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Canada

# Crisis Services: A Comparative Approach to Evaluation

**SEEI PHASE II REPORT**

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## Main Messages

### THE STUDY:

- A study compared communities with 3 different models of crisis service: 1. police as part of a specialised mental health team; 2. a mental health worker as part of a specialized police team; and, 3. an informal relationship between police and mental health crisis service
- Both rural and urban areas were included
- Focus groups were held with key stakeholders in each community: consumers, family members, service providers including police. Administrative data was reviewed. Job shadowing was conducted

### THE FINDINGS:

- While all communities valued their crisis services all identified limitations related to responsiveness during peak periods and transportation concerns.
- Rural communities were most disadvantaged by transportation issues which at times created safety issues
- Consumers in all settings wanted more peer support as part of the crisis services. They discussed the need for "warm lines" as well as "hot lines"
- Access to beds was a major issue. The lack of access created a bottleneck in emergency rooms, and tied up police as well as crisis workers
- Gaps in the continuum of care in each community will be reflected in the nature of and frequency of crises seen

### THE RECOMMENDATIONS:

1. Crisis programs require the capacity of mobility, particularly in rural areas. For this reason and because of the wide geographic spread of rural areas, the use of police teams with a mental health worker best address the needs in rural areas. This strategy requires attention to impact on police checks.
2. Crisis programs require staff members that are educated and sufficiently experienced to handle the full range of psychiatric crises including suicidal behavior, adolescent issues, family violence, psychogeriatrics and addiction issues. With sufficient volume, as in urban centres, specialized teams can be used to address this range, but in rural areas the individual mental health worker must have the skills to address the full range of crises. The volume and specialization issues in urban areas suggests that specialized mental health teams with attached police officers are most appropriate for urban centres.
3. A system for easier access to psychiatric beds is required such as a regional and provincial roster system.
4. No one calling a psychiatric crisis line should get a busy signal or have to leave a message. Since all crisis lines will experience peak periods, regional back-up phone systems need to be established.
5. Crisis services need to include peer support.
6. All police officers require extensive training and education on mental health matters, including addictions.
7. Common minimum data sets for crisis service need to be developed and adopted.
8. Local communities should regularly evaluate the types of crisis situations typically encountered to identify existing gaps in psychiatric services that need to be filled.
9. Psychiatric crisis and emergency services need to provide or address transportation.

## Executive Summary

To date, few formal evaluations of crisis service models have been conducted. However, the few studies available do indicate that crisis services are a valuable resource for helping individuals with mental health issues in both rural and urban areas. This evaluation examined three police crisis models: the police crisis models in place in the communities of Haldimand-Norfolk, Chatham-Kent, and Hamilton, to identify key issues pertaining to the development of crisis service programs across Ontario. Each model differed in terms of the relationship established between police and psychiatric crisis services. In Hamilton the police were part of the psychiatric crisis team, in Chatham Kent a psychiatric worker joined the police team, whereas in Haldimand-Norfolk the police and crisis services were distinct from each other and had a less formal working relationship.

Quantitative data collection included a description of the three communities. Chatham-Kent, Haldimand-Norfolk, and Hamilton contain rural and small urban cities with populations of 109,600 (2006 Statistics Canada), 112,100 (2006 Statistics Canada), and 531,000 thousand respectively (2006 Statistics Canada). Data on suicide rates in all three communities were examined. Chatham-Kent's suicide mortality rate in 1997 was 8.7 while in 2001 it was 7.4. In 1997, the suicide rate for both sexes in Chatham-Kent was 8.7 per 100,000 people according to Statistics Canada. The existing psychiatric resources varied between the settings. Hamilton serves as a regional resource area and includes many specialized services whereas Chatham-Kent has a psychiatric ward within a general hospital and community mental health programs but has few services for addictions while Haldimand-Norfolk has no psychiatric in-patient program but has well established community and addiction services.

Administrative data was requested from each crisis service. However, the data was not collected in a uniform manner and thus differences and discrepancies in the data arose. The consistent data found was in the context of the number of contacts and services experienced.

The HELP team collected the number of contacts by individuals accessing the service. According to their data, the number of people accessing the service rose from 122 in 1998 to 494 in 2007.

The Cast Team collected data from 2004 to 2008 regarding the number of contacts, the number of assessments, demographic information, and the reasons for contact. In 2007, there were 476 clients served by the program during the first six months. In 2007 there were 966 calls made in the first six months. Contacts were classified according to the reason why the contact was made such as; the manifestation of mental illness symptoms, relationship problems, and suicidal ideation. Suicidal ideation was the third most common reason for contact.

The COAST team is the largest of the three crisis services and collects data pertaining to the number of requests for service, responses to requests, services provided, referral sources, dispositions, and demographic information describing service users. In 2007, there were 2,171 requests made for services. The most prevalent diagnosis made by the COAST team was that of schizophrenia. However, the diagnostic categories used did not follow the format of the DSM-IVR and included terms such as "bullying, disruptive behavior and family dysfunction." The most prevalent presenting problem found in the study was that of suicidal ideation/threat which comprised 10% of all contacts.

The data collected indicates that HELP is experiencing a demand in growth, whereas CAST and COAST have been experiencing greater stability and hence predictability in demand. All three of the programs focus on crisis services.

Qualitative data collection included participant observation in the form of focus groups and job shadowing. The focus group sample included 143 focus group participants comprised of 46 consumers, 47 family members, and 50 individuals involved in the provision of services at various agencies. Overall, the date indicated that all three groups were satisfied. However, concerns were expressed by consumers and family members regarding the difficulties

they experienced while trying to access services in the midst of a crisis. Transportation and busy phone lines were identified as being impediments to access. Transportation within rural communities and between rural and urban centres could create unsafe conditions. For example, one women was forced to hitchhike home in the middle of the night in winter without a coat after having been taken to another community by police, but released with no way home and no way of paying for an $80 cab fee. Consumers in the study indicated they wanted to access to peer support services as part of their crisis care. Consumers described the difference between a "hotline" type of emergency service which requires professional intervention and a "warm-line" type of emergency service which could include peer support. Providers in all areas regarded the crisis team and police as being a critical part of the care provided in psychiatric emergencies.

Participants in the focus groups completed questionnaires. The responses to these questionnaires revealed that consumer and their family members felt varying feeling of satisfaction with community crisis services. On the whole, they were satisfied with having crisis services but they were not satisfied with the scope of the services provided. Families reported feeling less satisfied and/or neutral about how they felt about crisis services whereas consumers agreed or somewhat agreed with the statement that they were satisfied with the quality of crisis services. Just over 50% of consumers and families reported feeling that crisis services had responded to their crisis in a timely manner. Two thirds of consumers and families agreed or somewhat agreed with the statement that crisis services were easy to access. The remaining one third of consumers and their families indicated that they somewhat agreed or disagreed with the statement that crisis services were easy to access. Many consumers and their families generally reported feeling positive and satisfied about crisis services while some consumers and their families continued to express neutral attitudes and/or a lack of satisfaction with current services. These findings reflect the need for a further evaluation of consumers' and family members' feelings of satisfaction with the delivery of crisis services.

Job shadowing took place at all three sites for two to five shifts per site. Research team members shadowed a team in each of the three communities. The research team members observed how police officers and crisis workers responded to both routine and crisis situations involving mental health consumers. These observations revealed how crisis services responded to specific missing pieces of the mental health system within their community. The issues were broad and demonstrated that crisis services were acutely involved in assisting in psychiatric issues related to relapse, addiction, psychogeriatrics and responding to issues of domestic violence. The program teams varied in the amount of outreach services versus intake services they provided.

The systems varied in their ability to provide consumers with quick access to psychiatric beds thus serving to reduce the wait times of both staff and consumers. Attempting to find a suitable hospital bed was very time consuming for teams without direct access to beds. This also created increased crowding in the emergency room and consumed many hours of police time. During one observation period, a police supervisor arrived at the emergency ward to determine why all but one cruiser was at the hospital. All of the involved police were with people awaiting psychiatric services leaving few policing resources available for two counties.

This indicates an urgent need for the provision of easy access to psychiatric beds. The effective functioning of crisis programs requires the provision of readily accessible psychiatric beds. One way to response to this healthcare crisis would be the development of a centralized registry of available psychiatric beds, similar to existing registries pertaining to labor and delivery.

Since police officers are often called to resolve issues pertaining to individuals with mental health issues, they are often the first persons to come into contact with such individuals during a crisis. As a result, police officers often are the ones making the decision to bring individuals in crisis to hospital. Therefore, it is necessary for police departments to work collaboratively with community

service agencies and hospital emergency departments.

Another important issue identified in the study was the need for more timely responses. When in crisis, consumers and their families wanted immediate help and became very frustrated when their calls for help went directly to an answering machine or a busy signal. Staffing issues typically give rise to these situations given that in each service, there were times when available staff could not respond to all the calls they were receiving. This finding suggests the need for the development of a coordinated telephone service in which neighbouring areas can serve as back up for each other.

In general, crisis services were found to be immensely valued in all three communities. This observation indicated that all crisis services utilized various partnerships which demonstrated the need for inter-agency collaboration, specifically, a working collaboration between police and mental health, community agencies, crisis services and emergency departments.

**KEY RECOMMENDATIONS:**

1. Crisis programs require the capacity of mobility, particularly in rural areas. For this reason, and because of the wide geographic spread of rural areas, the use of police teams with a mental health worker best address the needs in rural areas.
2. Crisis programs require staff members that are educated and sufficiently experienced to handle the full range of psychiatric crises including suicidal behaviour, adolescent issues, family violence, psychogeriatrics and addiction issues. With sufficient volume, as in urban centres, specialized teams can be used to address this range, but in rural areas the individual mental health worker must have the skills to address the full range of crises. The volume and specialization issues in urban areas suggest that specialized mental health teams with attached police officers are most appropriate for urban centres.
3. A system for easier access to psychiatric beds is required such as a regional and provincial roster system.
4. No one calling a psychiatric crisis line should get a busy signal or have to leave a message. Since all crisis lines will experience peak periods, regional back-up phone systems need to be established.
5. Crisis services need to include peer support.
6. All police officers require extensive training and education on mental health matters, including addictions.
7. Local communities should regularly evaluate the types of crisis situations typically encountered to identify existing gaps in psychiatric services that need to be filled.
8. Common minimum data sets for crisis service need to be developed and adopted.
9. Psychiatric crisis and emergency services need to provide or address transportation.

The aim of this study is to help provide a better understanding of the issues related to creating effective crisis services. It is hoped that this information will assist in the development and evaluation of future crisis services and will help improve Ontario's existing crises services models to ensure that individuals with mental illness receive the most effective support possible.

## Detailed Report

### CONTEXT

In recent years, the number of contacts between police and persons with a mental illness has increased in Canada (Adelman, 2003). Consequently, efforts have been made to address the complexity of issues related to interactions between police and individuals with a mental illness through the identification of effective interventions and services. Police crisis services have become increasingly popular in Ontario since the introduction of the Crisis Outreach and Support Team (COAST) program in Hamilton in 1997, modeled after the Vancouver Car 87 Program (Landeen, Pawlick, Rolfe, Cottee & Holmes, 2004).

There is limited understanding about the essential components, processes, and outcomes for police crisis services to date. Thorough literature searches uncovered few Canadian articles pertaining to crisis services and mental health (i.e., Cotton, 2004; Jarvis, 2005; Matheson et al., 2005). There is consensus amongst the available research that police are commonly the first point of contact for individuals experiencing a mental health crisis within the community. Conclusions from the literature review revealed that only a few formal evaluations of crisis service models have been carried out. Those that have been conducted indicate that crisis services are an invaluable tool for helping individuals with mental health issues in both urban and rural areas (Cotton, 2004; Jarvis, 2005; Matheson et al., 2005). As new crisis teams are emerging with continued variation in structure and organization, there is a growing need for further understanding of these services to inform practice.

This project examined three different models of police crisis services in Ontario: Hamilton's Crisis Outreach and Support Team (COAST), Haldimand-Norfolk's Crisis Assessment and Support Team (CAST), and Chatham-Kent's HELP Team.

The COAST model partners a police officer within the mental health team and offers mobile services to a primarily urban population. The CAST model provides service to a largely rural population and offers a separate but collaborative approach between mental health and police teams. In the CAST model, the police serve as the mobile unit, bringing individuals experiencing a mental health crisis to the emergency department where a mental health worker is on duty to assist with the crisis situation. It is a collaborative relationship but the police and crisis workers are two separate teams. This compares to the HELP model in which the police officers receive specific training by a mental health professional to increase awareness and sensitivity to mental health issues and crises. The HELP team delivers service to a mixed urban and large rural population. When a mental health call comes in through police dispatch, an officer who has received HELP training is assigned to that particular call whenever possible. During the course of this research study, the HELP team implemented a 'pilot project' whereby a full time mental health worker was paired with a HELP team officer to attend mental health calls and conduct follow up assessments of individuals with mental health issues who had recent contact with police; Both models were captured during the data collection phase.

The ultimate purpose of this study was to identify and understand the impact of these different models of crisis programs and to further explore the needs of mental health consumers, their families and service providers during interactions with crisis services. The results provide a clearer understanding of issues and strengthen the empirical knowledge regarding the impact of community based crisis services.

### IMPLICATIONS

Understanding the inner workings and the impact of crisis models will inform and assist policy decision makers and program managers in the development and evaluation of crisis services across the province and in other communities. Direct service providers will be able to use the knowledge gained from this study to inform their everyday practice and improve provision of efficient and comprehensive client care. Additionally, mental health consumers and their families or other support persons will be able to consider these results in relation to their own experiences, and perhaps wish to share

these experiences within their own communities with a view of improving crisis care and addressing gaps in service.

The study used a variety of data sources, including focus groups, administrative data and participant observation/job shadowing, to identify a number of key recommendations.

**Key Recommendations:**

1. Crisis programs require the capacity of mobility, particularly in rural areas. For this reason, and because of the wide geographic spread of rural areas, the use of police teams with a mental health worker best address the needs in rural areas. This strategy requires attention to impact on police checks.
2. Crisis programs require staff members that are educated and sufficiently experienced to handle the full range of psychiatric crises including suicidal behavior, adolescent issues, family violence, psychogeriatrics and addiction issues. With sufficient volume, as in urban centres, specialized teams can be used to address this range, but in rural areas the individual mental health worker must have the skills to address the full range of crises. The volume and specialization issues in urban areas suggests that specialized mental health teams with attached police officers are most appropriate for urban centres.
3. A system for easier access to psychiatric beds is required such as a regional and provincial roster system.
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7. Local communities should regularly evaluate the types of crisis situations typically encountered to identify existing gaps in psychiatric services that need to be filled.
8. Common minimum data sets for crisis service need to be developed and adopted.
9. Psychiatric crisis and emergency services need to provide or address transportation.

## APPROACH

Ethics approval was obtained through the University of Western Ontario. A case study approach to evaluation was used to compare and contrast crisis service models in three Ontario communities: Haldimand-Norfolk, Chatham-Kent, and Hamilton. This case comparison approach was used to elicit rich data to understand similarities and differences between approaches and helped to identify key issues related to successful implementation of crisis services in Ontario.

An Advisory team was formed comprised of investigators as well as service providers and police linked to the three study sites. Through regular meetings and teleconferences, this group sought to better understand the critical components, processes, implications and outcomes of police crisis services. This included a comparison between stakeholder perspectives as well as a cross program comparison.

Descriptive data was collected from each organization including: staffing, organizational structure, services provided, volume, types of crisis addressed and community inter-relationships. Quantitative systems level data was compiled to include a general description of the communities served. Frequencies of emergency room use and police calls was captured where available and compared from a baseline point. Consumer and family satisfaction was assessed using written Likert scales as well as open-ended questions. The satisfaction scales will be used for descriptive purposes to augment the qualitative description.

The qualitative comparison encompassed ethnographic methods including participant observation and focus groups interviews. Research team members shadowed a team in each of the communities for a minimum of two shifts per site. Field notes were recorded and included a summary of key processes and the contexts of care provided. Efforts to preserve client confidentiality and anonymity were exercised at all times. Dialogue with staff, managers, family members and consumers occurred during the participant observation periods.

Key stakeholders in each community were identified and included police, emergency and crisis staff, community and hospital service providers, consumers of the service, and family members. Focus groups/interviews were conducted to answer the following: What is the perception of the service? What are aspects of the program that are considered important and useful? What are problems with the current approach? How could it be improved? The perceptions of each stakeholder group were analysed separately. A matrix analysis compared and contrasted both perceptions of different stakeholder groups and differences across communities. Sample size was determined by saturation of themes described and a repetition of the material presented (Germain, 1993; Leininger, 1985). In total, 20 focus groups were conducted across the three sites. The sample study consisted of 143 focus group participants comprised of 46 consumers, 47 family members and 50 individuals involved in the provision of services at various agencies.

### Analysis Technique

A matrix method of ethnographic analysis was used. Data from each stakeholder group and each community were first analysed separately and a grid of themes was developed. Themes were then compared across groups to develop larger patterns. Where differences between communities or stakeholder groups were apparent, these differences were identified in the larger patterns. The quantitative data were collected for descriptive purposes. Due to the differences in the nature of data at each site, more advanced statistical comparisons were not possible.

### Partners

Partners in this research included:

- Lawson Health Research Institute
- Crisis Outreach And Support Team (COAST) Hamilton
- St. Joseph's Healthcare Hamilton
- Crisis Assessment Support Team (CAST) Simcoe, Haldimand-Norfolk
- HELP team, Chatham-Kent Police Services

### Dissemination Plan

1. Presentations have been made in each of the participating communities. A dissemination conference including two other crises related research projects was hosted in London, Ontario in Oct, 2008. The research has been presented at several conferences targeted at academics, police and clinicians. Summaries will be available on the web including the one page and executive summary from this report. An academic paper will communicate the results to the research community and a more clinically based paper focusing on implications will be developed to communicate to clinicians and decision makers.

## RESULTS

### Administrative Data

Administrative data was requested from each of the three crisis services included in this study however the data was not collected in a uniform manner and as a result, differences and discrepancies arose. These differences made it extremely challenging to make a true comparison of service utilization across the three sites (see Appendix A). In fact, the only consistent variable was the number of contacts and the service experienced.

The HELP Team collected only the number of contacts. In 1998, HELP recorded only 122 contacts whereas they recorded 494 in 2007. This increase in demand has been steady and will likely continue to grow based upon past patterns. The HELP team did not collect data describing the actual contacts nor did it collect data pertaining to the disposition of these cases. It is unknown whether this increase in demand was due to increased community awareness of the service, increased need for service, or a combination of these and other factors

The COAST Team is the largest of the three services and collects data regarding the number of requests for service, the response to requests, the service provided, referral source, disposition of service, and demographic information describing service users. This program also has the largest volume of requests for service; 3064 requests for service was made in 2001, 3064 were made in 2002, 2900 were made in 2003, 3135 were made in 2004, 3236 were made in 2004, 3442 were made in 2006, and 2171 were made in the first six months of 2007. The number of these requests which were characterized as "Police Blue FYI" requests, numbered annually between 500 and 600. The data collected included information on the number of cases taken to hospital and how many of these cases subsequently resulted in an admission. Other data collected included data pertaining to the type of service provided, referral source, disposition, diagnosis, and presenting problem. The most prevalent diagnosis was schizophrenia. The diagnostic categories used in the study do not follow the format of DSM- IV R, and include terms such as 'bullying', 'disruptive behavior' and 'family dysfunction'. The most prevalent presenting problem of the epopulation was that of suicidal ideation/threat, which was found to be present in approximately 10% of all contacts.

The CAST Team collected data regarding the number of contacts, the number of assessments, demographic information, and reasons for the contact. Data is available from 2004 to the spring of 2008. This service serves a large number of clients; 2201 clients were served in 2004, 1625 were served in 2005, 1210 were served in 2006, and 478 people were served in the first six months of 2007. These services also experienced a high number of calls; 1951 calls were made to the service in 2004, 2115 were made in 2005, 1600 in 2006, and 966 in the first six months of 2007. In additions to taking these calls, the service also provided many assessments; 272 assessments were made in 2004, 293 were made in 2005, 254 were made in 2006, and 101 were made in the first six months of 2007. Overall, this data demonstrates some variability but no clear trend. Contacts were classified according to the reason they were made. The most common reason for making such a contact was the manifestation of the symptoms of mental illness, followed by relationship problems, and suicidal ideations.

The HELP service is experiencing a growth in demand while the CAST and COAST services has experienced more stable levels of demand. Each of these services collects data that is of direct interest and concern to the service.

### Focus Groups

Focus group interviews were facilitated by a member of the investigative team and were audio taped, transcribed and validated. Field notes were taken by experienced research staff. Several questions were explored, including: what is the perception of the service? What are the aspects of the program that are considered important and useful? What are problems with the current approach? How could the current approach be improved? There were a total of 20 focus groups conducted with consumers, family members and service providers (including hospital and community based staff) in

the three communities of Chatham-Kent, Haldimand-Norfolk and Hamilton. The sample size across all three regions totalled 143. The sample study consisted of 46 consumers, 47 family members and 50 individuals involved in the provision of services at various agencies. In Chatham-Kent, seven focus groups were conducted: two with consumers, three with family members and two with service providers. In Haldimand-Norfolk, seven focus groups were held: two consumer focus groups, one family member focus group and four service provider focus groups. In the Hamilton region, a total of six focus groups were conducted: two with consumers, two with family members and two with service providers.

The data from these focus groups provided a detailed description of the crisis services used in these communities, as well as a detailed description of instances in which the services are utilized. The following are consistent themes which emerged within the qualitative data:

(a) all communities value their crisis services,
(b) problems arise due to a lack of public transportation,
(c) there is need for immediate assistance when an individual is in crisis,
(d) crisis programs all have peak periods where they cannot handle the volume,
(e) improved access to psychiatric in-patient beds is essential,
(f) consumers want peer support as part of their crisis care,
(g) crisis services require inter-agency collaboration, and
(h) each area identifies specific gaps unique to their community.

See Appendix B for excerpts from focus group interview to substantiate the above themes.

**Consumer and Family Satisfaction Survey**

The Crisis Services Consumer and Family Satisfaction Survey(s) was administered to consumers of mental health services and their family members who attended focus groups. The questions included: (a) I have accessed the crisis service in my community, either for myself or a family member/loved one; (b) The crisis service in my community is easy to access; (c) The crisis services in my community conduct themselves in a professional manner; (d) The crisis service in my community responds in a timely manner, and (e) I am satisfied with the services offered by the crisis service in my community Participants were able to write comments in response to two questions: The thing I like most about the Crisis Service in my community is; and, The thing I like least about the Crisis Service in my community is. (Please see appendix C.)

The responses to these questionnaires revealed that consumer and their family members felt varying feeling of satisfaction with community crisis services. On the whole, they were satisfied with having crisis services but they were not satisfied with the scope of the services provided. Families reported feeling less satisfied and/or neutral about how they felt about crisis services whereas consumers agreed or somewhat agreed with the statement that they were satisfied with the quality of crisis services. Just over 50% of consumers and families reported feeling that crisis services had responded to their crisis in a timely manner. Two thirds of consumers and families agreed or somewhat agreed with the statement that crisis services were easy to access. The remaining one third of consumers and their families indicated that they somewhat agreed or disagreed with the statement that crisis services were easy to access. Many consumers and their families generally reported feeling positive and satisfied about crisis services while some consumers and their families continued to express neutral attitudes and/or a lack of satisfaction with current services. These findings reflect the need for a further evaluation of consumers' and family members' feelings of satisfaction with the delivery of crisis services.

### Job Shadowing

In total, ten participant observations involving job shadowing shifts occurred across the three study sites. A member of the investigative team and a consistent research assistant acted as participant observer in each community for two to five shifts, taking note of key processes and interactions in the context of the care provided. During these shifts, the researchers were able to observe how police officers and crisis workers respond to routine and crisis situations involving mental health consumers. Field notes were recorded and observations focused on discussions and interactions between and among crisis staff, ER staff, police, clients and families in each environment. These field notes were analyzed for re-occurring patterns and themes and compared both to other observations at the same site and to the other study sites to identify similarities and differences.

The observations revealed how each crisis service responded to gaps and deficits within the mental health system in their community. The teams varied in the amount of outreach versus intake in each program. Systems that provided quick access to psychiatric beds saved prolonged waiting by staff and consumers alike. The crises services were immensely valued in all three communities.

In comparing Halidmand-Norfolk's Crisis Assessment and Support Team (CAST), Chatham-Kent Mobile Response Team and Hamilton's Crisis Outreach and Support Team (COAST), similarities and differences were evident.

**Key differences in the crisis programs include:**

- Outreach versus intake approach for service delivery;
- transportation concerns;
- access to in-patient psychiatric beds;
- differences related to specialization versus generalists;
- differences related to other services available within each the community (e.g. domestic violence, addiction, and seniors).

**Differences among the crisis programs observed:**

Haldimand-Norfolk CAST program:

- The Mental Health program is not mobile; police serve as the mobile unit
- Serves clients 16 years or older
- assessment and referral is focus
- short term follow up counselling service available
- crisis "hot-line"

Hamilton COAST program:

- mobile crisis intervention team
- team serves children and teens
- crisis "hot line"

Chatham-Kent program:

- Specially trained police officers provide crisis assessment and intervention
- Focus is establishing safety with referral to mental health services
- Pilot project 'mobile team' pairs HELP team officer with mental health nurse to complete follow up and facilitate connection with formal mental health services
- Pilot project 'mobile team' wear non-uniform, unmarked car
- crisis "hot line" available in community, but run by a separate organization

### Resources in the community

In the community, the resources are limited but vary between communities. There are detoxification services and an addiction program in Haldimand-Norfolk but no psychiatric beds. In Hamilton there is tertiary and acute care services available and a wide range of psychiatric and addiction services. In Chatham Kent there is no detoxification or addiction treatment services, however there are acute care psychiatric beds. All communities have a telephone hot line.

**Similarities in processes include:**

Each program has adapted their service to address the unique gaps in mental health services within their community. However, all programs experienced challenges related to:

- human resources, specifically difficulties in staffing crisis services,
- issues for crisis lines when several calls come in at once and,
- A need for outreach work rather than assuming those in crisis can come to them.

A comparison of participant observations at each site suggests there is a distinct need for inter-agency collaboration. All crisis services required and used partnerships. This includes a working collaboration between police and mental health, community agencies and crisis services and crisis services and emergency room (ER).

The participant observations revealed that differences in community crisis services reflected differences in community resources. In other words, whatever service needs are not met in the community will be disproportionately dealt with in the crisis program.

Limited access to beds created major backlogs of work and created a ripple of deficiencies throughout the system. During one observation period, a police supervisor arrived at the emergency ward to determine why all but one cruiser was at the hospital. All of the involved police were with people awaiting psychiatric services leaving few policing resources available for two counties.

Differences between rural and urban needs were also apparent. For example, services in urban communities tend to be more specialized. For example, there are individuals or teams within the crisis services that specialist in adolescent or addiction issues. Public transportation is also more readily available so it is less of an issue for clients to come to the service. In rural settings mental health services were more generic since there was often only one worker on at a time and transportation is a major concern.

## DISCUSSION AND RECOMMENDATIONS

### Mobility of Crisis Programs

There were many differences observed in the distinct approaches to mental health crisis services offered in the three communities studied. Of critical importance was the fact that not all had a mobile service. The organization and delivery of services must take into account the context of the community in which the services are offered. For example, a lack of public transportation in rural communities means that clients often cannot readily access crisis services. Thus, outreach programs that are not dependent upon clients having or finding transportation are particularly important in these communities. The crisis model for rural settings must include a mobile component if universal access is a goal. As one hospital worker commented during a focus group:

"And so in an ideal world there would be something available 24/7 at the hospital and something more mobile to allow people to go out."

Of course, even in an urban community, clients may not be able to access public transportation when requiring crisis services and thus mobility is a key attribute of any mental health crisis service.

Presently, there is an absence of any integrated policy regarding transportation and access to mental health services in Ontario. Consumers need to be able to get safely to services and then safely back home, even in those situations when they are not formally admitted to hospital. Thus, the Hospital Act should be revised so that following a psychiatric assessment that does not lead to hospitalization transportation safely should be a requirement, especially when home is in another community not serviced by public transportation of any kind

### Access to Beds

Ready access to psychiatric beds is critical for effective functioning of the crisis programs, hospital emergency rooms and police officers who have a broad range of community safety and security responsibilities. Where access is problematic there are long waits in the emergency room for the client, families, community health workers and police. In one job shadowing situation there were six police cruisers on call for a two county area. Four of these were simultaneously attending to individuals awaiting assignment to psychiatric beds and thus not able to provide service to the community for several hours. As well, crisis staff too often spends an inordinate amount of time attempting to locate a single bed and thus are unable to respond to another client in crisis. One response would be the development of a centralized registry of available psychiatric beds, similar to that which exists for other specialties such as labour and delivery.

### Staffing

Staffing for crisis programs requires highly educated and experienced personnel. This is most acute in the context of rural areas. In these settings, a major barrier in rural communities is the lack of available public transportation, a finding which reinforces the important role played by outreach services. There is usually only one staff member on at a given time and to successfully perform their role, staff member must become expert generalist in mental health. Another important issue identified in the study was the need for more timely responses. When in crisis, consumers and their families want immediate help and became very frustrated when their calls for help go directly to an answering machine. Staffing issues in various services typically give rise to these types of situations given that there were times when staff members could not respond to all the calls they were receiving. This finding suggests the need for the development of a coordinated telephone service where neighbouring areas can serve as back up for each other.

Within a single shift, crisis calls that need to be responded to can be related to addictions, adolescents, geriatrics, psychosis, suicidal behaviour, family violence, family issues, psychogeriatric issues, and any other issues within the broad scope of mental health and the practitioner must be able to appropriately assess and triage the situation. Since urban

settings have a larger and denser population, the volume of service is much greater. In these settings, a team approach including an increased specialization of team members can occur so that there is an addiction specialist, a youth team, and/or a geriatric team to respond to different crisis situations.

Crisis services are in need of increased funding to recruit, support, and to maintain appropriate staff. The salaries of crisis team staff members should be raised so as to be considered comparable to the same pay of hospital staff. Crisis staff members that are highly trained and experienced should be paid according to their expertise; this would ensure recruitment and maintenance of appropriate staffing.

### Models

The need for increased mobility and generalists in rural communities indicates that police crisis teams supported by mental health workers constitute a superior approach. Contrarily, the larger volume and ability to specialize in larger urban centers suggests that a psychiatric team supplemented by police officers would form a better practice model.

The specific education of police officers on mental health matters is critical in all communities. As well, it is important to have specific assignment of police officers to respond to mental health issues. Without this assignment, situations can become crisis or emergencies that require a police response and the opportunity for preventing some crises may be lost. Introduction on this topic should occur as part of their training in the Police College and be carried on with ongoing professionals development opportunities once an officer is assigned to a detachment as their role will vary depending upon the community which they serve.

### Assessment of Gaps

The type of crisis situations commonly encountered in each community reflected the gaps in psychiatric services. Each program evolved to respond to the impacts of these gaps and adapted to the missing pieces within their community's health and social services. For example, where there are few or no addiction or withdrawal management services, the crisis services have an increased responsibility in responding to substance abuse emergencies. Where there is difficulty accessing senior's services that community's crisis service will have more calls relating to that population in crisis. A good strategy for assessing the gaps in a given community is to examine the nature of the crisis calls that are received. The "filling in of the gaps" function of a crisis service can be viewed in terms of an analogy of a Jell-O mould. The "Jell-O" flows to where the gaps are and takes on that unique shape. However, this results in crisis programs running the risk of being accused of "mandate drift" as they struggle to deal with the outcome of gaps in their system.

### Crisis Help Lines

Mental health consumers from all three communities who accessed crisis help lines found that the lines were at times tied up when they needed to access crisis support. The caller would hear either a busy signal or be transferred to an answering machine, neither of which is a good outcome for a person experiencing a crisis. In times of crisis, mental health consumers and families want immediate help and need to speak to a crisis service worker or a peer support volunteer immediately, which is the mandate of crisis response.

One solution to crisis phone lines that are busy is the creation of a regional back up system between crisis services within a geographical area. If one community's line was tied up the call could go to an adjacent community that would be most familiar with the local resources and contexts. Workers were serve as back ups to each other to allow for more direct contact for clients in crisis throughout the province.

### Peer Support

Consumers consistently valued the availability of peer support during crises, however this was inconsistently offered. Consumers described the difference between a "hotline" type of emergency that may require professional intervention and a "warm line" when support is required. Peers are a cost-effective alternative to supportive needs and should continue to be an integral part of the mental health crisis system.

### Consumer and Family Satisfaction

The satisfaction of over half the consumer and families was positive however there was some variability across sites. Generally, consumers agreed or somewhat agreed that they were satisfied with their crisis services. In contrast, families were less satisfied and neutral. Just over half of the consumers and families reported that their community crisis service responded in a timely manner; and one fourth of the respondents indicated they were neutral. Two thirds of the consumers and families agreed or somewhat agreed that crisis services were easy to access and the remaining one third were neutral or somewhat disagreed or disagreed. The satisfaction of consumers and families is generally positive however there are neutral attitudes and lack of satisfaction in current services which highlights the need for on-going evaluation of consumers' and family members' satisfaction with the delivery of crisis services.

### Conclusion

Crisis services are a critical component of the continuum of care for psychiatric care. Although all communities valued their crisis services, consistent gaps and concerns were identified. Different solutions are needed however to address the unique qualities of rural vs. urban settings. Attention to the recommendations can improve the access and quality of care provided.

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## Appendix A: Administrative Data/ Community Comparison Chart

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| Ratio:<br>Police officers to counsellors (a mental health worker that is placed on a crisis team) | • Mobile crisis intervention team: ***24 front-line officers*** who are trained as Crisis Intervention Team (CIT) officers<br>• CIT training offered to other officers, ie. jail guards<br>• In hospital Emergency Room (ER), there is a crisis nurse who works on the in-patient psychiatric ward when not needed in the ER | • ***29 staff members*** (Full and Part-time)<br>• ***4 Full-time police staff***<br>• ***4 Backup Full-time***<br>• ***75 Crisis Intervention Team (CIT) officers*** | • On the 24-hour Crisis Line and face-to-face Assess-ments in the Emergency Room:<br>• ***4 Full-time RN's*** (on one at a time) and ***7 part-time RN's***: Short Term Crisis Counsellors (1.5 Full-Time Equivalents)<br>• ***No police assigned to CAST***<br>• Between 2001-2006, CAST added Short Term Crisis Counselling (STCC) to the team; offered clients 6 sessions using brief/solution focused counselling |
| Training processes? | Workshops provided by Canadian Mental Health Association (CMHA) (very sporadic) | • Blocked training<br>• Advanced patrol training<br>• COAST has provided Crisis Intervention Team (CIT) training to Niagara, Halton, Hamilton,<br>• Begin training in Brantford | At the Resource Centre members are trained as peer specialists to provide after-crisis peer support<br>CAST:<br>• All eligible staff hold: Certified Psychiatric Mental Health Nurse (Canada) CPMHN(C)<br>• Concurrent disorders training (addiction screening tools, street drugs and interactions)<br>• Early Intervention in Psychosis (three-day training)<br>• Grief Counselling, Brief Focused Counselling<br>• Emergency Psychiatry conferences |
| Time worked?<br>• Hours of service<br>• Staff's years of experience | • Crisis Intervention Team (CIT)<br>• officers<br>• Temporary police officer and crisis nurse (January–June) | • COAST is staffed 24/7<br>• 50% of staff have been there since 1997, when the program began) | • CAST: 24-hour mental health crisis line with face-to-face assessments in the Emergency (ER) at either Simcoe and Dunnville site as per schedule |

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| Common referrals/resources used? | • Hospital Crisis Line<br>• Canadian Mental Health Association (CMHA)<br>• Community Care and Access Centre | • COAST Crisis Line<br>• referral process from police<br>• alert system from community service providers | • Haldimand-Norfolk Mental Health Common Intake Form<br>• Haldimand-Norfolk REACH (Child and Youth)<br>• Assertive Community Treatment Teams (ACTT), Erie's North Shore Support Services (ENSSS) Case Management, General Practitioner (GP's), Ontario Works, Developmental Delay Community Services |
| Is there an urban/rural mix? | • Mixed urban and rural. Heavy emphasis on agriculture.<br>• In Chatham Kent there are two reserves: Walpole and Moriavantown; they have their own police services, however, if more assistance is required the police team from Chatham-Kent will assist | Major urban and port city | • Rural population with large Aboriginal contingent (Six Nations and New Credit)<br>• Reserve population is served/ supported by the federal government<br>• Six nations have their own police team and mental health & addictions services |
| Funding | None | • Ministry of Health and Long-term Care funds the adult program<br>• Ministry of Community and Child Services funds child/ youth mobile team program<br>• Canadian Mental Health Association (CMHA) funds a part time social worker<br>• COAST and Hamilton Health Sciences have a partnership with Nurse Practitioner to respond to Youth Crisis Stabilization<br>• CMHA, Halton pays for COAST Hamilton to provide an overnight crisis line<br>• Human Services and Justice Coordinating Committee provides funding for to assist with clerical activities | • The Resource Centre has funding to provide peer support 12 hours/week<br>• Approximately $700, 000 annualized funding for CAST from Ministry of Health and Long-Term Care (MOHLTC) |

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| Detoxification availability?<br>• Waiting time<br>• Assessments | • No detoxification or withdrawal management services available in this area, clients must to go to Windsor | • Residential treatment (Wayside or Aftercare)<br>• Hamilton has 7 different addiction services<br>• There is a Woman's Withdrawal Management Centre (Women Kind)<br>• Men's Withdrawal Management centre, both managed by St. Joseph's Health care Hamilton (SJHH)<br>• 95% occupancy in both male and female centres<br>• There are methadone programs prescribing doctors in the area<br>• Management Alcohol Program | • The Resource Centre has funding to provide peer support 12 hours/week<br>• Approximately $700, 000 annualized funding for CAST from Ministry of Health and Long-Term Care (MOHLTC)<br>• Holmes Houses serves both men and women, not catchment-based, has only one bed for withdrawal management service (WMS)<br>• Currently 12 people on wait list.<br>• WMS is up to 72 hours.<br>• Holmes House has 21 day residential and day treatment<br>• Addiction assessments available through the CAMHS (Community Addiction and Mental Health Services of Haldimand/Norfolk)<br>• No wait list for initial appointment<br>• Staff that work for this service have a diploma or degree related to addictions service<br>• There are Methadone dispensers in the community pharmacies. Methadone clinics accessed in Brantford, Hamilton and Wellandport |
| Psychiatric bed availability (acute) (Schedule 1 facilities)?<br>• Youth beds/adult beds<br>• Output services, community services | • 21 hospital beds (Adult)<br>• Assessed and then admitted to bed if needed<br>• Always full | • Centralized access to beds at SJHH's (approximately 80) are for acute care and 100% occupancy<br>• 10 bed safe bed program (Barrett centre) | • Norfolk General site uses Regional Mental Health Care (RMHC) London and Brantford General; provides only three out of the six beds funded for Norfolk County by the MOHLTC<br>• Haldimand site uses St. Joseph's Health Care Hamilton |

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| What tertiary care is available? | • Consumer and Family Network<br>• Family doctors<br>• Hospital<br>• Canadian Mental Health Association (CMHA) and Community Care Access Centre | Approximately 140 beds at SJHH | Regional Mental Health Care (RMHC) – London provides Norfolk County with input Mood disorders, anxiety disorders, General Adult Psych, psycho-geriatric and Output STAR Program. St. Joseph's Hamilton provides Haldimand County with identical services |
| Crisis beds? (effect of new money?) | • Recently received through CMHA | • Crisis beds (10) Barrett Centre<br>• Emergency Psychiatric Assessment Unit at SJHH<br>• Court diversion program | • Community Safe bed is funded through Erie North Shore Support; there is funding for 0.5 Full-time Equivalents, Registered Nurses(RN) available providing short-term counselling<br>• (Proposed) Mental Crisis Holding Unit ER – funded through the hospital (1–2 beds)<br>• Funding to be announced; proposal from Erie's North Shore Support Services accepted by MOHLTC. |
| Access to Primary Health Care | • Few NPs other than in hospital mental health clinic<br>• Five NPs according to The Nurse Practitioner's Association of Ontario (NPAO) registry<br>• Nurse fractioned attached to mental health hospital | • Private Family Practice Physicians<br>• Health Service Organizations and Family Health Care<br>• 13 Nurse Practitioners NPs according to NPAO registry | • Short 13-20 Primary Care Physicians for counties of Haldimand and Norfolk<br>• Successful proposal for Primary Health Care Nurse Practitioner RN(EC) Designation and unable to find candidate for primary health care for consumers of mental health and addictions services who do not have a primary care physician<br>• Consumers try to access primary health care for mental health and physical health through either the two walk-in clinics or three ER's in the catchment area |

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| What follow-up practices are used (i.e. telephone calls, face-to-face visits)? | • Standard of Care: Transfer to ER as needed or informal referral to appropriate mental health services<br>• Pilot Project: Mental Health Nurse and HELP team officer follow-up within 24 hrs of police contact | • Referrals are made to Community Services<br>• COAST provides telephone support crisis<br>• Mobile Crisis outreach face | • Follow-ups are completed, but whether if it is via phone or face-to-face depends on the individuals<br>• Short-term crisis counselling (up to six sessions) with referral to applicable community<br>• resources often by phone |
| What databases are currently being used? What is tracked and for how long? | • There are clinical and police databases, but the two are not connected. HELP team documentation is completed as per police protocol and is not clinical in nature. | • Custom designed Microsoft Access database.<br>• consultant hired to match needs to data entry | • CAST: All offices have access to online database; can update caller's history etc. immediately for next shift to see<br>• Use COAST electronic database with modifications related to community; used it between 2001–2006<br>• Can incorporate immediate electronic documentations available for all programs of agency and community partners<br>• Electronic documentation available starting 2001 |
| What is the clientele volume?<br>• What is known about who they are (age, sex, etc.) | • Clientele varies with age and sex. | • COAST: 7474 calls from population of 500,000: 1.5% of population called | • CAST: 2502 calls from population of 110,000: 2.3% of population called<br>• Callers (2005-2006):<br>- Self- 88%<br>- Direct Relative- 9%<br>- Third Party- 3%<br>• Since increase of Short Term Crisis Counselling (STCC), phone calls have decreased, but counselling sessions have increased (CAST)<br>• Top 5 reasons for 55.3 % of calls received (2005-2006):<br>• Relationship<br>• Symptoms of Mental Illness Suicidal Ideation<br>• Substance Abuse<br>- Resource ID |

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| What is the pattern of peak usage? | • During the week between noon to 12 midnight<br>• Weekends are generally slow | • During the week between 1 p.m. and 12 a.m.<br>• Wednesdays are busiest, and therefore more staff are scheduled for that day | • Late afternoon to early evening; occasionally no calls from midnight to 6 a.m.<br>• Face-to face assessments in the Emergency Department: anytime |
| Admission Rates | Unavailable. | Admissions :<br>• 60% of the people the police took to hospital need psychiatric assessment (88% for COAST)<br>• 41% of the people the police took to hospital were released (12% for COAST) | Approximately 20% or less of CAST Emergency Room (ER) assessments result in an admission to a general hospital or Schedule 1 bed |
| Who initiates support contact? Providers? Consumers? | • 494 Mental Health incidents were received from family members, care givers, police initiated and consumers. | • Police<br>• Crisis line: family, friends, service providers, neighbours, clients | • Short Term Crisis Counselling (STCC) Offered and clients can call directly to arrange<br>• Calls for first-time callers from listing in phone directory page behind 911 page; and promotional literature available in doctors' offices, clinics, churches |
| What is the rate of support vs. crisis contact (warm line vs. hot line)? | • Process to gather statistics | • No warm line<br>• Crisis line: COAST 24 hours/ 7 days a week<br>• There is telephone support, which is post-crisis to see how a client is doing<br>• Difficult to determine | • Approximately 60% of callers are experiencing a crisis or are calling as a third party for a person in crisis<br>• Approximately 40% warm line callers; no warm line available 24 hours within community |
| Crisis Services – availability?<br><br>• All: Kids helpline, Telehealth, Ontario-wide database Connex Ontario Health Services-wide service, documents mental health and court diversion<br>• Can tell you how many referred to you | • HELP team<br>• Hospital crisis team<br>• Pilot project | • Victim Services<br>• COAST crisis line<br>• Distress Centre Hamilton<br>• Suicide Prevention Line<br>• Kids Help Line<br>• Psychiatric Services at SJHH. | • Haldimand-Norfolk REACH (Child and Youth)<br>• Adult Mental Health Services (Adult Clinical Program and Specialized GeriatricServices)<br>• Haldimand-Norfolk Women's Services (Shelter)<br>• CAST:Victim Services of Haldimand-Norfolk<br>• Addictions Services Crisis Line at Holmes House<br>• REACH: counselling available for those up to the age of 18, crisis line available 24 hrs and mobile home service crisis team |

| | CHATHAM-KENT | HAMILTON | HALDIMAND-NORFOLK |
|---|---|---|---|
| Population Base | 109, 600 (2006 census) | 531,100 (2006 census) | 112,100 (2006 census) |
| Specific Services<br>• adolescents<br>• children | Paediatricians<br>Chatham-Kent Integrated Services | • Hamilton and Chedoke and Family Services and Child and Adolescent services | • REACH provides child and youth clinical services and 24-hour crisis line for 0-18yrs |
| Suicide Rate | • Suicide rates for both sexes in 1997 per 100,00 was 8.7 (Stats Canada, 1997)<br>• morality rate of suicide was 7.4 per 100,000 (Stats Canada, 2001) | • Hamilton stats (1997–2001): 366 suicides, (77% male 23% female)<br>• 2005, 51 deaths as a result of suicide in Hamilton<br>• Suicide rates for both sexes per 100,00 was 6.4 (Stats Canada, 1997)<br>• 7.0 morality rate of suicide per 100,000 (Stats Canada, 200) | • Stats not available<br>• Reports from police and ER<br>• Staff was higher last 2–3 years<br>• Suicide rates for both sexes was 7.7 per 100,00 (Stats Canada,1997)<br>• 9.1 mortality rate of suicide per 100,000 (Stats Canada, 2001) |
| Transportation Services | • Public transit in Chatham, nothing at all in Kent | Community Health Bus:<br>• **A mobile service that provides health, medical, and dental care**<br><br>The Van Program:<br>• A mobile program which provides STD and sexual health care (Free Hepatitis B vaccine, HIV anonymous testing, pregnancy testing, counselling and referral)<br>• Good transportation availability | • No public transportation<br>• Use of two vans with volunteer drivers through the Haldimand Norfolk Resource Centre<br>• Taxis<br>• Apply to Ontario Disability Support Program (ODSP), Ontario Work (OW) for financial support for medical transportation<br>• CAST Program does not transport clients for assessment, Short Term Crisis Counselling (STCC), or follow-up |
| Self-rated mental health: Fair or poor self-rated mental health both sexes, 12 years and older<br>*Statistics Canada (June 2005)* | Too unreliable to be published | 27, 065 | Too unreliable to be published |

## Appendix B: Focus Group Excerpts

Consistent themes emerged within the qualitative data:

A. all communities value their crisis services,
B. problems arise due to the lack of public transportation,
C. there is a need for immediate help when an individual is in crisis,
D. crisis programs all have peak periods where they cannot handle the volume,
E. easy access to psychiatric beds is essential,
F. consumers want peer support as part of crisis care, and
G. crisis services require inter-agency collaboration.
H. each area identify specific gaps

### A. COMMUNITIES VALUE THEIR CRISIS SERVICES

Within this study, all participants confirmed that their communities value their crisis services. Prior to the initiation of services to mental health consumers, many expressed concerns with the lack of services. When programs were implemented differences were perceived in emergency room diversions, decreased use of the criminal justice system, decreased time in hospital and decreased time in emergency department. As well an increased sense of accomplishment in terms of service provision was reported in all three communities. These all benefit each community economically and socially and in turn, enhance the morale of those served by the program.

**Examples of valuing the services included:**

**A mental health consumer remarks on the HELP team:**
"I found it really, really good… following the time that I met them; they already had some history which was really good. But ya I've met other officers before that haven't had the help team training and they were just working within their job or whatever, who, its kind of hard to umm for them to determine how much of the problem here is illness and how much is criminal act or whatever, so I had really good responses from the Help team."

**A mental health consumer comments on the COAST team says:**
"I think it's nice when the crisis team intervention starts earlier before the problem really escalates. By the time you get to the crisis nurse, even though there is still a problem it hasn't got as severe as it could have got."

**A family member says:**
"You know one thing I really like with CAST is it's linked with a small enough system with adult mental health that people get tied in really quickly… if it's identified that this person needs to talk to somebody, they've at least got that six visits feature build in…"

**A family member comments:**
"The HELP team. They are special trained officers. They're trained on the mental, with mental patient. Before it would take 2-3 officers to get him in the ambulance. Since they have been thee, they go in and he suddenly walks in, if he is still able to stand up. The training they have had has been super, I have had extremely good luck with them and I am more than satisfied their help."…

**A service provider commenting on the COAST team says:**
"I think they provide a tremendous support network to the community, I mean I think that, some individuals ah, I think are very reassured to know that PMCS is there and that they can call. I hear they have saved lives on many occasions and know that because they were available to help people otherwise there wouldn't have been anything…"

**Another family member remarked how the CAST crisis program model acts as a safety net. The model gives mental health consumers support when health care institutions, such as hospitals, cannot provide the crisis treatment that is necessary:**

"Even if formally the psychiatrist may not be available for a month, at least they are not leaving you totally dangling; somebody is going to see you for those six appointments. That there's a safety extra safety net there so that people don't feel like they perpetually have to be in a crisis mode to have someone to go to…"

**One service provider commented that referring mental health consumers to the right resources provides the most effective care for the consumers:**

"Could be part of treatment plan absolutely so when patients come in repeatedly but you know they have assisted us in the past with putting together treatment plans and for the frequent flyers so and I know so that I know that they have the resources or what is aware if they're aware of what is out there. So I mean they're the perfect point for us to just refer to knowing that they will refer the patients appropriately."

**Service providers remarked on their experiences working with COAST services, and how police mobile crisis services have benefited the community.**

"My experience also with PMCS actually instigated actually training opportunities for police ah serving and booked training experiences to officers, I think that, that's all they see that as part of their role, not just to train individuals going out on crisis calls, but they help to raise a level of awareness generally in the police department about you the kind of problems you can run into with people with mental illness.

"During the crises and a long term services because I mean I'm also long term, so the fact that there's this crises present is a great benefit to long term services because we can't be there, were not there 24 hours and it's, ah well, we use out PMCS anytime…"

### B. PROBLEMS DUE TO LACK OF PUBLIC TRANSPORTATION

There is a lack of public transportation in rural areas which is problematic when needing crisis services. Without this people may not be able to a crisis service nor easily return for follow-up appointments.

**A HELP service provider says:**

"I might add in a rural …in the country you are isolated as well so the crisis nurse is going to the home with police then they both have back up as opposed to when you are out here on the country road all by yourself. If you call for help then it could be forever before you they get to you so going together you have specific backup."

**An ACT team service provider remarks on the social isolation in rural areas, which is further affected by the lack of available transportation.**

"… We are a small enough community that we can be very well connected…but then we have this geographical isolation and transportation issues. There is no city transportation at all. That is why we really need some kind of mobile services."

**A CAST service provider says:**

"I mean even transportation is such a major problem."

**A HELP team service provider says:**

"…We have a service that provides transportation there but won't provide transportation back. So there's all those kind of issues."

**A mental health consumer says:**

"…I was under form in a hospital, took off, eloped, umm whatever they call it and came back to Simcoe, was picked up by police, umm, Simcoe police didn't want to drive all the way to Brantford. Brantford police, that's where I was in hospital. Brantford police didn't want to drive all the way to Simcoe, so they drove half way, and there I sat and waited in the Simcoe police car for the Brantford police to get there and then got switched and taken from Brantford police back to the Brantford hospital, and you already feel like shit."

### C. WHEN PEOPLE ARE IN CRISIS THEY NEED HELP IMMEDIATELY

**COAST uses a support team that helps mental health consumers in crisis as pointed out by a mental health consumer.**

"I had a situation where I was upset one night and I called COAST crisis line and said, well I guess they're a support team, they actually came to my house and ah sat down together with my family members and uh and we and we discussed why you know ah discussed why I was so upset and they helped me…"

Mental health consumers comment on the need for an immediate crisis line.

**A HELP team consumer says:**

"And then that maybe would help people not get to the crisis, if there was a warm line."

**A CAST consumer remarks:**

"But if you're at home, in crisis and you've probably built yourself up to that level where, okay, now I'm going to call because it's so bad, and then you get an answering machine, what I mean."

**A family member comments:**

"And my situation ah was pretty similar ah they had an attitude when we phone it my niece was in distress ah so I called the COAST for her and they gave me an attitude ah they said they will come down and they never showed up."

### D. CRISIS PROGRAMS NEED THE CAPACITY TO HANDLE VOLUME.

Crisis by their nature are often unpredictable, at some points several crisis will cluster together and staff may be challenged to handle the volume at other times things can be slower.

**A CAST service provider commented on the shortage of staff within the crisis program.**

"…I mean one of the things that the local crisis program has had to deal with lately is the shortage of staff, that we have been informed off the record that there nobody available between 11 pm and 8 in the morning or 7 in the morning. Their people are going to leaving a message."

**A CAST service provider says:**

"And not get called back till 7 in the morning, right, so if it's 2 am and you're leaving a message and you're expecting a call back and you're not getting one for 5 hours. That is a concern from our standpoint and I'm not placing blame, there is a shortage of staff there, for whatever reason and I'm not sure why. But that, I am ware that's the situation they have been dealing with and trying to cope the best they can and I know that some of their staff is working 12-6 hours shifts on a crisis line…"

These points also highlight issues related to appropriate staffing in smaller communities.

**A COAST service provider says:**

"I think just going along with more resources sometimes quicker response would be and it's just not possible I know that there are limited ability to go out in the night cause there is only one staff and it would be great to be able to have that kind of all night, but I think these are tied to funding issues."

**A HELP team service provider remarks:**

"I think, you know, in terms of our service, our priority population is those with severely mental illness so we don't provide service for moderately mentally ill etc. Those are services afforded through, you know, employee plans etc., umm and it's not something we can provide it's you know, is that something that we could I'm sure certainly but if we don't have the provision or the resources to do so…"

### E. EASY ACCESS TO PSYCHIATRIC BEDS IS ESSENTIAL

During a psychiatric crisis a hospital bed may be needed. Without a system to access beds much time can be spend waiting in the emergency services.

**An Ontario Provincial police service provider, comments on the absence of beds for mental health consumers upon arriving in hospital.**

"One thing is, that when we go to the hospital, we can't keep them (police) there because there's no beds in this area."

**A CAST service provider says:**

"Because we can't I mean the first thing the patients the people you bring in have to be medically clear then we have challenges accessing beds or psychiatric even just psychiatric assessments when we try to make sure try to get the police out of here as soon as possible but you know here are some limitations."

### F. CONSUMERS WANT PEER SUPPORT AS PART OF CRISIS CARE

Peer specialists are regarded as a critical component in assisting consumers during crisis. They described the difference between a "hot line" which provides immediate attention and a "warm line" which provides support. Peers are seen as providing the support. Consumers described follow-up peer programs as an essential and describe it as a positive experience.

**A CAST mental health consumer comments:**

"Well, I worked as a follow-up with a (crisis team) and I found them great to get along with, and, and to work with, and I found that when you took someone over as a peer specialist they, they treated the person, well they treated the people fine anyways, but they treated them better when they had someone with them…"

In Chatham-Kent, the HELP team can contact the Chatham-Kent's community survivor network. There are peer supporters there to assist with mental health consumers in crisis.

**A HELP team service provider comments:**

"They've got some peer supporters there. And the (Crisis) team's got an open invitation, if they have somebody that's in crisis that maybe needs somebody that can understand a bit more, we can drop them off there."

**A CAST mental health consumer says:**

"And I think when you're in crisis knowing that you, having that person just sit there and take the time, that is, so that's life saving stuff, to have somebody take the time to just sit and be with you and not rush away."

**A COAST consumer says:**

"…So I think it would be good, you know, like, say a person just needs to talk, to talk things out, and to have some sort of, you know peer person there, that they're job alone is just to talk, talk to the person, listen to the person, I know that they're not a service for talking too…."

**A family member comments:**

"I think they need more people working there that have actually been through umm crisis or something someone that will understand. Like you said they don't take you seriously."

**A mental health consumer remarks:**

"Sometimes I find I'm not quite at the crisis point but I need somebody to talk to, when it's when it's like after hours because I don't have a psychiatrist anymore so sometimes I just need someone to talk to and calm me down before I reach that point where I am going to do something stupid and I know it's stupid but it's a release so it's, I don't know if it's because you need people like consumers who had gone through similar situations or if you need better train some of the staff or I had the same problems too with trying to get through to COAST sometimes it's impossible.

### G. CRISIS SERVICES REQUIRES INTER-AGENCY COLLABORATION

Many crises require collaboration between multiple agencies and systems. The collaboration also needs to include clients and their families.

**A family member says:**

"Okay, I have had several interactions with the police both before the (crisis) team and since the (crisis) team. I cannot think of anything against the (crisis) team; they have been super and they not only took care of my son but they were very concerned about my condition, my wife's condition. They were very professional. But I can't say the same about the people in emergency."

In the focus groups, individuals commented many times on the collaborative interaction between health care providers and police officers.

**A family member says:**

"I find that the police, …, since I've been involved with them have been very understanding been to meetings with him tried to get him what he needs but of course he uh he's not on his medication and I found them to be very, very genuinely interested in him, trying to help do what they could…"

**A service provider says:**

"For me maybe, with the corrections background, I like the connection between mental health and the police and a sense that the (team) are assisting them in the training of the police in terms of how to better work with, uhm or ah, handle psychiatric offenders in crisis, because obviously for years a lot of police officers didn't have that training and really didn't know how to respond, so I think that it's an excellent service."

Hamilton's addiction service program collaborates with COAST services, together they assist in mental health education.

**A service provider says:**

"I find it really comforting actually, I was ah supervising offsite addiction service when it first, when I first started at Police Mobile Crisis Services (PMCS)with the majority of my staff didn't have a background in mental health, just in addictions and it was nice to have something kinda, rather than that just the hospital 'cause there was lots of cases that we were able to uhm PMCS help probably prevent admission, uhm, and probably won't be able to do that without the help of PMCS."

**Services work in partnership with other agencies to help provide best practices for mental health consumers in their communities. COAST service providers commented on the positive effects of utilizing police mobile crisis services:**

"I think over the years PMCS has become well integrated into the existing system. I don't think it's seen as a separate entity so much as one part of a continuous chain of services. I think that has been a really good development…"

"… I'm only speaking as an administrator 'cause I don't work in the frontlines as a social worker, but what I see is if we have a difficult-to-manage or a difficult-to-place client, PMCS is quite good in the sense that we can bring the individuals' name to their attention and they will follow through in terms of assisting us with discharge planning, and even bringing other community agencies into the picture to assist in placing some of our guys…"

**Psychiatric services are viewed as an effective and beneficial means for developing and maintaining a continual relationship with mental health consumers**

"I think some of the patients as well, they've actually been able to have successful tenants in the community, because their phone calls are never turned away, so you know, I'm aware of clients who will phone PMCS at least once a day and that becomes their, like, their follow up in the community and has kept them out and prior to that, they of been in emerg, but to have that contact, and you know you have someone at the other end of the phone, keeps people successful in the community."

### H. EACH AREA IDENTIFIES SPECIFIC GAPS:

Positive comments were made valuing:

a) police officers out of uniform,
b) unmarked cars,
c) safe rooms in Emergency department

**a) Mental health consumers feel that interaction with a police officer in plain clothes is less intimating and helps to eradicate stigma surrounding mental illness.**

**A mental health consumer remarks how helpful it is that the HELP team police officer is in plain clothes.**

"It's easier to talk to someone who are in plain clothes and just one on one and it's a lot easier to talk to just your average Joe who understands you rather than calling someone with a badge and you know someone coming in, like a police officer."

**b) A COAST service provider comments on the importance of police officers not wearing uniform, which in turn, produces positive effects on individuals with mental illness.**

"A very simple point I think is that fact that the police don't show up in marked cars and wearing uniform and I think that's stimuli that you know can eventually provocative to a person in crisis.

**c) A service provider from CAST remarks:**

"And it's reassuring again to know you can take them to the hospital, and have somebody there that's gonna meet you there and try to get at the situation and the problem."

**A service provider from CAST comments:**

"The partnership has worked really well, and it's improved here a lot for the simple fact that we have quiet rooms in the hospital, (program) has an office there now. It benefits us that we can leave someone there in being reassured that they are going to get help."

**Negative identified specific gaps:**

a) stigma associated with mental health in all communities.
b) lack of resources in rural areas.

**a) A HELP team consumer says:**

"Getting into that hospital is the worst thing for anybody. To be brought into a hospital by police is probably the most stigmatizing thing that you can ever, you know imagine."

**b) A CAST service provider comments on the lack of reception of communication technology available in rural areas.**

"Well the computer issues can be very frustrating. We don't have the same access to internet services and things seem to go down…you can't even get the wireless phone service reception in all areas of the county."

## Gaps

Each community identified gaps within the three crisis models: HELP team, CAST and COAST services. From the focus groups findings, family and consumers have identified changes that can be made to the models. Community specifies difficulty in covering large geographic area.

In Chatham-Kent, participants comment on the HELP team:

**The participants' feedback on the HELP team model suggested the following:**

"So my perception when I was initially told about this the new mobile crisis response team was that it was very favourable. And having met with individuals involved with that umm I can maintain that perception my concern is that it will simply start and stop with two people covering an entire county and or disappear entirely."

**A Participant who called for HELP team services comment on the lack of staffing within the county.**

"we have a population of well over a hundred thousand within our municipality and one police officer and one nurse … it's not going to cut is for the moment for the municipality. When waiting for the help team which is a wonderful idea in theory and I have called numerous times and never once, I mean I have met health team members, health team members certainly not when they have been called. There are one or two health team members per shift to cover the whole municipality and they are not there specifically there for that reason, they are there as police officers maybe they can come, maybe they can't…"

**In Haldimand-Norfolk identified gaps found in CAST services:**

In Haldimand-Norkfolk there is a 24 hour crisis line and accessibility to face to face assessment in the emergency room. However, in this county there is no Police Mobile Crisis program. The findings illustrates that individuals with mental health crisis would benefit from a Police Mobile Crisis program.

**A mental health consumer comments:**

"The solution if we're back to dreaming is the mobile unit. They had a mobile crisis team that would solve a lot of problems because…"

**A mental health consumer says:**

"…It sounds like people are generally happy with the CAST program but that there in a perfect world there's be augmentations such as having more accessibility, in terms of things like warm water, warm bed, more peer support built into that umm the idea of transportation being a big issue so that mobility and mobile services again not necessarily crisis but jut having things available when you need them for recreational types of things. Umm that in rural areas compared to urban area there's a lot of issues around resources being spread more thinly, people having difficulty not only because of access to transportation but because they just don't exist in the same number, because there is not the same critical mass."

In Hamilton, identified gaps found within COAST services:

In Hamilton there is difficulty in needing all consumer/family expectations around urgency.

As indicated by a service provider from a focus group, family members find a prevalent gap in COAST services to be its stringent admission criteria

"Most of the feedback that I have ever got about PMCS has always been positive, the only time you ever get negative feedback is when you have frustrated families who want their family member admitted, but they don't meet the admission criteria or they don't, there not an formable, so they then they get frustrated for PMCA for that reason."

**A mental health consumer says:**

"And umm, then, then, the other people, the people can be concentrating on well, triaging as far as where, you know, do you need somebody sent out, a team sent out, or do you just need a just crisis plan or what, umm but they need to have more lines so that we can talk and umm then they need to start introducing a better suicide protocol."

**A mental health consumer says:**

"…So, I really think it would be good, you know like, say a person needs to talk, to talk things out, and to have some sort of, you know, peer person there, that they're job alone is just to talk, talk to the person, listen to the person."… But, there needs to be a proper service established that would do that, talk people down and that."

# Appendix C: Consumer and Family Satisfaction Survey

## CRISIS SERVICES

### CONSUMER/FAMILY SATISFACTION SURVEY

Date: ____________________

Location/City: ____________________

**1. I have accessed the Crisis Service in my community, either for myself or for a family member/loved one.**

☐ True ☐ False

**2. The Crisis Service in my community is easy to access.**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Agree | Somewhat Agree | Neutral | Somewhat Disagree | Disagree |

**3. The Crisis Service in my community conduct themselves in a professional manner.**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Agree | Somewhat Agree | Neutral | Somewhat Disagree | Disagree |

**4. The Crisis Service in my community responds in a timely manner.**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Agree | Somewhat Agree | Neutral | Somewhat Disagree | Disagree |

**5. I am satisfied with the services offered by the Crisis Service in my community.**

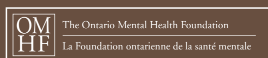
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Agree | Somewhat Agree | Neutral | Somewhat | Disagree |

**6. The thing I like most about the Crisis Service in my community is:** ____________________

**7. The thing I like least about the Crisis Service in my community is:** ____________________

## Notes

CONCEPT & DESIGN: SOAPBOX



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