An Evaluation of the Community Outreach and Support Team in London, Ontario

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Executive Summary

1. The Community Outreach and Support Team (COAST) operating in London, Ontario is intended to be a healthcare-led, police-supported program that attempts to provide proactive support to individuals in the community who are at risk of requiring police-led responses to their mental health issues or crises. The program is a partnership between the London Police Service (LPS), St. Joseph's Health Care London (St. Joseph's), the Canadian Mental Health Association Thames Valley Addiction and Mental Health Services (CMHA TVAMS), and the Middlesex-London Paramedic Service (MLPS).

2. The primary goals of the COAST are: (1) to reduce the requirement of LPS responses to individuals living in the community with mental health issues or experiencing a crisis, (2) to minimize high risk interactions (e.g., involuntary apprehensions) between frontline LPS officers and individuals with a mental illness or experiencing a crisis, and (3) to improve outcomes for individuals living in the community with a mental illness or experiencing a crisis who require assistance.

3. To assess whether the COAST is meeting its objectives, a multi-component, mixed-methods, pre-post evaluation of the program was conducted. The evaluation was designed to answer four fundamental questions: (1) Does the COAST decrease the need for a police-led response to individuals living in the community with a mental illness or experiencing a crisis?; (2) Does the COAST enhance the community mental health services and local hospital support provided to individuals living in the community with a mental illness or experiencing a crisis?; (3) Does the COAST provide a better experience (and outcomes) for individuals living in the community with a mental illness or experiencing a crisis who require additional supports?; and (4) Does the COAST allow frontline responders (e.g., LPS officers, paramedics, crisis workers) in London to manage mental health/crisis calls more effectively?

4. To address these questions, the evaluation included engagement with stakeholders to develop a logic model for the program and an evaluation strategy, a program implementation analysis, an analysis of operational data related to the COAST, pre- and post-implementation surveys of staff from the participating organizations, client satisfaction surveys, post-implementation interviews of staff and clients, and an examination of good news stories about the COAST that were shared with the partner organizations over the previous 15 months.

5. Logic models are used to explain how programs are likely to solve a given problem through their operation in a particular environmental context. The logic model developed for this project includes activities undertaken as part of the COAST program, outputs of the COAST (i.e., "products" produced from program activities), and outcomes of the COAST (i.e., changes expected to result from the program). The

outcomes in the model are listed as short-term (1-6 months), medium-term (6 months-2 years), and long-term (2+ years).

6. A program implementation analysis was conducted to determine if the COAST is operating as originally intended and to highlight contextual factors that may have impacted program implementation. An understanding of these two issues helps to contextualize the findings from the evaluation and generate hypotheses about why the program had the impact it did.

7. The implementation analysis suggests that the way the COAST operates is generally consistent with the original implementation plan. For example, in various ways the COAST is healthcare-led (e.g., with respect to client interactions, program oversight, operational management, and records keeping); the COAST regularly identifies at-risk clients in the community and engages with those individuals; the COAST supports frontline LPS staff in a variety of ways; follow-up calls with clients are a key COAST activity and allow the COAST to check on client well-being, ensure clients are following their care plan, and modify care plans as required; COAST members regularly receive training; the COAST engages in consultations with the broader crisis support community (e.g., to assist other support workers, such as transitional case managers); partner organizations collaborate regularly through the Governance and Steering Committees, and COAST members interact weekly during team meetings; and the COAST is monitored through regular data collection and analysis.

8. Deviations from the original implementation plan were also identified. For example, the COAST took on a reactive role (e.g., taking calls out of the LPS call queue) in addition to their proactive role earlier than anticipated; transportation of clients (e.g., to hospital) has deviated from the original plan due to COVID-19 restrictions and COAST vehicles not being properly equipped to transport; the COAST executes less mental health forms than originally expected and rarely relieves LPS officers with hospital handovers; the COAST delivers little training to other first responders (e.g., from partner organizations); and various deviations exist with respect to data-related issues (e.g., more limited access to clinical information than expected, additional data being collected on clients).

9. Various contextual factors influenced how the COAST was implemented, how it currently operates, or how it was/is likely received by those in the community. Some of these factors relate to global issues (e.g., reactions to high-profile police-involved deaths), some relate to provincial or local issues (e.g., managing restrictive COVID-19 measures), and some relate to organizational issues (e.g., lack of MLPS involvement in the COAST during certain time periods).

10. Operational data collected by the LPS and the CMHA TVAMHS between April 2021 and June 2022 suggests that the COAST is interacting with clients on a regular basis; most commonly, the COAST is interacting with each client once a month, but there

are a significant number of clients who the COAST interacts with multiple times a month; the COAST regularly receives referrals from LPS officers and the team is increasingly taking calls out of the LPS call queue; the COAST executes mental health forms (2, 9, 47) infrequently; the COAST also rarely gets involved in high-risk occurrences or hospital takeovers from LPS officers, but they are frequently involved in follow-ups with clients following their interactions with LPS officers; the COAST regularly interacts with people from LPS' list of prolific individuals, but the team is rarely involved with apprehensions; LPS officers who work on the COAST have not reported any use of force incidents since the program was implemented; COAST members regularly receive training, but rarely provide training to staff within the partner organizations; the partner organizations frequently collaborate with one another through meetings of the Governance and Steering Committees, and COAST members interact frequently during weekly meetings; and COAST data is regularly tracked and used to evaluate the program and modify program activities as necessary.

11. Pre- and post-implementation surveys were distributed to ask frontline staff from the partner organizations about their views of mental health supports, mental health/crisis calls, and the role of the partner organizations in these calls. These surveys indicated that staff from each of the organizations are mostly aware of the various mental health resources that are available to support clients, they often use these resources, and they generally perceive these resources to be effective. The only resource where significant issues exist, with respect to awareness, use, and perceived effectiveness, is the Connectivity Table.

12. When examining perceptions of mental health/crisis calls (e.g., whether staff feel safe when responding to these calls) and the organizations that play a role in managing these calls (e.g., the quality of police-hospital communications), very few significant differences were observed between the pre- and post-implementation surveys. This may reflect the inadequacies of survey methodology, indicate that the COAST does not impact the sorts of outcomes asked about on the surveys, or suggest its impact will only be realized once the COAST is adequately resourced (i.e., additional members) or has operated over a longer timeframe.

13. Various challenges associated with the COAST were identified by survey respondents, including views that COAST services are not always available due to limited staffing and that some people are confused about what the COAST does and does not do and how it complements existing support programs. Various impacts of the COAST were also identified, including views by some that the COAST results in better client outcomes (compared to "business as usual" approaches) and that COAST members are seen as less threatening by clients (compared to frontline LPS officers).

14. Client satisfaction surveys were also conducted. Most clients who were surveyed are satisfied with the COAST, satisfied with the explanations they receive from the COAST about available support services, and satisfied with how the COAST helps them understand available supports and how to access them. Most clients also indicated they did not need to attend the hospital within three days of interacting with the COAST or contact the police within three days of interacting with the COAST, providing some evidence of short-term diversion away from hospitals and the police. When asked what they would have done if COAST was not available for them, most clients indicated they would have called 911, tried to deal with the problem themselves, or would have called a crisis line. Approximately half the clients surveyed followed up with the supports provided by the COAST and indicated that further COAST support would be beneficial. Nearly all the surveyed clients indicated that, if needed, they would engage with the COAST again. Most open-ended comments about the COAST from clients were positive, but negative comments were also made. Most positive comments related to the compassion and kindness exhibited by the COAST and the value of the program generally. Most negative comments related to the lack of COAST availability and improvements that could be made to how the COAST interacts with clients (e.g., quicker follow-ups).

15. Post-implementation interviews were conducted with 32 staff members from the partner organizations and 6 COAST clients. The interviews were conducted primarily to examine perceptions of the COAST and how it operates.

16. The analysis of interviews with staff members from the partner organizations and clients who have used the COAST revealed 10 major themes, several of which had sub-themes. The identified themes suggest that the COAST is filling a gap in the London community and offering client-centered support, which has made a meaningful difference in the lives of individuals, including members of the COAST, staff in the partner organizations, staff in the hospitals, and most importantly clients who have relied on the COAST. The identified themes also suggest that the COAST is an evolving program, which is constantly adapting to emerging issues to better serve the needs of the London community. Several themes were identified that highlight key issues that should be considered as the COAST continues to evolve and adapt, including: (1) refining the mandate of the COAST, (2) providing more effective communication about the COAST to reduce confusion about its role, (3) exploring directions where there is potential for the COAST to have an impact, but that potential has not yet been realized, and (4) considering opportunities for COAST expansion to the extent that is feasible. Themes were also identified, which highlight that the impact of the COAST is affected by two overarching issues, a lack of sustainable program funding and issues associated with a healthcare system that is currently overwhelmed.

17. Numerous good new stories were shared with the partner organizations throughout the last 15 months. These stories came from clients who interacted with the COAST,

families of these clients, community agencies, and staff from the partner organizations. These stories reveal the positive impact that the COAST can have and highlight the diversity of people and situations that COAST members encounter.

18. Collectively, the data generated from the evaluation allowed us to answer key questions. Does the COAST decrease the need for a police-led response to individuals living in the community with a mental illness or experiencing a crisis? Yes, it appears to, although the decrease seems to be limited by the current size of the COAST (i.e., the decrease would be even greater if the COAST was larger and thus, more available). Does the COAST enhance the community mental health services and local hospital support provided to individuals living in the community with a mental illness or experiencing a crisis? The evidence is mixed. Does the COAST provide a better experience (and outcomes) for individuals living in the community with a mental illness or experiencing a crisis who require additional supports? The answer appears to be an overwhelming yes. (4) Does the COAST allow frontline responders (e.g., LPS officers, paramedics, crisis workers) in London to manage mental health/crisis calls more effectively? Again, the evidence is mixed.

19. Data from each of the data sources is drawn on to make various recommendations for how COAST operations and monitoring can be improved in the short- and long-term. If acted upon, these recommendations should allow the COAST to have an even bigger impact on the lives of people in need and benefit the broader ecosystem of crisis support services in London.

1. Introduction

In April 2021, the London Police Service (LPS), St. Joseph's Health Care London (St. Joseph's), the Canadian Mental Health Association Thames Valley Addiction and Mental Health Services (CMHA TVAMHS), and the Middlesex-London Paramedic Service (MLPS) rolled out their new healthcare-led, police-supported Community Outreach and Support Team (COAST). This program is intended to provide proactive support to individuals in the London community who are at risk of requiring police-led responses to their mental health issues or crises. The COAST was developed by an Implementation Working Group, which consisted of staff from the four partner organizations. Since implementation, the COAST has been overseen by a Governance Committee, consisting of leaders from the four partner organizations and other stakeholders from the London community, including an individual with lived experience. The day-to-day operations of the COAST are managed by a Steering Committee, which consists of members from the four partner organizations and a London community member.

The COAST has 3 primary goals:

To reduce the requirement of LPS responses to individuals living in the community with mental health issues or experiencing a crisis (i.e., to divert these individuals to community mental health services rather than police services).

To minimize high-risk interactions (e.g., involuntary apprehensions) between frontline LPS officers and individuals with a mental illness or experiencing a crisis.

To improve outcomes for individuals living in the community with a mental illness or experiencing a crisis who require assistance in managing their mental health issues (i.e., divert individuals from hospital support to community mental health services).

With the assistance of funds from the Social Sciences and Humanities Research Council, an evaluation of the COAST was undertaken by the authors to help answer four specific questions. Answers to these questions will better enable the organizations responsible for overseeing and managing the COAST to achieve the goals outlined above.

Does the COAST decrease the need for a police-led response to individuals living in the community with a mental illness or experiencing a crisis?

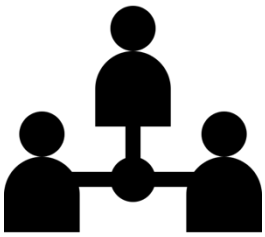
Does the COAST enhance the community mental health services and local hospital support provided to individuals living in the community with a mental illness or experiencing a crisis?

Does the COAST provide a better experience (and outcomes) for individuals living in the community with a mental illness or experiencing a crisis who require additional supports?

Does the COAST allow frontline responders (e.g., LPS officers, paramedics, crisis workers) in London to manage mental health/crisis calls more effectively?

2. Methodology

To address the questions listed above and determine if the goals of the COAST are being achieved, a multi-component, pre-post evaluation of the COAST was conducted. More specifically, the evaluation consisted of the following elements:



Engagement with Stakeholders. Through a formal focus group with the Implementation Working Group and regular attendance at Steering Committee meetings, a logic model was created that made explicit the theory underlying the COAST. An evaluation strategy was also co-developed with stakeholders to meet the needs of the participating organizations and community members requiring COAST services, and implementation issues were examined.

Operational Data. Operational data was collected from the LPS and the CMHA TVAMHS to examine how the COAST was operating. This data includes things like the frequency of interactions with clients, the length of these interactions, and the outcomes associated with these interactions.

Staff Surveys. Pre- and post-implementation staff surveys were conducted to examine, among other things, perceptions of current strategies for managing mental health/crisis calls, strain from having to respond to these calls, comfort level when interacting with people who are in crisis, knowledge of mental health issues and other factors that can contribute to crises, satisfaction with processes involved in managing mental health/crisis calls, and the perceived effectiveness of the COAST (post-implementation only).

Client Surveys. To capture the experience of community members who utilize COAST services, short surveys were used following interactions with COAST members to assess client satisfaction with different aspects of the interaction.

Post-Implementation Interviews. Semi-structured interviews were conducted with staff from each partner organization, COAST members, and a sample of clients who utilized COAST services. Staff and COAST interviews allowed us to gain a better understanding of how the COAST was operating, its perceived impact, challenges associated with the program, etc. Client interviews allowed us to further assess their satisfaction with COAST interactions in comparison to interactions with frontline LPS officers.

Good News Stories. Since the program was implemented, various individuals and groups have contacted the COAST partners to share stories of how the program has impacted them.

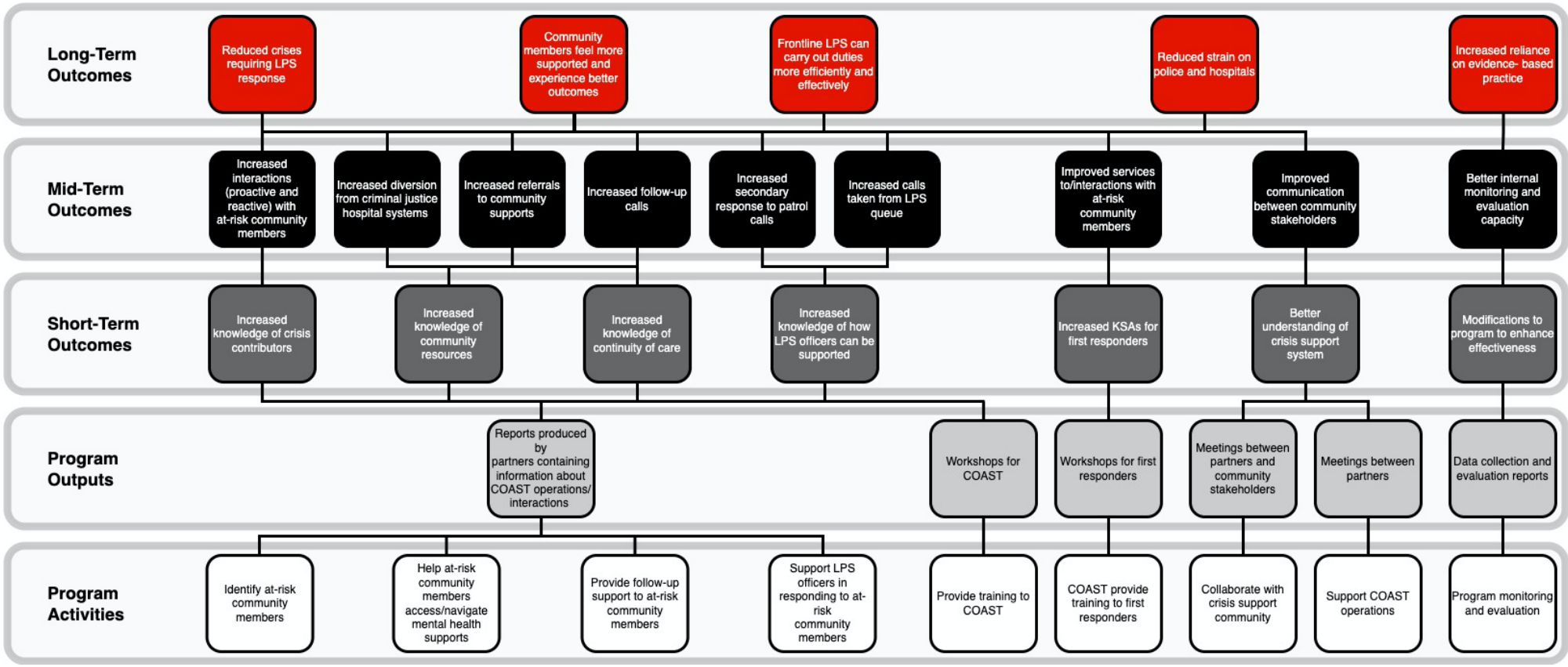
3. Logic Model

One of the key steps in the development of a program evaluation strategy is the creation of a logic model. Logic models are used to explain how programs are likely to solve a given problem through their operation in a particular environmental context. The logic model that guided the current evaluation was co-created with members of the COAST Implementation Working Group and members of the Steering Committee. While the logic model is a living document that is subject to change as program operation does over time, the current draft of the logic model is presented in Figure 1. The model includes activities undertaken as part of the COAST program, outputs of the program (i.e., "products" produced from program activities), and outcomes of the program (i.e., changes expected to result from the program). The outcomes are listed as short-term (1-6 months), medium-term (6 months-2 years), and long-term (2+ years).

In summary, Figure 1 suggests that by identifying community members in London who are at risk of experiencing crises (including mental health crises) that will likely result in a response from the LPS, by helping those individuals access and navigate mental health supports before, during, and after their crisis, and by supporting frontline LPS officers in managing mental health/crisis calls, the COAST is expected to reduce the number of crises over the long-term that require an LPS response, increase the degree to which community members in need feel supported and experience better outcomes, and allow LPS officers to carry out their other policing duties more efficiently and effectively. In addition, delivery of training to COAST members, which is designed to enhance knowledge of crisis vulnerability factors, awareness of local resources, how those resources can be leveraged for long-term care, and self-efficacy in interacting with individuals experiencing crises, should lead to these same outcomes. Furthermore, through training provided by the COAST to first responders, and increased opportunities for stakeholder interaction and collaboration, the COAST is expected to improve services to community members in need and increase the quality of communication between stakeholders, which should reduce system strain. Finally, by carefully monitoring and evaluating the COAST program, partner organizations should be able to develop their capacity to rely on evidence-based practices to manage the needs of community members in London who experience serious crises.

The evaluation was designed to test these assumptions.

Figure 1. Current Logic Model for the COAST



4. Implementation Analysis

An implementation analysis is an important component of program evaluation. In the current case, the analysis will: (1) provide information about how the COAST was intended to be implemented versus how it actually operates, and (2) consider contextual factors that may have impacted program implementation (and the evaluation). By examining these two issues, the implementation analysis will help contextualize the findings from the evaluation and generate hypotheses about why the program had the impact it did.

4.1. Adherence to the Implementation Plan

In this section, we draw on various data sources to determine if the COAST was implemented in the way that was initially intended. More specifically, we are interested in determining whether COAST members participate in the sorts of activities included in the logic model (see above) and whether additional tasks have been taken on by COAST members. If the COAST does not operate in accordance with the original implementation plan, it is important to consider this when reviewing the evaluation findings.

4.1.1. Focus Group Data

A focus group session that involved members of the Implementation Working group was held on November 19, 2021, to examine: (1) how the COAST was implemented, (2) challenges faced by the group during the implementation phase, and (3) how these challenges were managed. While the official start date for the COAST was delayed by several months due to the COVID-19 pandemic, the results from this focus group session did not reveal any other significant problems with implementing the COAST in the way that was generally intended. This is not to say that minor challenges were not encountered during implementation and continue to be encountered today.

Key findings from the focus group, which relate to the implementation analysis, include:

- There was consensus among focus group members that the COAST is in fact healthcare-led (for a different view, see Section 4.1.2. and the staff interviews in Section 8).[1] The group felt the healthcare members of the team often take the primary lead in supporting clients. There were some noted exceptions to this, however, such as when apprehensions are made (given that police officers are the only ones allowed to apprehend individuals under the Mental Health Act). It was also noted that, over time, police members have become increasingly more

[1] As discussed in Section 8, some interviewees expressed that the direction of the COAST has changed over time to be more reactive and police-led. In particular, some felt that the decision to take calls out of the LPS call queue was premature and was made to satisfy the needs of the LPS.

involved in providing care to clients, as they gained experience with their role and received more mental health training.

- The group felt that the healthcare focus of the COAST extends to oversight and management responsibilities. For example, the group highlighted the fact that the Governance and Steering Committees were also healthcare-led in that the co-chairs of both committees are from St. Joseph's and the CMHA TVAMHS. Some members of the focus group also indicated that the emphasis on healthcare also extends to records keeping, which is managed through the CMHA TVAMHS rather than the LPS.[2]
- The focus group discussed several documents that were developed to assist with program implementation. For example, a Memorandum of Understanding (MOU) between the partner organizations was developed before the COAST was implemented to ensure senior leaders from each agency were on board with the implementation plan. In addition, Standard Operating Procedures (SOPs) were crafted to ensure that the COAST operates as intended. Importantly, the SOPs include details about the roles and responsibilities of each partner organization. While the focus group members indicated that the SOPs have changed (in practice) since the COAST was implemented, these changes have been relatively minor and do not appear to impact the fundamental nature of the COAST. [As noted below, one exception to this is that the COAST has assumed a reactive role in addition to their proactive role. While there were discussions of this happening at some point, this was done earlier than expected.]
- Focus group members discussed the fact that significant effort was invested in ensuring that the right team members were in place to deliver on the activities outlined in the logic model (in terms of knowledge and skills, but also passion and core values). There was agreement among focus group members that this was accomplished and that it was having a significant, positive impact on COAST operations.
- Focus group members who are responsible for the day-to-day management of the COAST reported that each shift involves both phone and face-to-face interactions with community members in need. These interactions are often generated by referrals from the LPS, community members, businesses, and other partner organizations, or they are self-generated (by the COAST). A key part of each shift involves follow-up calls to check-in on community members who have interacted with the COAST, to ensure they are following through on their care plan and to modify that care plan as required based on identified barriers to care. These follow-up calls are also designed to minimize 911 calls from people in crisis, which decreases the pressure on LPS resources.
- To provide a better experience to community members in need, attempts were made by the Implementation Working Group to ensure that community members

[2] Other aspects of the evaluation suggest that, to some extent, this has changed over time. Over the last 15 months, LPS gradually began to collect more information on COAST-related calls, not only to better capture what their officers were doing, but also in the event that oversight bodies needed to investigate an incident.

feel comfortable with COAST members. For example, a lot of time was spent on uniform and vehicle decisions to make sure that interactions with COAST members were non-threatening and did not leave clients feeling unnecessarily stigmatized or criminalized (while still ensuring that members are safe).

- With respect to collaboration, focus group members highlighted the weekly team meetings that are held for COAST members. The primary goal of these meetings is to ensure that everyone is "on the same page and moving in the same direction". These meetings allow COAST members to brainstorm solutions to issues being encountered by the team and to develop care plans with input from diverse perspectives (e.g., nursing, social work, policing). Active clients are discussed at these meetings to ensure that all COAST members are following the same care plan.
- According to focus group members, COAST training has been a priority, both at the on-boarding stage and throughout its operation. Training needs are decided upon by all partner organizations. There was agreement that this training has allowed COAST members to "stay on the right side of legislation" and have the information they needed to make good decisions. Notably, COAST members have also received training in anticipation of COAST mandate expansion (e.g., eventually serving community members under 16).
- Program monitoring, including this evaluation, was seen as a key program activity from the earliest discussions about the COAST according to focus group members. To reflect this, evaluation activities were built directly into the MOU and SOPs.
- Challenges associated with program funding and the COVID-19 pandemic have created difficulties for COAST operations (see Section 4.2.). For example, some of the partner organizations experienced staff shortages due to COVID-19 and strict pandemic protocols created transportation challenges (e.g., COAST members were sometimes required to drive in separate vehicles, and it has been challenging to transport clients).

4.1.2. Steering Committee Meeting Data

Steering Committee meetings were also regularly attended by the evaluation team since program inception. One of the key reasons for doing so was to determine if the COAST was operating in the way that was originally intended, and to understand why deviations from the initial implementation plan were occurring. Two meetings, which took place in May 2022 were particularly relevant for the implementation analysis. At these meetings, COAST SOPs were reviewed and changes to these procedures were discussed. These changes included:

- Initially, the COAST was intended to be very proactive, focused primarily on preventing crises from occurring in the first place, or minimizing the seriousness of crises that did occur so that they did not require an LPS response. However, over time, LPS call volume has resulted in the COAST responding to calls taken from the LPS call queue, creating more of a hybrid reactive-proactive model.

- Consistent with what we heard in the focus group, community members have not been able to be transported by the COAST (e.g., to hospital) due to COVID-19 restrictions and the COAST van not being properly outfitted for this purpose. Instead, the team has relied on frontline LPS officers, the Crisis Response Team, or the MLPS for this purpose, none of which are ideal for community members. Not only do community members have to wait for these other resources to be called out, in some cases these resources may be stigmatizing (i.e., transport in a LPS cruiser).
- Originally, the COAST was supposed to execute various mental health forms (2, 9, 47), but it was quickly determined that this was not necessarily the best use of COAST resources, so they execute very few forms at present (see Section 5). In many cases, these types of calls were requiring the presence of frontline LPS officers anyway, so having COAST assist with these calls was not relieving the pressure on LPS. The same thing occurred with hospital takeovers. Initially, the COAST was relieving frontline LPS officers at the hospital. However, hospital handover protocols do not currently differ for COAST members, and hospital staff do not always know who the COAST members are, so wait times did not speed up because of these takeovers. Such takeovers now happen infrequently (see Section 5).
- While initially focused on adult clients (i.e., those over 16 years of age), the partner organizations are recognizing other population needs, such as youth under the age of 16 years who may benefit from the COAST approach. As noted above, in anticipation of meeting this need with enhanced and sustainable funding, COAST members have received relevant training.
- Despite initial intentions, the COAST has engaged in almost no training of frontline staff in the partner organizations, although they did help educate some staff about who they were and what they do when the COAST was first implemented. There are plans for the COAST to provide additional training soon (e.g., on the interRAI Brief Mental Health Screener). COAST members have made some presentations to other community agencies (e.g., Parkwood Family Council).
- To a greater extent than anticipated, COAST members have been used for case consultations to assist other support workers who are engaged with the same clients (e.g., transitional case managers). The COAST also occasionally assists in the Crisis Center in “all hands-on deck” situations, which was not originally intended.
- Initially, there was an expectation that COAST members would be able to leverage more clinical information about clients from available systems at St. Joseph’s and the CMHA TVAMHS, but various challenges related to file access and privacy (reflecting legislative barriers) have limited the extent to which this is possible.
- Reporting practices related to the COAST have changed in some of the partner organizations. For example, for evaluation purposes, the LPS and the CMHA TVAMHS now collect additional information about COAST calls and the LPS has started to record information about client interactions in order to document police work, which can assist frontline officers (e.g., by providing information on triggers,

helpful hints for building rapport) and in the event that such information is required by oversight bodies.
- Notably, while the various changes in COAST practices outlined above have occurred since program inception, it was clear from the meetings we attended that formal revisions to the written SOPs have yet to be made.

4.1.3. Operational Data

As discussed more thoroughly in Section 5, operational data was also collected to assess how the COAST was being implemented. This data covers the period from April 2021 to June 2022. Collectively, this data suggests that the COAST is generally operating in the way that was intended (i.e., in line with the activities outlined in the logic model). For example:

- The COAST is effectively identifying and providing support to many individuals in need within the London community each month (consistently between 100-150 individuals per month). Consistent with the focus group session, the data suggests that these interactions take place over the phone and in a face-to-face format. The COAST has also been interacting with a reasonable number of unique individuals each month (consistently between 40-80 individuals per month). We have been informed that the current volume of calls reflects COAST capacity.
- Many COAST interactions appear to be proactive in nature and a lot of time appears to be dedicated to follow-up activities to ensure that community members who have had contact with the COAST are doing well, and that the agreed upon care plan is proving effective. Modifications to these plans are made as required.
- COAST members are interacting with people in crisis in a variety of ways. These include assisting frontline LPS officers with high-risk occurrences, helping with hospital handovers to some extent, and following up with community members after they have interacted with LPS officers.
- Despite interacting with many members of the London community, the COAST has recorded no instances of use of force since inception. This is likely due to a variety of factors: the knowledge and skills COAST members draw on during interactions with community members, the compassionate approach they take when interacting with these individuals, and the fact that the COAST tends to respond to situations that are usually not high risk.
- In line with initial expectations, and consistent with the focus group data and SOPs, COAST members are exposed to regular training, having received training in 8 out of the 15 months since program inception.
- Consistent with the logic model, a high degree of interaction is taking place between the partner organizations responsible for the COAST and the broader crisis support ecosystem in London. Partner collaboration is facilitated by monthly meetings of the Governance and Steering Committees and weekly meetings involving COAST members. As highlighted above, the COAST is also engaged in

case consultations on a regular basis with a variety of care providers (e.g., transitional case managers).
- As is obvious in Section 5, regular evaluation of the COAST appears to be a priority. Those responsible for overseeing the COAST have been tracking data associated with its operation on a consistent basis, including collecting data from clients using client satisfaction surveys. Through the Steering Committee, these individuals have also been working closely with the evaluation team to facilitate data collection and analysis for the purpose of this evaluation.

In contrast to the operational data spoken to above, there are also instances where this data suggests that the COAST is operating in a manner that is different from what was originally intended. The most obvious discrepancies include:

- Consistent with what we heard during the meetings where SOPs were discussed, in addition to their proactive work, the COAST is also engaging with community members in a more reactive manner. Many of the individuals that COAST members interact with are referred to them by frontline LPS officers and the COAST also takes calls out of the LPS call queue when it makes sense for them to do so (e.g., mental health issues are relevant).
- In contrast to initial expectations, and consistent with other data sources, the operational data that has been collected indicates that the COAST is not executing many mental health forms (2, 9, 47) or relieving frontline LPS officers at the hospital.
- Also, in contrast to what was originally intended, but consistent with what we heard in other meetings, the COAST is not involved in a lot of training delivery (e.g., to partner organizations). In fact, there was only 2 months out of the 15 we have data for where such training was delivered, and this training was delivered to frontline LPS officers.

4.2. Contextual Factors

When conducting impact evaluations, it is important to be aware of contextual factors that can affect program implementation. A variety of events have taken place that have influenced the COAST, some which occurred before implementation in April 2021 and some which have taken place throughout the first 15 months of COAST operation. Some of these things occurred at a global level, others involved provincial or local events, and still others related to partner agency issues. Here, we provide a list of particularly notable contextual factors that should be considered as one reviews the evaluation.

4.2.1. Global Issues

Two sets of global issues are particularly important to discuss. The first is the worldwide COVID-19 pandemic, which was declared as such by the World Health Organization

(WHO) in March 2020. As discussed in more detail below when we review the provincial and local impacts of COVID-19, the pandemic had a devastating impact worldwide, including in cities across Ontario. Every sector was significantly impacted by the pandemic, including policing, healthcare, and social services. This was particularly true for community-based programs like the COAST given that the pandemic fundamentally impacted how communities functioned, including where people could go, what support people could receive, and how people could interact with one another. London's COAST was impacted in numerous ways by the COVID-19 pandemic, which we will discuss in more detail in Section 4.2.2.

The other global event that had a significant influence on policing during the evaluation period, including how the public perceives policing, involved the deaths of individuals at the hands of police officers. While some of these deaths occurred in Canada (e.g., Ejaz Choudry, Regis Korchinski-Paquet, Chantal Moore), others occurred in the United States. The murder of George Floyd by a Minneapolis police officer in May 2020 is particularly noteworthy. Floyd's death sparked worldwide outrage, including here in Canada. Anger over the events has resulted in strained police-public relations, which has made it even more difficult for police officers to carry out their duties. It has also led to calls by some to de-fund or de-task the police. Particular concerns have been raised about the involvement of police officers in mental health calls; the very calls that COAST members are meant to help manage. While we cannot turn to data to understand the impacts of these events in London, we think it is fair to say that these deaths, and the events that have taken place in their aftermath, have likely impacted the way in which some London residents perceive the LPS. We also think that it is highly likely that these events have impacted how COAST members are perceived by members of the public (and people in crisis specifically). Some people may even be asking whether the COAST should exist at all or why police officers are on a team designed to address the mental health needs of London residents.

4.2.2. Provincial and Local Issues

The COVID-19 pandemic had a clear impact in Ontario and, more specifically in London. Shortly after the WHO declared COVID-19 to be a worldwide pandemic in the early part of 2020, all non-essential businesses in Ontario were closed and other significant restrictions were put in place (e.g., related to travel, social distancing, the use of personal protective equipment [PPE]). These measures not only impacted how communities across Ontario functioned but also how police organizations, healthcare institutions, and social support agencies across the province delivered their services.

The impact of COVID-19 measures was felt by the COAST in numerous ways. Indeed, while it appears that the COAST did generally function throughout the past 15 months in the way that was initially intended, data we have collected for this evaluation clearly show the impact that the pandemic had on COAST operations. Below are just some of the contextual factors related to the COVID-19 pandemic that are important to consider when reviewing the results of the evaluation:

- The roll out of COAST was delayed by several months due to the pandemic
- The timing of initial COAST training also had to be delayed due to the pandemic, and training had to be delivered virtually during part of the onboarding process
- Transportation challenges were encountered (e.g., COAST members not being able to travel in the same vehicle, difficulty transporting clients to the hospital)
- Mandatory use of PPE by COAST members impacted their ability to communicate, read cues, and generally relate to community members; mandatory PPE use by community members likely had a similar impact on them during their interactions with the COAST
- Different COVID-19 protocols existed across the partner organizations, and still do, and COAST policies had to be designed that respected these differences; this was challenging for the partner organizations, and it was/is difficult to get frontline staff to adhere to these policies
- The types of interactions that took place between the COAST and community members changed, as behaviours (including crime), personal problems, and need for support were all impacted by the COVID-19 pandemic; for example, at times, community referrals to the COAST slowed down, which led the COAST to focus more of their time on calls from the LPS call queue
- The nature of COAST interactions changed (e.g., at times, phone interactions had to take the place of non-essential face-to-face interactions)
- Staffing issues had to be grappled with when individuals got sick or had to quarantine due to COVID-19 contacts

4.2.3. Agency Issues

Finally, there are some contextual factors at the organizational level that are important to consider when reviewing the evaluation findings. One important factor is that other programs like COAST were operating before the COAST was implemented and continue to operate now. Thus, it is important to understand that the COAST exists and operates within a larger ecosystem of support services, all of which are impacting community members in need. For example, a reactive Crisis Response Team (CRT) operates in London. This program impacted how COAST was designed, how it was implemented, and how it currently operates (i.e., a more proactive focus). The presence of other support programs also impacted the COAST evaluation in that it became clear there is some confusion about the roles that the various programs play in London and how they complement one another.

There were also some important changes to the COAST and how it functioned at an organizational level that are important to consider. These included: (1) several changes in leadership (e.g., key members of the implementation team moved on to new positions, taking valuable knowledge about the COAST with them); (2) changes in shift schedules (e.g., going to a full 7-day/week schedule in January 2022); (3) changes in where the COAST was operating from (e.g., to make things more efficient, teams began to start and end their shifts off site); (4) changes in who could refer cases to the COAST (e.g., initially

the community and most partner organizations could not refer, but that changed mid-way through the first 15 months of operation); (5) changes in how the COAST was taking calls (e.g., from referrals initially to taking calls straight out of the LPS call queue); and (5) changes in COAST activities (e.g., less focus on executing mental health forms).

Finally, program funding has been a key issue throughout the last 15 months. Indeed, finding sustainable funding for the program is a constant concern for each of the partner organizations, but particularly the healthcare partners. Not only are few funding options available, coordinating simultaneous access to funding for all partner agencies is a significant challenge, as is finding the time to apply for this funding. To address funding challenges, re-allocated funds from partner organizations were used to "turn the program lights on". To optimize staffing coverage during vacation and sick time, and in the absence of full-time dedicated staff, replacement positions were split/part-time to optimize service coverage. Additional support staff, leadership positions, and COAST training have been supported in kind. These funding challenges are extremely important to consider as one reviews the evaluation findings given that available funding has a significant impact on program activities (e.g., the availability of the COAST when they are needed; the ease with which the COAST can meet clients face-to-face, including for follow-ups; the ability of the COAST to train frontline staff in the partner organizations).

Relatedly, due to a variety of factors, the MLPS experienced a range of issues during the first 15 months of COAST operation, including funding and staffing issues. This led to St. Joseph's assisting with funding and the partner organizations backfilling staffing positions. Between March 2022 and June 2022, the MLPS played no role on the COAST, which not only impacted how the COAST functioned, but also how it was evaluated (readers will notice gaps in some aspects of the evaluation, including survey and interview responses from MLPS members).

4.3. Key Findings

Consistent with Original Implementation Plan

- The COAST is generally healthcare-led (e.g., with respect to client interactions, program oversight, operational management, and records keeping), although concerns are highlighted in other sections of this report that the program may be becoming more police-led
- The COAST regularly identifies at-risk clients and engages with those individuals
- Referrals to the COAST come from the community, businesses, and the partner organizations; other calls are taken from the LPS call queue or are self-generated by the COAST
- The COAST supports frontline LPS officers in a variety of ways, providing needed relief and freeing up resources to focus on other policing issues
- Follow-up calls with clients are a key COAST activity (to check on well-being, to ensure clients are following their care plan, to modify care plans as required)

- COAST members regularly receive training and take part in professional development opportunities
- The COAST regularly engages in consultations to assist other support workers (e.g., transitional case managers)
- Partner organizations collaborate regularly through the Governance and Steering Committees, and COAST members interact weekly during team meetings
- The COAST is monitored through regular data collection and analysis

Inconsistent with Original Implementation Plan

- The COAST took on a reactive role in addition to their proactive role earlier than anticipated due to LPS pressures
- Transportation of clients has deviated from the original plan due to COVID-19 restrictions and the vehicle not being appropriately equipped to transport clients
- The COAST executes less mental health forms than expected and rarely relieves frontline LPS officers with hospital handovers
- The COAST occasionally assists in the Crisis Centre
- The COAST delivers little training to other first responders (e.g., from partner organizations)
- Various deviations exist with respect to data-related issues (e.g., more limited access to clinical information than expected, additional data being collected on clients)

Contextual Factors

- Various contextual factors influenced how the COAST was implemented and how it currently operates; some of these factors relate to global issues (e.g., reactions to police-involved deaths), some relate to provincial or local issues (e.g., managing restrictive COVID-19 measures), and some relate to organizational issues (e.g., lack of MLPS involvement on the COAST during certain periods)

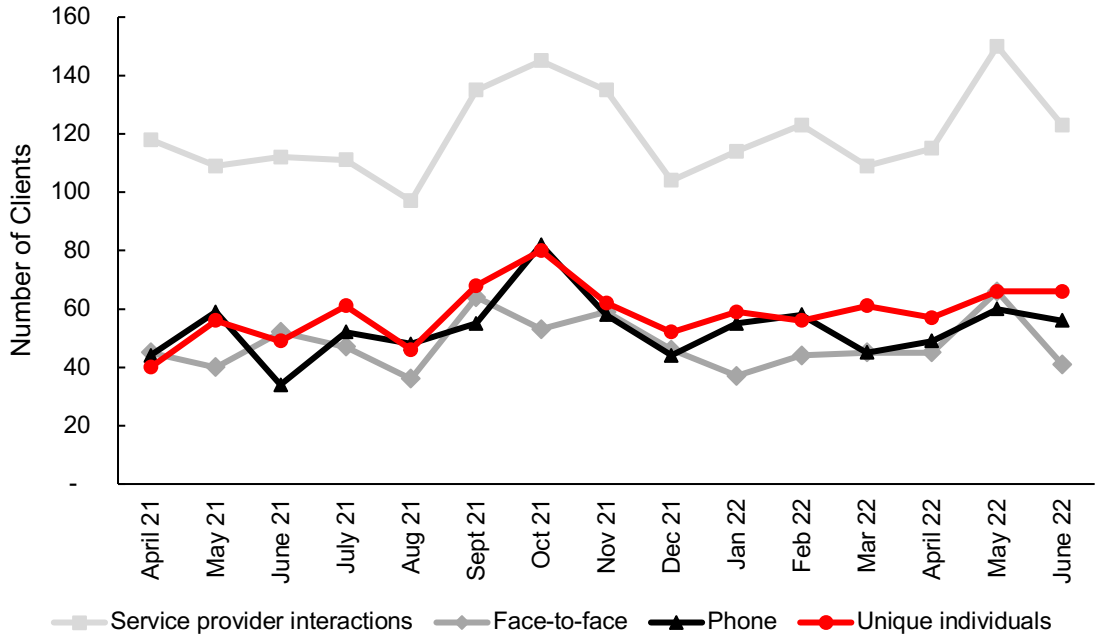
5. Operational Data

Operational data for the evaluation was provided monthly from the LPS and the CMHA TVAMHS. The data speaks to various issues, including: (1) support provided to clients, (2) the length and frequency of interactions with clients, (3) the origin of COAST calls, (4) COAST responses and outcomes, and (5) COAST education and training.

5.1. Providing Support to Individuals

Based on operational data collected from April 2021 to June 2022, it appears that the number of service provider interactions has remained relatively consistent over time, as have the interactions that have taken place over the phone and through face-to-face encounters (see Figure 2). It also appears that the number of unique individuals who have interacted with the COAST each month has remained relatively constant from April 2021 to June 2022.

Figure 2. Support for Clients by the COAST



5.2. Length and Frequency of Interactions

As seen in Figure 3, the average time spent on these interactions (in minutes) has remained relatively stable over time, regardless of whether the interactions were face-to-face or over the phone. The average time of a face-to-face interaction is 64.53 minutes and the average time of a phone interaction is 22.47 minutes. In terms of how frequently

the COAST interacts with individuals, the pie chart in Figure 3 reflects the fact that, most commonly, the COAST is interacting with clients once a month on average; however, there are a significant number of clients who the COAST is interacting with multiple times a month.

Figure 3. Average Time Spent on Interactions by the COAST

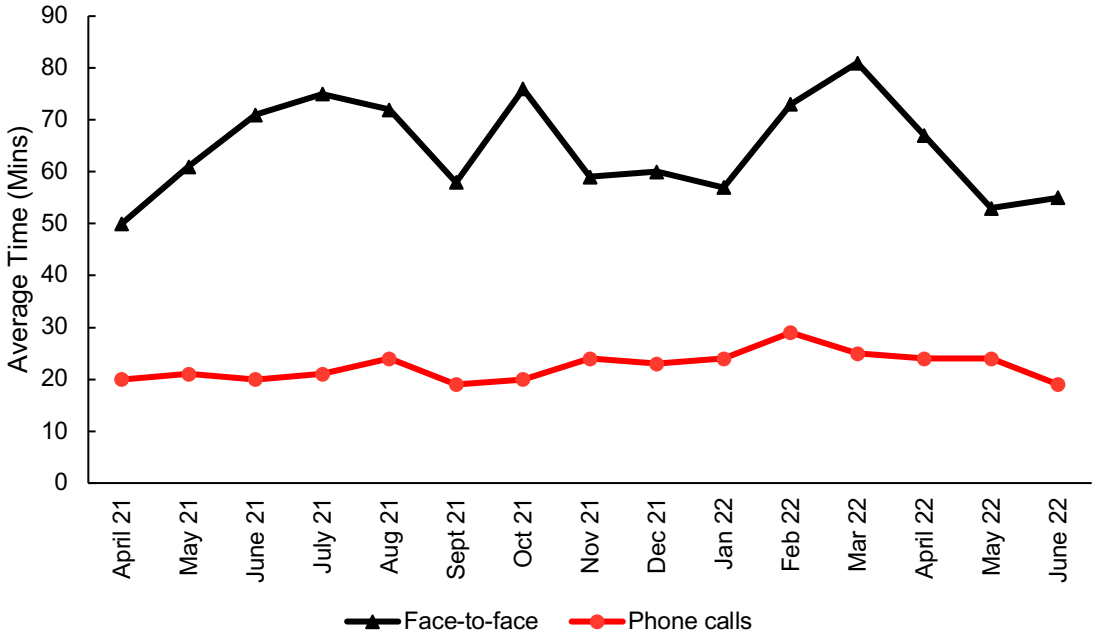
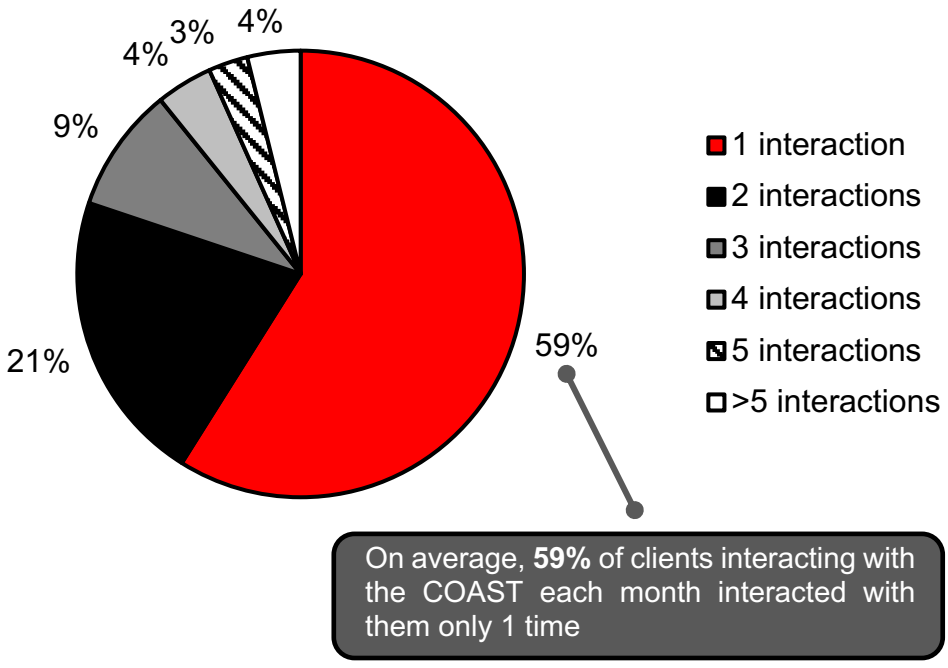


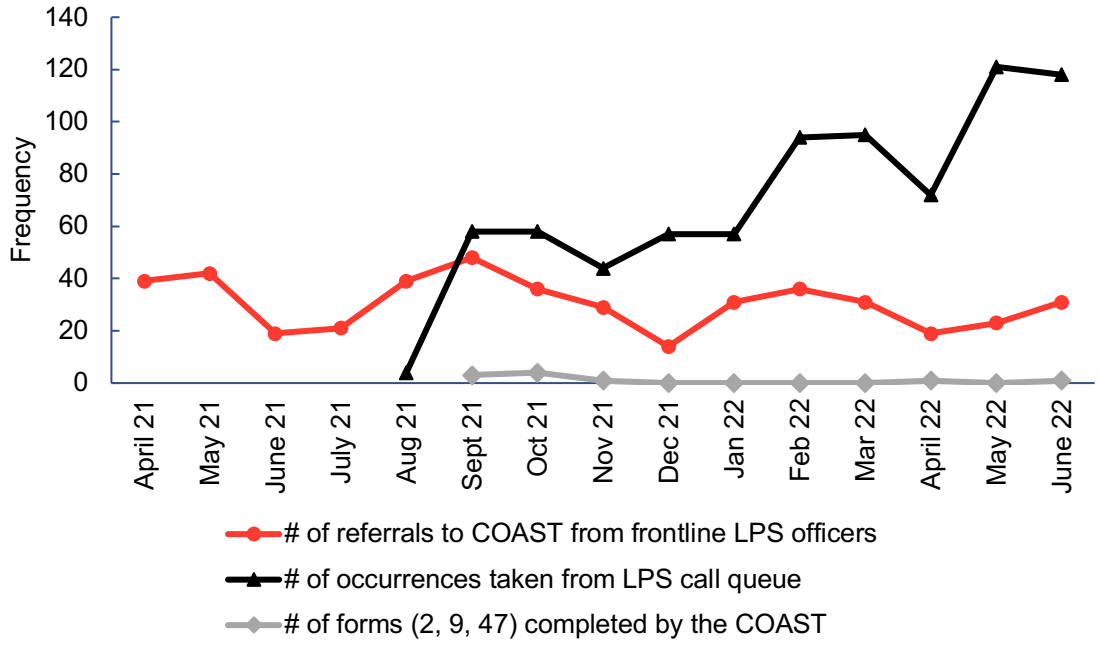
Figure 4. Frequency of COAST Interactions with Clients (per Month)



5.3. Origin of COAST Calls

As seen in Figure 5, the COAST has consistently received referrals from frontline LPS officers. Starting in August 2021, the COAST started to take calls from LPS' call queue. Since this began, COAST has generally done this at an increasing rate over time, although there are months where drops are observed. Starting in September 2021, the COAST started to execute mental health forms (e.g., Form 47s); however, they do so very infrequently.

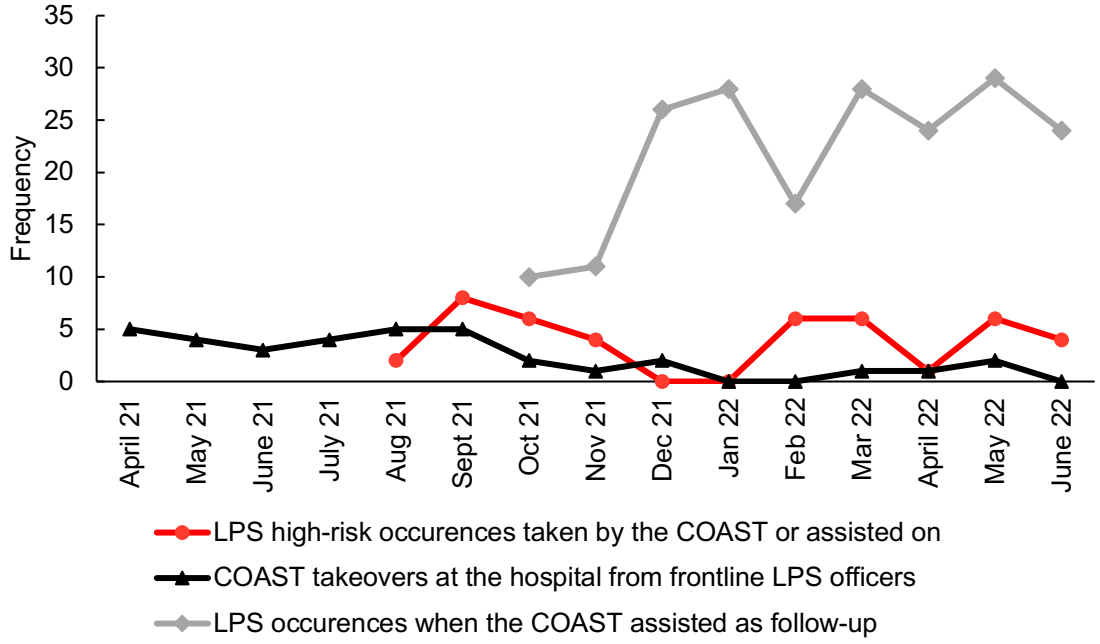
Figure 5. Origin of COAST Calls



5.4. COAST Responses

Since the COAST started to engage in high-risk interactions, the frequency of engagement has fluctuated slightly over time, but occurs relatively infrequently (see Figure 6). The COAST has also consistently taken over cases at the hospital from frontline officers, although this also happens infrequently and has generally decreased over time. Finally, in October 2021, the COAST started assisting LPS officers by completing follow-ups. Except for a notable dip in February 2022, the frequency of follow-ups has increased substantially since data began to be collected.

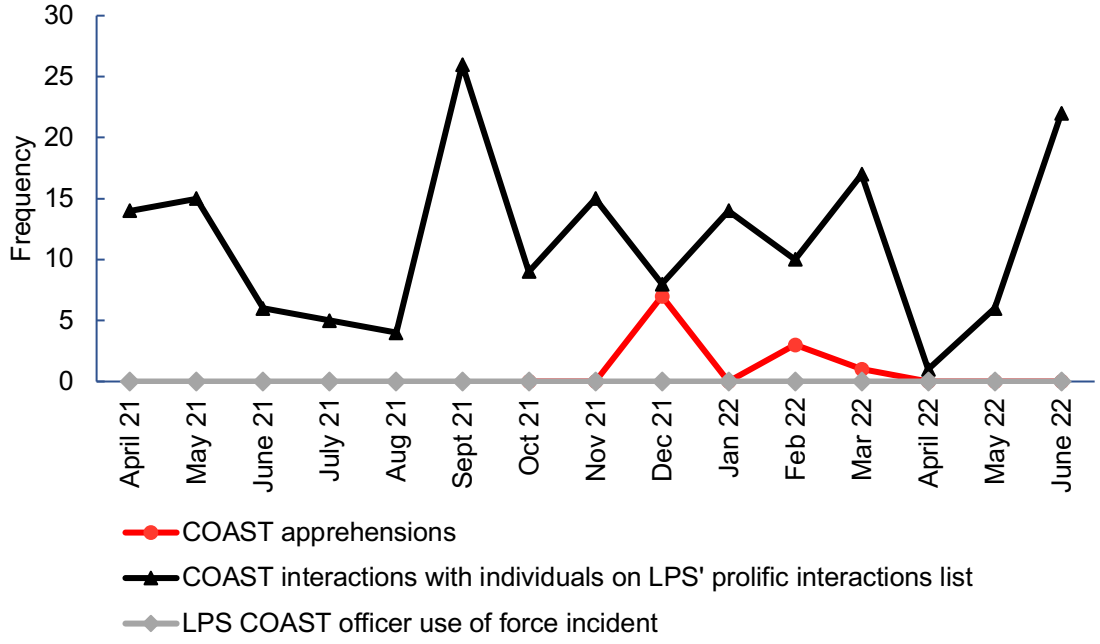
Figure 6. Frequency of COAST Reponses



5.5. COAST Outcomes

Apprehensions by the COAST started being recorded in October 2021. As illustrated in Figure 7, since that time, the number of apprehensions has been relatively consistent and infrequent. Since the program was implemented, the COAST has interacted with individuals on LPS' prolific interaction list; however, they have done so to varying degrees from April 2021 to June 2022. Finally, it is important to note that the COAST has not recorded any use of force incidents since it began operation.

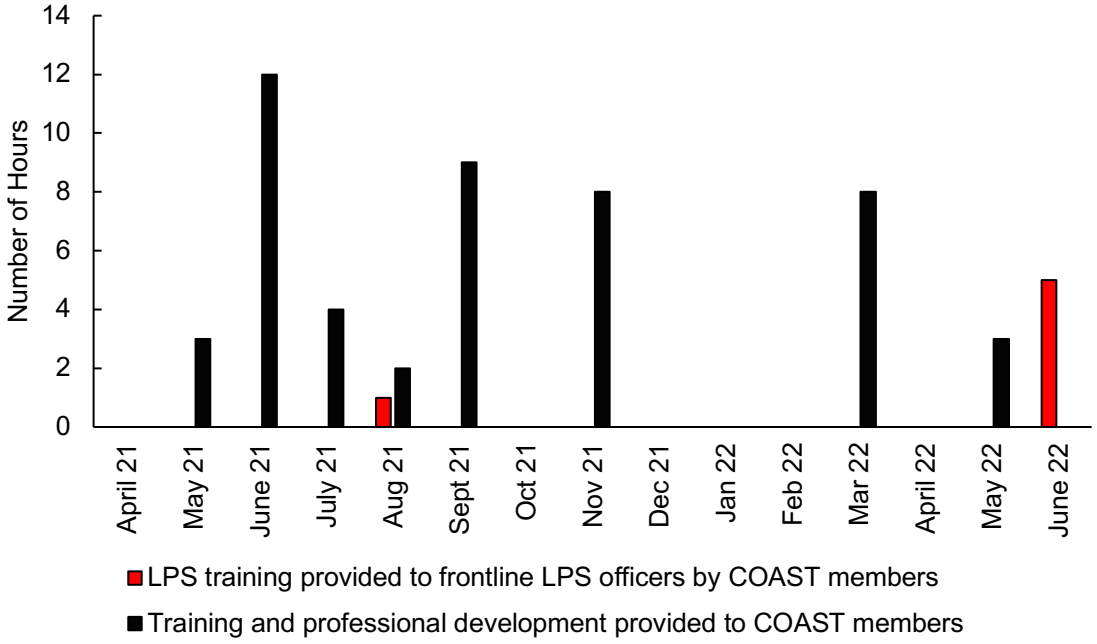
Figure 7. Frequency of COAST Outcomes



5.6. COAST Education and Training

The COAST has received training and engaged in training others to some degree between April 2021 and June 2022 (see Figure 8). The COAST received two weeks of initial training in March 2021 (about 63 hours). Beyond this, the team has received training in 8 out of the 15 months that the COAST has operated. The COAST also provided 6 hours of training to frontline LPS officers. There is currently no evidence that the COAST has provided training to frontline staff at any of the other partner agencies. The COAST has delivered various community presentations to educate the public about the COAST (e.g., Parkwood Family Council).

Figure 8. Number of Hours Spent on Training



5.7. Partner Engagement

Both the Governance and Steering Committees engage in monthly meetings to oversee the operation of the COAST. Each of these committees has representation from the partner organizations, in addition to other members (e.g., the Governance Committee has a member with lived experience and the Steering Committee has a member from the community). This facilitates inter-agency collaboration and oversight of the COAST. Additionally, the evaluation team has been attending Steering Committee meetings on a regular basis, and Governance Committee meetings periodically, to ensure that the team understands how the COAST is operating.

5.8. Program Evaluation and Monitoring

The COAST, and those responsible for overseeing the program, have regularly been tracking data associated with its operation, including from clients, and have been working with the evaluation team to facilitate data collection and analysis. Those responsible for overseeing the COAST have also incorporated our suggestions regarding data collection into their reporting, providing evidence of internal monitoring capacity. This internal monitoring was essential to the independent evaluation we conducted.

5.9. Key Findings

- The COAST is interacting with clients on a regular basis during face-to-face interactions and over the phone, including a reasonable number of unique individuals each month
- Most commonly, the COAST is interacting with clients once a month on average; however, there are a significant number of clients who the COAST interacts with multiple times a month
- The COAST regularly receives referrals from frontline LPS officers, and the team is increasingly taking calls out of the LPS call queue
- The COAST executes mental health forms (2, 9, 47) infrequently
- The COAST rarely gets involved in high-risk occurrences or hospital takeovers from LPS officers, but they are frequently involved in follow-ups with clients following their interactions with frontline LPS officers
- The COAST regularly interacts with people from LPS' list of prolific individuals
- The COAST is rarely involved with apprehensions
- LPS officers who work with the COAST have not reported any use of force incidents since the program was implemented
- COAST members regularly receive training, but rarely provide training to staff within the partner organizations; COAST members do occasionally deliver presentations to the broader community
- The partner organizations regularly collaborate with one another through Governance and Steering Committee meetings, and COAST members interact frequently during weekly meetings
- COAST data is regularly tracked and used to evaluate the program and modify it as necessary

6. Staff Surveys

Surveys were completed before and after COAST implementation. While the MLPS completed the pre-implementation survey, they did not complete the post-implementation survey (given that the post-implementation survey was distributed at a time when the MLPS was not involved in the COAST). Thus, only surveys completed by staff from the LPS, St. Joseph's, and the CMHA TVAMHS are presented. The surveys for each organization were slightly different, but each asked about the respondent's awareness and utilization of available mental health resources and the perceived effectiveness of those supports. Participants were also asked questions about their perceptions of mental health/crisis calls and their views about the COAST.

6.1. London Police Service

The following individuals completed the pre- and post-implementation survey for the LPS.

Table 1. Respondents, by Position, to the LPS Survey

Position	Pre-Survey	Post-Survey
Civilian	5 (4%)	14 (12%)
Patrol	64 (56%)	76 (67%)
Primary COAST Officer[3]	3 (3%)	2 (2%)
Secondary COAST Officer	3 (3%)	3 (3%)
Other[4]	40 (35%)	15 (13%)
Total	**115**	**110**

6.1.1. Awareness, Use, and Effectiveness of Mental Health Supports

As illustrated in Table 2, awareness, use, and perceived effectiveness was relatively high on the post-implementation survey for most of the mental health supports that LPS respondents were asked about.[5] This was particularly true of the LPS COAST members.

[3] COAST officers in the pre-survey refer to officers that were selected to work in the program.

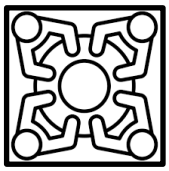
[4] "Other" includes, among others, those working in the Community Support Unit, Intimate Partner Violent Unit, Supervisors, etc.

[5] When examining awareness, use, and perceived effectiveness of mental health supports, post-implementation survey results are focused on because there was evidence that these questions were not understood by respondents when completing the pre-implementation survey. For example, some participants indicated they used a resource, or perceived a resource to be effective, but did not indicate

Three notable exceptions to this were:

70% of respondents were aware of the CMHA Stabilization Space; of those who were aware of it, **68%** used it and **82%** perceived it as effective

65% of respondents were aware of the LPS/LSHC[6] Handover Protocol; of those who were aware of it, **49%** used it and **54%** perceived it as effective



34% of respondents were aware of the Connectivity Table;[7] of those that were aware of it, **64%** used it and **65%** perceived it as effective

For those respondents who did not use these resources, the main reason that was provided was that the resource was not relevant to their duties. Many respondents also indicated that they simply have not required the resource yet, suggesting that they would use the resource if it was needed. Of note, when explaining why they had not used the CMHA Stabilization Space, four respondents (20% of those who provided a reason; *n* = 4) indicated there was insufficient capacity.[8]

In terms of perceived effectiveness, the LPS/LHSC Handover Protocol stands out as being perceived as particularly ineffective by respondents on the post-implementation survey (particularly patrol officers). The most frequent reason that was provided for this perception (43% of those who provided a reason; *n* = 12) was that handovers take too long. Other reasons included the view that hospital staff do not follow the protocol (39%; *n* = 11) and that the handover protocol creates more work for officers (14%; *n* = 4).

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that they were aware of that same resource. Modifications were made to the post-implementation survey to correct this issue (e.g., a participant could not indicate whether they used a resource or thought the resource was effective without first indicating that they were aware of the resource). This issue prevented us from examining differences between the pre- and post-implementation surveys for these items.

6 LHSC refers to the London Health Sciences Centre.

7 The Connectivity Table is a multi-disciplinary, inter-agency approach for addressing situations involving individuals who are demonstrating elevated risk. Each table brings together relevant professionals, from across sectors, to address the situation collaboratively and proactively.

8 During the evaluation period, there were only 5 stabilization beds available in the community. In July of 2022 a new 10 bed unit was opened at the Crisis Centre (the 5-bed unit closed) providing greater access for referrals.

Table 2. Awareness, Use, and Perceived Effectiveness of Resources by LPS Respondents

	Civilian			Patrol			COAST			Other			Overall		
Resource	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective
LPS/LHSC Handover Protocol	47%	14%	56%	68%	53%	50%	60%	75%	67%	67%	40%	70%	**65%**	**49%**	**54%**
InterRAI Brief Mental Health Screener	--[9]	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Crisis Response Team	100%	92%	92%	99%	88%	94%	100%	100%	100%	100%	67%	93%	99%	86%	94%
Crisis Centre	100%	100%	100%	100%	83%	95%	100%	100%	100%	100%	73%	93%	100%	85%	96%
Crisis Centre Walk-in	83%	100%	100%	88%	75%	95%	100%	100%	100%	67%	70%	90%	84%	79%	95%
CMHA Stabilization Space	92%	82%	91%	69%	65%	80%	100%	100%	80%	47%	43%	86%	70%	68%	82%
Reach Out Crisis Line	100%	92%	91%	85%	65%	91%	100%	100%	100%	67%	60%	60%	85%	71%	85%
Connectivity Table	27%	100%	50%	30%	64%	73%	80%	75%	75%	36%	25%	38%	**34%**	**64%**	**65%**
Average Ratings	**78.4%**	**81.4%**	**82.9%**	**77%**	**71.9%**	**82.6%**	**91.4%**	**92.9%**	**88.9%**	**69.4%**	**54%**	**75.7%**	**76.7%**	**71.7%**	**81.6%**

[9] The Inter RAI Brief Mental Health Screener was asked about on the pre-implementation survey, but not the post-implementation survey because the LPS paused its use temporarily during the time period when the survey was being completed.

6.1.2. Perceptions of Mental Health Calls

LPS respondents were also asked to indicate, on the pre- and post-implementation survey, the degree to which they agreed with various statements about mental health/crisis calls using the following rating scale: (1) Strongly Disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly Agree. To examine whether responses on the pre- and post-implementation surveys were significantly different, Bayes factors were calculated. The guidelines in Table 3 are commonly used to interpret Bayes factors. The larger the Bayes factor, the more the evidence supports that there is a difference between the pre- and post-implementation survey; the smaller the Bayes factor, the more the evidence supports that there is no difference between the pre- and post-implementation survey.

Table 3. Guidelines for Interpreting Bayes Factors

Bayes Factor	Interpretation
>100	Extreme evidence that *there is a difference* between the surveys
30 - 100	Very strong evidence that *there is a difference* between the surveys
10 - 30	Strong evidence that *there is a difference* between the surveys
3 - 10	Moderate evidence that *there is a difference* between the surveys
1 - 3	Anecdotal evidence that *there is a difference* between the surveys
1	No evidence
1/3 - 1	Anecdotal evidence that *there is no difference* between the surveys
1/10 - 1/3	Moderate evidence that *there is no difference* between the surveys
1/30 - 1/10	Strong evidence that *there is no difference* between the surveys
1/100 - 1/30	Very strong evidence that *there is no difference* between the surveys
<1/100	Extreme evidence that *there is no difference* between the surveys

As can be seen in Table 4, across both the pre- and post-implementation LPS surveys, the overall results (averaged across respondents in different positions) indicated that there was a relatively high level of agreement (>4/5) when respondents were asked whether mental health/crisis calls increase workload; whether the respondents thought they possessed a reasonable degree of knowledge related to mental illness, substance use, vulnerable living conditions, and trauma as potential contributors to crises; and whether they use the most appropriate mental health providers when handling mental

health/crisis calls. Slightly lower levels of agreement (3-4/5) were expressed when respondents were asked whether they feel safe during mental health/crisis calls; whether they find such calls to be emotionally draining; whether they possess the necessary knowledge, skills, and abilities to manage these calls; and whether they are satisfied with how the calls are handled.

The lowest levels of agreement (<3/5) were found when respondents were asked whether they were satisfied with the immediate outcomes of mental health/crisis calls and whether they were satisfied with the quality of communication between the police and hospital staff.

All significant differences between the pre- and post-implementation surveys are marked with a ** in Table 4. No differences between the surveys were found for civilians or patrol officers, and very few differences were found for the other groups of respondents. It is difficult to determine why so few differences emerged across the surveys. One possibility is that the survey methodology used might be inadequate for uncovering differences (e.g., response biases may be present). A second possibility is that, despite expectations, the existence of the COAST might not impact the sorts of outcomes asked about on the surveys. A third possibility is that the COAST might impact these outcomes, but only if other system adjustments are also made (e.g., changes at the hospital to improve police-hospital communications). A fourth possibility is that the COAST might have an impact on the sorts of outcomes asked about on the surveys, but only when it is adequately resourced or only after it has been functioning for a longer period of time.

In terms of the significant differences that were found, COAST members reported: (1) significantly lower levels of agreement on the post-survey when asked whether mental health/crisis calls are emotionally draining, (2) significantly lower levels of knowledge on the post-survey regarding how vulnerable living conditions can contribute to crises, and (3) significantly higher levels of satisfaction on the post-survey in the immediate outcomes of mental health/crisis calls. Respondents in the “Other” category reported significantly higher levels of satisfaction on the post-survey with how mental health/crisis calls are handled. Overall, when all positions were combined, the post-survey results revealed: (1) significantly lower levels of knowledge about mental illness and substance use as potential causes of crises, and (2) significantly lower levels of satisfaction with police-hospital communications.

Unfortunately, few reasons were provided by respondents on the open-ended survey questions to explain why these significant differences might have emerged. However, with respect to the declines in knowledge reported on the post-implementation survey, it may be worth highlighting that this appears to be due largely to substantial reductions in

knowledge reported by COAST members. While this may seem counter-intuitive, data collected from the interviews with COAST members suggest this may reflect the fact that COAST members “didn’t know what they didn’t know” until they started responding to more calls for service involving people with mental health issues alongside a mental health professional and receiving specialized training on how to effectively manage these calls. This might explain the recognition of greater knowledge gaps for COAST members on the post-implementation survey.

Table 4. Perceptions of Mental Health/Crisis Calls by LPS Respondents

	Civilian			Patrol			COAST			Other			Overall		
Survey Item	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes
Feel safe during mental health/crisis calls	--	3.67	--[10]	3.41	3.10	0.54	3.33	4.00	--[11]	3.23	3.33	0.34	3.35	3.23	0.21
Mental health/crisis calls are emotionally draining	4.40	3.64	0.70	3.83	4.00	0.28	**4.17**	**3.40**	**1.29****	3.70	3.92	0.36	3.84	3.91	0.17
Mental health/crisis calls increase my workload	4.40	4.55	0.46	4.31	4.56	0.49	4.17	4.80	0.60	4.00	4.08	0.33	4.22	4.50	0.88
Knowledgeable about mental illness	4.20	4.18	0.45	4.21	3.95	0.59	4.67	3.80	0.76	4.49	4.21	0.48	**4.33**	**4.01**	**2.98****
Knowledgeable about substance use	4.20	3.91	0.48	4.18	4.03	0.29	4.50	4.00	0.54	4.48	4.14	0.64	**4.31**	**4.03**	**1.34****
Knowledgeable about living conditions	4.20	3.63	0.57	4.01	4.06	0.20	**4.67**	**3.60**	**1.03****	4.31	4.07	0.43	4.21	3.99	0.70
Knowledgeable about trauma	4.20	4.18	0.45	4.05	3.86	0.35	4.67	3.80	0.76	4.31	4.07	0.42	4.18	3.93	0.94
Use most appropriate mental health provider	3.00	3.00	--	4.01	4.12	0.21	4.17	4.00	0.49	4.22	4.18	0.34	4.10	4.01	0.19
Possess KSAs to handle mental health /crisis calls	3.75	3.33	0.61	3.56	3.52	0.20	4.17	3.60	0.57	4.06	4.08	0.32	3.76	3.58	0.34
Satisfied with how interactions are handled	3.75	3.73	0.47	3.74	3.93	0.36	4.33	3.80	0.54	**4.03**	**4.50**	**1.78****	3.86	3.98	0.22
Satisfied with immediate outcomes of interactions	2.50	2.89	0.58	2.82	3.12	0.53	**3.50**	**4.75**	**1.67****	3.15	3.55	0.52	2.96	3.24	0.62
Satisfied with police-hospital communication	3.00	3.00	--	2.53	2.20	0.66	2.50	3.00	0.59	3.07	2.56	0.62	**2.69**	**2.33**	**1.33****

[10] No Civilians rated the degree to which they felt safe during these calls on the pre-implementation survey, so a Bayes factor could not be calculated.

[11] A Bayes factor could not be calculated for COAST members for this item because of a lack of variation in their responses.

6.2. St. Joseph's Health Care London

The following individuals completed the pre- and post-implementation survey for St. Joseph's (we asked them to indicate whether they primarily work in the health centre, the community, or as part of the COAST). Given the substantially reduced sample size for the post-implementation survey, caution is warranted when reviewing results presented in this section.

Table 5. Respondents, by Position, to the St. Joseph's Survey

Position	Pre-Survey	Post-Survey
Health Centre	58 (54%)	14 (38%)
Community	47 (44%)	22 (59%)
COAST	3 (3%)	1 (3%)
Total	**108**	**37**

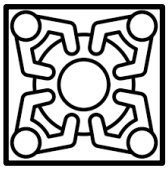
6.2.1. Awareness, Use, and Effectiveness of Mental Health Supports

As illustrated in Table 6, awareness, use, and perceived effectiveness was high on the post-implementation survey for most of the mental health supports that respondents from St. Joseph's were asked about. This was particularly true of the COAST member from St. Joseph's who completed the survey.

Three notable exceptions to this were:

78% of respondents were aware of Coordinated Care Plans; of those who were aware of them, **80%** used them and **88%** perceived them as effective

75% of respondents were aware of London Cares Homeless Response Services; of those who were aware of them, **79%** used them and **96%** perceived them as effective



44% of respondents were aware of the Connectivity Table; of those that were aware of it, **50%** used it and **86%** perceived it as effective

While few reasons were provided by survey respondents for why certain resources were not used or perceived to be ineffective, we believe the same reasons identified by LPS staff likely apply here: in most cases, the resources are either not relevant to the duties of the survey respondent or have not yet been required.

Table 6. Awareness, Use, and Perceived Effectiveness of Resources by Respondents from St. Joseph's

	Health			Community			COAST			Overall		
Resource	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective
Crisis Centre Walk-In	90%	89%	100%	100%	71%	91%	100%	100%	100%	97%	77%	94%
Withdrawal Management	50%	100%	80%	100%	67%	81%	100%	100%	100%	84%	74%	82%
CMHA Stabilization Space	100%	60%	100%	100%	86%	95%	100%	100%	100%	100%	78%	97%
Crisis Response Team	80%	63%	100%	91%	47%	94%	100%	100%	100%	88%	50%	96%
Reach Out Crisis Line	90%	89%	100%	100%	95%	95%	100%	100%	100%	97%	94%	97%
Connectivity Table	30%	67%	100%	48%	50%	80%	100%	100%	100%	44%	50%	86%
Coordinated Care Plans	90%	100%	78%	71%	67%	93%	100%	100%	100%	78%	80%	88%
London Cares	30%	100%	67%	95%	80%	100%	100%	100%	100%	75%	79%	96%
Average Ratings	**70%**	**82%**	**93%**	**88%**	**73%**	**92%**	**100%**	**100%**	**100%**	**83%**	**75%**	**92%**

6.2.2. Perceptions of Mental Health Calls

Like LPS respondents, respondents from St. Joseph's were also asked to indicate, on the pre- and post-implementation survey, the degree to which they agreed with various statements about mental health/crisis calls using the following rating scale: (1) Strongly Disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly Agree. To examine whether responses on the pre- and post-implementation surveys were significantly different, Bayes factors were again calculated.

As can be seen in Table 7, across both the pre- and post-implementation surveys, the overall results (averaged across respondents in different positions) indicated that there was a relatively high level of agreement (>4/5) when respondents were asked whether they possess the necessary knowledge, skills, and abilities to manage these calls; whether they feel satisfied with how the interactions are handled; whether they exhaust all options before involving the police; and whether they have knowledge of when to involve the police in a mental health/crisis call. Slightly lower levels of agreement (3-4/5) were expressed when respondents were asked whether they feel safe during mental health/crisis calls; whether they find mental health/crisis calls emotionally draining; whether they are able to focus on their role of providing services without worrying about safety; whether they are satisfied with the immediate outcomes of interactions involving people with mental health issues or in crisis; whether they are satisfied with how the police handle these interactions; whether they have knowledge of what role the police play during these calls; and whether they are knowledgeable about the role of community support services in London.

Low levels of agreement (2-3/5) were found when respondents were asked whether they are satisfied with police-hospital communication; whether proactive interventions to prevent crises are managed well; and whether they are satisfied with interactions between staff at St. Joseph's and individuals in crisis in the community or health centre. Very low levels of agreement (<2/5) were found when respondents were asked whether they are satisfied with interactions between police and individuals in crisis in the health centre; whether they are satisfied with police-hospital transfers; and whether they are satisfied with the quality of follow-up care.

In terms of significant differences between the pre- and post-implementation surveys, few differences were found. Possible explanations for this were presented in Section 6.1.2. All significant differences are marked with a ** in Table 7.

For respondents working in the health centre, they reported a significantly higher level on the post-survey of knowledge and skills necessary for managing interactions with people with mental illness or in crisis. Overall, when all positions were combined, the post-survey results also revealed: (1) significantly higher levels of feeling safe during interactions with

people with mental illness or in crisis, (2) significantly higher levels of knowledge and skills necessary for managing interactions, (3) significantly higher levels of satisfaction with the immediate outcome of interactions, and (4) significantly higher levels of satisfaction with how the police and individuals in crisis interact with one another in the health centre.

Unfortunately, few reasons were provided by respondents for why these significant differences were observed across the surveys.

Table 7. Perceptions of Mental Health Calls by Respondents from St. Joseph's

	Health			Community			COAST			Overall		
Survey Item	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes[12]	Pre	Post	Bayes
Feel safe during mental health/crisis calls	3.71	4.07	0.79	3.83	4.05	0.57	4.33	5.00	--	**3.78**	**4.14**	**2.00****
Mental health/crisis calls are emotionally draining	3.24	3.14	0.31	3.00	3.35	0.50	2.33	1.00	--	3.08	3.20	0.23
Focus on my role without worrying about safety	3.47	3.69	0.38	3.30	3.65	0.56	4.33	5.00	--	3.42	3.71	0.55
Possess knowledge and skills to handle interactions	**4.00**	**4.54**	**1.94****	4.32	4.43	0.33	4.67	5.00	--	**4.17**	**4.49**	**2.09****
Satisfied with how interactions are handled	4.09	4.38	0.59	4.32	4.24	0.29	4.33	5.00	--	4.19	4.31	0.29
Satisfied with immediate outcomes of interactions	3.47	4.00	0.95	3.83	3.95	0.31	3.33	4.00	--	**3.62**	**3.97**	**1.07****
Satisfied with how police manage interactions	2.93	3.18	0.37	3.09	3.24	0.30	3.33	5.00	--	3.02	3.27	0.31
Satisfied with police-hospital communication	2.75	3.20	0.61	3.07	3.20	0.27	3.67	5.00	--	2.93	3.26	0.42
Exhaust all options before involving police	4.15	4.40	0.46	4.47	4.24	0.50	4.33	4.00	--	4.30	4.28	0.21
Knowledgeable about when to involve police	3.91	4.00	0.33	4.34	4.24	0.30	4.33	5.00	--	4.11	4.19	0.22
Knowledgeable about the role of police	3.75	3.90	0.34	3.98	4.14	0.33	4.33	5.00	--	3.87	4.09	0.34
Knowledgeable about the role of community services	3.48	3.78	0.34	4.07	3.90	0.56	4.00	5.00	--	3.75	3.90	0.24
Satisfied with proactive intervention	1.96	1.89	0.53	2.09	2.21	0.29	2.33	3.00	--	2.04	2.14	0.23
Satisfied with SJHC interactions in community	2.07	2.13	0.40	2.07	2.58	0.68	2.00	3.00	--	2.08	2.46	0.25

[12] Bayes factors could not be calculated for the COAST responses because only one COAST member completed the follow-up survey.

Satisfied with SJHC interactions in health centre	2.29	2.56	0.34	2.32	2.50	0.80	2.33	3.00	--	2.31	2.54	0.56
Satisfied with police interactions in community	--[13]	2.13	--	--	2.11	--	--	3.00	--	**--**	**2.14**	**--**
Satisfied with police interactions in health centre	1.86	2.14	0.62	2.00	2.31	0.58	2.00	3.00	--	**1.93**	**2.29**	**2.37****
Satisfied with police-hospital transfer	1.91	2.33	0.34	2.03	2.33	0.90	1.50	2.00	--	1.95	2.32	0.82
Satisfied with follow-up care	1.93	2.22	0.40	1.95	2.29	0.49	2.33	2.00	--	1.95	2.26	0.22

[13] Data was not collected for this item on the pre-implementation survey.

6.3. Canadian Mental Health Association

The following individuals completed the pre- and post-implementation survey for the CMHA TVAMHS (we asked them to indicate whether they primarily interact with people with mental illness or in crisis over the phone, face-to-face, both, or as part of the COAST). Given the substantially reduced sample size for the post-implementation survey, caution is warranted when reviewing the results presented in this section.

Table 8. Respondents, by Position, to the CMHA TVAMHS Survey

Position	Pre-Survey	Post-Survey
Phone	15 (22%)	11 (36%)
Face-to-face	15 (22%)	2 (7%)
Both	36 (52%)	17 (55%)
COAST	3 (4%)	1 (3%)
Total	**69**	**31**

6.3.1. Awareness, Use, and Effectiveness of Mental Health Supports

As illustrated in Table 9, awareness, use, and perceived effectiveness was high on the post-implementation survey for the mental health supports that CMHA TVAMHS respondents were asked about. In contrast to the survey results found for LPS and St. Joseph's, this was true for all the supports that CMHA TVAMHS respondents responded to (and for respondents in all positions).

Table 9. Awareness, Use, and Perceived Effectiveness of Resources by CMHA TVAMHS Respondents

	Phone			Face-to-Face			Both			COAST			Overall		
Resource	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective	Aware	Use	Effective
Crisis Walk-in Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Withdrawal Management	100%	100%	100%	100%	100%	100%	100%	77%	85%	100%	100%	100%	100%	88%	92%
CMHA Stabilization Space	100%	67%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%	100%	88%	96%
Crisis Response Team	100%	89%	100%	100%	100%	100%	100%	92%	92%	100%	100%	100%	100%	92%	96%
Reach out Crisis Line	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Connectivity Table	67%	50%	100%	100%	50%	100%	77%	80%	90%	100%	0%	100%	88%	63.2%	95%
London Cares	100%	100%	89%	100%	100%	100%	100%	92%	92%	100%	100%	100%	100%	96%	92%
Average Ratings	**65%**	**86%**	**98%**	**100%**	**93%**	**100%**	**97%**	**92%**	**93%**	**100%**	**86%**	**100%**	**98%**	**90%**	**96%**

6.3.2. Perceptions of Mental Health Calls

Like LPS respondents, and respondents from St. Joseph's, CMHA TVAMHS respondents were asked to indicate, on the pre- and post-implementation survey, the degree to which they agreed with various statements about mental health/crisis calls using the following rating scale: (1) Strongly Disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly Agree. To examine whether responses on the pre- and post-implementation surveys were significantly different, Bayes factors were again calculated.

As can be seen in Table 10, across both the pre- and post-implementation surveys, the overall results (averaged across respondents in different positions) indicated that there was a relatively high level of agreement (>4/5) when respondents were asked whether they feel safe during mental health/crisis calls; whether they exhaust all options before involving the police; whether the COAST will provide better support than "business as usual"; whether they have knowledge of when to involve the police in a mental health/crisis call; and whether they are knowledgeable about the role of community support services in London. Slightly lower levels of agreement (3-4/5) were expressed when respondents were asked whether they are satisfied with the immediate outcomes of interactions involving people with mental health issues or in crisis; whether they are satisfied with how the police handle these interactions; whether they are satisfied with police- CMHA TVAMHS communications; whether they have knowledge of what role the police play during mental health/crisis calls; and whether they are knowledgeable about the role of the COAST and the CRT.

Low levels of agreement (2-3/5) were found when respondents were asked whether they are satisfied with interactions between CMHA TVAMHS staff and people in crisis within the community and Crisis Centre; whether they are satisfied with interactions between police and people in crisis within the Crisis Centre; whether they are satisfied with warm transfers between the police and the Crisis Centre and between the police and the CRT; and whether they are satisfied with the quality of follow-up care. Very low levels of agreement (<2/5) were found when respondents were asked whether they are satisfied with the quality of proactive interventions and whether they are satisfied with interactions between police and people in crisis within the community.

In terms of significant differences between the pre- and post-implementation surveys, few differences were found. Possible explanations for this were presented in Section 6.1.2. All significant differences are marked with a ** in Table 10.

For respondents who primarily interact with people with mental illness or in crisis over the phone, they reported: (1) significantly higher levels of satisfaction on the post-survey with how police manage interactions with people with mental illness or in crisis, (2) significantly

higher levels of agreement on the post-survey that they exhaust all options before involving the police, and (3) significantly higher levels of knowledge on the post-survey about the COAST and the CRT. For respondents who primarily interact with people with mental illness or in crisis face-to-face, they reported significantly lower satisfaction on the post-survey with police-CMHA communication.

Unfortunately, few reasons were provided by respondents for why these significant differences were observed across the surveys.

Table 10. Perceptions of Mental Health Calls by CMHA TVAMHS Respondents

	Phone			Face-to-Face			Both			COAST			Overall		
Survey Item	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes	Pre	Post	Bayes
Feel safe during mental health/crisis calls	4.13	4.45	.63	4.15	5.00	--	3.97	4.00	.31	4.67	4.00	--	4.10	4.25	.32
Satisfied with immediate outcomes of interactions	3.80	4.18	.61	3.69	4.50	.73	3.89	3.86	.32	4.33	4.00	--	3.85	4.04	.36
Satisfied with how police manage interactions	**2.47**	**3.18**	**1.09****	2.85	2.50	.58	3.45	3.21	.44	3.33	3.00	--	3.09	3.14	.24
Satisfied with police-CMHA communication	2.92	4.00	.65	**3.67**	**2.50**	**1.27****	3.72	3.73	.46	4.33	5.00	--	3.58	3.77	.41
Exhaust all options before involving police	**4.00**	**4.65**	**3.81****	4.17	5.00	--	4.56	4.50	.41	4.33	5.00	--	4.34	4.61	.48
COAST will provide better support	3.87	4.75	.79	4.33	4.00	.60	4.41	4.08	.49	4.67	5.00	--	4.27	4.33	.31
Knowledgeable about when to involve police	3.93	4.44	0.47	4.42	5.00	--	4.50	3.92	.49	4.67	5.00	--	4.36	4.24	.27
Knowledgeable about role of police	3.57	3.62	.42	4.00	3.00	--	3.91	3.54	.38	4.00	4.00	--	3.85	3.54	.32
Knowledgeable about role of community support services	3.86	4.67	3.47	4.08	3.50	.64	4.06	3.92	.64	4.33	4.00	--	4.03	4.16	.26
Knowledgeable about role of COAST and CRT	**3.00**	**4.00**	**1.05****	3.25	3.50	.56	3.00	3.38	.39	4.33	5.00	--	3.11	3.68	.93
Satisfied with proactive intervention	1.91	2.33	.51	1.73	1.00	--	2.13	2.17	.35	1.00	3.00	--	1.95	2.17	.33
Satisfied with interactions between CMHA staff and individuals in crisis in the community	2.45	2.78	.62	2.70	2.50	.62	2.50	2.67	.36	2.67	3.00	--	2.54	2.71	.28
Satisfied with interactions between police and individuals in crisis in the community	1.67	2.25	.47	1.82	1.50	.57	2.00	1.83	.59	2.00	2.00	--	1.90	1.96	.28

Satisfied with interactions between CMHA staff and individuals in crisis in the crisis centre	2.50	2.78	.46	2.70	3.00	--	2.79	2.70	.36	3.00	3.00	--	2.72	2.78	.27
Satisfied with interactions between police and individuals in crisis in the crisis centre	2.14	2.50	.44	2.00	2.50	.65	2.46	2.44	.48	2.67	3.00	--	2.31	2.50	.28
Satisfied with warm transfer from police to crisis centre	2.14	2.57	.76	2.00	2.50	.73	2.54	2.33	.42	2.33	3.00	--	2.34	2.47	.87
Satisfied with warm transfer from police to CRT	2.50	2.75	.45	2.33	3.00	.63	2.59	2.60	.44	2.50	.00	--	2.53	2.68	.30
Satisfied with follow-up care	2.22	2.50	.73	1.90	1.50	--	2.18	1.78	.45	2.50	3.00	--	2.15	2.00	.73

6.4. Challenges with the COAST

Across the three organizations that completed the post-implementation survey, a wide range of challenges associated with the COAST were identified. Some of the challenges were identified by staff in multiple organizations, including:

- Limited COAST resources, particularly staffing, which prevents 24/7 coverage and quick response times
- Role confusion, in terms of what the COAST does and does not do, and when to use the COAST versus other support programs
- Access to community resources (e.g., limited resources, available resources are unable to address client needs, wait times to access resources are lengthy)
- Poor communication between community support services, making it difficult to develop coordinated responses

Most of the other challenges that were identified were unique to each organization. These are described below. Importantly, most of these challenges were endorsed by only a small number of survey respondents (<10%), suggesting that most respondents either did not take the time to complete this section of the survey, were unsure of what challenges exist with the COAST, or do not believe there are any challenges.

6.4.1. Challenges Identified by LPS Staff

Additional challenges identified by LPS staff included:

- The COAST is unable to transport clients to hospital, meaning that frontline LPS officers are still required during some COAST calls
- No replacements have been made to frontline LPS officers who moved to the COAST, leaving patrol resources in a deficit
- The COAST has a limited impact on the workload of frontline LPS officers, because many COAST calls are self-generated (rather than taken from the LPS call queue) and because COAST does not respond to many high-risk calls
- COAST clients can be resistant to change, they don't always follow through on their care plan, and they contact the LPS frequently
- There are difficulties in transferring knowledge from the COAST to frontline LPS officers (e.g., best ways to manage mental health calls)

6.4.2. Challenges Identified by Staff from St. Joseph's

Additional challenges identified by staff from St. Joseph's included:

- The COAST is reluctant to apprehend clients
- It is difficult to access the COAST in a proactive manner
- People with mental health issues or in crisis are unable to self-refer to the COAST

6.4.3. Challenges Identified by CMHA TVAMHS Staff

Additional challenges identified by CMHA TVAMHS staff included:

- The COAST occupies CMHA TVAMHS building space, which is limited
- The COAST has limited capacity for finding long-term solutions to challenges experienced by clients
- LPS officers do not always trust CMHA TVAMHS assessments of clients and will do their own instead, often with different results
- The police do not always request support when it is needed
- The COAST is becoming more police-led than what was intended

6.5. Impact of the COAST

Across the three organizations that completed the post-implementation survey, a wide range of COAST impacts were also identified. Some of the impacts were identified by staff in multiple organizations, including:

- The COAST improves outcomes for clients (e.g., diversion away from the police and the emergency department)
- The COAST develops stronger relationships with clients, gets to know them better, and can provide them with more support than frontline LPS officers
- COAST members have a better understanding of mental health than do frontline LPS officers and more knowledge of available mental health resources (including how to access those resources)
- COAST members are less threatening to clients than frontline LPS officers and clients like having civilian members on the team

Other impacts were unique to each organization. These are described below. Like the challenges highlighted above, most of these impacts were only endorsed by a small number of survey respondents (<10%), suggesting that the majority of respondents either did not take the time to complete this section of the survey, were unsure of what impact that COAST is having, or do not believe the COAST is having an impact.

6.5.1. Impacts Identified by LPS Staff

Additional impacts identified by LPS staff included:

- The COAST frees up some LPS resources (e.g., by taking calls out of the LPS call queue and by reducing the number frequent contacts with clients)
- COAST members conduct follow-ups with clients, which is important for client well-being (e.g., seeing if they are following through on their care plan)
- The COAST reduces the need to use physical force during interaction with clients

6.5.2. Impacts Identified by Staff from St. Joseph's

Additional impacts identified by staff from St. Joseph's included:

- The COAST is accessible when other community support services are not
- The COAST can conduct assessments of clients
- The COAST helps bridge the gap between the police and hospital staff

6.5.3. Impacts Identified by CMHA TVAMHS staff

Additional impacts identified by CMHA TVAMHS staff included:

- The COAST can support higher need clients that frequently encounter the police better than frontline LPS officers can
- The COAST improves the relationship that clients have with the CMHA TVAMHS
- The COAST makes clients feel more supported and validated
- Interactions with the COAST make clients trust the police more

6.6. Key Findings

Awareness, Use, and Perceived Effectiveness of Mental Health Resources

- The staff from each partner organization are mostly aware of the mental health resources that are available to support clients, they often use them, and they generally perceive them to be effective
- When resources are not used, this is usually because the resources are not relevant to the duties of the staff or because the staff have yet to require them (but they would use the resource if needed)
- The only resource where significant issues were found was for the Connectivity Table; staff working within the LPS and St. Joseph's were generally unaware of this resource (34% and 44% awareness levels, respectively).

Perceptions of Mental Health/Crisis Calls

- With respect to perceptions of mental health/crisis calls and the organizations that play a role in these calls, very few significant differences were observed between the pre- and post-implementation surveys
- The lack of significant results may speak to the inadequacies of survey methodologies, the fact that the COAST does not impact the sorts of outcomes asked about on the surveys, that other system adjustments will be needed before we can see the impact of the COAST, or that the COAST will have an impact once it is adequately resourced or once it has been functioning for a longer time period

Challenges Associated with the COAST

- Various challenges associated with the COAST were identified by survey respondents, some of which were common to multiple organizations, including the views that COAST services are not always available due to limited staffing and confusion about what the COAST does and does not do
- Other challenges that were identified were organization-specific, such as the view that the transfer of frontline officers to COAST has left patrol resources in a deficit (LPS), that it is difficult to access the COAST in a proactive manner (St. Joseph's), and that the COAST is becoming more police-led than what was intended (CMHA TVAMHS)

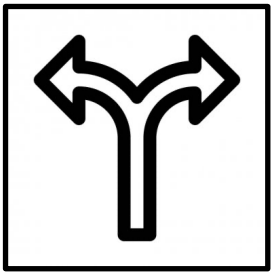
Impacts Associated with the COAST

- Various impacts of the COAST were also identified, some of which were common to multiple organizations, including the views that the COAST results in better client outcomes and COAST members are seen as less threatening by clients
- Other impacts that were identified were organization specific, such as the view that the COAST reduces the need to use physical force during interactions with clients (LPS), that the COAST helps bridge the gap between the police and hospital staff (St. Joseph's), and that interactions with the COAST make clients trust the police more (CMHA TVAMHS)

7. Client Surveys

Overall, the survey results from clients suggest they are generally satisfied with the COAST, that COAST is resulting in diversion away from police and hospital settings, and that the COAST reduces the need for 911 calls from people in crisis. More detailed data related to these findings are presented below.

High satisfaction



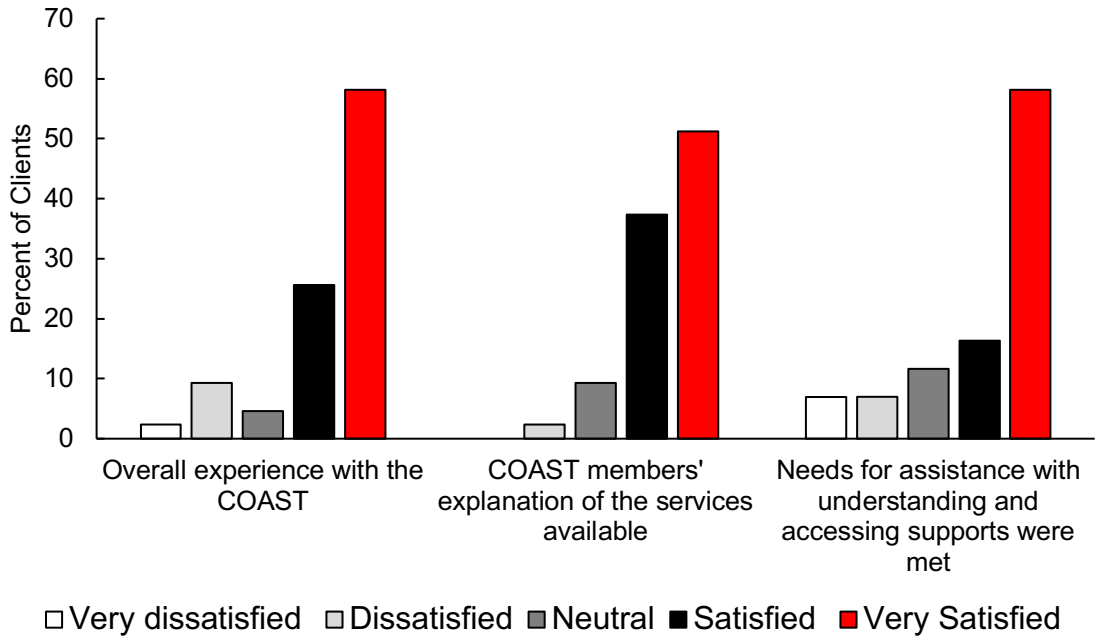
Diversion from hospital and police

Reduced need for 911

7.1. Client Satisfaction

As indicated in Figure 9, most clients that were surveyed (*N* = 43) are satisfied or very satisfied with their overall experience with the COAST (84%), COAST members' explanation to them of the services available (88%), and that their needs for assistance with understanding and accessing supports were met (74%).

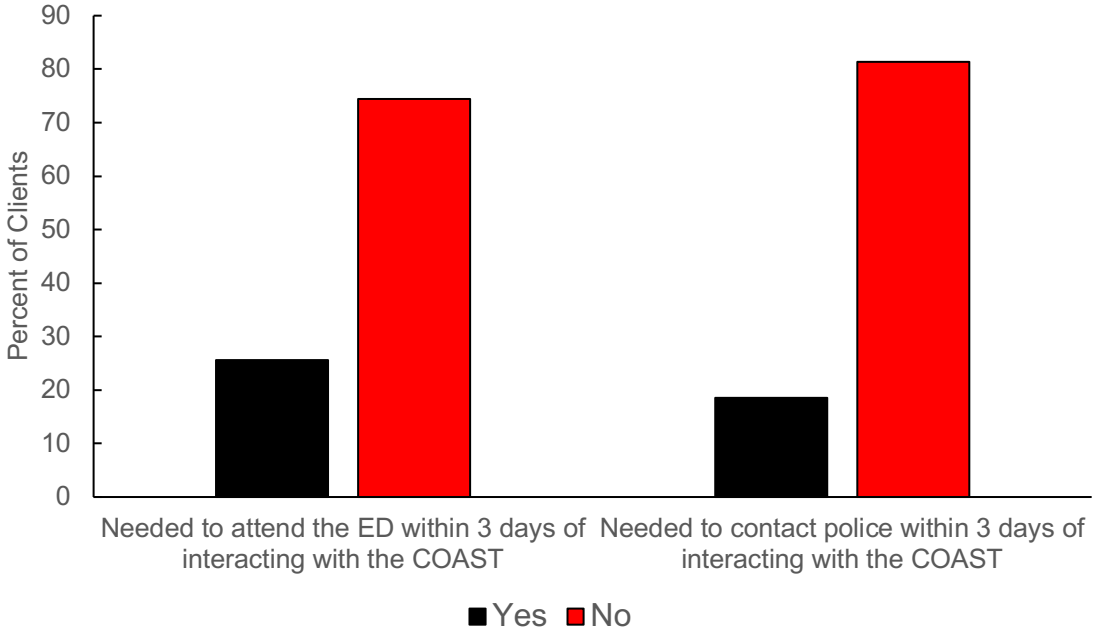
Figure 9. Client Satisfaction with the COAST



7.2. Diversion from the Hospital and Police

As indicated in Figure 10, there is some evidence that the COAST is resulting in short-term diversion. Thirty-two out of 43 (74%) clients indicated they did not need to attend the emergency department (ED) within 3 days of interacting with the COAST. In addition, 35 out of 43 (81%) clients indicated they did not need to contact police within 3 days of interacting with the COAST. Although not asked about explicitly in the client satisfaction survey, these findings also suggest that the COAST may be resulting in diversion away from the paramedic service given that the MLPS will often be responsible for transporting clients to the ED when 911 calls are made.

Figure 10. Diversion from the Hospital and Police



Notably, when asked what they would have done if COAST was not available for them, 12 of 36 (33%) clients indicated they would have called 911. Other alternative responses are included below. Of particular concern is the 28% of clients (*n* = 10/36) who indicated they would have tried dealing with things themselves.

33% would have called 911

28% would have done nothing, and tried dealing with things themselves

14% would have called crisis line (e.g., Reach Out through the CMHA TVAMHS)

8% would have called the hospital

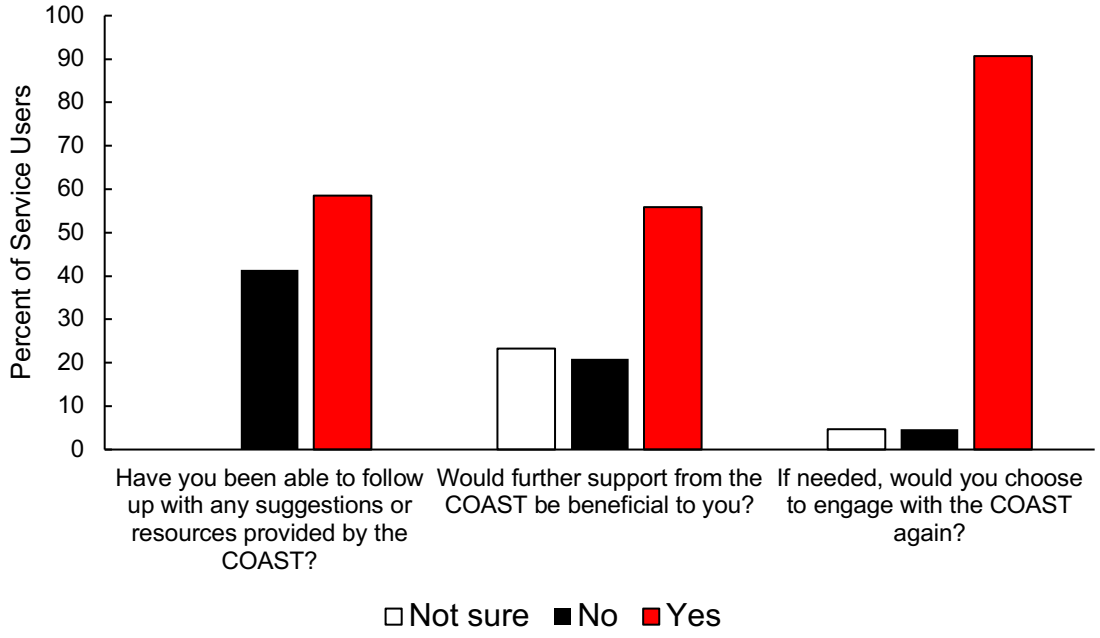
3% would have called their counsellor/mental health worker/doctor

0% would have called a family or friend for help

7.3. Further Support

As indicated in Figure 11, it appears that just over half of clients have followed up with the supports provided by the COAST (*n* = 24/41, 59%) and indicated that further COAST support would be beneficial (*n* = 24/43, 56%). It may be beneficial to investigate why clients are not following up with the supports provided to a greater degree given that lack of engagement with these supports may negatively impact the individual and reduce the impact the COAST can have. Similarly, it may be beneficial to understand why some clients did not feel further support from the COAST would be beneficial. Given that 91% of clients (*n* = 39/43) indicated that if needed they would engage with the COAST again, this may simply be a matter of their not being a need for further support.

Figure 11. Further Support from the COAST



7.4. Comments

When asked if they had any other comments they wished to share, numerous clients provided feedback. Most of the comments were positive, such as:

> "Thank you to the team that came. They treated me with so much compassion, empathy, and respect."

> "It's a shame that there aren't more of these teams available. They went far above and beyond what could have been offered by just having regular police come. It is such a valuable service."

> "They helped so much when we needed them. They were so friendly and provided so much helpful information and resources."

> "The COAST team approached me with respect, validated and normalized what I was going through. I appreciated their support very much."

> "This is such a wonderful program and group of people. This is really filling a need in our community and I am grateful to have involvement with COAST."

> "I like the partnership between a police officer and mental health worker. It is just so helpful. They were both so empathetic and went above and beyond to meet my needs."

But there were also some negative comments, or feedback on how the program could be improved:

> "I did not like that they assumed I was suicidal. I said I did not want to live without my dying husband, but that doesn't mean I want to kill myself. I don't like being judged like that."

> "Participant expressed that COAST's method of having participants follow up by phone was somewhat ineffective due to fears around others listening in to her phone calls."

> "Participant voiced he felt "abandoned" by COAST due to being told a follow-up would occur, however it did not occur in a timely manner according to him (he stated follow-up call was made 3 weeks after initial interaction)."

> "Wish I could have gotten a hold of them."

> "Participant shared that she was uncertain around how accurate the [survey] data she is providing would be, given that she had a few vastly different COAST interactions. Noted that improvements could be made within communicating when COAST can and cannot provide support given that she phoned COAST on Sunday Oct. 3rd and was told to phone police."

> "It would be helpful to speak with the same person every time. I get confused by how many of you there are."

> "Client expressed she wished COAST members were available during 'later times' (in the night) as this is when her mental health symptoms worsen."

7.4. Key Findings

- Most clients who were surveyed are satisfied with the COAST, satisfied with the explanations they receive from the COAST about available services, and satisfied with how the COAST helped them understand available supports and how to access them
- Most clients indicated they did not need to attend the hospital within three days of interacting with the COAST or contact the police within three days of interacting with the COAST

- When asked what they would have done if COAST was not available for them, the most common response from clients was that they would have called 911; the next most common responses were that they would have tried to deal with the problem themselves or call a crisis line
- Over half the clients surveyed followed up with the supports provided by the COAST and indicated that further COAST support would be beneficial; nearly all the surveyed clients indicated that, if needed, they would engage with the COAST again
- Most comments about the COAST from clients were positive, but negative comments were also made; most positive comments related to the compassion and kindness exhibited by the teams and the value of the program generally; negative comments related to the lack of COAST availability and improvements that could be made to how the COAST interacts with clients (e.g., quicker follow-ups)

8. Staff and Client Interviews

Thirty-eight in-depth interviews with staff from the partner organizations (*n* = 32) and COAST clients (*n* = 6) were conducted to examine their perceptions of the COAST. Of the staff members, 9 (28%) were from the LPS, 9 (28%) were from the CMHA TVAMHS, 8 (25%) were COAST members, 5 (16%) were from St. Joseph's, and 1 (3%) was from the MLPS. Eight (25%) interviewees were leaders from the partner organizations who were associated with the COAST in some way (e.g., members of the Governance or Steering Committees). Among the interviewees, we had representation from different roles within each organization except for the MLPS. Within the LPS, participants were foot patrol officers, patrol officers in the uniform division, as well as COAST leaders. Within the CMHA TVAMHS, participants were transitional case managers, Reach Out Crisis Line workers, members of the CRT, and individuals within various leadership positions. Within St. Joseph's, we interviewed a doctor, Assertive Community Treatment (ACT) nurses, and COAST leaders. A descriptive breakdown of the interviews and interview participants, including means, standard deviations, minimum values, and maximum values, is provided in Table 11. All but one of the participants we interviewed were Caucasian (*n* = 37, 97%); the remaining participant identified as mixed race.

Table 11. Descriptive Information about the Interviewees and Interviews

Participant Group	Interview Length (minutes)	Age (years)	Years of Experience	Gender	
				Male	Female
Staff (*n* = 32, 84%)	*M* = 62.6 *SD* = 13.6 Min = 36 Max = 99	*M* = 40.7 *SD* = 11.2 Min = 25 Max = 66	*M* = 13.1 *SD* = 9.0 Min = 1 Max = 36	13 (40.6%)	19 (59.4%)
Clients (*n* = 6, 16%)	*M* = 67.3 *SD* = 27.9 Min = 33 Max = 118	*M* = 46.3 *SD* = 23.6 Min = 18 Max = 77	N/A	2 (33.3%)	4 (66.7%)

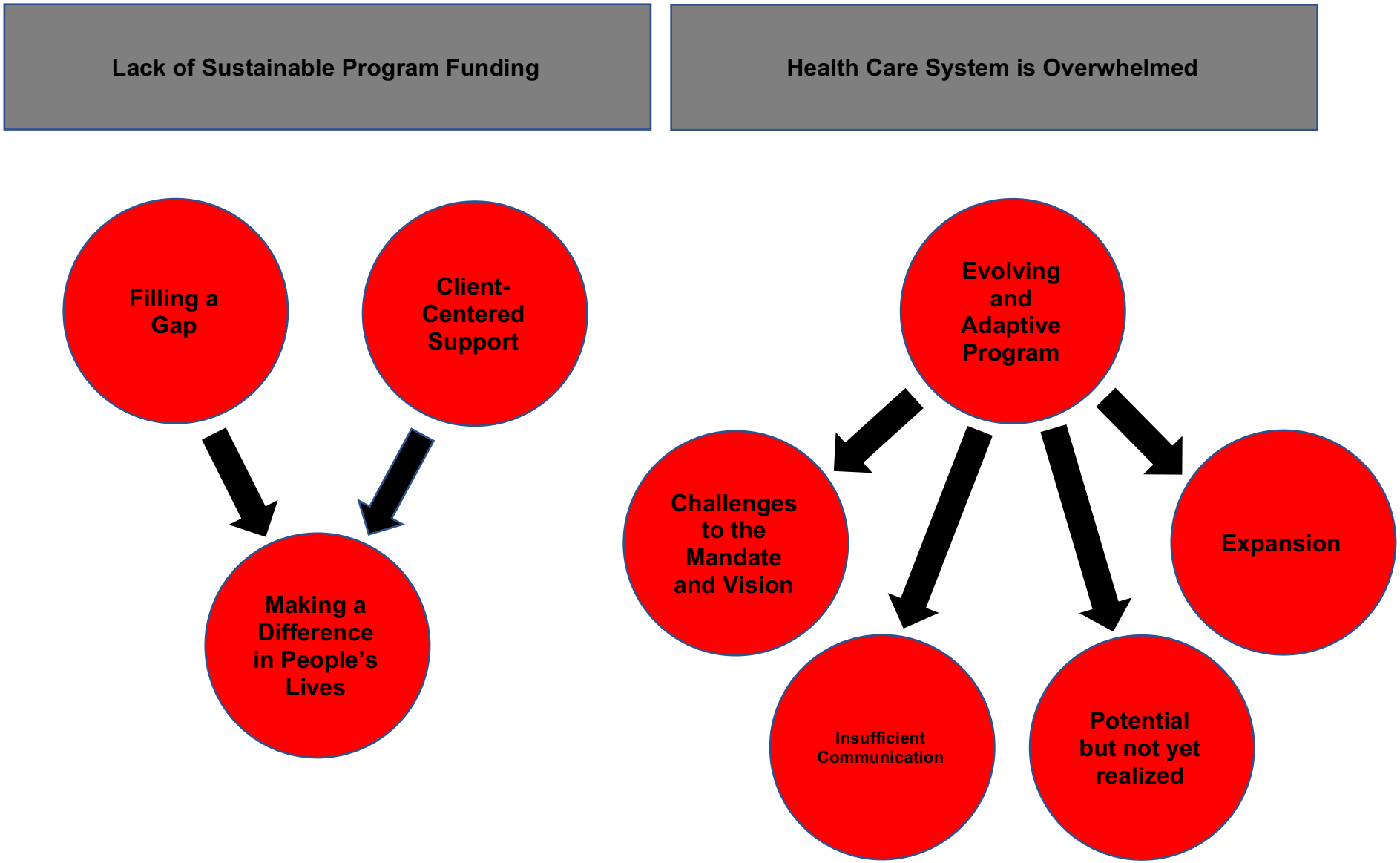
8.1. Thematic Map

The interviews were analyzed using an inductive reflexive thematic analysis that involved the identification of themes (and sub-themes) related to perceptions of the COAST. A condensed version of that analysis is presented in this section of the report for brevity, using the thematic map presented in Figure 12 as a guide.

The analysis revealed 10 themes, several of which had sub-themes. In general, the analysis determined that the COAST is filling a gap in the London community and offering client-centered support, which has made meaningful differences in the lives of individuals, including members of the COAST, staff in the partner organizations, staff from the hospitals, and most importantly clients who have utilized the COAST. We also found that

the COAST is an evolving program, which is constantly adapting to emerging issues to better serve the needs of the community. Several themes were identified that highlight key issues that should be considered as the COAST continues to evolve and adapt. These include: (1) refining the mandate and role of the COAST, (2) providing more effective communication and advertisement about the program, (3) exploring directions where there is potential for the program to have an impact, but that potential has not yet been realized, and (4) considering opportunities for COAST expansion to the extent that is feasible. Finally, we identified themes which highlight that the impact of the COAST is affected by two overarching issues facing the team. These themes speak to the lack of sustainable funding for the COAST and issues associated with a healthcare system that is currently overwhelmed.

Figure 12. Thematic Map of Interview Findings



8.2. Filling a Gap

Interviewees described how the COAST program is filling a gap in the available support system in London. During the interviews, it became clear that the COAST was not only an additional program that supports members of the London community, but that the program operates in a unique space where other programs are unable to offer support. Sub-themes related to this theme are presented below.

8.2.1. Another Resource

A significant number of interviewees expressed that the COAST complements the resources already available within London (*n* = 22). It was made clear that the COAST is not suitable for all individuals, however, for those individuals experiencing issues that are within the scope of the COAST, the program contributes to the level of support available for the London community. Further, the COAST was often viewed as a conduit for a variety of other services that allow for wrap-around client care.

8.2.2. Police Aren't Well Equipped for Mental Health Calls

The need for the COAST was underpinned by the fact that many interviewees felt that police officers are not adequately equipped to respond to mental health and crisis-related calls (*n* = 33). Interviewees noted that the police have taken on a significant number of mental health and crisis-related calls, however, they felt they were not the best suited to respond to these calls. Police responses were often described as band-aid solutions because officers have limited time to interact with clients, a limited awareness of community resources, and lack sufficient training related to interactions with individuals experiencing mental health crises.

8.2.3. Nature of the Pairing

Many interviewees noted how the pairing of a healthcare provider and a police officer allows for the provision of care in unique contexts (*n* = 29). Specifically, interviewees felt that the COAST enables the expertise of the healthcare provider to be applied to situations where they would not typically operate due to safety concerns or the need for consent-based care. In contrast, the officers' authorities allow for interactions that do not require the need for consent (e.g., wellbeing checks, apprehensions). Furthermore, the fact that the LPS member of the COAST is equipped with intervention options means that the COAST can operate as a primary response unit and therefore respond alongside LPS patrol during certain calls. Finally, the COAST can be involved throughout the duration of an incident, so that individuals in crisis do not have to repeat themselves numerous times during various handoffs (e.g., crisis response to police, police to hospital staff).

8.3. Client-Centered Support

Interviewees indicated that the nature of support offered by the COAST is client-centered and focuses on ensuring that support is tailored to an individual's needs so that they are supported in a meaningful way. The ability to offer client-centered support is facilitated in a variety of ways through the COAST. The sub-themes related to these facilitators are presented below.

8.3.1. Support is Flexible and Diverse

The nature of the support provided by the COAST is tailored to individual needs (*n* = 37). While there are a wide variety of ways in which the COAST was described to support individuals, this commonly included connecting individuals to resources, providing follow-ups, and assisting with system navigation. Somewhat unique to the COAST, it was also noted by interviewees that the team supports family members (e.g., when an individual is being apprehended under the Mental Health Act), provides legal advice, and perhaps most significantly, they advocate for individuals who are often unable to advocate for themselves in a variety of contexts (e.g., at the hospital with staff, with the housing board).

8.3.2. The COAST Has Therapeutic Qualities

Nearly all interviewees mentioned how the COAST embodies therapeutic qualities (*n* = 32). A large majority of these interviewees specifically highlighted how the COAST uniform and the unmarked van are less intimidating than LPS patrol officers responding in a marked cruiser. The softened optics of the COAST was seen as contributing to a reduction in stigma when interacting with the COAST and worked to minimize the power differential that was often felt when clients interact with frontline LPS officers. That being said, a few interviewees expressed concerns with elements of the COAST uniform regarding police intervention options. One client took issue with the fact that the LPS member of the COAST was equipped with a gun and felt its presence was unnecessary (which was expressed by a COAST member as well). An LPS patrol officer similarly expressed concern about the presence of a gun when the officer wasn't readily identifiable as a police officer (i.e., wearing the COAST uniform instead). Finally, one client felt the LPS member of the COAST should have more intermediate intervention options, so they aren't forced to use their firearm in the event a situation became escalated. Beyond the appearance of COAST members, the interactions with individuals were characterized as trauma-informed, empathetic, and more compassionate than when interacting with other healthcare or police practitioners.

8.3.3. The COAST Can Dedicate More Time than Patrol

One factor that allows the COAST to offer better client-centered support is the fact that they are able to dedicate more time to calls than patrol (*n* = 8). LPS patrol officers were

described as being tied to the queue of calls for service, which has grown significantly over the past few years. The fact that the COAST is less concerned about queue management results in the team being able to spend more time with individuals in crisis. This additional time was seen as critical for validating individuals and allowing for the development of better rapport.

8.3.4. The COAST Tries to Understand the Situation

Related to the fact that the COAST is able to dedicate more time to interactions, some interviewees (*n* = 10) felt that the COAST does a better job of trying to understand the situation that individuals are facing than frontline LPS officers. Understanding the situation from the individual's perspective allows the COAST to move beyond band-aid solutions and instead get to the root cause of issues. Moving beyond band-aid solutions was described as improving the outcomes for the individual once the COAST was involved.

8.3.5. Being Mobile is Helpful

A number of interviewees suggested that the COAST being mobile not only increases the number of people who can be supported by the program but also facilitates client-centered care (*n* = 9). Specifically, going to a person's residence provided COAST members with more information about their living conditions and allowed them to identify other areas where the individual could use support (e.g., a pet bank for pet food). Furthermore, the COAST being mobile enabled face-to-face interactions, which were limited by other services during the pandemic.

8.3.6. Officer Presence is Helpful

Some interviewees (*n* = 4) described how the presence of a police officer on the COAST was beneficial for providing client-centered support because the client was provided options as to who they would like to engage with (i.e., the officer or the healthcare worker). Additionally, it was mentioned numerous times that some individuals preferred to interact with police officers and that they seemed to feel more comfortable or validated because of the presence of officers.

8.4. Making a Difference in People's Lives

It was clear to interviewees that the COAST is making a difference in people's lives. While primarily focused on the lives of the individuals who have been supported by the COAST, there were also benefits to the London community more broadly. Interestingly, the COAST also appears to be making a difference in the lives of the COAST members, healthcare providers, as well as officers working for the LPS. Sub-themes related to this theme are presented below.

8.4.1. Perceived Need for the COAST

It was clear that across the interviewees there was a common perception that COAST is required within the London community (*n* = 29). From the perspective of individuals who have received support from the COAST, this was due to really positive interactions with team members, which often resulted in the individual specifically requesting the COAST when they required additional support.

8.4.2. Improved Relationships Between Police and Community Members

Individuals who have received support from the COAST, and the COAST members themselves, felt that positive interactions with the COAST repaired relationships between some community members and the police (*n* = 9). Primarily, the positive interactions were viewed as shifting individuals' perceptions of police away from being enforcement focused towards providing social support. For some individuals, the improved relationship generalized to police more broadly instead of just the officers on the COAST.

8.4.3. Reducing Unnecessary Institutional Interactions

One way in which the COAST is thought to make a difference in people's lives is by providing adequate support to them, which reduces the number of unnecessary institutional interactions such as hospital visits or police contacts through calls for service (*n* = 16). By stabilizing the individual in crisis and reducing the number of crises that occur within the community, the COAST is able to reduce the likelihood that individuals are criminalized or apprehended. A secondary benefit of providing support within the community that was mentioned by practitioners is that it reduces the demand on emergency services, which are currently beyond capacity.

8.4.4. Learning Within Organizations Improves Service

To many of the interviewees (*n* = 19), the implementation of the COAST has also created a ripple effect of learning within the partner organizations, which has ultimately improved service for the London community. The transfer of knowledge within and across organizations has improved service in a variety of ways. For example, each organization has learned about the challenges that other organizations involved in the COAST face and how the strengths of their own organization can be leveraged to minimize the impact of these challenges. Additionally, numerous interviewees spoke about knowledge transfer within the LPS, which has increased the quality of service that their members provide. According to some interviewees, learning through informal conversations and observing COAST members interact with the community has allowed LPS patrol officers to become more trauma-informed and has led them to contact appropriate community resources more frequently.

8.4.5. Impacting Other Programs

Some of the healthcare providers and police officers who were interviewed discussed how the COAST has had an impact on other support programs (*n* = 7). Specifically, the COAST has sparked conversations among other social support programs within the London community (e.g., advocacy groups for people without housing). It was suggested that the strong partnership between the four COAST organizations has motivated other programs to collaborate in ways they had not previously. One concrete example of the COAST impacting other programs is the creation of a COAST bed at the Salvation Army. It also appears that London's COAST has had an impact on co-response teams outside of the London community (e.g., other municipalities switching to internal vest carriers after learning more about London's COAST).

8.4.6. Consultations

Healthcare providers and patrol officers who we interviewed noted that they seek out the COAST for consultations regarding the best course of action for particular individuals (*n* = 10). Most commonly, the COAST is consulted in regard to whether an individual should be apprehended. The fact that the COAST works out of the CMHA TVAMHS building was seen as something that facilitates these consultations.

8.4.7. Mutual Respect Between the Hospital and the COAST

Some interviewees (*n* = 5) noted the development of mutual respect between hospital staff and the COAST. For example, when the COAST apprehended an individual, some people thought that the COAST had clearly demonstrated that they had done their best to avoid an apprehension. In contrast, sometimes hospital staff feel that LPS patrol officers apprehend individuals who do not meet the threshold (e.g., out of concerns for liability). Relatedly, the relationship between hospital staff and the COAST was facilitated by the fact that the COAST is more knowledgeable and has more information available to them about the individuals they interact with, and as a result, it is easier for hospital staff to make assessments.

8.4.8. Relief for Staff Knowing Client is Supported

Healthcare providers indicated there was a sense of relief knowing that their client was being supported by the COAST (*n* = 7). This sense of relief was particularly true for healthcare providers who work on an appointment basis; these individuals knew that the COAST was there to support their client if they required assistance before their next appointment. Similarly, being that most community resources operate Monday to Friday during business hours, knowing that the COAST was sometimes available outside of these hours was comforting.

8.4.9. Meaningful and Rewarding Work

Interviewees involved in the implementation of the COAST described their work as being very meaningful and rewarding (*n* = 11). Primarily, this centered around the feeling that they were significantly contributing to the wellbeing of the London community and supporting individuals in need. For these reasons, being involved with the COAST was described as an enriching experience, which for many marked the highlight of their careers. Additionally, these interviewees noted that they learned a lot throughout the implementation of the COAST, which has been a really positive experience.

8.4.10. Assisting Patrol Officers

Interviewees believed that the COAST assisted LPS patrol officers in a variety of ways (*n* = 34). The interviewees who felt that the COAST assists patrol officers were primarily healthcare providers and members of the LPS, although some clients mentioned this as well. The COAST is primarily perceived to assist patrol officers during in-progress calls. For example, the COAST may respond to an incident when requested by patrol, the COAST has relieved officers from the hospital during apprehensions, and the COAST occasionally self-assigns to calls in the LPS call queue in order to help support individuals and assist with queue management. Additionally, a few interviewees highlighted that the COAST sometimes provides guidance during higher-risk calls (e.g., suggesting avenues for the crisis negotiator to pursue). Finally, some interviewees described how information collected by the COAST could be leveraged by patrol officers during subsequent interactions with an individual (e.g., by providing topics that the officer can use to build rapport with the individual).

8.5. COAST is an Evolving and Adaptive Program

Interviewees discussed how the COAST has constantly evolved and adapted by taking on what they could, building on the program, identifying and adjusting to issues as they emerged, and constantly coming up with ways to better support their community. Some examples of how the program has evolved and adapted include: (1) learning how to navigate issues related to privacy laws and documentation, (2) pivoting away from a focus on executing mental health forms, and (3) establishing boundaries with individuals who suffer from mental illnesses that can be hindered by too much high intensity support (e.g., borderline personality disorder). The evolving and adaptive nature of the COAST appears to be facilitated by several factors. These factors will be discussed below.

8.5.1. Responsive Training

Given that COAST members are coming from backgrounds with varying educational requirements and different organizational perspectives, and that they support individuals with diverse needs in the community, a number of interviewees spoke to the importance

of training both initially and on an ongoing basis (*n* = 12). These interviewees viewed initial training as beneficial but felt that in the future it should: (1) be more tailored to their different educational backgrounds, (2) include more team building components so that they can better understand each other's different perspectives, and (3) if permitted by public health guidelines, be conducted in person to allow for things like role-play scenarios. Interviewees also spoke to training being something that should be done on a regular basis and be based on identified knowledge gaps in order to better equip the team to support the diverse needs of their community. Interviewees suggested a variety of different topics for training including trauma, supporting geriatric and youth clients, and what to do in cases where safety is compromised. In line with this, one of the clients suggested that the team gain more knowledge around the resources available in the community for different client groups (e.g., online addiction recovery programs, resources for single mothers, supports for the elderly).

8.5.2. Leveraging Diverse Perspectives

The multidisciplinary nature of the COAST offers diverse perspectives. This is both a strength of the program, as well as something that can cause challenges (*n* = 24). Interviewees spoke to how the partners bring different educational backgrounds, skillsets, and experiences that together strengthen the knowledge base of the program and can be leveraged to solve problems as they emerge, find better ways of doing things, and provide better support to clients who have complex needs. Through all four partner organizations, the COAST has access to robust knowledge on topics ranging from emergency medical intervention, medications, community treatment orders, crisis intervention, resources in the community, the law, and maintaining safety. These diverse perspectives are maintained at every level of the COAST, from the frontline to the Governance and Steering Committees (which also include individuals with lived experiences).

However, interviewees also suggested that, at times, the diverse perspectives offered by the partnership of four distinct organizations can create challenges. These challenges arise from disagreements on issues due to the diverse perspectives of program members, as well as through trying to reconcile practical differences in organizational operations (e.g., collective agreements, shift schedules, differing COVID-19 protocols). Related to this, it is worth noting that two interviewees indicated that it wasn't clear to them why paramedics are part of the COAST. Specifically, one interviewee expressed that they don't feel the paramedics are able to contribute to the program to the same extent as the other healthcare partners because they receive minimal mental health training (like the police), they were not provided with well-functioning equipment by their organization, and they don't have access to any additional documentation like other healthcare partners, which leaves them reliant on other partners. That being said, several participants also noted that the full-time paramedic on the team has a degree in social work, which makes this individual well-equipped to fulfill their role on the COAST.

8.5.3. Intentional Communication

Interviewees from various levels of the program, from the frontline to the Governance and Steering Committees, spoke to how ongoing communication amongst team members, guided by a focus on common goals and each other's strengths, was essential to the effective operation of the COAST (*n* = 14). This communication occurs regularly at weekly meetings where the team discusses issues that emerged in the previous week and leverages their differing expertise to problem solve. Further, this focused communication was discussed as particularly important for navigating disagreements or conflict, which usually arose because of the diverse perspectives of team members.

8.5.4. Having the Right People in Place

Interviewees spoke to the importance of having the right people on the COAST because not everyone is well-suited to this kind of work (*n* = 20). Interviewees discussed how well-suited the COAST members were for the team due to their knowledge, personalities, and passion to make a difference in the lives of people they support. Several interviewees also spoke to the closeness of the team and their ability to work together effectively and support each other in achieving their common goals despite encountering challenges and conflicts. All of the clients we interviewed (*n* = 6) spoke to how wonderful they felt the COAST members were and discussed how these members made them feel cared about and important. The only exception to this was that one client did not feel that the personalities of two of the team members were well-suited for the work – one was seen as overly directive and unwilling to listen to what was important to the client, and the other was seen as not supportive in nature.

8.6. Challenges to COAST's Mandate and Vision

Several interviewees discussed issues that challenge COAST's mandate and vision. In particular, these issues related to the program's healthcare-led/police-supported vision, the belief that the team should take on a more reactive (as opposed to proactive) role, and the view that there is a lack of clarity surrounding the program's mandate (and how it operates).

8.6.1. Challenges to the Healthcare-Led/Police-Supported Vision

Some of the interviewees suggested that, at times, the COAST operates in a way that challenges the healthcare-led/police-supported vision of the program (*n* = 8). Some interviewees indicated that it feels as though the LPS is driving decision-making, particularly in terms of moving the COAST mandate from proactive to reactive due to pressure to take more calls from the LPS call queue. The disparate financial situation of the partners appears to contribute to this. The LPS contributes a substantial portion of the team's resources (e.g., personnel and equipment), which positions them well to carry out

(and in some cases lead) day-to-day operations. On the other hand, some of the healthcare partners have faced financial challenges, which at various points throughout the last 15 months has made it difficult to contribute to the COAST to the extent that the LPS does. The healthcare partners have taken on additional roles throughout the pilot to ensure that the healthcare perspective is well-represented (e.g., in terms of team guidance and decision-making), but these financial challenges have had a significant impact in some ways (e.g., providing well-functioning equipment to COAST members).

8.6.2. Taking On More Reactive Work

A number of interviewees suggested it would be beneficial for the COAST to take on a more reactive role (*n* = 15). Specifically, these interviewees felt that the COAST should be taking more calls from the LPS call queue, particularly given that police officers are on the team. Further, some felt it would be beneficial for the COAST to take on higher risk calls and to have lights and sirens to be able to get to those calls more quickly. Other interviewees suggested that adding a separate, specially trained, police only rapid crisis response to the model (i.e., in addition to the COAST) would be beneficial. It is worth noting that one interviewee felt that the COAST taking on both reactive and proactive work puts them in an awkward position and doesn't allow them to carry out either role to their fullest potential.

8.6.3. Refining Standard Operating Procedures

Several interviewees felt that it would be beneficial for the COAST to clarify their SOPs to allow people to be on the same page (*n* = 7). In particular, interviewees suggested that it would be useful to define what the referral and care pathways are, to establish the number of follow-ups the team should be doing, to determine what types of calls are ideal for COAST versus the CRT, and to decide whether, or under what circumstances, they will be completing apprehensions.

8.7. Communication About the Program is Insufficient

While COAST members indicated that they provided several presentations to a variety of different groups to educate people about the team, participants from all four partner organization, the hospitals, and clients indicated that this communication was insufficient (*n* = 26). Specifically, interviewees indicated confusion surrounding how and when to access the team, what the team does or can do for people, and how the COAST fits in to the broader ecosystem of other crisis services. Many interviewees suggested there should be more communication about the program, including advertisements, so that everyone was clear about how to use the COAST, when they should be used, and what should be expected when they are used. Some suggested that it would be beneficial to include case examples of when the COAST could be used and what that process of COAST involvement would look like from start to finish. Further, one client mentioned that it would be useful to be left with multiple cards following an interaction with the COAST,

and another suggested that more information about COAST hours of operation would be useful.

8.8. The COAST Has Not Reached its Full Potential

Many participants indicated that while they see the potential in COAST, this potential is not being realized. This was due to various reasons related in large part to the way the team is currently operating. Specifically, there appears to be more work than the team has the capacity for, there is a disconnect between LPS patrol and the COAST, the COAST is unable to transport clients, and not all partners have sufficient access to the program. These reasons are expanded upon below.

8.8.1. There is More Work Than the COAST Has the Capacity For

A large number of interviewees suggested that there is far more work than the current size of the team can support (*n* = 18). Given that the team is small in size, that there are days of the week when there is only one team working, and that there is limited coverage overnight, the COAST is often not available when needed (e.g., by patrol, clients requesting them, staff seeking consultation). According to interviewees, COAST's lack of capacity for the amount of work available limits the impact that COAST is having and contributes to a perceived disconnect from LPS patrol.

8.8.2. Disconnect Between Patrol and the COAST

Generally, while the patrol officers we interviewed saw the potential of the COAST, they just didn't feel it was currently operating in a way that was beneficial to patrol. Several interviewees, including COAST members, indicated that there is a disconnect between patrol and the COAST (*n* = 11). For example, the interviewees indicated that many frontline LPS officers have barely interacted with the COAST, that patrol wasn't sure what the COAST was doing because they never saw them taking calls, that the COAST doesn't operate out of LPS headquarters making them even less visible, and that they were provided minimal information about the COAST. There was some indication that this disconnect between patrol and the COAST was negatively impacting how the COAST was being used. While some COAST members suggested that patrol purposefully uses COAST inappropriately when they don't want to deal with something, perhaps more problematically, some patrol officers suggested that there was a reluctance by some frontline officers to use the COAST. While this appears to be due in part to the COAST's lack of availability and being able to rely on the CRT, it also appears to be due to certain officers within the service not seeing the value in the COAST. This was typically attributed to more senior officers.

8.8.3. The COAST Cannot Transport Individuals in Crisis

While the COAST seeks to alleviate pressure on emergency services, especially the police, the inability to transport clients hinders its capability to do so (*n* = 8). A number of interviewees noted that for the COAST to transport a client they require a safety shield that prevents the individual being transported from accessing the front of the vehicle. While currently when an individual needs to be transported COAST will often rely on the CRT or an ambulance, they also rely on marked patrol vehicles, which potentially stigmatizes clients. This is important because one of the primary functions of the COAST is to provide trauma-informed outreach to clients, many of whom have had negative interactions with the police (and other emergency services) in the past. Additionally, the inability to transport clients limits the capacity of the COAST to achieve other program goals including reducing the impact on emergency services and executing mental health forms and apprehensions.

8.8.4. Disparate Access to COAST by the Partners Organizations

While the COAST receives referrals and takes calls for service from the LPS regularly, some interviewees indicated that, in contrast, other partners including St. Joseph's and the MLPS have minimally referred to the COAST or have less access to the COAST (*n* = 5). Further, two interviewees indicated that in the future, being able to take calls from the paramedic queue would allow the COAST to have more of an impact on the MLPS than the COAST is currently able to have.

8.9. Expansion of the COAST Would Broaden its Impact

Many interviewees felt that expansion of the COAST would allow it to have a more significant impact than it is currently having (*n* = 32). Specifically, interviewees felt that more teams/team members and additional hours of operation would increase the teams' availability to support clients. While many interviewees suggested 24/7 coverage would be ideal because mental health concerns are 24/7, a few felt that a 24/7 model may not be realistic or even necessary given the lack of availability of mental health resources overnight (limiting COAST's referral abilities during that time), the availability of other mental health resources in London (e.g., the crisis line), and the risk level of calls that occur at night, which might limit COAST's involvement in those calls. Interviewees also identified additional opportunities for partnerships and collaboration. Specifically, interviewees indicated that involving other partners and disciplines in the COAST, including nurses from the LHSC, harm reduction workers, and peer support workers, would expand the team's expertise and may help improve the COAST's ability to navigate certain challenges like transfer of care at the hospital. Further, some interviewees felt there were additional opportunities for collaboration between the COAST and Black, Indigenous, and People of Colour organizations, Ontario Works, the hospital, and the

CRT. Finally, some interviewees mentioned it would be nice if the COAST could be a mainstream response like police, paramedics, and fire.

8.10. Lack of Sustainable Funding Harms the Program

During the 15 months in which the COAST has been operational, each of the partner organizations self-funded the program with the exception of the MLPS who was largely funded by St. Joseph's. Lack of sustainable, long-term funding and funding coming from different pools created a variety of challenges for the COAST (*n* = 13). While the LPS did not experience significant challenges in funding the program, participating on the team, and contributing resources and equipment, the healthcare partners faced significant financial challenges that they have spent a large amount of time trying to manage. Perhaps the most significant of these challenges was when MLPS funding ran out leading them to temporarily suspend their involvement on the COAST. This was difficult for the team, both financially and personally. Given that the MLPS had a full-time member devoted to the team, when they had to disengage from the team it fell on the other healthcare partners to fill these shifts. This placed a lot of stress on these other organizations. Further, given the close-knit nature of the team, and how passionate they all are about the program, it was disappointing for team members to lose a partner. Members of the COAST and their leadership staff discussed how the lack of sustainable funding for the program, and the fact that the program is being run as a pilot project, creates stress and anxiety. Interviewees expressed that they really felt the work the team was doing was making a difference and they were worried about the program being terminated (and the impact this may have on retaining high quality staff in a competitive recruitment environment). Finally, limited program resources constrains the ability of the COAST to take on additional work that is available (e.g., taking more calls out of the LPS call queue), engage in supplementary training, and expand the mandate of the COAST. Ultimately, these realities reduce the impact that the COAST can have.

8.11. The Healthcare System is Currently Overwhelmed

While the ability of the COAST to support individuals in need often involves referrals to other supports in the community, or taking clients to the hospital when appropriate, their work is impacted by how overwhelmed the healthcare system currently is (*n* = 25). Many interviewees discussed a lack of resources available in the community and/or long waitlists for those resources (e.g., addictions counseling). While the COAST can support some individuals while they wait for supports to become available, when the team doesn't have the capacity to do this, these individuals continue to rely on emergency services, including the police. When the COAST attends the hospital with clients, they are faced with additional challenges including the fact that the healthcare system is overcapacity, which is resulting in overcrowding, long wait times, and overworked staff who can be unpleasant. These things can escalate situations with clients and result in other negative experiences. Additionally, long wait times can result in the team spending a significant

part of their shift in the hospital, which is time they can't spend helping others. Further, due to capacity issues, the hospital has at times refused to admit individuals that were deemed high need by the COAST clinician. Often, this is because the individual is not deemed unwell enough. In these cases, clients return to the community until they become too ill for the hospital to refuse, which can be frustrating for COAST members and clients.

8.12. Key Findings

- The analysis of interviews with staff members from the partner organizations and clients who have used the COAST revealed 10 major themes, several of which had sub-themes
- The identified themes suggest that the COAST is filling a gap in the London community and offering client-centered support, which has made a meaningful difference in the lives of individuals, including members of the COAST, staff in the partner organizations, staff in the hospitals, and most importantly clients who have relied on the COAST
- The identified themes also suggest that the COAST is an evolving program, which is constantly adapting to emerging issues to better serve the needs of the London community
- Several themes were identified that highlight key issues that should be considered as the COAST continues to evolve and adapt, including: (1) refining the mandate of the COAST, (2) providing more effective communication about the COAST to reduce confusion about its role, (3) exploring directions where there is potential for the COAST to have an impact, but that potential has not yet realized, and (4) considering opportunities for COAST expansion to the extent that is feasible
- Themes were also identified, which highlight that the impact of the COAST is affected by two overarching issues – a lack of sustainable program funding and issues associated with a healthcare system that is currently overwhelmed

9. Good News Stories

In addition to the many positive stories that came out of the interviews discussed above, numerous good new stories were shared with the partner organizations throughout the last 15 months. These stories not only show the positive impact that COAST can have, but also illustrate the diversity of people and situations that the COAST encounter. Below is a small sub-sample of the good news stories that were received.

COAST attended a high risk call with MLPS, London Fire, and LPS. Client at WISH shelter endorsed thoughts of suicide, and then walked out onto the ice at Fanshawe Conservation Area. Fire attended the scene with a boat in case the client fell in. WISH staff indicated that their client is afraid of emergency services and was paranoid, so he may run if he sees uniform police. COAST assisted in searching the path and shoreline for the client. COAST and fire located the client and COAST PC XXX and fire helped the client climb a high riverbank to safety. The client appeared under the influence and confirmed using fentanyl while on the ice. The client agreed to speak and walk with the COAST member, and agreed to be assessed by paramedic staff and the hospital due to the high suicidal ideation and fentanyl use. The client was apprehended under the Mental Health Act and attended hospital by ambulance for assessment. After the client was transported by MLPS, COAST connected with WISH and City of London staff on scene to plan for client getting his belongings (the client was evicted), and avoiding client coming back to further avoid police contact.

The COAST took a call from the queue. They supported a woman who is on her own with alcohol addiction and ended up apprehending her due to medical concerns and her inability to care for herself. While she did not want to go to hospital and was upset about decision to apprehend her, she did express appreciation for COAST and their care for her. This interaction also gave COAST the opportunity to educate frontline officers who attended to assist as they rarely see apprehensions for medical type situations. While the woman was not formed by doctors, they did keep her at the hospital to safely withdraw from alcohol and address her medical concerns. The woman would not have attended hospital independently, but with support from the COAST she was able to get the care she required.

Supported a woman who said Coast was a 'hidden gem' and really appreciated the follow up call. Woman indicated that the calls are helping hold her accountable to her goals. Spoke to really appreciating someone believing in her and validating her.

COAST received a referral from the street. An elderly woman was showing possible early signs of dementia/delusions. COAST engaged with her and provided support and a safety review. She requested support working with LMHC to see about a transfer and consented to engagement with her supports (housing, her adult son, and her family doctor). COAST was able to engage with housing to look at options to support her to feel safe in the midst of her delusions. Her family was engaged to increase support and provide education.

COAST supported a male who attempted suicide the night before. Through the support of COAST he reestablished contact with his family doctor, started taking his medications, gave COAST his method for suicide (rope) as part of his safety plan, established a link to Lifespin for income tax support, reviewed court procedures as he did not understand the process (criminal charges), and supported him to get a cell phone which resulted in him reconnecting with his family. COAST also connected him with the John Howard Society to get legal aid and he turned himself in on a bench warrant to address his legal issues. He shared "maybe the rope broke for a reason, maybe good things are going to happen".

St. Joe's SW called police reporting that a patient cancelled all of their appointments, and that they took this as a warning sign given recent suicidal ideation and a suicide attempt. COAST took the call to provide mental health support and divert frontline police. The client welcomed COAST into his home, where COAST could see a "Last Will and Testament" letter on the table and a calendar indicated mood, which said "Very depressed", for the last previous days. When asked, the client reported contemplating suicide today. The client reported that he does not feel safe being at home and that he is experiencing chronic back pain that won't subside and a lack of connection to family and friends. The client stated he saw suicide as a solution, and he believed he would attempt suicide again if left alone. The client voluntarily attended hospital with COAST support. COAST stayed with the client at hospital to support and advocate on behalf of client. The client stayed at hospital voluntarily for 3 days. COAST followed up on the fourth day. The client opened his door and presented with very positive affect and a large smile. The client repeatedly thanked COAST for their support and advocacy, and expressed how he is feeling so much better than a few days ago. COAST assisted in connecting client to senior social supports as well as assisted in connecting him to informal family supports.

XXX and XXX,

I wanted to touch base and let you know that my mother and I are doing well. I was able to find work and have been working for the last couple of weeks. My mother and I are still staying at the XXX thanks to the Unity program. I am awaiting to hear from Wish to hopefully receive help finding a permanent residence soon. I hope this email finds you both well and wanted to once again thank you for your thoughtful words last month. They were a game changer for me and 'kicked' me into high gear. I know that soon things will be stable for us again and we will prosper.

Take good care of yourselves and thank you for the work you do, from the bottom of my heart.

All the best,
COAST participant

Dear COAST Partners,

We could say thank you all day long and not say enough to truly let you know how much we appreciate what you have done for us as patients and families who support people with mental illness. You have proved that new teams and organizations can foster new goals to decrease the stigma towards mental health.

We are proud of how you have all pulled together as a team over the past year and the progress you have made in order to enrich and empower the lives of others you are serving, through this model and sharing this exciting news with our councils recently.

Thanks for your dedication, courage, compassion, selflessness and leadership. Thank you for deploying the COAST model that allows people to be connected or reconnected to the services that they need so much and should expect from a caring society. Thank you for this perfect gift to our community.

Deeds speak.

Sincerely,
The Patients' and Family Advisory Councils of St. Joseph's Parkwood Institute Mental Health Care

10. Conclusions

As indicated in the Introduction to this report, London's COAST was initially designed as a healthcare-led/police-supported program that was intended to provide proactive support to individuals in the London community who are at risk of requiring police-led responses to their mental health issues or crises. More specifically, the primary objectives of the program are to: (1) reduce the requirement of LPS responses to individuals living in the community with mental health issues or experiencing a crisis (i.e., to divert these individuals to community mental health services rather than police services), (2) minimize high-risk interactions (e.g., involuntary apprehensions) between frontline LPS officers and individuals with a mental illness or experiencing a crisis, and (3) improve outcomes for individuals living in the community with a mental illness or experiencing a crisis who require assistance in managing their mental health issues (i.e., divert individuals from hospital support to community mental health services).

This evaluation was designed to determine if these objectives were being met. More specifically, the goal of the evaluation was to provide answers to four specific questions: (1) Does the COAST decrease the need for a police-led response to individuals living in the community with a mental illness or experiencing a crisis?; (2) Does the COAST enhance the community mental health services and local hospital support provided to individuals living in the community with a mental illness or experiencing a crisis?; (3) Does the COAST provide a better experience (and outcomes) for individuals living in the community with a mental illness or experiencing a crisis who require additional supports?; and (4) Does the COAST allow frontline responders (e.g., LPS officers, paramedics, crisis workers) in London to manage mental health/crisis calls more effectively? In this section we will provide answers to these questions based on the data we collected from our multi-method evaluation. But first, we provide a few general comments about the COAST based on our findings.

Generally speaking, the COAST is operating as initially intended, although it became a hybrid reactive/proactive program earlier than anticipated, and some have argued that it is gradually becoming more police-led (as opposed to healthcare-led). Overall, the results of the evaluation are very encouraging with most data indicating that the COAST is having a significant, positive impact on the people it was designed to benefit, while relieving some of the pressures on frontline LPS officers who spend a lot of their time responding to mental health/crisis calls. With few exceptions, COAST members received rave reviews and are seen by clients as compassionate, supportive individuals who care deeply about people experiencing crises and make them feel validated and important. That being said, concerns still remain about how calls involving people in crisis are managed in London (by the LPS more generally, and by staff from St. Joseph's and the CMHA TVAMHS) and negative perceptions of the COAST linger, especially in the LPS. In large part this appears to be due to accessibility issues (i.e., COAST not being available when required) and confusion as to what the COAST does and when it should be used.

10.1. The Need for Police-Led Responses

The COAST appears to be decreasing the need for police-led responses to individuals living in London who have mental health issues or experience crises. For example, the operational data that was collected by the LPS and the CMHA TVAMHS indicates that the COAST is interacting frequently with clients in need within London. Many of these interactions are the result of referrals being made by the LPS and the COAST is also responding to calls out of the LPS call queue. Increasingly, referrals to the COAST are also coming from the community, businesses, and the partner organizations (calls that might have been made to 911 previously). The operational data also indicates that the COAST is spending a significant amount of time on follow-ups. These are done to make sure clients are following through on their care plan, which should decrease the frequency of contacts between the individual and the LPS, including 911 calls.

Staff and client surveys also provided some evidence that the COAST is decreasing the need for police-led responses to people in crisis. For example, some of the staff who completed the post-implementation surveys indicated that the COAST is able to develop stronger relationships with clients and provide them with more support than frontline LPS officers, resulting in improved outcomes for clients, including diversion away from the police. Clients who completed the client satisfaction survey also indicated that interactions with the COAST prevented them from having to contact the police. Indeed, 35 out of the 43 (81%) clients who completed the survey indicated they did not need to contact police within 3 days of interacting with the COAST, suggesting some degree of short-term diversion. In addition, when asked what they would have done if COAST was not available for them, 12 of 36 (33%) clients who answered this question indicated they would have called 911.

Finally, interview responses provided additional evidence that the COAST decreases the need for police-led responses to crises. For example, many interviewees expressed that the COAST was needed in London and individuals who had received support from the COAST reported positive interactions with team members, which resulted in them requesting the COAST when they required additional support. Interviewees also indicated that the COAST is making a difference in people's lives by providing them with adequate support and that this reduces the number of unnecessary institutional interactions such as hospital visits or police contacts through calls for service. The interview results generally suggest that by stabilizing individuals in crisis and reducing the number of crises that occur within the community, the COAST is able to reduce the likelihood that individuals are criminalized or apprehended by the police.

10.2. Enhanced Community and Hospital Support

The evidence is mixed regarding whether the COAST enhances community and hospital supports to individuals living in London with a mental illness or experiencing a crisis.

Results from the staff surveys provide limited evidence to support this proposition. Problems with the pre-implementation survey prevented us from determining whether awareness, use, and the perceived effectiveness of community and hospital supports improved as a result of the COAST, but few differences between the pre- and post-implementation surveys emerged for items related to the quality of care provided to individuals in crisis by community and hospital staff. For example, the implementation of the COAST did not appear to improve the degree to which survey respondents were satisfied with the quality of interactions between people in crisis and the police, staff from St. Joseph's, or staff from the CMHA TVAMHS, and the levels of satisfaction in these interactions that were expressed on the pre- and post-implementation survey were relatively low. So, while the COAST is appearing to have a localized, significant, positive effect on clients, it perhaps isn't having a broader, more pervasive impact on how interactions with people in crisis in the community or in hospital are handled. This could be due to the small number of COAST teams, and their associated workload, which might be preventing its impact from being more widespread.

On the other hand, the COAST is clearly referring clients to available mental health supports in the community and based on the results of the client satisfaction survey, many clients are following up with these referrals. Staff and client interviews also suggest that the COAST is resulting in enhanced community and hospital support. A reasonable number of interviewees noted that the implementation of the COAST has had a positive effect on learning within the partner organizations, which has ultimately improved service for the London community. For example, according to some interviewees, observing COAST members interact with the community has allowed LPS patrol officers to become more trauma-informed and has led them to make referrals to community resources more frequently. Other interviewees mentioned that the strong partnership between the four COAST organizations has motivated other programs in London to collaborate in ways they had not previously and has led to enhanced community support (e.g., the creation of a COAST bed at the Salvation Army).

10.3. Better Experiences and Outcomes for Clients

Does the COAST provide a better experience (and outcomes) for individuals living in the community with a mental illness or experiencing a crisis who require additional supports? In this case, we believe the answer is yes based on the findings from the evaluation. For example, the operational data we collected from the LPS and the CMHA TVAMHS reveals that COAST members are spending considerable time on mental health/crisis calls and dedicating significant effort to follow-up activities to make sure clients are following through on their care plans (and modifying care plans as needed based on identified barriers to care).

The client satisfaction surveys also overwhelmingly indicate that the COAST is providing a better experience to people in need and resulting in better outcomes. Nearly all clients surveyed were satisfied with their overall experience with the COAST, including how

COAST members explain available community supports to them. Most clients also indicated that they did not need to attend the hospital or contact the police in the days following an interaction with the COAST, suggesting that the COAST is at least achieving short-term diversion. Finally, most clients follow up with the supports recommended by the COAST and nearly all clients indicated that, if needed, they would engage with the COAST again, suggesting that they had a positive experience with them. This was supported by comments made by clients on the survey, which spoke to the compassion and kindness exhibited by COAST members and the value of the program generally.

Interviews with clients and staff from the partner organizations also overwhelmingly suggested that the COAST is providing a good experience to clients and resulting in more positive outcomes compared to "business as usual". Almost all interviewees felt that LPS officers are not the best suited to respond to mental health/crisis calls and don't have adequate time to spend on these calls. At best, police responses were seen as offering band-aid solutions because officers have a limited awareness of community resources and lack sufficient training related to interactions with individuals experiencing mental health crises. On the other hand, the support provided by COAST members was seen as flexible and diverse (i.e., tailored to individual needs); trauma-informed, empathetic, and more compassionate; and focused on understanding the root cause of situations facing individuals in crisis rather than providing band-aid solutions. According to many interviewees, COAST members were able to spend the necessary time with clients to develop real relationships with them and interactions were characterized as less intimidating, stigmatizing, and criminalizing. Compared to interactions with frontline LPS officers, COAST interactions were seen as less enforcement focused and more focused on providing social support, something that was seen as helpful in repairing relationships between community members and the police.

10.4. More Effective Management of Calls by Frontline Staff

The evidence is mixed regarding whether the COAST allows frontline staff, such as LPS officers, paramedics, and crisis workers to manage mental health/crisis calls more effectively. For example, based on findings from the staff surveys, the implementation of the COAST did not appear to improve the degree to which survey respondents were satisfied with the quality of interactions between people in crisis and LPS officers, staff from St. Joseph's, or staff from the CMHA TVAMHS. The levels of satisfaction related to these interactions was generally very low on both the pre- and post-implementation surveys.[14] On the other hand, available data suggests that referrals are regularly being made to the COAST from staff within the partner organizations, most frequently the LPS. So, to the extent that the COAST is providing effective support to people in need, its presence is indirectly benefiting frontline staff in London and allowing them to handle

[14] It is important to point out that, despite the good work of the COAST and all the partners in the field, there are still times when an individual in crisis may escalate and become threatening or violent. Those situations remain prominent in people's minds and can impact a staff member's sense of safety and self-efficacy.

mental health/crisis calls more appropriately (through referrals). Some evidence also emerged from the staff interviews that through conversations with the COAST and by observing the COAST, frontline LPS officers are learning to manage crisis calls more effectively and are relying on community mental health supports more frequently when responding to such calls. This suggests that if the COAST can provide more training to frontline staff in London, something that is rarely happening at the moment according to available operational data, the COAST may further improve how these staff manage crisis calls.

11. Recommendations

The following recommendations have been derived from the data made available through this evaluation. Some recommendations call for immediate actions to be taken, whereas others call for actions to be taken over the longer term. If acted upon, we are confident that these recommendations will allow the COAST to have an even bigger impact on the lives of people in need and benefit the broader ecosystem of crisis support services in London.

1. Update the logic model of the COAST as the program continues to evolve and continue to monitor COAST operations through data collection and analysis, with special attention being paid to how the COAST is aligning with, or deviating from, the activities outlined in the logic model. Use that monitoring to ensure that any deviations are warranted and beneficial to the partner organizations and, most importantly, to community members in London that will be utilizing the services of the COAST.

2. For activities embedded in the logic model that are not currently taking place (e.g., training of staff within partner organizations by member of the COAST), initiate steps to deliver those activities or consider adjusting the logic model so that it does not include these activities if they are no longer deemed beneficial.

3. Establish a mechanism to ensure that members of the COAST can have easy, direct contact with members of the Governance and Steering Committees so that any concerns they have about the COAST (e.g., the COAST becoming too police-led) can be quickly heard and incorporated into discussions of COAST operations and future planning.

4. Continue with monthly meetings of the Governance and Steering Committees, and the weekly meetings of COAST members, as these appear to be a useful way of managing ongoing challenges. Ensure that the Governance and Steering Committees continue to be co-chaired by staff from the healthcare partners and that people with lived experience continue to serve on these committees. Based on feedback from interviewees, additional opportunities for collaboration should be explored by these committees, potentially including Black, Indigenous, and People of Colour organizations.

5. Continue data collection related to COAST operations and continue sharing that data with all partner organizations on a regular basis. Continue to include discussions of this data at every monthly meeting of the Steering Committee so that decisions can be made about whether COAST is operating in the way that the partner organizations intended it to (e.g., balance between reactive and proactive activities).

6. Given the relatively low levels of awareness, use, and/or perceived effectiveness of certain resources that are relevant to staff in the LPS and at St. Joseph's (e.g., the CMHA TVAMHS Stabilization Space, the LPS/LHSC Handover Protocol, Coordinated Care Plans, London Cares Homeless Response Services, the Connectivity Table), extra effort should be put into informing staff from these organizations about these resources. Ideally, a pamphlet should be created as soon as possible, which describes the available mental health resources in London, including the COAST, and that should be broadly shared with staff from the partner organizations (and beyond). In addition, a laminated card for first responders that includes an abbreviated version of this material would be useful as a reference guide while on shift. Not only will this information raise awareness of the resources, but it will also help reduce confusion about how these resources complement each other.

7. Calls involving people with mental illness or in crisis are perceived to create a lot of work for LPS staff and be emotionally draining. Given this, appropriate resources should be put in place by the LPS, if they are not already in place, to address the well-being of LPS staff. This should include regular debriefs following particularly troubling calls. Given that some groups, including LPS COAST members, reported that such calls were less emotionally draining after the COAST was implemented, the LPS may want to examine why this occurred to see if any service-wide initiatives (e.g., certain training or supports available to COAST members) can be put in place to address well-being concerns.

8. The decrease in perceived knowledge by LPS COAST members following the implementation of the COAST may reflect the fact that COAST members "didn't know what they didn't know" until they started responding to more mental health/crisis calls alongside a mental health professional and receiving specialized training on how to manage these calls. Regardless of why this change occurred, it is important that COAST members feel they have the necessary knowledge to effectively handle these calls, so regular training should continue to be prioritized for all COAST members (and other frontline staff).

9. There is a clear issue with the perceived quality of communication between frontline LPS officers and hospital staff for many of the respondents from the LPS and St. Joseph's. In-depth discussions involving the LPS and the hospital should take place to identify what the key communication issues are. Processes and joint police-hospital training designed to enhance communication should be considered.

10. Survey respondents, particularly those from St. Joseph's and the CMHA TVAMHS, were very dissatisfied with how frontline staff in London interact with people with mental health issues or experiencing a crisis, even after the COAST was implemented. This was especially true when they were asked about how frontline LPS officers manage these interactions in a variety of settings (e.g., in the community, at the Crisis Centre, in the hospital), but concerns were also raised about frontline

staff from St. Joseph's and the CMHA TVAMHS. In the near future, targeted surveys of staff from these three organizations should be disseminated to determine: (1) the precise issues that are resulting in this high level of dissatisfaction, (2) whether dissatisfaction decreases after the COAST has been operating for a longer period of time, (3) what training could be implemented to potentially improve the quality of these interactions, and (4) whether additional support programs, particularly civilian-led programs, would have a positive impact on crisis response.

11. Very low levels of satisfaction were expressed when staff from St. Joseph's and the CMHA TVAMHS were asked about proactive interventions with people in crisis and follow-up care. Given that the COAST is intended to target these two activities in particular, additional effort should be invested to determine how the team (and other frontline staff) can improve the quality of proactive interventions and follow-up care. Data from the client satisfaction surveys highlight possible strategies (e.g., some clients stressed that follow-up calls should take place sooner and they preferred face-to-face follow-ups).

12. Overall, the client satisfaction surveys indicate a very high level of satisfaction with the COAST and the support that the team provides. One area of concern, however, is the fact that only 59% of the clients that were surveyed had followed up with the supports provided by the COAST and only 56% indicated that further COAST support would be beneficial. It may be useful to investigate why many clients are not following up with the supports provided given that lack of engagement with these supports may negatively impact the individual and reduce the impact the COAST can have. Similarly, it may be beneficial to understand why some clients do not feel further support from the COAST would be beneficial. Given that 91% of surveyed clients indicated that if needed they would engage with the COAST again, this may simply be a matter of there not being a need for further support.

13. The results from the interview analysis suggest that the composition of the COAST should remain the same (pairing a police officer with a healthcare professional). However, based on interviewee feedback, the Governance and Steering Committees may want to consider expanding the disciplines represented on the COAST to include nurses from the LHSC, harm reduction workers, or peer support workers. Expanding the team's expertise may help improve the COAST's ability to navigate certain challenges like transfer of care at the hospital.

14. To ensure that the COAST continues to have an impact on as many people as possible, it should continue trying to relieve some of the pressure on frontline LPS officers by taking calls out of the LPS call queue when possible and assisting officers on calls when the COAST can add value. The COAST should continue to be used as a catalyst for learning within the partner organizations and continue to act as consultants when requested regarding the best course of action for individuals in need. The COAST should also continue to benefit clients by reducing the number of

unnecessary institutional interactions such as hospital visits or police contacts through calls for service.

15. As a way of alleviating additional pressures on emergency services in London, and potentially providing better care to people in need, discussions should take place regarding the potential for frontline staff in London (e.g., paramedics) to activate the COAST in real-time to improve responses to mental health/crisis calls.

16. COAST training should continue to be a priority. Based on interviewee feedback, COAST managers should consider tailoring initial training to the different educational backgrounds of team members, including more team building components so that team members can better understand each other's perspectives, and building more role-play scenarios into training. Ongoing training should target specific knowledge gaps identified through regular surveys of team members in order to better equip the team to support the diverse needs of their community. Additional training on topics related to trauma, supporting geriatric and youth clients, managing cases where safety is compromised should be prioritized, as these training needs were specifically highlighted by COAST members when they were interviewed.

17. Discussions with all partner organizations, COAST members, and people with lived experience should take place about the value (or not) of maintaining the healthcare-led/police-supported focus of the COAST. Some interviewees argued that they have noticed a drift away from this focus towards a more police-led focus. If a healthcare focus is still desirable, and we believe that it should be, mechanisms will need to be put in place to recognize signs of drift and to correct this quickly.

18. Regular reviews of COAST SOPs should take place, with involvement of COAST members. Immediate consideration should be given to issues raised by interviewees, including: (1) defining what the referral and care pathways are, (2) establishing guidelines surrounding the number of follow-ups the team should be doing, (3) determining what types of calls are ideal for COAST versus the CRT, and (4) deciding whether, or under what circumstances, the COAST will be completing apprehensions.

19. The challenges associated with transporting clients was raised by numerous individuals across the evaluation, suggesting that it is a concern for many. In-depth discussions of this issue should take place with some urgency to see if solutions can be found. Solving this problem will likely increase the impact of the COAST. Solutions will need to consider: (1) safety concerns (e.g., a barrier between the front and rear seats of the vehicle), (2) COVID-19 protocols (e.g., easy sanitation), and (3) issues related to stigma, trauma, and criminalization (e.g., the use of unmarked vehicles).

20. Immediate effort should be invested in developing a comprehensive communication/ advertising/marketing plan for all partner organizations and the community to deal with role confusion as it relates to the COAST. The priority should be clarifying what

the COAST is, how and when the COAST should be used, what people can expect when they use the COAST, and how the COAST differs from other support programs like the CRT. As the COAST evolves, new material should be disseminated that clearly describes the changes. Relatedly, additional information should be provided to all stakeholders on a regular basis to promote the value of the COAST (e.g., how many calls the COAST is responding to, client satisfaction survey results, good news stories about the COAST).

21. If additional funding is secured and personnel are available, the number of COAST members/teams should be increased, the involvement of additional partnerships or disciplines should be considered, and the operating hours should be expanded to ensure that the COAST is available when requested.