Organizational Stakeholders' Perceptions of the Effects of the Implementation of a New Community-Based Rapid Response Team on Mental Health: A Qualitative Study

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Thesis submitted to the University of Ottawa
in partial Fulfillment of the requirements for the
Master of Science Interdisciplinary Health Sciences

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Preface

Ethics and Approval

This research was conducted with the approval of the University of Ottawa Research Ethics Board, under certificate number H-11-23-9794, as well as with approval from the Team Lead and the Chief of the Ottawa Paramedic Service.

Contributions

The student researcher, Maria Ibrahim (MI), acted as the principal investigator and was responsible for all aspects of the project, including the study design, stakeholder engagement, data collection, data analysis, preparation and writing of the article and thesis. Isabelle Marcoux (IM), the thesis supervisor, provided guidance and oversight throughout the research process, conducted a secondary review of the analysis, and reviewed all versions of the thesis and article, as well approved the final written work.

Abstract

This study examines organizational stakeholders' perceptions of a new Community-Based Rapid Response Team (CBRRT), a mobile mental health crisis intervention program in a Canadian municipality developed in response to the COVID-19 pandemic's exposure of critical service gaps. The CBRRT was designed to provide timely, community-based mental health support to individuals experiencing crises, particularly those underserved by traditional systems. Using a qualitative descriptive approach, data were collected through two small focus groups with frontline team members and two semi-structured interviews with program decision-makers.

The study aimed to: (1) describe the organizational stakeholders' perceived effects of the implementation of a new CBRRT on mental health; (2) explore if and why a mobile, intervention team that brings the service to the client is preferred over a traditional approach in improving access to mental health services; (3) explore any difference in perceptions concerning access to mental health services according to social identities; and (4) depict the perceived barriers and facilitators of the CBRRT in being able to reduce the mortality due to substance use problems.

Participants emphasized the CBRRT's role in improving access to timely, trauma-informed, and culturally responsive services, particularly for marginalized individuals who often face systemic barriers in traditional care pathways. The mobile nature of the team allowed for flexible, person-centered service delivery, built stronger trust with clients, and reduced the reliance on hospital or police-led interventions. Organizational stakeholders valued the team's capacity to meet individuals where they are, both physically and emotionally, while maintaining a non-judgmental and supportive approach. However, participants also identified several operational challenges, including staffing and resource limitations, a need for stronger inter-agency collaboration and data-sharing mechanisms to better support continuity of care.

This research contributes to the growing body of literature supporting the development of mobile crisis intervention models. Findings support the case for expanding and adapting mental health services to be more accessible, equitable, and community-centered, particularly for individuals at greater risk of being excluded from traditional systems of care.

Acknowledgements

I would like to formally acknowledge and thank my thesis supervisor, Dr Isabelle Marcoux, for her invaluable guidance, support, and expertise throughout the entirety of this research project. I also wish to extend my appreciation to the members of my Thesis Advisory Committee, Dr Jeffrey Jutaï and Dr Ian Graham, for their insightful feedback and contributions, which greatly enhanced the quality of this work.

I am sincerely grateful to the Ottawa Paramedic Service, and Logan Martin (Team Lead of the Mental Wellbeing Response Team) for their collaboration and support. Their assistance in facilitating access to the team, providing guidance on internal processes, contributing to the development of the interview guide, and disseminating the research poster to employees was essential to the successful completion of this study.

Finally, I would like to acknowledge my friends and family for their unwavering support and encouragement throughout this journey.

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Chapter 1 – Background

1.1 Mental Health Introduction

Much like physical health, everyone has mental health. Mental health is defined by the World Health Organization (WHO) (2025) as “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is integral to our well-being.” Although many people use the terms "mental health" and "mental illness" interchangeably, they are quite distinct (Canadian Mental Health Association [CMHA], 2020). Mental illness is defined as “a disturbance in your thoughts, perceptions, and emotions that affects your ability to think, make decisions, and function on a day-to-day basis” (Mood Disorders Society of Canada [MDSC], 2019). Mental illnesses can range from mild to severe and are classified in the Diagnostic and Statistical Manual, which include, but are not limited to diagnoses such as depression, anxiety disorders, and personality disorders (MDSC, 2019).

It is important to understand that mental health is not simply the absence of mental illness, and living with a mental illness does not mean one cannot have good mental health (CMHA, 2020). Recovery from mental illness is possible and should be the goal. Recovery means that an individual experiencing symptoms of mental illness can manage these symptoms and live a satisfying, meaningful, and rewarding life beyond their illness (Carr & Ponce, 2022; Mental Health Commission of Canada (MHCC), 2024; MDSC, 2019). Support systems at the micro, meso, and macro levels can aid individuals in their recovery journey (Carr & Ponce, 2022), which will look different for

each person (MHCC, 2024). Therefore, it is crucial to have services in place to help people navigate their symptoms and achieve recovery, allowing them to thrive.

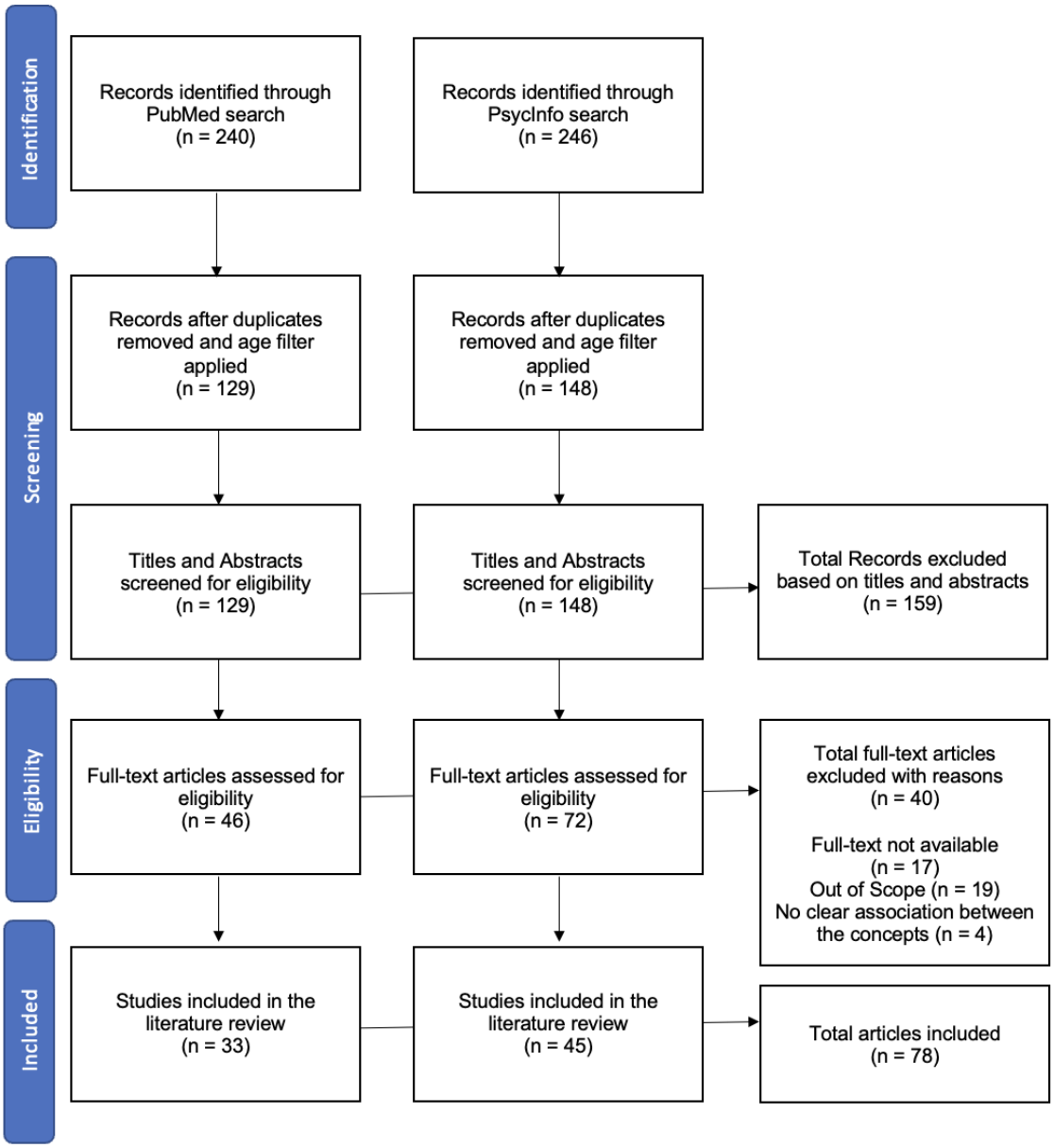
1.2 Global Mental Health Prevalence

Mental illness is currently the leading cause of disability worldwide (Centre for Addiction and Mental Health (CAMH), 2025b). As of 2019, 970 million people, or every 1 out of 8 people, were living with a mental health disorder (WHO, 2022). Among many types of mental health disorders, anxiety and depression are the most common, representing approximately 301 million people and 280 million people respectively (WHO, 2022). The onset of the COVID-19 pandemic in 2020, lead to a significant increase in one year of people living with an anxiety disorder and depressive disorder by an estimate of 26% and 28% respectively (WHO, 2022). It has also increased the barriers to accessing quality care (Grant et al., 2023). Despite the prevalence of mental illness, “most people do not have access to effective care” (WHO, 2022). Prior to the onset of the pandemic, the WHO had implemented, and continues to implement the *Comprehensive Mental Health Action Plan 2013-2030* that has 4 main objectives, one of which is “to provide comprehensive, integrated and responsive mental health and social care services in community-based setting” (WHO, 2022). As mental illness continues to be an emerging public health concern, there is a need to address barriers and facilitators to access mental health service, as for different options of service delivery such as community-based services.

1.3 International Literature Review on Access to Mental Health Services and Community-based Services

A review of the literature was conducted using PubMed and PsychInfo. Key concepts used were Community Engagement, Mental Health, Substance Use, Mobile Crisis Team, and Utilization. Additional similar terms and synonyms were used for each main concept and the Boolean operator “OR” was used between similar concepts. To note, all terms related to Mental Health and Substance Use were connected with the Boolean operator “OR”. The Boolean operator “AND” was used between all the categories of the key concepts. The results of the review are shown in the PRISMA flowchart below. Grey literature (including government health departments, public health agencies, and non-profit mental health organizations) and news articles were also assessed to complement the information found in the scientific literature and to frame the problem in a global, Canadian, and local (Ottawa) context.

Graph 1. PRISMA flowchart for literature review



1.3.1 Barriers to Access Mental Health Services

Barriers to accessing mental health services fall under the 4-level socio-ecological model; individual, relationship, community and societal (Centers for Disease Control and Prevention, 2024). The barriers identified in the current available literature have been summarized and listed below under their respective levels.

Individual - Identified individual barriers to accessing mental health services are related to education, socioeconomic factors, and emotional intelligence. Educational barriers are limited literacy, lack of mental health literacy, for instance knowing the signs and symptoms of common mental illnesses (Collier et al., 2012; Crane et al., 2019; Kamimura et al., 2013; Lincoln et al., 2016; Linney et al., 2020; Mathur Gaida et al., 2014; Snell-Rood et al., 2019; Williams et al., 2013), and a lack of knowledge of available resources (Sheffer et al., 2016). Socioeconomic factors that can be obstacles to accessing care include low socio-economic status (Sheffer et al., 2011; Williams et al., 2013) and its related components, such as, limited income, unstable housing, and employment status (Arevian et al., 2019; Collier et al., 2012; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Gray & Price, 2014; Lincoln et al., 2016; Marlow et al., 2010; Shattell et al., 2008), as well as transportation barriers (Collier et al., 2012; Cristofalo et al., 2009; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Pringle et al., 2006; Sheffer et al., 2016; Williams et al., 2013), lack of or limited insurance (Ashford et al., 2019; Cristofalo et al., 2009; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Lincoln et al., 2016; Marko et al., 2015; Rust et al., 2005; Shattell et al., 2008; Williams et al., 2013) and a lack of access to the required technology to be able to participate in e-mental health services (Sheffer et al., 2016; Tse et al., 2021). Limitations relating to emotional intelligence are feelings of powerlessness (Sukhera et al., 2017), concerns about potential negative health outcomes related to seeking treatment (Sheffer et al., 2011) and self-management, for instance facing difficulties with being able to pick up the phone to make an appointment (Pyne et al., 2019; True et al.,

2015). In sum, there are many individual barriers to consider when implementing a mental health service.

Relationship - Relationship barriers identified are related to interactions with family, peers, and mental health care providers. Familial barriers identified are people not prioritizing themselves due to competing priorities (Snell-Rood et al., 2019; Williams et al., 2013), such as, but not limited to, childcare (Ashford et al., 2019; Pringle et al., 2006) and other family priorities (Birkenstock et al., 2022; Williams et al., 2013). With regards to relationships with peers, negative experiences reported by peers who have used mental health services (Pyne et al., 2019; True et al., 2015) or being led to believe by others that mental illness is not treatable (Mathur Gaida et al., 2014) can also hinder seeking and obtaining appropriate help. Additionally, obstacles identified regarding relationships with mental health care providers include having a lack of trust in the providers (Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Marlow et al., 2010; Morgan et al., 2015; Pyne et al., 2019; Shattell et al., 2008, 2014; Sheffer et al., 2011, 2016; True et al., 2015; Williams et al., 2013) and feeling that the services are impersonal (Matthews, 2019). In summary, the inter relationships that the individual has with the people in their lives can sometimes be detrimental to their access to mental health services.

Community - At a community level, barriers identified are related to infrastructures, program administration and culture. One of the infrastructure related barriers is the physical distance of services and it being too far for many to access (Marlow et al., 2010; Piwowarczyk et al., 2014; Pyne et al., 2019; True et al., 2015; Williams et al., 2013). In addition, the lack of public transit is another infrastructural obstacle that also

amplifies the previous one listed (Collier et al., 2012; Cristofalo et al., 2009; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Pringle et al., 2006; Sheffer et al., 2016; Williams et al., 2013). Some of the program administration impediments identified are logistical problems such as administration issues, billing problems (Marlow et al., 2010; Piwowarczyk et al., 2014; Pyne et al., 2019; True et al., 2015; Williams et al., 2013), inconsistent funding for programs (Williams et al., 2013), lack of available services (Abolarin, 2020; Cordova et al., 2015; Crane et al., 2019; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Ingram et al., 2015; Linney et al., 2020; Mosier et al., 2010; Shattell et al., 2014; Snell-Rood et al., 2019; Waldron et al., 2023; Williams et al., 2013), and lack of privacy (Birkenstock et al., 2022; Lee et al., 2023; Sheffer et al., 2016). From another perspective, cultural barriers are related to a lack of local cultural knowledge, language, holistic culturally sensitive treatment, and culturally appropriate services (Abolarin, 2020; Auger, 2019; Collier et al., 2012; Doornbos et al., 2013; Goodkind et al., 2015; Linney et al., 2020; Mantovani et al., 2017; Mathur Gaida et al., 2014, 2014; McEvoy et al., 2017; Piwowarczyk et al., 2014; Rocha et al., 2022; Sheffer et al., 2016). Although there are many individual and relationship barriers that can impact access to care, the community they reside in can also be a limitation to the individuals.

Societal - At a societal level, barriers identified are relating to negative stereotypes, the health care structure and language related issues. Stigma (Abolarin, 2020; Arevian et al., 2019; Cordova et al., 2015; Crane et al., 2019; Cristofalo et al., 2009; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Ingram et al., 2015; Lincoln et al., 2016; Linney et al., 2020; Mantovani et al., 2017; Marko et al., 2015; Marlow et al., 2010; Mathur Gaida et al., 2014, 2014; Pyne et al., 2019; Sajatovic et al., 2018; Shattell et al.,

2014; Snell-Rood et al., 2019; True et al., 2015; Williams et al., 2013) discrimination and racisme (Abolarin, 2020; Burgess et al., 2008; Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Shattell et al., 2014) have been identified as negative stereotypes. Additionally, many perceive the practice of Western medicine as a quick fix (Collier et al., 2012; Marlow et al., 2010). Furthermore, a Canadian scoping review presented that the cultural differences that immigrant populations face can lead them to withdraw from the services and stereotyping mental problems (Dombou et al., 2022). Identified barriers relating to the health care structure are a lack of trained health professionals, long wait times to access care, limited clinic hours and long waitlists (Crane et al., 2019; Sukhera et al., 2017; Williams et al., 2013). In addition, there is sometimes a lack of continuity of care, for instance, many people are unable to transition from Children and Adolescent Mental Health Services to Adult Mental Health Services (Crane et al., 2019). Finally, the language and communication style implemented can also be consider as obstacles in accessing mental health services (Collier et al., 2012; Shattell et al., 2008; Williams et al., 2013). Going back to the Canadian scoping review, the Chinese and Latino immigrant population identified that their limited English proficiency impacted their access to mental health service, and that the women felt disrespected by the health care providers in the way they were communicating to them (Dombou et al., 2022). Despite an individual's willingness to want to overcome certain barriers, some are imposed at a much higher level (societal level), and they make it more difficult for the individual to have control of their situation.

The listed barriers to access to mental health services reduce the opportunity for people to use the limited services available, which exasperated people's mental health

symptoms, forcing them to psychiatric emergency services (Lincoln et al., 2016). Unfortunately, most emergency departments (ED) are not well equipped to support people in psychological distress. Based on the current ED structure, people will be triaged to attend to the most urgent cases first and people in psychological distress may not receive adequate care in a timely manner (Shattell et al., 2014), unless they are brought to the ED by police, as a threat to others or themselves. People with both mental health disorders and substance use disorders have a higher hospitalization rate than people who only have a mental health disorder (Chang et al., 2015). The burden must be shifted off EDs to best support the community, and to do so, there is a need for community-based services.

1.3.2 Mental Health Services and Community Engagement

Over the last decade, there has been a rapid expansion of community health centers in low-income and underserved communities across 146 countries, which has contributed to a decline in psychiatric ED visits (Bruckner et al., 2019). This underscores the critical need for community-based mental health services, particularly in supporting individuals recovering from mental health and substance use disorders (Dahlem et al., 2021; Fleury et al., 2019; Mayston et al., 2016), especially for "psychological problems caused by disastrous infectious disease outbreaks" (Yoon et al., 2016), like the recent COVID-19 pandemic. These services must be individualized, carefully planned, and multidisciplinary to effectively meet diverse community needs (Fleury et al., 2019; She et al., 2020). Furthermore, culturally adapted interventions have been shown to be more effective for racially minoritized populations, as culture shapes beliefs and

understandings of mental health, thereby enhancing treatment accessibility, acceptability, and therapeutic relationships (Shahnaz et al., 2025).

Co-design (community engagement) has emerged as a promising approach in mental health interventions, involving end users and stakeholders in the developmental process to ensure alignment with community needs (Shahnaz et al., 2025). Engaging youth, caregivers, and practitioners in co-design processes has improved mental health research by identifying specific challenges, increasing participant recruitment, and enhancing data collection. However, barriers such as resource limitations, power imbalances, and selection bias must be addressed (Shahnaz et al., 2025). Similarly, cultural safety remains a key concern, particularly for Indigenous communities, as the lack of culturally safe mental health services contributes to health disparities (Milroy et al., 2024). Embedding cultural safety within research processes fosters knowledge-sharing beyond traditional Western quantitative methods, further supporting effective intervention development (Milroy et al., 2024).

Stigma, lack of trust in healthcare services, and limited access to culturally competent providers remain significant barriers to mental health care, particularly among marginalized communities (Waldron et al., 2023). For example, African Nova Scotians experience additional barriers, including a lack of awareness about available services, negative perceptions of police involvement, and financial constraints (Waldron et al., 2023). Addressing these issues requires strengthening community organizations' capacity to support individuals, fostering collaboration between healthcare providers and community organizations, and ensuring financial and structural supports such as

transportation and medication coverage are in place (Kangwana et al., 2024; Waldron et al., 2023).

Youth mental health services warrant particular attention, as evidence suggests a declining trend in the mental well-being of vulnerable youth despite increased service utilization (Yang et al., 2024). In Canada, prioritizing youth mental health within healthcare plans is crucial to ensuring effective service provision and long-term outcomes (Yang et al., 2024). Mental health challenges such as depression, anxiety, and behavioral disorders are leading causes of illness and disability among adolescents, highlighting the need for integrated, community-based mental health services that support adolescents, parents, and mentors alike (Kangwana et al., 2024). While youth mental health services present unique access challenges, these findings also highlight broader systemic issues that apply across populations served by community-based mental health services, especially as youth age into young adults who will be utilizing them. The evidence points to the need for flexible, mobile, and community-embedded services that can respond to diverse needs in real time.

Community engagement plays a vital role in addressing these challenges. It can facilitate recovery (Arevian et al., 2019; Ariss et al., 2019), reduce recidivism (Peterson et al., 2006), and empower individuals through autonomy and self-determination (Ariss et al., 2019). Participants who have received client centered interventions that are catered to their needs, are more likely to use them (Ariss et al., 2019). By including participants in the research process, it provided them with empowerment, autonomy, and self-determination (Ariss et al., 2019). Additionally, community engagement as an outcome measure has demonstrated improvements in mental well-being (Adrian et al.,

1998; Barceló et al., 2019; Lam et al., 2016; Mehta et al., 2017; Peterson et al., 2006; Springgate et al., 2018), quality of life (Barceló et al., 2019; Chung et al., 2014; Gomez, 2012; Izquierdo et al., 2018; Kelly & Pich, 2014; Wells et al., 2013), resilience, self-efficacy, homelessness risk, and financial stability (Kelly & Pich, 2014; Springgate et al., 2018). It also contributes to reducing hospital visits, reliance on antidepressants, and systemic barriers to care (Chung et al., 2014; Ngo et al., 2016; Ong et al., 2017; Peterson et al., 2006; Wells et al., 2013).

Despite these benefits, the implementation of community-based mental health programs is hindered by challenges such as inadequate infrastructure, financial constraints, and workforce shortages (Arriola-Vigo et al., 2019; Morgan et al., 2015). Furthermore, considering diverse cultural and motivational factors is crucial to fostering participation in these programs (van der Velde et al., 2009). Addressing these barriers through tailored, community-driven interventions has shown promise in enhancing emotional resilience among BIPOC adolescents (Scott, 2024). Additionally, identifying and expanding outreach and mobile mental health services can mitigate logistical challenges such as transportation costs and privacy concerns (Kangwana et al., 2024).

Ultimately, community engagement is essential in reducing health equity gaps (Gray & Price, 2014; Izquierdo et al., 2018; Mantovani et al., 2017; Mathur Gaida et al., 2014; Morgan et al., 2015; Piwowarczyk et al., 2014), alleviating burdens on overstretched healthcare systems with the current nurses and doctor shortage (Morgan et al., 2015; Petersen et al., 2012), and lowering costs associated with mental health services and hospitalizations (Adrian et al., 1998; Chung et al., 2018; Peterson et al., 2006). It also improves emergency response efficiency by reducing ambulance use for non-

emergency mental health cases (Witbeck et al., 2000). By embedding cultural competency, co-design principles, and systemic supports into mental health services, community-based interventions can be more effective, accessible, and sustainable in addressing population needs.

In summary, the international literature highlights barriers to mental health services for various populations, including marginalized groups, refugees, Indigenous people, veterans, victims of domestic abuse, and individuals experiencing homelessness. The studies varied in country of origin, and each had a specific population group. However, there hasn't been a study conducted that analyzes how the results could vary between different populations and how other factors, such a demographic information, could have a role to play in people's perceptions to access to mental health services. Despite growing interest in alternatives to police-led mental health crisis interventions, which aim to reduce emergency room visits and improve continuity of care, the peer-reviewed literature on community-based mental health services remains sparse (Marcus & Stergiopoulos, 2022). Of 78 reviewed studies, only 9 were Canadian, and just one examined mobile intervention teams. Most of them instead focused on general barriers to accessing care to traditional models such as emergency departments or hospital-based crisis units. There is limited empirical research examining how community-based mental health services are implemented or how they are perceived. This gap underscores the need for qualitative studies that explore staff perspectives, especially within Canadian contexts where health systems and social needs are evolving rapidly.

1.4 Paramedicine and Mental Health in Canada

Emergency department overcrowding (EDOC) has been a persistent issue in Canada for more than two decades, with root causes extending beyond the physical confines of EDs. It reflects systemic challenges that require solutions at multiple levels within the healthcare system (Affleck et al., 2013). Many patients turn to EDs as their primary access point for healthcare due to limited availability of primary care providers or difficulties in securing timely appointments. This reliance on EDs results in increased patient volumes, which exacerbates missed opportunities for preventative care and leads to patients presenting with more advanced illnesses (Affleck et al., 2013).

The factors contributing to EDOC include staffing shortages among ED physicians and consultants, limited inpatient and community care resources, and a lack of integration between community-based and hospital-based services (Affleck et al., 2013). Furthermore, overcrowding in EDs creates a ripple effect that impacts ambulance services, as paramedics face delays transferring care to ED staff. These delays compromise patient safety, create staffing pressures for paramedics, and increase response times for emergencies in the community. For patients housed in EDs due to lack of inpatient beds, care quality is often suboptimal compared to ward-based care, while hospital overcrowding leads to delayed or canceled elective surgeries, increased nursing workloads, and decreased provider and patient satisfaction (Affleck et al., 2013).

The rising volume of mental health and addiction-related emergencies in Ontario has further strained emergency services and paramedic roles (Ford-Jones & Chaufan, 2017; Ford-Jones & Daly, 2022; Meijer et al., 2024). Current policies and systems restrict

paramedics to transporting individuals in crisis to EDs, which may not be the most appropriate setting for care (Ford-Jones & Chaufan, 2017; Ford-Jones & Daly, 2022; Kuehl et al., 2023; Prener & Lincoln, 2015; Wise-Harris et al., 2017). Studies estimate that 30–50% of ambulance transports are deemed "inappropriate" or “misuse” of paramedic and ED time for mental health and substance use related calls, with half of patients being discharged without significant treatment or referral (Bigham et al., 2013; Cuddeback et al., 2010; DeJean et al., 2016; Ford-Jones & Daly, 2022; Meijer et al., 2024). This points to an urgent need for alternative care models that address the root causes of crises and connect patients to more appropriate services, such as community-based mental health resources (Meijer et al., 2024; Tavares et al., 2017; Wise-Harris et al., 2017).

Barriers to effective mental health crisis management in the ED include stigma, poor treatment in EDs, long wait times, a lack of accessible, acceptable alternatives, and a lack of continuity of care. Participants in mental health studies report experiencing discrimination and unsympathetic care in EDs, leading to perceptions of inadequate support (Wise-Harris et al., 2017). To address these issues, paramedic services, community services and policymakers in Ontario have begun exploring patient care models that provide timely and appropriate care outside the ED (Kuehl et al., 2023; Meijer et al., 2024; Ministry of Health, 2022). Non-medical, community based, destinations staffed by supportive mental healthcare professionals represent a step toward de-medicalizing mental health care and addressing the challenges posed by existing regulations (Emond et al., 2019; Ford-Jones & Daly, 2022; McCann et al., 2018; Meijer et al., 2024). Prior to 2019, this was not previously possible with systems and

policies in place like the “the Ambulance Act (1990), the Public Hospitals Act (1990), and the Ontario Health Insurance Act (1990)” who had prohibited this alternative, restricting all transport to land in ambulances (Meijer et al., 2024).

Crisis response teams play a critical role in ensuring that paramedic services provide high-quality care for individuals experiencing mental health crises while also fulfilling their professional obligations (Ford-Jones & Daly, 2022). Although further research and programmatic analysis are necessary, current practices suggest that this response models hold significant potential for addressing mental health emergencies effectively (Boscarato et al., 2014; Choi et al., 2019; Ford-Jones & Daly, 2022; Watson & Compton, 2019). Additionally, as with other chronic conditions, implementing well-managed care plans with strong community support can help prevent crises, reduce ED visits, and minimize costly hospital stays (CIHI, 2019). These innovative approaches, coupled with investments in primary care and community-based resources, hold potential to alleviate EDOC and enhance continuity of care for this vulnerable population.

1.5 Overview of Mobile Mental Health Crisis Response Models

Various mobile crisis response models have been developed across Canada and internationally to reduce emergency department visits and improve care for individuals in mental health crises. As outlined in a rapid review by Marcus & Stergiopoulos (2022), mobile mental health crisis response models differ significantly in team composition and outcomes. These include police-led Crisis Intervention Teams (CITs), co-responder models (pairing police with mental health professionals), and non-police community-based models. Based on their review, police-involved models have faced criticism for

escalating distress or discouraging service use among marginalized populations. In contrast, emerging non-police models aim to provide trauma-informed, client-centered care without the presence of law enforcement. Table 1 summarizes key differences among commonly implemented models.

Table 1. Comparison of Mental Health Crisis Response Models

(adapted from Marcus & Stergiopoulos, 2022)

Model Type	Team Composition	Police Involvement	Key Outcomes	Strengths	Limitations
Police-Led (CIT)	Police with 40 hours of mental health training	Yes	- Arrest rates ~5% - Use of force in 4–12% of calls - 45–51% transported to treatment	Increases awareness of mental health issues; standard across jurisdictions	Inconsistent impact on arrest/use of force; linked to criminalization and escalation
Co-Responder	Police + mental health clinician	Yes	- Arrest rates 0.8–2% - Referrals 17–40% - 23–36% resolved on scene - Lower ED wait times	Reduced escalation and arrest; better triage and referrals	Role confusion; limited availability; still police-led and not always trauma-informed
Non-Police Model	Mental health profession + paramedic or peer worker	No	- 50–71% referral rates - 0.006–1.2% police backup - High satisfaction and access to care	Trauma-informed; avoids criminalization; high trust among service users	Fewer high-quality studies; model structure varies; limited coverage and scalability

1.6 Access to Mental Health Care in Canada

An important step in contextualizing this study is to clarify the key indicators that influence access to mental health care. The CIHI has worked in collaboration with federal, provincial, and territorial governments to identify 12 Shared Health Priorities indicators aimed at improving access to home and community care, as well as mental health and addictions services (CIHI, 2019, 2021, 2022). These indicators are:

1. “Hospital Stays for Harm Caused by Substance Use”
2. “Frequent Emergency Room Visits for Help with Mental Health and/or Addictions”
3. “Hospital Stay Extended Until Home Care Services or Supports Ready”
4. “Self-Harm, Including Suicide”
5. “Caregiver Distress”
6. “New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home”
7. “Wait Times for Community Mental Health Counselling”
8. “Wait Times for Home Care Services”
9. “Home Care Services Helped the Recipient Stay at Home”
10. “Navigation of Mental Health and/or Substance Use Services”
11. “Early Intervention for Mental Health and/or Substance Use Among Children and Youth”
12. “Death at Home/Not in Hospital”

Indicators, 1, 2, 7, 10 and 11 are particularly relevant as they highlight gaps in community-based services, such as high hospitalization rates for substance use, which suggest the need for improved access to prevention, mental health care, or addictions

services. Frequent ED visits for mental health and addictions issues often reflect poorly managed conditions in the community or barriers to accessing available services, such as long wait times or inadequate awareness of community resources (CIHI, 2019). When appropriate services are available in a timely manner in the community, it can improve Canadians mental health outcomes and reduces hospitalization or unnecessary visits to the ED (CIHI, 2019; Children's Mental Health Ontario, 2020; MHCC, 2017; Organisation for Economic Co-operation and Development, 2020).

Factors influencing hospital stays for harm caused by substance use include access to harm reduction services, geographic disparities, trauma and social determinants of health such as housing, and income (CIHI, 2019). Another important factor is the "availability and effectiveness of paramedic and emergency services prior to the hospital stay" (CIHI, 2019). These hospitalizations account for more days in hospital than heart attacks and strokes combined, with over 155,000 stays in 2017–2018 alone, amounting to 2 million hospital days annually (CIHI, 2019). Similarly, rural areas report higher rates of repeat ED visits for mental health and addictions care compared to urban areas, reflecting disparities in service availability and care coordination. Populations experiencing homelessness, poverty, or other challenges related to the social determinants of health are particularly at risk for severe illness and increased hospitalizations (CIHI, 2019).

Timely access to mental health and addictions care remains a challenge, with half of Canadians waiting up to a month to access ongoing community counselling services and 1 in 10 waiting more than four months (CIHI, 2021). The availability and coordination of services, as well as navigation challenges within the health system,

contribute to these delays. The strength of connections between primary health care providers and community services can impact patient outcomes, while barriers such as stigmatization, financial constraints, and scheduling conflicts often prevent individuals from receiving the care they need (CIHI, 2021). Additionally, missed appointments for counselling services are common, especially among younger individuals, those from low-income neighborhoods, and those living farther from their healthcare providers (Dantas et al., 2018; Glauser, 2020). Long wait times exacerbate these issues, further discouraging patients from attending their first appointments (Gallucci et al., 2005).

The COVID-19 pandemic has intensified these challenges, increasing demand for mental health and substance use services while straining health system resources. Virtual care delivery has expanded, particularly in rural and remote areas, but has also introduced additional complexity in navigating services (CIHI, 2022). For example, only 2 in 5 Canadians consistently received support navigating mental health and substance use services, and nearly 30% reported rarely or never receiving such support (CIHI, 2022). Effective navigation requires better communication and coordination among providers, as well as addressing gaps in services and financial barriers to access (Slaunwhite, 2015). The pandemic's associated anxiety, social isolation and loneliness have also had serious consequences for mental and physical health, further burdening individuals and families (CIHI, 2022; Statistics Canada, 2021).

Improving access to effective home, community, mental health, and addictions care will require sustained effort and planning. Addressing systemic barriers, enhancing service coordination, and supporting navigation within and between services are critical for reducing inequities and improving outcomes for Canadians (CIHI, 2019, 2022).

1.7 Mental Health within the Canadian and Local Context

As of spring 2021, the national yearly prevalence of Canadians living with a mental problem or illness has increased to one out of four and was previously one out of five Canadians in fall 2020. The increase in prevalence can be linked with the onset of the COVID-19 pandemic (Statistics Canada, 2021). In 2022, the prevalence has returned back to its original incidence 1 in 5 people experiencing a mental illness each year, and it is estimated that by the age of 40, 1 in 2 Canadians will have experienced a mental illness (Statistics Canada, 2023). Similar to the international statistics, mental illness is also the leading cause of disability in Canada (CAMH, 2025b). Substance use disorders are classified as mental disorders under the DSM-5 (American Psychiatric Association, 2013), but the data provided from the grey literature makes a distinction between both when presenting the results. With that said, the estimated annual economic cost of mental illness in Canada is $50 billion, and $40billion for substance use (CAMH, 2025a). Substance use is also an emerging problem in the Canadian society with an estimated 67 000 deaths per year attributed to it, and 14 700 opioid-related deaths from 2016-2019 (CAMH, 2025a). Over a course of a year, 2014-2015, Ottawa Public Health saw an 32% increase of drug overdose related deaths, while the Ontario province only saw an increase of 6% (Ottawa Paramedic Service, 2021). It is estimated that the 9-1-1 service in Ottawa receives approximately 25 mental health calls daily & 9500 mental health and substance use calls yearly, yet those numbers are underestimated (Ottawa Paramedic Service, 2021). Mental illness and substance use disorders are highly prevalent at a national and local context and are costly both in monetary value and in lives.

In a recent news article, Fady Dagher, the Chief of Police for the City of Montreal stated that there is a need for community services to support with non-criminal 9-1-1 mental health related calls. He has indicated that the use of police services in these situations is not beneficial to the officers or to the community. The use of police officers in this situation can lead to mistrust with the community (Marin, 2023). During a mental health crisis, a trained provider should be responding to the 9-1-1 distress calls, instead of the police to maintain trust in the community.

In response to the increase in prevalence and lack of available resources, the Mental Health Commission of Canada recommends the use of “community-based rapid response teams” since they have yielded impressive qualitative and quantitative results worldwide (CAMH, 2025a). Also known as mobile treatment teams, they provide treatment to those who may otherwise not be able to receive it (Wiebe & Huebert, 1996).

1.8 Ottawa’s Community Based Rapid Response Team

Following the Mental Health Commission of Canada’s recommendation, the Ottawa Paramedic Service (OPS) and The Ottawa Hospital (TOH) have partnered and created the Mental Wellbeing Response Team (MWRT) (Ottawa Paramedic Service, 2021). The MWRT fits under the Ministry of Health’s “treat and refer” model of care, to provide community care (City of Ottawa, 2022). The team operates 12 hours/per day, 7 days/week and is comprised of a paramedic from OPS and a mental health professional (social worker) from TOH who respond to 9-1-1 non-violent and non-criminal mental health and substance use calls in an unmarked vehicle and casual uniform to remove any potential triggers or stigma (City of Ottawa, 2022). The paramedic conducts a

medical assessment and provides medical care as needed, while the mental health professional provides a mental health assessment, care plan, safety assessment and follow up (City of Ottawa, 2022; Ottawa Paramedic Service, 2021). The MWRT is grounded in the principles of accessibility, client-centered care, and harm reduction. The core assumption is that many mental health crises can be effectively managed in the community without resorting to hospital visits which often involve long wait times and may not result in appropriate care. By bringing care to clients in their own environments, the MWRT seeks to reduce common barriers such as transportation, costs, stigma, and caregiving responsibilities. This approach is also based on the assumption to enable quicker, more tailored support and to help prevent unnecessary use of emergency departments. The MWRT functions as the frontline response team and operates within a defined leadership structure, reporting to superintendents, commanders, deputy chiefs, and ultimately to the Chief of OPS.

In comparison to other Ontario mobile crisis rapid response teams (ex: Hamilton, Haldimand, Norfolk, Shelburne, etc.), this program is similar as the team on duty will respond to calls and provide support to people who are in a mental health or substance use related crisis. However, the MWRT is distinguished from these other programs by its exclusion of police officers from the crisis response team, unlike the other Ontario mobile crisis rapid response teams, and hence they only respond to non-violent and non-criminal related calls (Community Addiction and Mental Health Services of Haldimand and Norfolk, 2017; Government of Ontario, 2020). This non-police model is designed to reduce stigma, foster community trust, and offer a safer, more therapeutic response for individuals in crisis. According to a CBC article (2022), crisis response

teams in Toronto and Victoria County have reportedly reduced violent outcomes during crisis calls. Based on their similar composition to the MWRT, it could be expected that the MWRT would yield comparable results. Marcus and Stergiopoulos (2022) also describe in the literature how teams of this composition are generally associated with fewer violent outcomes. The MWRT conducted a soft launch in 2022 and was pilot tested between January and December 2023 in order to evaluate the performance of the program from an operational standpoint. The program was then officially launched in January 2024 and continues to operate.

Chapter 2 – Article

2.1 Article Preface

This chapter presents the main article of this thesis, titled *Organizational stakeholders' Perceptions of the Effects of the Implementation of a New Community-Based Rapid Response Team on Mental Health: A Qualitative Study*. Prepared for publication and structured as a standalone manuscript, the article explores organizational stakeholders' perceptions of the Mental Wellbeing Response Team (MWRT) in Ottawa, with a particular emphasis on access to care for marginalized populations and the potential of mobile crisis intervention models to address service gaps. This brief preface precedes the article to outline changes in the initial objective, the contributions of co-authors, a positionality statement, relevant annexes, and ethics approval.

2.1.1 Initial objective's changes

Due to challenges encountered during recruitment, the original study objectives were revised retrospectively. The overall aim had been to include participants with lived

experience of receiving services from the MWRT; however, because of recruitment challenges, this was not possible. As a result, objective 3, which was to explore differences in perceptions concerning access to mental health services between stakeholders based on their social identities, was adapted, as the absence of diverse stakeholder groups made such comparisons unfeasible. Consequently, the article is based on data collected exclusively from frontline team members and decision-makers within the paramedic service. While publication constraints limited the inclusion of certain contextual details, such information is important for understanding the scope and interpretation of the findings.

2.1.2 Contributions of Co-Authors

This article was co-authored by the MSc candidate, Maria Ibrahim (MI), and her thesis supervisor, Dr Isabelle Marcoux (IM). MI was responsible for designing the study, obtaining ethical approval, leading data collection and analysis, and drafting the manuscript. IM provided support through supervision, methodological guidance, and critical revisions and approvals of the manuscript.

2.1.3 Positionality Statement

As a graduate student in Interdisciplinary Health Sciences, I approached this research with a commitment to equity-oriented, trauma-informed, and community-centered care. My academic training, professional experience and personal values have shaped my understanding of the systemic barriers that marginalized populations face in accessing mental health services. I recognize that my position as a researcher affiliated with the University of Ottawa, and collaboration with the Ottawa Paramedic Service, may have

influenced how participants engaged with me and how I interpreted their narratives. This study is grounded in a constructivist epistemological stance, which assumes that knowledge is co-constructed through interactions between the researcher and participants. I do not identify as a member of all the communities represented in this study and acknowledges the privileges and limitations that come with my social location. Throughout the research process, I engaged in reflexive practices to remain aware of how my own assumptions, experiences, and positionality could shape the research design, data collection, and analysis. I also relied on guidance from my supervisor, thesis advisory committee and feedback from organizational stakeholders to ensure that the findings were interpreted with contextual sensitivity. This research was conducted with the intention of amplifying the voices of frontline responders and decision-makers, and of contributing to the development of more inclusive, accessible, and responsive mental health crisis services in Canada.

2.1.4 Annexes and Ethical Approval

Additional methodological details, including consent forms, full interview guides, and the ethics certificate are provided in Annexes A-E of the thesis. The ethics approval for this study was obtained from the University of Ottawa Research Ethics Board (Certificate number: H-11-23-9794), and all participants provided informed consent prior to participation. This article will be submitted to the Canadian Journal of Community Mental Health.

2.2 Article

Organizational Stakeholders' Perceptions of the Effects of the Implementation of a New Community-Based Rapid Response Team on Mental Health: A Qualitative Study

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English Abstract: In response to growing mental health needs, a Community-Based Rapid Response Team (CBRRT) was implemented to provide mobile crisis intervention services. This study explores organizational stakeholders' perceptions of the program's implementation and effectiveness, based on focus groups and interviews with frontline staff and decision-makers, respectively. Participants highlighted their perceptions of increased access to care, stronger support for marginalized clients, and the value of mobile, client-centered delivery over traditional responses. These findings offer new insights into how mobile mental health teams can fill post-pandemic service gaps and inform the design of more equitable, accessible crisis interventions across local, national or international communities.

Keywords: Mental Health, Mobile Services, Crisis Intervention, Community, Organizational stakeholders

French Abstract: En réponse aux besoins croissants en santé mentale, une Équipe d'intervention rapide communautaire (ÉIRC) a été mise en place afin d'offrir des services mobiles d'intervention en situation de crise. Cette étude explore les perceptions des parties prenantes au niveau organisationnel concernant la mise en

œuvre et l’efficacité du programme, à partir de groupes de discussion avec le personnel de première ligne et d’entretien avec les décideurs. Les participants ont souligné un meilleur accès aux soins, un soutien accru pour les clientèles marginalisées, ainsi que la valeur d’une approche mobile centrée sur le client par rapport aux interventions traditionnelles. Ces résultats offrent de nouvelles perspectives sur la manière dont les équipes mobiles en santé mentale peuvent combler les lacunes des services postpandémie et guider la conception d’interventions de crise plus équitables et accessibles aux échelles locale, nationale ou internationale.

Mots-clés : Santé mentale, Services mobiles, Intervention en crise, Communauté, Parties prenantes, Niveau organisationnel

Article words count: 5410 – maximum 6000, including references, and excluding text in tables

2.2.1 Introduction

According to the World Health Organization (2022), mental illness is the leading cause of disability worldwide, affecting approximately 970 million people. Among the most common disorders are anxiety and depression, impacting 301 million and 280 million individuals, respectively. The COVID-19 pandemic has further intensified these issues, leading to a 26% increase in anxiety disorders and a 28% increase in depression, while also exacerbating existing barriers to care. Despite the high prevalence, a significant proportion of individuals still lack access to effective mental health treatment. In Canada, the situation is similarly alarming, with 1 in 5 individuals experiencing mental illness annually, and 1 in 2 Canadians affected by age 40 (Centre for Addiction and Mental Health [CAMH], 2025). Substance use is also an emerging problem in the Canadian society with an estimated 67,000 deaths per year attributed to it, and 14,700 opioid-related deaths from 2016-2019 (CAMH, 2025). Over the course of the year 2014-2015, Ottawa Public Health saw an 32% increase of drug overdose related deaths, while the increase was of 6% for the province of Ontario (Ottawa Paramedic Service, 2021). Rising mental health and substance use disorders contribute to high economic and social costs, underscoring the urgent need for innovative, community-driven interventions (Marin, 2023).

Mental health, defined as a state of well-being that enables individuals to cope with life's stresses, realize their potential, and contribute to their community, differs from mental illness, which involves disturbances in thoughts, emotions, and behaviors that affect daily functioning (World Health Organization, 2025). Mental illness can range from mild to severe, but recovery is possible with adequate support systems, allowing individuals

to manage symptoms and lead fulfilling lives (Carr & Ponce, 2022; Mental Health Commission of Canada, 2024). However, systemic barriers often hinder recovery. Indicators such as frequent emergency department (ED) visits, long wait times for community mental health services, and hospitalizations for substance use reflect significant gaps in the availability of adequate care (Canadian Institute for Health Information (CIHI), 2019, 2021).

Barriers to accessing mental health care exist at multiple levels. Individual challenges include limited literacy, poor socioeconomic status, and emotional constraints like powerlessness (Mathur Gaida et al., 2014; Sheffer et al., 2016). Relational barriers involve family responsibilities, peer influence, and mistrust of healthcare providers (Pringle et al., 2006; Sheffer et al., 2016; True et al., 2015). At the community level, challenges include service inaccessibility, funding limitations, and cultural mismatches (Abolarin, 2020; Mathur Gaida et al., 2014; Sheffer et al., 2016). Finally, societal barriers such as stigma, systemic discrimination, and inefficiencies in the healthcare system like long wait times and inadequate professional training compound the issue (Abolarin, 2020; Mathur Gaida et al., 2014; True et al., 2015).

ED have become overburdened, in part due to rising mental health and addiction-related cases (Haas et al., 2023). Many individuals in crisis are transported to EDs despite other service options being more appropriate (Ford-Jones & Daly, 2022). High hospitalization rates for mental health crises suggest a lack of sufficient community-based care and highlight the barriers to accessing timely treatment (CIHI, 2019). Crisis response teams, such as mobile mental health teams, present a promising solution by providing timely, appropriate care outside of ED settings (Meijer et al., 2024; Watson &

Compton, 2019). These community-based services have demonstrated success in improving mental health outcomes, reducing hospital visits, and supporting recovery, and particularly for underserved populations (Bruckner et al., 2019; Fleury et al., 2019). It is important to remember that social and cultural factors can influence individual's acceptance of care (Levesque et al., 2013), and programs involving community engagement can enhance the quality of care, reduce barriers, and empower individuals (Chung et al., 2014; Ngo et al., 2016). Knowing the social identities of those who provide care, such crisis responders, offers valuable insight into how they perceive and respond to the needs of clients. These identities can shape their attitudes, behaviours, and interactions with marginalized populations, influencing the effectiveness and equity of the services delivered (Feller & Berendonk, 2020). Yet, few studies explore how these intersecting social identities impact delivery of service in the mobile crisis intervention contexts.

Mobile crisis teams have emerged as an innovative, community-driven approach to addressing mental health challenges. They have yielded such impressive qualitative and quantitative results worldwide, that the Mental Health Commission of Canada recommends the use of community-based rapid response teams (CBRRT) (CAMH, 2025). However, while these teams continue to expand, each utilizing different models of care, there is little research on their actual implementation. The CBRRT being studied differs as it does not involve police officers in their model, aiming to deliver timely, accessible, and culturally competent care to individuals in crisis. This study aims to describe and verify the perceived effect of its implementation.

The objectives of this study are: (1) describe the organizational stakeholders' perceived effects of the implementation of a new CBRRT on mental health; (2) explore if and why a mobile intervention team that brings the service to the client is preferred over a traditional approach in improving access to mental health services; (3) explore any difference in perceptions concerning access to mental health services according to social identities; (4) depict the perceived barriers and facilitators of the CBRRT in being able to reduce the mortality due to substance use problems.

2.2.2 Methods

The *Standards for Reporting Qualitative Research* (O'Brien et al., 2014) and *Sex and Gender Equity in Research Guidelines Checklist* (Epps et al., 2022) were utilized as guides for this study.

Research Design

This study employs a qualitative descriptive approach to explore organizational stakeholders' perceptions of the effects of a new CBRRT. This study design is ideal to allow people to describe their personal perceptions and experiences, as it isn't as focused on interpretation as other methods (Sandelowski, 2000). While this study contains evaluative elements, it does not consist of a formal program evaluation.

Participants

Participants were categorized into two groups: 1) CBRRT decision makers in a commander role, who oversaw first responders and daily operations, and 2) CBRRT staff and related first responders, including social workers, administrative staff, researchers, paramedics, police officers, and emergency room staff. Eligibility required

participants to be 18 years or older, have direct CBRRT experience, internet or cellular access for virtual participation, and proficient in English or French. Participants from any religion, culture, sexual orientation, gender, and sex were eligible to participate.

Interview and Focus Group Guides

The study used the Levesque conceptual framework to develop the guide and establish themes and questions, which examines access to care through five domains: (1) Approachability, (2) Acceptability, (3) Availability and Accommodation, (4) Affordability, and (5) Appropriateness (Levesque et al., 2013). These domains helped contextualize issues related to service access, considering factors such as social and geographic disparities, cultural influences, service reachability, economic constraints, and service suitability.

The following surveys guided question development on access to mental health services and experiences: The *Mental Health and Access to Care Survey* (Statistics Canada, 2022) and the *Navigation of Mental Health and Substance Use Services Survey* (CIHI, 2022). The principal investigator (PI: MI) developed the interview guides, which were first reviewed by the thesis supervisor (IM), and then by the CBRRT team lead who provided feedback on whether the questions could be answered by each group based on their specific roles and responsibilities. The PI made the necessary revisions and conducted a second consultation to confirm the guides were suitable.

Procedures

Participants were recruited through non-probability sampling, utilizing volunteer and snowball sampling techniques. For the first group, the CBRRT team lead shared the

study details and the PI invitation with eligible decision-makers. Interested participants contacted the principal investigator via email. Interviews were conducted on Microsoft Teams in English, scheduled at participants' convenience, recorded, transcribed promptly, and lasted 30–45 minutes. Two to three decision-makers were targeted for individual semi-structured interviews in their preferred official language. Given the total eligible population was only seven individuals, this sample size aligns with Braun & Clarke (2021), who note that in relatively homogeneous groups with a narrow research focus, code saturation can be reached with a smaller number of interviews.

For the second group, the CBRRT team lead distributed the recruitment poster among CBRRT first responders. Two distinct focus groups with four to six participants each were targeted to be conducted in English via Microsoft Teams, lasting 60–90 minutes. Although focus groups typically include 6 to 8 participants (Guest et al., 2017; Nyumba et al., 2018; Tuttas, 2015), smaller groups can still generate meaningful dialogue in homogeneous settings (Nyumba et al., 2018), and thematic saturation is often reached with two to three groups (Guest et al., 2017).The PI moderated the sessions, recorded the discussions, and transcribed the data verbatim immediately after. At the end of the focus group, participants completed a socio-demographic questionnaire through *Survey Monkey* before disconnecting. Social identity, defined as individuals' self-categorization based on group memberships, encompassing attributes such as race, ethnicity, gender, socioeconomic status, sexual orientation, age, religion, and disability (Oswego, 2023), was collected to answer the third objective.

Ethics approval was obtained from the Research and Ethics Board at the University of Ottawa (Certificate number: H-11-23-9794).

Data Analysis

Interview and focus group transcripts were coded and categorized. Thematic analysis was conducted following the six-step process outlined by Kiger & Varpio (2020) using NVivo 15. Saturation occurred when no new codes emerged in the final two interviews and focus group, with all themes well-developed. It was confirmed through iteratively analysis of code frequencies, data redundancy, and theme completeness. To ensure the trustworthiness and credibility of the findings, we used the member-checking approach outlined by McKim (2023), the search for alternative explanations (counter explanation) (Anderson, 1982) and a peer reviewer (Ahmed, 2024).

2.2.3 Results

Participants

The sample consisted of 8 members of the paramedic service, 2 commanders out of 6 (excluding one team member who was involved directly in the research project) and 6 paramedics out of 10. While group 2 was open to different groups of CBRRT staff and related first responders, only paramedics, were successfully recruited as participants. To the question: “What is your gender identity?”, the majority of paramedics self-identified as female (n=4, 66.66%), with one participant identifying as non-binary trans woman (16.67%) and one participant identifying as male (16.67%). Most of the paramedics self-identify as Caucasian (n=5, 83.33%) and one participant identified as Métis and French Canadian (16.67%). Further demographic information on the participants is available in Table 1 below. Sociodemographic data were not collected from the commanders, as they were not likely to provide analytically meaningful

information according to the logic underlying our research objectives. All interviews and focus groups were completed and all questions were answered.

Table 1. Demographic Information of Paramedic Participants

Pseudonym	Age	Years of work as a paramedic	Time worked with the CBRRT	Tenure
Kelly	29	3.5	1 year - < 1.5 year	Full-time permanent
Vic	40	21	1.5 year – <2 years	Full-time permanent
Aidan	30	4	< 3 months	Full-time permanent
Jamie	34	4	2+ years	Full-time permanent
Alex	27	6	1 year - < 1.5 year	Full-time permanent
Sky	27	2	< 3 months	Full-time temporary

Qualitative Analysis and Identified Themes

The analysis was conducted separately for each research objective, resulting in a total of 18 themes across all four objectives. Specifically, Objectives 1 through 4 yielded 6, 8, 2, and 2 themes, respectively. In Table 2, each of the 18 themes and their corresponding sub-themes, identified across the four research objectives, are described in detail, along with illustrative quotes. These themes and sub-themes capture the various perceived effects of the CBRRT from the perspective of the organizational stakeholders. The results presented in this section are drawn from both the focus groups conducted with paramedics and the individual interviews carried out with commanders. When certain themes emerged from only one method of data collection, and therefore from only one type of participant, this is clearly indicated in the presentation of the results.

Table 2. Themes, Sub-themes, Detailed descriptions and Quotes Across the Four Research Objectives

Theme	Sub-themes & detailed descriptions	Quotes
Organizational Stakeholders' Perceived Effects of the Implementation of the CBRRT		
Theme 1. Perceived Benefits and Long-Term Impact	One of the key perceived benefits of the program, as identified by paramedics, is its ability to eliminate barriers for clients. They highlighted how the service provides a less intimidating alternative to visiting an ED, especially for those experiencing mental health challenges. By offering immediate support and ensuring follow-up appointments, the program helps clients avoid the stress and stigma associated with seeking care in traditional hospital settings.	"I think it also removes a lot of barriers for people because they might have kind of an internal barrier about going to emerge [emergency] for a mental health problem, […] And the idea of going and sitting and waiting to be seen is just unimaginable. […] But if we're able to come and kind of get things rolling, and then they'll have their follow up appointment the next day, like that just kind of removes that huge emergency department barrier and we're a lot less kind of intimidating looking than this idea of going to the hospital for a mental problem" (Aidan)
	Paramedics also emphasized that the program addresses a gap within the current healthcare model by offering a safety net for individuals who might otherwise fall through the cracks. While they acknowledged that the program cannot resolve systemic issues	"[U]nfortunately, many patients have been falling through the cracks for a very, very long time when it comes to mental health crisis concerns, issues, et cetera. And I see the [CBRRT] as almost a safety net that is kind of in between catching some of them that fall and whatnot" (Vic)

Theme	Sub-themes & detailed descriptions	Quotes
	in healthcare or mental health access entirely, it represents an important step toward filling these voids and improving care delivery.	
	Participants highlighted the program's innovation and growth potential, noting it as a model for other paramedic services. Despite some remaining gaps, organizational stakeholders see it as a strong, impactful start with opportunities for expansion and long-term community benefit.	"And like they see us as like a really innovative service like I think all a lot of services even paramedic services in Ontario are like trying to copy kind of what we did here because we were the first that kind of did this in the area. And so I think, yeah, it's positive and I think it'll just continue to grow and hopefully help with services." (Sky)
Theme 2. Perceived success and effectiveness	When it comes to measuring the success of the program, paramedics and commanders acknowledged the lack of official mechanisms to capture outcomes directly from their interactions. Instead, success is perceived indirectly, such as when clients do not repeatedly access the service or call 911 shortly after receiving support. While this	"We don't see too much of the success, but I guess one way I can measure it myself is like well, this person hasn't called again today let's say or hasn't called in you know X amount of weeks or at least from what I know that hasn't called. […] they haven't had to access MWRT again or 911 again for me that's a success referral […] [but] it's really hard to know what happened after." (Alex)

Theme	Sub-themes & detailed descriptions	Quotes
	perspective offers some insight, the official data on program outcomes is primarily collected and analyzed by the Team Lead, making it difficult for paramedics to assess long-term impacts firsthand.	“I think it completed a very successful pilot and other I don't have the metrics of the patient care and the results at my fingertips. I know they were highly successful in meeting what they needed, and I think they they've proved their importance and impact to the city.” (Sam)
	Despite measurement challenges, both paramedics and decision-makers view the program as effective and impactful. It offers compassionate care to individuals who might avoid traditional emergency services and has successfully completed its pilot, demonstrating its value to the city. Stakeholders noted that it connects clients to appropriate resources, addressing gaps in traditional paramedic care through holistic support. The program is seen as a success with room for continued growth.	“And then, especially I find for people kind of going through it, […], they feel really well supported and I think a lot of people fear the ER they've been judged before. And so, the fact I feel like I've had a lot of really positive experiences where we've been able to give that compassionate care and provide them better support if they just went to the hospital.” (Kelly) “My perception is, is that we're doing a great job and it's well received.” “I think that team has a bunch of objectives, and they know, they've learned a lot and they know where they wanna go next.” (Sam)

Theme	Sub-themes & detailed descriptions	Quotes
Theme 3. Perceived Appreciation from Clients	Although there are no formal mechanisms to gather direct client feedback, participants generally expect positive perceptions of the program. While most interactions are likely favorable, challenges occasionally arise with frequent users who experience inconsistencies. Organizational stakeholders observed that familiarity with the service varies widely, and while confidentiality limits direct feedback, there is confidence that the program is well-received and provides meaningful community support.	“Definitely for most part positive, because there's a few people that we see often that we have to sometimes limit our interactions and sometimes it can be a little bit frustrated or not understanding of you know why they have different experience depending on who they see sometimes as well.” (Alex) “I mean, I've had people who've never heard of the team before, and I've also seen people who see the team on a daily basis. So, like pretty wide variety.” (Aidan)
Theme 4. Perceptions from colleagues	According to the paramedics, colleague perceptions of the program are a mix of positive and neutral views. They noted some initial confusion and mixed opinions within the paramedic and healthcare community, particularly around the team’s role and scope. Over time, education and clearer	“It's sometimes a little bit mixed as like there's a bit of confusion as what we can and cannot do I guess.” (Alex)

Theme	Sub-themes & detailed descriptions	Quotes
	communication have helped address these misunderstandings.	
	On the positive side, both paramedics and commanders reported strong support from colleagues who see the program as a needed innovation. Many expressed appreciations for its ability to treat and refer patients without defaulting to hospital transport, recognizing its effectiveness for mental health cases. Overall, the program seems to be viewed as a valuable addition, with generally favorable reactions from colleagues.	“And I think there is an understanding that, uh, treat and refer where possible as opposed to the default transport to a hospital, is not only emerging but really can be really effective for this type of patient group.” (Sam)
Theme 5. Operational Limitations and Constraints	Both focus group and interview participants noted that clients who know about the service beforehand are more likely to find it effective. However, a paramedic identified the lack of public awareness is not a major issue, primarily due to limited resources,	“[B]ecause the team is still in its infancy, it's just not well known within the community or the full details of it aren't fully understood. […] I don't find that people are aware of our team, but I don't think that's necessarily a bad thing.” (Vic)

Theme	Sub-themes & detailed descriptions	Quotes
	however, it still points to a need for stronger communication. A decision-maker also raised the difficulty of changing long-standing expectations around 911 services, as this team offers an alternative model focused on connecting clients with more appropriate resources rather than default hospital transport, requiring broader cultural and system-level shifts.	“Barriers, I would say are more of external barriers as we are moving away from the norm of what a 911 system does by transporting a patient to a hospital, and that's kind of the end of our role as seen by our society and stakeholders historically. […] Not every patient that is calling 911 is seeking out a fast expedited response for something life threatening to a hospital […]. [T]here are other resources out there for patients that are far better suited than just going to an ER or an ED.” (Bailey)
	Paramedics raised concerns about operational limits, specifically the challenge of having only one team available during limited hours. While the current model helps reduce hospital strain and ED wait times, its overall community impact remains constrained without increased availability. To improve reach and effectiveness, organizational stakeholders recommended	“I'm proud of what we have, but I would say right now it's not optimized to capture our patients 24 hours a day and we're 911. We're a 24-hour day service, right? Like it feels like there could be more there. […] And the thing is that we can only do 1 call at a time, right? We're one crew. […] I think that there is more that we could be doing with either a second crew in the daytime or a later crew.” (Jamie)

Theme	Sub-themes & detailed descriptions	Quotes
	extending service hours or adding more teams.	
Theme 6. The need for training & the educational impact	This theme emerged across all conversation groups, highlighting its relevance to both the team and the clients, as perceived by participants. Participants noted that public awareness of the team's role and services remains limited, often resulting in surprise when the team arrives. Additionally, the program has required ongoing education for new paramedic staff to clarify the team's scope, particularly regarding mental health cases.	"Sometimes, like we have a lot of new staff coming in constantly, they see MWRT, they just think anything mental health and sometimes crews will call in and they'll tell us the details of like, oh, it's mental health, we called you guys. And so, a lot of the times a crew calls in giving report and so we're educating those crews […]over the phone" (Kelly)
	Beyond its immediate impact, the program has also fostered professional growth for team members. The development and implementation process provided valuable experience in managing large-scale projects with multiple stakeholders, equipping the	"I think it's just the experience of building a program and doing a project of that scope with so many stakeholders was a great experience for the Team Lead to be able to bring back to the rest of our group and be able to help brace, you know, members of our group going through with any major projects ourselves and knowing those

Theme	Sub-themes & detailed descriptions	Quotes
	team to navigate similar challenges more effectively in the future.	hurdles and being able to anticipate them, plan and prepare for them […] and any other similar big projects in the future with a bit more ease." (Bailey)
Organizational Stakeholders' Perceived Clients Perceptions of Preferred Models of Care in Mental Health Service Delivery		
Theme 1. Avoiding Hospitalization	A key theme was clients perceived strong preference for the mobile intervention, as it avoids hospitalization and long ED wait times. Participants noted that clients reported feeling relieved to receive care in their own environment and often described feeling genuinely heard, unlike in past hospital experiences. Operationally, this also keeps emergency vehicles available for urgent calls while ensuring appropriate mental health support, reinforcing the program's value to both clients and the broader healthcare system.	"[P]eople have really appreciated an alternate to going to the hospital and that's been definitely appreciated by, I would say like the vast majority of the clientele" "Like that, people are seeing the value in not waiting for 12 hours to quite literally talk to the same crisis social worker that we brought in their living room upon discharge." (Jamie)

Theme	Sub-themes & detailed descriptions	Quotes
Theme 2. Continuity of care	A key benefit of the program is its ability to ensure continuity of care, unlike traditional methods that may end with transport to a hospital and no follow-up. This continuity is supported by both those close to the client and healthcare workers, who help guide clients to the next steps in their care, improving the chances of successful outcomes.	“[I]f we have permission, we'll try and get others that are maybe on scene to be involved as well so that they can act as, not the ones to provide follow up, but the ones that can continue to say, OK so then they informed us to do this, maybe this should be your next step now, to kind of help with accountability of accessing those services and having a better outcome or a better chance of success or you know forward progression after accessing the services.” (Vic)
Theme 3. Cost mitigation	A key advantage of the program is cost mitigation for clients. By avoiding hospital transport and paramedic fees, and through social workers connecting clients to affordable mental health and community services, the program ensures necessary support without financial burden. Its no-cost approach offers significant financial relief.	“[T]he social workers try to get, like, mitigate the costs wherever they can. Like for example, yesterday I was on a call and our patient was on ODSP and they were saying that they couldn't afford their regular therapist, […] my social worker’s resolution to that was to, have them maybe stop those services for the meantime and just follow up with the MCT team because that would have been like a free service […] for the next little while.”(Sky)

Theme	Sub-themes & detailed descriptions	Quotes
Theme 4. Crisis management	The program's ability to provide specialized crisis management is a key preference for organizational stakeholders. Trained to support individuals in mental health crises, the team offers immediate assistance and connects clients with timely resources. This short-term intervention helps bridge the gap until clients can access longer-term support, offering quick relief and guidance during critical moments. Paramedics skilled in mental health crises ensure clients receive necessary care, especially for those new to mental health challenges who may not know where to find help.	"I think the just the sort of immediate response and like we can kind of do whatever quick fixes or possible to sort of get them through the immediate crisis. And just like, that's super valuable and having people who are actually like specifically trained with like how to manage that stuff is huge" (Aidan) "A good aspect to this program is the fact that we often get those emergency calls, for somebody who is new to experiencing these mental health symptoms and they don't necessarily even know where to get those traditional supports even. So, it bridges the gap of them having to go out and find them and go to the hospital, we can now bring it directly to them in a critical time of need"(Bailey)
Theme 5. Empowers clients	Another program element that team members believe aligns with client preferences is its focus on empowering clients to take control of their health and recovery. By providing education and	"They're just trying to get through with the here and now, but what's nice is we are able to give them that education to help them" (Kelly)

Theme	Sub-themes & detailed descriptions	Quotes
	options, the team helps clients regain a sense of control during a time when they may feel overwhelmed by their mental health challenges. This empowerment is seen as therapeutic, helping clients make informed decisions and feel more involved in their own recovery process.	
Theme 6. Time constraints	A final preference for the program is its ability to shorten the time needed to access necessary resources. The specialized knowledge of the team allows for immediate information sharing and quicker access to services, reducing wait times and expediting visits, especially when clients need to be seen in the hospital.	“[I]t's definitely beneficial and I say that because you're essentially removing a long-time constraint when you're accessing mobile.[…] because the information can be provided immediately with the access as well of accessing that therapist or whoever it may be.” (Vic)
Theme 7. Service Limitations	Despite widespread client preference, some individuals with complex mental health histories do not fully appreciate the service. These clients often require more extensive	“I find it's often the patients, the clients that have those complex issues that like Jamie was saying that we're seeing very often and sometimes we just again, we can't offer them what they're really looking for.” (Alex)

Theme	Sub-themes & detailed descriptions	Quotes
	care than the mobile crisis team can provide, which can limit the effectiveness of the program for certain individuals.	
Theme 8. Service Accessibility	A key program barrier identified is the accessibility of the service. The team currently has limited capacity, with only one truck available from 9 AM to 9 PM for the entire city. This limits the ability to respond to direct calls and effectively publicize the service to the broader community, as increased demand could exceed their capacity, potentially undermining community trust and the progress they have already made.	“We have a lot of paramedics that are interested. You know the goal down the road would be to have two trucks because right now we only have one truck that is available from 9:00 AM to 9:00 PM, uhm, but the thing is we're one truck for the whole city.” (Kelly)
Exploring Differences in Organizational Stakeholders’ Perceptions of Clients Accessing Mental Health Services, Based on Social Identities		
Theme 1. Diversity and disparities	The service is accessed by people from diverse social identities, but disparities exist, particularly among lower-income individuals,	“[W]e see a good variety of people from all over, but one group that we definitely do not see what I've noticed again are those that have a higher income and live in a

Theme	Sub-themes & detailed descriptions	Quotes
	youth under 16, people with disabilities who are not working and newcomers to Canada. Being that there were no significant differences in the self-identified social identities of the participants, no meaningful analysis could be made on whether their social identities impacted their perceptions of the diversity of the clients.	more a more predominantly wealthy lifestyle or life. So, but otherwise, yeah, it varies in age. It varies in gender. It varies in culture. It varies in in quite a bit" (Vic) "I would also maybe say like newcomers to Canada. Whether they were like immigrants or migrants or, you know, whatever the situation was, I think that's just a population that we often see just in general in the 911 system." (Sky)
Theme 2. No stats or feedback	Participants noted that they lack access to data or direct feedback from patients, relying instead on personal observations. As a result, they cannot accurately assess trends or outcomes.	"[T]rends the same as most calls to 911 from what I can tell, just the population base, but I could be wrong. I don't have the stats." (Jamie)
CBRRT Insights on Barriers and Facilitators to Reducing Mortality from Substance Use		
Theme 1. Barriers	Participants highlighted two main barriers to serving the substance use community. The first is operational limitations, such as the	"[I]t's sometimes hard for us to go to some of those calls because sometimes the mental health is so I guess masked in their substance use that it's just like a hard

Theme	Sub-themes & detailed descriptions	Quotes
	team not being available during late hours, potentially missing clients in crisis (program barrier), who may dive into their substance use at night, after working hours and/or when they are alone. Additionally, with one team serving a large geographic area during limited hours, decisions about who receives care are sometimes based on location and availability rather than on who might benefit most during a crisis. The second is client consent and safety, as intoxication can complicate meaningful conversations and obtaining informed consent for treatment (implementation barrier).	aspect for us to cover and help with those resources." (Sky) "I mean, people who use substances, I think the challenge is, […] that degree of intoxication and being able to have that meaningful conversation and consent for treatment and ensure safety and all those kinds of things that need to need to happen as a foundation for the rest of the work to occur." (Jamie)
Theme 2. Facilitators	Three key implementation facilitators were identified. First, support from the municipal government, where increased funding and coordination with other services assist clients facing homelessness, addiction, and mental health challenges. Second,	"In the inner core of the city […] there has been money introduced within the city to assist these patients [(patients who are either homeless or face addictions or mental wellbeing type problems)]. There's certainly a lot of attention, not just from paramedic service, but from our service partners. It seems that a lot of the city's

Theme	Sub-themes & detailed descriptions	Quotes
	the implementation of Suboxone, a key medication introduced by the team to support opioid users. Lastly, the team's community presence**,** where their reputation has grown, and they're now recognized and requested by name in the community.	resources have a team now focusing and looking to collaborate and coordinate how to help these patients." (Sam) "I think it just took a little while to realize that that team was there and now they're getting asked for by name when they're on shift, when people are calling in because they've built such a report with the community." (Bailey)

2.2.4 Discussion

This study examined organizational stakeholders' perceptions of a new mobile mental health crisis intervention model. Findings highlight how the CBRRT improves access to care by addressing barriers such as transportation, stigma, and fear of police involvement. Organizational stakeholders emphasized that the team's mobile, community-based approach fosters trust, provides more appropriate crisis support, and is particularly beneficial for marginalized populations.

Using Levesque's access to care framework (Levesque et al., 2013), this study illustrates how mobile teams enhance approachability, acceptability, and appropriateness of mental health services. However, challenges such as community awareness and resource limitations remain. By integrating frontline and leadership perspectives, this research provides practical insights for improving mobile crisis models and contributes new Canadian data to the literature on alternative mental health response systems. The findings support the CBRRT as a promising approach for expanding equitable access to crisis care and reducing system-level gaps exposed during the COVID-19 pandemic.

While the Levesque framework was originally developed to assess access to care from the perspective of service users, it was adapted in this study to guide data collection and analysis from the perspective of organizational stakeholders. Although service recipients were not included as participants, the framework's five dimensions provided a useful structure for exploring how staff perceived the accessibility and responsiveness of the service they delivered. In particular, the framework helped illuminate how staff

interpreted client needs, barriers, and preferences based on their frontline experiences. However, it is acknowledged that the absence of direct client input limits the ability to fully assess certain dimensions, such as affordability and acceptability, from the user's point of view. Future research should aim to incorporate service user perspectives to more comprehensively evaluate access using this framework.

The organizational stakeholders perceived effects of the CBRRT's implementation has elicited mixed but largely positive perceptions from organizational stakeholders, emphasizing both its benefits and operational challenges. One of the most significant implementation barriers identified is limited public awareness, which affects service utilization and stakeholders' expectations. However, the team is reluctant for a big promotional campaign due to concerns in not being able to meet community demand. Additionally, organizational stakeholders highlighted the constraints of operating with a single team on limited hours, restricting the program's capacity to fully meet community needs, an issue observed in similar programs (Canadian Mental Health Association, 2014, 2025; Royal Canadian Mounted Police, 2020). Ford-Jones & Daly (2022) reported that while these teams are in the best position to support the community, further investment into them is needed for their success. Expanding service availability could enhance accessibility and impact, reinforcing the importance of sustainable funding and policy support for alternative crisis interventions.

Despite these limitations, organizational stakeholders recognize the program's success in bridging gaps in mental health services. Traditional emergency medical services have historically focused on acute, hospital-based interventions, often overlooking the long-term needs of individuals with mental health challenges (Meijer et al., 2024). The

CBRRT's model shifts away from this reactive approach by providing on-site crisis stabilization and referral to appropriate community resources, which organizational stakeholders view as instrumental in reducing ED overcrowding and improving patient outcomes. This echoes findings that pre-hospital crisis teams reduce unnecessary hospital transports while enhancing continuity of care (Bigham et al., 2013; Ford-Jones & Daly, 2022; Meijer et al., 2024).

The program's perceived effectiveness in reducing barriers to care is another key theme. Paramedics and decision-makers emphasized that individuals experiencing mental health crises often avoid traditional emergency services due to fear, stigma, or past negative experiences (CIHI, 2021; Wise-Harris et al., 2017). By providing a community-based, trauma-informed approach, the CBRRT mitigates these barriers and ensures more equitable access to care, an approach widely advocated in contemporary mental health service models (Ford-Jones & Daly, 2022; McCann et al., 2018; Meijer et al., 2024).

Finally, while formal outcome measurement remains a challenge, organizational stakeholders perceive the program as successful based on qualitative indicators such as reduced reliance on 911 and positive client interactions. This underscores the need for robust evaluation frameworks to systematically assess program success and inform future expansions (Provincial System Support Program, 2018). Overall, the CBRRT represents a promising shift in emergency mental health care, with stakeholders supporting its continuation and growth to maximize long-term community impact.

The organizational stakeholders' perceptions of clients' preferred models of care in mental health service delivery indicate that a mobile intervention team that brings services directly to clients is preferred over traditional mental health care approaches. Findings suggest that organizational stakeholders view the mobile model as significantly enhancing access to mental health care by reducing barriers such as hospitalization, service costs, and long wait times. This aligns with broader research on community-based crisis intervention, which emphasizes the importance of immediate, accessible care in improving mental health outcomes (CIHI, 2022; Meijer et al., 2024). Participants highlighted that many clients experience relief in avoiding hospital visits, which are often associated with stigma and prolonged ED wait times (CIHI, 2021; Wise-Harris et al., 2017). Instead, the mobile team allows for crisis resolution in familiar environments, fostering a sense of safety and autonomy for clients.

An essential aspect of the program's success is its focus on continuity of care. Unlike traditional emergency responses that often end with hospital transport, the mobile team facilitates follow-up and connections to ongoing support, increasing the likelihood of sustained recovery. This model aligns with best practices in crisis response, which emphasize the importance of follow-up care in preventing future crises (Meijer et al., 2024). Furthermore, the cost-saving benefits for both clients and the healthcare system reinforce the program's value. By reducing unnecessary hospitalizations and providing free or low-cost alternatives, the model addresses financial and social barriers that often deter individuals from seeking care (Meijer et al., 2024).

The presence of social workers within the team is particularly beneficial, as they are professionally oriented toward working with marginalized populations (Bartram, 2019).

Their expertise in navigating systemic barriers ensures that clients receive appropriate referrals and advocacy, ultimately strengthening the program's impact. However, service limitations remain a challenge, particularly regarding availability and accessibility. With only one team operating within restricted hours, gaps in service coverage persist, highlighting the need for program expansion to maximize its effectiveness. Addressing these constraints could enhance the program's ability to serve a broader population and further establish mobile crisis response as a preferred alternative to traditional mental health services.

As originally intended, exploring organizational stakeholders' perceptions of access to mental health services, while considering both their own social identities, and their perceptions of the client's social identities was not entirely successful. Due to the homogeneity of the sample, as indicated by the participant self-identification survey, no meaningful analysis or distinctions could be made. Interestingly, although organizational stakeholders' own social identities showed little variability and client identifies were not formally identifies, all participants shared similar perceptions of the clients' social identities and how these influenced their interactions with the team. The only notable social distinction emerged when discussing clients' experiences, where financial status was identified as the primary factor influencing service utilization. Participants highlighted that individuals with lower incomes, including those receiving government aid due to disabilities, were more likely to use these services. This finding aligns with existing literature, which suggests that financial disparities significantly impact access to mental health care (CIHI, 2022). Bartram (2019) found that higher-income individuals in Canada are more likely to access mental health services outside of the public system,

such as psychologists, whose services are not publicly funded, creating inequitable access based on financial means. This reinforces the participants' observations that economic barriers continue to limit access to necessary mental health care, while also highlighting the potential of mobile services to reduce these access inequities by reaching individuals in their own environments.

The initial intention to collect data on barriers and facilitators from the CBRRT's perspective in reducing mortality rates due to substance use was due to Ontario's high opioid-related mortality rates (CAMH, 2025) and the recognition of substance use disorders as mental illnesses, as classified in the DSM-5 (American Psychiatric Association, 2013). However, the results did not fully align with expectations, as participants highlighted significant challenges in effectively serving individuals with substance use disorders, as opposed to being able to reduce mortality rates. While the CBRRT is eager to provide support, they face considerable obstacles, including limited resources and the difficulty of obtaining client consent. This reflects broader concerns in Canada, where policymakers are debating involuntary treatment measures for substance use due to rising opioid-related deaths (Paperny & Williams, 2024). While some argue these measures could help individuals access care, experts caution that forced treatment may not be the most effective solution and could infringe on individual rights. These complexities mirror the CBRRT's struggle to engage with individuals facing substance use challenges. Despite these difficulties, participants emphasized that continued education, training, and resource allocation could help the team improve service delivery and ultimately expand their reach to those most in need.

Interviewing both frontline staff and decision-makers provided a more complete understanding of how the CBRRT functions in practice and within the broader system. Both frontline staff and decision-makers acknowledged the strengths of the CBRRT model, particularly in improving access to mental health care. A key common gap raised by both groups was the lack of direct access to client feedback. They noted that only the team lead has access to this information, which limits their ability to personally evaluate service impact. While frontline workers emphasized operational challenges and decision-makers focused on system-level planning, this shared gap highlights a need for better feedback mechanisms across all roles to support continuous improvement.

This study has several limitations. First, while the original design intended to include clients and their relatives, recruitment efforts over five months, including outreach via MWRT staff and social media, were unsuccessful. Consequently, group one was revised to include MWRT decision-makers instead. Second, several findings reflect organizational stakeholders' perceptions of how clients experience the service, rather than direct input from clients themselves. These second-hand accounts may not fully capture clients lived realities and should be interpreted with caution. Third, as all participants were directly involved in delivering or overseeing the MWRT, their perspectives may be shaped by confirmation bias or a vested interest in the program's success, which could influence how challenges or impacts were reported.

Recommendations and Future Research Directions

Based on these findings, several recommendations emerge for policymakers, practitioners, and researchers. First, participants identified the need for expanded funding and resources to support the CBRRT's continued development and

sustainability. Policymakers should consider integrating mobile crisis teams into broader mental health service frameworks to ensure continuity of care beyond immediate crisis intervention.

Second, continued inter-agency collaboration should be strengthened to address the broader social determinants of mental health. The CBRRT cannot operate in isolation; rather, partnerships with housing services, employment programs, and peer support networks are critical to fostering long-term stability for individuals experiencing crises.

Third, implementing mechanisms that facilitate the direct sharing of client feedback with frontline staff and decision-makers can significantly enhance healthcare workers' motivation. Recognition and appreciation from managers, colleagues, or the community have been identified as crucial motivating factors for health workers. Studies have shown that such recognition not only acknowledges the critical contributions of staff but also fosters a sense of being valued, which is essential for maintaining high levels of motivation, job satisfaction and service quality (Willis-Shattuck et al., 2008). These findings suggest that creating intentional spaces for clients to share their feedback directly with frontline teams, not just through formal evaluations but also through meaningful, personal expressions, could reinforce workers’ sense of purpose while offering a simple, yet powerful, way to sustain motivation and connection in emotionally demanding roles.

Finally, future research should build upon these findings by incorporating participatory action research, involving individuals with lived experience, as it could provide deeper insights into service effectiveness and areas for improvement. Comparative studies

between mobile teams and traditional crisis response models could further illuminate best practices in crisis intervention. Longitudinal studies on this topic are also needed to assess the sustained impact of mobile crisis teams on mental health outcomes over time.

2.2.5 Conclusion

This study contributes to the growing body of research on mobile crisis intervention by centering organizational stakeholders' perspectives on a new CBRRT. The findings highlight the program's strengths in improving accessibility, reducing reliance on hospitalization, and addressing mental health crises in real-time. However, they also underscore ongoing challenges related to structural inequities, inter-agency collaboration, and resource limitations. Moving forward, targeted policy interventions and continued research are essential to refining the CBRRT's model and ensuring that crisis response services are equitable, effective, and responsive to community needs. By adopting a holistic and inclusive approach, mobile crisis teams have the potential to transform mental health service delivery and improve outcomes for vulnerable populations.

2.2.6 Funding

This study did not receive any funding.

2.2.7 Conflict of Interest

The authors declare no conflict of interest.

2.2.8 References

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Chapter 3 – General Discussion

3.1 Primary Research Findings Overview

This study aimed to understand how organizational stakeholders perceived the impact of implementing a new Community-Based Rapid Response Team (CBRRT) on mental health, including whether bringing services directly to clients improves access compared to traditional models. It also explored how perceptions of access to care may differ based on social identities and what factors organizational stakeholders felt helped or hindered the team's ability to reduce deaths related to substance use. Drawing from two focus groups with frontline CBRRT staff and two interviews with decision-makers, findings revealed widespread support for the mobile, community-based model as a compassionate and trauma-informed alternative to police-led crisis response or ambulance transfer to hospitals. Participants emphasized that the CBRRT filled a critical service gap, particularly for individuals who face systemic barriers to accessing care, including those living with poverty, racialization, or substance use challenges. The ability of the team to meet clients where they are was described as a key driver of improved accessibility, trust-building, and early intervention. Many participants perceived the model as not only more acceptable and appropriate but also potentially lifesaving, particularly in cases of overdose risk or acute mental health crises. These perspectives align closely with Levesque et al's (2013) framework on access to care, while also highlighting how intersecting social identities shape service experiences in distinct ways. Although participants described the CBRRT as a promising innovation, they also acknowledged ongoing limitations such as staffing constraints, limited hours of operation, coordination challenges with other services, and the emotional demands

placed on responders. Still, the study suggests that the CBRRT represents a meaningful step toward more equitable and responsive mental health care. By incorporating diverse organizational stakeholders' insights and utilizing an interdisciplinary approach, this research provides timely, grounded evidence that can inform future policy, funding decisions, and expansion efforts for mobile crisis response programs.

This study yielded both confirmatory and unique insights into mobile mental health crisis intervention. Consistent with existing literature, participants emphasized the importance of timely, community-based, and trauma-informed care in improving access to mental health services, particularly for individuals facing systemic barriers. These findings reinforce the growing consensus that mobile crisis teams can reduce reliance on emergency departments and enhance continuity of care. Uniquely, this study contributes new evidence from a Canadian context by centering the perspectives of frontline paramedics and decision-makers involved in the implementation of a newly launched mobile crisis team. Their reflections highlighted the value of flexibility, client empowerment, and culturally responsive care as key enablers of success. One particularly distinctive feature of this model is the inclusion of a paramedic as a core member of the response team, alongside a mental health professional. This pairing was noted to offer a valuable clinical advantage: the paramedic conducts an initial medical assessment, which helps differentiate between physiological and psychological symptoms (ex: distinguishing a panic attack from a cardiac event). This dual-capacity approach ensures that any urgent physical health needs are addressed before proceeding with mental health intervention, enhancing both safety and diagnostic clarity.

This integrated model represents a promising innovation in crisis response and expands the current understanding of how interdisciplinary teams can function effectively in real-world settings. Additionally, the study offers a rare examination of how mobile teams navigate operational constraints, such as limited hours and staffing, while still achieving high levels of perceived effectiveness. These insights expand the current understanding of how mobile crisis models function in real-world settings and provide practical guidance for future program development and evaluation.

3.2 Additional Discussion Points Not Included in the Article

The findings of this study offer important insights into both the functioning of innovative crisis interventions and the broader landscape of mental health service delivery. Beyond the immediate outcomes observed, several themes warrant further discussion, as they illuminate critical pathways for future research and program development.

3.2.1 System-Level Pressures and the Role of Paramedic Services

A recurring observation among participants was that the CBRRT plays a substantial role in alleviating pressures on EDs by effectively redirecting mental health and substance use crises away from traditional, hospital-based responses. Organizational stakeholders noted that rather than transporting individuals to hospitals—where timely, specialized mental health care is often difficult to obtain—the CBRRT provides care directly at the scene. This on-scene intervention not only meets the immediate needs of individuals but also facilitates timely follow-up care, thereby creating a more efficient care continuum. Ford-Jones and Daly (2022) support this perspective, highlighting that alternative care models implemented by paramedic services are designed not only to reduce call volume but also to optimize resource allocation by ensuring that patients

receive the appropriate level of care as close to their point of need as possible. By bypassing the delays often encountered in hospital settings, the CBRRT model enables early intervention and smoother transitions to ongoing community support, which in turn can lead to cost savings and improved patient outcome.

3.2.2 Enhancing Patient Autonomy and Shifting Power Dynamics

A key insight from this study is that the CBRRT model promotes patient autonomy by offering individuals experiencing a mental health or substance use crisis the ability to choose between a hospital ED and an alternative care destination, if needed, as well as decide on a care plan. This contrasts with conventional emergency response models, where individuals in crisis are often presumed to lack the capacity to make informed decisions, leading to more coercive and paternalistic approaches to care (Meijer et al., 2024). Participants emphasized that the CBRRT's structure challenges these assumptions by treating clients as capable decision-makers, even in moments of acute distress.

This shift aligns with findings by Meijer et al. (2024), who report that providing alternative care destinations in crisis response not only empowers patients but also leads to a wide range of systemic benefits. Specifically, the programs evaluated by Meijer et al. (2024) reported improved efficiency for paramedic services, reductions in offload delays at EDs, shorter wait times for both patients and paramedics, and an overall better care experience, particularly for individuals who are frequent users of ED services. Additionally, paramedics involved in the program reported greater satisfaction in their roles, as they were able to provide more appropriate and person-centered care.

These operational improvements reinforce the idea that empowering patients and addressing their needs outside of hospital settings does not only serve ethical or therapeutic goals but also enhances system functionality. Organizational stakeholders in the current study echoed these benefits, noting that the CBRRT allowed care to be delivered more efficiently while also fostering a sense of dignity and respect in the patient experience. The opportunity for follow-up care through community connections, rather than short-term hospital stabilization, was particularly valued, as it positioned the intervention as not just a reactive service, but one capable of promoting sustained well-being.

3.2.3 Equity-Oriented Care and Socioeconomic Considerations

As remarked by the participants, a significant subset of CBRRT clients was found to be dealing with complex socioeconomic challenges, including housing instability and stigma. National data substantiate that such populations, particularly those residing in lower-income neighbourhoods, experience a disproportionately high burden of mental health and substance use issues, as well as hospitalization due to them (CIHI, 2019). The ability of the CBRRT to reach these marginalized groups “where they are” underscores its potential role in addressing entrenched structural inequities. By bringing care directly into the community, the CBRRT model appears to mitigate some of the barriers imposed by geographic isolation and financial constraints. These findings reinforce the need for crisis response strategies that are not only responsive in the moment but also sensitive to the broader social determinants of health influencing client well-being.

3.2.4 Addressing the Unmet Needs of Youth and Early Intervention Strategies

Although the CBRRT primarily serves an adult population, organizational stakeholders recognized that youth represent a critical group with significant unmet needs. Participants expressed that many young individuals in distress could benefit from the CBRRT model. However, they noted that extending these services to youth is complicated by legal and ethical constraints, particularly issues surrounding consent and age requirements. As a result, despite a strong desire to assist this vulnerable population, service providers are unable to engaging with youth less than 16 years old under the current operational mandates.

The urgency of early intervention is well established in the literature. For the majority of people living with a mental disorder, their symptoms begin before the age of 18. “In Canada, up to 20% of children and youth — approximately 1.2 million individuals, are affected” (CIHI, 2022). Early, targeted support not only has the potential to alleviate immediate distress but also to prevent or delay the progression of these disorders into adulthood (CIHI, 2022). Yet, children and youth frequently face longer wait times and significant barriers to accessing timely care (CIHI, 2021; Government of Ontario, 2020). These combined challenges highlight the need for developing alternative service models or policy adjustments that can circumvent current consent-related hurdles, thereby enabling more inclusive and effective support for younger individuals in crisis.

3.2.5 Improving Service Navigation Amid System Fragmentation

Another key theme that emerged from organizational stakeholders’ feedback was the difficulty of navigating a highly fragmented mental health system. Prior to CBRRT

intervention, many clients reported that the complexity of existing services posed significant hurdles to receiving timely and appropriate care. As highlighted by the CIHI (2022), barriers such as poor coordination among services, geographical isolation, and inadequate community supports can drastically hinder access. The CBRRT's role in not only managing immediate crisis presentations but also in linking clients to short and long-term, community-based supports illustrates a promising strategy for overcoming systemic fragmentation. This integrative approach is particularly relevant for vulnerable groups, offering a model for how coordinated care pathways can lead to improved outcomes across the continuum of mental health services.

3.2.6 The Impact of the COVID-19 Pandemic and the Need for Flexible Models

Although the CBRRT was established in 2023, postdating the peak pandemic period, the experiences of COVID-19 have profoundly influenced contemporary approaches to mental health service delivery. As documented by the CIHI (2022), the pandemic exposed significant deficiencies in traditional, hospital-centered crisis care, highlighting persistent gaps in accessibility and responsiveness during periods of heightened demand. These insights have informed the development of more flexible service models capable of meeting urgent mental health needs more effectively.

Informed by these lessons, the design of the CBRRT emphasizes the importance of providing on-scene care that bypasses the delays inherent in hospital-based services. Organizational stakeholders observed that delivering care directly where individuals are located—not only during crises but also through coordinated follow-up support—significantly improves the continuity and timeliness of care. This proactive approach not only addresses immediate needs but also enhances system resilience, ensuring that

services remain effective even when traditional models are under strain. In integrating these adaptive strategies learned during the pandemic, the CBRRT offers a promising framework for future public health preparedness and improved crisis response.

In sum, these additional discussion points reveal that the CBRRT model is more than a temporary fix; it is emblematic of a broader shift towards integrated, patient-centred, and equity-informed crisis care. By addressing systemic inefficiencies, promoting patient autonomy, mitigating socioeconomic disparities, and navigating the fragmented landscape of mental health services, the CBRRT provides a roadmap for future innovations in mental health care delivery.

3.3 Strengths of the study

This study offers several key strengths that enhance its contribution to the literature on mental health crisis response. First, it addresses a timely and relevant issue by exploring organizational stakeholders' perceptions of a mobile CBRRT implemented in the wake of service gaps exposed by the COVID-19 pandemic. The focus on a client-centered, mobile intervention model reflects a shift toward more accessible and community-based care, offering practical insights that can inform program improvements and policy decisions. Grounding the analysis in the Levesque conceptual framework for access to care provides a strong theoretical foundation and allows for a comprehensive exploration of barriers and facilitators to mental health services. The study also incorporates an interdisciplinary lens to better understand experiences of access, adding depth and equity-focused analysis to the findings. Methodologically, the inclusion of both frontline workers and decision-makers through focus groups and interviews strengthens the validity of the results by capturing a range of perspectives.

The decision to adapt the data collection strategy, shifting from one large focus group to smaller ones, demonstrates responsiveness to participant availability and respect for the operational realities of the CBRRT. Finally, the integration of member-checking in the final phase of the research reinforces a participatory and ethical approach, enhancing the trustworthiness of the data and supporting the credibility of the study's conclusions.

Additionally, this study adopts an interdisciplinarity approach, bringing together expertise from public health, psychology, human and social sciences, epidemiology, and paramedicine. The research team reflects this diversity, comprising members with expertise across these fields. This composition enables the study to draw on a range of theoretical frameworks and methodological tools, enhancing the depth and breadth of analysis.

The interdisciplinary nature is also evident throughout the research process. For example, the concept of community engagement, central to the study’s methodology, is relevant across all involved disciplines. The study uses the Levesque conceptual framework, an interdisciplinary model conceptualizing access to care, to guide the methodology of this project and the disciplines listed above are integrated into the framework. At every step/domain of the framework, different disciplines collaborate to assess a variety of factors impacting access to health care (Levesque et al., 2013). By combining these disciplinary lenses, the study is better equipped to explore complex issues related to access to care, particularly in the context of mental health and substance use. This approach not only enriches data interpretation but also ensures that the findings are relevant to a broad range of stakeholders.

3.4 Rigor

To enhance study credibility and trustworthiness, technics such as member checking (McKim, 2023), a search for counter explanations (Anderson, 1982) and a peer reviewer (Ahmed, 2024) were used. Alternate explanations were explored by comparing the findings with existing literature and analyzing divergent participant responses, which were highlighted in the results.

The member-checking process was conducted following the approach outlined in McKim's article (2023) to ensure the accuracy and credibility of the findings. Once a strong draft, including all direct quotations, was prepared, all participants were invited via email to review and provide feedback. They were asked to confirm the interpretation of their experiences and given the opportunity to clarify quotes or summaries from their interviews. Participants expressed agreement with the findings and interpretation. As transcripts were translated verbatim, a couple of participants requested that their quotes be cleaned up to remove filler words like “uhm” to ensure a cohesive message, and those updates were made. This approach also fostered participant engagement in the research process, reinforcing their role in shaping the study’s outcomes.

The transferability of this study’s findings is shaped by the specific organizational, geographic, and demographic context in which the CBRRT was implemented in Ottawa, Ontario. The study draws on the perspectives of a small group of frontline paramedics and program decision-makers involved in the early implementation of a mobile mental health crisis response model. While the findings are contextually grounded, they offer insights that may be relevant to other urban settings seeking to develop or refine interdisciplinary, community-based crisis interventions. In particular, the inclusion of a

paramedic as a core member of the response team, alongside a mental health professional, represents a novel approach that may be of interest to jurisdictions exploring integrated models of care. The study provides contextualized descriptions of the program's structure, operational challenges, and perceived impacts, which support readers in assessing the applicability of the findings to their own settings.

3.5 Limitations of the study

This study presents several limitations, stemming both from its original aim and from methodological and contextual factors that influenced the scope and interpretation of its findings. First, while the initial research design aimed to include service users (clients and/or their relatives) as participants, recruitment efforts in this group were ultimately unsuccessful. The original strategy involved asking CBRRT paramedics to share the research poster with clients after service interactions. However, paramedics often forgot or felt uncomfortable initiating the recruitment process. Monthly check-ins were conducted with the team to provide reminders and updates, but interest remained null. As a result, a revised strategy was implemented, including an amendment to the ethics protocol to allow recruitment through the CBRRT's social media platforms. Despite this post remaining active for an additional two months, no clients or family members expressed interest in participating. After a total of five months of recruitment with no success, a methodological change was made: group one was redefined to consist of CBRRT decision-makers instead.

A second limitation concerns the nature of the data collected. Several themes in the results reflect what organizational stakeholders perceive clients may think or feel about the service. However, since clients themselves were not interviewed, these findings

represent second-hand impressions rather than first-person accounts. This distinction is essential, as the interpretations offered may reflect organizational stakeholders' assumptions and biases.

Third, a limitation of this study lies in the composition of the participant group recruited for group 2. Only paramedics were interviewed, excluding other professional roles (ex: mental health clinicians or administrative staff) who may have had different perspectives on the CBRRT's functioning and outcomes. This limited diversity of internal perspectives may be due to the recruitment methods used, which relied on intermediaries. As a result, the range of viewpoints on the CBRRT's functioning and outcomes was narrower than originally intended.

Fourth, the study is based on the perspectives of individuals who are actively involved in the implementation and delivery of the CBRRT. As such, their views may be influenced by confirmation bias or a vested interest in portraying the program positively. While the fact that participants openly discussed the program's challenges suggests a level of reflexivity, it is important to consider how such biases may have shaped both the data shared and the analysis conducted. Moreover, thematic analysis itself relies heavily on the researcher's judgment, and although steps were taken to ensure consistency (ex: codebook review by a peer reviewer), the risk of interpretation bias remains inherent in qualitative research. However, the use of a descriptive qualitative design helps reduce this potential bias, as it relies less on the interpretation of the researcher. This is especially important to keep in mind when assessing claims about program success or impact.

Fifth, there was little variation in the social identities of participants, which limited the ability to compare how different groups may have experienced or perceived the CBRRT differently. As such, the intersectional dimension of access to care could not be explored as initially intended.

Finally, although the CBRRT model is intentionally designed to operate without police officers as part of the core response team, police services still play a central role in the broader emergency response system, often being the default first responders to mental health crises. However, in the context of this study, police involvement did not emerge as a significant theme during focus groups or interviews. Participants primarily focused on the team's internal operations, client interactions, and service delivery. While some participants noted that police may be dispatched as backup in rare cases involving safety concerns or criminal activity, they emphasized that police do not participate in the intervention itself. This procedural detail was mentioned in passing and not explored in depth, suggesting that the absence of police was normalized within the team's practice and not perceived as a defining feature by staff. This normalization may reflect a broader shift in expectations around crisis intervention, particularly in light of growing interest in non-police models that emphasize de-escalation, trauma-informed care, and community trust, especially among marginalized populations where police presence may be associated with harm or distrust. Although participants did not explicitly compare the CBRRT model to police-involved alternatives, the structural absence of police aligns with these emerging approaches. As such, while the non-police model may have implications for trust and engagement, particularly among marginalized populations, this study did not generate sufficient data to draw conclusions about how

the absence of police shaped staff perceptions or client outcomes. Future research could explore this dimension more explicitly, especially in comparative studies of police-involved versus non-police crisis response models.

3.6 Future Recommendations

Based on these findings, several recommendations emerge for policymakers, practitioners, and researchers. First, the participants shared that there is a need for expanded funding and resources to support the CBRRT's continued development and sustainability. Policymakers should consider integrating mobile crisis teams into broader mental health service frameworks to ensure continuity of care beyond immediate crisis intervention. In parallel with funding, innovative models should be piloted and refined gradually ensuring that expansion is thoughtful rather than rushed. A measured approach can help avoid unintended consequences that may arise from a premature rollout of an imperfect model, while still encouraging innovation and continuous learning.

Second, continued inter-agency collaboration must be strengthened to address the broader social determinants of mental health. The CBRRT cannot operate in isolation; rather, partnerships with housing services, employment programs, and peer support networks are critical to fostering long-term stability for individuals experiencing crises. Collaborative initiatives should also explore formal mechanisms for the exchange of client feedback. Empowering frontline staff and decision-makers with direct insights from service users will reinforce a sense of value among healthcare workers, boosting motivation, satisfaction, and service quality.

Third, future research and service development should pay particular attention to the representation and diversity of both the workforce and service users. The current small sample size may not fully reflect the demographic composition of staff within the service, raising critical questions about representation:

- **Team Diversity:** There could be a need to hire a more diverse team that accurately represents the community served, ensuring that the voices of all demographic groups are integrated into service design and delivery.
- **Participation Barriers:** There is also the possibility that individuals from certain groups who do work for the service might feel hesitant to participate in studies due to fears of reprisal or stigmatization. Addressing these barriers is essential for obtaining a true picture of the workforce and their experiences. This dual consideration will help ensure that future evaluations not only capture the full demographic spectrum but also inform training and hiring practices that promote inclusivity.

Fourth, community education about the scope and capabilities of the mobile crisis teams is critical. Enhancing public awareness will serve two purposes:

- **Faster Access to Care:** By demystifying the roles and offerings of the team, community members will better understand when and how to seek help, potentially expediting on-site care and improving outcomes.
- **Informed Utilization of Resources:** As the public becomes more aware of available services, it can lead to more appropriate service utilization and help reduce the stigma attached to seeking mental health support.

Fifth, there is a pressing need to establish mechanisms that support vulnerable populations, particularly youth who are in acute distress. Interventions tailored to young people can address specific challenges and ensure timely support. Concurrently, scaling up operational capacity to a 24/7 model, to fit withing the requirements of a 911 service, should be prioritized. This means:

- **Resource Allocation:** Securing additional resources to maintain continuous service.
- **Multiple Teams:** Strategically positioning multiple mobile crisis teams across wider geographic areas to meet high demand.
- **Expanded Service Scopes:** While current operations focus on non-violent and non-criminal cases for adults, efforts should be made to create frameworks that can safely extend support to all community members as needs evolve.

Finally, before any large-scale expansion is implemented, it is crucial to resolve existing challenges. For instance, current difficulties in reaching the substance use population must be addressed so that the service can fully meet its intended scope. The aim should be to refine and optimize current service delivery, rather than delaying progress while waiting for an ideal model. Pragmatic incremental changes, combined with rigorous evaluation and stakeholder feedback, will allow the program to learn, evolve, and successfully scale over time. Successful models and best practices should be documented and shared across municipalities, facilitating national scalability across Canada.

Across all these recommendations, the active involvement of service users is imperative. Integrating clients into consultation and co-design processes not only helps to tailor services to actual needs but also fosters an environment where users feel empowered and invested in the programs. This participatory approach ensures that the developed interventions are both relevant and desirable to those who will ultimately rely on them.

Chapter 4 – Conclusion

This study explored organizational stakeholders' perceptions of a new CBRRT, a mobile mental health crisis intervention service designed to bridge critical gaps in access to care. Through two focus groups with frontline workers and two interviews with decision-makers, the findings contribute valuable insights into the perceived impacts, benefits, and challenges of this innovative model.

Participants emphasized the importance of mobility and community-based outreach, noting how these features foster trust, reduce barriers for marginalized populations, and present a meaningful alternative to traditional, clinic-based interventions. Moreover, the data suggest that the CBRRT's approach aligns closely with the values of responsiveness, trauma informed practice, and client-centered care; characteristics that are particularly relevant in a post-pandemic context marked by growing mental health needs and systemic inequities.

This research contributes to the expanding literature on mobile crisis teams and enhances the applicability of the Levesque framework on access to care by utilizing it in a mental health context, which is limited. It also offers practical implications for policy

and program development, especially as governments consider how to scale up or adapt mobile mental health services in response to increasing demand.

As municipalities and health systems seek to reimagine crisis response, this study underscores the value of listening to those directly involved in service delivery and decision-making. By capturing their perspectives, we can better understand the nuanced barriers and facilitators to care and design services that are both more effective and more equitable.

Future research should continue to engage diverse community voices, especially service users, to deepen our understanding of how mobile mental health interventions can be optimized. Ultimately, the CBRRT serves as a promising model of care; one that reflects a shift toward more accessible, compassionate, and community-rooted approaches to mental health support.

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Appendix A – Consent Forms for Focus Groups

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Consent Form

Title of the study: Stakeholders' Perceptions of the Effects of the Implementation of the Mental Wellbeing Response Team in Ottawa Using a Community Engagement Approach

Maria Ibrahim
Interdisciplinary School of Health Sciences,
Faculty of Health Sciences
[redacted]

Isabelle Marcoux, PhD
Interdisciplinary School of Health Sciences,
Faculty of Health Sciences
[redacted]

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Maria Ibrahim, under the supervision of Isabelle Marcoux, PhD, for the academic purposes of a master's thesis.

Purpose of the Study: The purpose of the study is to collect the perceptions of the effects of the implementation of the Mental Wellbeing Response Team from an employee's perspective. Employees can be from the Mental Wellbeing Response Team or from an affiliated stakeholder.

Participation: My participation will consist of participating in a one, approximately 90-minute virtual focus group that will be comprised of other members/colleagues working within the MWRT. During the focus group, I will be asked about my perceptions of the effect of the Mental Wellbeing Response Team, as well as my perceptions of other mental health services. I will also discuss topics related to substance use and mortality rates due to substance use. I will participate in a Microsoft Team focus group that will be audio/video recorded for transcription purposes. I will be participating in the review of the interpretations of what I said in the focus group.

Risks: My participation in this study will entail that I volunteer personal information and discuss sensitive topics, and this may cause me to feel emotional or psychological effects. I may also face being negatively judged by other members of the focus group, as I will be speaking about the program with my peers. I have received assurance from the researchers that every effort will be made to minimize these risks by giving me the option to refuse to answer, the option to withdraw, confirmed that identities will not be revealed.

Benefits: My participation in this study will allow for the improvement of the Mental Wellbeing Response Team, as well as possibly the development of similar programs in Canada and/or internationally. My participation will also help with the advancement of knowledge in the field of study.

Confidentiality and Privacy: I have received assurance from the researchers that the information I will share will remain strictly confidential. I understand that the contents will be used only for the purposes of this thesis and the improvement of the Mental Wellbeing Response Team and that my identity will be protected by anonymizing all information provided, and not sharing my identity.

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In order to minimize the risk of security breaches and to help ensure my confidentiality, it is recommended that I use standard safety measures, such as signing out of my account, closing my browser, and locking my device when I am no longer using it/when I have completed the study.

I understand that this study is being conducted independently from the MWRT, and that my decision to participate (or not) to this study, will not impact my employment or involvement with the MWRT.

Conservation of Data: The data collected (hard copy; field notes & electronic data; including audio/video recordings, transcripts, and consent forms) will be kept in a secure manner on the primary researcher's personal password protected laptop and personal protected uOttawa OneDrive account. The primary researcher will be the only one to access the data, except for the thesis supervisor who may have access to the data for validation purposes. The video recording will be deleted immediately after transcription, and all other files, including audio recordings, will be conserved, and deleted after 5 years.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. Given that focus group data are highly dependent on the overall group discussion the data will be used should one choose to withdraw given the collective nature of the group discussion.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

It is recommended that I save a copy of this consent form for my records.

Acceptance: By selecting the consent statement below, I agree to participate in this research study.

- ☐ Yes, I want to participate.
  (Name/Code): _____
  Email/Telephone number: _____
- ☐ No, I do not want to participate.

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Appendix B – Consent Forms for Interviews with Decision Makers

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Consent Form

Title of the study: Stakeholders' Perceptions of the Effects of the Implementation of a New Community Based Rapid Response Team in Ottawa Using a Community Engagement Approach

Maria Ibrahim
Interdisciplinary School of Health Sciences,
Faculty of Health Sciences
[redacted]

Isabelle Marcoux, PhD
Interdisciplinary School of Health Sciences,
Faculty of Health Sciences
[redacted]

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Maria Ibrahim, under the supervision of Isabelle Marcoux, PhD, for the academic purposes of a master's thesis.

Purpose of the Study: The purpose of the study is to collect the perceptions of the effects of the implementation of the Mental Wellbeing Response Team (MWRT) from the perspective of decision makers for the team.

Participation: My participation will consist of one virtual interview lasting approximately 30-45 minutes. During the interview, I will be asked about my perceptions of the effect of the Mental Wellbeing Response Team, as well as my perceptions of other mental health services. I will also discuss topics related to substance use and mortality rates due to substance use. I will participate in a Microsoft Team interview that will be audio/video recorded for transcription purposes. I will be participating in the review of the interpretations of my interview.

Risks: My participation in this study will entail that I volunteer personal information and discuss sensitive topics, and this may cause me to feel emotional or psychological effects. I have received assurance from the researchers that every effort will be made to minimize these risks by giving me the option to refuse to answer, the option to withdraw, confirmed that identities will not be revealed.

Benefits: My participation in this study will allow for the improvement of the Mental Wellbeing Response Team, as well as possibly the development of similar programs in Canada and/or internationally. My participation will also help with the advancement of knowledge in the field of study.

Confidentiality and Privacy: I have received assurance from the researchers that the information I will share will remain strictly confidential. I understand that the contents will be used only for the purposes of this thesis and the improvement of the Mental Wellbeing Response Team and that my identity will be protected by anonymizing all information provided, and not sharing my identity.

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In order to minimize the risk of security breaches and to help ensure my confidentiality, it is recommended that I use standard safety measures, such as signing out of my account, closing my browser, and locking my device when I am no longer using it/when I have completed the study.

I understand that this study is being conducted independently from the MWRT, and that my decision to participate (or not) to this study, will not impact my employment or involvement with the MWRT.

Conservation of Data: The data collected (electronic data; including audio/video recordings, transcripts, and consent forms) will be kept in a secure manner on the primary researcher's personal password protected laptop and personal protected uOttawa OneDrive account. The primary researcher will be the only one to access the data, except for the thesis supervisor who may have access to the data for validation purposes. The video recording will be deleted immediately after transcription, and all other files, including audio recordings, will be conserved, and deleted after 5 years.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study, unless otherwise approved by me.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

It is recommended that I save a copy of this consent form for my records.

Acceptance: By selecting the consent statement below, I agree to participate in this research study.

- ☐ Yes, I want to participate.
  Name: _____
  Email: _____
- ☐ No, I do not want to participate.

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Formulaire de consentement

Titre du projet : Perceptions des parties prenantes sur les effets de la mise en œuvre d'une nouvelle équipe d'intervention rapide communautaire à Ottawa à l'aide d'une approche d'engagement communautaire

Maria Ibrahim
École interdisciplinaire science de la santé,
Faculté des sciences de la santé
[redacted]

Isabelle Marcoux, PhD
École interdisciplinaire des des science de la santé,
Faculté des sciences de la santé
[redacted]

Invitation à participer : Je suis invité(e) à participer à la recherche, nommée ci-haut. Elle est menée par Maria Ibrahim, sous la supervision d'Isabelle Marcoux, PhD, à des fins académiques dans le cadre d'un mémoire de maîtrise.

But de l'étude : Le but de l'étude est de recueillir les perceptions des effets de la mise en œuvre de l'équipe d'intervention pour le bien-être mental (EIBEM) du point de vue des décideurs de l'équipe.

Participation : Ma participation consistera en un entretien virtuel d'environ 30-45 minutes. Au cours de l'entretien, on me posera des questions sur mes perceptions de l'effet de l'équipe d'intervention en matière de bien-être mental, ainsi que sur mes perceptions des autres services de santé mentale. Je discuterai également de sujets liés à l'utilisation de substances et aux taux de mortalité attribuables à la l'utilisation de substances. Je participerai à un entretien sur Microsoft Teams qui sera enregistré en audio/vidéo à des fins de transcription. Je participerai à l'examen des interprétations de mon entretien.

Risques : Je comprends que puisque ma participation à cette recherche implique que je communique de l'information personnelle et que j'aborde des sujets sensibles, il est possible qu'elle crée un inconfort émotionnel ou psychologique. J'ai reçu l'assurance de la chercheuse que des mesures sont prises en vue de minimiser ces risques en me donnant la possibilité de refuser de répondre, la possibilité de me retirer de l'étude, la confirmation de la non-divulgation de l'identité du participant.

Bienfaits : Ma participation à cette recherche aura pour effet d'améliorer l'équipe d'intervention pour le bien-être mental, et possiblement de développer des programmes similaires au Canada et/ou à l'étranger. Ma participation contribuera également à l'avancement des connaissances dans le domaine de l'étude.

Confidentialité et vie privée : La chercheuse m'a donné l'assurance qu'elle traitera l'information que je partagerai avec elle de façon strictement confidentielle. Je m'attends à ce que le contenu ne soit utilisé que pour cette thèse et pour l'amélioration de l'équipe d'intervention pour le bien-être mental, et que mon identité sera protégée en rendant anonymes toutes les informations fournies et en ne communiquant pas mon identité.

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Afin de minimiser les risques de bris de sécurité et pour assurer ma confidentialité, le chercheur me recommande d'utiliser des mesures de sécurité standard, telles que mettre fin à la session, me déconnecter de mon compte, fermer mon navigateur Internet et verrouiller mon écran ou appareil lorsque je ne les utilise plus / lorsque j'ai terminé l'étude.

Je comprends que cette étude est menée indépendamment de l'équipe d'intervention pour le bien-être mental et que ma décision de participer (ou non) n'aura pas d'incidence sur mon emploi ou ma participation avec l'EIBEM.

Conservation des données : Les données collectées (données électroniques, y compris les enregistrements audio/vidéo, les transcriptions et les formulaires de consentement) seront conservées en toute sécurité sur l'ordinateur portable personnel de la chercheuse principale, protégé par un mot de passe, et sur son compte OneDrive de l'Université d'Ottawa, protégé par un mot de passe personnel. La chercheuse principale sera la seul à accéder aux données, à l'exception de la superviseure de thèse qui pourra y avoir accès à des fins de validation. L'enregistrement vidéo sera supprimé immédiatement après transcription, et tous les autres fichiers, incluant les enregistrements audios, seront conservés et supprimés après 5 ans.

Participation volontaire : Ma participation à cette recherche est volontaire et je suis libre de me retirer en tout temps, de refuser de répondre à toute question à laquelle je ne veux pas répondre sans subir de conséquences négatives. Si je choisis de me retirer de l'étude, les données collectées jusqu'à ce moment seront détruites et ne seront donc pas utilisées dans l'étude, sauf approbation contraire de ma part.

Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec la chercheuse ou sa superviseure. Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Bureau d'éthique et d'intégrité de la recherche de Université d'Ottawa au (613) 562-5387 ou ethique@uottawa.ca.

La chercheuse me recommande de sauvegarder une copie du formulaire de consentement.

Acceptation : En choisissant la phrase ci-dessous, je consens ou ne consens pas à participer à cette recherche.

- ☐ Oui, je veux participer.
  Nom: _____
  Adresse de courriel/numéro de téléphone : _____
- ☐ Non, je ne veux pas participer.

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Appendix C – Interview Guide and Sociodemographic Questionnaire for Focus Groups

The discussion for each section will be limited to approximately 15 minutes.

Good afternoon everyone,

Thank you for taking the time to participate in this focus group. Your insights are invaluable to my research on the implementation and impact of the Mental Wellbeing Response Team (MWRT) in addressing mental health and substance use issues. My study aims to explore several key areas related to the MWRT's operations and its effects on the community.

Before we get started, I am hoping to take a few minutes to just request that anyone who hasn’t sent me their consent form do it now before we can proceed with this meeting, please.

We will cover several topics over the next 60-90 minutes, including perceptions regarding the MWRT, preferences for mobile versus traditional interventions, and any barriers or facilitators you have encountered.

This focus group will be audio and video recorded for transcription and analysis. Do I have your consent to start recording?

I would like to remind you that you are free to not answer any of the questions and/or withdraw at any time. The transcription of this focus group will be anonymized.

To ensure a safe and respectful environment, I want to emphasize that everything shared during this session will remain confidential. I also ask that you respect the privacy of your colleagues by not discussing any personal information shared here outside of this group.

Please note that there are no right or wrong answers. I might ask for clarifications during the interview to better understand the topic. There may be some overlap with some of the answers and that is alright.

If at any point you would like me to repeat or elaborate on my question, please let me know.

Do you have any questions for me before we get started?

We have 8 main questions to discuss, and if time permits, we will cover 2 additional ones. You may notice that I will be looking away from the screen at times. This is because I'll be taking notes or timing each section to ensure we stay on schedule, but please know that I am still listening.

For the success of our discussion, I kindly ask that you keep your cameras on whenever possible. This helps us stay engaged and connected. Let's get started.

Before we dive into the first question, let's start with a round table. I'd like each of us to briefly introduce ourselves by sharing our name, favorite summer activity and, if you're comfortable, your preferred pronouns. This will help us address each other appropriately and create a more inclusive environment. I'll start: My name is Maria, my

favorite summer activity is heading to the cottage on the weekends and my preferred pronouns are she/her.

Approachability

1. What are your perceptions of the effects of the Mental Wellbeing Response Team regarding access to mental health services in Ottawa?

2. How would you describe the client's awareness levels of the MWRT?
    a. Have you noticed an increase in awareness as the program continues to run?
    b. Are you having to do a lot of education about your service on site before being able to start providing care?

Acceptability

3. How do you perceive mobile interventions, in comparison to traditional services regarding improving [or not] access to mental health services?
    a. How has the mobile intervention been received by clients?

Availability and Accommodations

4. Are the MWRT's services available when needed/requested?
    a. If no, what happens?
    b. What are the barriers in reaching the substance use population?
    c. What are the facilitators in reaching the substance use population?

5. Do you find that certain social identities are under- or over-representing in your clientele?
    a. Social identities:
        i. Age
        ii. Gender
        iii. Marital status
        iv. First Nations, Métis and/or Inuk/Inuit
        v. Racial background
        vi. Income

Affordability

6. Have clients had to incur any costs related to the service provided by the MWRT or with any referrals they made?
    a. Has that affected their ability to receive or seek care?
        i. If yes, how?

Appropriateness

7. Do you believe that MWRT was able to provide appropriate services to support the needs of the community?
    a. If yes or no, why?

8. Were the referrals made by the MWRT for outpatient services appropriate/successful (used by the clients following treatment)?

a. If yes or no, why?

Additional questions that can be asked, should there be enough time

9. Would you say the clients' propensity (willingness/tendency) to use mental health services has increased since receiving care from the MWRT? **(acceptability)**
    a. If yes, how?
    b. If not, why?

10. Would you say that the MWRT's services are adapted to individual's needs? **(availability and accommodations)**
    a. If yes, how?
    b. If no, why?

<u>Socio-demographic Questions</u>

Send questionnaire in the chat at the end of the focus group:

https://www.surveymonkey.ca/r/HGGWNQ8

1. What is your name?
2. How old are you?
3. What is your gender identity?
4. Do you identify as First Nations, Métis and/or Inuk/Inuit?
    a. If yes, which category or categories best describe you?
5. How would you best describe your race or racial background?
6. What is your current role within the Mental Wellbeing Response Team?

a. First Responder (paramedic or social worker)
b. Supervisor
c. Administrative Staff
d. Decision Maker
e. Other: _____

7. How many years have you been working in your sector (ex: if you are a paramedic, how long have you been a paramedic)?
8. How long have you been working with the MWRT?
    a. < 3 months
    b. 3 months - < 6 months
    c. 6 months - < 1 year
    d. 1 year - < 1.5 year
    e. 1.5 year – <2 years
    f. 2+ years
    g. Pre-implementation: I have been working with the MWRT since the idea of developing the program.
9. What is your current employment tenure?
    a. Full-time permanent
    b. Full-time temporary
    c. Part-Time permanent
    d. Part-time temporary
    e. Other: _____
    f. Prefer not to answer

Conclusion

Before we end, is there anything else you would like to share with me, that we may not have addressed during the discussion?

I will be reaching back out in a few weeks, following the analysis of the information to confirm my interpretation of the information you shared with me today. I would appreciate your collaboration on that piece, at the appropriate time, to ensure the rigour of the findings.

Thank you for taking the time to speak to me today.

If you have any questions or concerns after today, please do not hesitate to reach out by email. I hope you have a great day/evening.

Appendix D – Interview Guide for Interviews with Decision Makers

Hello _____,

Thank you for taking the time to participate in this interview. Your insights are invaluable to my research on the implementation and impact of the Mental Wellbeing Response Team (MWRT) in addressing mental health and substance use issues. My study aims to explore several key areas related to the MWRT's operations and its effects on the community.

We will cover several topics over the next 30-45 minutes, including perceptions regarding the MWRT, preferences for mobile versus traditional interventions, and any barriers or facilitators you have encountered.

This interview will be audio recorded for transcription purposes and the recording will be deleted as soon as that is completed. Do I have your consent to start recording?

I would just like to remind you that you are free to not answer any of the questions and/or withdraw at any time. The transcription of this interview will be anonymized.

Please note that there are no right or wrong answers. I might ask for clarifications during the interview to better understand the topic. There may be some overlap with some of the answers and that is alright.

If at any point you would like me to repeat or elaborate on my question, please let me know.

Do you have any questions for me before we get started?

Background and Role Description:

1. Can you describe your role and responsibilities in relation to the MWRT?
    a. How long have you been involved with this program?

Program Overview:

2. The MWRT, a collaborative initiative between the Ottawa Paramedic Service and The Ottawa Hospital, aims to provide immediate, on-site mental health and medical assessments and interventions to individuals experiencing non-violent and non-criminal mental health or substance use crises. One of the primary objectives of the MWRT is to divert individuals from emergency departments when hospitalization is unnecessary, thereby improving patient outcomes and maintaining the availability of emergency resources for other critical needs. Given the program's objectives and the crucial role it plays in our community, I would like to ask:

   Has the MWRT been able to effectively reach its intended target population?

Program Development:

3. How was the need for this program identified?

Stakeholder Involvement:

4. Can you tell me about how different stakeholders were involved in the planning and implementation phases?

5. How is the program perceived among stakeholders?

Challenges and Adaptations:

6. What have been the barriers (internal or external) in implementing this program, and how have they been addressed?
    a. How about for the substance use population?
7. What have been the facilitators (internal or external) in implementing this program, and how have they helped?

Program Evaluation:

8. Has the MWRT program been evaluated?
    a. If yes, what methods are used to evaluate the effectiveness of the program?
9. Can you share some successes or improvements that have resulted from the program?
    a. Can there be any comparison to traditional service?

Impact Assessment:

10. In your opinion, how has this program been received/perceived by the target population?
11. Are there any unintended consequences that have emerged from the program's implementation?

Policy Influence:

12. How does this program align with local or national health policies?
13. Has this program influenced health policy decisions? If so, how?

Future Directions:

14. Are there plans to expand the program or modify its scope based on current results?

Lessons Learned:

15. What are the key lessons learned from working on this program?
16. What advice would you give to someone planning a similar health program?

Conclusion

Before we end, is there anything else you would like to share with me, that we may not have addressed during the interview?

Thank you for taking the time to speak to me today.

If you have any questions or concerns after today, please do not hesitate to reach out by email. I hope you have a great day/evening.

Appendix E – Certificate of Ethics Approval

06/12/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-11-23-9794
Titre du projet / Project Title	Stakeholders' Perceptions of the Effects of the Implementation of the Mental Wellbeing Response Team in Ottawa Using a Community Engagement Approach
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	06/12/2023
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	05/12/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Maria IBRAHIM	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator
Isabelle MARCOUX	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

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06/12/2023

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Kim THOMPSON
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board**

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Appendix F – Standards for Reporting Qualitative Research (SRQR) Checklist

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	p.27
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	p.27
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	p.29-31
Purpose or research question - Purpose of the study and specific objectives or questions	p.32
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	p.32
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	p.25-26
Context - Setting/site and salient contextual factors; rationale**	p.33
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	p.33-34
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	p.34
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	p.33-34

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	p.33
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	p.35-36
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	p.35
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	p.35
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	p.35

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	p. 38-52
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	p. 38-52

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	p. 53-59
Limitations - Trustworthiness and limitations of findings	p. 59

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	p. 61
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	p. 61

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:
O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

Appendix G – Sex and Gender Equity in Research Guidelines (SAGER) Checklist

Table 1. SAGER guidelines checklist
Studies with human participants

Section / topic	Item number	Checklist item	Reported on page number
General			
	1	The terms sex/gender used appropriately	All pages
Title			
	2	Title specifies the sex/gender of participants if only one included	N/A
Abstract			
	3a	Abstract specifies the sex/gender of participants if only one included	N/A
	3b	Study population described with sex/gender breakdown*	N/A
Introduction			
	4a	If relevant, previous studies that show presence or lack of sex/gender differences or similarities are cited	N/A
	4b	Mention of whether sex/gender might be an important variant and if differences might be expected	p.31 - encompassed under social identities
	4c	The demographics of the study population with regard to sex/gender (eg, disease prevalence among male/female study participants) are outlined*	N/A
Methods			
	5a	Method of definition of sex/gender (eg, self-report, genetic testing)	p.34
	5b	Description of how sex/gender was considered in the design, whether authors ensured adequate representation of male and female study participants, justification of the reasons for any exclusion of male or female participants, or explanation if not considered. Justification of other sex/gender-specific interventions of study designs (eg, mandating contraception for women).* Explicit reporting of the scientific rationale for	p.33

		contraception requirements and exclusions for pregnancy and lactation should be required*	
Results			
	6a	Study population description with complete gender/sex breakdown for all categories considered*	**p.35**
	6b	Where appropriate, data presented disaggregated by sex/gender, and sex/gender differences and similarities are described	**N/A**
	6c	Sex- and gender-based analyses reported regardless of outcome (in main paper if pre-specified; otherwise in appendix)*	**N/A**
	6d	For clinical trials, adverse event data disaggregated by sex/gender (in main paper if pre-specified; otherwise in appendix)*	**N/A**
	6e	Patient-reported outcome data disaggregated by sex/gender (in main paper if pre-specified; otherwise in appendix)*	**N/A**
	6f	For epidemiological studies, the effects of other exposures on health problems examined for all genders and analysed critically from a gender perspective	**N/A**
	6g	Table 1 includes separate rows for male sex/gender, female sex/gender and other categories if collected*	**N/A**
Discussion			
	7a	Potential implications of sex/gender on the study results and analyses, including the extent to which the findings can be generalized to all sexes/genders in a population	**N/A**
	7b	If a sex/gender analysis not done, a rationale is given and implications of the lack of such analysis on the interpretation of the results are discussed	**p.57 - encompassed under social identities**

Adapted from SAGER guidelines. Sex and Gender Equity in Research: rationale for the SAGER guidelines and recommended use. Research Integrity and Peer Review 1, Article number: 2 (2016) https://researchintegrityjournal.biomedcentral.com/articles/10.1186/s41073-016-0007-6.
* These points extend beyond the original SAGER table