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Canada

Building Capacity: Mental Health and Police Project Evaluation
Final Report for the Canadian Mental Health Association
December 15, 2006

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Executive Summary

The *Building Capacity: Mental Health and Police Project* (BC:MHAPP) was initiated in February 2005 with a mandate of developing a process to address emergency response to people with mental illness in six communities in the province of BC (Cranbrook, Delta, Nanaimo, Richmond, Vancouver and Williams Lake). The initial project was funded by the BC Mental Health and Addiction Services, Provincial Health Services Authority and the Vancouver Foundation and the BC Mental Health and Addiction Services PHSA funded the evaluation. Each community was supported to establish a steering committee of relevant representatives from the sectors that work most closely with mentally ill people when they are in crisis (e.g., police/RCMP, mental health service providers, consumers, family members, hospitals, ambulance and other first response services). The steering committee was meant to come together regularly over a six month period to discuss what currently happens in their community when a mentally ill person is in crisis and to develop an action plan to address identified problems.

The research evaluation team was contracted by CMHA in August 2006 to undertake an evaluation of the BC:MHAPP. A process evaluation methodology was employed and the following methods were used:

1. Fifty-four online surveys were sent out to all steering committee members in each community;
2. Six focus groups were conducted with steering committee members in each community;
3. Ten individual interviews were conducted with CMHA project coordinators and involved CMHA staff in each community;
4. Ten additional interviews were conducted with selected key informants and individuals who were unable to attend the focus groups.

In order to evaluate the leadership role of CMHA, CMHA coordinators and staff did not participate in focus groups and were not asked to complete the online survey.

The BC:MHAPP was taken up uniquely in each community. The process and action plans that were developed reflected local contexts, political opportunity, timing, the degree of steering committee participation and the strength of leadership in each community. Steering committees in each community met regularly and all developed an action plan. In some communities the main task of the committee over the six months was in developing relationships between different steering committee members in order to build trust and understanding of each other's respective roles and mandates vis a vis responses to people with mental illness. In other communities, especially if collaborations and partnerships existed prior to the project, the steering committee was able to actively collaborate to address items on their action plan. In our discussion below we highlight our key findings with respect to steering committee composition, partnerships and collaborations, knowledge transfer, impact on consumers, the action plan and the structure of the project, including CMHA involvement.

Although the specifics of the challenges faced in each community differed, what was uniform across all communities was that mentally ill people being brought into hospital emergency wards by police/RCMP faced lengthy wait times. Steering committee members described these wait times as detrimental and potentially traumatic for people with mental illness and as using up valuable police/RCMP time. This issue raised the critical importance of engaging emergency department staff in steering committee activities. In the evaluation most respondents indicated that attempts were made to include all key constituents concerned with emergency response to mentally ill persons in crisis in their community on the steering committee, but these attempts were not always successful. The most commonly mentioned group *not* included in the steering committees was emergency department staff from local hospitals. The reasons for this were not known but committee members speculated that it might be because of the workloads of emergency staff, their inability to see the committee as relevant to their work and/or concerns that their participation would not necessarily lead to changes in wait times.

All of the committees had some form of consumer representation on their committee, but this varied from community to community and was sometimes dependent on how well the consumer representative was during the course of the project. Some communities, like Nanaimo, engaged a larger group of consumers in a focus group held separately from the committee to get information about their experiences with emergency response to feed back into the committee process. In evaluating the role of consumers on the committees, some respondents felt the committees would have been stronger had there been more consumer representation. All comments supported the feeling that consumers on the committees did have opportunities for meaningful participation.

With the exception of Vancouver and Richmond, few steering committees had representation from Aboriginal populations or from members of ethnic minority groups, limiting their ability to address issues specific to these communities. With respect to who else should have been engaged in the steering committee, some respondents felt that representatives from health authorities or municipal governments might have given the committees more political clout to move forward on action plan items.

Collaborations and partnerships between mental health, consumers, police/RCMP, first responders (i.e., crisis centres, ambulance personnel and emergency room staff) and in at least one instance a family member[1] did form as a result of the BC:MHAPP, and this result was one of the most commonly mentioned positive outcomes of the project. For example, in Williams Lake steering committee activities resulted in several meetings between emergency physicians and police, which led to a Memorandum of Understanding (MOU) to improve service. When asked about collaborations or partnerships that didn't happen but would have been helpful, the most commonly mentioned partnership was the one that committee members wish had been forged with local hospital personnel.

[1] It is difficult to estimate the number of family members involved in steering committee activities. Only one person identified themselves in this way to us during the course of the research.

Respondents were split in their opinion as to whether these collaborations and partnerships would continue long-term. Some respondents felt that partnerships that had been established before the BC:MHAPP began were strong enough to continue beyond the timeframe of the project, while newer collaborations may not be strong enough to endure now that the project has formally ended.

There was evidence of some knowledge transfer activities that occurred as a result of the project. For the most part these activities included education that took place at the steering committee level where most respondents indicated that they had gained a better understanding of each other's respective jobs and mandates. In other instances, educational tools were developed that were used beyond the committee. For example, the development of power point presentations for educational purposes occurred in both Williams Lake and Delta, and wallet size cards with information about emergency mental health resources were prepared for first responders in Williams Lake and in Cranbrook. Generally, however, when asked to describe ways in which information about mental illness or mental health services has been disseminated beyond the steering committee members, (e.g., to other members of the police or first responders) we were given very few concrete examples of knowledge transfer, although a common comment was the hope that this knowledge transfer would happen when and if certain elements of the action plan were implemented.

When asked whether persons with mental illness in their community have benefited from changes resulting from the BC:MHAPP, respondents were generally unable to give concrete examples. Respondents in Nanaimo (where a focus group was held with consumers) and some other communities indicated they felt that consumers, like other committee members, benefited from being involved in the process. It was also suggested that the development of an MOU between RCMP and emergency physicians in Williams Lake was already decreasing hospital wait times and resulting in better care for people with mental illness in crisis. Respondents felt that more changes might emerge as action plans are implemented.

Regarding implementation of action plan items, few communities managed to get to this stage. Williams Lake was one example where (as discussed above) they developed an MOU that resulted in service changes. Likewise an MOU development process was also underway in Delta. Some communities, like Nanaimo, saw changes as a result of initiatives outside of the committee process. Mounting pressure on the hospital system in this community has led to provincial commitments for more acute psychiatric care beds. Other communities had well developed action plans but had not yet been able to implement the items.

When asked about the six-month timeline for the project, generally respondents felt six months was too short, and most agreed that one year would have helped to better cement partnerships and move toward actualizing action plan items.

Generally respondents felt that CMHA involvement and leadership was very helpful (indeed some stated that the support received was key to the success of the project), but

almost unanimously there was discussion about the lack of communication since the end of the project, and a hesitance to recommend the project until they can see actual results of the work put into developing the action plan.
Overall, our findings suggest that the BC:MHAPP was an excellent process for engaging police/RCMP and first responders with those working in mental health services and with consumers to share information about their respective experiences, roles and mandates. This information exchange was seen as foundational for developing collaborative partnerships that could result in concrete changes. The CMHA was seen as the most appropriate organization to lead the process and many respondents were enthusiastic in their praise for the role that CMHA both locally and provincially had played in supporting the process. Most respondents also recommended the process for other communities.

The work of steering committees was hampered by the fact that in many instances members did not have the authority to make the changes that the committees identified were needed for better responses to people with mental illness. For example, across all communities hospital wait times were identified as problematic, and additionally, many respondents pointed out that the lack of supportive services like housing for people with mental illness exacerbated and in some instances precipitated crises. Respondents strongly articulated that they wanted to see concrete actions taken as a result of their work on the committee and expressed skepticism that this was possible without political leadership in the form of provincial and regional health authority commitments. Below are the key recommendations arising from the research of relevance to implementing the BC:MHAPP in other communities:

Steering Committee Composition

- Given that hospital wait times in Emergency were a clear issue across all communities the involvement of emergency room personnel was seen as critical for steering committees to be able to effectively address the issues.
- Consumer engagement on committee steering committees could be enhanced through the use of focus groups (the Nanaimo model).
- Stronger support from CMHA BC for getting more ethnically diverse representation on steering committees, including Aboriginal representation and members from BC's Indo-Canadian and Chinese-Canadian communities.
- The involvement of provincial and regional health authority representatives with a political commitment to helping communities implement their actions plans.

Structure of the Project

- The project timeline should be increased from six months to a year.
- CMHA BC should give clear direction to each committee at the outset regarding the expectations of each committee and should follow-up with committee members after the project is formally completed to keep them apprised of further developments.
- An external evaluator should be engaged at the outset of the process to assist committees with defining their goals and deciding how best to measure outcomes.

- Different communities may require slightly different models – success is dependent on size of community, strength of leadership, existing opportunities, timing and other contextual factors.
- Experienced facilitators should be used to lead the steering committee process.

A. Introduction

> I've been on a lot of committees in my life, and I really feel that this one has done something… I really feel it was beneficial, and I don't always feel that. Like a lot of committees you're just collecting information. Whereas I really can see, other players are actually doing something. And so for me, yeah, I'm just really, really excited about what's happened (BC:MHAPP steering committee member).

The mandate of the *Building Capacity: Mental Health and Police Project* (BC:MHAPP) was to engage six communities in the province of BC (Cranbrook, Delta, Nanaimo, Richmond, Vancouver and Williams Lake) in a process designed to address emergency response to people with mental illness who come into contact with the police/RCMP in the context of a psychiatric crisis. The process was initiated in February 2005 and led by CMHA BC who engaged CMHA coordinators in each community to develop and lead a steering committee of relevant representatives from the sectors that work most closely with mentally ill people when they are in crisis (e.g., police, mental health service providers, consumers, family members, hospitals, ambulance and other first response services). The steering committee was meant to meet regularly over a six month period to discuss how mental health crises were currently handled in their communities, identify problems and develop an action plan. Communities were not expected to implement their plans at this stage, but were expected to think about how to sustain community partnerships and collaborations over time in order to help bring about changes in emergency mental health response.

CMHA contracted an evaluation research team in August 2006 to undertake an evaluation of the BC:MHAPP. Through a series of meetings and discussions with the BC:MHAPP coordinator Camia Weaver, and with CMHA Policy and Research Director Catharine Hume, the team decided that a process evaluation design would be most suitable for evaluating the BC:MHAPP. Process evaluations are typically used when evaluating a community-based project where no baseline data exists and where the emphasis is on assessing the success of the process rather than on outcomes. Process evaluations provide a general assessment of how things are going and the results can be used to feed into future project planning. Project evaluations typically proceed with the development of a logic model that clearly outlines the goals of the project, what the markers of success are (short and long term indicators) and how these will be evaluated. The logic model for the BC:MHAPP can be found in Appendix A.

In the following final report we discuss the methods of our research, our findings organized by community, conclusions and recommendations.

B. Methods

Three methods were employed to evaluate the BC:MHAPP:

a) An online survey of all steering committee members in each community
b) Focus groups with steering committee members in each community
c) Individual interviews with CMHA project coordinators/involved staff in each community and with selected individuals who were unable to attend the focus groups

In addition, the researchers were given access to the final reports submitted by each community at the end of the project.

The research tools (survey, focus groups and interviews) were developed by the team with input from CMHA BC. A copy of the survey can be found in Appendix B and the focus group and interview questions for non CMHA members can be found in Appendix C, Interview questions for CMHA coordinators and staff can be found in Appendix D.

Survey

As a part of the BC:MHAPP process evaluation, a survey was designed to assess Phase 1 of the project. The survey questions were developed to target the short term indicators identified in the logic model for the evaluation of the project. The survey consisted of seven closed-ended questions and two open-ended questions. The results of the survey were evaluated separately for each community and are integrated into the analysis of the focus groups and interviews below.

Fifty-four surveys were sent out by e-mail or handed out during focus groups to all committee members in Cranbrook, Nanaimo, Richmond, Vancouver and Williams Lake. Surveys were not given to CMHA project coordinators or staff. Because of delays in being able to access Delta steering committee members, surveys were only handed out to the six members that participated in the focus group. A total of thirty-four surveys were returned. This resulted in an overall response rate of 63%. As indicated in Table 1 below, the response rates differed across the five communities. From the Cranbrook and Nanaimo committee only two responses each were returned. These low numbers made it problematic to analyze the survey results of these two communities, thus for the discussion of these two communities no graphs are used to represent the survey results but comments concerning the results are included.

In the process of the evaluation it became increasingly clear that the devised survey was an imperfect tool for the evaluation of Phase 1 of the BC:MHAPP process. Several participants did not feel that the survey was relevant to assess the work done by the steering committees during Phase 1 of the project. For example, some felt that the survey forced positive or negative answers when more nuanced discussions were required. These individuals were encouraged to participate in the focus groups to voice their experiences

and opinions. In light of these limitations, the results of the survey are best viewed in the context of the analysis of the focus groups and interviews.
Table 1: Number of returned surveys out of the total number of surveys distributed in each community

Community	Response Rate
Cranbrook	2 out of 4
Delta	6 out of 6
Nanaimo	2 out of 8
Richmond	10 out of 11
Vancouver	10 out of 16
Williams Lake	4 out of 9

The survey data was broken down according to the following categories:

- Mental health workers: anyone working in the mental health field including Mental Health Emergency Service (MHES) workers and family members working as advocates
- First responders: this includes police and ambulance personnel
- Consumers: individuals that use mental health services

The majority of received responses were from mental health professionals. Out of 34 surveys sent out to mental health workers, 22 responses were received. Mental health workers comprised the majority of the steering committee members. Out of the 15 first responders participating in the committees, 10 surveys were received. Two out of the 5 mental health service consumers that participated in the various committees returned the survey (two consumers replied that they were too ill to participate).

Focus groups and interviews

Focus groups were held in each of the six communities as were interviews with all CMHA project coordinators and in some cases with involved CMHA staff (ten interviews). The project coordinator in Delta was not interviewed[2]. In order to assess CMHA leadership, CMHA coordinators and staff were not involved in focus groups. Additionally ten individual interviews were conducted with people who were unable to attend the focus group but who had been active steering committee members or were considered by the project coordinators to be key informants.

Focus groups were not always well attended. As much as possible this gap was addressed by adding additional interviews. It was especially difficult to get the consumer representatives involved in focus groups and interviews (due to circumstances beyond their control).

[2] The project coordinator in Delta was deceased.

C. Findings

Cranbrook

Evaluation activities

A focus group was held on November 20th in Cranbrook, although only two former members of the Cranbrook BC:MHAPP steering committee were able to attend. These members were the director of East Kootenay Addiction Services, and a psychiatric nurse working with Mental Health Services. Additionally, individual interviews were conducted with Melissa Bax, Project Director for the BC:MHAPP in Cranbrook; Darrell McNeil of the Cranbrook RCMP; and the consumer member of the Cranbrook BC:MHAPP steering committee. Janice Bradshaw, Executive Director of the East Kootenays branch of CMHA was unavailable due to a family emergency. Due to the lack of e-mail contacts for two of the six committee members we were only able to send out four surveys to this steering committee, two of which were returned.

Summary of evaluation

The BC:MHAPP in Cranbrook has helped establish some partnerships within the community among people concerned with crisis response to mentally ill persons. Members of the steering committee expressed guarded optimism that the solutions proposed during their meetings might have some future impact on services for mentally ill persons in crisis in their community. The action plan generated ideas for items that have the support of all members of the steering committee, and could reasonably be implemented with the appropriate resources.

Composition of steering committee

Focus group participants mentioned that a representative from the local hospital, and especially a representative from the emergency department, would have strengthened the work of the committee and one of the interview respondents felt that it also would have been helpful to have someone from Interior Health authority participate. A suggestion was made at the focus group that perhaps offering to hold the steering committee meetings at the hospital would overcome some of the perceived barriers to hospital personnel participating on the committee.

Consumer involvement on steering committee

While some members of the steering committee felt that consumer involvement was adequate, two members stated that more consumers on the committee would have been helpful. The consumer member felt that consumers were well represented and that their concerns were heard.

Partnerships/collaborations

Focus group participants stated that some important partnerships began to develop between the local RCMP and other first responders, but in our interview with the RCMP participant on the committee, we heard that the project was a "stepping stone" towards the goal of better collaborations, and he stated "I still haven't seen any real policy and procedures that have come down that can set out a guideline for us." This ambiguous view concerning greater collaboration was also reflected in the survey results, as both of the respondents either indicated a positive or neutral response with regards to increased collaboration between the involved agencies.

Knowledge transfer

Some focus group and interview participants indicated that being part of the steering committee resulted in important sharing of information and that it increased committee members' understanding of each other's roles. In one instance, the BC Ambulance Service representative was made aware of the CMHA Mental Illness First Aid training, something he previously was not aware he could access. Reflecting on the role of the committee in sharing information one focus group participant said "I think really as we sat around there was a good sharing of what our roles were…and I think it was useful for everybody to get a sense of, okay, this is what your role is versus my role, and to share what we saw through our clientele, and where we might see a need or a gap."

Not all participants agreed that knowledge transfer has occurred. The RCMP representative, for example, felt that his officers do not yet have a better understanding of how to resolve a mental health crisis, but he stated that he sees the BC:MHAPP action plan as a first step that will hopefully lead to more mental health training for the local RCMP and other first responders.

Effects of the project on consumers

All participants in the evaluation agreed that consumers were not yet affected by the BC:MHAPP, although one member commented that it would be difficult to evaluate this measure because "good experiences aren't likely to be commented on. It would be bad experiences that would be in the press." Likewise, both survey responders indicated a neutral response in terms of whether the project had resulted in positive effects for consumers at this initial stage.

Action plan

At the focus group, participants stated that the action plan items had not yet been implemented. This view was also echoed in the survey results; both respondents indicated a neutral response concerning the positive impact of the action plan. Possible exceptions are the distribution of informational cards- one card is for consumers to carry (voluntarily) and it lists diagnosis, medications and emergency contacts; the other card is for first responders and provides a reminder of the services that are locally available for

people with mental illness. The RCMP, Ambulance Service and CMHA were working on developing and distributing these cards. One interviewee described the cards as "something that our group felt was really tangible, and something that we could definitely look at" (for future implementation). Regarding the action plan, one steering committee member stated "I think where we got to seemed quite exciting…You know, there seemed to be goodwill between first responders and the RCMP, and everybody seemed to agree that what we were coming up with could be helpful." The RCMP member concurred, "there was consensus, because we were all there for one goal, and that is to reduce harm to all parties involved, including the client and first responders."

Structure of project

As stated previously, one suggestion from the Cranbrook focus group was to hold steering committee meetings at the hospital to make it easier for hospital staff to participate in the project. The project coordinator felt that six months for a project of this nature was too short, and suggested a one-year time frame. She also stated that she would have appreciated clearer expectations of what her steering committee should accomplish in their six months.

CMHA involvement

There was a general feeling expressed that support from local and provincial CMHA was helpful and useful. This positive evaluation of CMHA's involvement in the project was also mirrored in the survey results.

Would you recommend this project?

The following quote from one steering committee member represented the general feeling that this process should only be undertaken in other communities if it resulted in concrete changes, "if we move into the phase 2 and we actually got something happening. At this point, if it goes no further, it unfortunately would be like many other committees I sat on, where there's good discussion, and that's all it is. So I tend to say, no sense wasting our time on good discussions…I thought what we were trying to achieve through the Action Plan was very doable. It wasn't a large-scale thing. I thought it had the chance of actually having some concrete impact."

Delta

Evaluation activities

A focus group with Delta BC:MHAPP steering committee members was held on November 23rd and was attended by six members, including representatives from the Delta Police Department, Delta Community Committee on Mental Health, Delta Advocates for Community Mental Health, Fraser Health, a parish nurse, and the Mental Health Liaison with Delta Hospital. The six surveys that were handed out at the focus group were returned and analyzed. No CMHA interviews were held in Delta as the former Executive Director and Project Coordinator for the BC:MHAPP is deceased, and the current Executive Director of the Delta CMHA is not familiar with the project.

Summary of evaluation

The CMHA executive director in Delta assembled a highly motivated team and the BC:MHAPP was a very successful project in Delta. The steering committee brought key constituents to the table, mapped out the current process for assisting mentally ill persons in crisis, decided upon action plan items, and then implemented some of the items. A sub-committee broke off from the BC:MHAPP and held their own meetings in addition to attending the BC:MHAPP meetings. This smaller committee was instrumental in bringing about significant changes in the local community's approach to working with mentally ill persons in crisis, as outlined below under the Partnerships/collaborations and Knowledge transfer sections. The story below, shared by the DELTA POLICE DEPARTMENT member, illustrates some of the mental health challenges currently faced in Delta:

> Just recently, at 5:00 in the morning our guys [Delta police] arrested someone under the Mental Health Act, this lady who had overdosed on pills, was intent on suicide. And they phoned up Surrey Hospital to say they were bringing her in and Surrey said "No, we won't take her. We're full." And so the dispatcher, it was on tape, it was digitally recorded, they phoned probably whatever hospital in the Lower Mainland and nobody would take her. And so this lady sat in the back of the police car for an hour while we phoned all the hospitals. And it was all, it was like I got it on a CD, so I phoned up Merrill McDowell (at Surrey Hospital), and I said "You need to listen to this" and she brought in all her managers and we sat down. I made it through about halfway through the CD and she finally asked me to stop it, because it was so brutal. She realized that the service – you know, just the response from some of the nurses, it was, it was really frustrating…But what it did is, they know that there's some accountability because they know now that every time we want to bring a patient over that there's a problem or something like that someone's going to be phoning the next day to ask why, and to arrange a meeting with them. But it's also frustrating to have somebody that is suffering that's in a crisis in the back of your police car. I think it's getting better but I think we're a long ways away.

Composition of steering committee

There was consensus among focus group participants that the steering committee had good representation, but would have been strengthened by participation from both Delta and Surrey Hospitals. Delta hospital does not have a psychiatric ward, so mentally ill clients in crisis are often transported to Surrey Hospital. Currently the Delta Police Department is struggling with long wait times at both hospitals. Regarding hospital participation on the steering committee, one participant at the focus group stated "what we continually came up against was that people in positions to make decisions were not present at the table, and we couldn't get those people to the table."

Consumer involvement on steering committee

All participants at the focus group felt that consumers were well represented on the steering committee. One participant stated "it was important to have them there because they confirmed that their sense of frustration wasn't just with the police, but it was also with the hospitals and the doctors and the associations."

Partnerships/collaborations

One key partnership was described by the Delta Police Department member of the steering committee. He stated that following the initial BC:MHAPP meetings he approached the steering committee member from Delta Mental Health and the steering committee member from BC Ambulance Service as well as the representative from the British Columbia Schizophrenia Society (BCSS) and they agreed to hold a series of parallel meetings. He stated, "We ended up calling it (their solution) the "Community Health Intervention Program"... It's been a great process... And what we were able to produce out of that, probably the biggest thing I think, is we have a Memorandum of Understanding, which is just about finished now, which will permit the sharing of information (between hospitals, Delta Police Department and Fraser Health)."

Other steering committee members agreed that the Community Health Intervention Program and the MOU have led to improvement in their work with mentally ill persons in crisis, in part because the Fraser Health nurses can now communicate their concerns about specific patients to the mental health assessment team at Delta Hospital. One committee member explained that her assessment team had developed an "alert binder" in the emergency department "on folks that are frequently in crisis and involved in hospital visits where police attendance is called. And so we actually can start to track, plan and be proactive with folks as well." She felt that these changes were helpful to the hospital as well as the patient and the police.

The Delta Police Department steering committee member stated that partly as a result of the work of the BC:MHAPP committee, his police chief has approved the creation of a full-time position within the Delta Police Department for a police office who will be a mental health specialist with additional training in mental health crisis intervention. He also stated that since joining the BC:MHAPP he has been identified as somebody in the police department who deals with mental health issues on a regular basis: "So since that

committee started I've been the person that handles and looks after most of the mental health issues... and what it did, it provided some continuity and consistency in response….So now the (Delta Police) Chief all of sudden realizes that we're way behind (in addressing mental health issues), like we needed to get caught up on this. And this (committee) sort of provided the catalyst in doing that."

These positive examples of partnerships that developed as a result of the BC:MHAPP were complemented by positive survey results. The majority of the responders in Delta felt that the committee meetings and activities led to increased collaboration and partnerships in the community. Similarly, the majority of responders agree that police, mental health and hospital personnel, as well as first responders in their community, have a better understanding of each other's mandates, policies and procedures as a result to the project.

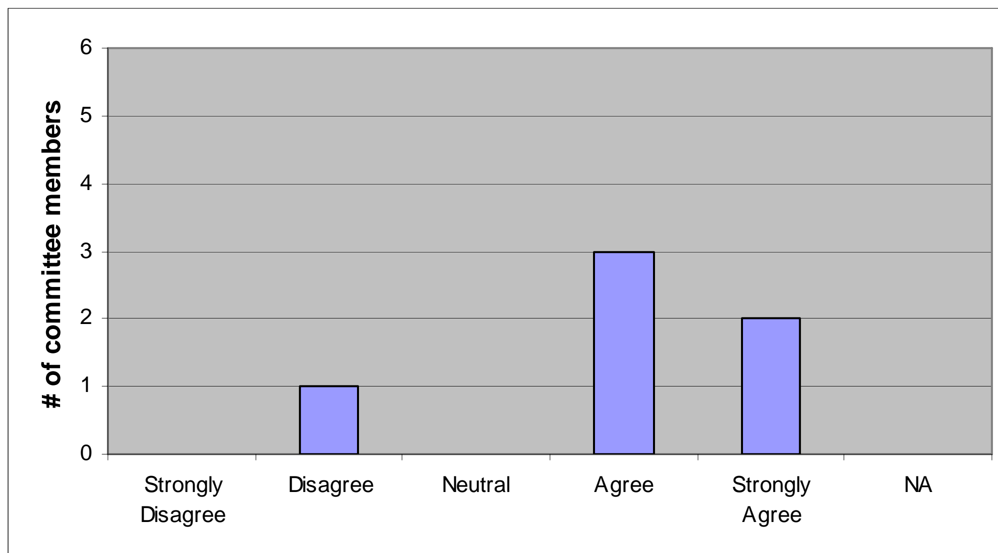

Figure 1: Response frequencies by level of agreement for increased collaboration

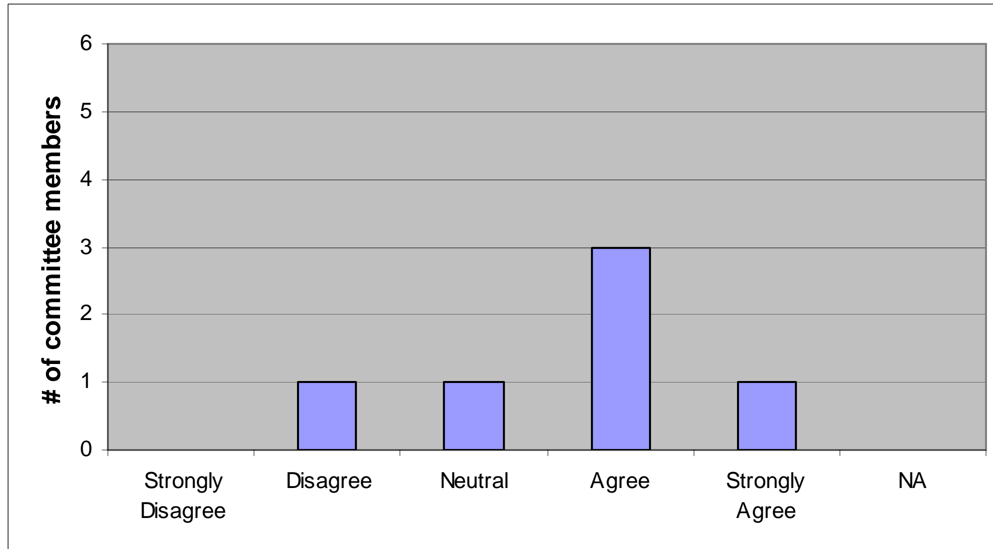

Figure 2: Response frequencies by level of agreement for increased understanding of the mandates of the involved agencies

Knowledge transfer

The Delta Police department steering committee member stated that "we don't have the training or background at all, zero. I've been here almost 21 years and I've had almost no training in mental health issues." But he added that over time, and partly through the work of the BC:MHAPP, "the guys (police officers) are now learning to differentiate between mental illness and a criminal act. And you know that putting handcuffs on somebody that's in crisis and putting them in the back of a police car is not a good thing…You wouldn't have seen that 10 years ago, you probably will be seeing it more now. And you got young guys coming in, so they're getting the training, or they're getting the message early in their career."

Additionally, a Power Point presentation on mental illness was developed and shown to the Ambulance Service, Delta Police Department, and staff at the hospital by members of the steering committee.

While it appears that there have been some positive changes in terms of education concerning mental illness in the community, the survey results indicated that most respondents were either neutral or disagreed as to whether the project resulted in the dissemination of information and education about mental illness in Delta.

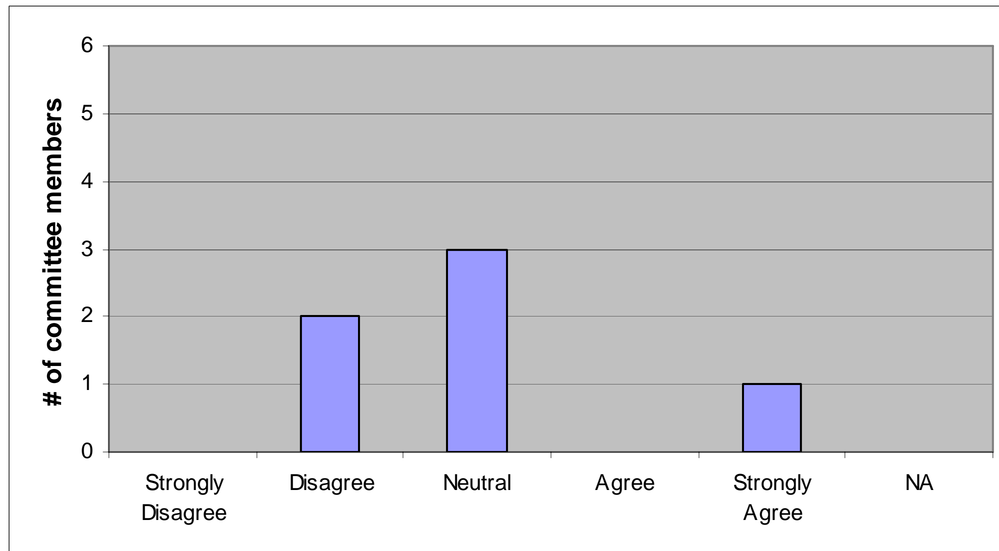

Figure 3: Response frequencies by level of agreement for information dissemination into the community

Effects of the project on consumers

The police member told this story to illustrate effects of the project on consumers: "In Tsawwassen we had an older fellow that was in crisis, and the guys were getting him ready to go in the ambulance. And we called the ambulance, and then they decided that they were going to put him in the (police) car and drive him to Delta Hospital. And I had the number (for the Fraser Health mental health nurses) so I called and said 'Do you have a file on this guy?' And he said 'Yeah, we do.' And I said 'Well, they're just about to ship him off to Delta Hospital.' And he said 'Don't do that. We'll send somebody there.' So rather than take this old guy out of his apartment and take him to Delta Hospital, we'll spend hours and probably no one to get him home, the nurse came to his apartment, looked after him, and he was just off his meds and he just needed someone to talk to and go back on his medicine, and that was an easy solution." Prior to the BC:MHAPP and the MOU that it generated, he stated he would not have been able to make the call to Fraser Mental Health.

Another steering committee member commented "I think that police officer's capacity to be empathic and have greater understanding of what it is these people are facing has increased, and it's been growing and changing over time, despite this committee as well, but I think that this group has definitely contributed to that."

One member stated "Well, I think from a parent point of view we're more confident. I've had my family member in a jurisdiction that was under RCMP and they seemed to be well trained and it was totally different. She's had very bad experiences previously. I definitely think we as parents feel a lot more confident about what will happen. I really think it's important that a consumer now feels confident that they can phone the police and they're there to help, not be the enemy."

These positive examples of how mental health service consumers in Delta benefited from the BC:MHAPP were also reflected in the survey results. Most respondents indicated a positive or neutral response concerning the benefits for consumers from the activities and collaborations of the committee.

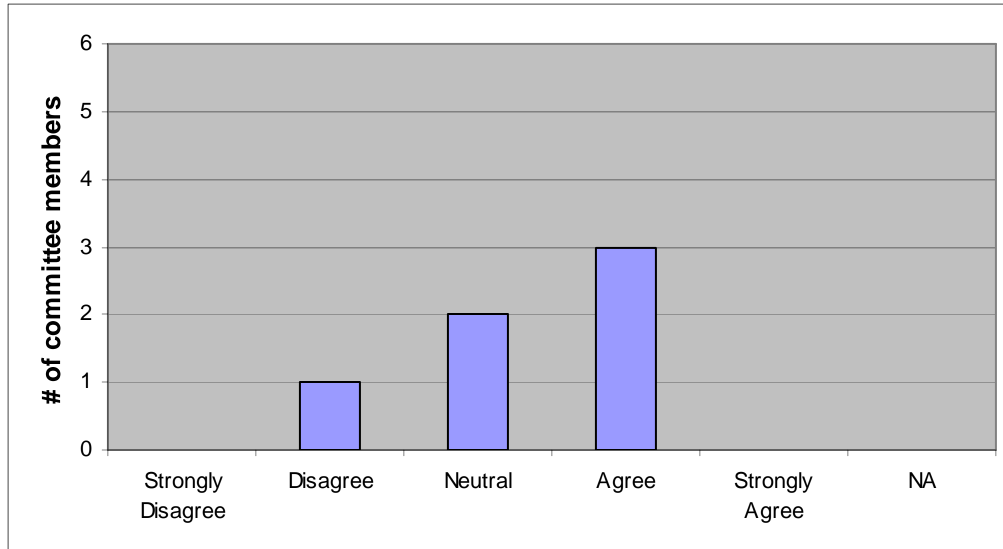

Figure 4: Response frequencies by level of agreement for consumer benefit

Action plan

Steering committee members agreed that they were able to identify issues that could be addressed within the committee, and they drafted their action plan items accordingly, without much dissension. Their action plan included the Power Point presentation to increase awareness of mental illness and constructive response to mentally ill persons in crisis, as well as information about local mental health resources. The action plan has come to include the work of the Community Health Intervention Program and the Memorandum of Understanding. The majority of the Delta committee members felt that the developed action plan had a positive impact on the community.

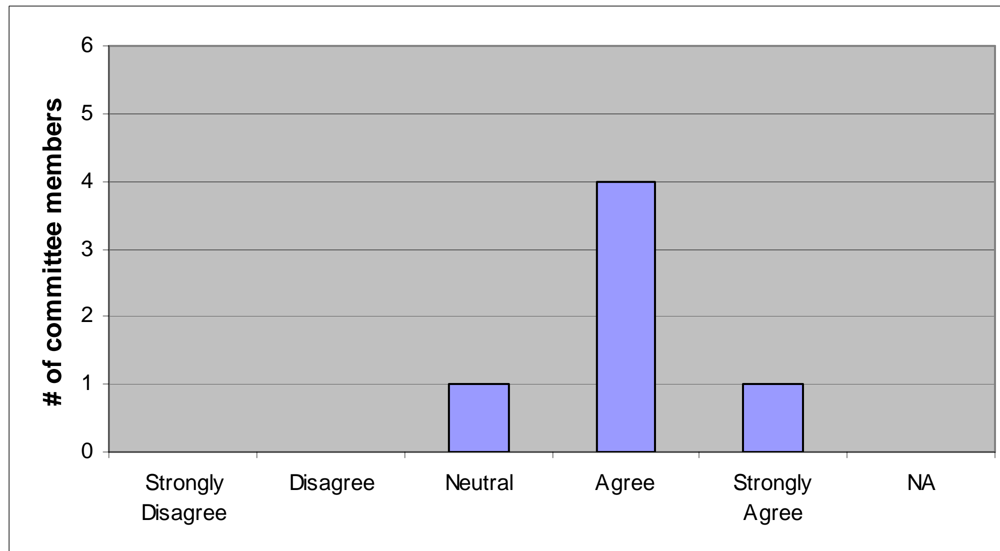

Figure 5: Response frequencies by level of agreement for the impact of the action plan on the community.

Structure of project

Committee members felt that six months was an adequate amount of time for meeting to draft an action plan, but that if implementation was to be included then the timeframe should be extended.

CMHA involvement

A great appreciation was expressed for Tom Wright, the previous Executive Director of CMHA in Delta and project coordinator for the BC:MHAPP, and there were comments that he had communicated well with steering committee members and kept them on task. However, one of the group's criticisms was the lack of communication after the initial six months of the project had concluded. One member stated "after Tom's passing or even when he was stricken ill, there was no communication, absolutely none. I found out through rumor that he was ill and there was no communication that the meetings were cancelled, there was no communication after that whatsoever – zero – from CMHA, whether it be in Delta or from the BC group, absolutely no communication until we were called about this (evaluation) meeting."

Despite the perceived lack of communication on the part of CMHA and even though the Delta committee had to proceed under difficult circumstances due to the decease of the BC:MHAPP project coordinator, the majority of respondents felt that the involvement of staff at the local CMHA office in the project was helpful and appropriate.

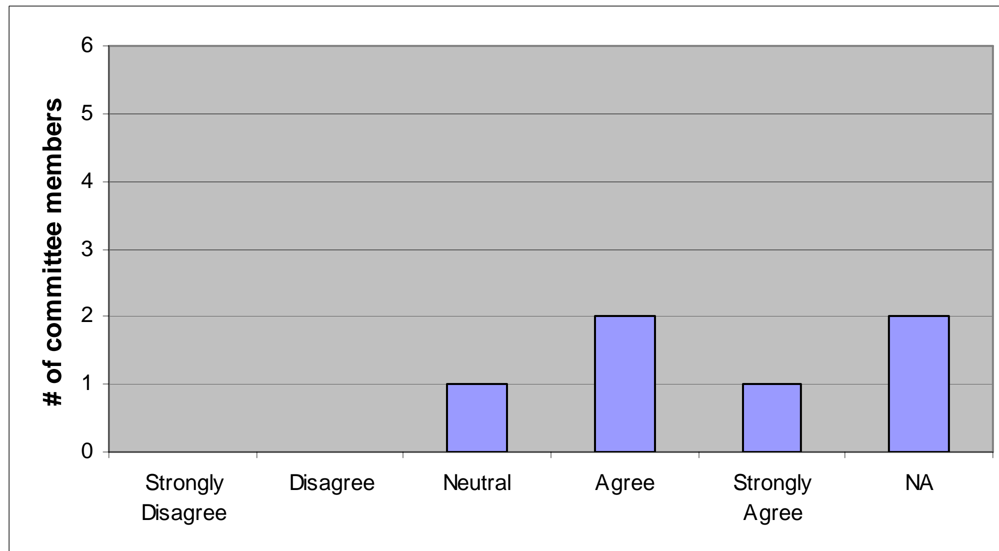

Figure 6: Response frequencies by level of agreement for the support from the local CMHA office

Would you recommend this project?

The steering committee in Delta unanimously recommended the project to other communities. There was a general sense that communication was enhanced among all the players involved in working with mentally ill persons in crisis in Delta. The Delta Police Department member stated "We've made such huge improvements and if we hadn't started the committee then none of this would have happened**.** The liaisons with the hospitals, like Surrey. We've been out there three or four times now, just trying to deal with the issues, you know."

Nanaimo

Evaluation activities

A focus group was held in Nanaimo on October 23rd, and was attended by two former members of the local BC:MHAPP steering committee; an RCMP officer and a representative from the Nanaimo branch of the BCSS. Additionally, individual interviews were conducted with Cathie Cameron, the Project Director for the Nanaimo BC:MHAPP, and Chris Martens, the Executive Director of CMHA in Nanaimo.

Because the Nanaimo focus group was attended by only two people, we attempted to contact three other former members of the steering committee, but received no response. Unfortunately, the consumer representative on the Nanaimo BC:MHAPP steering committee was ill during the time of this evaluation and was therefore unable to participate in either the focus group or an interview. This rather low participation of the steering committee in the evaluation process was also evident with respect to the survey

response rate. Out of eight distributed surveys we received two responses therefore no survey graphs accompany this section.

Summary of evaluation

At the time of the evaluation Nanaimo Hospital had received commitment from the Vancouver Island Health authority (VIHA) for an expansion of the emergency department and the addition of acute psychiatric care beds. While the BC:MHAPP did not take credit for this expansion, the steering committee process was credited with cementing already existing partnerships between the hospital, mental health and police that were ongoing as a result of the recognition of the need for more acute psychiatric beds. However, like most of the other committees, emergency representation was absent from the steering committee. Committee members credited the committee with getting the hours of the local crisis line extended, so that it could better respond to people with mental health problems occurring in the evening.

The process in Nanaimo included the involvement of a consumer on the steering committee and the canvassing of consumer opinions about the issues through the use of a focus group that brought consumers together to talk about their experiences with the police, hospitals and mental health during times of crisis. The issues that emerged from the focus group were fed back into the steering committee process. There was a feeling that some of the issues faced by the community, especially the wait time at the hospital for people with mental illness accompanied by police, could not be addressed through the committee but required higher level political commitments.

In the focus group and interviews there was evidence of some initial tensions on the committee between groups who were either not used to working together or who historically had had difficult relationships (e.g., the RCMP and mental health agencies, consumers and the RCMP and crisis response personnel). It appeared that the process made people's experiences and the challenges they face in their respective roles more visible thereby fostering a better understanding between sectors and stakeholders.

Composition of steering committee

The steering committee in Nanaimo had representation from a range of groups, including mental health, the police, BCSS and ambulance personnel, although as reflected in the following quote the ambulance service could not always be active participants, "They [ambulance] were involved. They would come to some things but they couldn't come to all of them, just because of the nature of their work.... So, we did have some representation from them, but it wasn't over the full course of the project" Groups that were not represented included hospital emergency personnel and First Nations organizations. One committee member felt that youth mental health should also have been represented.

Consumer involvement on steering committee

One consumer sat on the steering committee, but as mentioned above consumers were also involved in the process through the use of a focus group which brought consumers together to talk about their experiences with police, emergency and mental health. As indicated in the following quote it was estimated that about 10-15 consumers participated in this process, "…. There was quite a few [consumers]. I don't remember if it was 10 or 15 or how many it was, but I know that it was quite a few people. And there actually had been people who weren't part of it [the focus group] who came up and talked to [the coordinator] about their experience outside of that."

Partnerships/collaborations

The collaborations that exist in this community pre-date the steering committee process and focus on dealing with hospital wait times for people with mental illness accompanied by RCMP. These collaborations included a series of meetings between RCMP, ambulance personnel and the hospital but also included other related collaborations between the RCMP and the crisis line personnel. A representative from VIHA was also involved in the decision making process regarding hospital wait times. Regarding the BC:MHAPP collaborations, one steering committee stated, "I think it strengthened the police-crisis bond, because they both had to listen to each other's side of the story instead of just having it as a kind of a training, I'm the mental health professional, you're the law professional relationship. There's a bit more interaction there so there's some understanding that happened. And I think Crisis Services took heart, and police, about the consumer's point of view. And what their feelings were, so I think that was really a good piece of learning right there."

In terms of the development of increased collaboration and understanding between the involved agencies the two survey respondents indicated conflicting opinions. One of the survey respondents felt that the project resulted in greater understanding and collaboration while the other respondent disagreed.

Knowledge transfer

Steering committee members felt that knowledge transfer activities were ongoing in their community but were strengthened by the process. One committee member stressed that the process had educated people in mental health about the police and reduced the tensions that are sometimes felt between these two groups, "Well I think I was enlightened just because of my experience with the RCMP... so there were some people here … who learned an awful lot from a police point of view, and I think it was more that way than the other way".

Another committee member indicated, "Yes. I firmly believe that there is a better understanding as to each other's mandates. As mentioned, an improvement in the hospital with respect to accepting some of our staff. There could be some more improvement but I am hopeful that when the new wing opens with more rooms and that,

that the bottleneck will dissipate. But I don't want to be too critical at this point in time because they're working toward that goal..."

One of the CMHA staff felt that the committee process had helped to reduce stigma about mental illness. In referring to the involvement of consumers she said, "I am always a firm believer that the personal story is probably the most powerful way to get information out there. And I think, for a lot of people who are service providers or professionals, those are the only things that really break apart what you already think about them. So that was really important for the community, just the fact that there's some stuff in the paper about the project, and just the fact that there can be other ways of dealing with people…like not all people with mental illness are scary."

Effect of the project on consumers

As illustrated in the following two quotes as well as in the survey results, this committee felt that consumers had positively benefited from the process: "I can say that…yes, being the fact that the waiting times to go out to see the doctor in the hospital has been reduced. I think that benefits a lot rather than being out in the foyer or in the back of a police car for hours. I think that it's been great that VIHA actually stepped up to the plate on this issue and corrected things as quickly as possible."

"I think that our consumers [CMHA] and the crisis people had a better connection. That's always kind of a difficult relationship anyway, but I think there was some relationship building going on there….the community members understand better the police's difficult situation that they're in, in terms of what do they do with people once they have them…It's not good for them (the police) and it's not good for people with mental health issues to have to have the police sitting there with them all the time."

Speaking of the consumer focus group, one respondent stated "…that group of people finally had a chance to talk about the trauma that they went through when this happened to them, and how it affected them, because nobody had ever asked them before. And so that I think was worth the whole thing right there. If nothing else ever happened that would be enough for me."

Another comment was, "Yeah, we have, you know, police attending and they're much more respectful, ambulance attendants come and they're not so, you know, needing to strap people down. So I think it has been beneficial…so that people aren't so fearful about when the police do come, or when the ambulance does come."

Action plan

The action plan for was built through a consensus process over the six months duration of the project and led to a number of changes in Nanaimo. Some changes were not a direct result of the project, but were facilitated in ways by the steering committee. Examples include plans for increased psychiatric bed capacity in Nanaimo, longer hours for the

crisis line and shortened wait times in emergency for people with mental illness accompanied by RCMP.

Structure of the project

Generally people felt the process should have been a year long (although the opinion on this was not unanimous) and that CMHA BC could have played a stronger role in keeping people up-to-date on activities following the end of the six month process. Also it was felt that some of the issues (hospital wait times) could not really be advanced through the work of a committee but needed higher level political involvement.

CMHA involvement

The focus group participants, as well as the survey respondents, were mixed in their feelings about CMHA involvement. One member felt that CMHA might be negatively biased against police and that it might make sense for another organization to take on the coordinating role of such a project. For example, "…because, you come with, and I don't mean baggage in a bad way, but you come with baggage because the police, the police is an issue for anybody who works in the mental health field…so if anybody from CMHA or even the mental health group comes to a meeting realizing that the police are an issue, I don't know that there was an open mind that they can reach solutions." Other participants felt that CMHA BC leadership had been key in dissipating tensions on the committee.

In speaking to how the committee could have played a more powerful role, this CMHA staff person indicated, "I think provincially what we could have done is really got at the provincial offices involved, or the head offices of organizations that we wanted on our steering committee, and impressed upon them the importance of this project. I think it was fabulous that it came out of the Coroner's Office, because they have a fair bit of push…But I think if we could have gotten the Coroner's Office to contact the Health Authority and RCMP and the ambulance and the emergency room head, and said, this is important to me, I need you to be there, I think that would have been good…But that's the nature of our community, and I think pressure from above would have been good".

Would you recommend this project?

There was a general feeling that the project had been worthwhile and would be useful for other communities.

Richmond

Evaluation activities

A focus group was held on October 24th in Richmond, and was attended by four members of the local BC:MHAPP steering committee. The members were: an RCMP officer, a representative from BC Ambulance Service, a psychiatric nurse who works for Mental Health Emergency Services, and a child/family therapist working for the Richmond Health Service. Additionally, individual interviews were conducted with the following persons:

Scott Woodburn, the consumer representative on the BC:MHAPP steering committee;
Carolina Romero, representative from the BC Schizophrenia Society;
Barbara Fee, the Project Director for the Richmond BC:MHAPP; and
Dave MacDonald, the Executive Director of CMHA in Richmond.

For the Richmond committee we were able to report very high survey response rate. Ten out of eleven members of the committee returned the survey.

Summary of evaluation

The steering committee in Richmond worked together well and came up with a sound action plan, but there was a high level of frustration expressed regarding the lack of communication from CMHA after the conclusion of the six month term. Members felt that they had worked hard on drafting the action plan, and many felt that they would see improvements in mental health services and police response to mentally ill persons in crisis if the action plan items were implemented, but members stated that they had received no information about whether or not the action plan was being implemented.

Composition of steering committee

Several members mentioned that their committee would have been strengthened by representation from the Ministry of Children and Family Development, and the consumer member felt it would have been beneficial to have more than one consumer on the committee. Other suggestions were to include a representative from the Vancouver airport RCMP, and inclusion of more agencies representing multicultural mental health services.

Consumer involvement on steering committee

Most committee members agreed that consumers were not adequately represented, although all agreed that the consumer member did participate fully when he was able to attend meetings. One member commented "That was a bit challenging, finding someone that, you know, would feel comfortable disclosing they were a consumer, or maybe well enough to be able to participate." One member who works as a family counselor stated that he tried to bring his clients' concerns to the committee members when appropriate.

Partnerships/collaborations

The RCMP member stated that the BC:MHAPP meeting “strengthened what we already had, but added a few other little dimensions of issues that we ran into, such as the Chinese community and some other groups that were having some issues that we were able, you know, unite in. And as a result with the RCMP itself we’ve actually formulated a few different ways of dealing with that end of it, like our Domestic Violence team now, which is new since that group, has been meeting with, oh, a multitude of the groups that were here, and as a result of that I think it’s just strengthened it in a bit of a cohesive way.” The RCMP member also stated that one of the challenges he faces is the lack of partnership between the RCMP and the local health units: “We cross borders here, but the problem we found is that the health units don’t appear to want to work with us in regards to that. Everybody has their own little project and they want to work on it…”

Several members agreed that the town of Richmond excels in the area of cross-workplace collaboration: “A lot of it (partnerships and collaborations) had already started even before this committee…It’s just another venue for the parties to come to the table, meet face to face and hash up some issues, come up with some brainstorming ideas…”

There were also comments that because committee members have exchanged contact information they are more likely to work together outside of the BC:MHAPP meetings. One member stated that she saw a good relationship begin between members of the mental health agencies and the RCMP: “There was talk about how they could iron that out better, because the RCMP felt that since MHES was not 24 hours a day at our hospital, RCMP could phone there but they wouldn’t necessarily get them. And if there was a crisis they needed somebody quick. And so there was some ironing out of issues around that. I remember thinking, “I didn’t know that Richmond Addiction Services didn’t have a relationship with the RCMP, and here they are smiling at each other and saying let’s make an appointment to get together and, oh so-and-so’s doing an agreement. I would like to do that as well with you...” So I saw that take place.”

In survey responses, the majority of the Richmond steering committee also stated they felt that the committee meetings and activities led to increased collaboration and partnerships within their community.

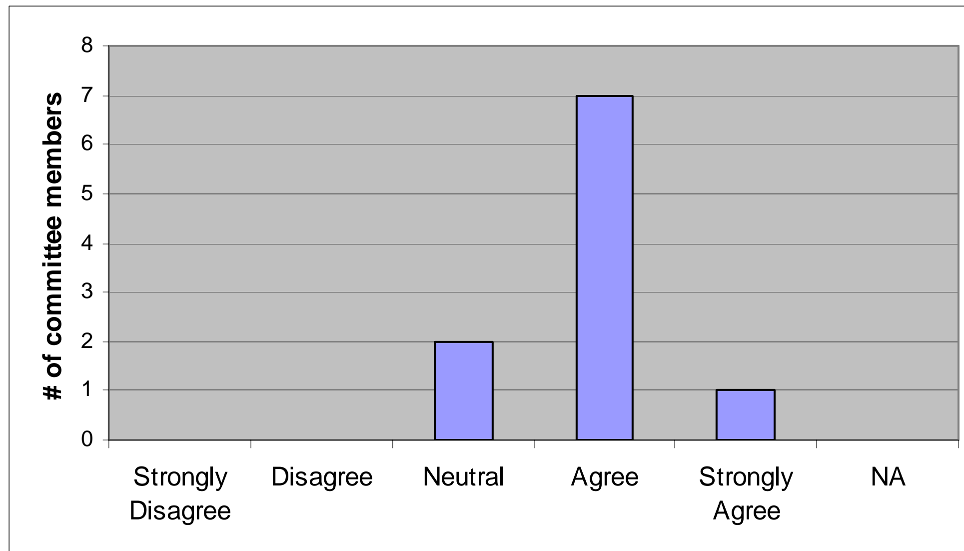

Figure 7: Response frequencies by level of agreement for increased collaboration

Knowledge transfer

A steering committee member stated "One of the pieces that was really helpful and I think it was probably illuminating for all of us was just doing all the flow charts of how somebody goes from the first call and how different people and organizations move in. And I think that the time spent on that was really illuminating in terms of people going "Do you do that? I thought I was supposed to do that…" And so I think that was really helpful in terms of just realizing that what we had presumed would be a simple, clear, logical, common sense process is not always simple, not always clear and not always filled with a lot of common sense."

The RCMP member stated, "We all have our borders and I guess we don't have to know each other's business, but we have to know how each other operates, and I think we did that very well with this group."

The representative from MHES said "I've done some education with the RCMP this year… I've gone up three or four times to explain the different sections of the Mental Health Act. RCMP have been calling more often for collaborations with MHES. So hopefully that was a result of this meeting." A representative from a local mental health agency felt that the RCMP member had been receptive to her attempts to offer education about how police might better approach mentally ill persons in crisis, and that in turn she took her new knowledge about RCMP protocols and used it in educating family members of mentally ill persons about how they might work more effectively with the police should they need to call for police assistance for their family member.

However, the BC Ambulance Service representative felt that there had been no knowledge transfer for his agency, and others agreed that most knowledge transfer would take place when and if the action plan is implemented.

The survey results echo these sentiments. The majority of survey respondents agreed that police, mental health and hospital personnel, as well as first responders in Richmond, achieved a better understanding of each other's mandates, policies and procedures thanks to the work of the committee. However, most respondents indicated a neutral response as to whether the project has resulted in the dissemination of information and education about mental illness in Richmond.

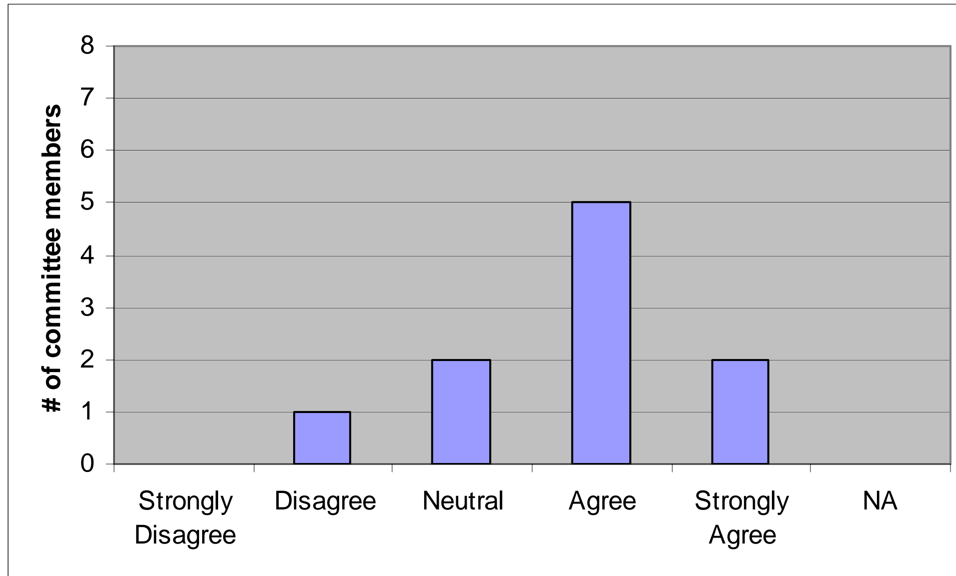

Figure 8: Response frequencies by level of agreement for increased understanding of the mandates of the involved agencies

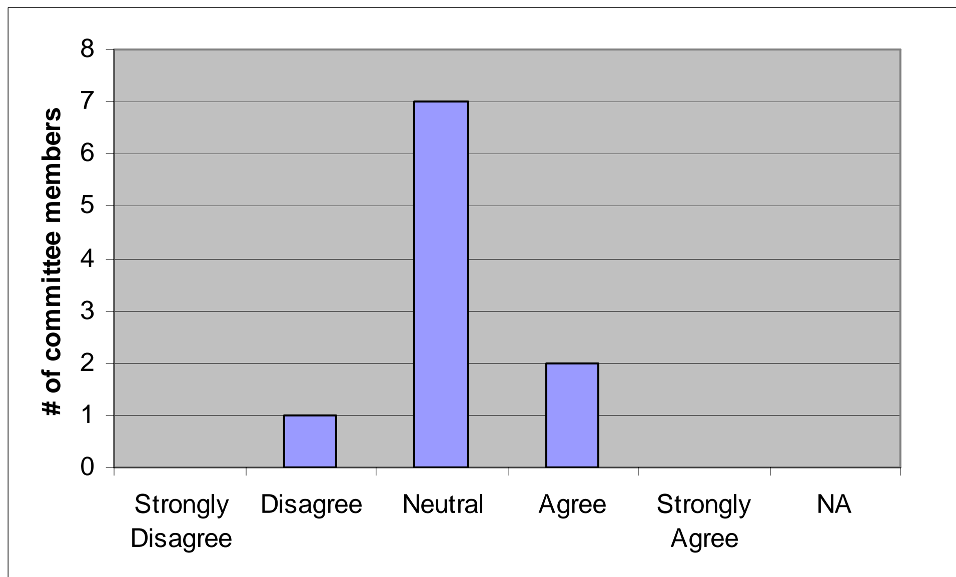

Figure 9: Response frequencies by level of agreement for information dissemination into the community

Effects of the project on consumers

Most members agreed that it is still too soon to tell whether this project has had an impact on consumers. One member posed the question: "So how do you know if the stuff from this group has gone anywhere, let alone if it has actually made it back down to the people using the system?" A representative from a mental health agency said that she continues to hear "horror stories" of police response to mentally ill persons in crisis, where the police don't seem to have adequate understanding of mental illness or how to resolve a mental health crisis. Nonetheless, most respondents indicated a positive or neutral response with regards to the benefits for consumers resulting from the activities and collaborations of the committee's work.

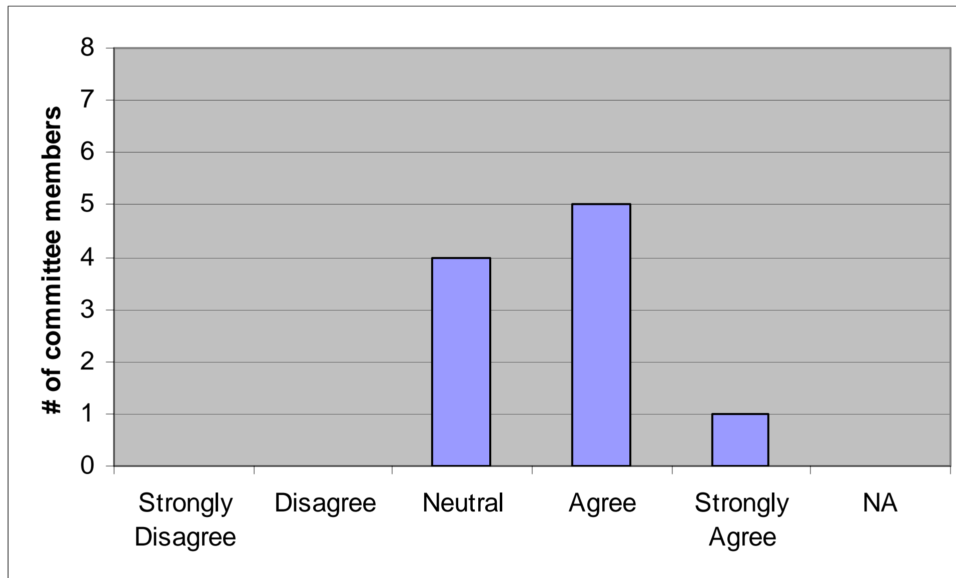

Figure 10: Response frequencies by level of agreement for consumer benefit

Action plan

One member described the action plan by saying "I think we did it (developed the action plan) by clustering what we saw as sort of themes that emerged. I think we had four…themes that we clustered into. One was sort of a Car 87, one was community education, community education awareness, one was sort of a broad-based multicultural training plan." All members agreed that the action plan contained very good suggestions but are concerned about when and whether any parts of the action plan will be implemented. One stated "I think what would make us really happy is if we see some progress in it. I think that would really help us out," and another echoed "So we had some great ideas, I mean I don't think there was ever any dissension,… and we all sort of agreed, yeah, these are problems we have to deal with. But somebody should have said 'Okay, now what? Where did it go and what's being done with the information that we provided?'"

One CMHA employee stated that the action plan was “not fully implemented but steps have been taken,” such as an improved working relationship between the RCMP and MHES. With regards to whether the action plan had had a positive impact on the community the majority of the committee members indicated a positive or a neutral response.

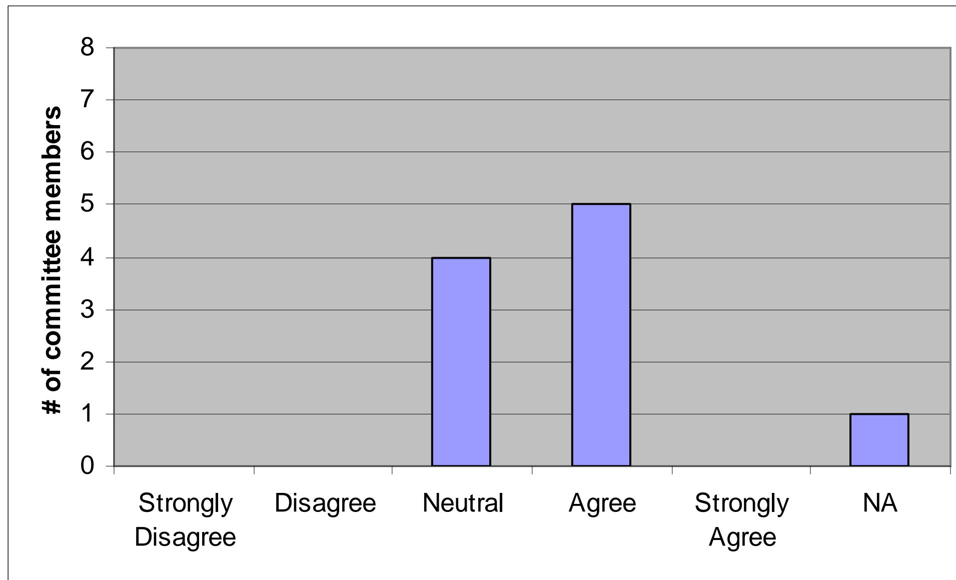

Figure 11: Response frequencies by level of agreement for the impact of the action plan on the community.

Structure of project

There was some debate among the focus group about whether it would have been preferable to meet more often, work more intensely, and complete the project in six months or less, but some members felt that six months was too short no matter how often the group could meet.

The CMHA project director stated that there were challenges for her in combining her full-time job as Education Director for the Richmond CMHA with the six-month part-time work of being the project director for the BC:MHAPP: “So one of my frustrations was trying to focus and concentrate on paperwork around the project in a busy environment where there’s lots of people interrupting all the time. (The timeline was) too short. It’s fine to have a designated coordinator for a period of time, but there was no designated coordinator to take the project on thereafter. There were discussions at the end about who’s going to carry on with this.”

CMHA involvement

Comments were all positive about CMHA involvement and ranged from “Very enthusiastic” to “I think the facilitation of the project went well” and “She (the project

coordinator) did a great job I think. She's got a great sense of humor and sense, and she can keep everybody focused when she really wants to."

The project coordinator expressed her appreciation for CMHA BC's role: "I do appreciate the fact that we had a Provincial coordinator. She was terrific. She was very supportive, knowledgeable, and was prepared to help as best she could when she could. So that's really important to have that person as a leader. And the other thing that was good is we would have teleconferences. The Steering Committee, the coordinators were their titles, so if we could hear about each other's issues, and so it was interesting and felt really reassuring when other people had the same kind of conflict, whether it was a personality conflict, dealing with difficult people on the committee, or overbearing people or no-shows or a policy issue amongst agencies or what have you. . Oh, I know what wasn't helpful, is the Provincial coordinator was not accessible five days a week."

The positive evaluations of CMHA's involvement in the BC: MHAPP, were mirrored in the survey where the majority of survey respondents felt that the support of staff from the Richmond CMHA branch was helpful and appropriate.

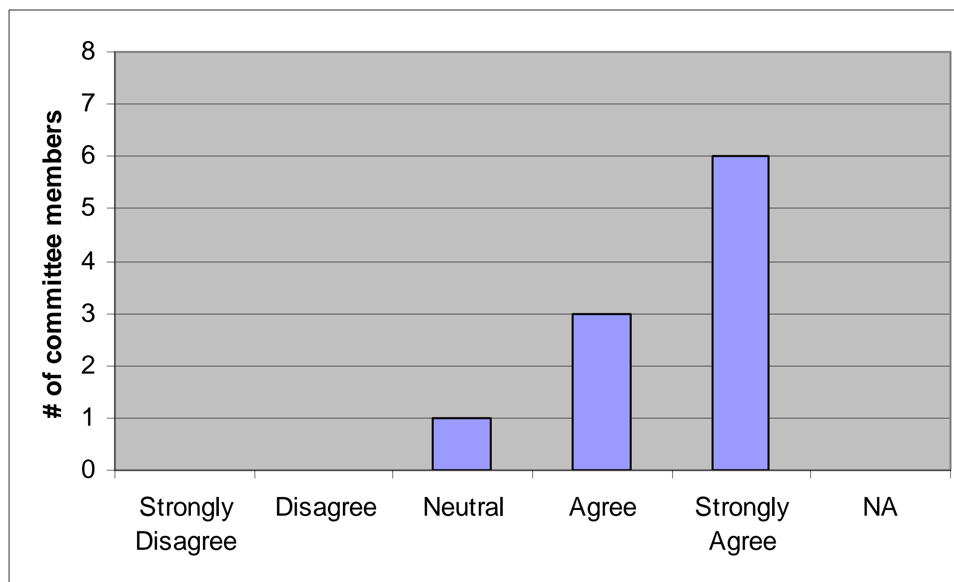

Figure 12: Response frequencies by level of agreement for the support from the local CMHA office.

Would you recommend this project?

Members expressed reluctance to recommend the project until they can see that their action plan is being implemented. One concern was stated "I think we have to be a little bit more proactive with what we did here, and it has to go beyond us. And if it doesn't go beyond us I think we're a failure." Another member commented, "My understanding was, we were putting input into a bigger project that was being done by a collection of communities. There's been nothing from that. I mean, there's been no status report…let alone a thank you... It would be nice to know where stuff has gone, because…we

definitely don't want to feel like we wasted our time… I mean does the mental health patient benefit from this committee? I don't know. We haven't changed how we did work. You know has anything changed to get those people assistance that they need before 911 is initiated? I have no idea."

Vancouver

Evaluation activities

A focus group was held on November 2, and was attended by five former members of the Vancouver BC:MHAPP steering committee. The members were: a representative from the BC Ambulance Service; a representative from the MPA society; a representative from the VGH Psychiatric Assessment Unit; a representative from the Coast Foundation; and an employee of the Vancouver Coastal Health (VCH) Aboriginal Wellness office. Additionally, individual interviews were conducted with the following persons:

Camia Weaver, Provincial Coordinator of the BC:MHAPP;
Jonathan Oldman, Executive Director of the Vancouver-Burnaby branch of CMHA;
Ann McNabb, Manager of Mental Health Emergency Services at VCH;
Lorna Howes, director of mental health for VCH;
Bob Rich, Deputy Chief with the Vancouver Police Department;
Ross Taylor, consumer and employee of Coast Foundation;
Steve Schnitzer, Commander-District One, Vancouver Police Department; and
Rennie Hoffman, Mood Disorders Association of BC.

The survey response rate for the Vancouver committee was fairly high, ten out of sixteen surveys were returned.

Summary of evaluation

The issue of developing better responses to mentally ill persons in crisis was felt to be very timely and important in Vancouver. As one respondent stated, "In the last two, three years it has gotten absolutely, dramatically worse. The number one call police officers go to in the north half of this city is called the Person's Annoying Call, and it is almost always a conflict between somebody who's mentally ill, or seriously drug-addicted, and having a place to go (to find assistance for the mentally ill person in crisis) at that point is the problem." Police were very motivated to work on this issue, and a commonly stated outcome of this project was members achieving a better understanding of each other's mandates, policies and procedures.

Some members were concerned that the Vancouver service area is overwhelmingly large, and the number of agencies working on mental health issues is too numerous to include in a single steering committee. Consequently, some members felt the process was unwieldy and that no large changes were effected by the process. However, some

participants expressed optimism about future implementation of the action plan and the benefits that might be associated with that implementation.

Composition of steering committee

The BC:MHAPP steering committee included consumers, Vancouver police department members, representatives from psychiatry departments at two Vancouver hospitals, members of the Aboriginal health care communities, as well as others concerned with crisis response to the mentally ill in Vancouver. Many interviewees noted that ECOMM (the emergency call center) was not represented on the committee and should have been. Also noted was that representatives from local hospital emergency rooms would have strengthened the committee. One participant commented that it was very challenging to select the right composition for the BC:MHAPP steering committee without getting too large. One member found that others were not taking the task seriously enough and stated, "I found that discouraging, people came and went as if there was nothing more on the calendar that day. I just wasn't particularly impressed with the commitment. It was demoralizing."

Consumer involvement on steering committee

The steering committee included two consumers, and consumer concerns were also brought to the table by mental health advocates who were steering committee members. One person noted that perhaps organizing a separate focus group of consumers who have had involvement with the police would be a way to include consumer perspective on this committee. One consumer felt there should have been more consumer participation, but recognized that this can be challenging for several reasons, including the fact that illness can preclude or limit their participation in committee work.

Partnerships/collaborations

Several participants noted that steering committee meetings provided a good forum for sharing of basic information about which agencies provide which services to the mentally ill, and phone numbers and business cards were shared. For example, the representative from BC Ambulance Service was not previously aware of the Mental Illness First Aid course offered by CMHA, and he is hoping to use that training for his staff.

One key partnership that was strengthened through the work of the BC:MHAPP was between Vancouver Coastal Health and the Vancouver Police Department (VPD). As the VPD member of the steering committee noted, "We have a tighter collaboration now with Lorna Howes from Vancouver Coastal Health. And I'm involved in another mental health committee as well, so I think this has strengthened the ties for me personally. And I'm sort of now the go-to person when it comes to this issue for the police department."

Another committee member commented "I can say that by being involved in this committee I also got involved in facilitating some education workshops at the Justice Institute with the Sheriff's service." In survey results the Vancouver committee members

predominantly felt positive or neutral concerning whether the committee meetings and activities led to increased collaboration and partnerships within their community.

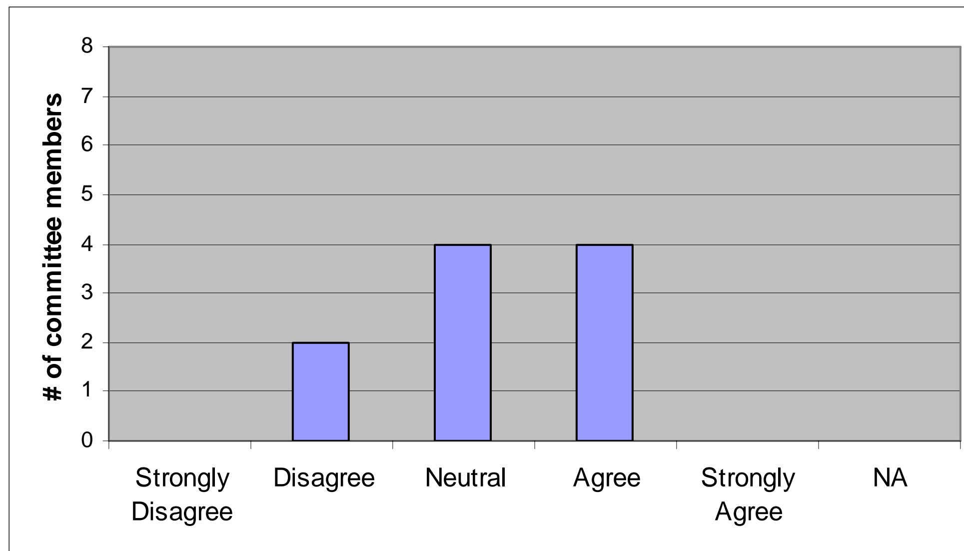

Figure 13: Response frequencies by level of agreement for increased collaboration

Knowledge transfer

Many respondents felt that their participation on the steering committee led to a greater understanding of resources available to people working with the mentally ill. When we asked the question "Do police, mental health and other first responders in your region now better understand each other's mandates, policies and procedures" one respondent answered "I think that was a huge benefit, and yes, they do. They have a better understanding also of each other's challenges, and how to deal with those in a better way." Another respondent noted that the committee meetings raised awareness of challenges the VPD face, including lengthy delays when transporting mentally ill persons in crisis to local hospitals.

The VPD member noted "I have brought up my involvement on the Committee a couple of times during other meetings that I've been to. But probably any dissemination of information will stem in the next few months from what we give police officers, and I am currently working towards that…but certainly by getting together in a steering committee such as this and discussing the issues is a great first start."

One participant felt that the meeting made little difference in how agencies interact, and stated "There was a lack of willingness to commit to any particular course of action, and that was likely because the people at the table did not have the authority to do that." His opinion was shared by two other members who felt that the meetings had not yet led to any concrete examples of knowledge transfer.

The survey results mirrored the mixed responses concerning the development of a better understanding for the mandates of the involved agencies. In terms of the dissemination of

information about mental illness there was a slightly more uniform neutral to negative response.

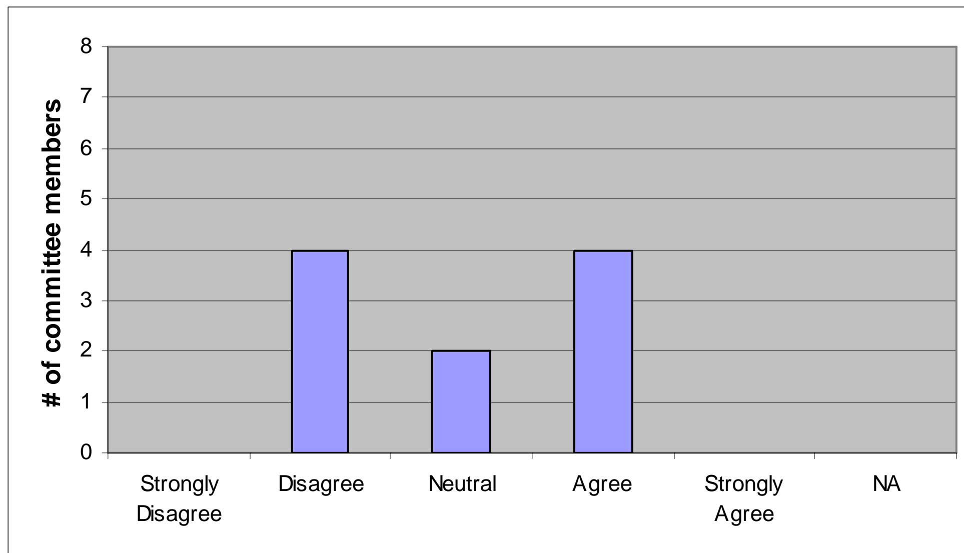

Figure 14: Response frequencies by level of agreement for increased understanding of the mandates of the involved agencies

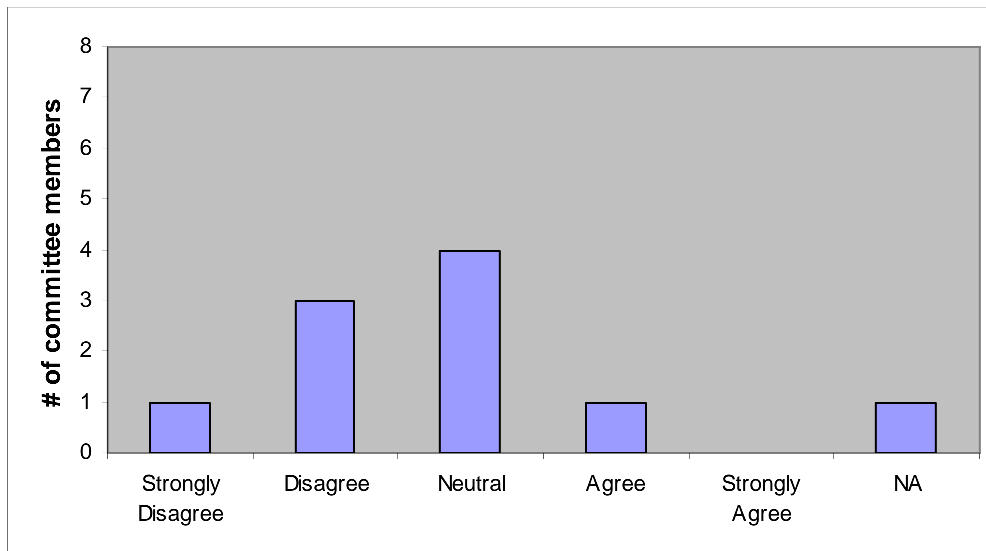

Figure 15: Response frequencies by level of agreement for information dissemination into the community

Effects of the project on consumers

All members of the steering committee felt that it was too soon to evaluate whether this project has had any positive impact on consumers, but several were hopeful that with implementation of parts of the action plan improvements would be noted. Reflecting this

view, most survey respondents indicated a neutral response concerning the benefits for consumers that resulted from the activities and collaborations of the committee's work.

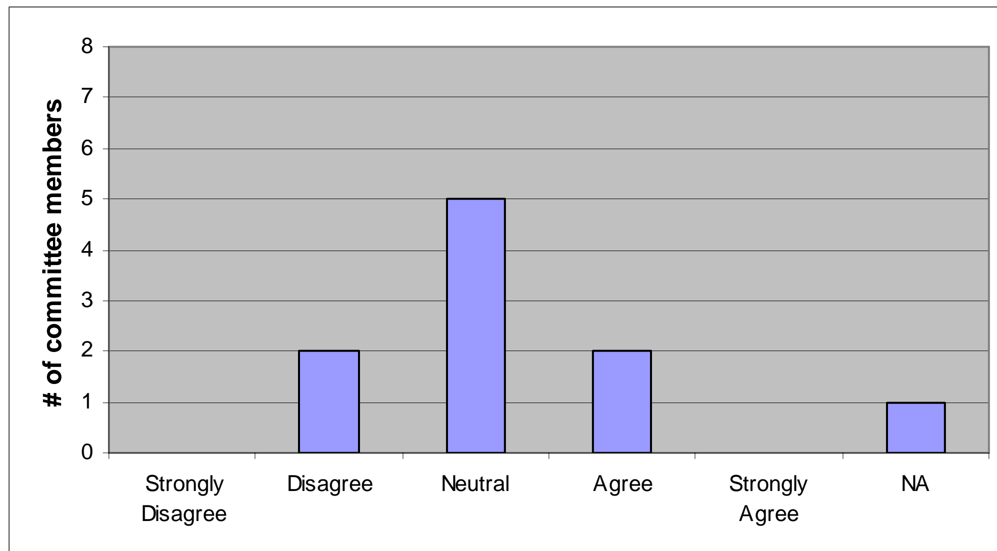

Figure 16: Response frequencies by level of agreement for consumer benefit

Action plan

The Vancouver committee drafted a detailed and ambitious action plan, which seemed to meet the approval of most committee members, although one member described some periods of "heated discussion" about the action plan. Several members felt that the action plan items were quite practical, and once implemented, would make a positive and lasting contribution. The coordinator stressed "I was really intent that people look at creative solutions that did not cost money that you weren't asking for major funding to build a reception centre or whatever..."

One example of a low-budget creative solution involved the action plan recommendation for distribution of the CMHA publication "Mental Health Rescource Guide" to all VPD officers. Another member noted that Lorna Howes (VCH) and Steve Schnitzer (VPD) are very involved in Phase 2 of the BC:MHAPP which involves implementing the recommendations from the action plan.

Since the action plan has not yet been implemented most Vancouver survey respondents indicated a neutral or negative response concerning the positive impact of the action plan that was developed.

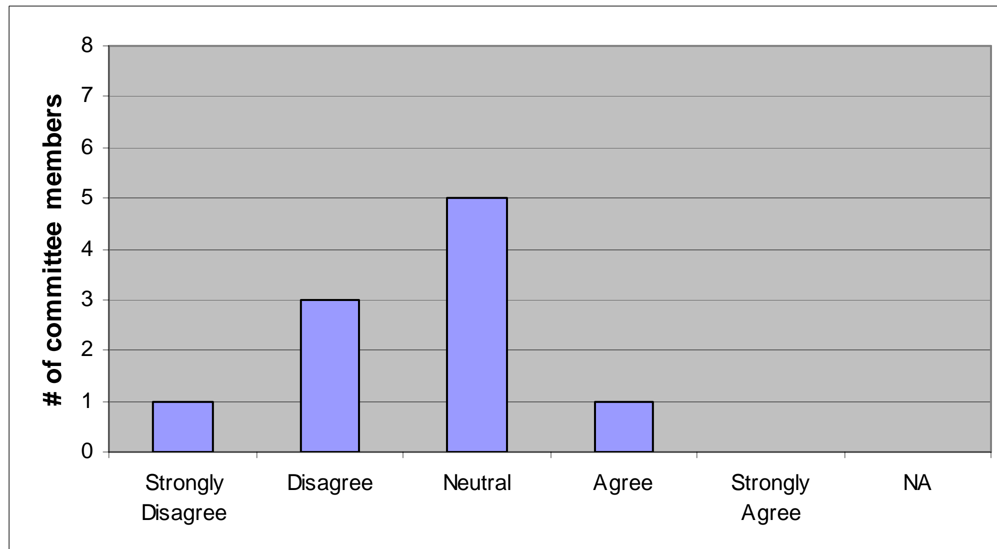

Figure 17: Response frequencies by level of agreement for the impact of the action plan on the community.

Structure of project

There was general consensus throughout the steering committee that six months is "much, much too short, especially in the big city," and there was a recommendation that one year would have been a more realistic term for this project, although some participants also expressed a concern that it might be harder to get commitment from steering committee members for a one-year term. One member pointed out that CMHA might consider the fact that doing a project of this type is different in Vancouver than in a smaller town, and therefore allocate more resources to the larger cities. Another person mentioned that taking a break from meetings during the summer months may have led to a loss of momentum.

One participant suggested "If I would make any recommendations to do it differently next time, I would have an evaluator right at the front. So that as people move forward they understand what indicators can be or how they measure if this is making a difference."

Two interviewees were very outspoken in their criticism of the structure and even the concept of the project. One stated "I think the project was ill-advised in the first place. I think that it was an identified problem, and most assuredly police dealing with people with mental illness is a huge problem." But, he continued, "…the interaction between police and people with mental illness is as tender as it can be. The police are very caring individuals, and they understand mental illness. They also understand that when the mentally ill guy is swinging a garden hoe at you, that he could kill you."

One VPD respondent commented "I guess the premise of the study is that the police need to change in order to provide better access to mental health. I question the premise. I'm not sure it was the right place to start… we put our officers through a four-day crisis

intervention course…and from our perspective that's a pretty significant investment…but the people who premised this thing (by saying) the police need to be better trained, and I thought "Do you know how trained we are not, or" you know. "Are we responding inappropriately to calls? Are you sure that you got that part figured out first?" If you don't actually look at the system and see where the choke points are, I guess I think that the people that authored this study made the assumption that the police were the issue, and without first doing an analysis of where the choke points were."

CMHA involvement

Most participants felt that CMHA was the appropriate organization to lead a project such as this one: "I think the CMHA was probably the only group that had a broad enough mandate and the community base to do it" according to one respondent, and many felt that the CMHA BC Division was skillful at facilitating the process. One participant commented "CMHA BC was very helpful with resources and staff time and coordinating the whole effort -- I think they were fabulous. They really made this happen."

One person suggested that leading a large steering committee like the BC:MHAPP in Vancouver was very challenging, and that perhaps "CMHA should invest in getting some group facilitation support" for the person leading the group meetings. Another expressed this concern: "I know that CMHA is a very hard proponent of spreading education through the public and into different services within the system. I'm not sure what their strength is in terms of taking their proposed recommendations and advocating."

The survey results revealed that the vast majority of respondents felt that the involvement of staff from the Vancouver CMHA branch was helpful and appropriate.

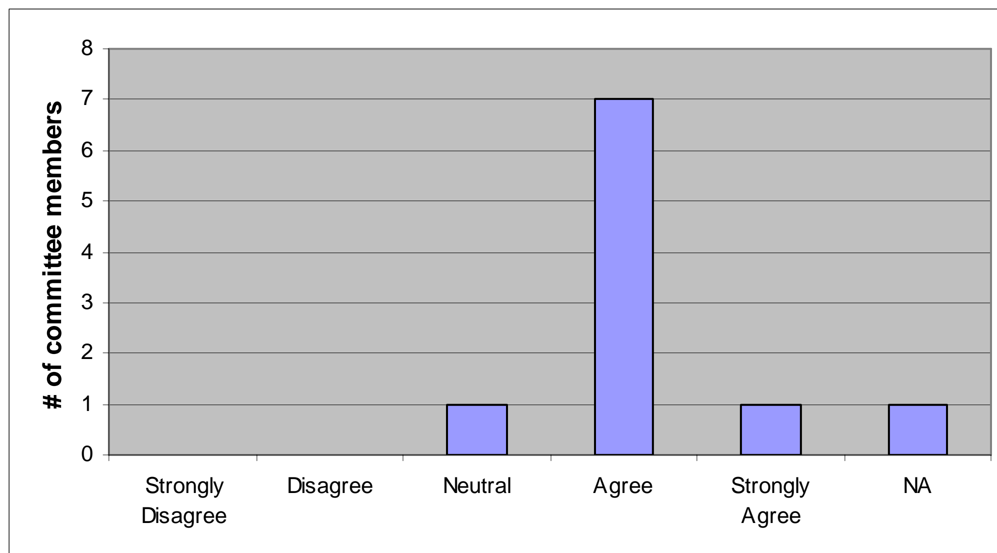

Figure 18: Response frequencies by level of agreement for the support from the local CMHA office.

Would you recommend this project?

Most participants felt that they would recommend this process to other communities, especially as a first step in developing better responses to mentally ill persons in crisis. One respondent commented "Well I think having this project flow from "Blue and Gray" was really useful. CMHA as a movement had credibility and knowledge in this area, and some expertise having already done research, at a sort of theoretical level, and now we take it to a local level … it gives credibility with local stakeholders to say 'Okay, you actually know something about this.' It's not just another report that sits on the shelf somewhere."

Several participants commented that the unmet social needs of the mentally ill population limit the ability of well-intentioned projects to effect change. One comment from a consumer was "if some of those systemic problems, like access to housing and employment were resolved or addressed, then there would be less need for working on police response to mentally ill people in crisis… I think the two have to go together."

Another respondent thought the structure of this project may be better suited to smaller communities, while the representative from BC Ambulance Service stated "We're (BCAS) governed by provincial policies that aren't specific to a small community, and although sometimes it's great, the same rules apply province-wide, it's also a hindrance in that it's tough to change a provincial policy."

Another interviewee felt he could not recommend the process as it is currently structured: "When I heard the premise of this study at the beginning, I was like, why are we thinking that it's police officers who need to be better set up to handle these calls in the first place?" He went on to say that he felt more thought needed to go into discovering the root causes of increased interactions between the police and mentally ill persons in crisis, and he expressed concern that the problems are exacerbated by the unmet social needs of the mentally ill.

Williams Lake

Evaluation activities

A focus group was held on November 14th in Williams Lake, with attendance of a representative of the RCMP, a psychiatric nurse, and the nurse-manager of the ER at Cariboo Memorial Hospital. Additionally, individual interviews were conducted with:

Trevor Barnes, Executive Director of CMHA in Williams Lake,
Penny Reid, CMHA employee, also involved in the BC:MHAPP,
Catherine Doverspike, Project Director of BC:MHAPP in Williams Lake.

From the Williams Lake committee four out of the nine distributed surveys were returned and included in the analysis.

Summary of evaluation

The process in Williams Lake resulted in a MOU between the hospital, police and mental health and was endorsed by the IH. The feeling was that as a result of this MOU important information was now being exchanged across sectors and the MOU has ensured that this will continue over time. There was a strong feeling that members of this community had really come together over the issues, that concrete changes in practice would result, and that consumers were beginning to be affected by the changes.

Composition of the steering committee

In general the participants felt that all important organizations and groups were part of the steering committee except for emergency room personnel, who joined the committee after the first few months. The project coordinator identified the lack of Aboriginal representation on the committee and explained that she had made many efforts to include Aboriginal organizations, but had been unsuccessful.

Consumer involvement in the steering committee

Two consumers were involved on the steering committee, although one was unable to participate regularly due to illness. In speaking about the active role of consumers this committee member said, “They contributed. They made emergency contact cards for us. They helped and advised us about information that we should use and how to present information to the public about their own language. And it was wonderful actually to have them on the committee.”

The CMHA member had a differing opinion, “Well I think it’s harder for consumers to stay at the table for any length of time, and I haven’t found that methodology yet to keep consumers at the table. I can keep them there for a little while then they drift. And I think that, you know, they get overwhelmed I think, with what’s happening, or it’s just not moving quickly enough for them. Because you get people who are also zealots, right – “Hey, I’ve been through that, I know what needs to happen…”

Partnerships/collaborations

The participants on the committee felt that partnerships within the community were strengthened. Because Williams Lake is a small community most members were already aware of each other but there was evidence that people became further aware of each other’s mandates and one member felt that because the committee had continued to meet after the project was over that the partnerships were becoming more active and meaningful over time.

Similarly, all of the survey respondents of the Williams Lake committee agreed that the committee meetings and activities led to increased collaboration and partnerships within their community.

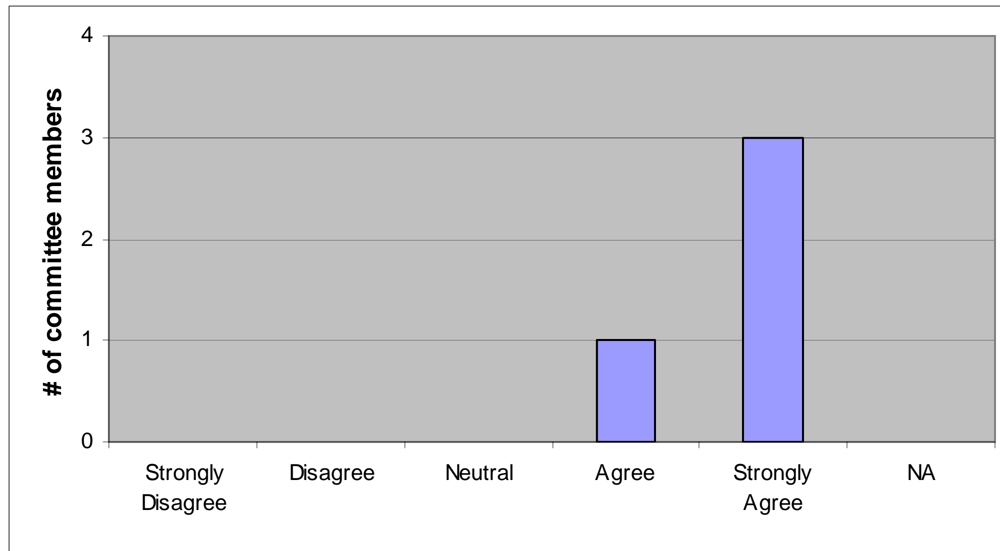

Figure 19: Response frequencies by level of agreement for increased collaboration

Knowledge transfer

Knowledge transfer activities in this community included the development of cards with emergency mental health information on them. These cards were being distributed to all of the mental health service agencies involved. In reference to this one member indicated, "… So that is now a sustainable little resource that we've created. We do talks in the community and…I'm on my way to Bella Coola with some information about how we respond to critically ill people with mental illnesses and drug problems…how we respond in this community and I'm going to share that with the Bella Coola community…So I think it's all sustainable stuff."

The steering committee also facilitated face to face meetings between physicians and police to assist them in better understanding each other's role and challenges (e.g., the issue of police waiting for hours with mentally ill people at the hospital)**.** In the following passage the success of these meetings is described, "We had just two meetings. And it was more to understand each other's roles and some of the challenges that we face…it was very informative on both sides, and I think some of the information that was exchanged back and forth…involved mostly when the police officer goes to the hospital with someone they've apprehended under the Mental Health Act and there were two to three hour waits for those officers at some times, and doctors didn't quite understand that that left no one behind to do police work…at the same time the doctors were able to explain…the difficulties that they deal with committing someone under the Mental Health Act, and what information they are looking for. So it was a really good exchange of information for each other…"

Committee members felt that the gains that had been made in this process, however, would only be sustainable if physicians and police continued to meet and if emergency room nurses were also brought into the discussion. One move that had been made to increase the chances of sustaining this process was to set out a service agreement or

MOU that was signed by the IH and the police, the hospital and mental health. In describing this agreement the coordinator indicated “I don’t think there’s agreements in too many other places in BC where we sort of try to define what happens when the police arrive with a person with mental illness who’s in crisis. And it was working, and it will continue to work well, it’s just that what happens is that you get personnel changes and then people aren’t fully oriented, so we have to go back again, and just remind everybody and orient the new people and then it’ll be fine.”

The survey results further complemented the statements of committee members concerning improved understanding for the mandates of the involved agencies, and the resulting education and information dissemination about mental illness in the community.

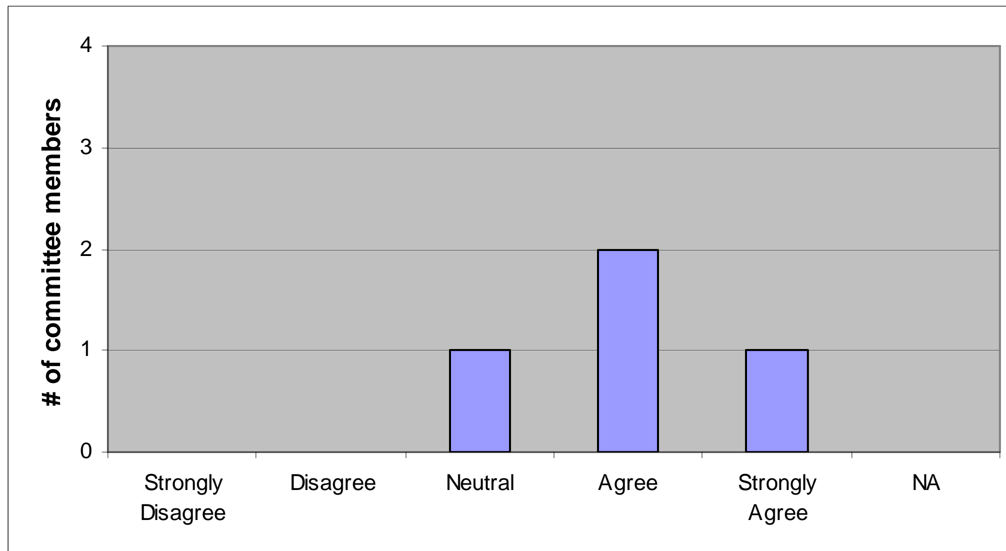

Figure 20: Response frequencies by level of agreement for increased understanding of the mandates of the involved agencies

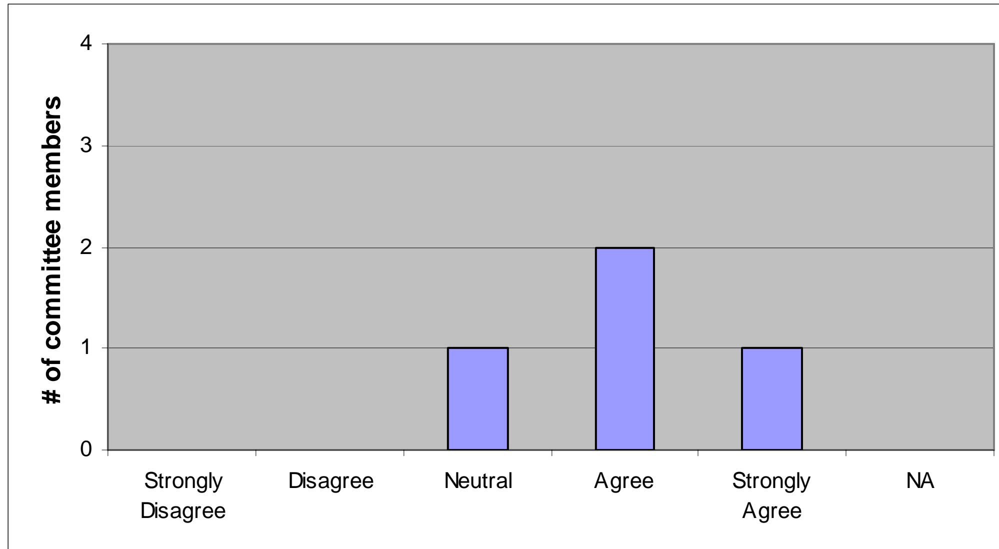

Figure 21: Response frequencies by level of agreement for information dissemination into the community

Effects of the project on consumers

As expressed in this quote, members of the steering committee felt that consumers had been positively affected by the collaborations and resulting changes: “Unequivocally yes, period. They have, we’ve seen it. They have very much so”. The changes that were cited were the result of better interagency collaboration and understanding. In fact, members of the steering committee were able to give concrete examples of how police and other practices had changed in ways they felt were good for consumers.

This positive evaluation of the impact of the BC: MHAPP was also reflected in the survey responses. Most respondents indicated a neutral or positive response concerning the benefits for consumers resulting from the activities and collaborations of the committee’s work.

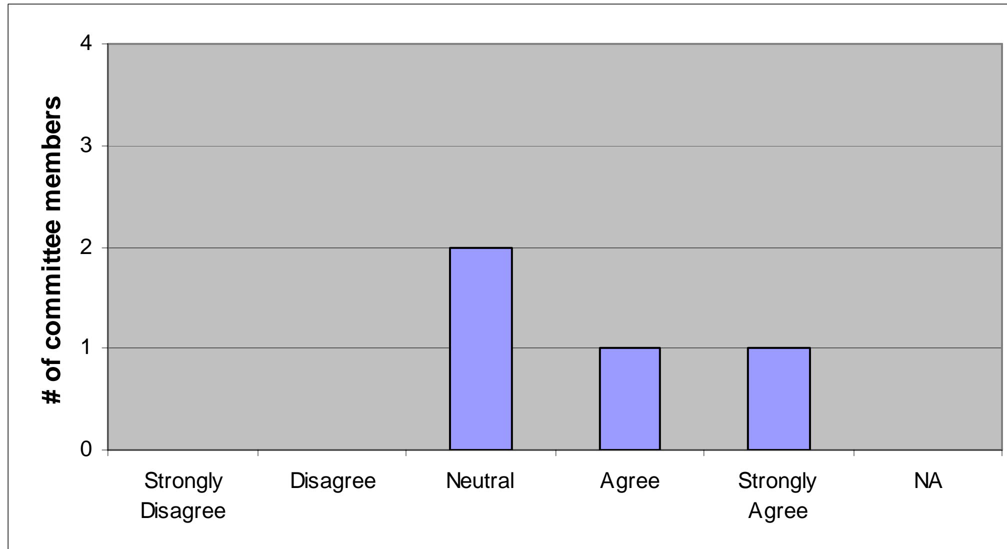

Figure 22: Response frequencies by level of agreement for consumer benefit

Action plan

In Williams Lake the process of developing the action plan was described as very successful and consensus oriented, and some of the items have already been implemented. For example, some consumers were using wallet cards designed by consumer committee members that identify their mental illness, medications, etc. Police and other first responders had been given cards that had emergency mental health information on them. The MOU between hospitals, police and mental health had been signed and meetings on these issues were ongoing. The Mental Illness First Aid course was being regularly offered to groups and another power point presentation had also been developed by the committee and was being shown across service sectors.

Not surprisingly the majority of the Williams Lake survey respondents indicated agreement regarding the positive impact of the action plan.

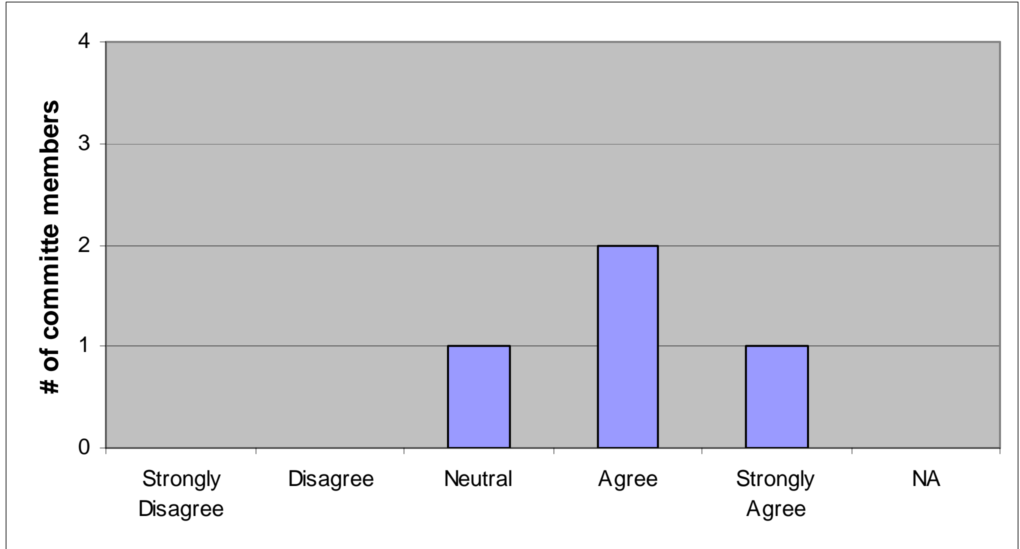

Figure 23: Response frequencies by level of agreement for the impact of the action plan on the community.

Structure of the project

The steering committee felt that the process worked well in their community, in part because of its small size and the fact that it is easier in some ways to get key players to the table. Most people felt that the project should have been longer than six months.

CMHA involvement

All agreed that CMHA had played a key role in the process and that CMHA BC had provided excellent support. This opinion was also reflected in the survey responses.

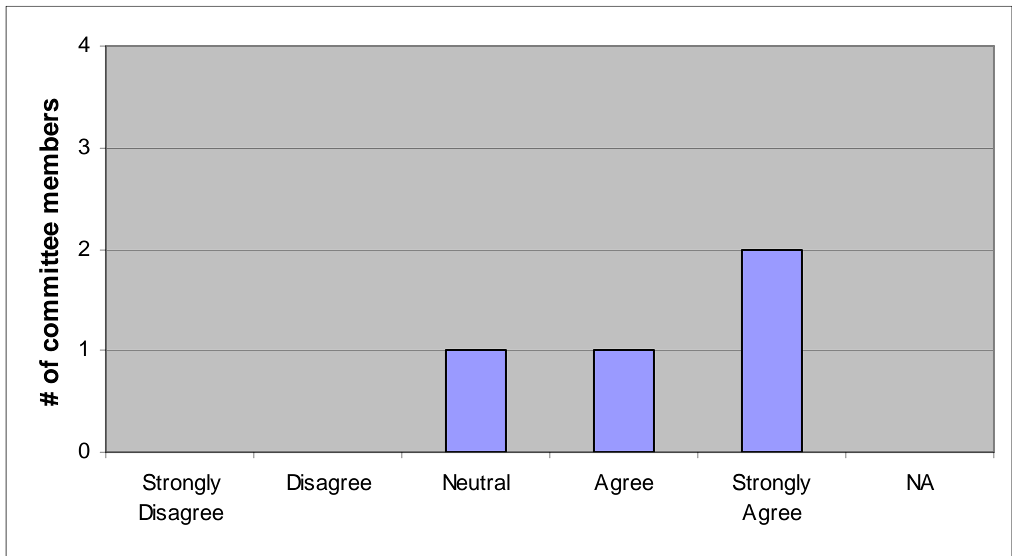

Figure 24: Response frequencies by level of agreement for the support from the local CMHA office.

Would you recommend this project?

The steering committee in Williams Lake unanimously recommended this project for other communities, but it was felt that the structure may need to differ depending on community size.

D. Conclusions

Our findings suggest that the BC:MHAPP was most successful in bringing together mental health workers, consumers, RCMP/police and other first responders to form collaborative working relationships through the exchange of information about their respective experiences, roles and mandates. This information exchange was seen as one of the most valuable aspects of the BC:MHAPP by its participants and in some instances led to concrete partnerships across sectors. Although knowledge transfer activities at this stage of the process were mainly restricted to the steering committees in each community, there were some exceptions where communities were able to implement processes that were beginning to facilitate changes in practice with respect to responding to people with mental illness in crisis.

The CMHA was seen as the most appropriate organization to lead the BC:MHAPP process and most respondents praised the work that local coordinators provided to the committee and the leadership role of CMHA BC. Respondents generally recommended the process for other communities, provided that more follow-up by CMHA was provided following the six months and that support and resources were provided so that action plans could be implemented.

Respondents felt that the work of steering committees was limited by the lack of authority that most steering committee members had to make changes. Some members felt that participation on steering committees of representatives from the Provincial Health Services Authority, regional health authorities and municipalities would give committees more power to make the changes that the committees identified were needed for better responses to people with mental illness. Systemic problems like emergency room wait times and the general lack of social supports (e.g., housing) for people with mental illness were seen as critical problems but ones that committees could rarely concretely address.

E. Recommendations

The following recommendations arising from the research are offered for their relevance for implementing the BC:MHAPP in other communities:

Steering Committee Composition

- Given that hospital wait times in Emergency were a clear issue across all communities the involvement of emergency room personnel was seen as critical for steering committees to be able to effectively address the issues.
- Consumer engagement on committee steering committees could be enhanced through the use of focus groups (the Nanaimo model).
- Stronger support from CMHA BC for getting more ethnically diverse representation on steering committees, including Aboriginal representation and members from BC's Indo-Canadian and Chinese-Canadian communities.
- The involvement of provincial and regional health authority representatives with a political commitment to helping communities implement their actions plans.

Structure of the Project

- The project timeline should be increased from six months to a year.
- CMHA BC should give clear direction to each committee at the outset regarding the expectations of each committee and should follow-up with committee members after the project is formally completed to keep them apprised of further developments.
- An external evaluator should be engaged at the outset of the process to assist committees with defining their goals and deciding how best to measure outcomes.
- Different communities may require slightly different models – success is dependent on size of community, strength of leadership, existing opportunities, timing and other contextual factors.
- Experienced facilitators should be used to lead the steering committee process.

Appendix A

Logic Model for Evaluation of Phase 1 "Building Capacity: Mental Health and Police Project"

Goals:

1) Evaluate progress and impact of action plan implementation at all sites
2) Evaluate sustainability of actions taken
3) Identify and assess existence of and effectiveness of collaborations within the community beyond action plan
4) Identify innovative initiatives beyond action plan
5) Assess initial community impacts, including impacts on consumers
6) Evaluate the extent of knowledge transfer to, and education of, police, mental health workers and first responders
7) Evaluate effectiveness of provincial/CMHA supports to sites

Population(s) of Interest:

1) Police
2) Mental health service providers
3) First responders (paramedics, hospitals, etc.)
4) Consumers and family members
5) Other key constituents (e.g. populations w/specific needs)

Short-term Objectives:

1) Action plans are underway in all six communities
2) Collaborations between some or all stakeholders have been established and are ongoing
3) Evidence of initiatives emerging from collaboration are apparent
4) Initiatives are beginning to result in practice and policy changes
5) Ongoing training of and knowledge transfer to police, mental health and other first responders in dealing w/mentally ill persons in crisis
6) Evaluate other actions, collaborations, initiatives taking place

Short-term indicators:

1) Action plans continue to guide process and implementation of changes
2) Collaborative relationships have been maintained and are inclusive and effective (e.g., key constituents are involved, represent the community makeup and interact regularly)
3) Evidence that people with mental illness have been meaningfully involved in the process
4) Police, mental health and other first responders have a better understanding of mental health services available (e.g., training and knowledge transfer are taking place)
5) Police, mental health and other first responders better understand each other's mandates, policies and procedures (e.g., training and knowledge transfer)
6) Evidence of innovative initiatives and plans for sustainability (e.g., development of information systems and joint protocols)
7) Evidence that consumers have been positively effected by this process (e.g., improved crisis response)

Long-term objectives:

1) Capacity of police, first responders and mental health system to work collaboratively has improved
2) Effective models of response to people with mental illness in crisis are in place
3) Plans for sustainability have been developed and initiated
4) Ongoing evaluation continues
5) Training and knowledge transfer activities are ongoing
6) Evidence that consumers have been positively affected by this process (e.g., improved crisis response)

Long-term Indicators:

1) Police, first responders and mental health services have established sustainable means of communication/collaboration
2) Overall community response to people with mental illness in crisis has improved
3) Information systems and joint protocols have been developed
4) Evidence that consumers have been positively affected by this process (e.g., improved crisis response)

Strategies:

Evaluation of action plan process through:
1) Interviews
2) Focus groups
3) Surveys

Activities:

1) Site visits
2) Meetings with key informants
3) Surveys
4) Interviews & Focus groups

Appendix B

Survey

Building Capacity: Mental Health and Police Project (BC: MHAPP)

Background: In the 04/05 fiscal year, the BC Mental Health and Addiction Services division of the Provincial Health Services Authority and the Vancouver Foundation provided funding to the CMHA BC Division to implement the BC: MHAPP. This community capacity building project was designed to improve responses by police officers to people with mental illness who are in crisis in six BC communities (Delta, Richmond, Vancouver, Cranbrook, Williams Lake and Nanaimo). Following an internal evaluation of this project, CMHA BC Division has now contracted with Dr. Marina Morrow and her research team (Agnes Black and Andrea Penney) to conduct an external evaluation of the BC:MHAPP. The survey which follows is the first step in this external evaluation. Your assistance with this evaluation is greatly appreciated!

Survey Questions

Please indicate below each statement whether you agree or disagree with the statement. Check 5 if you strongly agree, check 1 if you strongly disagree, etc.

Example:

strongly disagree	disagree	neutral	agree	strongly agree
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

1) Our committee meetings and the activities that resulted from our meetings have led to increased collaboration and partnerships within our community.
   ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

2) Police, mental health, hospital personnel and first responders in our region now better understand each other's mandates, policies and procedures.
   ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

3) Information and education about mental illness have been disseminated in our community as a result of our committee's work.
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

4) Consumers of mental health services have benefited from activities and collaborations resulting from our committee's work.
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

5) The involvement of staff at my local office of CMHA in this project was appropriate and helpful.
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

6) The involvement of staff at CMHA BC Division in this project was appropriate and helpful.
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

7) The action plan developed by our BC:MHAPP steering committee has had positive impacts on the community.
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

8) Please list any additional comments you would like to add about the BC:MHAPP. What were the most effective aspects of the project, least effective aspects, suggestions for changes, etc?

9) If applicable, give examples of any recent cases of mental health crises in which police were involved which resolved differently/faster/better than prior to the BC:MHAPP.

Appendix C

Focus group or interview questions for non CMHA members

Building Capacity: Mental Health and Police Project (BC: MHAPP)

Background/Preamble

In the 04/05 fiscal year, the BC Mental Health and Addiction Services division of the Provincial Health Services Authority and the Vancouver Foundation provided funding to the CMHA BC Division to implement the BC: MHAPP. This community capacity building project was designed to increase collaborations between police, mental health, hospital personnel and first responders in communities in order to improve responses by police officers to people with mental illness who are in crisis. The project was undertaken in six BC communities (Delta, Richmond, Vancouver, Cranbrook, Williams Lake and Nanaimo). Following an internal evaluation of this project, CMHA BC Division has now contracted with Dr. Marina Morrow and her research team (Agnes Black and Andrea Penney) to conduct an external evaluation of the BC:MHAPP. We are here today to discuss with you the process and outcomes of the project in your community.

We understand that each of you played a role in this process through your involvement in a Steering Committee and the development of an Action Plan. So to begin with we would like to ask you some questions about the steering committee and its composition.

Focus Group or Interview Questions

Steering Committee

1) Was your steering committee comprised of individuals representing key constituents concerned with crisis response to mentally ill persons in crisis in your community? Were there people or groups that you think should have been included but weren't?

2) If you did not have representation from some groups, what were some of the barriers to their participation?

3) Do you feel that consumers of mental health services were adequately represented on your steering committee and did they have opportunities for meaningful participation?

Partnerships/Collaborations

1) Discuss the collaborations or partnerships within the community that formed as a result of your project, either during or after the end of the project. Were there collaborations or partnerships that didn't happen but would have been helpful?

2) Do you think these collaborations/partnerships will continue long-term? Why or why not? Were steps taken to try and ensure the sustainability of agency collaboration/partnership (as opposed to individual collaboration/partnership)?

Knowledge Transfer

1) Describe any ways in which information about mental illness or mental health services has been disseminated throughout your community as a result of your project.

2) Do police and other first responders in your region now have a better understanding of mental illness or resources to assist mentally ill persons in crisis?

3) Do police and other first responders in your region have a better understanding of how to more effectively resolve a mental health crisis? Are they able to use this understanding effectively as individuals and at an agency level?

4) Given changes in personnel, are there mechanisms to sustain this knowledge transfer?

5) Do police, mental health, hospital personnel and first responders in your region now better understand each other's mandates, policies and procedures? Has this been beneficial?

6) Has the knowledge been transferred on an agency level (rather than just on the individual committee member level)?

7) Has this changed the way the agencies and/or individuals interact?

8) Have persons with mental illness in your community benefited from this change? If so, how? Can you give some examples of these changes and how they have been documented?

Action Plan

1) Your steering committee developed an action plan. Can you tell me more about the process of developing the action plan?

2) Do you feel all members of your steering committee had input in drafting the plan?

3) Was there consensus about the action plan items?

4) Could you describe any challenges in developing the action plan? How were those challenges addressed?

5) In your community have you been able to implement some parts of the action plan already? What has facilitated this? What has made it difficult? If yes, then ask:

    a. What has resulted from the implementation of your plan?

    b. What impact have these changes had on the response to people with mental illness in crisis in your community? Can you give some specific examples?

    c. Are the activities resulting from your action plan implementation ones that will have a lasting impact?

    d. Discuss the ways in which you feel consumers of mental health services have benefited from activities undertaken by your project. Can you give some examples of these changes and how they have been documented?

    e. Who else has benefited from the project and what other changes have occurred?

    f. Given the inevitable changes in personnel, are there mechanisms to sustain knowledge transfer and/or changes in practice that have occurred as a result of the action plan?

CMHA Involvement in Process

1) How do you feel about the involvement and support of your local CMHA office in the BC:MHAPP in your area? How might their involvement have been improved?

2) How do you feel about the support and involvement of the CMHA BC Division in the BC:MHAPP in your area? How might their involvement have been improved?

Final Questions

1) Would you recommend this project to other communities? Why or why not?

Appendix D

Interview questions for CMHA coordinators and staff

Background/Preamble

In the 04/05 fiscal year, the BC Mental Health and Addiction Services division of the Provincial Health Services Authority and the Vancouver Foundation provided funding to the CMHA BC Division to implement the BC: MHAPP. This community capacity building project was designed to increase collaborations between police, mental health, hospital personnel and first responders in communities in order to improve responses by police officers to people with mental illness who are in crisis. The project was undertaken in six BC communities (Delta, Richmond, Vancouver, Cranbrook, Williams Lake and Nanaimo). Following an internal evaluation of this project, CMHA BC Division has now contracted with Dr. Marina Morrow and her research team (Agnes Black and Andrea Penney) to conduct an external evaluation of the BC:MHAPP. We are therefore here today to discuss with you the process and outcomes of the project in your community.

We understand that each of you played a role in this process through your involvement in a Steering Committee and the development of an Action Plan. So to begin with we would like to ask you some questions about the steering committee and its composition.

Interview Questions for CMHA

Steering Committee

1) Was your steering committee comprised of individuals representing key constituents concerned with crisis response to mentally ill persons in crisis in your community? Were there people or groups that you think should have been included but weren't? Discuss any attempts that were made to involve these groups.

2) If you did not have representation from some groups what were some of the barriers to their participation?

3) Do you feel that consumers of mental health services were adequately represented on your steering committee and did they have opportunities for meaningful participation?

Partnerships/Collaborations

1) Discuss the collaborations or partnerships within the community that formed as a result of your project. Were there collaborations or partnerships that didn't happen but would have been helpful?

2) Do you think these collaborations/partnerships will continue long-term? Why or why not?

Knowledge Transfer

1) Describe any ways in which information about mental illness or mental health services has been disseminated throughout your community as a result of your project.

~~2)~~2) Do police and other first responders in your region now have a better understanding of mental illness or resources to assist mentally ill persons in crisis?

~~3)~~3) Do police and other first responders in your region have a better understanding of how to more effectively resolve a mental health crisis? Are they able to use this understanding effectively as individuals and at an agency level?

~~4)~~4) Given changes in personnel, are there mechanisms to sustain this knowledge transfer?

~~5)~~5) Do police, mental health, hospital personnel and first responders in your region now better understand each other's mandates, policies and procedures? Has this been beneficial?

~~6)~~6) Has the knowledge been transferred on an agency level (rather than just on the individual committee member level)?

~~7)~~7) Has this changed the way the agencies and/or individuals interact?

8) Have persons with mental illness in your community benefited from this change? If so, how? Can you give some examples of these changes and how they have been documented?

Action Plan

1) Your steering committee developed an action plan. Can you tell me more about the process of developing the action plan?

2) Do you feel all members of your steering committee had input in drafting the plan?

3) Was there consensus about the action plan items?

4) Could you describe any challenges in developing the action plan? How were those challenges addressed?

5) In your community have you been able to implement some parts of the action plan already? What has facilitated this? What has made it difficult? If yes, then ask:

    a. What has resulted from the implementation of your plan?

    b. What impact have these changes had on the response to people with mental illness in crisis in your community? Can you give some specific examples?

    c. Are the activities resulting from your action plan implementation ones that will have a lasting impact?

    d. Discuss the ways in which you feel consumers of mental health services have benefited from activities undertaken by your project. Can you give some examples of these changes and how they have been documented?

    e. Who else has benefited from the project and what other changes have occurred?

    f. Given the inevitable changes in personnel, are there mechanisms to sustain knowledge transfer and/or changes in practice that have occurred as a result of the action plan?

Structure of the Project

1) What are your thoughts about the timeline for the project (six months)?

2) What other suggestions do you have that might have improved the project, locally, regionally or provincially (such as methods to sustain knowledge transfer)?

3) Would you recommend this process for other communities?

CMHA BC Division Support

1) Was the support from the Provincial Coordinator and CMHA BC Division helpful? What parts were particularly helpful? What additional things would have been helpful? Were there any parts that were not helpful?