the justice system and officer's time handling psychiatric emergency situations); 5) reduce pressure on the health system (e.g. by decreasing unnecessary visits to the emergency department); and 6) ensure program accountability [3]. In order to operate, each MCIT team requires funding, full- and part-time experienced nurses, a full-time officer from each district, hospital office space, computer hardware and software, communication infrastructure, a police vehicle, safety equipment, a police radio, mobile workstation and screen, as well as training manuals, program

memorandum and guidelines. Primary Response Unit (PRU) officers are dispatched to all EDP calls to assess the safety of the situation and appropriateness of an MCIT response. If considered appropriate by the PRU, the MCIT will be dispatched to the call by the Toronto Police Communications Department [3]. The Communications department occasionally receives calls from community agencies, family members, and consumers asking for the MCIT to attend, and MCITs also occasionally respond directly to radio calls.

In their final report, the City of Toronto MCIT Coordination Steering Committee recommended that the Centre for Research on Inner City Health (CRICH) conduct an implementation evaluation to further guide MCIT program development [3].

Methods

Evaluation Questions

The evaluation focused on five key questions:

- What is the level of satisfaction with the program design and service delivery for stakeholders, staff members, and consumers?
- What is working well in implementation of the MCIT program?
    - What are key facilitators to implementation?
- What are the challenges in implementation?
- What are areas of improvement for service delivery?

Design

The evaluation study involved a series of qualitative interviews and focus groups with program stakeholders to learn more about program operations. Purposive sampling was used to engage 57 stakeholders at system, managerial, team and consumer-levels. Interviews and focus groups were conducted between November 2013 and February 2014. Informed consent was received for all interviews and focus groups, and they were approximately 45 minutes to 2 hours in length. Administrative data (e.g., call volume) was also used to present a description of the program, and aggregate results of an online, annual police personnel survey on experience and awareness of the MCIT program are also assessed. Ethics approval for the study was sought and received through research ethics boards (REBs) at the five participating hospitals with MCITs.

Participants and recruitment

Recruitment of consumers

Teams were asked to introduce the evaluation study to every consumer who met the study's eligibility criteria. Eligibility criteria included: 18 years of age or over, and had an interaction with MCIT in the past 6 months. Teams were not to recruit consumers during a crisis, but during a follow-up call, typically after a period of time had elapsed following the initial interaction with the team. Consumers interested in

participating in the study were asked for verbal consent to share their contact information with the research coordinator. The research coordinator subsequently contacted the consumer, explained the study, and scheduled an interview. A total of 11 MCIT consumers were interviewed for this study at a location of their choice, e.g., CRICH offices, private space in a library. Consumers were given $25 and 2 TTC tokens to cover their travel expenses to and from the interview. One interviewer conducted all consumer interviews and was joined by a second interviewer for two of the interviews.

Recruitment of program staff

Five focus groups with MCIT team members were coordinated with the help of MCIT managers, who shared information about the study with the team frontline service providers. Focus groups were held at locations of the teams' choice: CRICH, one of the participating hospitals, or a police station.

A total of 10 nurses, nine police officers and one administrative support person participated in the focus groups. Despite efforts to accommodate staff schedules, part-time hours and shift scheduling prevented every team member from attending. In addition to the MCIT team members, one focus group was held with Toronto Police Service dispatchers and call takers to clarify the process by which MCITs are dispatched to EDP calls. Recruitment of police dispatcher participants was facilitated by staff in the Toronto Police Service Communications Department. A total of five dispatchers and call-takers attended the focus group.

Recruitment of program stakeholders

MCIT evaluation working group and steering committee members recommended key stakeholders to interview for the study. The research team contacted these stakeholders and invited them to participate in a one-time in-depth, interview. A total of 13 program stakeholders were interviewed for the study – five health systems stakeholders, five MCIT program staff affiliated directly with the program, and three Toronto Police stakeholders. Two of these interviews were conducted over the phone due to scheduling challenges. Three interviewers conducted these interviews. A focus group was also held with members of a community mental health advisory committee, facilitated by the research coordinator. A total of seven community stakeholders attended the focus group, representing community mental health agencies, mental health advocates and policy-makers.

Data analysis

Descriptive frequencies were calculated for the participant socio-demographic data, Toronto Police Service administrative and survey data. Furthermore, crosstabs were run for the Toronto Police Service survey data to demonstrate differences in awareness and experience with the MCIT program by type of police staff.

All interviews and focus groups were audio-recorded and transcribed verbatim. Transcripts were analyzed using thematic analysis techniques, involving reading, coding and comparing transcripts for theme development [14] based on the topics explored in the interview guides. The coding and analysis process was conducted by two researchers in consultation with the rest of the research team, and was facilitated by the use of QSR NVivo version 10 software.

Study sample

Table 1 reflects the demographics of the program stakeholder sample of the study[1]. A total of 43 stakeholders involved in the program completed a demographic form. Of those 43 participants, the majority were between the ages of 45 and 64, and 51% were female. Stakeholders occupied a range of roles in relation to the MCIT program; 23% were police partners, 35% were frontline MCIT members, 16% were community stakeholders, 12% were program managers, 7% were hospital partners, and 7% were program funders.

Table 1. Program stakeholder demographics, N=43

	%
Age (n=41)	
25-34	13%
35-44	24%
45-54	29%
55-64	29%
65-74	5%
Gender	
Female	51%
Male	44%
Transgender	5%
Role in relation to MCIT program	
Manager	12%
Team member – police officer	14%
Team member – nurse	21%
Hospital partner	7%
Police partner	23%
Community stakeholder	16%
Funder	7%
Years working with current organization - Mean	13.5

[1] It should be noted that not all interviewees completed a demographic form.

Table 2 describes demographics of the program consumers who participated in interviews. Twenty-seven percent of consumers were between the ages of 20-29, 18% were aged from 30-39, and 27% were between the ages of 40-49. Fifty-five percent of the consumer participants were male, 36% were female and 9% were transgendered. Twenty-eight percent had completed university, college or trade school, 9% had completed some university/college or trade school, 27% had completed high school, and 27% had not completed high school. Sixty-four percent were living in a rented room, apartment or house, and 36% were unstably housed, indicating living in multiple locations (e.g., rented room, shelter and/or with friends/relatives) or living in a public space.

Table 2. Program consumer demographics, N=11

	%
Age	
20-29	27%
39-39	18%
40-49	27%
50-59	18%
60-69	10%
Gender	
Female	36%
Male	55%
Transgender	9%
Race/Ethnicity	
White/Caucasian	46%
Black or African descent	27%
Asian or Pacific descent	19%
Other	8%
Primary Language	
English	82%
Other	18%
Education	
Completed graduate school	9%
Completed university/college/business or trade school	19%
Attended university/college/business or trade school	9%
Completed high school	27%
Attended high school, not completed	27%
Completed grade 8 or less	9%
Housing Situation	
Rented room, apartment or house	64%
Unstably housed (living in rented room and/or a shelter, couch surfing or in a public place)	36%

Results

In this section, we first present quantitative, administrative data on program trends, and awareness of the program within the Toronto Police Service. Then we discuss results from the program stakeholder interviews, focus groups with teams and interviews with program consumers that highlight key facilitators and challenges to program implementation and service delivery.

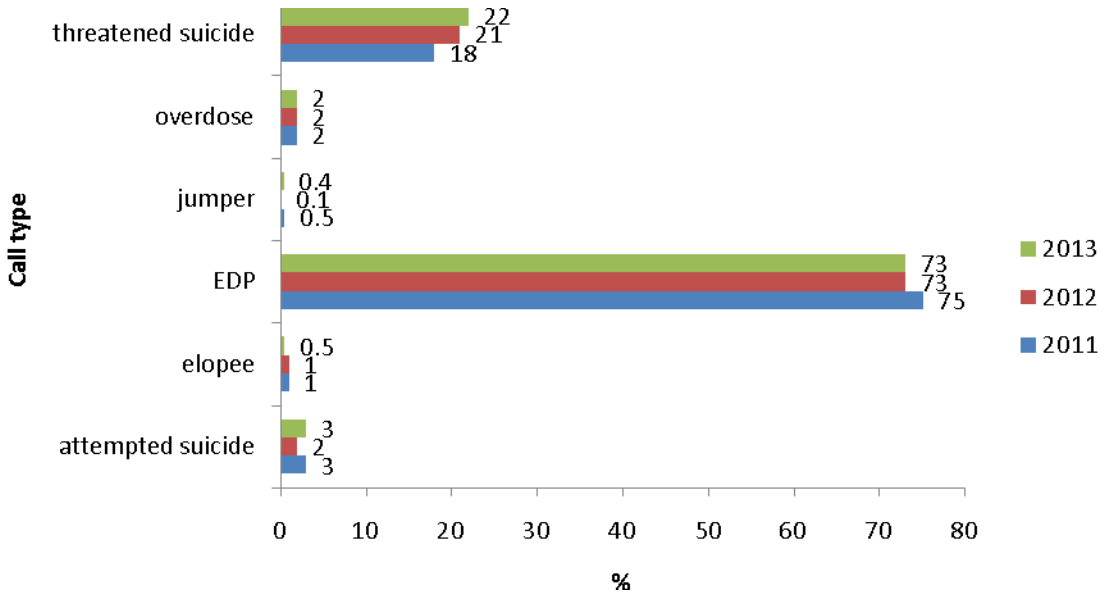
Program trends and population

Call volume trends

The total number of calls involving emotionally disturbed persons attended by MCITs has been increasing gradually in the last three years. In 2011, MCITs attended 2,017 calls. This number increased to 2,177 calls in 2012, and up to 2,332 calls in 2013[2]. Figure 1 reflects the percentage of different types of calls that are classified as EDP calls, attended by the MCITs per year. Over the course of the last year, MCITs have predominantly attended EDP calls (75% in 2011, decreasing slightly to 73% in 2013), followed by threatened suicide calls (18% in 2011, increasing to 22% in 2013).

[2] These data come from ICAD Report 52, and include calls for attempted suicide, elopee, emotionally disturbed person, jumper, overdose, and threatened suicide; these call types are the same criteria used by the TPS Business Intelligence unit in the annual EDP Report.

Figure 1. Types of calls attended by MCIT, by year



Awareness and use of the MCIT program within the Toronto Police Service (TPS)

Figure 2 depicts the percentage of TPS annual survey respondents (including uniform members in divisional policing command, detective services and operational services, who indicated awareness of the MCIT program or requesting MCIT was applicable to their job) who are aware of the MCIT program in 2013. Ninety-three percent of police officers in divisional policing command agreed that they were aware of the MCIT program, 95% of police officers in detective services reported being aware of the program and 94% of officers in operational services indicated awareness of the program.

Figure 2. Percent of Toronto Police Service officers aware of MCIT program (N=772)

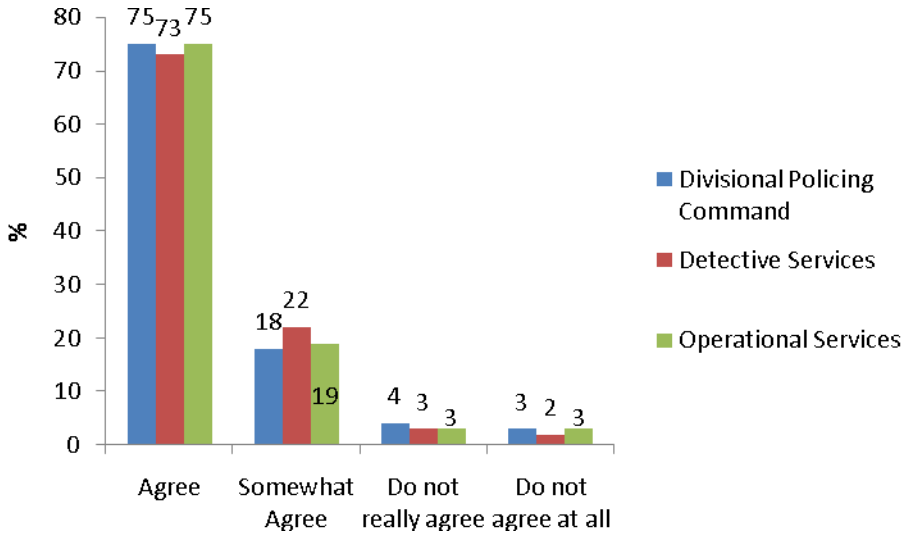


Figure 3 shows the percentage of TPS survey respondents who are civilian members (e.g., communications operators or court security in divisional policing command, detective services and operational services and who indicated that being aware of MCIT or requesting MCIT was applicable to their job) who are aware of the program. Less awareness of the program was reported among civilian members than among police officers. Seventy-seven percent of civilian members in divisional policing command agreed that they are aware of the program, 78% in detective services indicated that they are aware, and 82% of civilian members in operational services (which would include dispatchers and call takers) indicated being aware of the program.

Figure 3. Percent of Toronto Police Service civilian members aware of MCIT program (N=110)

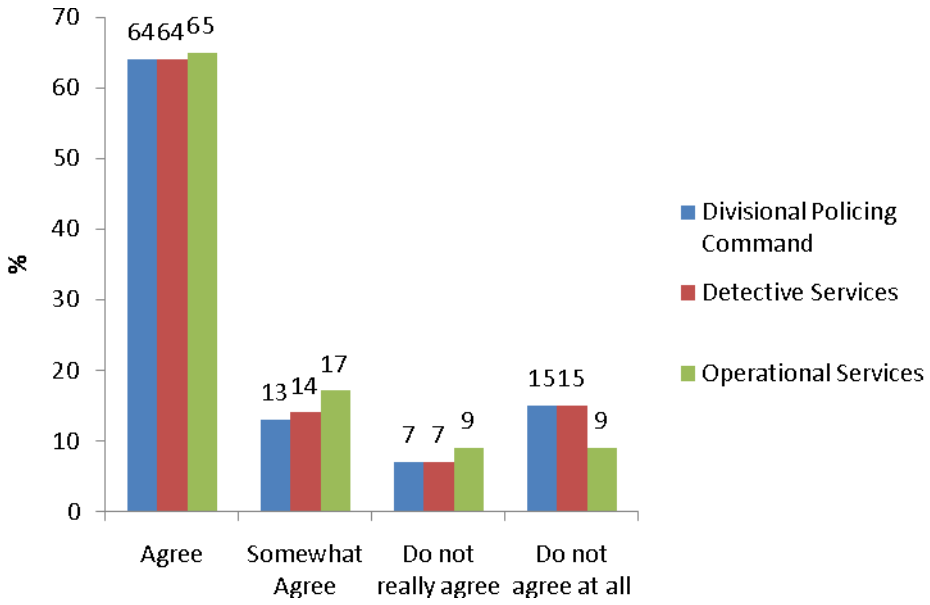


Figure 4 shows the percentage of TPS officers who have ever requested the MCIT program to attend an EDP call, with 65% of officers in divisional policing command indicating some agreement that they had requested the program, 83% of officers in detective services having requested the program, and 45% in operational services reporting having requested the program.

Figure 4. Percent of Toronto Police Service officers who have ever requested MCIT program (N=772)

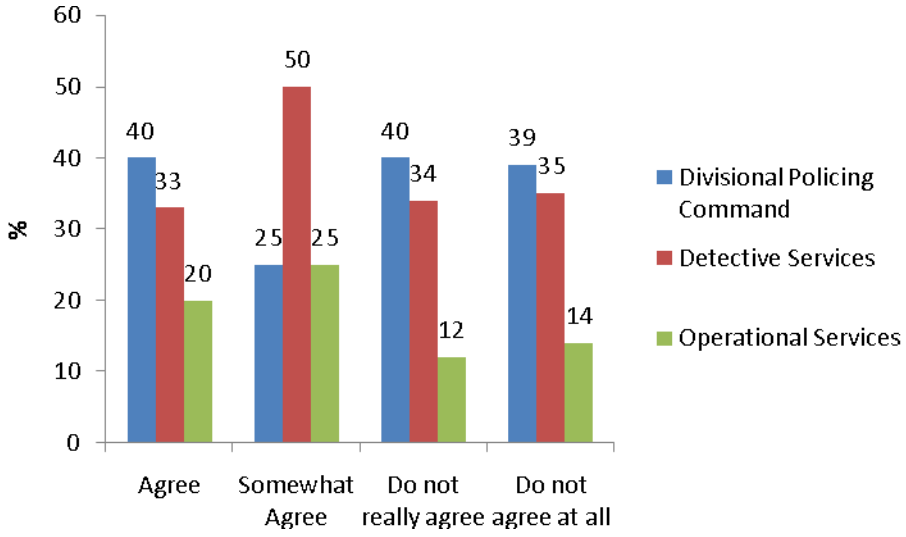
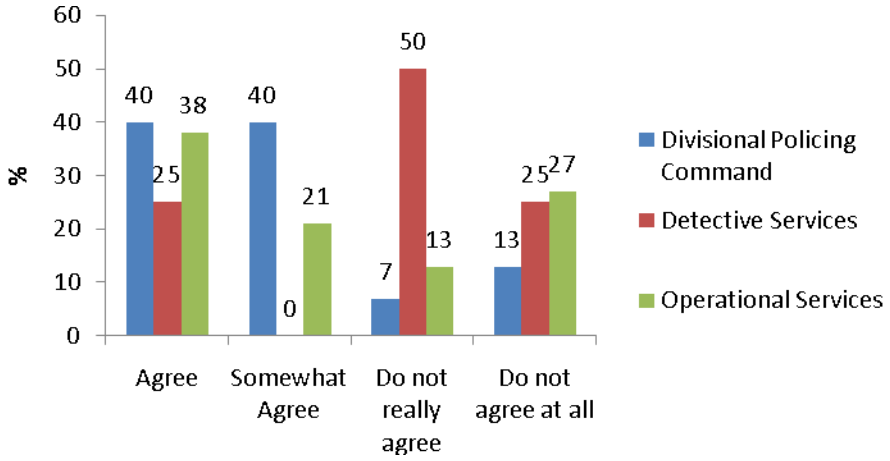


Figure 5 depicts the percentage of TPS survey respondents who are civilian members (e.g., communications operators or court security in divisional policing command, detective services and operational services and who indicated that being aware of MCIT or requesting MCIT was applicable to their job) who have ever requested the MCIT program. Eighty percent of civilian members in divisional policing indicated agreement that they had ever requested the program, while 25% of civilians in detective services and 59% in operational services indicated having requested the program.

Figure 5. Percent of Toronto Police Service civilian members who have ever requested MCIT program (N=110)



Level of satisfaction with program implementation and service delivery

Stakeholder perceptions

Program is meeting goals

Generally many participants shared positive comments of the program and how it is functioning as a whole. Several participants described that the program is meeting its key goals to respond to individuals in crisis in the community, divert consumers away from the hospital and the criminal justice system, and free up Primary Response Unit time for other calls:

> *…We know…that they do… diversion from hospital rates and their apprehension rates… We know in divisions where there is a team versus there isn't a team that the apprehension rates are quite different. – Health system stakeholder*

This participant discussed how the program has saved lives:

> *I think the [MCIT] interventions themselves have been successful in de-escalating some potentially explosive situations, and I think there have been situations where lives have been*

saved as a result of the intervention of the team. So, I think those things are the primary successes of it. – Health system stakeholder

Furthermore, some participants also mentioned that they feel the MCITs have a good reputation in the community and work well with community agencies to meet the needs of individuals in crisis:

…we do have, from what I hear, a good reputation. I think our MCIT has a good reputation. I hear that from community agencies when I'm out there, and so, I think our standards…are viewed as high… - MCIT program staff

In particular, a number of participants noted that the joint response of police and mental health nurses is highly valued in order to meet consumer needs, but that the role of the nurse is viewed as particularly important within teams, within the police force, and in the community. The role of the nurse is believed to bring a caring response and professional mental health expertise in conducting mental health assessment, which is considered to enhance police ability to respond to crises.

The…prompt response to a request by the police for the team to reply or the team to attend and then a reasonably quick but thorough assessment at the scene so that the team members, the police officer and the mental health professional, the nurse in our case, can make a decision about what stream of care is most appropriate, community based or hospital based. – Toronto Police stakeholder

Yet, differences in opinion seem to exist between the community and program stakeholders on one of the main functions of the program. It is perceived that the community believes that MCITs should be first responders to EDP calls, while the expectation of the program is that MCITs are secondary responders. This participant expressed that it is difficult to manage community expectations in this regard:

There's this perception that mobile crisis intervention teams are a panacea that…if you have somebody in crisis that's armed with a weapon, they're going to show up and the nurse is going to talk the person off the ledge…And that's…not what they are going to do. – Toronto Police stakeholder

Desire to learn from other crisis response models

A number of participants noted a desire to learn from other crisis response models to explore whether the police/nurse co-response model is the right model for Toronto, as the appropriateness of the model is highly context dependent and community specific, for example, given the needs of the community. Participants also noted that this could help inform improvement of the current program model through learning about better service integration. Specifically, some participants were interested in learning more about community interdisciplinary crisis teams (non-hospital, non-police based), in order to ensure that community needs are being met:

Originally what people said that they wanted when they were surveyed before the MCIT team existed is they wanted something like the…model where you've got sort of non-medical crisis workers who would come on a call rather than a cop and a nurse… - Community stakeholder

Consumer perceptions

Several consumers spoke about positive interactions with the MCIT. Feeling listened to and respected was seen as very important by consumers:

Yeah, like, they seemed to be, like, very willing to listen to me. That's my biggest thing is, like, if I feel like people are just attacking me or not listening to my side of the story or treating me like I have…like, I don't have a brain to think with, then I get very defensive and, like, scared, so I put my back up and it doesn't always go well. - MCIT consumer

A number of consumers also appreciated when they were given options instead of being told what to do in the context of an interaction with MCITs:

One of the big things that I really appreciated was that they made it, like…I'm not a hundred percent sure whether or not it was my full decision, but they made it seem like it was and, like, asked me what I wanted to do instead of being, like, "Okay, well you're going to Safe Beds and you have no choice. - MCIT consumer

This approach helped consumers feel supported and not like they were 'criminals', as one consumer discussed:

Well, just by them identifying them within the situation before hand, they didn't know when they came. They only knew a couple things about the situation, and bringing the nurse right away, that's telling me that they cared about my mental state. Yes, and that's making me know that they're looking at me as a mental person rather than a criminal, and that's the way I want to be looked at now. - MCIT consumer

Some consumers mentioned that they felt safe in the care of the MCIT team. One consumer talked about how the police officer took care of him, while another consumer described conversations with the team as non-confrontational. Mostly positive comments regarding the nurses and police officers on the teams emerged in interviews with program consumers. These consumers saw the nurses as respectful and comforting, and one consumer saw MCIT police officers as figures of authority who ensured safety. Many consumers also compared their interactions with the MCIT to previous interactions with the PRU, and found interactions with the teams more positive than the PRU for the above-mentioned reasons.

Nevertheless, some consumers discussed negative experiences with the program. Some of these consumers discussed not feeling respected or given a choice in the process:

I couldn't…bring my stuff that I want to bring…to the hospital…I didn't feel like I have the choice there. I was, like, forced to leave immediately. – MCIT consumer

A few consumers discussed being confused about team identity. Consumers for the most part realized the nurse was in a specialized role, but were unclear on the nature of that role. One consumer thought the nurse was actually a detective because of the way she was dressed (e.g., in a dark blue jacket and bullet proof vest). When another consumer was asked if he could tell the difference between the nurse and police officer, he said no, adding that they were dressed in the same way.

Finally, some consumers stated that they were not happy with the services to which they were referred. One consumer discussed not wanting to go to a particular hospital, but was taken there despite this request. Another participant expressed dissatisfaction with a housing service referral:

Like, that's the thing…I think the people think it's going to be good because…when…the mental health nurse was explaining it, it seemed like a really good program and it was, like, "Oh, there's… counselors there 24/7 and whatever that you can talk to" and it's, like, "Yeah, but they don't talk to you." - MCIT consumer

What is working well in implementation/service delivery of the MCIT program

Relationships

Multiple cultures and positive partnerships

The program has engaged a number of stakeholders and cultures (e.g., Toronto Police Service, hospital/health system, community service agencies, consumer groups; LHINs) in program implementation, and study participants perceived that the relevant stakeholders are currently at the table. Many stakeholders discussed being appreciative of several types of partnerships involved in program implementation, namely partnerships between the Toronto Police Service and the health system, the MCITs and the emergency departments (EDs) at partner hospitals, and MCITs and community organizations.

Police and health system

The partnership between Toronto police officers and mental health nurses - the co-response program model for crisis intervention - was valued as integral to meet the needs of individuals in crisis in the community. The partnership was viewed as important and positive because it brings together expertise from two areas/disciplines, criminal justice/policing and mental health/health care, which reflect primary elements of EDP calls. Furthermore, this partnership was viewed as beneficial for raising

awareness and educating police officers on the complex issues of mental illness and addictions and appropriate response:

> *I think the partnership between the police and the mental health workers is quite positive. I think that that has had an effect educating not just the officers on the team, but the officers throughout the department on some of the issues related to mental health and addictions, and their complexity – Health system stakeholder*

MCIT and ED

A number of participants mentioned positive partnerships between MCITs and ED staff with respect to accompaniment of consumers in crisis to the hospital. The positive aspects of the MCIT-ED partnerships arose from early relationship-building activities by MCITs with EDs. This was viewed as helping to raise awareness among ED staff of their mandate and establish approaches for working together for consumer "hand-off" - whereby consumers are transferred from the care of the MCIT to the care of the ED. One stakeholder suggested that these early relationship-building activities improved ED staff understanding of the MCIT mandate to prevent unnecessary hospitalization. Furthermore, it was viewed that there is an understanding among ED staff that when consumers are brought to hospital, the preceding work of the MCITs makes the consumer hand-off process more efficient:

> *That they're able to triage and not bring everyone to the emergency room. When they do bring someone to the emergency room, then we do know that there's already been a mental health assessment done. – MCIT program staff*

Furthermore, several participants discussed that, through this relationship-building, there is now an understanding among ED staff in some partner hospitals that the MCIT program does not inundate them with people in crisis, but that teams are working hard to de-escalate and treat consumers in the community:

> *I think we've built a rapport with a lot of the people not just nurses but the doctors at the hospitals and through that rapport I think they recognize that when we bring people in, they're there for a reason – MCIT program staff*

However, it was noted by several participants that efficient procedures for consumer hand-off and a clear understanding of the program mandate are not necessarily present in all partnering hospital EDs – this will be discussed further in the challenges to program implementation section of the report.

MCIT and community

A number of community stakeholders expressed appreciation for the educational, outreach work that the MCIT program has done in raising awareness of the program and building partnerships with community agencies. As a result, awareness of the program in the community is perceived to be

growing. One participant discussed that calling the MCIT to engage with a consumer in crisis at a community agency can be a collaborative process:

> *We've had the situation…safe and everything is contained but there are some issues and when the MCIT comes, we can talk to them about what's going on…what's happening with the person, what the issues are and help them with their interaction – Community stakeholder*

Many also discussed that one of the beneficial outcomes of this community outreach work has not only been increased awareness of the program, but also increased access to the program through service providers at community agencies, family members and consumers asking for the MCITs by name when calling 911:

> *Well I've noticed since being on the team we do get requested now by family. It's not 'oh I need the police to help, my son's having a psychotic episode'. It's more can you have the CIT team come, they've been here before…so we are getting recognized slowly like I'm seeing it more often now than we did a few years ago… – MCIT program staff*

Nevertheless, asking for MCIT by name is viewed by some as presenting issues for the dispatch process – this will be discussed further in the challenges section.

Within and between team collaboration

Program staff perceive that efforts to build relationships at the team level are effectively creating team cohesion, and that these efforts continue as new teams are created and team membership changes over time. There is also a sense that communication and collaboration across teams is important and growing, and that more opportunities for teams to meet should be created:

> *I think one of the things that I've really noticed is encouraging the communication between the teams. So, the weekly status check-ins that we have I think are very successful. I think there's a lot of conversation there, and a lot of co-ordination. – MCIT program staff*

Furthermore, a number of staff noted a collective sense of pride in the work that they do and consider themselves lucky to work in the program:

> *…The thing is…the people in this room, I think we've expressed how proud we are to be a part of the team and how we think it works and I described myself as the white chariot pulling up because officers are so happy to see us to come deal with something. I think this team is great. – MCIT program staff*

Team Practice

Consumer engagement

A number of aspects of MCIT practice emerged as factors that are working well within the program. For example, with respect to consumer engagement, several participants (including consumers) felt that a positive interaction with a consumer was related to the nurse taking the lead, and the officer taking a supporting role:

> *I think specifically with the team is I've had some excellent experiences with them and also not so great experiences. And I think the difference, if I can pinpoint it to what led to a good experience and what led to a not so good experience for the consumers that we work with, was if the nurse, you're right – if the nurse takes the lead, things seem to go a lot smoothly right because they're giving direction to the officer. 'He's fine, this is what we should do'. – Community stakeholder*

> *The nurse actually did really a good job. She talked to me really nicely, she said, "I understand. Take a deep breath. Take a deep breath. What's going on? How's your day? What triggered? What, what happened? - MCIT consumer*

Teams discussed that they work together to decide who should take the lead in an interaction, and this process is dependent on contextual factors such as whether they have previous experience with the consumer, consumer preference and type of call. For example, if a consumer might be concerned that someone has broken into his/her home, he/she may want to talk to the officer first, whereas if the primary reason for the call is related to a mental health crisis, then he/she may want to speak to the nurse:

> *Yeah, if it's somebody that we're unfamiliar with then we're going together and if it's somebody we've dealt with before [nurse] take[s] the lead. Sometimes it's, you know it all depends on the situation and the person we're dealing with. – MCIT program staff*

Community referrals

Many participants discussed that referral to community services is working well. Teams discussed feeling knowledgeable about resources in the community, and that nurses' psychiatric training facilitates effective consumer referral:

> *…I know that the nurses that we have on this team are very familiar with community resources because they've had experience through our psych emerg because they were trained there first and then they went out…Referrals to community resources is something that's always predominant in their mind. Like that's one of the first interventions they'll think of because that's our work. – MCIT program staff*

Types of services to which teams typically refer consumers include: community crisis case managers (where available), Safe Beds, shelters, out-patient (hospital) mental health services, and other

community agencies. However, some team members found it challenging to ensure they have access to updated information on referral resources:

> *Honestly, if you want to give, make some improvements with this…give me an MCIT handbook that's always updated with a list of people we can start referring people to… MCIT program staff*

Follow-ups

Follow-up procedures, whereby MCITs follow up with consumers with whom they have interacted and whom they may have referred to services, were viewed by a number of participants as important and working well to prevent future consumer crises:

> *…If you follow-up on the other half of it when you go back to a call or if we get a generated report you go to them and they've actually followed through with their doctors, they're taking their meds and you know there's been no call for services for these people and you've made a positive contact with that person – MCIT program stakeholder*

A number of consumers appreciated having follow-up contact with teams, but preferred a phone call from the team nurse, as opposed to MCITs showing up at their door:

> *MCIT Consumer: They should have phones that say at the top MCIT Nurse, because if we come home one day, and we were having a bad day, and we look on the phone, it's going to see, we can see that the nurse called.*
> *Interviewer:* And just knowing that she called would make a difference?
> *MCIT Consumer: Yeah….Even if they called, like every 30 days, if they have one person that that's their job to call…*

Currently, teams do not provide consistent follow-up with every consumer, but use their discretion based on the consumer's needs. However, there seems to be confusion among program stakeholders as to whether follow-ups are a program priority and a lack of standardization on the follow-up process (this is discussed in further detail in see the challenges section).

Challenges in implementation/service delivery of the MCIT program

Relationships

Differences in police and health system culture

Many participants described a difference between police and health systems cultures, which can make working together challenging. Often, this had to do with differences in goals. While police were seen to be responsible for public safety, nurses were viewed as accountable for the well-being of individual consumers, often acting as advocates.

'Cause I think we just have kind of two different viewpoints where the police have multiple calls that they go through every single day so their idea is get in, get out as quickly as possible, let's resolve this situation right here so I can move onto the next call whereas we're kind of thinking more holistically with the client like there is a lot of information that might not seem relevant to the police officer but it's relevant to us and how we might think of resources… - MCIT program staff

Lack of mental health knowledge on the part of the PRU can complicate this problem, as officers may not understand mental health issues to the extent that the nurses do. These differences can make team members feel like they are 'guests' in another culture, as well as another space:

So, it's both [nurses and officers] learning their boundaries and respecting those boundaries and figuring out how to be a guest in someone else's space. It's kind of curious that way. – MCIT program staff

MCIT & the emergency department

Many participants described long wait times at the hospital as a major challenge to service delivery. Although this was recognized as a systems-level problem that affects all service-users, participants also felt that the triage process in some hospital settings was ineffective. Program staff expressed frustration with not being prioritized in the ED. They discussed that waiting at the hospital with a consumer "ties up" the team and prevents them from responding to other calls.

If we're going to keep a [M]CIT team on the road, either the hospital has to fast track us and so we can get back out there or we just have to help with the form and the initial part of the apprehension and let the uniform take in or we're going to be hostage in the hospital…And hostage in the hospital means not responding to those radio calls. - MCIT program staff

Some participants discussed that part of the issue with ineffective triage relates to the requirement that ED doctors medically clear consumers before admission. Given the fact that ED doctors are in high demand, this slows down the admission process.

… You have a patient that's been assessed by the psychiatric nurse, they've been apprehended, they go to a hospital and they're waiting…for two to four hours before they can see the psychiatrist. The psychiatrist could be right in the room next door, but they have to be pre-cleared, medically cleared, by the ER doctor… - Toronto Police stakeholder

Furthermore, a number of participants identified a lack of private space for teams to wait with consumers as another challenge. As a result, consumers must wait in the main ED waiting room, visibly accompanied by police, which can be very uncomfortable and stigmatizing for consumers. Some team members also talked about challenges relating to duplication of work. For example, sometimes ED staff

will reassess consumers that have already been assessed by the MCIT staff, which also slows down the admission process.

> *We don't need you to go through the questioning that we've already done. We've already got all these answers so you're just asking the same questions and then they go back into crisis…so why is there, why are we sitting in the triage for? - MCIT program staff*

MCIT & community agencies

There is a perceived need for better linkage between the MCITs, community agencies, and consumers to increase community awareness and allow for ongoing feedback on the program.

> *[W]e don't get client feedback no matter what we do, right? I mean, once in a while you'll get someone who will take the time to send a letter and say, you know, they did… a really good job or whatever, or this officer handled this situation really well. – Toronto Police stakeholder*

Some stakeholders suggested that a community advisory committee would facilitate more opportunities for communication, awareness raising and feedback between the program, consumers and the community.

Organization and System-Level Factors

Lack of awareness of MCIT mandate

Many participants discussed a lack of awareness of the MCIT mandate as a challenge affecting the program's utilization, particularly lack of awareness of the program mandate among the PRU. Some participants noted that police divisions that had greater exposure to the MCIT team had greater awareness of the program mandate and called the team more often, while other divisions with limited awareness may not even think to call MCIT. One participant discussed the relationship between awareness and call volumes:

> *They should be seeing about three to four on a shift. Now why they have volumes that are low is…I'm not clear. So again, that sort of increasing awareness within the police service that this service exists. Increasing the confidence that they can call and access them easily -MCIT program staff*

There was also a feeling that some PRU sergeants were not aware of MCIT's efforts and successes. One participant described that some sergeants did not know about the impact of the teams, for example, the number of calls the team was preventing, or how hard the team works to ensure consumers follow-up with their doctors.

Another participant thought that emergency medical services (EMS) also needed more education about the MCIT team, noting that sometimes when the team is dispatched, an ambulance will already be on scene and that EMS staff may decide to take the consumer to the hospital instead of waiting for an MCIT's assessment.

Varying organizational buy-in in police divisions

Organizational buy-in for the program seems to vary across police divisions, in that knowledge and capacity to support the program differs. Capacity issues often arise due to staffing changes at upper-ranks and a resultant lack of awareness of the program and its mandate among these new staff. Some stakeholders mentioned that these factors lead to low team use or inappropriate use whereby teams are being asked by the PRU to attend calls that are not part of their mandate, for example to relieve officers in the ED:

> *They [PRU officers] call 'hey, can you meet me at the hospital.' If I'm feeling that they want a babysitter I'll let them know 'no, we're not coming', but well there was a couple of times where it's like I thought they had information to pass on to us or would like us to follow-up with this person, I go to the officer and I'm like 'yeah I'll come help you',… 'yeah here's your prisoner and like take them'. No, that's not what we do - MCIT program staff*

At times, commanding officers will express the desire to use MCIT officers for other calls which also challenges the work of MCITs:

> *[Some] commanding officers within the division will say, 'Oh, well, you know, we need to take MCIT off the road because we need them to do something else right now' and it's, like, 'No, you can't do that. You can't take that officer', you know? – Toronto Police stakeholder*

Furthermore, some participants mentioned that a lack of awareness of the program at the divisional level may lead to delays in replacing officers that have rotated off the MCIT. Some participants also discussed that at times higher ranking officers may over rule MCIT decision making due to a lack of buy-in to the program:

> *…or if we're on the scene and the sergeant is sort of saying 'this is what's going to happen and these guys are going to take you to hospital' then you're going to be like 'well that's up to the CIT team and we have to do the assessment and that's our, you know, we'll determine that piece'.- MCIT program staff*

Lack of external and internal feedback mechanisms

A few stakeholders mentioned the value of determining how consumers and caregivers perceive the MCIT team. A number of participants noted that there is currently no formal mechanism to gather community feedback about the MCIT program and as a result teams do not know how well they are delivering services:

For me personally…the hospital is like magic when you're on the road, like the hospital is like I'm going to take this person and I'm going to give them to you and I expect that when they walk out of this magic box they're going to be better again…and…we have no idea what happens with that person – MCIT program staff

Some mentioned that a key challenge in getting feedback from consumers is the difficulty in reaching them, as consumers sometimes do not have phones or may move frequently.

Internal feedback mechanisms were identified as lacking. Some team members expressed frustration about being "left out" of program decision-making and not being asked if there were any issues the team wanted to bring forward.

Resources

Uniforms

A number of disadvantages with the police and nurse uniforms were discussed, as well as advantages that were seen to be affecting service delivery. Perceived advantages of the police and nurse uniforms included that police uniforms in particular could be viewed as a de-escalation tool in that they reflected police presence and that the situation was being treated seriously. A number of participants felt that current uniforms clearly distinguish police officer and nurse roles:

Well I think it's easy for them to identify us as the nurse cause it, when you're walking in they're like okay you are the nurse and I don't even need to say anything cause they can see like okay, you're with the police but you're dressed differently or they can read on me that it says nurse. - MCIT program staff

With respect to disadvantages, some participants (including some consumers) felt the police uniform was intimidating for consumers, and preferred that officers be dressed in plain clothes, stating that uniforms can draw unwanted attention to consumers, who may not want to be seen interacting with police.

Several participants also mentioned challenges related to distinguishing the nurse from the police officer. One participant thought the bullet proof vest was a barrier for consumers, as it caused them to think the nurses were really police officers. When one consumer who was unsure a nurse was present, based on confusion with the uniform, was asked if clearer identification of the nurse would have changed his/her perception, the consumer responded:

Maybe that would have been better…because when they entered, I thought they were all police trying to capture me. - MCIT consumer

Cars

A debate regarding the effectiveness of marked versus unmarked cars for team response emerged from the interviews and focus groups. Marked and unmarked cars were seen as having both advantages and disadvantages. With respect to advantages, a number of participants viewed marked cars with light packs as helpful in getting teams through traffic to the scene of EDP calls quickly. However, marked cars were also perceived by many to bring unwanted attention to consumers and were seen as stigmatizing. One consumer described feeling like a criminal when in the police car:

> *I'm kind of self-conscious when they drove me and… "Are people looking at me now?" from on the outside. - MCIT consumer*

Conversely, a number of participants discussed that while an unmarked car may be less stigmatizing for consumers, an unmarked car without a light pack could make it difficult for teams to get from one place to another quickly. Another complication was the fact that PRU officers in marked cars are typically on scene anyway, thus contributing to stigma for consumers.

Some team members described the police car as very uncomfortable for consumers, referencing the lack of air conditioning in the summer, lack of heat in the winter, and lack of space in the backseat. One participant thought it was inappropriate to transport certain consumers in the police car, especially those who are elderly or disabled:

> *…You're not going to put [the] elderly in the back of a police car because it's just not appropriate…It's a very tight, confined space. They probably have physical issues that aren't appropriate for them so we need the ambulance to transport right - MCIT program staff*

Furthermore, access to a police car was brought up as a concern for a few teams. For example, sharing a car between divisions sometimes meant waiting for a vehicle to become available and delayed the teams' response to calls. One participant noted that this problem is made worse when there are not designated cars for MCITs. For some teams, the car is available for any PRU officer to use, while other teams stated that they had their own dedicated cars.

Staffing

Many participants felt that finding the "right staff" is highly important to the functioning of the teams and can be challenging. The hiring process was believed to be challenged by the need to find both police and nurse staff with the appropriate (police and nursing) skill sets and knowledge, as well as staff who are proficient in team-based work and are invested in working with consumers who have complex needs:

> *We want somebody that's got good communication skills, good job skills, ability to work with somebody else…ability to take instruction from somebody else who's not a police officer, who's not a superior to them. – Toronto Police stakeholder*

Participants also identified that ideal staff need to be "self-directed" with the ability to work independently given the large amount of time that teams spend out in the field without direct supervision. Some participants mentioned that joint police/hospital hiring processes, whereby each partner can assess potential staff on these abilities, can assist with the process of finding the "right staff".

A few participants discussed that police officer turnover on teams is challenging to service delivery. While there is no limit for the length of time a nurse can serve on an MCIT team, police officers typically serve for two to three years. Participants felt that this period of time that police officers spend on teams is challenging because some officers only begin to feel comfortable with the work in that time, and are then rotated off of the teams. Team members discussed that some officers really enjoy the position and do not want to leave, and that mental health training is something that needs to be conducted over time. Furthermore, this shorter time frame requires regular replacement of officers by divisions - a lengthy process which is further challenged in divisions where there is less awareness and buy-in of the program.

Training

A number of participants expressed challenges with the training process. They felt that nurses and police officers on MCITs had limited understanding of each other's cultures. They suggested the need for more cross-over training for police officers and nurses to build respective knowledge, better equip teams and help bridge cultures. For example, more training on how to engage with consumers, mental health de-escalation techniques and general mental health system information was needed for officers. For nurses, more training on safety issues and police culture was suggested to improve service delivery.

> *… it would probably be good like when we started to go over things like such as working the radios just for you know for in case, for emergency situations, things, just some little basic things…that they could have covered. – MCIT program staff*

Program Processes

Dispatch process

Focus groups with program stakeholders highlighted that there are a number of challenges to the dispatch process that can negatively affect access to the program and service delivery. Generally, dispatchers expressed that MCITs are often not available to them to dispatch to EDP calls because they have a difficult time locating MCITs associated with their division. Communication between MCITs and the dispatch centre occurs through the radio and through the computer system in their cars. If an MCIT is sitting in the emergency room with a consumer and does not have their radio or if they are in another division on another radio band, then they are unavailable to the dispatch centre.

This dispatcher describes the process of 'hunting down' the MCIT:

You voice out over your band first. If they [MCITs] don't respond, you have to find them and you can see where their GPS is, what Division they're in and then see if they're at a station, at a hospital, you can voice that out to like [name of division], if you're on [another band], if they're in there so voice that over your band to see if they respond there so like kind of a hunting them down. - Toronto Police stakeholder

There may also be challenges with general dispatch awareness of the MCIT program:

Participant 2: They'll [dispatch] voice out for us and see if we're available to go…to that call, yes. Participant 4:…but that was a struggle that we had for a long time is… it's having the dispatchers even aware…that we're on the board… - MCIT program staff

As part of the educational, outreach work that MCITs do to raise program awareness and facilitate dispatch, they ask consumers, family members and service agencies to ask for them by name when calling 911 for assistance with consumers in crisis. However, from the dispatch perspective, this process is difficult to manage, because when community members ask for MCIT by name, the call takers cannot guarantee that it will be MCIT that responds due to the above mentioned availability issues. As a result, some participants are concerned that sending the PRU when the MCIT was requested by name could escalate the situation:

…But there's also that consideration if they describe a situation they may want that CIT team…we're going to have to send somebody (someone) which could escalate the situation if they're expecting a friendly face or someone they know or a CIT specialist and all we have is two primary response officers – Toronto Police stakeholder

Lack of clarity on certain team responsibilities

Secondary versus primary response

According to program protocols, MCITs are a secondary response unit intended to respond to EDP calls after the PRU has determined that the team is needed and the situation is safe. However, there are different views as to whether MCITs should be first or secondary responders and this seems to create confusion, and a lack of standardization on response protocols across the program.

Some community stakeholders discussed that MCITs should be first responders so that consumers in crisis receive the assistance of a mental health professional as soon as possible. Other stakeholders believe that it is not the role of MCITs to be first responders and that it is not safe for only one police officer and a civilian nurse to respond to potentially violent EDP calls:

…there's this perception that mobile crisis intervention teams are a panacea, that, if you have somebody in crisis that's armed with a weapon, they're going to show up and the nurse is going to talk the person off the ledge. And, and that's not what they are going to do…it may be that somebody responds better to the nurse or responds better to the officer on that crisis team, but

just the design of the teams, the memorandums of understanding with the hospitals, there are legal documents that we've had to enter into in order to continue to make the partnership require that the nurses are a secondary…can only be a secondary responder to any incident… – Toronto Police stakeholder

Nevertheless, in practice, a mix of primary and secondary responses, that are context dependent, seem to be occurring across the teams. For example, for radio calls, MCITs are often dispatched at the same time as the PRU and subsequently arrive on scene at the same time. MCITs often listen to radio bands for calls that might fit their mandate and could arrive first or second in this circumstance. This team discussed often being on scene first:

Well I think that, I mean we're supposed to be a secondary response team where PRU is supposed to be dispatched, assess the safety, assess the call, call us if we're needed but nine times out of ten that doesn't happen. Nine times out of ten we are a primary response with some backup. - MCIT program staff

Others specified that teams respond first only when they have had previous interaction with the consumer and they know the situation is safe.

…if it's a house on the street and I've got a safe place to go and the nurse to back away then you know that sort of thing but…it's really got to feel good for both of us…it's got to feel good for us to be going to it and feel like we're safe and we know the consumer then sometimes we will [respond first]…but it's a rare occasion. – MCIT program staff

One participant discussed that teams should be responding at the same time as the PRU, because the PRU does not necessarily always have time to wait for the MCIT to arrive and may decide to apprehend the consumer in the absence of a mental health assessment.

Consumer follow-ups

While following-up with consumers is viewed as a key component of team service delivery for a number of stakeholders (as discussed in the 'what is working well' section), it seems there are different views on whether follow-ups are a program priority and how they should be conducted:

They [MCITs] are not an after-care, or after-treatment, service. They are not designed to… provide follow-up and monitoring of individual cases and they're not to be used to take care of people who would otherwise be introduced into some other stream of response, particularly criminal. – Toronto Police stakeholder

…I think there seems to be a disconnect between our command. I know they want us to be proactive but…we're reactive in the sense it takes, to do the follow-up component and things like that, what they want really is carrying the client and we're not we don't have that capacity

to carry those clients…we're usually responding to a priority type of call right –MCIT program staff

Some teams are doing follow-ups by phone, others in person, and other teams do not seem to be doing consistent consumer follow-up. Some participants noted that there is a lack of a common definition for what is considered a follow-up (for example, telephone vs. in –person follow-up, a meeting with a consumer's doctor). Others mentioned that follow-ups were not being accurately documented, nor included as part of performance indicators of their work. For example, these participants discussed that they are unclear as to how follow-ups are recorded in the reporting system because they are not 911 calls documented through dispatch:

Follow-ups it's, we do the report, it goes into the system. I don't know how that's captured… I don't think it's recognized as much as what it would be for like a radio call. – MCIT program staff

Limited procedural standardization

Limited standardization of procedures across teams is viewed by many as a challenge to service delivery. A number of participants expressed a desire for increased standardization across teams to create a more cohesive program in practice and in public perception, as well as to facilitate ongoing evaluation. However, some participants questioned whether complete standardization of the program was possible given differences in local context that can affect implementation and team practice, for example different types of calls, geographical areas, and consumer subpopulations:

I think those standardizations really need to take into account the geography, and the potential diversity of the clientele – Health systems stakeholder

Documentation procedures

A key example of issues with standardization relates to the area of documentation. A number of participants noted a lack of standardization in documentation procedures across teams. Several participants discussed that certain teams are doing electronic data entry, and some have implemented additional reporting tools like the OCAN. These differences were viewed by some as not only creating additional work for some teams but also complicating evaluation and movement towards a more standardized program:

…some teams have different...like I talked about documentation. I mean, some teams have electronic medical records, and electronic patient charts, and others don't. So, we have to do everything manually because we don't have electronic …So, again you know, one of the barriers to us all doing the same thing is that we don't have the same systems in place… - MCIT program staff

Furthermore, some team members noted that the paperwork that nurses do is more comprehensive than that of officers, but that fitting in this extra paperwork after each consumer

interaction is onerous and difficult to manage within the context of one shift. They also discussed a need to streamline the data entry process so that information did not need to be recorded in so many different places:

> *…Our follow-up forms, etcetera, aside from our own documentation and then our stat sheet we're doing all of this extra, we're doing a sheet to register them, we're doing a sheet for consent for their information to be shared at OCAN, we're registering them in the system, we're doing all of the information on OCAN, we're putting everything into a binder, we're doing a spreadsheet of information. It feels like we're putting information into so many different places where, and it doesn't make sense that we're not just putting all of the information into one place that could then--generate us that report. – MCIT program staff*

Program Processes - Team Practice

Role clarity

A number of participants emphasized that the role of the nurse and the role of the police officer within teams is very distinct, and that situations in which nurses or police officers step into the role of the other team member are not ideal for service delivery. They discussed that the same is true in relationships between teams and PRU officers, and that they each must respect each other's role in order to effectively interact with consumers:

> *…I can speak for myself and you guys can chime in. I don't feel like the nurses ever overstep the boundaries like we, I never take on a police role. I'm never going to push my way in, try to restrain someone…you know be the first person through the door….but I think through the years…we get a lot of police maybe stepping into our role a little bit… - MCIT program staff*

Handcuffing procedures

Despite the fact that a revised policy on handcuffing allowing for officer discretion has been issued, a number of participants, including team members, expressed discomfort with the procedure of handcuffing consumers who are being transported in a police car. These participants discussed that handcuffing consumers in crisis must be very frightening and stigmatizing for the consumers. Many teams indicated that they use discretion based on their assessment of the situation, and if the consumer is deemed non-violent and they do not have any weapons, they do not use handcuffs. Some noted that this approach is in contrast to PRU officers who more often deal with 'criminals' as opposed to those with mental illness:

> *…these persons are in crisis, they're experiencing an incident that is not criminal, alright so we try. Where handcuffs is used is always used for safety. – MCIT program staff*

This participant also described a reluctance to handcuff non-violent consumers, especially those who are suicidal:

We had that guy too like he you know and kind of told his doctor yeah I'm thinking about killing myself so they put a form out and I went there and one of the big things was 'oh this is great like you've come here now, you're going to take me in a police car to the hospital' like it's the last thing in the world you need is thinking I want to kill myself is that now I'm going to cuff you and drag you out--in front of all of the tenants in your building and your security, your concierge and you're going to be put in a police car so like we always kind of say if I feel comfortable okay … - MCIT program staff

Study Participants' Suggestions for Program Improvement

Improved police organization support

Several participants discussed that greater support for the MCIT program is needed. Suggested forms of support included investment by the Toronto Police Service in raising awareness of the program within the PRU; for example on the mandate of the MCIT program, training on how to respond to individuals with mental health issues, and improving knowledge of mental health resources in the community:

I know that as I said, that sometimes the volumes seemed fairly low. They should be seeing about three to four on a shift. Now why they have volumes that are low is…I'm not clear. So again, that sort of increasing awareness within the police service that this service exists. Increasing the confidence that they can call and access them easily. So, it would be more of that awareness piece. – MCIT program staff

Other participants noted that awareness of the program and its purpose needs to be better communicated to higher ranking officers across divisions to improve organizational buy-in for the program and improve support for team decision-making:

…Well, I hope that… we can figure out how to communicate clearly to, you know, the higher ranks that the teams are to be respected, the decisions that they make… are well thought out… - Toronto Police stakeholder

Program expansion

Many participants suggested a need to expand the program by the addition of more teams to adequately cover all divisions, subsequently increasing the capacity of the teams to respond to more calls. More teams on the road would contribute to greater coverage across divisions and ensure smaller service areas. However, this approach would require greater resources from partnering police and hospitals:

So…at a kind of material or very…immediate level, it's getting more teams available, so we need to get more hospitals partnered with us so we can have more teams out on the road. – Toronto Police stakeholder

Participants showed less support for increased hours of operation, and many felt that hours of operation should be based on demand. Some participants suggested a move to a more centralized program that can be dispatched to any area of the city. It was thought that this approach could alleviate some of the challenges with varying divisional support and difficulties with dispatch awareness and in locating the teams across divisions:

But then when you have a centralized unit right like you say each Division may operate differently or different hours and whatnot right when you have a centralized unit everybody is on the same page…You'd get more rapport with a wider range of people right…and hospitals – MCIT program staff

Greater communication between stakeholder groups

A number of participants suggested a variety of ways to increase communication between program stakeholders. Some suggested the need for a formal mechanism for community feedback on the program and greater input from consumers. One participant suggested that this should take the form of a community advisory committee:

I think by having an advisory committee will help to create that. I don't know where exactly you're locating it but and the idea of having like peer supports or consumer survivors, however people are going to be called. People who are really good at this kind of stuff, really understanding and sensitive to help, you know, guide the process along. It seems like a good idea. – Community stakeholder

In order to increase staff member feedback, a mechanism for frontline staff to provide input on program decision-making was suggested, as well as more opportunities for teams to meet and debrief.

Clarification of certain team responsibilities

Different views on consumer follow-up procedures and the debate regarding whether MCITs should always be secondary responders show a need for clarification of these responsibilities. Follow-up procedures are valued by teams and consumers, and many expressed a preference for telephone follow-up calls to consumers at the teams' discretion. However, some participants mentioned that consumers often do not have phones, so if teams were going to do an in-person follow-up, that this would have implications on the type of vehicle used to visit consumers. For consumer privacy, an unmarked car with a light pack was preferred in these situations.

I phoned, I spoke to the mother … but it, sometimes too, another flipside of that is a lot of people in this world do not like police because of whatever reasons and us just showing up unannounced for no reason, they haven't called us, they're going to start swearing at us…it could escalate. – MCIT program staff

The program should also clarify whether and when primary response of teams is appropriate.

Improved procedural standardization

A number of study participants suggested increased standardization across team procedures. Specifically, a number mentioned a need to streamline hand-off procedures in EDs to avoid long waits and free up the teams to attend other calls. The streamlining process was believed to be facilitated through increased awareness of the program mandate in the ED and extensive relationship-building work with ED partners. Furthermore, some participants suggested the need to streamline data collection procedures in order to decrease the number of sources where information is required and to facilitate evaluation of the program. This is work that should be addressed through the MCIT Program Steering Committee Standardization and Evaluation Working Groups.

Training

Many participants suggested that training for PRU officers on the MCIT program mandate would increase awareness of the program, its utilization, and support more positive PRU engagement with the consumer population. Some participants discussed the importance of this training for PRU officers to be real-time with MCITs so that officers can see the role of the MCITs and gain understanding of the work that they do in person.

Moreover, it was emphasized that the training be ongoing, as opposed to annual, to ensure reinforcement of information. It was also suggested that the training should be taught by mental health professionals to make sure that the most accurate information is conveyed:

…On a regular basis and understanding you know you can tell us how to do it, we can react with, based on our skill base but if you're not giving us other skills to, how to handle it and how to watch real professionals handle it then you don't get, you know you just do what you have, you just use what you have but learning the skills and how she speaks to people I take on those skills… - MCIT program staff

Some program staff also suggested more training for team members on each other's procedures to enhance service delivery and increase understanding of each other's culture.

More coordinated system

Various participants urged that more work needs to be done to achieve a more coordinated, integrated mental health service system to ensure effective program partnerships, appropriate consumer referral

and care. For example, some stakeholders discussed the need for greater awareness and availability of non-police crisis services to reduce the demand on police services and MCITs to meet the needs of individuals in crisis. A number of consumers echoed this recommendation for a more coordinated system, and expressed a desire for greater assistance with accessing supportive services that assist with system navigation like case management:

> *So, like, that's frustrating. And just, like, I don't know, setting people up with, like, counselling or a case worker, being more, like…like, doing more to actually get people set up with services – MCIT consumer*

Summary of Findings

The implementation evaluation of the Toronto MCIT Program has yielded a number of important findings on the process of program implementation and service delivery. Overall, program stakeholders, including police, staff, community agencies, health system partners and consumers, feel that the program is meeting its key goals to respond to individuals in crisis, and treat them in the community with the goals of preventing unnecessary hospitalization and criminalization. Consumers interviewed expressed having positive experiences with the teams, and emphasized that these experiences were related to interactions whereby the teams were caring, made the consumer feel respected and heard, and gave them choice in the context of the interaction. Less positive interactions reflected a lack of these qualities and left consumers feeling criminalized. Administrative data illustrate that call volumes of the program have gradually been increasing over time, and program awareness is relatively high in certain police service areas. However, in-depth data from interviews and focus groups have illustrated that greater awareness of the program mandate is needed within the police service, among hospital partners and in the community to further increase utilization of the program.

A number of facilitators and challenges to program implementation and optimal service delivery were identified through the study. With respect to facilitators, existing partnerships between the police and the health system, between the MCITs and emergency departments (EDs), and MCITs and community agencies are viewed as positive and instrumental to the functioning of this complex program. Furthermore, team members are proud and invested in the work that they do. In the area of team practice, teams are viewed as knowledgeable in how to engage with consumers in crisis, and to refer consumers to relevant community services. The knowledge and experience brought by the nurse is highly valued by a variety of stakeholders in these interactions, as are team procedures for following-up with consumers to prevent repeat crises.

Challenges to program implementation and service delivery reflect the complexity of the program. Despite the fact that partnerships between the various program stakeholders are viewed as positive, some of these relationships could be strengthened and require more work in order to better support the program. Toronto Police and health system stakeholders feel removed from each other's cultures, and this is often reflected in a lack of awareness of the program mandate among the PRU and a lack of buy-

in for the program in some divisions. Also related to this cultural/organizational distance were issues of role clarity, whereby team members may step into each other's roles, and a desire by many team members to be more involved in program decision-making. Further relationship-building appears to be needed in some hospital EDs, as teams often report a lack of prioritization of consumer admission leading to long wait times and an inability for teams to attend other calls.

Mixed views on certain resources and team practices emerged in discussions with stakeholders. There appears to be a debate among program stakeholders as to whether police officers should be in uniform or in plain clothes, and the extent to which current uniforms distinguish the nurse from the police officer. Differing views also emerged on whether teams should be driving marked or unmarked cars, and concern that current vehicles are uncomfortable for consumers. A lack of clarity on certain team responsibilities, such as whether teams should always be secondary versus primary response, as well as whether and how teams should be conducting consumer follow-ups, also appear to hinder service delivery. There also appears to be some discomfort among teams with current handcuffing procedures. Challenges in communication between dispatchers and teams were discussed as negatively affecting team ability to attend EDP calls, and documentation procedures lack standardization and are viewed as onerous.

Many of these findings echo those of previous implementation evaluations of the Mobile Crisis Intervention/Co-Response Model. For example, other implementation evaluations have found relatively high levels of satisfaction with the service teams among consumers, families and program stakeholders [7, 9, 13], but have encountered challenges with team capacity to respond to calls related to staffing issues [9, 13], long wait times in emergency departments [9, 13], education of police officers on appropriate mental health response [9, 13], availability of appropriate vehicles for transportation of consumers [13], and challenges in team communication with dispatch[13].

Study limitations

There are limitations to the study that should be considered when interpreting findings. It should be noted that consumer recruitment was challenging, thus limiting the extent to which their perspectives are captured in the evaluation. Challenges included: consumers remaining in distress following their interaction with the MCIT thus preventing introduction of the study by the service teams; a limited number of follow-up calls to consumers conducted by some teams; difficulties in contacting consumers without telephones or a stable residence; limited capacity by some consumers to give informed consent; and variable interest about the study among consumers. It should be noted that some consumers approached by teams did not want to discuss their experience with the program, thus perhaps over-representing positive experiences with the program among the consumer sample. Given a staggered REB approval process, there was variable time to recruit consumer participants across teams resulting in under-representation of consumers from specific MCITs. As a result, the consumer sample is not representative of experiences with all of the teams. Nevertheless, similar themes emerged in the consumer interviews, and saturation in themes, whereby similar ideas and concepts emerge, was reached. Furthermore, we did not fully capture in-depth PRU officer perceptions of the MCIT program or the program perceptions of consumer family members. While survey data provide a preliminary view

into program awareness and utilization among the PRU, this perspective as well as that of consumer family members should be further explored in future program evaluations.

Key recommendations for program improvement

The evaluation study has highlighted a number of program strengths to be built upon and challenges to be addressed in order to improve implementation and service delivery across MCITs. Key recommendations for program improvement include:

- Improved police organizational support for the program by raising awareness of the program mandate among the PRU. Raising awareness of the program mandate will also serve to improve capacity to respond appropriately to mental health issues and knowledge of resources in the community within divisional policing.
- Clear communication to program partners and community on the mandate of the MCIT program. This is necessary to address different perceptions of the purpose of the program, for example the types of calls to which the MCITs should be responding in light of confusion among community members regarding whether MCITs should be involved in more volatile, potentially violent encounters between PRU and EDPs
- Clarification of certain team responsibilities and procedures is required:
    - It should be clarified whether primary response (without the PRU) by teams is ever appropriate, for example when teams have had previous contact with a consumer.
    - Clarification on whether follow-ups should be a program priority is needed. If teams will be conducting more consistent follow-up, it should also be considered whether they should follow-up with consumers in person or by phone. One possible suggestion would be to contract out phone follow-ups to a 3rd party agency.
    - Program management should clarify with program staff that they can use their discretion, based on nature and safety of the call, on handcuffing consumers
- Improved external and internal feedback mechanisms have been requested by a number of stakeholders. In the area of external mechanisms, more communication and input from community stakeholders and consumers was recommended and could be addressed through the creation of a community advisory committee or linkage with an existing committee. With respect to internal feedback, greater inclusion of frontline staff in program-decision making should be considered.
- Resolution of debates on resource issues, such as team cars and uniforms is recommended. With respect to cars, some stakeholders have recommended that an unmarked SUV with a light pack would address challenges concerning vehicle comfort and potential stigma when transporting consumers to hospital.
- More comprehensive training for teams and PRU officers was recommended. It was recommended that teams receive more cross-over training in each other's areas of expertise for the purposes of bridging their different professional cultures (i.e., nursing/mental health and police cultures). For example, additional training in safety and the police system for nurses, and training in mental health de-escalation and the mental health system for police officers were viewed as helpful. It was also recommended that PRU officers receive real-time training involving ride-alongs with MCITs to raise awareness of the program mandate and build capacity

for positive engagement with consumers. Furthermore, given the intensive work of the MCITs, more opportunities for teams to meet and debrief were recommended as this was viewed by many as a valued activity – the same opportunities should be provided to PRU officers.

- The program is already exploring program expansion – it is recommended that this process involve the consideration of a more effective dispatch process whereby dispatch and MCITs are in more regular communication. This will overcome challenges in ability for dispatch to locate the teams and increase capacity for teams to respond to calls. In the future, the program may want to consider a more centralized dispatch system to overcome current issues with dispatch and the impact of varying divisional support on service delivery.
- The program is also currently developing more standardized team protocols. In this process, it is recommended that a more streamlined process for data entry be developed to minimize the number of data entry points and data sources that require staff completion.
- In order to avoid some of the limitations encountered by this study, future program evaluation design must incorporate realistic timelines to accommodate research ethics board approvals in all partnering organizations, and related participant recruitment delays. Moreover, early planning and development of partnerships, resources and timelines needs to be conducted in order to provide adequate support for the recruitment and representation of the consumer population in future evaluations.

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