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Canada

Supplementary Report: Summary of Knowledge Exchange Events

Waterloo Wellington Crisis System Evaluation:
Understanding the Impact of Enhanced Programs and Coordination

Systems Enhancement Evaluation Initiative (SEEI)
Phase 2 Study

October 2008

seei
systems enhancement evaluation initiative

The Ontario Mental Health Foundation
La Fondation ontarienne de la santé mentale

Ontario

trellis
MENTAL HEALTH AND DEVELOPMENTAL SERVICES

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

This project was supported by:

The Ontario Ministry of Health and Long-Term Care

Through a System Enhancement Evaluation Initiative grant administered by:

The Ontario Mental Health Foundation

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1.0 Introduction

In the late fall of 2007, funding was made available through the Systems Enhancement Evaluation Initiative (SEEI) Phase 2 Studies Knowledge Exchange Fund to enhance the knowledge transfer and exchange components of the SEEI Phase 2 studies. Based on a proposal submitted to the fund by the Waterloo Wellington Crisis System Evaluation (a Phase 2 study), two Knowledge Exchange Events were held in Wellington County and Waterloo Region in September 2008.

The Waterloo Wellington Crisis System Evaluation was a two-year, formative evaluation of the Waterloo Wellington Regional Crisis System involving multiple stakeholder perspectives. The overall purpose was (1) to assess formatively[1] the development of the Waterloo Wellington Regional Crisis System, and (2) to document in a preliminary way, the impact of crisis system enhancements on the quality of services received by people with lived experience who were 18 years of age or older. Given the formative nature of the evaluation and the early developmental stage of the regional crisis system, crisis system outcomes were not directly measured.

The specific investigative aims of the evaluation were to measure the extent to which various crisis system service components[2] made progress towards the following:

1. Increasing the Five Components of Continuity of Care: Coordination, Timeliness, Accessibility, Comprehensiveness, and Intensity
2. Implementing system-level coordination activities consistent with best practices.
3. Increasing the appropriate use of hospital emergency rooms, police services, and crisis services.
4. Resolving presenting crises within a community setting.
5. Promoting practices consistent with principles of recovery.

The resources created to design and implement the evaluation included a review of the relevant literature on evaluating crisis services and systems, the development of a system-level logic model, and a multi-method evaluation plan that included:

- Interviews with people with lived experience and family members residing in Waterloo Region, Wellington County, and the City of Guelph (n = 35)

[1] Formative evaluation focuses on describing and strengthening service design and delivery, in support of improved outcomes (Scriven, 1967; Posavac & Carey, 2003). As a result, it looks primarily at processes of service/system design and implementation.
[2] Regional crisis system service components include crisis telephone lines, mobile crisis teams, police services, and hospital-based services (e.g., hospital emergency rooms).

- A survey provided to police officers, hospital emergency room staff, and front line staff of crisis services based within community mental health organizations (n = 73)
- Statistical data from police agencies, hospitals, and community mental health organizations
- Publicly available documents, reports, and statistics

The purpose of the Knowledge Exchange Events was to engage in an interactive dissemination and discussion of findings of the Waterloo Wellington Crisis System Evaluation with key local stakeholders, including:

(a) People with lived experience and family members

(b) Members from the Waterloo Wellington Regional Crisis Committee and the Mental Health and Addictions Planning and Advisory Committee

(c) Representatives from:

- The Local Health Integration Network
- The Ministry of Health and Long-Term Care
- The Ontario Mental Health and Addictions Knowledge Exchange Network
- Mental health crisis services (e.g., crisis lines, mobile crisis services, crisis respite beds)
- Local hospitals
- Guelph Police Service
- Waterloo Regional Police Service
- Wellington County Ontario Provincial Police

(d) The research team

Invitations to attend the knowledge exchange events were circulated primarily via email to several organizations and individuals operating, working and living within the region, including:

- People with lived experience and family members[3]
- The Ministry of Health and Long-Term Care
- The Ontario Mental Health and Addictions Knowledge Exchange Network
- The Waterloo Wellington Local Health Integration Network
- The Systems Enhancement Evaluation Initiative (SEEI) Coordinating Centre
- The Centre for Addiction and Mental Health (CAMH)

[3] People with lived experience and family members who had participated in an interview as part of the evaluation were contacted individually via telephone regarding the knowledge exchange events. If interested, they were asked to provide their email or mailing address so that information regarding the knowledge exchange events could be sent to them.

- The Waterloo Wellington Regional Crisis Committee
- The Mental Health and Addictions Planning and Advisory Committee
- The Human Service & Justice Committee
- Individuals within each Waterloo-Wellington crisis system organization (i.e., community-based mental health agencies, police services, and hospitals) who had served as the main evaluation contact for either (1) the distribution of the staff survey, (2) the collection of crisis system statistical data, or (3) hospital Research Ethics Boards
- The Self Help Alliance (a verbal announcement was made at two separate staff meetings)
- The volunteer coordinator of Trellis Mental Health and Developmental Services, and the Faculty of Social Work at Wilfred Laurier University[4]

All invitees were asked to circulate the invitation to anyone they thought might be interested in attending. Persons planning to attend were asked to register in advance of the events.

Both knowledge exchange events were attended by representatives from all the key stakeholder groups identified, as shown in Tables 1 and 2:

Table 1: Attendance at the Wellington County Knowledge Exchange Event

Wellington County, September 8, 2008: Total attendance = 36	
No. of participants	**Stakeholder Group**
3	People with lived experience and family members
4	Waterloo Wellington Regional Crisis Committee and the Mental Health and Addictions Planning and Advisory Committee
1	Waterloo Wellington Local Health Integration Network
3	Ontario Mental Health and Addictions Knowledge Exchange Network
12	Mental health crisis services, including the crisis line, mobile crisis, peer support
5	Local hospitals
3	Local police services
2	Community researchers
3	Waterloo Wellington Crisis System Evaluation research team
36	**Total**

Table 2: Attendance at the Waterloo Region Knowledge Exchange Event

Waterloo Region, September 10, 2008: Total attendance = 28	
No. of participants	**Stakeholder Group**
2	People with lived experience and family members
3	Waterloo Wellington Regional Crisis Committee and the Mental Health and Addictions Planning and Advisory Committee
1	Waterloo Wellington Local Health Integration Network
1	Ministry of Health and Long-Term Care
1	Ontario Mental Health and Addictions Knowledge Exchange Network

[4] Invitations were circulated to these two groups so that students working in the area of mental health could attend as a means of promoting knowledge exchange in the field.

Waterloo Region, September 10, 2008: Total attendance = 28	
No. of participants	**Stakeholder Group**
11	Mental health crisis services, including the crisis line, mobile crisis, crisis respite, and peer support
4	Local hospitals
2	Local police services
3	Waterloo Wellington Crisis System Evaluation research team
28	**Total**

2.0 Overview of Knowledge Exchange Events

Both knowledge exchange events followed the same agenda:

1) Presentation of the objectives, methods and findings of the evaluation, followed by a question and answer period.

2) Breakout Session #1

Participants were assigned to small groups, with each group having representation from as many stakeholder groups as possible. Each group was asked to consider the following questions from the perspective of either police services, hospital emergency departments, or community-based crisis services (i.e., crisis lines, mobile crisis teams, crisis respite beds, service resolution with flex funds):

Q1: What was significant about the evaluation findings for your particular sector?

Q2: What did you learn from each of these local sectors that would be important to carry forward toward future service planning and development?

Once the small group discussions were finished, participants reconvened and presented the results of their discussion to the larger group. A question and discussion period within the larger group setting regarding these results was also held.

3) Breakout Session #2

Participants remained in the small groups assigned during the first break out session, and were asked to consider the following questions from the point of view of the crisis system as a whole:

Q3: What have we learned that will help us evaluate and monitor the regional crisis system as we move forward?

Q4: Are there specific indicators that have emerged that we can use?

Q5: With respect to a recovery focus in the regional crisis system, what did we learn that will be important to carry forward to future service planning and development?

Again, participants reconvened into the larger group setting to present and discuss their results.

Participants were then asked to engage in a "dotmocracy" process, in which everyone was provided with two different coloured dots and asked to select their first and second priorities for evaluating and monitoring the regional crisis system.

4) Wrap Up and Next Steps

Concluding comments and announcements regarding other upcoming meetings and knowledge exchange events were made. Participants were advised that the Waterloo Wellington Regional Crisis Committee will begin developing an action plan based on the results of the evaluation and the feedback received from both knowledge exchange events. Participants were invited to complete a Knowledge Exchange Event Feedback Form, and thanked for their participation.

3.0 Findings from the Knowledge Exchange Events

The following section summarizes the feedback received from participants over both days through (1) the breakout sessions, (2) the "dotmocracy" process, and (3) the evaluation feedback form.

3.1 Breakout Session Feedback

The feedback from the breakout sessions has been summarized according to the five questions that were asked over both sessions.

Q1: What was significant about the evaluation findings for your particular sector?

Participants reported that they found the following evaluation findings to be the most significant, depending on whether they were coming from a police service, hospital emergency department, or community-based crisis service perspective.

Police Service Perspective

- Police officers are not trained to deal with mental health issues, and spend too much time in hospital emergency departments
- There is a lack of integration regarding some community resources, and some confusion regarding who police should call and when
- Police have concerns regarding access to inpatient and crisis respite beds: more immediate access to crisis respite and safe beds is needed
- There has been an increase in the use of mobile crisis teams by police
- Police have a good partnership with the mobile crisis team in Guelph
- Urban police response times perceived as favourable, while rural response times are seen as a concern
- The evaluation findings emphasized the importance of education and awareness between the sectors of the crisis system, and the importance of collaborations, partnerships, and inter-agency service protocols
- Given current data management systems, police have limits in their ability to contribute to data and evaluation
- The increased regional funding to hospitals and community based services has not yet translated into reduced hospital emergency room wait times for police – when and how will the changes to the system benefit police services?
- Number of *Ontario Mental Health Act* apprehensions in the region has decreased – have there been any increases in violent activity or criminal charges?
- Number of interviews conducted with people with lived experience and family members may be low for the population being represented
- Regional service resolution has been a good support for police services: allows police to be person-focused after the initial crisis

Hospital Emergency Department (ED) Perspective

- ED wait times may need to be measured using the same criteria at all six hospital sites for meaningful comparison
- Hospitals need to look at how they connect with the person with lived experience at the front door: even if there is a wait, how can the hospital ensure that the individual receives privacy and respect
- Some concern regarding the high expectations surrounding the Emergency Mental Health Service at Guelph General Hospital: will not be the answer to all of the issues facing the regional crisis system
- Areas of improvement noted (e.g., funding, expansion of services) between hospital and community-based services
- May be some possible frustration and disappointment that system efforts at improvements do not seem to be reflected in the perceptions of people with lived experience
- There are limitations to hospital (and community-based) responsiveness to emerging needs and gaps in system due to various funding structures

- Lack of community services for transitional care can perpetuate individual's crisis, especially for people with more intensive needs such as borderline personality disorder
- Community may not have resources to absorb the number of individuals who present at the ED
- There is a need for more high-support beds outside of a hospital setting
- Historically, there has been a lack of acknowledgement regarding Wellington County needs: the current evaluation findings highlight some of these needs and service gaps
- It is hoped that the evaluation findings will encourage better handling of mental health issues in the ED (e.g., increased use of crisis line and crisis respite by hospital ED staff)
- Family members first reaction may be to go to the ED even if there are more appropriate services in the community
- Hospitals are part of the crisis system and needs to work with community services (sometimes hospitals think they are their own system)
- Cambridge is a very separate community and needs more connections to outpatient services

Community-based Crisis Service Perspective

- Police are not mental health experts, and do not always know what to expect on a mental health related call for service
- Police may also not have the necessary resources in place
- Education and awareness of services for people with lived experience is needed: continue to advocate for the crisis line as good source of information
- There are regional gaps in 24/7 response for seniors and children: need to integrate these services with adult services
- Community-based crisis services need to be accessible 24 hours
- Rural transportation to community-based crisis services remains an ongoing issue
- Evaluation findings provide a lot of useful information regarding who is accessing crisis services, but we need to know more about who is not accessing services because of barriers related to culture, language, age, poverty, complex needs (e.g., borderline personality disorder), disabilities, etc.

Q2: What did you learn from each of these local sectors that would be important to carry forward toward future service planning and development?

Participants reported that the following issues should be considered further as part of ongoing service planning and development.

Police Service Perspective

- Police are seeing the same individuals repeatedly: how can the crisis system address this more effectively?

- Currently, services appear fragmented around individual: more service integration could lead to lower rates of recidivism
- Region needs more crisis respite and safe beds (introduction of new youth shelter will help the situation)
- The large geographical area of the Waterloo Wellington LHIN poses challenges in developing inter-agency protocols
- Need continued partnership development, including education, protocol development and implementation
- Agencies involved in the crisis system have different mandates and roles: need to be aware of each other's roles
- Need increased sharing of information between sectors
- Recovery oriented follow-up services are important so that people with lived experience and family members are supported in the community after the crisis has passed
- Awareness and usage of individualized crisis plans (WRAP) needs to increase so that individual can access resources and services as needed
- Need to consider the unique needs of children, youth, seniors and individuals with differing cultural backgrounds
- How do we change service pathways so that the usage of inappropriate police time decreases?
- Need to implement training methods that will continue to increase police knowledge and experience regarding mental health services and the crisis system:
    - dispatch police with mobile crisis teams (shadowing)
    - restorative justice model (youth and police)
    - police training days
    - invite police into community agencies

<u>Hospital Emergency Department (ED) Perspective</u>

- Emergency departments are seeing the same individuals repeatedly: how can we track the individuals who present to the ED continuously → this can help us to better identify potential gaps in the system (e.g., lack of community follow-up)
- Are there peak times for the occurrence of mental health issues? If this occurrence is predictable, then ED can bring in more staff at peak times
- A more coherent use of individualized crisis plans (WRAP) and history of the person with lived experience's mental health issues is needed at the hospital door/entry to service: this information needs to be accessible across the crisis system
- Access to community-based psychiatric care and follow-up at discharge from hospital is needed (including medical follow-up)
- Need more extensive community-based supports and resources (e.g., crisis respite beds) to take the pressure off hospital ED to be "everything to everyone" - ED is still viewed as the default service in crisis situations
- How should hospitals link to community services and invite them into the ED?

- Crisis system needs to be supportive of innovative community services and approaches (e.g., peer-run initiatives)
- More seniors are presenting in the ED who shouldn't – need a system in place so that seniors can be successfully diverted to community services
- There is a recognized lack of linkages between youth, adult, and senior services: service silos exist not just across sectors but across age groups as well (regional service resolution is looking at these links)
- More education is needed across the sector about the roles within crisis service provision: do we know what limitations exist for each area of the crisis system?
- Need to continue education and relationship-building between hospitals and police services
- Need to focus on inter-ministerial collaborations to respond to high need individuals (e.g., police, hospitals, corrections, community agencies, etc.)
- Would be ideal to have a peer worker and community-based crisis worker available in the hospital ED working together: easier to move people back into community when appropriate
- Mental health triage that provides a quite, secure area for waiting is absolutely necessary: will help change people's perceptions of wait times and overall hospital experience
- When a person is in crisis, anytime to wait is too long…therefore we need to focus on providing a comfortable, safe environment if the person has to wait (while continuing to address wait times)
- More consistency needed in liaison between ED and after-hours crisis services
- The issues facing the ED are actually system-wide issues related to service provision capacity in the community: we need to learn to not blame each other for system flaws – we are all part of the solution
- Need to continue working on system-wide information systems (e.g., crisis plans) so that hospital data can contribute to system evaluation
- Need to keep the focus on early intervention and support so that the crisis system does not need to rely on the *Ontario Mental Health Act* (e.g., forming someone to get service)
- Target resources at prevention to reduce criminalization of MH issues
- Need more feedback from rural hospitals in the region
- Is more collaboration possible across the hospitals in the region?
- Cambridge Memorial Hospital relies on services in London, ON for all serious mental health efforts: future enhancements to the regional crisis system need to ensure that Cambridge Memorial Hospital has its own resources
- A significant issue for the region is crisis staff turnover: individuals leave a position and there is no knowledge or experience translation → need systematized linkages for knowledge translation rather than links that are dependent on individual people
- A related issue is the overall need for more staff working within the crisis system: enhancements to the system are highly positive, but need staff to implement and maintain them

- Hospitals need to continually keep recovery principles in mind (e.g., through ongoing staff training)
- Hospitals can promote stigma regarding mental health issues, but are recognizing this and working to reduce the stigma

Community-based Crisis Service Perspective

- Need to expand continuum of community-based services to include peer run crisis or safe beds
- Need to divert crises away from the hospitals and into community: crisis services have to start in community, not the ED
- ED as gateway to community mental health is not an ideal entry point: need to move to community directly
- System should continue to support and advertise the crisis line for police and people with lived experience
- Access to referrals and follow-up after crisis is over needs to be addressed: remove barriers to access and longer-term services
- Also need to increase access to practical life-skills training and education
- Individualized crisis plans (WRAP) need to be developed in advance of a crisis so that the crisis system knows how to respond
- Consider adding medical consult services to mobile crisis teams
- Evaluation findings highlighted the ongoing issues of accessibility for rural populations: need to continue to address this issue
- Why is it sometimes the case that an individual has to be in crisis to get good services?
- Relationships between the different sectors are very important in creating efficient access to services – more work is still needed
- Need to involve people with lived experience and families in planning and evaluation of the crisis system
- The crisis system should link to other partner systems (e.g., domestic violence)
- Transition aged youth highlight a gap in the system that needs to be addressed
- Would there be a need for crisis services if there were more long-term supports available within the mental health sector? Examples include case management (2-3 contact/week), ACTT (more in the region), housing, outreach, supported housing, borderline personality disorder services, bridging supports from youth to adulthood

Q3: What have we learned that will help us evaluate and monitor the regional crisis system as we move forward?

Building on and connecting back to the findings of the evaluation, participants reported a number of issues, items, and ideas for evaluating and monitoring the regional crisis system:

- Need to have system-wide consensus on how we define a crisis
- Need to ensure common, consistent data indicators across all services: need to address staffing, resources, and other issues such as data management systems
- Look at success stories so we can learn from what's working
- How can evaluation help us to address immediate concerns of the system?
- Qualitative and quantitative aspects are both important to understanding and evaluating the system
- Future evaluation efforts should increase sample size in order to get broader perspective
- This evaluation should become the baseline for future studies
- Have learned the importance of benchmarking for future studies
- Recidivism: same people are constantly in and out of system →how do we evaluate what impact this has on follow-up services?
- Recidivism: how many times are services used? What's working for the individual?
- ED wait times and recidivism rates: need to investigate the adverse outcomes of continuous ED visits vs. community interventions
- Need to measure the amount of time police spend with people with lived experience
- Need to identify the best points or service junctures to collect evaluation data from people with lived experience and family members
- Need a way to track individuals across services
- Need to continue to evaluate and monitor system communication
- There is a lack of information regarding populations who are not accessing the system: need to gather this information somehow
- Agencies should collect the list of services that an individual uses during a crisis, then check in 6 months to track services that individual uses or is linked to: may highlight a whole area of services not being accessed
- Should track the ages of people who access services
- Should raise awareness of available crisis services through on-line resources, especially for youth and young adults
- Only the formal sections of the crisis system were evaluated: need to consider the informal as well such as spiritual, family, education, work, recreation, etc.
- Need to evaluate how recovery principles operate within the crisis system: the language used, labelling, medical connotations
- Need to evaluate the outcomes for complex needs: dual diagnosis, people with mental health and developmental concerns, substance abuse issues

Q4: Are there specific indicators that have emerged that we can use?

Participants reported that the following indicators, many of which were used and/or identified in the evaluation, would be useful for future evaluation studies:

Table 3: Outcomes and Associated Indicators for the Regional Crisis System

Outcome	Indicator
Reduce wait times for crisis services	▪ Average number of hours spent by police in ED waiting for resolution to mental health cases ▪ Average length of ED wait time for individuals in crisis (define what is meant by "ED wait time" consistently across the system) ▪ Average response time of mobile crisis teams ▪ Average numbers of hours (or days) wait from ED presentation to disposition (e.g., admission, community follow-up, etc.) ▪ Average wait times for community based services ▪ Number of days spent in inpatient bed waiting for a Schedule 1 bed (as an indicator of wait time not spent in the hospital ED)
Reduce recidivism rates	▪ Number of repeat client cases including those related to (1) police involvement and/or (2) presentation at the ED, and (3) community-based crisis services ▪ Number of ED readmissions related to mental health issues
Increase appropriate use of community-based crisis services	▪ Number of diversions from hospital ED to mobile crisis teams and distress centres ▪ Number of Form 1 and Form 2 ▪ Referral sources to crisis respite beds ▪ Number of individuals served by short-term crisis respite beds ▪ Number of individuals served by regional service resolution (including the flex fund) ▪ Number of discharge plans created for individuals leaving hospitals ▪ Number of community services that are available for discharge and/or diversion ▪ Number of times that police contact mobile crisis ▪ Number of times police bring individuals in crisis to ED compared to total number of mental health calls received (%)
Increase crisis resolution (within a community setting when possible)	▪ Number of attempted suicides, and number of actual suicides ▪ Number of individuals who do not require hospital admission but who are not sent home because there are no community crisis services available to them ▪ Number of service resolution meetings conducted after a crisis ▪ Number of individuals who decline services: who, what, and why
Reduce inappropriate contact with the criminal justice system	▪ Number of Ontario *Mental Health Act* apprehensions ▪ Number of mental health coded calls received by police resulting in apprehension compared to total number of mental health coded calls (%) ▪ Total number of mental health related calls to police and their outcomes: apprehensions, referral to mobile crisis, criminal charges, ED presentation, etc. ▪ Comparison between number of mental health related calls for police service (and nature of contact) pre WRAP development and post WRAP development
	▪ Number of WRAPS being created, shared and used across the

Outcome	Indicator
Increase use of individualized crisis plans or WRAPS	system ▪ Number of WRAPS that are revised annually ▪ Number of WRAPS on file at different agencies ▪ WRAPS can include consent for data to be used in future evaluation studies
Increase satisfaction with the crisis system	▪ Level of satisfaction among people with lived experience, family members, and crisis system staff members

Q5: With respect to a recovery focus in the regional crisis system, what did we learn that will be important to carry forward to future service planning and development?

Participants commented on numerous issues related to a focus on recovery within the crisis system and to the findings of the evaluation regarding the implementation of recovery principles, including the following:

- Recovery principles should be valued and commonly and consistently applied by everyone working in the crisis system
- Need to develop a mechanism to evaluate the application of recovery principles in the crisis system
- The importance of input and involvement from people with lived experience and family members needs to be recognized with regard to the planning, development, evaluation, and improvement of crisis services
- The role and benefit of peer support in crisis situations should be acknowledged by the entire crisis system
- An ongoing training and support system for peer workers is needed
- Education and training efforts should continue for police and hospital staff
- Need to continue education and training regarding WRAP and in incorporating recovery principles into crisis system
- Part of the WRAP development process needs to include plans that are self-directed by person with lived experience
- WRAPS need to be continually updated and utilized
- Crisis respite offers a place to stay, and this crisis service component is an important part of recovery
- System needs to ensure a seamless transition from crisis to intensive community support and follow-up
- It is the crisis system that needs to be flexible, not the individual
- Crisis system should recognize the “no wrong door” approach: it is everyone’s responsibility to assist a person in navigating to the right service
- The principles of recovery need to be translated and applied to various ethno-cultural communities

- Crisis system needs to be person-centered at all points of the continuum of care
- Need to be multiple ways for people in crisis to access the system
- Should encourage access to informal supports by providing assistance and support in using them

3.2 The "Dotmocracy" Process

Participants were asked to engage in a "dotmocracy" process, in which everyone was provided with two different coloured dots and asked to select their first and second priorities for evaluating and monitoring the regional crisis system. The results of this process are shown in Table 4.

Table 4 – Evaluation Priorities Identified Through the "Dotmocracy" Process

1st Priority	2nd Priority	Description
8 votes	1 vote	Continue to evaluate and monitor crisis system communication
7 votes	2 votes	Evaluate and monitor the populations who are not accessing the crisis system and why
6 votes	0 votes	Evaluate recidivism (individuals who are constantly in and out the system) and what this impact has on follow-up services
2 votes	13 votes	Ensure the collection of common, consistent data indicators across all services through the allocation of appropriate staffing, resources, and data management systems
2 votes	4 votes	How can evaluation help us to address immediate concerns of the system?
1 vote	2 votes	Need to evaluate the adverse outcomes of emergency department wait times and recidivism rates and compare to community-based interventions
1 vote	1 vote	Need mechanisms in place to track individuals across crisis services
1 vote	0 votes	Look at success stories so we can learn from what's working
1 vote	0 votes	Both qualitative and quantitative aspects are important to understanding and evaluating the system
0 votes	2 votes	Evaluate how recovery principles operate within the crisis system: the language used, labelling, medical connotations
0 votes	1 votes	Increase sample size in order to get broader perspective

3.3. Knowledge Exchange Event Feedback Form Ratings

Participants were invited to complete an feedback form that asked them to rate their level of agreement with various items related to the expected outcomes of the knowledge exchange events. These expected outcomes were:

- An increased knowledge of the findings of the Waterloo-Wellington Crisis System evaluation
- An increased understanding of how the research might be applied to the sectors working within the crisis system
- An increased understanding of the existing linkages between these various sectors
- An increased understanding of how the research might be used to develop an action plan regarding program design, service delivery, and crisis system integration
- An increased understanding of local monitoring and evaluation mechanisms[5]

All items were rated on a 5-point scale (1 = "strongly disagree", 5 = "strongly agree"), and a total of 37 participants completed the form. The items and participants' average level of agreement with each item are shown in Table 5.

Table 5 – Participants' Level of Agreement with the Expected Outcomes of the Knowledge Exchange Events

Feedback Form Item	**Average Rating (out of a maximum of 5.0)**
As a result of this event…	
My knowledge of the findings of the Waterloo Wellington Crisis System evaluation has increased.	4.1 (0.7)
My understanding of how the evaluation findings might be applied to sectors working within the crisis system has increased.	3.8 (0.6)
My understanding of the existing links that exist between the various sectors working within the crisis system has increased.	3.3 (0.9)
My understanding of how the evaluation findings might be used to develop an action plan regarding program design, service delivery, and crisis system integration has increased.	3.8 (0.6)
My understanding of the monitoring and evaluation mechanisms for the LHIN 3 (Waterloo-Wellington) crisis system has increased.	3.4 (0.8)

[5] The underlying purpose of this outcome was to encourage stakeholders to brainstorm about potential monitoring and evaluation mechanisms that could be implemented in the future, in light of the findings and the challenges related to system-wide evaluation uncovered in the Waterloo Wellington Crisis System Evaluation.

I think that the various sectors involved in the local crisis system (e.g., community based mental health services, policing, hospitals, etc.) were properly represented at today's event.	3.8 (0.9)
Attending and participating in this event was a good use of my time.	4.1 (0.7)

4.0 Conclusion

Both knowledge exchange events were attended by representatives from all identified stakeholder groups in the region. The findings of the evaluation and the breakout sessions led to extensive feedback from key stakeholders regarding priorities and next steps for the crisis system. This feedback and the results of the evaluation will be used by the Waterloo Wellington Regional Crisis Committee to develop a formal action plan for the ongoing monitoring and evaluation of the regional crisis system.