BRANT COUNTY HEALTH UNIT

Evaluation of the Brant Community Response Team Initiative: Six-month Report

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Executive Summary

The Brant Community Response Team (BCRT) is a collaborative, multi-agency initiative that was launched in March 2015 with funding from the Ontario Ministry of Community Safety and Correctional Services' Proceeds of Crime Frontline Policing Grant. The initiative aims to mitigate acutely-elevated risk of harm through collaboration of community agencies and mobilizations of their resources. To date, over 20 community agencies from multiple sectors across Brant have joined the BCRT to offer services and support to individuals and families at risk.

The Brant County Health Unit collaborated with the BCRT to conduct a process evaluation of the initiative in the first six months of its implementation (March to September, 2015). The evaluation aimed to examine whether project activities were being implemented as planned and assess its initial effects on individuals/families' acutely-elevated risk situations and community agencies' service provision and collaboration.

A mixed-methods (quantitative and qualitative) approach was employed in the process evaluation, including: 1) baseline and follow up surveys of community agencies; 2) interviews and a focus group with community agencies; and 3) analysis of program data (Collaborative Risk-Driven Intervention Database and Risk Factor Tracking Tool).

Key findings of the evaluation are:

- In the first six months of the initiative, the BCRT reviewed a total of 144 situations involving individuals or families at risk. One hundred thirty-three of the situations (92.4%) were accepted as acutely-elevated risks and most of them (87%) were concluded by connecting individuals or families to services or informing them about services.
- The most common risk categories associated with the accepted situations fall within BCRT members' organizational mandate. They include: antisocial behavior, mental health, suicide, drug abuse, and threat to public health and safety.
- Several community agencies (St. Leonard's Community services, Brant Police Service, Canadian Mental Health Association and Brant Family and Child Services) have been the originating, leading and assisting agencies more often than others. Nevertheless, the overall number of agencies referring situations to the BCRT and taking the lead or assisting on accepted situations has grown over the past 6 months.
- The most common factors that have facilitated the implementation of the initiative and service provision are: the rapport and trust established between community agencies; communication and information sharing between agencies; knowledge of each other's roles and services; ability to refer clients to the BCRT members for support; availability of a wide range of services and supports; quicker access to services; presence of a defined structure and guidelines for running discussions and executing interventions; and commitment of the community agencies to the initiative.
- Various types of challenges were experienced by the community agencies over the past 6 months. The most common ones were: client specific factors, such as client refusal of services and client misconception about the role of agencies; those related to internal capacity, such as lack of staff time or skilled staff to dedicate to the initiative; and external factors, such as a lack of certain service providers at the BCRT meetings.

- Evidence regarding the impact of the initiative on individuals and families at risk is very limited. Existing limited program data on the status of risk situations over time suggests that continuous support to high-risk individuals and families is needed in order for behavior change to occur and for risks to be mitigated.
- While community agencies noted that it was too early to determine an impact of the initiative on individuals or families at risk, some of them reported successfully changing perceptions that the individuals or families had of the community organizations and connecting more clients to services.
- Community agencies have observed a number of changes in service provision as a result of their participation in the BCRT, such as: an increase in their ability to identify and address acutely-elevated risk situations; an increase in referrals within their organizations; and organizational policy changes to accommodate the initiative.
- The BCRT appears to have promoted collaboration among community agencies as all of them reported building new or strengthening existing partnerships as a result of the initiative. They perceived improvements in many aspects of inter-organizational collaboration, particularly the knowledge of each other's roles, information sharing and client connection to services, where the progress was more pronounced over the past 6 months.
- Although community agencies were pleased with the progress made so far, they provided suggestions for further improvement of the initiative, such as having: dedicated resources for the discussion process, clear procedures and protocol for lead agency assignment and intervention planning, and adequate communication and representation at the discussion meetings and interventions.

While the BCRT initiative is still in the early stages of implementation, the findings indicate it is a very promising initiative able to consolidate community efforts to increase access to services and support for individuals and families at risk, as well as increase collaboration among diverse community partners. Future evaluation should focus on examining the long-term impact of the initiative on individuals and families and community agencies' collaboration and service delivery.

Background

Origin of the Brant Community Response Team Initiative

The Brant Community Response Team (BCRT) is a collaborative, multi-agency initiative that was launched in March 2015 with funding from the Ontario Ministry of Community Safety and Correctional Services' Proceeds of Crime Frontline Policing Grant. The initiative aims to mitigate acutely-elevated risk of harm through collaboration of community agencies and mobilizations of their resources. Acutely-elevated risk situations are defined as those involving multiple and interrelated risk factors that: are likely to cause harm or be detrimental to individuals; cannot be addressed within the mandate and resources of any one agency; and require an intervention of multiple agencies to minimize or prevent the anticipated harm (Nilson, 2014).

The BCRT is modeled after the Community Mobilization Prince Albert, Saskatchewan and the Gateway Hub in North Bay, Ontario. These community initiatives were introduced because evidence demonstrated that the only way to positively influence community safety and wellness was to use a multi-agency approach to address the needs of high risk individuals and families (Nilson, 2014). The Hub model, as it has become known, is a forum for human service providers to exchange limited information for the purposes of mitigating acutely-elevated risks affecting the clients they serve.

The project launch was preceded by a substantial amount of preparatory work carried out by the Brantford Police Service. In March 2014, Brantford Police Chief Geoff Nelson was introduced to a new initiative to mobilize collaboration around community safety. This was followed by members of the Brantford Police Service having attending a symposium held by the Ontario Working Group for Collaborative Risk-Driven Community Safety and Well-Being. Subsequent meetings with other community safety stakeholders confirmed that a multi-sector collaboration for community safety warranted further exploration. To this end, the Brantford Police Service appointed Sergeant Brad Cotton to lead the development of a multi-sector collaborative initiative aimed at reducing risk before crisis occurred. Immediately, Sgt. Cotton began the process of exploring options for funding the start-up costs and consultancy that would be required for a successful launch.

In August 2014, the Brantford Police Service received a Proceeds of Crime Frontline Policing Grant from the Ontario Ministry of Community Safety and Correctional Services. The grant was used to cover the cost of community safety advisors and information sessions with community agencies to increase their awareness of a collaborative risk–driven intervention.

Over the coming months, the Brantford Police Service held several meetings with community agencies to promote a collaborative risk–driven intervention. Community agencies provided overwhelmingly positive feedback highlighting the need for such an initiative and expressing their interest in participating in it (Brad Cotton, personal communication – September, 2015).

In February 2015, the Brantford Police Service, in partnership with Wilfrid Laurier University's Dr. Carrie Sanders and Dr. Debra Langan, secured a grant from the Social Science and Humanities Research Council of Canada to hold a community safety conference in Brantford: *"No More Silos" Collaboration for Community Safety and Risk Management*. Despite poor weather, almost 300 people attended the conference and listened to presentations from a number of experts in the collaborative risk-driven

community safety, such as Karyn McCluskey (Scotland), Superintendent David Veitch (Alberta), Dr. Hugh Russell (Ontario), Dr. Chad Nilson (Saskatchewan), Brent Kalinowski (Ontario), and representatives from the North Bay's Gateway Hub. The following day, Brant and Brantford community agencies took part in a day-long workshop led by some of the keynote speakers. The workshop concluded with a mock situation discussion where human service providers from multiple sectors applied the knowledge they just learned.

Motivated by the successes of other Ontario communities with the Hub Model, the Brant Community Response Team Initiative was launched on March 3, 2015 with the full understanding and support of all its partner agencies and their executive directors. Initially called the CRISIS Table, the Brant Community Response Team (BCRT) currently involves over 20 agencies from multiple sectors across Brant, such as: education, primary health, public health, mental health, addictions, law enforcement, justice, harm reduction, victim services, employment support, housing, homelessness, Aboriginal services, and youth community support. The BCRT members meet twice a week to discuss and identify situations with acutely-elevated risks, and connect individuals-in-need to appropriate services.

BCRT initiative components

The three main components of the BCRT initiative are: the discussion process, intervention process and community collaboration. Each component is described below.

BCRT discussion process

The discussion process involves review and identification of situations involving individuals or families at acutely-elevated risk. A situation that is brought forward for discussion by an originating agency is assessed by the BCRT members against a set of pre-defined questions (see Table 1 below for the list of questions). If the answer to all these questions is "Yes", the situation is accepted as an acutely-elevated risk situation. Otherwise, it is rejected and returned to the originating community agency for further review and intervention.

Table 1: Questions to determine acutely-elevated risk situations

Question
Are there presenting risk(s) of such concern that the individual or family's privacy intrusion is justified by bringing the situation to the Hub for discussion?
Are the risk factors higher than what can reasonably be considered the norm?
Is there a reasonable expectation of probable harm if nothing is done?
Would that harm constitute damage or detriment and not mere inconvenience to the individual?
Is it reasonable to assume that disclosure to the Hub will help minimize or prevent the anticipated harm?
Are these risks applicable across multiple agencies?
Have we done everything that we can within our mandate to mitigate the risk?
Is the risk such that it is outside of our mandate, understanding or expertise?
Are there 3 or more risk factors present?

As part of the discussion process, the BCRT utilizes a "four filter approach" to sharing information with other community agencies regarding individuals or families in need of support (see Table 2). This means that only limited personal information is shared with the BCRT members at each stage of discussion, with more information being disclosed after the situation has met the acutely-elevated risk definition and only to the agencies that will be addressing the risk situation.

Table 2: BCRT four filter approach

Filter	Process
First Filter	Screening process occurs within the community agency that brings forward a situation for discussion (i.e. originating agency).
Second Filter	Originating community agency presents the situation to the BCRT in a de-identified format to collectively determine if the situation meets acutely-elevated risk across a range of agencies.
Third Filter	If community agencies conclude the threshold is met in the second filter, limited personal information is disclosed to determine community collaboration.
Fourth Filter	Only those community agencies identified above meet to discuss the personal information that needs to be disclosed to inform the outcome of the solution of the acutely elevated risk factors. No identifiable information is recorded in the central records of the integrated service.

BCRT intervention process

Along with identifying individuals or families with acutely-elevated risk situations, community agencies discuss possible service solutions to address those risk situations. From there, leading and assisting community agencies are identified and initiate contact with individuals or families to offer services tailored to their needs. If services are accepted at the time of contact, community agencies provide those services as part of their routine practices, although with more inter-community collaboration than would usually occur. It is important to note, that the BCRT intervention process is not a case management exercise. Rather, it is a rapid mobilization of multiple human services to address an acutely-elevated risk situation within the next 24 to 48 hours.

Community collaboration

Collaboration between the community agencies involved in the BCRT is critical to addressing the complex needs of high-risk individuals and families. It brings community agencies together to close the gap in services and achieve the mutual goal of reducing risk (Nilson, 2014). Potential benefits of collaboration may include an increased awareness of each other's roles and responsibilities, seamless information sharing, and ultimately, an increased capacity of community agencies to identify and reduce various acutely-elevated risks (Nilson, 2014).

The evaluation of similar initiatives has demonstrated that collaboration is likely to facilitate relationship building and strengthen communication among community agencies. For example, the Prince Albert Hub Model found that collaboration between community agencies breaks down barriers and facilitates more efficient access to services for individuals or families to address risk situations (Nilson, 2014). Furthermore, the Gateway Hub in North Bay found that collaboration among community agencies helped to develop relationships, increase knowledge of each other's roles and responsibilities, and increase communication among them to better deliver services to individuals or families (North Bay Parry Sound District Health Unit, 2014).

Purpose and scope of evaluation

The Brant County Health Unit collaborated with the BCRT to conduct an evaluation of the BCRT initiative. The overall purpose of the evaluation was to provide the BCRT member organizations and other relevant community agencies with systematic and objective information on the progress of the initiative in the first six months of its implementation (March to September, 2015). The evaluation was conducted to: validate that project activities were being implemented as planned; explore variations (if

any) in project delivery; and assess its initial effects on individuals/families' acutely-elevated risk situations, service provision by community agencies and their collaborative capacity. Examining the impact of the initiative on individuals' or families' outcomes was out of the scope of the evaluation.

The logic model for the BCRT initiative is presented in Appendix A. It describes the relationships among the resources to operate the initiative, the planned activities as well as the intended outputs and outcomes that the initiative is believed to achieve.

Key evaluation questions

This evaluation sought to answer the following questions:

1. To what extent is the initiative being implemented as intended?
    1.1 To what extent has the initiative been successful in connecting individuals and/or families to the right local support services? Why?
    1.2 What have been the challenges and facilitators to the initiative implementation? Why?
    1.3 How could the initiative be improved?

2. What are the initial effects of the BCRT initiative on individuals and/or families with acutely-elevated risks?
    2.1 Is the initiative progressing in lowering individuals' or families' level of risk? What contributed to this process?
    2.2 How sustainable are the changes in individuals' or families' level of risk over time?

3. What are the initial effects of the BCRT initiative on community agencies' service provision and collaboration?
    3.1 Is the initiative improving community agencies' ability to identify and mitigate acutely-elevated risk situations?
    3.2 Is the initiative enabling community agencies to collaborate and build relationships to address acutely-elevated risks?

The BCRT evaluation matrix can be found in Appendix B. It summarizes the key evaluation questions, relevant indicators, methods and data sources, and timeline for data collection.

Methods

A mixed-methods (quantitative and qualitative) approach was employed in the evaluation of the BCRT initiative, which allowed for an in-depth understanding of the process and impact of the BCRT on both individuals/families and community agencies.

The evaluation used a number of data collection methods, including: 1) baseline and follow up community agency surveys; 2) interviews and a focus group discussion with community agencies; 3) the Collaborative Risk-Driven Intervention Database; and 4) a risk factor tracking tool. The following provides a detailed account of the data collection methods that were used:

Baseline and follow-up community partner surveys

Baseline and follow-up surveys were conducted using an online survey technology (Fluidsurvey). A baseline survey was conducted prior to the launch of the initiative (February-March 2015) to capture community agencies' perspectives on the risk factors of individuals or families, their capacity to provide services and their collaboration experience with other community organizations. All community agencies who were members of the BCRT at that time (20 organizations) completed the baseline survey.

A follow-up survey was conducted 6 months after the start of the initiative (August-September 2015). The purpose of the follow-up survey was to learn about the progress made by the BCRT members since the start of the initiative, including changes that may have occurred in their capacity to identify and address clients' acutely-elevated risk situations, experience of collaboration with other community organizations as well as barriers and facilitators encountered when addressing clients' complex needs and BCRT members' suggestions for improvement of the initiative. All 21 current member organizations were invited to the follow-up survey and 19 of them completed it.

Interviews and focus group with community agencies

Interviews and a focus group were conducted with representatives of the member-agencies of the BCRT initiative. A focus group discussion was conducted in July 2015 to obtain the BCRT member's perspectives on the current progress of the initiative, challenges and facilitators, as well as suggestions for moving forward. Twenty representatives from community agencies participated in the focus group discussion, which lasted approximately 3 hours.

Phone or in-person interviews took place at 6 months following the start of the initiative to examine community agencies' perceptions regarding: barriers and facilitators to implementing the initiative, its impact on their organizational capacity to address acutely elevated risks and collaborate with other community agencies; changes in individuals/families' risk level as a result of the initiative; and suggestions for further improvement of the BCRT. All community agencies were invited to participate in the interviews. A total of 17 interviews were conducted with representatives of 13 community agencies between August and September 2015. On average, interviews lasted 35-40 minutes.

It should be noted that according to the original evaluation plan, interviews with a convenience sample of individuals or families were also proposed at 6 months after the start of the BCRT. Given the complexity of risk situations and to ensure cooperation of individuals or families with the evaluators, leading and assisting community agencies were asked to provide support in the recruitment process. However, the recruitment of interview participants proved to be challenging for a number of reasons, including the timing of data collection (i.e. summer holidays), community agencies' busy schedules and the limited staff resources to complete all the planned data collection activities. While interviews with community agencies provide some insight into the initials effects of the BCRT initiative on high-risk individuals or families, future evaluation should focus on gaining an in-depth understanding of their experience with the services and support received as part of the initiative.

Collaborative Risk-Driven Intervention Database

BCRT uses the Collaborative Risk-Driven Intervention Database, also known as the Hub Database (Nilson, Winterberger & Young, 2014), to document the discussion and intervention processes related to each individual or family identified as being in an acutely-elevated risk situation. The following

information is recorded for each identified risk situation: a originating agency, risk factors associated with individuals or a family, their demographic characteristics, reason(s) for a concluded situation (e.g. individuals connected to services, informed about services, etc), reason(s) for a rejected situation (e.g. not an acutely-elevated risk situation, a referring agency has not exhausted all options to address the issue, etc), originating, leading and assisting community agencies to address the risk situation. The evaluation team extracted data from the database at 3 and 6 months following the start of the initiative to track progress in the discussion and intervention processes. The 3-month Hub database summary was shared with BCRT members in June 2015. The current report provides key statistics about the risk situations identified, assessed and concluded in the first 6 months of the initiative, specifically from February 19 to September 15, 2015.

Risk factor tracking tool

A Risk Factor Tracking Tool was developed by the BCHU evaluation team to monitor changes in individuals' or families' risk situations over time. All lead and assisting agencies assigned to risk situations (with input from the originating and assisting agencies) were asked to assess progress of each situation at 1, 3, and 6 months after the discussion of the situation concluded and intervention executed by the BCRT. At each follow-up point, these agencies were asked to indicate the following information:

1. The current status of each identified risk factor (risk mitigated, risk being addressed or risk still present);
2. Whether the situation is still viewed as an acutely-elevated risk situation;
3. The reason why the situation is viewed as acutely-elevated risk or not; and
4. Any additional comments necessary to explain the current situation.

After completing the 1-month follow up for the first set of situations (19, in total), community agencies provided feedback to the evaluation team regarding the difficulties they encountered with the Risk Factor Tracking tool. They pointed to their inability to properly assess the risk situation of the individuals or families in such a short timeline particularly due to a chronic nature of risk factors being addressed or longer periods of time required to locate and connect individuals or families to services. Given this feedback as well as community agencies' busy schedules, it was decided to focus their efforts on completing a 3-month follow-up on the situations instead.

As of September 15, 2015, a total of 72 situations were due for 3-month follow-up. However, the evaluation team was able to obtain information for 39 situations only (54.1%). Thus, the results presented in the current report are limited to a subsample of situations and should be interpreted with caution.

Data analysis

Both qualitative and quantitative data analyses were conducted for this evaluation. Each type of analysis is described below.

Qualitative analysis

The individual interview data, open-ended questions from the surveys and risk factor tracking tool were analyzed using NVivo 10, a computer software program that manages data. Thematic analysis of the data was used to identify themes and patterns within the data. Qualitative analysis began with identifying words or phrases that occurred frequently within and across the interview data and were relevant to the evaluation questions. Codes were developed to describe what the participants were saying. The codes were then categorized into basic, organizing and global themes (Attride-Stirling, 2001). Basic themes are

the simplest form of data that contributed to organizing themes. Organizing themes take a group of similar basic themes and cluster them together, which then contributed to a global theme. A global theme is the highest order theme that encompasses the central organizational concepts to provide a fundamental interpretation of the data (Attride-Stirling, 2001).

Quantitative analysis

Key statistical analysis was performed using SPSS v.21. Descriptive analysis was conducted using data obtained through the Hub database, Risk FactorTracking Tool as well as baseline and follow-up surveys of community agencies. Frequencies were computed for each survey question (community agency surveys) or variable (Hub database and Risk Factor Tracking Tool). The Wilcoxon Singed Ranks Test was used to examine the difference between baseline and follow-up ratings of progress in inter-organizational collaboration among community agencies. Results were considered statistically significant at $p<0.05$.

Limitations

This evaluation study has some limitations. First, due to the ongoing nature of the BCRT initiative, the evaluation findings are relevant only to the first six months of its implementation. Second, not all community agencies participated in the interviews, which may have resulted in a biased sample. It is possible that community agencies who are more engaged in the initiative or hold strong positive views about it were more likely to respond to the interview request. Nevertheless, the interviews with community agencies provided an opportunity to validate findings from the follow-up survey and enrich our understanding of the community agencies' experience with the BCRT initiative and practice changes occurred as a result of their participation in it. Finally, no interviews with individuals or families were conducted as the recruitment of interview participants proved difficult. Furthermore, only partial data on the progress of individuals' or families' risk situations over time was obtained through the Risk Factor Tracking Tool. Thus, evidence regarding the initial effects of the BCRT initiative on high-risk individuals or families is very limited and should be interpreted with caution.

Results

Evaluation results presented in this report are organized by the key focus areas of the BCRT process evaluation, including: the assessment of risk situations and client connection to services, facilitators and challenges to project implementation and service provisions, initial effects of the initiative on individuals and families, and its impact on community agencies' service provision and collaborative capacity.

Assessment of risk situations and client connection to services

Accepted, rejected and returned situations

Between February 19 and September 15, 2015, a total 144 situations involving individuals or families at risk were reviewed by the Brant Community Response Team (BCRT). One-hundred and thirty-three (92.4%) were accepted as acutely-elevated risk situations and 11 (7.6%) were rejected. Table 3 summarizes the reasons for rejections.

Table 3: Reasons for referral rejections (n=11)

Rejection Reason	n	%
Originator has not exhausted all options to address issue	6	54.5
Already connected to appropriate services with potential to mitigate risk	2	18.2
Situation not deemed to be one of acutely elevated risk	2	18.2
Single agency can address risk further	1	9.1

As of September 15, 2015, 131 of the accepted cases (98.5%) were concluded and 2 (1.5%) remained open. Most situations (87%) were concluded by connecting an individual or family to services or informing them about services. Table 4 summarizes the reasons for concluded situations.

Table 4: Reasons for concluded situation (n=131)

Reasons Concluded	n	%
Connected to services/cooperative	98	74.8
Informed about services	16	12.2
Unable to locate	10	7.6
Refused services/uncooperative	5	3.8
Connected to services in other jurisdiction	2	1.5

One-hundred twenty-five people were assisted directly by the BCRT in 62 of 131 concluded situations. In some situations (37) only one person was directly involved, whereas in others as many as nine individuals received assistance from community agencies through the work of the BCRT. The number of people assisted was missing in 68 situations and was recorded as zero in one situation. Assuming that at minimum one person was involved in each situation, it brings the total to 194 people assisted in the 131 concluded situations.

Of the 144 situations reviewed by the BCRT, 15 (10.4%) returned for another assessment for various reasons, such as: the situations were not identified as involving acutely elevated risks during the first assessment, the referral agency had not exhausted all options to address the situation, individuals or families refused the services or were informed of services the first time. Table 5 provides details regarding the status of these situations.

Table 5: Status of the situations re-assessed by the BCRT (n=15)

Description
One situation was first rejected as it was not deemed to be acutely-elevated risk; it was accepted as acutely-elevated risk a second time and the individual was informed of services. This situation returned a third time and the individual was connected with services.
The other rejected situation was brought to the BCRT attention twice and rejected both times since it was not believed to be acutely-elevated risk.
One situation was rejected because the originator had not exhausted all options to address the situation. This situation later returned for another assessment and the individual was connected with services.
Another situation was accepted by the BCRT, however the individual refused services. This situation was reviewed a second time and the individual was connected to services.
Two situations were accepted as acutely-elevated risk and the individuals were informed of services. Both situations returned to the BCRT, with one being connected with services and the other informed of services again.
Eight situations were accepted by the BCRT and individuals connected with services; however, these situations were reviewed by the BCRT later and individuals were connected with services once again. The reason for the round of assessment is unknown at this point.
One situation initially involved an individual, but changed to a family situation after a second assessment. The family was then informed of services.

Types of accepted situations

Of the 133 accepted situations, 110 (82.7%) involved individuals and 23 (17.3%) included families (see Table 6). Homelessness was identified in 17 (12.8%) of the situations; a child was involved in 14 (10.5%) situations; and domestic violence in 21 (15.8%) situations. A similar distribution of the types of situations was identified at 3-month follow-up indicating that the situations referred to and addressed by the BCRT have been consistent over the past 6 months.

Table 6: Accepted situations, by type (n=133)

Situation Type	n	%
Individuals	110	82.7
Family	23	17.3

The situations discussed and accepted in the first 6 months of the initiative, involved more females than males (Table 7).

Table 7: Accepted individual situations, by sex (n=110)

Sex	n	%
Male	49	44.5
Female	61	55.5

Individuals of various ages were assisted by the BCRT in the first 6 months of the initiative, most commonly youth and young adults aged 16-24 (35.5%), followed by adults between 30 and 59 years of age (33.7%; Table 8).

Table 8: Accepted individual situations, by age group (n=110)

Categories	n	%
Children 10-11	1	0.9
Youth 12-15	11	10.0
Youth 16-17	18	16.4
Adult 18-24	21	19.1
Adults 25-29	11	10.0
Adult 30-39	18	16.4
Adult 40-59	19	17.3
Older Adult 60+	11	10.0

Service mobilization time

Service mobilization time, i.e. the amount of time required to discuss and intervene in an acutely-elevated risk situation, varied over the past 6 months. In particular, four situations were concluded on the same day they were brought to the BCRT, whereas one situation stayed open for 28 days. Because these extreme cases can affect the average amount of discussion and intervention time, the median (or middle value) rather than mean service mobilization time was calculated. Over the past 6 months, the median time required to discuss and intervene in a situation was 5 days. The median duration of discussion and intervention was highest among the situations involving youth, aged 16-17 (12 days), and lowest among the situations involving adults, aged 25-29 (2 days). No difference in the length of service mobilization was observed between the individual and family situations.

It should be noted that the median service mobilization time is likely to be inflated due to the limitations of the current Hub database used by the BCRT. Presently, the documentation of each situation's discussion and conclusion status occurs twice a week at the BCRT meetings rather than in real time. The clarifications received from the BCRT indicate that team members typically come up with an intervention plan and connect with an individual-in-need on the same or next day the situation is brought to the BCRT; however, the situation is formally concluded and recorded at the next scheduled BCRT meeting. As a result, the amount of time the situation stays open may be greater than the actual time required to identify an acutely-elevated risk situation and mobilize resources to intervene in it. Thus, the current median time of service mobilization should be treated with caution.

Risk categories in accepted situations

A wide range of risk categories were identified and discussed at the BCRT meetings over the course of 6 months. The top 5 categories associated with the 133 accepted situations included mental health (77.4%), physical health (69.9%), antisocial behaviour (63.9%), drugs (55.6%) and criminal involvement (53.4%). Table 9 shows the risk categories identified among the accepted situations.

Table 9: Accepted situations, by risk categories (n=133)

Risk Category	n	%
Mental Health	103	77.4
Physical Health	93	69.9
Antisocial Negative Behaviour	85	63.9
Drugs	74	55.6
Criminal Involvement	71	53.4
Suicide	50	37.6
Parenting	50	37.6
Physical Violence	46	34.6
Alcohol	44	33.1
Threat to public health and safety	41	30.8
Emotional Violence	38	28.6
Basic Needs	34	25.6
Housing	33	24.8
Self Harm	28	21.1
Negative Peers	23	17.3
Crime Victimization	22	16.5
Missing School	20	15.0
Sexual Violence	18	13.5
Poverty	10	7.5
Missing	8	6.0
Social Environment	6	4.5

Supervision	2	1.5
Unemployment	2	1.5
Elder Abuse	1	0.8

The distribution of top 5 risk categories was similar by type of the accepted situations, except for criminal involvement, which was more often used to describe the family rather than individual situations (65% vs. 51%). Other risk categories more frequently represented among the family than individual situations include: parenting (70% vs. 30%) and emotional violence (70% vs. 20%). In contrast, a few risk categories were more often associated with the situations involving individuals than families, such as: housing, self-harm and sexual violence.

Analysis of the top risk categories by demographic characteristics of individual situations revealed no difference between males and female for drugs as a risk category. The other four top risk categories, especially criminal involvement and anti-social behaviour, were more often associated with the situations involving males. Threat to public health and safety is another risk category highly represented among the situations involving males than females. In contrast, negative peers, sexual violence and parenting were substantially more often used to characterize the situations involving females.

There is a variation in the distribution of the top 5 risk categories by age groups. Drugs was more often associated with the situations involving youth, 16-17, and young adults, 24-29; mental and physical health were more common risk categories associated with young adults and adults, 30-59. Criminal involvement and anti-social negative behaviour were highly represented among youth and adults, 30-39. With respect to other risk categories, physical and emotional violence as well as parenting were more often associated with the situations involving youth, 16-17, whereas basic needs was more common among the situations involving older adults, 40-59.

Individual risk factors in accepted situations

The risk categories represented a total of 74 individual risk factors identified by the BCRT to describe the 133 accepted situations. Some risk factors were assigned more than others. For each situation an average of seven risk factors was identified, indicating that individuals or families brought to the BCRT attention had complex needs. The top 14 risk factors are shown in Table 10. A complete list of risk factors and the frequency of their occurrence in accepted situations can be seen in Appendix C.

Table 10: Accepted situations, by top 14 risk factors (n=133)

Risk Factor	n	%
Antisocial/Negative Behaviour - person exhibiting antisocial/negative behaviour	52	39.1
Drugs - drug abuse by person	50	37.6
Mental Health - diagnosed mental health problem	50	37.6
Suicide - person current suicide risk	42	31.6
Mental Health - suspected mental health problem	41	30.8
Threat to Public Health & Safety - persons behaviour is a threat to public health and safety	41	30.8
Parenting - parent-child conflict	38	28.6
Alcohol - alcohol abuse by person	34	25.6
Antisocial/Negative Behaviour - antisocial/negative behaviour within home	33	24.8
Criminal Involvement - assault	30	22.6
Housing - person does not have access to appropriate housing	30	22.6
Basic Needs - person unable to meet own basic needs	29	21.8
Physical Violence - person perpetrator of physical violence	28	21.1
Criminal Involvement - other	27	20.3

Risk categories addressed by community agencies

The risk categories identified among the accepted situations are those currently being addressed by the BCRT member-organizations as part of their mandate. The follow-up survey of community agencies reveals that BCRT members' organizational mandate entails addressing a wide spectrum of risk categories when working with their clients. The most common risk categories include: mental health (78.9%), emotional violence (73.7%), self-harm (73.7%), parenting (68.4%), suicide (68.4%), basic needs (68.4%), antisocial behavior, drugs, physical violence, alcohol, sexual violence and housing (each 63.2%; Table 11).

Table 11: Risk categories addressed by community agencies, 6-month follow-up (n=19)

Categories	n	%*
Mental health	15	78.9
Emotional violence	14	73.7
Self-harm	14	73.7
Parenting	13	68.4
Suicide	13	68.4
Basic needs	13	68.4
Antisocial/Negative behavior	12	63.2
Drugs	12	63.2
Physical violence	12	63.2
Alcohol	12	63.2
Sexual violence	12	63.2
Housing	12	63.2
Criminal involvement	11	57.9
Poverty	11	57.9
Negative peers	10	52.6
Missing school	9	47.4
Social environment	9	47.4
Crime victimization	9	47.4
Physical health	9	47.4
Missing/runaway	8	42.1
Threat to public health and safety	8	42.1
Unemployment	6	31.6
Elderly abuse	6	31.6
Gambling	5	26.3
Gangs	5	26.3
Supervision	4	21.1
Other**	3	15.8

*Percentages do not add up to 100%, as respondents were allowed to check more than one response
****** Other risk factors include: fires, developmental health, sex work and trafficking

Originating community agencies

In total, nine agencies referred cases to the BCRT in the first 6 months of the initiative, with the Brantford Police Service making the majority of the referrals (73.6%). Overall, the number of originating agencies is constantly growing. In particular, four out of nine agencies started referring cases to the BCRT during the last three months. See Table 12 for a total list of originating agencies.

Table 12: Accepted situations, by originating agencies (n=144)

Agency	n	%
Brantford Police Service	106	73.6
Grand-Erie District School Board	10	6.9
Brant County OPP	9	6.3
Brant Family and Child Services	9	6.3
St. Leonard's Community Services	3	2.1
Brant County Ambulance	2	1.4
Sexual Assault Centre	2	1.4
Victim Services Brantford	2	1.4
Nova Vita	1	0.7

Lead community agencies

In total, 17 agencies took the lead on the accepted situations. St. Leonard's Community Services was the lead agency most often (27 times, 20.3%), followed by Brant Family and Child Services and the Brantford Police Services (21 times, 15.8%, each). See Table 13 for a complete list of lead agencies.

Table 13: Accepted situations, by lead agencies (n=133)

Agency	n	%
St. Leonard's Community Services	27	20.3
Brant Family and Child Services	21	15.8
Brantford Police Service	21	15.8
Brantford Native Housing	12	9.0
Canadian Mental Health Association	11	8.3
Grand-Erie District School Board	10	7.5
Nova Vita	10	7.5
Woodview Children's Centre	5	3.8
Sexual Assault Centre	4	3.0
Aboriginal Health Centre	2	1.5
Brant County Ambulance	2	1.5
Brant County OPP	2	1.5
Victim Services Brantford	2	1.5
Brant Haldimand-Norfolk District Catholic School Board	1	0.8
Brantford Social Services	1	0.8
Why Not Youth Centre	1	0.8
Youth Justice Services	1	0.8

Assisting community agencies

In total, 22 agencies offered assistance on the accepted situations. St. Leonard's Community Services was identified as an assisting agency most often (72.2%), followed by the Brantford Police Service (63.2%) and Canadian Mental Health Association (53.4%). See Table 14 for a complete list of assisting agencies.

Table 14: Accepted situations, by assisting agencies (n=133)

Agency	n	%
St. Leonard's Community Services	96	72.2
Brantford Police Service	84	63.2
Canadian Mental Health Association	71	53.4
Brantford Social Services	46	34.6
Brant Family and Child Services	43	32.3
Woodview Children's Centre	42	31.6
Nova Vita	34	25.6
Sexual Assault Centre	33	24.8
Brant Community Health Care System-Mental Health	30	22.6
Victim Services Brantford	26	19.5
Grand-Erie District School Board	25	18.8
Brant County Ambulance	21	15.8
Why Not Youth Centre	21	15.8
Brantford Native Housing	15	11.3
CCAC	15	11.3
Brant County OPP	13	9.8
Brant County Health Unit	8	6.0
Youth Justice Services	7	5.3
Aboriginal Health Centre	4	3.0
Adult Probation	4	3.0
Brant Haldimand-Norfolk District Catholic School Board	4	3.0
Brantford Fire Department	2	1.5

Overall, in the past 6 months, fours agencies – St. Leonard's Community services, Brant Police Service, Canadian Mental Health Association and Brant Family and Child Services – have been identified most often as lead and assisting ones. This is likely a reflection of the dominant risk factors identified among the accepted situations that these agencies are typically dealing with as part their agency mandates.

Facilitators and challenges to implementation of the initiative and service provision

Facilitators

Data from the follow-up survey of community agencies indicates that the most common factors that have facilitated service provision in the 6 months after the start of the BCRT initiative are related to building or strengthening relationships between the BCRT members. These factors include: the rapport established between representatives of the organizations, communication and information sharing between the BCRT members, knowledge of the roles and services of the BCRT members, clients' referrals to the BCRT members for support, ability to connect clients to services faster than previously, and availability of a wide range of services and supports (Table 15).

Table 15: Facilitators to service provision, 6-months follow-up (n=19)

Facilitators	n	%*
Rapport established between representatives of the organizations-BCRT members	19	100
Communication between BCRT members	18	94.7
Information sharing between BCRT members	16	84.2
Knowledge of the roles and services of other organizations who are BCRT members	15	78.9
Clients' referrals to other BCRT members for support	15	78.9
Ability to connect clients to services faster than previously due to the BCRT table discussions	15	78.9
A wide range of services/supports available through the BCRT initiative	14	73.7
Staff knowledge, skills and passion	11	57.9
BCRT members' previous involvement with the same clients	11	57.9
Ability to follow-up with clients periodically	6	31.6
Other	3	15.8

*Percentages do not add up to 100%, as respondents were allowed to check more than one response

Interviews with representatives of the community agencies support the survey findings and further expand a list of key factors that have facilitated the service provision and implementation of the initiative, in particular. Interviews revealed a number of key facilitators, including: the presence of a defined structure for conducting discussions and implementing interventions; trust between community agencies; community agencies' commitment to the initiative; knowledge of each other's roles and service capacity; and quicker access to services.

Structure for discussions and interventions

BCRT members discussed the importance of having structure to both the discussion meetings and the intervention implementations because it facilitates consistency, routine and a guided process that is straightforward and easy to follow. As one agency representative commented:

> "Whoever is presenting the situations brings an organized account of what they need to present and is able to answer questions that are asked…being prepared helps".

Having structure also facilitates an understanding of the previous involvement and history that each service provider has had with the individual or family. Each service provider offers an account of the history they have had with the individual or family on a confidential, need-to-know basis to help determine which route the intervention should take based on previous experience. One interview participant explained:

> "Being able to hear briefly which agencies are connected and what that connection looks like…look back into the histories of those involved and see what has worked and what hasn't…it helps to put all the pieces together".

Trust between community agencies

Another key ingredient to the success of this initiative is having trust among the community agencies. Trust was consistently talked about by the community agencies as a critical component because they are disclosing confidential information when necessary to help assist their clients. Community agencies felt that trust among the team was important and ensured that everyone felt safe and comfortable to agree or disagree within the group. As a community agency representative stated:

> "Having the building of positive working relationships with each other that are trusting, helps to have open honest communication and conversation. Sometimes when challenging something, we are not afraid to ask for clarification, even though we don't always agree—the relationship piece has helped".

Community agencies commitment to the initiative

Commitment and dedication of the BCRT members is perceived as key to the success of this initiative. Community agencies talked about their passion for the work and their willingness to be part of this initiative that brings diverse organizations together for the same purpose. But it is also critical to have the commitment of their agency as a whole to ensure that they are able to maintain their commitment to attending the discussion meetings and interventions.

> "There is very strong commitment from around the table. The support of all agencies allow us to continue to grow. I get the sense that it's there. We have lots of support…if I have a meeting and the [BCRT] table meeting, the table meeting comes before the meeting".

Knowledge of each other's roles and service capacity

All of the community agencies discussed how beneficial it has been to learn about other agencies and what they have to offer. This knowledge has facilitated better working relationships among agencies who are now working more closely than before to find supports for their clients and connect them to services. Understanding each other's roles has also developed respect among the agencies and an appreciation for what each agency can bring to the initiative. As one interview participant pointed out:

> "We all have different lenses to look at situations and see different things, we each have our own risks individually…It's been helpful at the table we are looking through each others' lenses, people start to understand our lenses a bit differently"

Quicker access to services

The community agencies felt that this initiative has enabled their clients to have quicker access to multiple agencies for service and support. They mentioned that prior to the initiative they had lengthy wait times for service or were unable to refer clients to other service providers because they lacked extensive knowledge of these service providers. They are now able to make connections immediately, eliminate barriers and provide a variety of services to help support their clients. As a community agency representative said:

> "For some who are struggling and don't know how to access or reach out for help, it gets them access to services. The majority of clients have willingly accepted help, a few have declined and some don't follow through, but it gives them a better understanding of what can help them and they can access it when they are ready".

Challenges

Similar to the results obtained at baseline survey (prior to the start of the BCRT initiative), the common barriers encountered by the community agencies in the 6 months after the start of initiative are client specific. They include: client refusal of services (52.6%), client misconception about the role of the organization (26.3%), and inability to follow-up with clients (21.1%). Other key barriers were related to limited internal capacity, such as a lack of staff time to dedicate to the BCRT initiative (42.1%) and stress or burnout of staff working with high-risk clients (15.8%; Table 16).

Approximately one third of community agencies identified internal and external systemic factors impeding their organizations' ability to provide services to their clients. The internal systemic factors included organizational mandate constraints and limited capacity, such as limited staff, staff time and lengthy wait times for services and support.

External systemic restraints included: lack of participation or representation from some agencies in the BCRT; restrictive privacy and consent regulations at some agencies; gaps in services within the community, such as a lack of transitional and affordable housing, limited support for clients with developmental delay and/or deficits in adaptive functioning; and a lack of ongoing and long-term treatment.

Table 16: Barriers to service provision, 6-month follow-up (n=19)

Barriers	n	%*
Client refusal of services	10	52.6
Lack of staff time to dedicate to the BCRT initiative	8	42.1
Internal systemic restraints	7	36.8
External systemic restraints	6	31.6
Client misconceptions about the role of your organization	5	26.3
Inability to follow up with clients and confirm engagement in services	4	21.1
Limited understanding of other BCRT member's policies re: client confidentiality and privacy	3	15.8
Stress or burnout of staff working with high-risk clients	3	15.8
Limited opportunity to be creative in building solutions for clients	2	10.5
Limited knowledge, tools or skills to address complex client needs	1	5.3
Limited knowledge of the roles and services of other BCRT members	1	5.3

*Percentages do not add up to 100%, as respondents were allowed to check more than one response

The key challenges identified through the follow-up survey were also discussed in depth during the interviews. Community agencies have encountered a number of key challenges since the launch of the initiative, including: a lack of time/resources required to attend regular discussion meetings; a lack of experienced or skilled staff to participate in discussion meetings and interventions; agencies who are not part of the BCRT that should be; and the refusal of individuals or families to accept support or follow through. The interview findings are consistent with the baseline and follow up surveys.

Lack of time/resources to attend discussion meetings and interventions

Although community agencies recognize their commitment to the BCRT as a key facilitating factor to the initiative implementation, time or resource constrains are consistently identified as a challenge for ongoing participation in it. BCRT members felt that this initiative demanded a lot of staffing time and resources to consistently attend meetings and interventions. Some agencies found it difficult to send someone every week because they have a smaller number of staff employed. Other agencies who were able to send someone every week still found it challenging because this initiative is on top of their current full-time positions.

> "We are managing it yes, but it would be nice if we can contribute more staff to it, but we can't without more funding. We have to do it with the jobs we have. Some days may be more manageable than others, lots of clients in crisis, it's not manageable for us coming and doing the follow up, but we do it".

However, the importance of this initiative in providing immediate access to services and supports is the driving force for community agencies to do what they can to attend.

Lack of experienced or skilled staff

A challenge that was noted by a number of community agencies related to the experience and skill level of the agency staff who attend the discussion meetings and interventions. Interview participants felt that when a regular participant of the BCRT was substituted by an inexperienced person, it became a barrier to effective discussions as well as intervention planning and execution, particularly if the person did not have the skill or knowledge required.

> "If people are assigned to sit there just to fill a seat---if they don't have the skill set or wisdom or knowledge, it's a huge barrier, if they don't know their own job or limitations or situation or abilities, it's also a barrier".

This issue is particularly pronounced at the intervention execution stage, when a lead agency is represented by a non-regular participant of the BCRT. In such situations, more experienced assisting agencies take the lead to ensure a coordinated and smooth process of connecting clients to planned services. In this regard, the community agencies suggested to have a guideline or script for intervention implementation that all community agencies could follow to maintain professionalism for their clients and prevent a scenario where service providers were not able to contribute effectively.

Lack of service providers

A number of community agencies shared concerns about the lack of service providers available as part of the initiative, such as faith-based organizations, Aboriginal health services and those offering developmental services. They felt it was important to identify community agencies missing from the BCRT and reach out to them to further enhance a range of services available to support clients.

> "When there isn't an agency there that needs to be part of the filter 4---people that aren't part of the table and should be—such as developmental services, they would know better how to support them".

It was also suggested that some of the existing members of the BCRT become more actively available for referral, such as: Community Care Access Centre, Catholic School Board, Wilfrid Laurier University, Brant County Health Unit, Brant Community Healthcare System, and Youth Justice Services.

Client refusal to accept support

Community agencies mentioned how challenging it is when clients refuse services or support or simply do not follow through with connections made for them with other agencies. As described by the interview participants, there is a time commitment for agencies and a great deal of planning that goes into connecting clients to services; therefore, when clients refuse services or cannot be located, it is taxing on the service providers. Members felt that very little progress could be made with the risk factors if clients are refusing services. As one community agency representative stated:

> "Sometimes it's not being able to find the individual or the individual is resistant or not open to services…people have to be willing to step up for help".

Meanwhile, a few community agencies shared observations from the current situations being addressed by the BCRT, which suggest that (a) an individual at risk may require time to recognize the need for

support or (b) the refusal of services may still trigger a change in behavior. An example of changes in two acutely-elevated risk situations is provided below:

> "Though a client refused, there was not necessarily a negative effect. One client who refused, was very thankful of the concern. The individual, who had been a 3-5 times a week user of [name of service] and 3-5 times a week user of emergency services, had no incidents for over 4 months. A second client who refused, did so only because he did not have the cognitive ability due to physical and mental illness to accept that he was at risk and needed help. That individual eventually was admitted to the hospital for treatment of severe, life threatening illness".

Initial effects of the initiative on individuals or families

Status of risk situations over time: results of the Risk Factor Tracking Tool

As of September 15, 2015, a total of 72 situations were due for 3-month follow-up. However, the evaluation team was able to obtain information for 39 situations (54.1%). Thus, the results about the initial effects of the initiative on individuals or families are limited to a subsample of the situations and should be interpreted with caution.

Among the 39 situations, 15 (38.5%) were assessed as "risk being addressed", another 15 (38.5%) as "risk still present" and 9 (23%) as "risk mitigated". Two main reasons were provided by community agencies for assessing the risk as mitigated, including: individual or family is engaged in services and the situation has improved. For the risk factors still being addressed, reasons included: individual or family engaged in or connected to services, individual or family situation has improved or the risk factors are chronic in nature. When the risk factors were assessed as still present, agencies noted that the individual or family did not follow up with the services offered or they still needed to be connected to services.

Overall, at 3-month follow-up, 15 of the 39 situations (38.5%) were still identified as acutely-elevated risk situations, suggesting that more and an ongoing support to high-risk individuals and families is needed in order for behavior change to occur and for risks to be mitigated.

Benefits for individuals and families: Interview results

During the interviews, community agencies noted that it was too early to determine an impact of the initiative on the individuals or families at risk. Nevertheless, they felt that they had succeeded in changing perceptions that individuals or families had of community agencies and connecting more clients to services and support.

Breaking down myths

A number of community agencies mentioned that due to a better understanding of other agencies' roles and responsibilities, they were able to increase their clients' awareness of the available supports and break down any previous myths or misconceptions they had about community agencies. As one interview participant noted:

> "[The impact] has been huge, finding out about other organizations and how to connect them, helps me squash a myth with the youth about particular organizations…it helps change the way of thinking and accessing support".

Connecting more clients to services

Community agencies talked about being able to connect more clients to services, particularly reaching out to people that might not have come to their attention prior to the BCRT. The initiative appears to have enhanced opportunities of community agencies to help more clients because of the access they now have to diverse service providers and the relationships that have been built with them. As one agency representative stated:

> "The key piece is being able to connect clients more, it's beneficial 100%, there is no negative from connecting people. Even if they don't want help, it's been planted with them, and the connection is there for the future when they are ready…we have made it easy when one step, one visit and we can help connect them".

Initial effects of the initiative on community agencies' service provision and collaboration

Internal changes within organizations

Improved capacity to identify and address acutely-elevated risk situations

According to the follow-up survey of community agencies, a vast majority of BCRT members (79%) reported having a *great deal* or *a lot* of ability to identify the acutely-elevated risk situations of their clients (Table 17). Furthermore, more than half of the community agencies (57.9%) reported that their ability to identify acutely-elevated risk situations have somewhat improved as a result of participating in the BCRT initiative, while another 3 agencies (15.8%) have observed a significant improvement in their capacity over the past 6 months (see Table 18).

Table 17: Community agencies' perceived ability to identify acutely-elevated risk situations, 6-month follow-up (n=19)

Response	n	%
Very little	1	5.3
Some	3	15.8
A lot	6	31.6
A great deal	9	47.4

Table 18: Community agencies' perceived changes in ability to identify acutely-elevated risk situations, 6-month follow-up (n=19)

Response	n	%
Significantly improved	3	15.8
Somewhat improved	11	57.9
Remained unchanged	5	26.3

Slightly more than half of the community agencies (52.7%) considered having *a great deal* or *a lot* of ability to address the acutely-elevated risk situations of their clients (Table 19), while another 6 agencies (31.6%) reported having *some* ability to deal with such situations. There appears to have been an increase in agencies' capacity over time, as many community agencies perceived somewhat (68.4%) or significant (10.5%) improvement in their ability to address the acutely-elevated risk situations as a result of participating in the BCRT initiative (Table 20).

Table 19: Community agencies' perceived ability to address acutely-elevated risk situations, 6-month follow-up (n=19)

Response	n	%
Not at all	2	10.5
Very little	1	5.3
Some	6	31.6
A lot	6	31.6
A great deal	4	21.1

Table 20: Community agencies' perceived changes in ability to address acutely-elevated risk situations, 6-month follow-up (n=19)

Response	n	%
Significantly improved	2	10.5
Somewhat improved	13	68.4
Remained unchanged	4	21.1

Analysis of the comments provided by the survey participants suggests that an increase in agencies' capacity to identify acutely-elevated risk situations could be attributed to a number of factors: a greater understanding of different types of risk, more information sharing about the clients between agencies and, in general, a greater knowledge of services offered by other community agencies. Those who perceived that their capacity remained unchanged explained that the identification of high risk situations was already part of their mandate or their services were not intended for acutely-elevated risk situations.

Similarly, the community agencies who observed a significant or somewhat improvement in their capacity to address acutely-elevated risk situations as a result of the BCRT, tended to attribute this change to an increase in: collaboration and information sharing between agencies, knowledge of services provided by other agencies, and ability to connect clients to services much faster than previously. Among those agencies who felt that their capacity remained unchanged over the past 6 months, only one provided a comment explaining that the assessment of clients' complex needs and provision of support to address those needs was already part of their agency's mandate.

Interviews revealed additional organizational changes that community agencies attributed to their participation in the BCRT, such as: an increase in referrals within their organizations and changes to their agencies process or policy to accommodate this initiative.

Increase in referrals within organizations

An increase in referrals was not something all community agencies noticed and it depended on their organizational mandate. Community agencies who did observe this change, noticed an increase in both the number of referrals being made and the number of staff making referrals within the agency. As one interview participant said:

> "We have one more tool to help staff identify risk and refer [clients] to be presented to the response team. The number of referrals from [all levels] of staff is non-stop".

Some agencies also saw an increase in referrals within their agencies because staff were now more connected to the initiative through education and awareness within their agencies.

> "We have changed our practice. Communication has increased and staff are more aware of what is acute or chronic and when to know it will become acute".

Process or policy changes to accommodate the initiative

Not all of the community agencies have had the capacity to make changes in their organizations for this initiative. Some community agencies discussed policy changes that have been made in order to develop procedures for their staff to ensure immediate access and attendance at meetings and interventions. The following is an example provided by one community agency representative:

> "We have had policy changes, there was a whole process need for the team because we wanted it to be number one in terms of dealing with changes…We developed a policy for process, where the person at the table would call in to get a person out on an intervention right away, and all the staff had training on the policy to provide the best service while we are there, it has to be immediate".

While some community agencies have simply had to adjust the workload and activities of staff members to attend the BCRT, others have been able to provide a dedicated staff position.

> "We have created a new position…this did not exist prior to the BCRT, so they have redirected those resources…Policies are still being written, but the staff are receiving training on how referrals can be made".

Other community agencies mentioned exploring a possibility of increasing their services to accommodate an evident need in the community. As one community agency stated:

> "Crisis oriented was not something we had considered. We have transitional housing, but now we are looking at the criteria of not needing to be beyond the crisis point to fit it because we now have other people to refer the support to".

Improved collaborative capacity of community agencies

All community agencies who participated in the follow-up survey reported that their collaboration has expanded or strengthened as a result of the BCRT initiative. At 6 months after the start of the initiative, they rated their progress in most areas of inter-organizational collaboration positively as indicated by high average scores (4 or higher) on a 1 (very poor) to 5 (very good) scale. Moreover, compared to the baseline results, there were significantly higher ratings of progress at 6-month follow-up in the following areas: knowledge of the roles and responsibilities of other community agencies, information sharing about clients, and efficiency in connecting clients to service. In other words, these are the areas where progress has been particularly pronounced over the past 6 months, as perceived by community agencies. There also appear to be positive changes in the areas of awareness of risk factors outside of agency's mandate and service planning, although no statistical difference was observed between the baseline and follow-up mean ratings given to those areas. Finally, prevention of risk behavior is the only area where the current state of progress was rated relatively low both at baseline and follow-up (Table 21).

Table 21: Status of inter-organizational collaboration as perceived by community agencies, baseline and 6-month follow-up, mean scores

	Mean score	
	Baseline	Follow-up
Knowledge of the roles and responsibilities of other community agencies	4.0	4.3
Awareness of risk factors outside of an agency's mandate	3.9	4.3
Service planning to address clients' needs between agencies	3.9	4.2
Efficiency in connecting clients to services*	3.6	4.3
Information sharing about clients between agencies*	3.3	4.0
Prevention of risk behaviors	3.7	3.5

Note: Wilcoxon Singed Ranks Test used
*Differences between groups are significant at p<0.05

Interviews with community agencies support the survey findings and provide insight into the current benefits of collaboration perceived by the BCRT members. The BCRT appears to have rapidly encouraged and improved the collaborative capacity among all the community agency and provided an avenue to build new or strengthen existing relationships, increase the understanding of each other's roles and resources, and work outside of the BCRT to address the needs of individuals or families before they are identified as being in acutely-elevated risk situations.

Developing new or strengthening existing connections

All of the community agencies talked about how they have been able to developing new connections with agencies they had not worked with prior to this initiative. Community agencies also discussed how existing connections with other community agencies have been strengthened. The BCRT has provided the opportunity for community agencies to meet face-to-face and solidify relationships to collaborate and help improve the number of services and supports their clients have access to, instead of working independently.

> "We all work in the same field, but not together…[This initiative] has pulled us together as a team…the collective response and approach has really solidified". Working together really strengthens the community agencies ability to break down the silos.

Increased understanding of each other's roles and resources

All community agencies talked at length about how their knowledge of the roles, resources and responsibilities of other agencies has increased as a result of being part of this initiative. They now have a better understanding of what agencies have to offer in terms of staff, support and resources and they are able to share this information with their clients to improve access to services.

> "[You] get to know people and what they offer, building trust, makes everything else easier. You get to know their struggles, their worries, see them as people. Knowing them as a person makes it easier to understand where they are coming from".

Community agencies also talked about how being able to discuss client situations and look at them from the different lenses of other agencies helps to provide a holistic picture of the client and makes them aware of prior connections with other agencies. As one community agency representative noted:

> "It opens the door, agencies are now able to understand the total picture of how the risk is affecting families…It expedites the process, it doesn't put them in front, but opens the door to

connecting to services because not all the risks were known for individuals prior to coming to the table".

Working together outside of the BCRT

Many interview participants mentioned that the BCRT has shown them that working together collaboratively is the most efficient and effective way to help their clients. Participation in the BCRT has enabled community agencies to proactively connect with fellow team members beyond the initiative to help their clients, especially those who are not identified as being in an acutely-elevated risk situation, but need to be connected to services and support before a crisis occurs.

> "We are looking beyond the table to other partnerships that can be formed for quicker response to clients beyond those who are just acutely-elevated risk".

Suggestions for moving forward

Although many community agencies are pleased with the progress made by the BCRT, in the survey and interviews they provided suggestions for further improvement of the BCRT core activities, such as the discussion process, intervention planning, intervention implementation and reporting back. Their suggestions are summarized below.

Discussion process (Discussion and identification of acutely elevated risk situations):

The suggestions for the discussion process revolved around dedicated resources, presentation style for the situations and access to data during the meetings. Community agencies expressed the need for more dedicated resources to facilitate participation in the initiative, including resources to help mine data from within agencies' records management system regarding individuals and families at risk and funding to dedicate one staff member to the initiative. To facilitate decision making at BCRT meetings, it was suggested that all agencies presenting situations should identify the specific risk factors from the Hub database list, provide sufficient information at each filter-level and be able to clearly articulate the elevated level of risk. Finally, although some agencies access their information electronically during the meetings, BCRT members wanted electronic access to data during discussion meetings improved so it was not a barrier to participating in the discussion and obtaining a comprehensive understanding of a risk situation.

Intervention planning (Filter 4 discussion, development of an action plan):

The suggestions for the intervention planning focused on procedures. Community agencies considered it important to choose a lead agency before moving on to the intervention in order to have a clear understanding of the roles and responsibilities of each organization assigned to a risk situation. A number of community agencies also talked about the need to streamline the intervention planning by focusing on planning rather than on case management. They felt that the case management discussions should be left to the lead and assisting agencies after a situation is concluded. In addition, agencies felt that an action plan template or protocol would be needed for all filter 4 members to facilitate a smooth intervention implementation. This protocol would also help to eliminate questions for newer members or staff regarding the intervention planning and implementation.

Intervention implementation (contacting clients, connecting them to services):

The intervention implementation suggestions from community agencies revolved around agency representation, connecting with clients, and scheduling. Agencies considered it important to have a

representative from the lead agency always involved in the intervention implementation and client encounters, in particular. Agencies also suggested connecting more often with clients to help ensure their engagement with services or minimize the risk of service refusal. Lastly, to enable representation of all necessary players at the intervention, community agencies called for a better coordination of busy and conflicting schedules among agencies when arranging visits to clients or connecting them to services.

Report back (assessing client progress, providing update to BCRT):
With respect to the reporting back process, BCRT members recognized the importance of adequate communication within an agency to ensure the most up-to-date information is available if different representatives attend discussion meetings. They also suggested that all filter 4 members should first inform the lead agency about the progress of a risk situation so that the lead agency could update all BCRT members on the status of the situation and progress made. Finally, community agencies felt that a less detailed report should be provided at BCRT meetings in order to avoid compromising client's confidentiality and privacy.

Conclusion

The Brant County Health Unit conducted an evaluation of the Brant Community Response Team initiative in the first six months of its implementation. The evaluation utilized a mixed-methods approach (surveys, interviews, focus group, and analysis of program data) to address the following key evaluation questions: To what extent is the initiative being implemented as intended? What are the initial effects of the BCRT initiative on individuals and/or families with acutely-elevated risks? What are the initial effects of the BCRT initiative on community agencies' service provision and collaboration?

To what extent is the initiative being implemented as intended?

The results of this evaluation demonstrate that the BCRT initiative has been successful in identifying individuals or families with acutely-elevated risks and connecting them to services. Over the course of six months, a vast majority of situations (92%) brought to the attention of the BCRT were accepted as involving acutely-elevated risks and most of them (87%) were concluded by connecting individuals or families to services or informing them about services. Furthermore, individuals or families appear to be connected to the appropriate services as the most common risk factors associated with the accepted situations fall within the mandate of lead and assisting agencies.

The evaluation reveals that the median service mobilization time stayed consistent at 5 days in the first six months of the initiative. However, this value is likely to be inflated as the documentation of each situation's discussion and conclusion status occurs twice a week at the BCRT meetings rather than in real time. The BCRT has started recording the intervention time for each situation in the Hub database (i.e. connected to services the same day, in two days, etc) to reflect the current efforts of addressing an acutely-elevated risk situation within the next 24 to 48 hours.

The current evidence on the service mobilization time also demonstrates that some risk situations, particularly those involving youth, may require more time to address than others. Youth were found to be associated with many top risk categories, which likely affected the amount of time required to identify them as being at acutely-elevated risk and connect them to appropriate services. Although variation in the service mobilization time is expected given the complexity of risk situations being addressed by the BCRT, a reduction in the discussion and intervention time for situations involving youth, would help the initiative further improve the efficiency of connecting clients to services.

Evaluation results indicate that some community agencies have been originating, leading and assisting agencies more often than others. This is likely a reflection of the dominant risk factors identified among the accepted situations that these agencies are typically dealing with as part of their organizational mandate. Nevertheless, the number of community agencies referring situations to the BCRT and becoming a lead or assisting agency has grown over the past 6 months. This is likely due to an increase in the capacity of community agencies to identify acutely-elevated risk situations and an enhancement of collaboration as evidenced by this evaluation study.

Collaboration appears to be a driving force for the BCRT initiative as the most common factors found to facilitate the implementation of the initiative are related to collaboration and relationship building among community agencies. They include the rapport and trust established between community agencies, information sharing between agencies, knowledge of each other's roles and services, quicker access to

services and other key factors. Meanwhile, the initiative continues to evolve, but not without internal or external systemic restrains, most commonly the lack of staff time or skilled staff to dedicate to the initiative, and service gaps in the community. Addressing the internal and external restrains as well as other identified challenges is important to further improve the implementation of the initiative and ensure its sustainability over time.

What are the initial effects of the BCRT initiative on individuals and/or families with acutely-elevated risks?

Evidence regarding the initial effects of the initiative on individuals and families at risk is very limited. The existing data on the status of risk situations over time suggests that continuous support to high-risk individuals and families is needed in order for behavior change to occur and for risks to be mitigated.

Evaluation findings demonstrate that client refusal of services is a persisting challenge for the initiative, partially due to client misconception about service providers. This indicates the need for putting more efforts into addressing individuals/families myths about the roles and responsibilities of community agencies. Some agencies have reportedly made progress in breaking down those myths and therefore could serve as an example to other BCRT member organizations dealing with the same challenge.

BCRT members need to continue to systematically monitor changes in risk situations to enable understanding of the initiative's impact on individuals or families. Additional pilot testing of the Risk Factor Tracking tool would be beneficial to determine its feasibility in capturing changes in individual risk factors and overall risk situations. In addition, future evaluations should strive to collect data directly from clients to gain an in-depth understanding of their experience with the services received as part of the initiative and its impact on their safety and well-being.

What are the initial effects of the BCRT initiative on community agencies' service provision and collaboration?

The BCRT initiative appears to have affected the service provision as indicated by an increase over time in the capacity of community agencies to identify and address acutely-elevated risk situations. Evidence is emerging around internal organizational changes as a result of the initiative. In particular, several community agencies reported introducing policy changes to accommodate the initiative, creating a designated position focused on the BCRT, educating staff members about acutely-elevated risks and, ultimately, increasing referrals within an organization.

There is strong evidence demonstrating that the BCRT has promoted collaboration and relationship building among community agencies. The progress has been observed in many aspects of inter-organizational collaboration, but most notably in: the knowledge of the roles and responsibilities of other community agencies, efficiency in connecting clients to services and information sharing about clients between agencies. Community agencies appear to have a well agreed understanding that working together is the most efficient and effective way to help their clients. Evaluation findings indicate that such understanding tends to strengthen their connections within the BCRT and even promote their partnership outside of the initiative to address the needs of clients that do not meet the acutely-elevated risk definition. Future evaluation should focus on examining the long-term impact of the initiative on individuals and families and community agencies' collaboration and service delivery.

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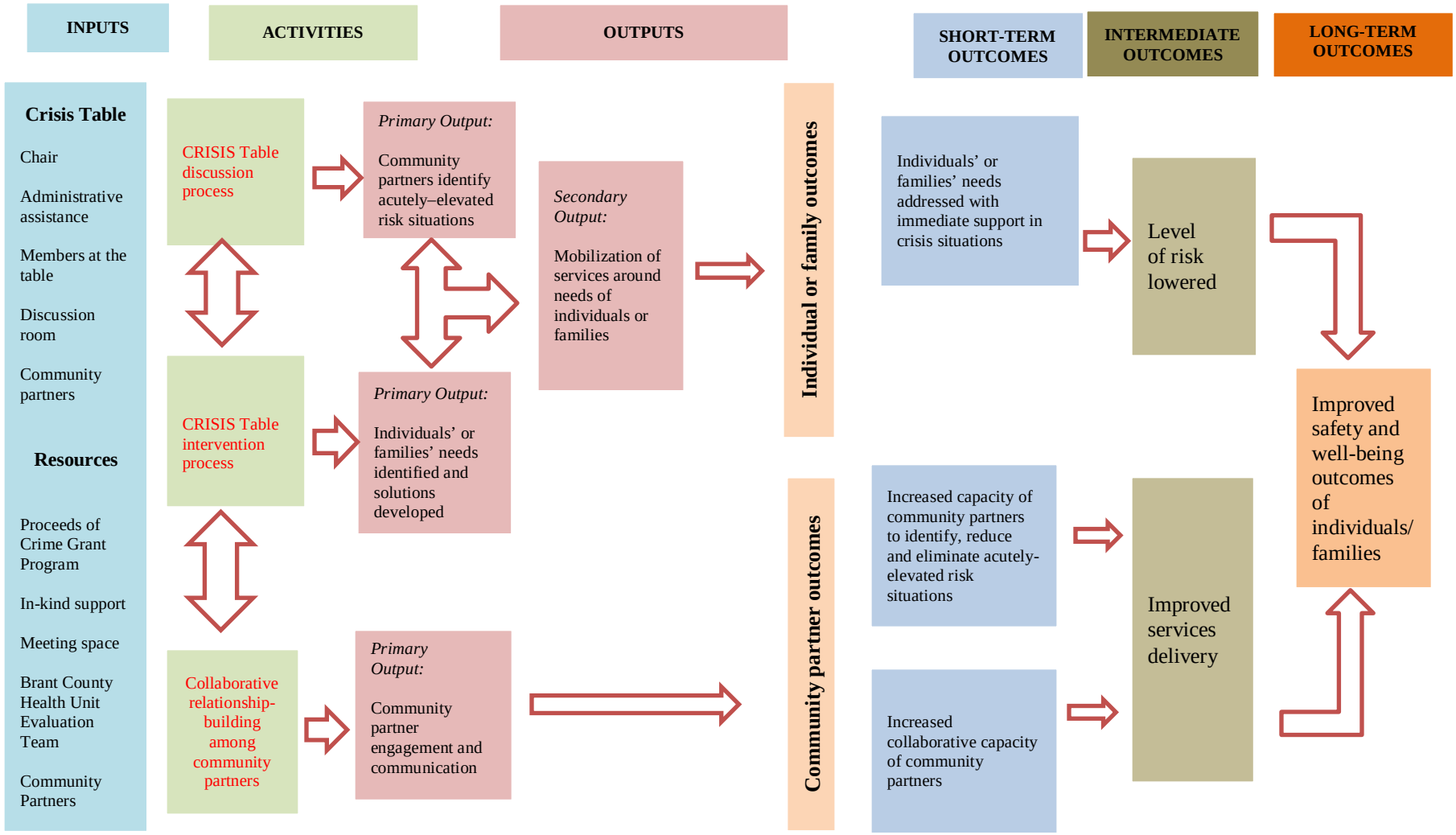
Appendices

Appendix A: BCRT logic model

Goal: To mitigate acutely-elevated risk situations and improve service delivery through community collaboration and resource



Appendix B: BCRT initiative evaluation matrix

Evaluation Questions	Key Indicators	Methods and Data Sources	Timeline
1. To what extent is the initiative being implemented as intended?			
1.1 To what extent has the initiative been successful in connecting individuals and/or families to the right local support services? Why?	- Community partners referring clients to the BCRT (originating agencies) - # of discussions, total - # of discussions by status (open, concluded, rejected) - # and type of risks identified - Conclusion status for acutely-elevated risk individuals or families (e.g. connected to service, refused, informed about services, unable to locate, etc.) - Changes in discussion and/or intervention protocols	- Collaborative Risk-Driven Intervention Database - Interviews with community agencies	June, Sept 2015 Aug-Sept 2015
1.2 What have been the challenges and facilitators to the initiative implementation? Why?	- Barriers and facilitators to service provision identified by community partners	- Focus group with community agencies - Interviews with community agencies	July 2015 Aug-Sept 2015
1.3 How could the initiative be improved?	- Community partners' reported suggestions for improvement	- Focus group with community agencies - Interviews with community agencies	July 2015 Aug-Sept 2015
2. What are the initial effects of the BCRT initiative on individuals and/or families with acutely-elevated risks?			
2.1 Is the initiative progressing in lowering individuals' or families' level of risk? What has contributed to this process?	- Individual or family risk factors status at 1, 3, and 6 months (e.g. , risk mitigated, risk being addressed, risk not addressed at all) - Individual or family satisfaction - Community partners' perceived determinants of project success	- Risk factor tracking tool - Interviews with community agencies - Interviews with individuals or families	Apr-May 2015 June-Sept 2015 Aug-Sept 2015 N/A
2.2How sustainable are the changes in individuals' or families level of risk over time?	- Decrease in number of situations returning to the BCRT - Community partners' and clients' perceived challenges to sustainability	- Collaborative Risk-Driven Intervention Database -Interviews with community partners - Interviews with individuals or families	June, Sept 2015 Aug-Sept 2015 N/A
3. What are the initial effects of the BCRT initiative on community partners' service provision and collaboration?			
3.1 Is the initiative improving community partners' ability to identify and mitigate acutely-elevated risk situations?	- Community partners' perceived ability to address acutely-elevated risk situations of individuals or families	- Baseline survey of community agencies - Follow-up survey of community agencies - Interviews with community agencies	Mar 2015 Aug-Sept 2015 Aug-Sept 2015

3.2 Is the initiative enabling community partners to collaborate and build relationships to address acutely-elevated risks?	- # of community partners involved in the BCRT initiative - Community partners referring clients to the BCRT (originating agencies) - Community partners' assessment of: • knowledge of the roles and responsibilities of other community organizations • Information sharing about clients • Service planning to address clients' needs • Clients' risk factors • Community partner collaboration	- Baseline survey of community agencies - Follow-up survey of community agencies - Interviews with community agencies	Mar 2015 Aug-Sept 2015 Aug-Sept 2015

Appendix C. Supplementary data

Table 1: Detailed list of risk factors identified among the accepted situations (n=133)

Risk Factor	n	%
Antisocial/Negative Behaviour - person exhibiting antisocial/negative behaviour	52	39.1
Drugs - drug abuse by person	50	37.6
Mental Health - diagnosed mental health problem	50	37.6
Suicide - person current suicide risk	42	31.6
Mental Health - suspected mental health problem	41	30.8
Threat to Public Health and Safety - persons behaviour is a threat to public health and safety	41	30.8
Parenting - parent-child conflict	38	28.6
Alcohol - alcohol abuse by person	34	25.6
Antisocial/Negative Behaviour - antisocial/negative behaviour within home	33	24.8
Criminal Involvement - assault	30	22.6
Housing - person does not have access to appropriate housing	30	22.6
Basic Needs - person unable to meet own basic needs	29	21.8
Physical Violence - person perpetrator of physical violence	28	21.1
Criminal Involvement - other	27	20.3
Negative Peers - person associating with negative peer	22	16.5
Mental Health - not following prescribed treatment	20	15.0
Self-Harm - person threatens self-harm	18	13.5
Drugs - drug use by person	15	11.3
Mental Health - grief	13	9.8
Emotional Violence - person perpetrator of emotional violence	13	9.8
Emotional Violence - emotional violence in the home	13	9.8
Drugs - drug abuse in home	11	8.3
Self-Harm - person has engaged in self-harm	11	8.3
Physical Violence - person affected by physical violence	11	8.3
Missing School - Chronic absenteeism	11	8.3
Suicide - person previous suicide risk	10	7.5
Emotional Violence - person affected by emotional violence	10	7.5
Sexual Violence - person victim of sexual violence	10	7.5
Parenting - person not providing proper parenting	10	7.5
Poverty - person living in less than adequate financial situation	10	7.5
Alcohol - alcohol use by person	9	6.8
Crime Victimization - sexual assault	9	6.8
Missing School - Truancy	9	6.8
Criminal Involvement - break and enter	8	6.0
Physical Violence - physical violence in the home	8	6.0
Criminal Involvement - threat	6	4.5
Crime Victimization - assault	6	4.5
Physical Violence - person victim of physical violence	6	4.5
Physical Health - Nutritional deficit	5	3.8
Physical Health - Not following prescribed treatment	5	3.8
Criminal Involvement - theft	5	3.8
Criminal Involvement - Drug Trafficking	5	3.8
Crime Victimization - other	5	3.8
Emotional Violence - person victim of emotional violence	5	3.8
Sexual Violence - person affected by sexual violence	5	3.8
Social Environment - frequents negative locations	5	3.8
Mental Health - self-reported mental health problem	4	3.0
Criminal Involvement - Possession of Weapons	4	3.0
Sexual Violence - person perpetrator of sexual violence	4	3.0
Basic Needs - person unwilling to have basic needs met'	4	3.0
Missing-Runaway with parents knowledge	4	3.0
Crime Victimization - robbery	3	2.3
Housing - person transient, but has access to appropriate housing	3	2.3
Alcohol - harm caused by alcohol abuse in home	2	1.5

Criminal Involvement - damage to property	2	1.5
Criminal Involvement - robbery	2	1.5
Criminal Involvement - sexual assault	2	1.5
Crime Victimization - break and enter	2	1.5
Supervision - person not properly supervised	2	1.5
Basic Needs - person neglecting others basic needs	2	1.5
Parenting - person not receiving proper parenting	2	1.5
Missing-Runaway without parents knowledge	2	1.5
Missing - person reported to police as missing	2	1.5
Alcohol - alcohol abuse in home	1	0.8
Drugs - harm caused by drug abuse in home	1	0.8
Suicide - affected by suicide	1	0.8
Criminal Involvement - arson	1	0.8
Criminal Involvement - homicide	1	0.8
Sexual Violence - sexual violence in the home	1	0.8
Elderly Abuse - person victim of elderly abuse	1	0.8
Negative Peers - person serving as a negative peer to others	1	0.8
Unemployment - person chronically unemployed	1	0.8
Unemployment - caregivers chronically unemployed	1	0.8
Social Environment - negative neighbourhood	1	0.8