APPENDIX B

Toronto Mobile Crisis Intervention Team (MCIT):

Outcome Evaluation Report

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The views expressed in this report are those of the evaluation team, and do not necessarily reflect those of the Toronto Central Local Health Integration Network or the Government of Ontario.

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EXECUTIVE SUMMARY

Background

Police are often first responders to mental health emergencies that take place at home and other community settings (1, 2). These calls for service are often termed Emotionally Disturbed Persons (EDP) calls. The Toronto Police Service (TPS) received 22,386 such calls for service in 2014.[1] However, the literature suggests that police officers find responding to these types of situations challenging. This may be due to a number of factors including perceived lack of training on how to respond effectively to mental health crises and uncertainty in referrals to appropriate community services (3, 4). To begin to address these challenges, the City of Toronto (Toronto) Mobile Crisis Intervention Teams (MCITs), comprising a mental health clinician and a police officer trained in crisis intervention, were implemented to act as secondary responders to crises in Toronto (5, 6).

Toronto's MCIT program provides clients with prompt assessment and support. MCIT may also refer clients to community services and follow up with clients to verify their safety following a crisis. In accomplishing these tasks, the program aims to avert escalation and injury to both individuals in crisis and crisis responders, and reduce pressure on justice and health systems (5). MCIT operates as a collaborative partnership between TPS, St. Michael's Hospital (SMH), St. Joseph's Health Centre (SJHC), The Scarborough Hospital (TSH), Humber River Hospital (HRH), Toronto East General Hospital (TEGH), and North York General Hospital (NYGH), and is jointly funded by TPS and three Local Health Integration Networks (LHINs).

Each MCIT is comprised of one police officer specially trained in mental health crisis intervention and one mental health nurse. MCIT is not the first response sent to a person in crisis. Rather, MCIT acts as secondary responders following an assessment by Toronto Police Service Primary Response Unit (PRU) officers and their conclusion that there is no risk of violence. Less frequently, MCIT may be sent to transport a client to hospital under a Mental Health Act (MHA) form apprehension or may happen upon a person in crisis and engage in an interaction.

Purpose and methods

The current study aimed to understand client experiences and outcomes of crisis interactions with MCIT and TPS Primary Response Unit (PRU) officers, explore MCIT's role in Toronto's crisis response system, and learn from the MCIT Steering Committee's implementation of a coordinated MCIT program. This was a mixed-methods evaluation, involving 15 qualitative interviews with individuals who have experienced MCIT and/or PRU crisis responses and 4 focus groups with 46 varied stakeholders across Toronto's mental health crisis response system.

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[1] This includes all calls for service formally classified as *emotionally disturbed person, attempt suicide, threaten suicide, jumper, overdose,* or *elopee.* Information provided to the study by Toronto Police Service Business Intelligence and Analytics, July 22 2015.

Additionally, de-identified administrative records created by MCIT and PRU responders through July 2014 – March 2015 were accessed and analyzed to examine impact of the program on key outcomes. This included 4,314 MCIT service activities and 19,254 calls for PRU service.

Findings: Qualitative interview and focus group data

Experiences of people in crisis:

Regarding client experiences with crisis response services, two key themes emerged. First, clients highly value crisis responders who adopt a supportive and empowering stance, enabling them where possible to regain control. Second, clients value providers who have knowledge of mental health challenges and resources. These interpersonal and practical skills were regularly experienced in MCIT interactions, whereas clients reported greater variability in interactions with PRU and less knowledge of mental health challenges and resources by PRU officers. In general, people in crisis:

- Reported more positive experiences when MCIT and PRU were flexible, responsive to their needs and preferences, and offered non-criminalizing, measured, and appropriate responses.
- Preferred when there were fewer responders rather than more – they often felt overwhelmed or intimidated by larger groups of crisis personnel.
- Felt criminalized by the use of handcuffs and marked police vehicles.
- Emphasized the value of of de-escalation and calming communication, which is possible when more time is invested in an interaction. PRU seemed to be under time pressure in these situations.
- Preferred having a choice of hospital. Current policies encourage MCIT to offer this choice.

The role of MCIT in the broader mental health crisis response system:

Key findings include:

- As a component of TPS crisis response processes, MCIT is seen as a valued asset due to:
    - Their ability to complement the work of PRU and existing police processes;
    - The expertise of mental health nurses both in terms of frontline care and referral to resources;
    - Building TPS capacity in relation to mental health skill sets as trained MCIT officers work with and transfer to other units.
- Currently there are limitations to MCIT's effectiveness within TPS due to:
    - Internal confusion about MCIT's mandate;
    - Limited staffing and hours of operation;
    - Challenges in supervising and supporting MCIT officers.
- MCIT is a small but valued component of the broader crisis system, and most clients and stakeholders agree MCIT is better suited to respond to moderate to serious mental health crises.
- Discussions of the crisis response system as a whole repeatedly drew attention to a perceived inadequacy in crisis prevention, and perceptions that timely and high-quality mental health services, including crisis services, are insufficiently available in hospital and community settings.

Findings: Administrative data

MCIT and PRU teams document their contacts with people in crisis. Several key findings can inform future planning of an adequate crisis response system:

- From July 2014 to March 2015, the Toronto MCIT attended 2,774 crisis interactions and completed more than 525 follow-up contacts, compared to 16,226 crisis interactions attended by PRU.
- MCIT facilitated approximately 1,256 connections to community-based services, including completion of 891 referrals for new health and social services.
- 29% of MCIT crisis interactions were with repeat clients.
- Clients were transported to a hospital ED for further assessment in 38-45% of MCIT crisis interactions, compared to 27% of PRU interactions.
- Compared to PRU crisis interactions, MCIT was less likely to make a Section 17 apprehension, that is, to obligate a client to attend a hospital Emergency Department (ED) under the Mental Health Act, and more likely than PRU to bring a client to hospital voluntarily.
- ED wait times were shorter for MCIT, who reported a mean wait time of 56 minutes, compared to 85 minutes for PRU.
- Over 38% of MCIT escorts to the MCIT's home hospital resulted in hospitalization.
- Though comparable data on PRU interactions are not currently available, MCIT interactions demonstrate positive outcomes in several other key indicators. Injuries to clients, crisis responders, or others occurred in only 2% of MCIT crisis interactions, and charges were laid in less than 2% of MCIT crisis interactions.

Summary of Recommendations

Study findings support a series of recommendations for policy and practice relevant to MCIT and crisis response services. Recommendations are organized within five themes: training and education; matching crisis needs to appropriate and measured responses; availability and flexibility of crisis responders; referrals to community based services; and crisis response planning and community engagement. It is recommended that:

- Training and education:
    - TPS conduct an assessment of PRU training curricula relevant to mental health, focusing on materials and processes on trauma-informed and anti-oppressive approaches to crisis response, as well as practical communication and de-escalation skills in crisis situations.
    - MCIT mandate be thoroughly communicated to all PRU officers.
- Matching crisis need to appropriate and measured response:
    - Handcuff use be reduced in police interactions involving mental health.
    - MCIT program consider shifting MCIT responders' dress to plainclothes.
- Availability and flexibility of crisis responders:
    - MCIT hours of operation be increased.
    - Supervisors of PRU officers encourage investment of adequate time into interactions involving mental health.

    - Clients' choice of hospital be considered when transporting clients to hospital EDs.
- Referrals to community-based services:
    - MCIT strengthen referral processes through improving MCIT responders' access to information on local mental health and social services.
    - MCIT explore partnership with a centralized service referral organization.
- Crisis response planning and community engagement:
    - MCIT Steering Committee include representation from participating hospitals' consumer advisory panels and community-based consumer initiatives.
    - MCIT teams host or attend events for mental health service users and their support networks.
    - TPS explore possibility of designating a subset of PRU officers to attend interactions where mental health may be relevant.

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INTRODUCTION

Police are often first responders to mental health emergencies that take place at home and in other community settings (1, 2). These calls are often termed Emotionally Disturbed Persons (EDP) calls. In 2014, Toronto Police Service (TPS) received a total 1,922,176 calls for service, which included 22,386 EDP calls.[1] However, the literature shows that police officers find responding to these types of encounters challenging. This may be due to a number of factors including perceived lack of training on how to effectively respond to mental health crisis and uncertainty in referrals to appropriate community services (3, 4). In response to these issues, Mobile Crisis Intervention Teams (MCITs), comprising a mental health clinician and a police officer trained in crisis intervention, were introduced to act as secondary responders to mental health crises in the community (5, 6).

BRIEF REVIEW OF THE LITERATURE

The MCIT program is an example of a police and mental health worker co-response model. In this model, local mental health workers are partnered with police officers, and collaboratively respond to mental health crises in the community. For a thorough overview of the outcome evaluation literature focused on co-responding police-mental health programs, please see Shapiro, Cusi, Kirst, O'Campo, Nakhost & Stergiopoulos (2014) (full citation can be found in References). Their findings are summarized below.

Co-responding police-mental health programs often aim to decrease clients' involvement with justice and acute health services; this is believed to support clients' health and wellbeing and to reduce demands on publicly funded services. These programs have been associated with reduced pressure on the justice system through lower rates of arrest (2, 8, 9), as well as reductions in officers' time spent on location (1, 10) and accompanying clients to Emergency Departments (EDs) (11). There is mixed evidence on the programs' capacity to decrease health system pressures; some work has found significant reductions in client hospitalizations when compared to usual services (12), while others have found hospitalization rates to be unaffected by these programs (13). However, some research has found these programs frequently connected clients to community-based services (1, 2), which may lead to reduced use of acute care services over time. There is also some evidence that co-responding police-mental health programs have been cost-effective due to aforementioned savings to justice and health systems (10-12).

Stakeholder perceptions have also been assessed in outcome evaluations. Research examining changes to officers' knowledge and perceptions of mental illness have often found co-responding programs are associated with improvement in these areas; this has been attributed to improved access to mental health training and officers' ability to observe the mental health service providers in the field (14). Officers that do not work in the co-responding program held varied perceptions of

[1] The number of EDP calls includes all calls for service formally classified as *emotionally disturbed person, attempt suicide, threaten suicide, jumper, overdose, or elopee*. Information provided to the study by Toronto Police Service Business Intelligence and Analytics, July 22 2015 (EDP calls) and August 18 2015 (total calls).

the programs' utility, with both positive (14, 15) and negative perceptions reported in the literature (4). However, clients of co-responding programs and their family members often spoke favourably of the programs, and reported positive experiences (11, 16).

Finally, some evaluations have examined whether co-responding police-mental health teams have prevented escalation and injuries during the interaction. Though a key goal of these programs, it has proven to be particularly difficult to measure. One study found the programs are associated with reduced frequency of use of force (10), while several others reported staff perceptions that the program is conducive to improved client and staff safety (11, 15).

MENTAL HEALTH CRISIS RESPONSE IN TORONTO

Overview of apprehension processes

A person experiencing a mental health crisis in the community may request an emergency response by calling 911, or someone may do so on their behalf. The dispatcher then sends a Toronto Police Primary Response Unit (PRU) of two or more officers to attend the call and assess the situation. If considered important for the health or safety of the person in crisis or others around them, and the person agrees to go to a psychiatric facility, the officers may transport the person voluntarily to a facility for assessment by a physician.

If the person does not agree to go to an Emergency Department (ED) voluntarily, the officers will assess if eligibility criteria for an involuntary apprehension are met. As it is Section 17 of the MHA that empowers police officers to apprehend an individual, these events are commonly called "Section 17 apprehensions". Officers may perform an apprehension if there are a) reasonable and probable grounds to believe that the person is acting or has acted in a disorderly manner, and b) serious risk of bodily harm to the person in crisis or others, or the person is unable to care for themselves, and c) the person appears to be suffering from mental health challenges of a nature or quality that they are likely to result in serious bodily harm or physical impairment, and d) it is considered "dangerous" to obtain a Form 2 (defined below) (17).

Police officers may also be involved in transporting a person for psychiatric assessment under Form 1 (request made by physician for psychiatric assessment), Form 2 (order for examination issued by a Justice of the Peace, which can be requested by any member of the public), Form 9 (order for return to a psychiatric facility following unauthorized departure), or Form 47 (order for examination due to non-compliance with a Community Treatment Order). In each of these situations, TPS is contacted by another party and asked to send officers to apprehend the person; the officers do not have decision-making powers in the process.

Within Toronto, persons apprehended under Section 17 or with Forms 1, 2, 9, or 47 are nearly always brought to hospital EDs for psychiatric assessment. When a police officer is involved in any of the aforementioned apprehensions, the police officer takes legal custody of the person, and the police unit must wait at the hospital ED until the hospital assumes custody (17).

Toronto's MCIT program

The aims of Toronto's MCIT program are to: a) provide prompt assessment and support to EDPs; b) link EDPs to appropriate community services if follow-up treatment is recommended; c) avert escalation and injury to both police and individuals in crisis; d) reduce pressure on the justice system (e.g. by decreasing encounters with the justice system and officer's time handling psychiatric emergency situations); e) reduce pressure on the health system (e.g. by decreasing unnecessary visits to the emergency department); and f) ensure program accountability (5). 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 PRU, the MCIT will be dispatched to the call by the Toronto Police Communications Department. MCIT works with a small percentage of all crisis interactions; the majority is addressed solely by PRU officers. MCIT's chieftask is to attend crises where mental health is believed to be a relevant factor. The MCIT may also refer the client to community-based services, and complete a telephone or in-person follow-up contact with the client in the weeks following the crisis interaction to confirm the client's safety.

MCIT operates as a collaborative partnership between Toronto Police Service (TPS), St. Michael's Hospital (SMH), St. Joseph's Health Centre (SJHC), The Scarborough Hospital (TSH), Humber River Hospital (HRH), Toronto East General Hospital (TEGH), and North York General Hospital (NYGH). The program is funded by the Toronto Police Service, Toronto Central Local Health Integration Network (LHIN), Central LHIN, and Central East LHIN.

The MCIT program currently includes six primary teams, each based out of one of the above hospitals and covering two to three police district divisions. Each primary team operates seven days weekly for ten hours per day. Three supplementary, or "expansion teams", are also in operation, with one based out of each of St. Joseph's Health Centre, Humber River Hospital, and Toronto East General Hospital. Expansion teams provide enhanced coverage and support four days weekly, for ten hours per day. Each on-duty primary and expansion team includes one police officer trained in crisis intervention and one mental health nurse. All officers are employed by TPS and supervised by a Community Response Unit (CRU) staff sergeant. Officers are encouraged to stay with MCIT for a minimum of two years; there is no mandatory minimum or maximum length of time an officer may be with MCIT. All nurses are employed by one of the six partnered hospitals and supervised by a mental health team manager. Nurses are recruited directly to the MCIT and retained as a permanent position.

PURPOSE OF EVALUATION

The current study aimed to understand client experiences and outcomes in MCIT and PRU crisis interactions, and explore MCIT's role in Toronto's crisis response system. More specifically, evaluation questions included:

1. How do clients experience crisis interactions with MCIT and PRU?
2. How frequently does MCIT make service referrals and follow-up contacts, and how do clients experience these processes?

3. What similarities and differences are seen in key outcomes for MCIT and PRU interactions, including:
    a. Number of calls attended
    b. Time to travel to the scene
    c. Time spent waiting in hospital ED, where applicable
    d. Total time spent on the interaction
    e. Injuries to clients/crisis responders/others
    f. Interaction outcomes
        i. Presentations to hospital ED
        ii. Mental Health Act apprehensions
        iii. Arrests
4. What is MCIT's role in the existing crisis system?
    a. From the perspective of participants, what are the current and ideal roles for MCIT to play in the crisis response system?
5. What can be learned from the Steering Committee's success in MCIT program implementation?
6. What can the crisis response system learn from MCIT program outcomes?

RESEARCH METHODS

STUDY DESIGN

The current study is a mixed-methods evaluation, involving a series of interviews with individuals that have experienced MCIT and PRU crisis responses and focus groups with several different stakeholders of Toronto's crisis response system. Qualitative data from a previous MCIT implementation evaluation (5, 6) were also reviewed in relation to current evaluation questions. Each of this study's 61 qualitative interview participants provided voluntary and informed consent. Quantitative de-identified administrative records created by MCIT and PRU responders through July 2014 – March 2015 (nine months) were also analyzed, in order to understand similarities and differences in key outcome indicators. This study received approval from the research ethics boards (REBs) at the six hospitals involved in the MCIT program, and maintained a data-sharing agreement with Toronto Police Service (TPS).

QUALITATIVE INTERVIEWS AND FOCUS GROUPS

Clients

This study sampled 15 clients of crisis response services. This includes 14 clients that have experienced an MCIT crisis response, and 13 clients that have experienced a PRU crisis response. As 10 client participants had experienced both MCIT and PRU crisis responses, these clients readily made comparisons between these experiences and shared them with interviewers. MCIT clients were referred by MCIT program staff, and PRU clients were referred by TPS staff. Two interviewers were responsible for obtaining consent and data collection; one or both interviewers attended each interview. Clients received a $25 honorarium and public transit fare in compensation for their time and transportation to and from the interview.

Stakeholders in the Crisis Response System

This study sampled 46 stakeholders in Toronto's crisis response system. This includes one focus group with each of the following: TPS staff sergeants, TPS PRU officers, MCIT Steering Committee, and community-based mental health and addictions service managerial staff or their designate. TPS officers were invited to participate by a TPS staff person. A focus group of the MCIT Steering Committee explored the planning and implementation process. Community agency staff were invited by MCIT research staff. Two interviewers were present at each focus group to obtain consent and facilitate the focus group.

DATA COLLECTION

Qualitative data

All qualitative interviews and focus groups utilized semi-structured interview guides, which maintained focus on the subject of study while drawing out each participant's unique experiences. Client interviews focused on the most recent MCIT and PRU interactions, including reasons for the interaction, perceptions of responders, characteristics of the interaction that were and were not

helpful, and comparison of MCIT and PRU interactions. Stakeholder focus groups focused on their organizations' relationship with MCIT, as well as strengths and weaknesses of both MCIT and the crisis response system. Client interviews ranged from approximately 20-70 minutes in length, with a mean of 45 minutes. Focus groups ranged from approximately 45-120 minutes in length, with a mean of 80 minutes.

Administrative data

The study accessed administrative records created by MCIT and PRU responders for July 2014 – March 2015 (nine-month period), including program operation and client outcome indicators. Data on MCIT client characteristics for the April 2014 – March 2015 (twelve-month period) were also obtained. MCIT data were created through documentation made by MCIT officers and nurses. Some information on services and outcomes of the MCITs staffed by North York General Hospital and TPS Divisions 32 and 33, as well as Toronto East General Hospital and TPS Divisions 53, 54, and 55 are not included here, as these teams formed more recently and some documentation processes were not yet standardized during the July 2014 – March 2015 period. PRU data was accessed through Toronto Police Service, and included documentation of interactions where the dispatcher classified the call as *emotionally disturbed person, attempt suicide, threaten suicide, jumper, overdose,* or *elopee*, and interactions where the officer noted that mental health was highly relevant (often involving the Mental Health Act (MHA)).

DATA ANALYSIS

Qualitative data

All interviews and focus groups were audio-recorded and transcribed verbatim. Transcripts underwent thematic analysis, involving careful reading and line-by-line coding of each transcript, and comparison of emerging findings across transcripts (18, 19). The two research staff that conducted interviews coded all transcripts, and in collaboration with the lead researcher, identified broader themes. Qualitative data analysis was facilitated through use of QSR NVivo version 10 software.

Administrative data

PRU data included in analyses were restricted to interactions where MCIT was not involved at any stage. Where MCIT data was compared to PRU data, MCIT data were restricted to crisis interactions and MHA form apprehensions, so that data on follow-up contacts and consultations were excluded. For both PRU and MCIT data, comparative analyses were restricted to calls where the unit arrived at the scene and the client was present, that is, a call wherein a unit was dispatched and cancelled before arrival were excluded. Where MCIT data are presented independently of PRU data in frequency tables or cross-tabulations, the inclusion or exclusion of follow-up contacts and other non-crisis service activities is noted. Program partners at TPS and the six participating hospitals informed interpretations of the datasets.

MCIT nurses and MCIT officers use separate documentation forms for their interactions, and complete documentation independently of one another. A small number of indicators appear on

both forms, and the data sources can produce somewhat different results. Where this is applicable, results from both datasets are presented and explained.

Results for administrative data are presented with both descriptive frequency tables and cross-tabulations, and statistical tests for correlation. Unless stated otherwise, descriptive tables exclude missing data from calculations of percentages. Statistical tests for correlation were completed when data was obtained at the interaction level; however, some data could only be accessed in aggregate form. Continuous outcome variables were checked for normality of distribution, and those that were not normally distributed were analyzed with appropriate nonparametric and parametric tests to determine statistically significant correlations. If both tests were statistically significant ($p<0.05$), results of the parametric tests are shown below.

FINDINGS: QUALITATIVE INTERVIEW DATA

Results of qualitative interviews with MCIT and PRU clients, as well as qualitative focus groups with stakeholders of Toronto's crisis response system are presented here. Following the Description of Sample, results are presented in three sections: A. Client Experiences with Crisis Response, B. MCIT and the Crisis Response System, and C. MCIT Planning Process.

DESCRIPTION OF SAMPLE

Descriptions of client interview participants and stakeholder focus group participants can be seen in Table 1 and Table 2, respectively. In age and gender, the client participant sample is diverse, and similar to the total population of recent MCIT clients (see Table 3 on page 34). Although information on other characteristics listed in Table 1 is not available on the total MCIT client population, it can be noted that the client participant sample is not fully representative of Toronto's population. The primary language of the sample can be attributed to restrictions of the research study. As translation in qualitative interviews is highly challenging, participation was restricted to clients with proficiency in English.

Table 1: Description of client sample

Characteristic	No. (%) Total: 15 (100.0%)
AGE	
18-34 years	8 (53.4%)
35-54 years	6 (40.0%)
55 years or older	0 (0.0%)
Unknown/Declined	1 (6.7%)
GENDER	
Female	8 (53.4%)
Male	6 (40.0%)
Other	0 (0.0%)
Unknown/Declined	1 (6.7%)
RACE / ETHNICITY[1]	
White	6 (40.0%)
Racialized	8 (53.4%)
Unknown/Declined	2 (13.3%)
PRIMARY LANGUAGE[1]	
English	14 (93.3%)
French	0 (0.0%)
Other	1 (6.7%)
Unknown/Declined	1 (6.7%)
HIGHEST LEVEL OF EDUCATION	
Attended and/or completed university or business, trade, or technical school	9 (60.0%)
Completed high school	3 (20.0%)
Has not completed high school	2 (13.3%)
Unknown/Declined	1 (6.7%)

HOUSING TYPE[2]	
Rented or owned room, apartment, or house	10 (66.7%)
Living with family	4 (26.7%)
Temporary housing (eg. Shelter, transition house, motel)	2 (13.3%)
Public place (eg. Street, park, subway, underpass)	0 (0.0%)
Health facility (eg. Hospital, substance treatment)	0 (0.0%)
Unknown/Declined	1 (6.7%)

[1] Participants were asked to check all that currently apply.

[2] Participants were asked to check all that have applied within past 6 months.

Table 2: Description of stakeholder sample

Characteristic	No. (%) Total: 46 (100.0%)
AGE	
18-24 years	0 0 (0.0%)
25-34 years	2 (4.3%)
35-44 years	9 (19.6%)
45-54 years	22 (47.8%)
55-64 years	9 (19.6%)
65 or older	1 (2.2%)
Unknown/Declined	3 (6.5%)
GENDER	
Female	15 (32.6%)
Male	30 (65.2%)
Other	0 (0.0%)
Unknown/Declined	1 (2.2%)
ROLE IN RELATION TO MCIT	
Hospital partner/staff	4 (8.7%)
Police partner/staff	34 (73.9%)
Community-based service manager/staff	6 (13.0%)
Unknown/Declined	2 (4.3%)
YEARS AT CURRENT ORGANIZATION	
5 years or fewer	6 (13.0%)
6-20 years	15 (32.6%)
21-40 years	22 (47.8%)
41 years or more	2 (4.3%)
Unknown/Declined	1 (2.2%)

A. CLIENT EXPERIENCES WITH CRISIS RESPONSE

This section outlines key ingredients of a positive client experience within MCIT and PRU crisis interactions. Analyses in this section are primarily based on client interview data, and are supplemented with staff focus group data.

SUPPORTIVE AND EMPOWERING APPROACH BY CRISIS RESPONDERS

Many of the qualities that created a positive or negative interaction for MCIT and PRU clients were interpersonal skills of the staff. Clients more commonly described positive interpersonal characteristics amongst MCIT responders, though several clients also had positive PRU experiences. Supportive and empowering approaches included helping clients de-escalate, showing kindness or compassion, and offering choices. Constructive interpersonal skills have the potential to be developed and effectively applied by any crisis responder. These approaches are described below.

As part of the experience of being in crisis, clients were often experiencing strong negative emotions at the time of the crisis responders' arrival. This included feelings of being fearful, panicked, and suicidal. As part of this supportive approach, a positive crisis interaction often included a process of calming the client and de-escalating the situation. Clients described being effectively calmed through a combination of responders' direct and indirect actions. Direct actions included providing information relevant to the client's concerns, encouraging slower breathing, and remaining calm themselves. Indirect actions included demonstrating concern for the client's wellbeing and appearing friendly. Effective calming and de-escalation processes were more commonly experienced in MCIT interactions than PRU interactions. Several MCIT clients identified the de-escalation process as the most helpful contribution made by their crisis responders.

> [MCIT staff] were compassionate interveners...that was what I found made the biggest difference, like they weren't trying to escalate the situation. They were trying to de-escalate it, make it calmer. (Client)

> *Interviewer: Was there anything in that interaction that was particularly helpful that they did to make you, you know feel better or-* They just stayed really calm and friendly. (Client)

Another important element of a positive crisis interaction was the demonstration of compassion and responsiveness to clients' needs. This included using humour where appropriate, expressing concern for the client's wellbeing, complimenting client's talents or skills, and for clients with suicidal ideation, affirming the value of their lives. Other examples of compassion included small but meaningful gestures, such as suggesting that a client with a nicotine addiction have a cigarette before entering the ED, or expressing sympathy for the physical discomfort imposed by the police vehicle's backseat.

> *Interviewer: What things were helpful about the way MCIT worked with you?* Just little things, like they didn't make me feel like my whole life was in shambles or anything like that. They appreciated the layout of my apartment, they apologized for delaying my breakfast, and things like that. So it was – I got that general feeling that they cared. (Client)

Support and compassion often manifested through information sought or offered, and opportunities for clients to tell their stories. Upon arrival, clients nearly always described MCIT staff beginning the interactions by asking clients their perspectives on their crisis and its causes, and what forms of support or treatment they felt would be helpful. Some clients had comparable

levels of communication with police responders, but others described an absence of conversation or assessment, and quick decisions to bring clients to hospital.

> [PRU officers] can let me know why they're there and how I messed up... just state why you're there. (Client)

> [With MCIT,] it's voluntary... they're asking you questions about how you're doing, your psychological state, how you're coping, just about your life...whereas when the police come, they don't ask anything. They just say to bring you to the hospital. (Client)

Many clients were generally fearful of police or saw the arrival of police as a negative outcome. In several cases, this was due to a perception that police-only teams, including PRU officers, are unnecessarily aggressive in their approach to people experiencing mental health challenges. In many cases, the arrival of PRU made clients feel that they were being viewed as criminals. There was considerable variety in the quality of clients' crisis interactions with PRU officers. Several clients had poor crisis experiences wherein responding officers were perceived by clients to be dismissive or overly directive. Clients felt these responders assumed control of the situation, rather than helped the client to regain control.

> They should recruit a lot better police...a person that can talk to you that's more understanding, you know uses their words, other than their badge, to just like assert their authority. (Client)

At the same time, many clients often had positive experiences of being supported by PRU officers, and described individual police officers as kind and understanding in their mental health crises.

> The two policemen who had taken me to [hospital], again they were lovely, and so we had times where you had to wait and so we were just chatting. (Client)

Clients with positive crisis interactions included those that began their crisis experience with fear or apprehension about police involvement, whether through PRU or MCIT. It is thus important to note that while it is common for clients to be apprehensive about police involvement, apprehensiveness can be countered when police take a supportive approach with clients.

> Well I didn't talk to the cop [on the MCIT team]...I don't like cops. *Interviewer: No? And why do you-* Well, it really depends, like I was recently in [hospital] and there was a really nice cop...we had a cool conversation. Like he treated me like a normal human being. (Client)

Finally, the provision of options and support of client choice is important in creating a more positive crisis experience. This was most commonly seen in selection of hospital. Where clients were brought by MCIT to hospital, many first had a conversation regarding which hospital the client would prefer. Clients often preferred a hospital if they are currently or were recently engaged with services there, or if they had positive experiences with the hospital in the past.

> [MCIT nurse] was talking to my parents privately about going to [hospital A] to get assessed, and then they're like "no"...I feel like I've gotten worse over the hospitalizations

> when I was at [hospital A]. We contemplated on what hospital I was going to go to, so we went to [hospital B]. (Client)

CRISIS RESPONDERS' KNOWLEDGE OF MENTAL HEALTH CHALLENGES AND COMMUNITY RESOURCES

Clients perceived that MCIT staff had knowledge of mental health challenges, and that knowledge provided staff with a framework to effectively understand and approach the client in crisis. Many clients perceived that PRU officers were not sufficiently knowledgeable of mental health challenges or resources. The nurse was seen to have considerable knowledge, and many clients felt this greatly improved the quality of the crisis response. The MCIT officer was often perceived to be less knowledgeable than the nurse, but more knowledgeable than PRU officers.

> It's better when the nurse is there...maybe the police are not so trained with mental health, and the nurse knows more about mental health. So she knows how to treat the person or help with understanding what's going on, explaining to the police officer about mental health. (Client)

The greater level of knowledge on mental health by MCIT staff was perceived by clients to lead to a more positive interaction through more compassionate care and more effective de-escalation of the situation.

> It seems these people have received very effective training on how to approach mental disease. They don't look at it as a taboo, they don't treat you like a criminal. (Client)

Responders' knowledge of mental health was also perceived to decrease the risk of negative client outcomes, including being harmed by police, handcuffed, or brought involuntarily to an ED.

> It is terrifying for me that you know, something like this could happen, and I could...be killed by a police officer or something. I do think the MCIT really does a lot to prevent that from happening, because there are people there that are trained for that sort of thing. (Client)

> When you do go to the repeats [clients], [MCIT] can assess the medication quick, they can assess..."you don't need to come to the hospital". So that saves a headache and a half. Whereas a PRU officer will go there and then the next thing you know we're tying up another car. (TPS PRU officer)

In some cases, the client's medications were a focus of the interaction, and the nurse's capacity to better inform clients about their medications was highly valued. In these cases, it appears that the crisis was caused by symptoms that recently added medications had insufficient time to resolve, or by medication side effects. The nurse offered information to help the client understand their negative state, and suggested items to discuss at the client's next appointment with their physician.

> They are registered nurses and they know some of this medication. Like sometimes they tell me "well, you started this new medication, you have to give it time to work" (Client)

While very few clients interviewed had received formal referrals from their crisis responders to community-based health or social services, a number of clients perceived that the MCIT staff had a good knowledge of the mental health service system. This was detected by the MCIT staff's provision of information on distress phone lines and their knowledge of the ED.

> [The MCIT was] so great because they just like right away just kind of were problem-solving... I got the sense like they really knew what they were doing. (Client)

> [The nurse] advocated for me trying to go in, and say "Okay, is there anyone here yet? Can we get the doctor to write the [prescription] to get the needle? Do we have to take her into another room?". Like she was really on the ball. (Client)

IMPACT OF ORGANIZATIONAL POLICIES & FRONTLINE PRACTICES

Several of the themes that clients identified as affecting the quality of their crisis interactions were also raised in Steering Committee, police, and other stakeholder interviews, revealing the role played by organizational policies and practices in promoting positive client experiences.

Flexibility and Responsiveness

Several clients spoke very positively of crisis interactions wherein the crisis responders took the time to de-escalate and help shift the client to a more calm state. In all of these cases, the de-escalation process required crisis responders to have prior training, and during the interaction, to invest time to the de-escalation process. Program stakeholders discussed that work cultures vary in their support for time investments to improve client experiences and outcomes.

> Most of us that have been on the job a while, we've had to sort of change the way we think about the job, and it's changed dramatically...frontline officers in the PRU, they're still of that triage mindset. As quickly as they get to the radio call and deal with the person, they want to get closure and move on. (TPS staff sergeant)

Some TPS staff sergeants perceived that emphasis on short interactions without service referrals or follow-up contacts created a pool of clients that were frequently in crisis.

> A general consensus is the time constraints. Everybody is trying to just restrict that down, bring it down, build that rapport, not tie up people, and you can see that's what's happening. We're going, going, going, going. So everybody is trying to move things quicker then, and I think what happens is we lose sight of all those resources...whereas if we could have that person doing the follow-ups and making the calls to make sure these people are directed in the appropriate area, it might save that repeat. (TPS staff sergeant)

Where MCIT clients were brought to hospital, clients and MCIT staff often decided together which hospital they would go to. Ordinarily, clients would be directed to the closest hospital, but the ability to select the hospital based on client needs and preferences was an exception achieved by the MCIT Steering Committee. This flexibility created space for the client to make choices in the crisis resolution process, and often promoted better continuity of care.

> Arising out of deliberate attention by the Steering Committee, hospitals have agreed to...accept clients coming from outside of their catchment area if they're brought to them by the Toronto [MCIT]... so you've got hospitals now cooperating, dealing with the same client, and actually working out how to better serve that client without duplicating, repeating or constricting resources. (MCIT Steering Committee member)

Measured and Appropriate Responses

Several clients were intimidated by the simultaneous arrival of three or more crisis responders. This was flagged in interactions where multiple PRU officers arrived simultaneously, and when PRU officers and EMS were present at the same time.

> The cop was banging on the door...anyway so I opened the door and then EMS came...so I had a mental breakdown because there was too many people crowding me, and I was like you guys need to back up. (Client)

Some clients similarly felt intimidated when PRU officers and MCIT staff arrived simultaneously. Clients could not always quickly discern that one responder was a mental health nurse, due to resemblance in uniforms.

> Unhelpful is three police officers coming to the door. That's unhelpful. That's scary, when you're in that state of mind...it's very intimidating when you open your door, and there's a nurse who looks like a police officer 'cause she has vest on, and then three police officers standing there. (Client)

Furthermore, the usage of police vehicles and handcuffs in crisis interactions was a source of frustration for many clients. Police vehicles are physically uncomfortable for those sitting in the backseat and highly visible to neighbours. Where handcuffs were used, they were described as quickly applied, and caused clients to feel criminalized. Though no interviewed clients experienced being handcuffed by MCIT, approximately half of interviewed clients had been handcuffed by PRU during a crisis episode on at least one occasion. Several clients became emotional when recounting their experiences of being handcuffed while in crisis.

> It just is a really bad feeling, like I really don't like being put in handcuffs. It just makes me feel like I'm a criminal, and I'm not a criminal. I just have mental health problems. (Client)

Language and Culture

Although not discussed by clients, the language used by some PRU officers and staff sergeants in focus groups suggests that more work is needed to improve mental health literacy and combat stigma and discrimination. Amongst staff sergeants, involuntary transportation of an EDP client to hospital was commonly described as an "apprehension" or "arrest". This event is an apprehension under the Mental Health Act; the perception or depiction of the event as an arrest is inaccurate, and unnecessarily criminalizes the individual. It is worth noting that one staff sergeant participant attempted to correct colleagues' language, but the term "arrest" continued to be utilized at times.

They have to make a mental health arrest. (TPS staff sergeant)

We arrest them and take them to hospital. (TPS staff sergeant)

Terms applied to EDP clients themselves also revealed some problematic customs. A number of PRU officers referred to the people in crisis as "bodies", particularly when discussing transportation to hospital. In a single case, a staff sergeant referred to the EDP client as a "prisoner".

Either [MCIT] take[s] the body, or the program doesn't work. (TPS PRU officer)

[MCIT] used to come over and take your body. (TPS PRU officer)

If you have a question about health of a prisoner. (TPS staff sergeant)

B. MCIT AND THE CRISIS RESPONSE SYSTEM

As a crisis response program, MCIT aims to promptly assess client's immediate needs and, if a health service is needed, to facilitate that connection. Service connections may entail presentation to a hospital ED and/or referral to a community-based health or social service. A successful crisis response will thereby provide both immediate supports during the crisis and prevent future crises. This section reports participants' views on MCIT's role in Toronto's crisis response system.

This study found substantial variability in how participants used the term "crisis", and the circumstances labeled as "crisis situations". Interviewers frequently encouraged participants to provide definitions, and elaborate on beliefs that a "crisis situation" warrants an MCIT response.

MCIT ROLE IN CRISIS INTERACTIONS

Small Component of the Crisis System

The Steering Committee and community agency staff interviewed recognized that the term "crisis" referred to not a single type of event, but a diverse range of issues and levels of severity. MCIT focuses on only one small aspect of crises, that is, mental health emergencies with a policing component. Within mental health emergencies with a policing component, PRU officers address the majority of situations, and MCIT address a small portion of situations.

We're a piece, but we're not the whole...if we start talking about crisis, we're at everything from housing to food. (MCIT Steering Committee member)

Officers are doing the bulk of the EDP calls anyway...we're taking most of them. Like [MCIT] may hit one out of ten. (TPS PRU officer)

Acuity and Risk

Interviews and focus groups explored participants' views on when MCIT response was most appropriate. Many clients and community agencies perceived that MCIT was an appropriate

response to a mental health crisis of sufficient severity that those already present could not promptly and safely resolve it. Some clients felt MCIT involvement was always inappropriate, because they did not identify as requiring mental health services. However, most clients did perceive their need for occasional or regular mental health services, and described MCIT-appropriate crises as those where their coping skills were insufficient or where a trusted source recommended contacting 911.

> If...I feel like the brain cells aren't working properly, or I'm too anxious or if I'm too depressed, down. Then I reach out for help, if I know I cannot handle the situation by myself. (Client)

Participants from community agencies felt well-prepared to address a range of more moderate crises independently. When crises became more serious, they valued the extra support provided by MCIT or PRU officers with a skilled approach to mental health crises.

> For us it's really the medium- to high-risk... when we know somebody is not likely to be hospitalized, but we need something...we're not sure how safe they really are. (Community agency staff)

In contrast, many PRU officers believed that after they apprehend clients, MCIT should transport them to hospital. PRU perceive this as a low urgency task, as they have already contained the individual and determined the outcome. This view held by PRU officers indicates a misperception about MCIT's intended role, and is discussed below in *Confusion regarding MCIT mandate*.

> I used to utilize them just if you have an arrest, and you were really busy on the road to have them attend and maybe expedite the process of bringing them to the hospital, take them off our hands. (TPS PRU officer)

Clients whose crises centered on suicidality often agreed that MCIT services were very well-matched to their needs. In these situations, their crises had a high level of urgency, and they could not independently cope for any period of time. The clinical skill and compassionate care, paired with prompt arrival times of the MCIT, was highly valued.

> *Interviewer: In what situations would you prefer to use MCIT?* When I'm really, really bad, like when I can't handle my thoughts, when I can't get them to go away. When I can't think of anything else except dying. (Client)

> In cases of very high risk, right. I think that for me...it really saved my life, like I don't know what would have happened if they hadn't have come. (Client)

Participants from community agencies were primarily interested in MCIT for serious crises, particularly those with a risk of danger to self or others. They perceived that police involvement, through MCIT or otherwise, was only warranted if there was a risk of harm.

> Ideally they would be for emergencies or near-emergencies where there's a policing component to the emergency. Ideally, [MCIT] wouldn't be going out to people in psychiatric crisis unless there was some level of danger in the situation, either to the

person or by the person. Ideally, we'd be able to respond to people in psychiatric crisis apart from that situation in a different way. (Community agency staff)

However, the majority of police participants believed that MCIT should not attend a situation with risk of danger to others.

If it's violent, we've got to go, we got to make sure it's safe...they can't go if it's not safe. (TPS PRU officer)

Repeating Clients

MCIT was reported by TPS staff to be an appropriate response for individuals that repeatedly experienced crises, because they would become more familiar with client histories than PRU officers. MCIT would also be able to refer these repeat clients to health and social service agencies, whereas PRU officers rarely complete referrals to community-based services.

It's good having MCIT have that knowledge of that repeat customer. (TPS staff sergeant)

TERTIARY PREVENTION / RESOLUTION OF CRISES

Service Referrals

Although a potential key ingredient of an effective MCIT response, the current participant sample could not provide detailed information on the process and outcomes of referrals by MCIT to community-based health and social services. One client participant recalled receiving a referral to a service, and a small number of additional participants recalled receiving information pamphlets. Clients varied in their interest in accessing health services, so the small number of referrals amongst interviewed clients could be due to both staff's decisions not to refer to additional services, as well as clients' decisions to decline additional services.

Like all crisis responders, MCIT can only complete a service referral, and it is then dependent upon the client to contact the service, and the service to provide timely and high-quality care. While interviewed clients could not specifically inform the study on MCIT referral processes, participants from all samples emphasized the perspective that the health and social service system fails to adequately prevent mental health crises. An absence of sufficient support for individuals with recent crises or hospitalizations at the system-level was perceived to be responsible for clients' continuing ill health and pressure on healthcare and justice systems.

Services that [frontline staff] need to be able to refer clients to are closing because of money, and now in our LHIN there has been a new form for referrals and it's a twenty-three page form, and we are not going to get referrals. We're just going to end up with volume back in the Emerg. (MCIT Steering Committee member)

Interviewer: Do you feel like you can access good services for you when you're in a crisis situation? This was a good experience right. I guess I'd have to say yes...but... you kind of feel despair right, because your problems have been going on for so long that you think that – you just can't keep putting band-aids on. (Client)

> People shouldn't be at that point in their mental health where it's either go to jail or go to the hospital on a form. Like if we were thinking about general physical health, and people were at that level of general sickness, there'd be a human cry-out... nobody's being well served by that system. (TPS staff sergeant)

Some participants perceived these system flaws, but could not identify specific causes. Where participants commented on reasons for insufficient follow-up care, they commonly identified difficulty in accessing current information on services and lengthy community service waitlists.

> Members of the general public don't have practical access to crisis responses, because there's no way that they would know about all of the options... they're at a real loss as to how to get help. (Community agency staff)

> Who do you refer them to? How quickly can you get that referral? How quickly can you get them into some sort of treatment?...There's no confidence that these groups are going to be able to respond quickly to minimize the crisis that somebody is in, and prevent it from escalating. (MCIT Steering Committee member)

Additionally, several participants identified a systemic prioritization of short-term crisis management over long-term resolution of the causes of crises. Participants perceived that this contributed to preventable ill health and health system costs.

> I and a lot of other people have cost the healthcare system in terms of ER visits... you go in with a panic attack and they're giving you a pulmonary function test and chest x-rays and blood tests and everything. It probably costs quite a lot of money... that same money is not available for that person to see a psychologist. (Client)

> Crises are noisier...they draw attention, and the reality [is] that for multiple reasons, people access service at a point when things look not good to them. So almost all services are doing primarily crisis, and we neglect the ordinary life considerations that would support people in crisis, that would prevent crises. (Community agency staff)

Follow-up Contacts

Many interviewed clients had received a follow-up contact from the MCIT after their crisis. Amongst interviewed clients, all reported to MCIT that their crises were resolved, and they did not require additional crisis support at that time. Likely because they did not require follow-up from MCIT, most clients in the current study described the follow-up support in neutral terms. It was not described as either a valued or disliked component of MCIT service. However, it should be noted that a recent implementation evaluation of Toronto's MCIT program found follow-up contacts were often highly valued by clients(5).

MCIT'S ROLE IN TORONTO POLICE SERVICE

Officers within Toronto Police Service (TPS) are frequently dispatched when an individual calls 911 regarding a possible mental health crisis. In 2014, TPS received 22,386 such calls, signaling that

such calls are not a negligible component of TPS work.[2] MCIT was developed, in part, to complement and build upon this crisis response work.

Valued Asset

Knowledge of Mental Health Challenges and Community Resources

Many TPS staff sergeants and PRU officers placed a high value on the clinical knowledge of the MCIT nurse. A professional clinical assessment could alleviate an officer's concerns about a client and prevent an unnecessary ED visit.

> Look at the man-hours that we spend sitting in hospitals when you haven't had that nurse intervene, and decide whether or not, first of all, the person should be admitted...and you just bring them in. (TPS staff sergeant)

The MCIT nurse was familiar with medications and diagnoses, and could advise officers and clients on the symptoms from which the client was likely suffering. Additionally, both the MCIT nurse and officer were perceived to be informed on a range of community-based health and social services, and could recommend helpful services for clients.

> Some of the nurses get further though when they call up some of these agencies as opposed to us calling them. Sometimes you don't get a very warm reception...whereas a nurse with some expertise who can call them up, and is familiar with navigating the system – right, that's a big, big help. (TPS PRU officer)

Spread of Skill Sets

As a program embedded within TPS, MCIT was perceived to promote skills in working with mental health and substance abuse crises to other programs. This occurred firstly through the availability of MCIT training to non-MCIT officers. Though PRU officers often felt sufficiently trained for their mental health work, many staff sergeants felt MCIT trainings were an important opportunity that more TPS officers could benefit from.

> We're trying to get all our neighbourhood officers MCIT trained, not just so they can back-up with the nurse, but also they have a lot of interaction with a lot of people with the EDP issues. (TPS staff sergeant)

> I think it's becoming obvious – good training is good for everybody. (TPS staff sergeant)

Secondly, TPS officers who had formerly worked with MCIT continued to apply the skills and knowledge they developed within MCIT. Staff sergeants hold a supervisory role within TPS, and saw this transferability of skills to be a significant asset for the organization. As outlined, MCIT

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[2] This includes all calls for service formally classified as *emotionally disturbed person, attempt suicide, threaten suicide, jumper, overdose,* or *elopee.* Information provided to the study by Toronto Police Service Business Intelligence and Analytics, July 22 2015.

officers are encouraged but not mandated to remain with the team for a minimum of two years, and it is common for MCIT officers to transfer to other TPS duties after some time with MCIT.

> I've had, I guess the fortune of two of the previous MCIT officers...they don't just use those talents while they're in there. They bring them with them later on...all our contacts for social agencies and crisis nurses...and it helps in dealing with elder abuse issues, it helps them deal with people suffering from dementia. (TPS staff sergeant)

Complements Existing TPS Work

A small number of Community Safety Officers (CSOs) are based out of each TPS Division, and complete follow-up contacts with individuals identified through PRU interactions to be at risk. CSO and PRU officers would both communicate with MCIT when they encountered an individual that they could not support, but could benefit from follow-up contact.

> The CSOs...and the MCIT, they're working together on a regular basis now. They feed off each other, use each other's' expertise to kind of just get a grip on the issues within the community, and the people that are more at-risk so it's a combined effort. (TPS staff sergeant)

Several PRU officers did not consider EDP calls to be a core component of their work, and the majority strongly appreciated being relieved by MCIT. However, as elaborated below in the *Confusion regarding MCIT mandate* section, misperception can be found as to MCIT's mandate and what services they should provide in these situations.

> In our mind, it would be best for someone else to take [EDP clients], and we have all our guys to deal with - and we can send them out to other calls that don't involve EDPs. You know stabbings, shootings, all that's our priority. (TPS PRU officer)

> *Interviewer: So the biggest thing for MCIT, the biggest help for-* For us, is saving time...not tying up the car. (TPS PRU officer)

For clients requiring evaluation in the ED, many TPS officers perceived that MCIT experiences shorter wait times due to the nurses' ability to encourage a faster transfer in custody.

> They develop a certain rapport with the hospitals because they have the nurse, and ...they're more fluid going through the hospital process. (TPS staff sergeant)

Limitations on Effectiveness

Confusion Regarding MCIT Mandate

Though TPS staff sergeants were often familiar with MCIT's mandate, a number of TPS PRU officers reported that it was always the PRU officers' role to control a crisis situation and determine the client's outcome. From their perspective, once an assessment was completed and a client needed transport to hospital , MCIT should take over the transport to hospital, so that PRU can return to other duties. MCIT's official mandate, however, includes the provision of prompt assessment and

support to EDP clients. MCIT is not intended to function as a transportation service. This discordance between perceived and actual contributions that MCIT can make to crisis situations resulted in some PRU officers' exasperation with the program.

> Once you got the cuffs on [clients], a lot of nurses don't like taking them. Once you apprehend them, then they're yours...when [MCIT] first started, that was part of the beauty of it. They'd come over, take the body off your hands, and then the nurse could speed things up right into the hospital. (TPS PRU officer)

Several staff sergeants were aware of this discordance between PRU perceptions and the actual mandate. Many staff sergeants were very supportive of the MCIT program, and believed that PRU required more thorough introductions to the MCIT program and staff in order to maximize the utility of the program.

> That seems to be a bit of a misconception with the PRU, that you know they're going to call MCIT and magically you're going to take their call. And that's not necessarily their role. They'll come out and assess, they may transport, but they may also leave [clients] with the PRU, but they'll assist then. (TPS staff sergeant)

> It's a great resource, but if it's abused, it's useless. (TPS staff sergeant)

Limited Coverage

As with other participant samples, there was wide agreement amongst TPS staff that MCIT's hours of operation were too limited. TPS receives high volumes of EDP calls, and many believed that MCIT availability needs to be increased in order to better support these interactions. While potential differences between regions with and without MCIT Expansion teams could not be addressed in this study, participants voicing this concern included those with and without Expansion teams.

> There's not enough of them, and they're not there all the time. (TPS PRU officer)

> If we had two teams that would be great, because then you could have a day shift and an evening shift. (TPS staff sergeant)

In addition to limited hours of operation, TPS staff sergeants believed that the geographic region covered by any individual MCIT was too large. TPS staff believed that distance and traffic congestion created slow arrival times, which reduced quality of crisis response and discouraged PRU from waiting for an MCIT assessment. Additionally, EDP calls tend to be highly concentrated in specific regions of the city, so even some smaller regions were believed to require increased MCIT staffing.

> I didn't even know there was a [MCIT in TPS Division] 43, so it's like – that's huge out there. How do you get two guys to cover three divisions? That's ridiculous. (TPS staff sergeant)

Supervision Challenges

MCIT officers are seen as a resource for PRU work, but are supervised by Community Response Unit (CRU) staff sergeants. CRU officers are assigned to a selection of Toronto neighbourhoods, and their work occurs largely within that neighbourhood. They do regular patrol by foot or bicycle and may be dispatched to attend TPS calls for service; CRU officers are not typically first responders to calls for service. As PRU and CRU are distinct and separate components of TPS, some staff sergeants felt they were not positioned to supervise and support MCIT officers as they do with their CRU officers. Additionally, MCIT officers' work crosses police division boundaries, whereas each staff sergeant is based in a single division. As a result, staff sergeants communicated with MCIT officers infrequently.

> I'm still mystified why the MCIT is in the CRU...I guess at some point, they said, "well he's got to report to somebody", but this is a PRU resource...the two of them don't really affect my day-to-day life and the forty guys that work for me, so I don't even really know why he's under the CRU...they seem a little bit orphaned. (TPS staff sergeant)

> Once [MCIT officers] disappear to another division they're gone, [and]...you don't have that control. (TPS staff sergeant)

While MCIT's strength comes through its partnership between police and health services, the staff sergeants were aware that they could not manage MCIT nurses, who each had an employer, manager, and union outside of the staff sergeant's purview. Specifically, staff sergeants could not control MCIT nurses' hours of work or time off of work, or ensure an adequate supply of back-up nurses for their vacation and sick coverage.

> The issue that I have as far as staffing goes is, I can control my people generally speaking, but I have no control over the nurses, because obviously they have a different working agreement. (TPS staff sergeant)

C. MCIT PLANNING PROCESS

The current study included a focus group with the MCIT Steering Committee to explore perceived strengths and weaknesses of the process of implementing a coordinated MCIT program, and its role in this sphere of the crisis response system. As the MCIT implementation process was not explored among other participant samples, data on this subject is derived solely from this focus group.

REASONS FOR SUCCESS

Strong Collaborative Relationships

The MCIT program is a partnership of three LHINs, six hospitals, and all 17 Toronto Police Service divisions. Partnerships that bridge sectors and organizations can be difficult to develop, and

several Steering Committee members spoke of the strength of collaboration experienced in the MCIT program development.

Commitment by Decision-makers

The MCIT Steering Committee is chaired by Deputy Chief Michael Federico of TPS, and CEO Robert Devitt of Toronto East General Hospital. Further, one LHIN tied MCIT funding and expansion to formation of the Steering Committee. It was believed that members of the executive leadership committed to a genuinely collaborative spirit, encouraging their organizations to follow suit.

> There's something special here...police and healthcare have gotten to know each other a lot better. I don't hear anymore the kind of us/them that I used to hear... some of it is the executive leadership, like having the deputy chief and a hospital CEO – we can, by virtue I guess of our positions just say, we're going to act differently. (MCIT Steering Committee member)

> It required an executive commitment, which we got from the LHIN. (MCIT Steering Committee member)

Some members partially attributed success to the direct involvement of service provision representatives.

> It was quite astute and appropriate...we've actually got the service deliverers now managing the committee that's going to look at developing the program and creating it in a way that can actually serve frontline needs. (MCIT Steering Committee member)

Attention to Work Cultures

The partnership has been successful due in part to deliberate efforts to recognize and understand the distinct work cultures of involved organizations.

> One of the things that [we] were really deliberate about was understanding cultures. Really the police culture and the hospital culture are very different... and every hospital has its own subculture as well...we have learned about each other's culture and been quite deliberate and open to that enhanced understanding. (MCIT Steering Committee member)

Maintaining Narrow Focus

Members spoke of the breadth and complexity of crisis experiences, and the corresponding complexity of crisis response services. A key decision that led to successful MCIT review and recent expansion was believed to be firm delineation of the scope of work and resistance to being drawn into other areas of crisis response, however important.

> One of the reasons we've been successful is because we started by focusing on a little piece. And in fact, if I recall the early meetings, we kept trying to boil the ocean, and we had to keep coming back to, no, we're here to set up an MCIT system only. And all that

other stuff is really important, but we're only doing this. (MCIT Steering Committee member)

AREA OF WEAKNESS

Accessing Client Input

Clients of mental health services have not been significantly involved in MCIT planning processes, and this gap was described to be a significant weakness in the Steering Committee. Some Committee members had experience at their home organizations with successful integration of client input; however, many were uncertain as to the best pathway to solicit client input. The primary obstacle was described to be uncertainty in how to select clients that will participate, given the diversity of client views and experiences.

> It's extremely diverse... even though there are [clients] that are on these committees, they don't represent everybody, or they don't consult with the people that they purport to represent. And that's very difficult to bring to the table...which groups do you pick? Which leaders of these different groups do you pick? (MCIT Steering Committee member)

> [At my home organization,] we've overcome those challenges. We've had very positive experiences, but it's developed over years. So for example, I know our [client council] has been in existence for sixteen years, so they are accustomed to bringing the more global voice, and not just the personal voice. (MCIT Steering Committee member)

FINDINGS: ADMINISTRATIVE DATA

This study included analysis of data documented by MCIT officers, MCIT nurses, and PRU officers. Unless stated otherwise, all administrative data reflect the time period of July 2014 – March 2015.

MCIT CLIENT CHARACTERISTICS

Characteristics of the client in each MCIT crisis interaction can be seen below in Table 3. The fields *Age* and *Client known to MCIT* reflect the July 2014 – March 2015 period. All other fields reflect the April 2014 – March 2015 period. Note that because current documentation does not allow repeating clients to be identified across interactions, a client with multiple interactions is represented here multiple times. Clients are diverse in all presented characteristics. Nearly 30% of MCIT crisis interactions involve clients that have had previous interactions with MCIT.

Table 3: Characteristics of MCIT clients in crisis interactions

Characteristic	MCIT interactions No. (%)
AGE[1]	
17 or younger	222 (5.9%)
18-34 years	1,177 (31.2%)
35-54 years	1,243 (32.9%)
55-74 years	682 (18.0%)
75 or older	234 (6.2%)
Unknown/Declined	219 (5.8%)
Total	3,777 (100.0%)
GENDER[2]	
Female	1,464 (48.3%)
Male	1,537 (50.7%)
Other	17 (0.6%)
Unknown/Declined	12 (0.4%)
Total	3,030 (100.0%)
ABORIGINAL ORIGIN[3]	
Aboriginal	29 (1.4%)
Non-aboriginal	1,627 (80.7%)
Unknown/Declined	359 (17.8%)
Total	2,015 (100.0%)
RESIDENCE TYPE[4]	
Private housing (owned or rented at market or subsidized rates)	935 (58.4%)
Non-profit housing	86 (5.4%)
Supportive housing or long-term care	98 (6.1%)
Rooming or boarding home	49 (3.1%)
No fixed address (shelter, domicillary hostel/shelter or homeless)	200 (12.5%)
Other	29 (1.8%)
Unknown/Declined	204 (12.7%)
Total	1,601 (100.0%)
DIAGNOSTIC CATEGORY[5]	
Adjustment disorders	27 (1.3%)

Anxiety disorder	69 (3.4%)
Delirium, dementia, and amnestic and cognitive disorders	63 (3.1%)
Disorder of childhood /adolescence	33 (1.6%)
Eating disorder	3 (0.1%)
Impulse control disorders, not elsewhere classified	3 (0.1%)
Mental disorders due to general medical condition	22 (1.1%)
Mood disorders	331 (16.4%)
Personality disorders	67 (3.3%)
Schizophrenia and other psychotic disorders	552 (27.4%)
Substance related disorders	104 (5.2%)
Developmental disorder	8 (0.4%)
Other	3 (0.1%)
Unknown/Declined	728 (36.2%)
Total	2,013 (100.0%)
PRESENTING ISSUE[6]	
Threat to others / attempted suicide	612 (13.3%)
Specific symptom of Serious Mental Illness	1,441 (31.3%)
Housing	288 (6.3%)
Financial	72 (1.6%)
Legal	106 (2.3%)
Problems with Relationships	454 (9.9%)
Problems with substance abuse / addictions	327 (7.1%)
Activities of daily living	329 (7.1%)
Other[7]	856 (18.9%)
Unknown/Declined	122 (2.6%)
Total	4,607 (100.0%)
CLIENT KNOWN TO MCIT[8]	
Yes	1,105 (29.3%)
No	2,590 (68.6%)
Unknown	82 (2.2%)
Total	3,777 (100.0%)

[1] All MCITs are represented in *Age* data

[2] SMH, HRH, SJHC, and NYGH MCITs are represented in *Gender* data

[3] SMH, HRH, and NYGH MCITs are represented in *Aboriginal origin* data

[4] SMH, TSH, and NYGH MCITs are represented in *Residence type* data

[5] SMH, HRH, and NYGH MCITs are represented in *Diagnostic category* data

[6] SMH, HRH, TSH, SJHC, and NYGH MCITs are represented in *Presenting issue* data

[7] Examples of "Other" include issues with food, education, physical health, and physical abuse.

[8] All MCITs are represented in data on *Clients known to MCIT*

MCIT AND PRU CRISIS RESPONSE

Volume of Service

The MCIT program's primary function is to respond to crises in the community after they have been cleared for safety by PRU officers (termed crisis interactions). Correspondingly, 60% of all MCIT services are classified as such crisis interactions (see Table 4). Subsequent to a crisis interaction, MCIT may determine a client would benefit from a follow-up contact, and such follow-up contacts comprise 13% of all service activities. A smaller proportion of MCIT service activities are

consultations, wherein a colleague seeks input from the MCIT without requesting their attendance. Variability in rates of follow-up contacts and consultation can be noted by hospital and corresponding police divisions.

It should be noted that nearly 20% of all MCIT service activities are classified as cancelled calls, which refers to situations where an MCIT is dispatched to a crisis interaction, and is either cancelled while en route or cannot locate the client upon arrival.

Table 4: MCIT services completed July 2014 – March 2015

Hospital/Police Divisions	Service activity					Total
	Crisis interaction No. (% of all services)	Follow-up: In-person, No. (% of all services)	Follow-up: Telephone, No. (% of all services)	Consultation No. (% of all services)	Cancelled call No. (% of all services)	No. (% of all services)
HRH/12, 23, 31	481 (64.0%)	40 (5.3%)	17 (2.3%)	70 (9.3%)	144 (19.1%)	752 (100.0%)
TSH/41, 42, 43	518 (63.9%)	100 (12.3%)	20 (2.5%)	80 (9.9%)	93 (11.5%)	811 (100.0%)
SJHC/11, 14, 22	409 (52.9%)	87 (11.3%)	67 (8.7%)	23 (3.0%)	187 (24.2%)	773 (100.0%)
SMH/51, 52	503 (64.6%)	16 (2.1%)	43 (5.5%)	35 (4.5%)	182 (23.4%)	779 (100.0%)
TEGH/53, 54, 55	549 (56.4%)	66 (6.8%)	69 (7.1%)	103 (10.6%)	187 (19.2%)	974 (100.0%)
NYGH/32, 33	314 (100.0%)	not available	not available	not available	not available	314 (100.0%)
TOTAL	2,774 (63.0%)	309 (7.6%)	216 (5.3%)	311 (7.6%)	793 (19.4%)	4,403 (100.0%)

TPS operates across 74 patrol zones in the city of Toronto; the 10 patrol zones with the highest proportions of MCIT and PRU crisis response services can be seen in Tables 5 and 6, respectively. Interestingly, patrol zone 145, located in the Parkdale area and managed by TPS 14 Division, experiences the highest proportion of PRU crisis interactions, and has a relatively low proportion of MCIT crisis interactions. Location of MCIT service impact can be seen by LHIN where the client resides in Table 7.

Table 5: Patrol zones with highest proportion of MCIT crisis interactions

Patrol zone	Crisis interactions	
	MCIT interactions No. (%) Total: 2,686(100.0%)	PRU interactions No. (%) Total: 16,216 (100.0%)
514	77 (2.9%)	416 (2.6%)

435	74 (2.8%)	183 (1.1%)
553	72 (2.7%)	202 (1.2%)
222	70 (2.6%)	315 (1.9%)
532	70 (2.6%)	260 (1.6%)
541	67 (2.5%)	231 (1.4%)
542	67 (2.5%)	357 (2.2%)
433	66 (2.4%)	164 (1.0%)
434	61 (2.3%)	226 (1.4%)
332	55 (2.0%)	245 (1.5%)

Table 6: Patrol zones with highest proportion of PRU crisis interactions

Patrol zone	Crisis interactions	
	MCIT interactions No. (%) Total: 2,709 (100.0%)	PRU interactions No. (%) Total: 16,216 (100.0%)
145	39 (1.5%)	473 (2.9%)
514	77 (2.9%)	416 (2.6%)
513	52 (1.9%)	382 (2.4%)
542	67 (2.5%)	357 (2.2%)
111	32 (1.2%)	356 (2.2%)
144	36 (1.3%)	355 (2.2%)
511	48 (1.8%)	348 (2.1%)
143	36 (1.3%)	337 (2.1%)
512	55 (2.0%)	335 (2.1%)
522	41 (1.5%)	328 (2.0%)

Table 7: MCIT crisis interactions by client's home Local Health Integration Network (LHIN)

LHIN	MCIT interactions No. (%) Total: 1,882 (100.0%)[1]
Toronto Central LHIN	798 (42.2%)
Central East LHIN	518 (27.5%)
Central LHIN	505 (26.8%)
Central West LHIN	59 (3.1%)
Mississauga Halton LHIN	2 (0.1%)

[1] Data on NYGH and TEGH MCIT clients' home LHIN are not represented here

Comparison of service outcomes

As may be expected, PRU officers can respond to a call for service more quickly than MCITs (see Table 8). Specifically, PRU requires a shorter period of time to travel to a location. This is likely due to greater levels of staffing and focus on smaller geographic areas.

Interactions resulting in transportation to a hospital ED under the MHA require crisis responders to take custody of the client and wait in the ED until custody can be transferred to the hospital. Transportation to the ED when a client attends voluntarily and does not meet MHA apprehension criteria does not legally require crisis responders to wait for the hospital to take custody, though responders may choose to wait if it will promote the client's health. Additionally, crisis responders may be asked to stay after the hospital accepts custody if there are significant safety concerns. Regardless of legal requirement, the time that crisis responders spend waiting in EDs is consequential in terms of health and justice system costs and their availability to attend other requests for service. Current results show that MCITs experience shorter durations between arrival at an ED and ability to depart the ED (see Table 8).

Table 8: Expenditures of time in MCIT and PRU interactions

Expenditure of time	MCIT interactions	PRU interactions
Time between dispatch and arrival (minutes)		
Mean	15.7*	12.3*
Median	12.0	8.7
Minimum	0.0	0.1
Maximum	1,609.0	405
Time waiting in hospital ED (minutes)		
Mean	56.6*	85.7*
Median	50.0	75.0
Minimum	0.0	0.0
Maximum	360.0	1,470.0

* Difference between MCIT and PRU is statistically significant ($p<0.001$)

Comparison of presentation to ED through voluntary or Section 17 processes can be seen in Table 9. MCIT interactions are more likely to include transportation to ED in these circumstances. This may be explained by the types of calls that MCIT attends, which may involve clear mental health challenges. Alternatively, MCIT may be more likely to respect the wishes of clients that feel they need a psychiatrist's assessment.

Table 9: Transportation of client to hospital ED, through voluntary or Section 17 processes

Transportation to ED	MCIT interactions No. (%) Total: 2,743 (100.0%)	PRU interactions No. (%) Total: 16,226 (100.0%)
Client transported to ED	884 (32.2%)*	3,708 (22.9%)*
Client not transported to ED	1,859 (67.8%)*	12,518 (77.1%)*

* Difference between MCIT and PRU is statistically significant ($p<0.001$)

Comparisons of MCIT and PRU utilization of MHA can be seen in Table 10. Interaction with an MCIT unit is significantly associated with decreased likelihood of a Section 17 apprehension, meaning that the MCIT unit is less likely to obligate a person to attend a hospital ED for assessment by a physician. Interaction with an MCIT unit is also significantly associated with an increased

likelihood of voluntary transportation to a hospital ED. Together, these results suggest that MCIT may be dispatched to less dangerous or less serious situations. Alternatively, MCIT may be better able to support a client to go voluntarily to the ED. Jointly considering PRU interactions involving Section 17 apprehensions and voluntary transportation to hospital shown in Table 10, it is notable that 96% of transportations to hospital occur by invoking the MHA. This may be explained by qualitative findings reported above, which include clients' experiences that PRU often decide quickly that the client must attend the ED, as well as TPS officers' uncertainty in determining a client does not need psychiatric attention and officers' experiences of pressure to complete interactions quickly.

Table 10 also shows that within the July 2014 – March 2015 period, MCIT is significantly more likely than PRU officers to be called in to transport clients to hospital under Forms 1, 2, 9, and 47. However, in March 2015, MCIT protocols were changed to decrease MCIT involvement in form apprehensions. Changes were made due to the more straightforward nature of these apprehensions, which can be completed by PRU, and the lack of need for nursing clinical assessments.

Table 10: Transportation to hospital under voluntary and Mental Health Act (MHA) circumstances

Circumstances of transportation to hospital	MCIT interactions No. (%) Total: 2,726 (100.0%)[1]	PRU interactions No. (%) Total: 16,226 (100.0%)
Voluntary transportation to hospital ED	364 (13.3%)*	165 (1.0%)*
MHA apprehension: Section 17	523 (19.2%)^	3,565 (22.0%)^
MHA apprehension: Form 1	145 (5.3%)*	336 (2.1%)*
MHA apprehension: Form 2	136 (5.0%)*	212 (1.3%)*
MHA apprehension: Form 9	10 (0.4%)^	21 (0.1%)^
MHA apprehension: Form 47	69 (2.5%)*	52 (0.3%)*

[1] Data for *Voluntary transportation to hospital* in MCIT interactions is based on a total of 2,743 cases.

* Difference between MCIT and PRU is statistically significant ($p<0.001$)

^ Difference between MCIT and PRU is statistically significant ($p<0.01$)

MCIT SERVICE OUTCOMES

Health service connections

MCIT aims to support clients' health and safety by facilitating connections to community-based health services. MCIT may support the client in connecting with existing services, including setting an appointment with their current psychiatrist or sharing information on telephone support lines. MCIT may also complete a formal service referral, defined as one requiring a referral form or intake appointment, as would be required to access a new primary care physician or short-term housing. A summary indicator of all facilitated connections to existing services and new service referrals can be seen in Table 11. Detailed tables on service referrals can be seen in Appendix A.

Table 11: MCIT supported service connection, any type (Summary indicator)

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person No. (% of interaction type)	Follow-up: Telephone No. (% of interaction type)	
HRH/12, 13, 23, 31				
Supported service connection (any type)	175 (36.4%)	14 (35.0%)	8 (47.1%)	197 (36.6%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Supported service connection (any type)	317 (61.2%)	65 (65.0%)	8 (40.0%)	390 (61.1%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Supported service connection (any type)	139 (34.0%)	24 (27.6%)	13 (19.4%)	176 (31.3%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Supported service connection (any type)	157 (31.2%)	8 (50.0%)	2 (4.7%)	167 (29.7%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55[1]				
Supported service connection (any type)	271 (49.4%)	31 (47.0%)	24 (34.8%)	326 (47.7%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Supported service connection (any type)	1,059 (43.0%)	142 (46.0%)	55 (25.5%)	1,256 (42.1%)
Total	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

[1] TEGH MCIT data includes informal service referrals made October 2014 - March 2015 (6/9 months of total study period).

In the days or weeks following a crisis interaction, MCIT may perform follow-up contacts with clients through in-person visits or telephone to verify the client's safety and resolution of the mental health crisis. See Table 4 above for the proportion of follow-up contacts in relation to all MCIT service activities.

Health service connections for repeating clients

Each MCIT nurse identifies repeating clients, defined as clients the current team has previously seen within the fiscal year (April - March). This subsample of clients is known to have required MCIT intervention by the current team on at least two incidents within 12 months or less. In the period of study (July 2014 - March 2015), 33.0% of clients seen in crisis were previously seen by the same MCIT within the fiscal year, that is, since March 2014.

A summary indicator of all facilitated connections to existing services and new service referrals, divided by repeating and new clients, can be seen in Table 12 (note this is the same indicator seen above in Table 11). Within crisis and follow-up interactions, repeating clients appear to experience supported service connections at similar rates as new clients.

Table 12: MCIT supported service connection, any type (Summary indicator), by identification as repeating client

Service connection (any type)	Interaction type						Total, No. (%)
	Crisis interactions No. (% client subsample)		Follow-up: In-person No. (% client subsample)		Follow-up: Telephone No. (% client subsample)		
	Repeating client	New client	Repeating client	New client	Repeating client	New client	
Supported service connection (any type)	270 (44.6%)	753 (43.8%)	98 (49.2%)	40 (42.1%)	35 (27.8%)	18 (25.0%)	1,214 (43.1%)
Did not support service connection (any type)	335 (55.8%)	965 (56.2%)	101 (50.8%)	55 (57.9%)	91 (72.2%)	54 (75.0%)	1,601 (56.9%)
Total	605 (100.0%)	1,718 (100.0%)	199 (100.0%)	95 (100.0%)	126 (100.0%)	72 (100.0%)	2,815[1] (100.0%)

[1] Data on NYGH MCIT clients' interactions are not represented here

As can be seen in Table 13, repeating MCIT clients are much more likely to receive follow-up contacts than new MCIT clients, suggesting MCIT has greater concerns regarding the client's full crisis resolution and short-term health needs.

However, given limitations to the documentation form, it is possible that some MCIT nurses noted the follow-up interaction as taking place with a repeating client due to having recently seen that client in a crisis interaction. In other words, some clients receiving follow-up contacts that are identified as repeating clients may have actually had only one MCIT crisis interaction.

Table 13: MCIT follow-up interactions, by identification as repeating client

Type of follow-up interaction	Client subsample		Total
	Repeating client	New client	
In-person	199 (67.7%)	95 (32.2%)	294 (100.0%)
Telephone	126 (63.6%)	72 (36.4%)	198 (100.0%)
Total	325 (66.1%)	167 (33.9%)	492 (100.0%)[1]

[1] Data on NYGH MCIT clients' interactions are not represented here

To supplement the above result, MCIT officers' documentation of crisis interactions with planned follow-up contact was examined by client subsample. MCIT officers documented 29.3% of all clients seen in crisis interactions as repeating clients. As shown in Table 14, MCIT is nearly twice as likely to plan a follow-up contact with repeating clients in crisis, compared to new clients in crisis, and this difference is statistically significant. As noted above, this finding suggests MCIT has greater concerns regarding the client's full crisis resolution and short-term health needs.

Note that MCIT officers and MCIT nurses utilize different definitions for repeating clients. While MCIT nurses define a repeating client as someone seen in the last fiscal year, MCIT officers define a repeating client as one that is known to the current team or appears in TPS records as known to MCIT; an MCIT interaction that occurred several years prior may still mean that an individual is identified in MCIT officer records as a repeating client.

Table 14: MCIT crisis interactions with planned follow-up, by identification as repeating client

Follow-up interaction planned	Client subsample		Total No. (%)
	Repeating client	New client	
Yes, planned	178 (20.5%)*	239 (11.8%)*	417 (14.4%)
No, not planned	690 79.5%)*	1,793 (88.2%)*	2,483 (85.6%)
Total	868 (100.0%)	2,032 (100.0%)	2,900 (100.0%)

* Difference between repeating and new clients is statistically significant ($p<0.001$)

If considering all crisis interactions, there is no statistically significant difference in the likelihood of a repeating client being transported to the ED compared to a new client (see Table 15). However, if the analysis excludes MHA form apprehensions wherein responders could not legally avoid transportation to ED, it is found that repeating clients are less likely than new clients to be transported to the ED (see Table 16).

Table 15: Transportation to ED in MCIT crisis interactions, by identification as repeating client

Transportation to ED	Client subsample		Total No. (%)
	Repeating client	New client	
Client transported to ED	380 (44.4%)	852 (45.6%)	1,232 (45.2%)
Client not transported to ED	476 (55.6%)	1,015 (54.4%)	1,491 (54.8%)
Total	856 (100.0%)	1,867 (100.0%)	2,723 (100.0%)

Table 16: Transportation to ED in MCIT crisis interactions, by identification as repeating client (excluding MHA form apprehensions)

Transportation to ED	Client subsample		Total No. (%)
	Repeating client	New client	
Client transported to ED	233 (32.9%)^	639 (38.6%)^	872 (36.9%)
Client not transported to ED	476 (67.1%)^	1,015 (61.4%)^	1,491 (63.1%)
Total	709 (100.0%)	1,654 (100.0%)	2,363 (100.0%)

^ Difference between repeating and new clients is statistically significant ($p<0.01$)

Other key service outcomes

Rates of injury in MCIT crisis interactions are presented in Table 17. Comparable data for PRU crisis interactions are not presently available. In total, only 2.1% of interactions involve an injury incurred by any involved party. Most injuries incurred were minor, defined here as not requiring medical attention. Further, injuries that were not self-inflicted by the client are exceedingly rare in MCIT crisis interactions, occurring in only 0.5% of cases. The authors are not aware of any previously published work examining rates of injury in co-responding police-mental health programs, so no comparisons to other programs can be made at the present time.

Table 17: Injuries in MCIT crisis interactions

Injury type	No. (% of crisis interactions) Total: 3,496 (100.0%)[1]
Serious injury to client, by client	7 (0.2%)
Minor injury to client, by client	49 (1.4%)
Serious injury to client, by others	1 (0.02%)
Minor injury to client, by others	4 (0.1%)
Serious injury to responders or others, by any	0 (0.0%)
Minor injury to responders or others, by any	13 (0.4%)
No injuries	3,425 (97.9%)

[1] Some interactions included multiple injuries

Results on most serious charge laid within MCIT crisis interactions are presented in Table 18. Comparable data for PRU crisis interactions are not presently available. Charges were laid in only 1.6% of interactions. In an additional 0.1% (n=6) of crisis interactions, the client was arrested and released without being charged. These rates of arrest are slightly lower than the 5% arrest rate found in Knoxville, Tennessee's co-responding police-mental health program (2), and are comparable to the 2% arrest rate found in Los Angeles, California (9).

Table 18: Most serious charge laid in MCIT crisis interactions

Most serious charge laid	No. (% of crisis interactions) Total: 3,225(100.0%)
No charges laid	3,187 (98.4%)
Threatening	5 (0.2%)
Assault - major	4 (0.1%)
Assault - minor	4 (0.1%)
Sexual assault	1 (0.0%)
Weapons	1 (0.0%)
Robbery	1 (0.00%)
Other	17 (0.5%)
Charge unknown	19 (0.6%)

Rates of transportation to ED in MCIT crisis interactions are presented in Table 19. MCIT service providers' documentation indicates that individuals are transported to a hospital ED in 38-45% of MCIT crisis interactions, compared to 26.5% (n=4,305) of PRU crisis interactions. The difference in officers' and nurses' documented number of *Total crisis interactions* is due to the omission of NYGH MCIT data from the study's MCIT nurses' dataset; if NYGH MCIT data are also omitted from MCIT officers' dataset, the total numbers of crisis interactions are nearly identical. However, there is a noted discrepancy in proportion of crisis interactions resulting in transportation to ED that cannot be explained by omission of NYGH MCIT data, and may be due to differences in documentation practices of MCIT officers and nurses.

Rates of transportation to ED in MCIT crisis interactions are likely lower than those found in a co-responding police-mental health program in DeKalb County, USA, which found 45% of interactions resulted in hospitalization following transportation to ED (12). However, MCIT's rates of transportation to ED are higher than those found in a similar program in Victoria, BC (11), where only 15% of program interactions resulted in transportation to the ED.

Table 19: Crisis interaction resulted in transportation to a hospital ED

Information source	No., (% of total)
MCIT officer documentation	
Client transported to ED	1,233 (45.2%)
Total crisis interactions	2,726 (100.0%)
MCIT nurse documentation[1]	
Client transported to ED	944 (38.4%)
Total crisis interactions	2,460 (100.0%)

[1] Data on NYGH MCIT clients' interactions are not represented here

The study was able to obtain some data on the rates of hospitalization following presentation to the ED, as shown in Table 20 below. Data are only available where the MCIT transported the client to the MCIT nurse's base hospital, which occurred in 50.8% of transportations to ED. In the remaining 49.2% of transportations to ED, data on hospitalizations are unavailable. For example, if the HRH MCIT transported a client to HRH, that visit is included in the below table. If the HRH MCIT transported a client to any other hospital, that visit is excluded from the below table.

Table 20: Rates of hospitalization following transportation to MCIT's base hospital ED (MCIT crisis interactions only)

Result of transportation to ED	No. (%) Total: 480 (100.0%)[1]
Client admitted to hospital	183 (38.1%)
Client not admitted to hospital	99 (20.1%)
Unknown	198 (41.3%)

[1] Data on NYGH MCIT clients' interactions are not represented here

Where MCIT crisis interactions resulted in transportation to a hospital ED, the proportions received by each hospital can be seen in Table 21. Variability may be due to the hospital's placement in

relation to areas with a higher frequency of mental health crisis interactions, client needs and preferences, and hospitals' reputations for length of time that responders typically wait before transferring custody of the client.

Table 21: Hospital ED receiving clients from MCIT crisis interactions

Hospital ED	No. (%) Total: 1,178 (100.0%)
Humber River Hospital	203 (17.2%)
North York General Hospital	139 (11.8%)
The Scarborough Hospital	58 (5.0%)
St. Joseph's Health Centre	92 (7.8%)
St. Michael's Hospital	134 (11.4%)
Toronto East General Hospital	120 (10.2%)
Centre for Addiction and Mental Health	159 (13.5%)
Mount Sinai	58 (4.9%)
Rouge Valley Health System (Centenary)	119 (10.1%)
Sick Kids	1 (0.1%)
Sunnybrook Hospital	35 (3.0%)
Toronto General Hospital	7 (0.6%)
Toronto Western General Hospital	53 (4.5%)

SUMMARY OF FINDINGS

Experiences of people in crisis:

Regarding client experiences with crisis response services, two key themes emerged. First, clients highly value crisis responders who adopt a supportive and empowering stance, enabling them where possible to regain control. Second, clients value providers who have knowledge of mental health challenges and resources. These interpersonal and practical skills were regularly experienced in MCIT interactions, whereas clients reported greater variability in interactions with PRU and less knowledge of mental health challenges and resources by PRU officers. In general, people in crisis:

- Reported more positive experiences when MCIT and PRU were flexible, responsive to their needs and preferences, and offered non-criminalizing, measured, and appropriate responses.
- Preferred when there were fewer responders rather than more – they often felt overwhelmed or intimidated by larger groups of crisis personnel.
- Felt criminalized by the use of handcuffs and marked police vehicles.
- Emphasized the value of of de-escalation and calming communication, which is possible when more time is invested in an interaction. PRU seemed to be under time pressure in these situations.
- Preferred having a choice of hospital. Current policies encourage MCIT to offer this choice.

The role of MCIT in the broader mental health crisis response system:
Key findings include:

- As a component of TPS crisis response processes, MCIT is seen as a valued asset due to:
    - Their ability to complement the work of PRU and existing police processes;
    - The expertise of mental health nurses both in terms of frontline care and referral to resources;
    - Building TPS capacity in relation to mental health skill sets as trained MCIT officers work with and transfer to other units.
- Currently there are limitations to MCIT's effectiveness within TPS due to:
    - Internal confusion about MCIT's mandate;
    - Limited staffing and hours of operation;
    - Challenges in supervising and supporting MCIT officers.
- MCIT is a small but valued component of the broader crisis system, and most clients and stakeholders agree MCIT is better suited to respond to moderate to serious mental health crises.
- Discussions of the crisis response system as a whole repeatedly drew attention to a perceived inadequacy in crisis prevention, and perceptions that timely and high-quality mental health services, including crisis services, are insufficiently available in hospital and community settings.

Findings: Administrative data

MCIT and PRU teams document their contacts with people in crisis. Several key findings can inform future planning of an adequate crisis response system:

- From July 2014 to March 2015, the Toronto MCIT attended 2,774 crisis interactions and completed more than 525 follow-up contacts, compared to 16,226 crisis interactions attended by PRU.
- MCIT facilitated approximately 1,256 connections to community-based services, including completion of 891 referrals for new health and social services.
- 29% of MCIT crisis interactions were with repeat clients.
- Clients were transported to a hospital ED for further assessment in 38-45% of MCIT crisis interactions, compared to 27% of PRU interactions.
- Compared to PRU crisis interactions, MCIT was less likely to make a Section 17 apprehension, that is, to obligate a client to attend a hospital Emergency Department (ED) under the Mental Health Act, and more likely than PRU to bring a client to hospital voluntarily.
- ED wait times were shorter for MCIT, who reported a mean wait time of 56 minutes, compared to 85 minutes for PRU.
- Over 38% of MCIT escorts to the MCIT's home hospital resulted in hospitalization.
- Though comparable data on PRU interactions are not currently available, MCIT interactions demonstrate positive outcomes in several other key indicators. Injuries to clients, crisis responders, or others occurred in only 2% of MCIT crisis interactions, and charges were laid in less than 2% of MCIT crisis interactions.

RECOMMENDATIONS

Study findings support a series of recommendations for policy and practice relevant to MCIT and crisis response services. These recommendations were identified by the study authors in collaboration with the City of Toronto MCIT Community Advisory Committee, MCIT Steering Committee, and MCIT Evaluation Working Group. Recommendations are followed by comments on areas of alignment with recommendations recently developed by The Honourable Frank Iacobucci in his independent review of police encounters with people experiencing crisis (20).

CURRENT RECOMMENDATIONS

Recommendations are organized within five themes: training and education; matching crisis needs to appropriate and measured responses; availability and flexibility of crisis responders; referrals to community based services; and crisis response planning and community engagement. It is recommended that:

Training and education

1. TPS conduct an assessment of PRU training curricula relevant to mental health with consultation from professionals in mental health service and adult education. Recommendations for improvements to training can be informed by these professionals as well as mental health service users and their families. This assessment would pay particular attention to:
    a. Materials and processes for teaching trauma-informed and anti-oppressive approaches to crisis response, with the objective of building strong practical and interpersonal skills in working with people experiencing mental health crises, as well as combatting stigma of mental health challenges.
    b. Materials and processes for teaching communication and de-escalation within crisis situations, with the objective of enhancing client comfort and protecting the safety of clients and crisis responders.

2. PRU officers undergo "ride-alongs" with MCIT to allow direct observation of skilled crisis response practices in action.

3. Effective management of mental health crisis interactions is explicitly and consistently included in formal and informal communications regarding frontline TPS officers' duties, and these expectations are reinforced through job performance assessments. These interactions warrant the same levels of officers' attention as other calls for police service.

4. MCIT mandate and work processes be thoroughly communicated to PRU officers.

Matching crisis need to appropriate and measured response

5. Reduce handcuff use for interactions involving mental health. This may include requiring justification for officers' decisions to use handcuffs in these interactions.

6. MCIT officers and/or nurses wear plainclothes in order to reduce the fear and intimidation experienced by some clients, reduce the impact of stigma associated with police interactions, and visibly differentiate MCIT from a police response.

7. When dispatching PRU officers, TPS dispatchers remind PRU to consider, upon arrival, whether the interaction would benefit from MCIT intervention.

Availability and flexibility of crisis responders

8. Availability of MCIT services be increased by extending hours of operation.

9. Clients' choice of hospital be considered when PRU officers are transporting clients to hospital EDs for assessment.

10. Supervisors of PRU officers encourage responding units to invest adequate time into calls involving mental health to allow calm, thorough and appropriate communication with clients, and reduce likelihood of adverse outcomes for clients and officers.

Referrals to community-based services

11. MCIT increase ease and rates of referrals through development of a robust and location-specific toolbox of available resources. This may include psychiatric outpatient program offering rapid access, drop-in peer support programs, and pre-charge diversion programs.

12. MCIT consider partnerships with community-based crisis support agencies, such as Gerstein Crisis Centre and The Scarborough Hospital's Regional/Mobile Crisis Program, as well as other distress lines.

13. MCIT consider partnership with a centralized service referral organization such as The Toronto Mental Health and Addictions Access Point (also known as The Access Point) or community-based service providers in order to increase rates of service referrals for clients not connected to other services.

Crisis response planning and community engagement

14. MCIT Steering Committee include representation from participating hospitals' client or consumer advisory panels and mental health service user initiatives that are actively involved in the area of policing and mental health, such as Sound Times, Voices from the Street, and the Empowerment Council.

15. Explore possibility of designating a subset of PRU officers to attend interactions where mental health may be a relevant factor, similar to the Memphis/Hamilton model for police responses to mental health crises.

16. MCIT to host and/or attend events for people living with mental health challenges and their support networks. This would allow the population served by MCIT to become familiar with the program and enhance community engagement.

17. LHINs with jurisdiction in Toronto and TPS jointly develop a standardized approach to reducing the length of time spent by police officers waiting in hospital Emergency Departments before transfer of care. This may be piloted at hospitals already receiving high numbers of clients with police.

NEXT STEPS

A mapping of the crisis response system and current organizational capacity in Toronto, coupled with a review of crisis response systems in other jurisdictions, including evidence supported interventions, is needed to guide further steps in planning a high quality, comprehensive, and evidence-informed crisis system in Toronto.

A NOTE OF CAUTION

1. Education and training alone, without parallel attention to prevailing organizational cultures, are unlikely to affect improvements needed in providing appropriate crisis response and in decriminalizing mental illness.

2. Organizational consultations might be helpful in identifying opportunities to enhance organizational learning capacity for embracing a culture of inclusion, and opportunities to reflect on the use of language to inform practice in community, hospital and police settings.

3. Crisis response systems without access to timely psychiatric consultations are unlikely to reduce reliance on the ED for an assessment.

CURRENT RECOMMENDATIONS' AREAS OF ALIGNMENT WITH RECOMMENDATIONS MADE BY THE HONOURABLE FRANK IACOBUCCI

In his independent review of police encounters with people experiencing mental health crises , The Honourable Frank Iacobucci offered a series of 84 recommendations to Toronto Police Service to grow capacity in this area of their work (20). There are some noted areas of alignment with recommendations developed from the current study. These include further attention to training for both newly recruited and current officers on communication and de-escalation skills specific to EDP interactions, as well as a review of usage of police equipment including handcuffs in Procedure 06-04 "Emotionally Disturbed Persons". Additionally, increased attention to efforts to decrease stigma of mental health challenges and enhanced community engagement amongst people with lived experience of mental health challenges will be valuable investments. Justice Iacobucci's report highlighted that continual improvement of work culture around mental health is paramount in making space for positive change in frontline practices.

Justice Iacobucci's report also emphasized that MCIT is a vital resource in work involving people in crisis, and should be furthered. There is ample opportunity to increase MCIT engagements by involving supervisory and coach officers in promoting MCIT and ensuring that all frontline officers are aware of this valuable resource. This increased awareness may be coupled with mandating PRU officers to assess appropriateness of the situation for MCIT involvement, and if appropriate, requesting MCIT. To address a heightened demand for MCIT, the teams' availability would need to be increased in staffing and hours of operation. However, MCIT may not be necessary or available for all crisis interactions, and TPS may benefit from piloting a second Crisis Intervention Team comprised solely of specially trained TPS officers, similar to the Memphis/Hamilton model.

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APPENDIX A: Service Referrals and Connections by Hospital

SECTION 1: FORMAL SERVICE REFERRALS

MCIT may complete a formal service referral, defined as one requiring a referral form or intake appointment. Formal service referrals are typically required to access services such as a new primary care physician or short-term housing.

Table 1. Referrals to shelters

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person, No. (% of interaction type)	Follow-up: Telephone, No. (% of interaction type)	
HRH/12, 13, 23, 31				
Shelter referral completed	12 (2.5%)	0 (0.0%)	0 (0.0%)	12 (2.2%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Shelter referral completed	7 (1.4%)	2 (2.0%)	0 (0.0%)	9 (1.4%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Shelter referral completed	6 (1.5%)	0 (0.0%)	0 (0.0%)	6 (1.1%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	557 (100.0%)
SMH/51, 52				
Shelter referral completed	18 (3.6%)	0 (0.0%)	0 (0.0%)	18 (3.2%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
Shelter referral completed	13 (2.4%)	2 (3.0%)	0 (0.0%)	15 (2.2%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684 (100.0%)
TOTAL				
Shelter referral completed	56 (2.3%)	4 (1.3%)	0 (0.0%)	60 (100.0%)
Total interactions	2460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

Table 2: Referrals to Mental Health and Justice Network (MHJN)

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person, No. (% of interaction type)	Follow-up: Telephone, No. (% of interaction type)	
HRH/12, 13, 23, 31				
MHJN referral completed	2 (0.4%)	0 (0.0%)	0 (0.0%)	2 (0.4)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
MHJN referral completed	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
MHJN referral completed	4 (1.0%)	1 (1.1%)	0 (0.0%)	5 (0.9%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
MHJN referral completed	4 (0.8%)	0 (0.0%)	0 (0.0%)	4 (0.7%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
MHJN referral completed	10 (1.8%)	0 (0.0%)	0 (0.0%)	10 (1.5%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
MHJN referral completed	20 (0.8%)	1 (0.3%)	0 (0.0%)	21 (0.7%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

Table 3: Referrals to community crisis services

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person, No. (% of interaction type)	Follow-up: Telephone, No. (% of interaction type)	
HRH/12, 13, 23, 31				
Crisis service referral completed	7 (1.5%)	0 (0.0%)	0 (0.0%)	7 (1.3%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Crisis service referral completed	185 (35.7%)	29 (29.0%)	6 (30.0%)	220 (100.0%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Crisis service referral completed	30 (7.3%)	4 (4.6%)	2 (3.0%)	36 (6.4%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Crisis service referral completed	27 (5.4%)	0 (0.0%)	0 (0.0%)	27 (4.8%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
Crisis service referral completed	109 (19.9%)	6 (9.1%)	8 (11.6%)	123 (18.0%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Crisis service referral completed	358 (14.6%)	39 (12.6%)	16 (7.4%)	413 (13.8%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

Table 4: Referrals to community mental health services

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person, No. (% of interaction type)	Follow-up: Telephone, No. (% of interaction type)	
HRH/12, 13, 23, 31				
Mental health service referral completed	9 (1.9%)	0 (0.0%)	0 (0.0%)	9 (1.7%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Mental health service referral completed	21 (4.1%)	10 (10.0%)	1 (5.0%)	32 (5.0%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Mental health service referral completed	25 (6.1%)	4 (4.6%)	2 (3.0%)	31 (5.5%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Mental health service referral completed	13 (2.6%)	4 (25.0%)	0 (0.0%)	17 (3.0%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
Mental health service referral completed	54 (9.8%)	9 (13.6%)	3 (4.3%)	66 (9.6%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Mental health service referral completed	122 (5.0%)	27 (8.7%)	6 (2.8%)	155 (5.2%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

Table 5: Referrals to community addictions services

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person No. (% of interaction type)	Follow-up: Telephone No. (% of interaction type)	
HRH/12, 13, 23, 31				
Addictions service referral completed	2 (0.4%)	0 (0.0%)	0 (0.0%)	2 (0.4%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Addictions service referral completed	16 (3.1%)	1 (1.0%)	0 (0.0%)	17 (2.7%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Addictions service referral completed	3 (0.7%)	0 (0.0%)	0 (0.0%)	3 (0.5%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Addictions service referral completed	4 (0.8%)	0 (0.0%)	0 (0.0%)	4 (0.7%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
Addictions service referral completed	9 (1.6%)	1 (1.5%)	0 (0.0%)	10 (1.5%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Addictions service referral completed	34 (1.4%)	2 (0.6%)	0 (0.0%)	36 (1.2%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

Table 6: Referrals to services not classified elsewhere

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person No. (% of interaction type)	Follow-up: Telephone No. (% of interaction type)	
HRH/12, 13, 23, 31				
Other service referral completed	67 (13.9%)	9 (22.5%)	5 (29.4%)	81 (15.1%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Other service referral completed	31 (6.0%)	3 (3.0%)	0 (0.0%)	34 (5.3%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Other service referral completed	41 (10.0%)	11 (12.6%)	4 (6.0%)	56 (9.9%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Other service referral completed	12 (2.4%)	3 (18.8%)	0 (0.0%)	15 (2.7%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
Other service referral completed	134 (24.4%)	20 (30.3%)	15 (21.7%)	169 (24.7%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Other service referral completed	285 (11.6%)	46 (14.9%)	24 (11.1%)	355 (11.9%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

Table 7: Formal referrals to any of the above services (Summary indicator)

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person No. (% of interaction type)	Follow-up: Telephone No. (% of interaction type)	
HRH/12, 13, 23, 31				
Any service referral completed	93 (19.3%)	9 (22.5%)	5 (29.4%)	107 (19.9%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Any service referral completed	239 (46.1%)	41 (41.0%)	7 (35.0%)	287 (45.0%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Any service referral completed	92 (22.5%)	19 (21.8%)	8 (11.9%)	119 (21.1%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Any service referral completed	71 (14.1%)	6 (37.5%)	0 (0.0%)	77 (13.7%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55				
Any service referral completed	253 (46.1%)	27 (40.9%)	21 (30.4%)	301 (44.0%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Any service referral completed	748 (30.4%)	102 (33.0%)	41 (19.0%)	891 (29.8%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

SECTION 2: FACILITATING CONNECTIONS TO EXISTING SERVICES

MCIT may support the client in connecting with existing services, including setting an appointment with their current psychiatrist or sharing information on telephone support lines. These processes do not require formal service referrals.

Table 8: Facilitation of service connections to existing services

Hospital/Police divisions	Interaction type			Total, No. (% of total)
	Crisis interaction No. (% of interaction type)	Follow-up: In-person No. (% of interaction type)	Follow-up: Telephone No. (% of interaction type)	
HRH/12, 13, 23, 31				
Informal service referral completed	121 (25.2%)	5 (12.5%)	5 (29.4%)	131 (24.3%)
Total interactions	481 (100.0%)	40 (100.0%)	17 (100.0%)	538 (100.0%)
TSH/41, 42, 43				
Informal service referral completed	139 (26.8%)	40 (40.0%)	2 (10.0%)	181 (28.4%)
Total interactions	518 (100.0%)	100 (100.0%)	20 (100.0%)	638 (100.0%)
SJHC/11, 14, 22				
Informal service referral completed	57 (13.9%)	8 (9.2%)	6 (9.0%)	71 (12.6%)
Total interactions	409 (100.0%)	87 (100.0%)	67 (100.0%)	563 (100.0%)
SMH/51, 52				
Informal service referral completed	105 (20.9%)	4 (25.0%)	2 (4.7%)	111 (19.8%)
Total interactions	503 (100.0%)	16 (100.0%)	43 (100.0%)	562 (100.0%)
TEGH/53, 54, 55[1]				
Informal service referral completed	37 (6.7%)	4 (6.1%)	3 (4.3%)	44 (6.4%)
Total interactions	549 (100.0%)	66 (100.0%)	69 (100.0%)	684(100.0%)
TOTAL				
Informal service referral completed	459 (18.7%)	61 (19.7%)	18 (8.3%)	538 (18.0%)
Total interactions	2,460 (100.0%)	309 (100.0%)	216 (100.0%)	2,985 (100.0%)

[1] TEGH data includes informal service referrals made October 2014 – March 2015 (6/9 months of total study period).

APPENDIX B: Acronyms Used in this Report

MCIT Service Providers

HRH: Humber River Hospital

NYGH: North York General Hospital

SJHC: St. Joseph's Health Centre

SMH: St. Michael's Hospital

TEGH: Toronto East General Hospital

TPS: Toronto Police Service

TSH: The Scarborough Hospital

Other

CRU: Community Response Unit (within Toronto Police Service)

CSO: Community Safety Officer (within Toronto Police Service)

ED: Emergency Department

EDP: Emotionally Disturbed Person

LHIN: Local Health Integration Network

MCIT: Mobile Crisis Intervention Team

MHA: Mental Health Act

MHJN: Mental Health and Justice Network

PRU: Primary Response Unit (within Toronto Police Service)

REB: Research Ethics Board