Systems Enhancement Evaluation Initiative (SEEI)
Phase II

Waterloo-Wellington Crisis System Evaluation

October 2008

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The Ontario Mental Health Foundation
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MENTAL HEALTH AND DEVELOPMENTAL SERVICES

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Table of Contents

Foreword

As I reflect back on this evaluation and my roles as Co-Principal Investigator and Regional Crisis System Coordinator, I want to take this opportunity to share some of my learning and experiences.

The newly formed Waterloo Wellington Dufferin Regional Crisis Committee had not yet held its inaugural meeting and I was in my first month as the Regional Crisis System Coordinator when the request for proposals for Phase II of the *Systems Enhancement Evaluation Initiative* arrived in November 2005. The Committee was supportive and excited about the opportunity and appreciated the Ministry of Health and Long-Term Care's support for evaluation initiatives. At the same time, the Committee and the research team recognized the challenges inherent in conducting research on a system that would be changing and forming as it was being evaluated. I want to acknowledge the Waterloo Wellington Dufferin Regional Crisis Committee for being open to evaluation so early in your formation. This willingness certainly demonstrates your transparency and your commitment to partnership, improvement and excellence.

The reader's bottom line questions will probably be 'What have we learned?' and 'What does it mean for me in my work?' Each contributor will likely scan the report to see if their perspective is included or accurately reflected, and whether the evaluation found evidence of positive results from their agency's contribution, as well as the collective hard work which has been done to improve our crisis services over the last several years.

There may be some disappointment that we did not find evidence of progress in some areas. It will be important to keep in mind that the evaluation focused on the system as whole and not on any particular service or program. The value of this research is found not simply in the summary of results but in understanding what the results mean, why they are important, and in discerning what actions we as a crisis system need to take as a result of the findings.

From the outset, the research team discussed the potential for conflicts of interest. My dual roles as Co-Principal Investigator and as a subject of the study led to the decision that I would contribute in all areas of the study, but would step aside when the data were collected and analyzed by the researchers.

An unanticipated benefit and area of learning for me came through the partnership between the 'field' (service providers and people with lived experience) and the research community. There was tremendous learning and networking when the researchers from all the SEEI studies met and reported on their work. The field/researcher partnership has great potential in supporting research which is well grounded in the realities at a service-delivery level, and in building the capacity for research and evaluation within the service system.

In providing and evaluating crisis services in our communities, I want to emphasize that people and their families who have experienced the crisis system must be at the centre of our work. Our mental health system has adopted recovery principles but learning how to move beyond ‘agreement in principle’ to implementation is a much longer journey. As a crisis system we are charting new territory. My hope is that this evaluation will help us keep the voices of people with lived experience and their families at the heart of our work as we move forward, and that the findings will help us understand how to make progress on this journey.

This report reflects the tremendous efforts of all the contributors and supporters of this evaluation. I am confident that with continued coordination and cooperation between service partners, people with lived experience, and family members, we will continue successfully on this journey toward a recovery-oriented crisis system in Waterloo Region and Wellington County.

Elly Harder, Co-Principal Investigator

Acknowledgements

First and foremost, the research team wishes to thank the people with lived experience and family members who participated in this endeavor. This evaluation would not have been possible without your openness to sharing your experiences and your willingness to devote your time to the research.

Thank you also to the Waterloo Wellington Dufferin Regional Crisis Committee. Your support and your collective commitment to making our crisis services better made this evaluation tenable from the start.

We want to thank our funders, the Ontario Mental Health Foundation and the Ministry of Health and Long-Term Care. Your recognition of the need for research and evaluation and your financial support is essential in assisting the field to provide high quality, recovery-focused services to people in crisis.

The research team is appreciative of the importance attached to knowledge exchange within the System Evaluation Enhancement Initiative (SEEI). The SEEI has provided funding support for knowledge exchange events which create the opportunity both locally and provincially for us to share our findings and to explore ways to improve services. The development of the Ontario Mental Health and Addictions Knowledge Exchange Network (OMHAKEN) with its potential for knowledge exchange, connecting researchers with the field, and connecting researchers with each other, is an exciting innovation.

The research team itself had a variety of perspectives: Paul represented lived experience and the self-help perspectives. I represented service providers. Karen brought a broader citizen's view and Joan, Janos, Erica, Andrea, and Linda contributed a broad range of training and research experience. Each member had a unique role and brought valued expertise to the project. Thanks to the whole team for your hard work and dedication to this project.

There were many contributors and supporters and as you read this report I hope you are sharing in our joint sense of accomplishment. You know who you are!

Elly Harder, Co-Principal Investigator

Executive Summary

In the spring of 2005, the Ministry of Health and Long-Term Care announced funding for additional crisis services in Waterloo Region and Guelph/Wellington County, and directed that a process be developed to integrate crisis services across the Waterloo-Wellington Local Health Integration Network. Enhancements to regional crisis services included additional funding for crisis respite beds, crisis line, mobile crisis teams, and an Emergency Mental Health Service to be housed within Guelph General Hospital. At the same time, three full-time positions were created to support the integration of regional crisis services: the Regional Crisis System Coordinator, the Service Resolution Coordinator, and the Regional Support Worker.

In March of 2006, the Ministry of Health and Long-Term Care, through a System Enhancement Evaluation Grant Initiative (Phase 2) administered by the Ontario Mental Health Foundation, allocated funds to conduct a two-year evaluation of enhancements made to the Waterloo Wellington Crisis System. The overall purpose of this evaluation was to assess formatively the impact of crisis system enhancements on the quality of services received by people with lived experience who were 18 years of age or older. The specific investigative aims were to measure the extent to which various crisis system service components made progress towards the following:

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

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

- Interviews with people with lived experience and family members residing in Waterloo Region, Wellington County, and the City of Guelph (n = 35)
- A survey provided to police officers, hospital emergency room staff, and front line staff of crisis services based within community mental health organizations (n = 73)
- Statistical data from police agencies, hospitals, and community mental health organizations
- Publicly available documents, reports, and statistics

Following data collection and analysis, findings of the evaluation were presented to the Waterloo Wellington Dufferin Regional Crisis Committee, and were disseminated to key community stakeholders through two Knowledge Exchange Events funded by the System Enhancement Evaluation Grant Initiative (Phase 2) Knowledge Exchange Supplement.

Key Evaluation Findings

Coordination of Crisis Services:

- Regional crisis system coordination activities and inputs were highly aligned with best practices.
- System data collected from the regional crisis system are beginning to demonstrate a shift towards preferred service pathways regarding the delivery of crisis services and supports.
- Additional coordination efforts are required between police, hospitals, and community-based agencies, especially according to the perceptions of people with lived experience, family members, and police services.

Timeliness of Crisis Services:

- The timely delivery of crisis services has long been perceived as a key issue facing not just Waterloo Region and Wellington County, but the province of Ontario as well.
- Delays in crisis services were perceived by most key stakeholders, and at most points of entry into the regional crisis system.
- A minority of people with lived experience noted an improvement in hospital emergency room wait times.
- Most participants reported long waiting lists for referrals to community based programs and services.

Accessibility of Crisis Services:

- Most people with lived experience and family members reported that they were aware of crisis lines and how to access them, indicating that crisis system promotion efforts, which have positioned the crisis lines as the ideal point of entry into the crisis system, may be having a positive impact.
- The availability of crisis respite beds was seen as an important change to the accessibility of the regional crisis system.
- More crisis respite beds are needed to divert people with lived experience from inappropriate contact with hospital emergency rooms.
- The number of individuals accessing service resolution in the region has increased, indicating that more individuals have been able to gain access to the services they require during a crisis.

Comprehensiveness and Intensity of Crisis Services:

- The regional crisis system needs to improve its ability to create and sustain mechanisms for tracking individuals through the crisis system.

Appropriateness of Crisis Services:

- People with lived experience and family members perceived the appropriateness of the regional crisis system differently, depending on which service they were discussing. Crisis respite beds were viewed as the most consistently appropriate.
- Mental health staff members reported that the greater availability of crisis services and supports had resulted in improvements in care.
- System data did not indicate an overall decrease in the use of police and hospital services.
- System data may be beginning to show a shift towards preferred service pathways in the delivery of crisis services and supports, as indicated by the decrease in the number of apprehensions under the *Ontario Mental Health Act.*

Crisis Resolution:

- Most people with lived experience reported that their crisis was not properly resolved, and/or that the immediate crisis was resolved but that they did receive necessary follow-up services and supports.
- Most staff members perceived improvements in crisis resolution but that more follow-up services and supports were needed for the individual.
- Participants' perceptions of crisis resolution were largely based on anecdotal evidence. As the ability to track individuals through the crisis system develops, it is anticipated that data regarding crisis resolution rates can be collected.

Recovery Principles:

- Most people with lived experience reported not having developed an individualized crisis plan. An important priority for the regional crisis system is the implementation of standardized individualized crisis plans by Fall 2008. It is anticipated that this will result in increased usage and an increase in the application of recovery principles within the crisis system.
- Overall, the regional crisis system has made important advancements towards incorporating principles of recovery into its services and supports. However, the perceptions of people with lived experience and family members suggest that there is still work to be done towards developing a truly recovery-focused crisis system.

Satisfaction with the Regional Crisis System

- The vast majority of people with lived experience and family members reported on their satisfaction with individual service components rather than the crisis system as a whole, and these accounts are embedded in other evaluation themes.
- Staff members working in mental health organizations were the most satisfied with the regional crisis system.
- Staff members working in urban setting were more satisfied with the regional crisis system than staff members working in rural settings.

Based on these findings, recommendations were made regarding (1) the refinement of system-level performance indicators, (2) the development of outcome-based evaluations, and (3) the use of evaluation as a guide for crisis system enhancement.

System Enhancement Evaluation Initiative (SEEI) – Phase II

Waterloo Wellington Crisis System

Evaluation Report

October, 2008

1.0 Introduction

This report summarizes the system-level evaluation of the Waterloo Wellington Crisis System. A brief introduction is provided regarding the background and context of the Waterloo Wellington crisis system. This is followed by an overview of the evaluation framework, including (a) the investigative aims of the evaluation, (b) a summary of the literature on best practices regarding crisis systems and their evaluation, (c) the system-level logic model, (d) the evaluation plan, and (e) the data collection template. Findings of the evaluation are presented next, followed by key messages and recommendations.

1.1 Mental Health Enhancements to Waterloo Region and Wellington County

As with the rest of the province, the past several years have involved significant changes to the mental health system in Waterloo Region and Wellington County. In addition to the creation of the new Local Health Integration Networks, investments have been made towards the creation of new services and enhancements to existing services through federal Accord funding and the provincial Transition Fund. This new funding has supported enhancements to local mobile crisis services, crisis lines, and crisis respite beds. At a broader level, the funding stimulated the development of region-wide activity aimed at improving overall system quality through coordinated and integrated services anchored in inter-agency collaboration. Appendix A contains a more detailed description of these enhancements.

1.2 The Emergence of a Recovery-Oriented Mental Health System within the Waterloo Wellington Local Health Integration Network

Beginning in the late 1980's, the province of Ontario highlighted citizen participation as a key element of mental health reform. It recommended that

consumer/survivors should hold a central role in all aspects of the mental health system, including local service planning and delivery[1].

At the federal level, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, released in May 2006[2], called for a recovery-oriented mental health system in Canada:

> *In the past, much of mental health planning has not focused sufficiently on the outcomes achieved by people using the services provided within the mental health system. Recovery provides a focus for re-orienting the design and delivery of mental health programs, services and supports. Importantly, it allows us to define the role of the system: it is to facilitate the ability of people living with mental illness to deal actively with the limits imposed by their conditions (p. 44).*

Recovery refers to a view of mental health that entails a belief in the ability of individuals to recover from mental illness and participate meaningfully in the life of their communities. According to Anthony (1993)[3], it is

> *[A] deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*

More recently, it has been suggested that, in North America,

> *Recovery is the most significant principle in the organization and delivery of mental health treatment, services and supports (including peer support) for people with serious mental health problems. It is increasingly difficult to find policies and programs that do not reference the concept and claim to be working toward full integration and expression of its principles[4].*

Recovery-focused services typically involve a person-centred, holistic, approach that aim to support an individual's expression and exercise of personal choice. Key activities include person-centred planning and the coordination of formal and

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[1] Ontario Ministry of Health (1993). *Putting people first: The reform of mental health services in Ontario*: Toronto: Author.

[2] Kirby, M. J. L. & Keon, W. J. (2006). Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada. *The Standing Senate Committee on Social Affairs, Science and Technology.* Retrieved May 8, 2008 from http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06part1-e.pdf

[3] Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16(4*), 11-24.

[4] Botschner, J., Sylvestre, J., Roth, D., Jones, J., & Trainor, J. (2003, September). *Recovery as civic engagement.* Panel discussion held at the annual meeting of the Canadian Mental Health Association, Ontario Division, Niagara Falls, Ontario.

informal supports to enable the achievement of self-identified goals that promote the wellbeing of the person being served.

Concurrent with the development of the Waterloo Wellington Local Health Integration Network, the Waterloo Wellington Dufferin Mental Health and Addictions Planning and Advisory Committee and the Waterloo Wellington Support Coordination Management Committee began the process of developing a recovery-oriented mental health system, and using recovery principles as an organizing framework for the region. As part of this process, the Self Help Alliance[5] articulated a set of recovery values and principles for a recovery-oriented mental health system[6]. In turn, these values and principles were formally adopted by the Waterloo Wellington Dufferin Regional Crisis Committee and are referenced in its ongoing work, with an emphasis on recovery principles in the design, implementation and ongoing evaluation of the crisis system.

A key activity of this emphasis on recovery has been the development and implementation of individualized crisis plans across the region. A person with lived experience[7] develops this plan in collaboration with relevant service providers and/or peer supporters. A version of crisis planning has been used by the region's crisis services since 1997 but the current process is being revised. Based on the work of Copeland[8], the new process includes a greater emphasis on peer supports and recovery training for people with lived experience and crisis workers. An emphasis on recovery principles has historically not been a core component of crisis services and supports, particularly in services where interventions may be involuntary.

The goals of the plan are (1) to enable the sharing of information amongst crisis system service providers and informal supports in the event of a crisis, and (2) to empower the individual using crisis services to have input into planned responses by the system[9]. The plan is designed to increase communication among agencies and crisis workers, and to reduce the need for the person with lived experience to repeat their story or to feel "bounced around" by the system. It is created when the individual is not in crisis so that his or her preferences are explicitly stated in the event of a subsequent crisis (when the individual may not be able to state their preferences).

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[5] The Self Help Alliance consists of Cambridge Active Self Help, Mood Disorders Association Waterloo Region, Opening New Doors, Waterloo Region Self Help, and Wellington-Dufferin Self Help.

[6] Self Help Alliance (n.d.). *Recovery values and principles in the mental health and addiction service system*. Guelph, ON: Self Help Alliance. Retrieved May 8, 2008 from http://www.wrsh.ca/Values_and_Principles

[7] The research team chose to use the term "people with lived experience" when referring to individuals who are currently experiencing and/or have experienced a mental health crisis in the past (in the literature, terms such as "consumer/survivor", "client" or "patient" are also used).

[8] Copeland, M. E. (2002). *Wellness Recovery Action Plan.* West Dummerston, VT: Peach Press.

[9] Crisis Intervention System: Mental Health Services for Wellington/Dufferin Residents. http://cisinfo.ca/cisworks.html

1.3 The Creation and Role of the Waterloo Wellington Dufferin Regional Crisis Committee

In the spring of 2005, the Ministry of Health and Long-Term Care announced funding for additional crisis services in Waterloo Region and Wellington-Dufferin County, and directed that a process be developed to integrate crisis services across the Waterloo-Wellington Local Health Integration Network.

By June 2005, Waterloo Regional Homes for Mental Health and Trellis Mental Health and Developmental Services were leading and financially supporting a comprehensive planning process with key community stakeholders to identify service gaps in the community, and to set priorities for this funding[10]. Based on this planning process, the Waterloo Wellington Dufferin Regional Crisis Committee was created in January 2006. At the same time, a proposal was submitted to the Ministry of Health and Long-Term Care for the creation of three new regional positions: the Regional Crisis System Coordinator, the Service Resolution Coordinator, and the Regional Support Worker job roles.

The central mandate of the Waterloo Wellington Dufferin Regional Crisis Committee is to ensure that regional planning and allocation decisions be carried out in a coordinated way through the development of supported partnerships among key service providers and consumer groups. This mandate is supported through several system-wide Committee functions, including[11]:

1. Enhancing crisis system coordination.
2. Providing support for local planning groups and sub-committees.
3. Identifying evidence-based best practices and education/training opportunities.
4. Providing venue for resolving system service issues and develop/oversee the individual service resolution mechanism.
5. Ongoing monitoring and evaluation of the crisis system

The Committee's mandate is also supported through the work of three staff: the Regional Crisis System Coordinator; the Service Resolution Coordinator; and the Regional Support Worker. The Regional Crisis System Coordinator has three main roles: (1) to engage in activities that improve service integration and consistency; (2) to facilitate the recognition, development and implementation of solutions to system barriers to integrated service delivery; and (3) to develop and maintain formal inter-agency collaborative service agreements that establish clear pathways to required services and promote integrated service delivery.

[10] For a copy of this document entitled *Gaps and Priorities Presented by Theme and Geography*, please contact Elly Harder, Co-Principal Investigator.

[11] For a copy of the Waterloo Wellington Dufferin Regional Crisis Committee's Terms of Reference, please contact Elly Harder, Co-Principal Investigator.

Reporting to the Regional Crisis System Coordinator, the Service Resolution Coordinator coordinates regional service resolution services at the level of the individual. Within the same reporting relationship, the Regional Support Worker provides a full range of administrative support services to the Waterloo Wellington Dufferin Regional Crisis Committee and other regional initiatives as required.

2.0 The Waterloo Wellington Crisis System Evaluation

The overall purpose of this evaluation was twofold: (1) to assess formatively[12] the development of the Waterloo Wellington Regional Crisis System; and (2) to document in a preliminary way, the impact of crisis system enhancements on the quality of services received by people with lived experience who were 18 years of age or older. Given the formative nature of the evaluation, crisis system outcomes were not directly measured. The Waterloo Wellington Regional Crisis System consists of several service components, including crisis telephone lines, mobile crisis teams, police services, and hospital-based services (e.g., hospital emergency rooms).

Although not directly measured because of the early developmental stage of the regional crisis system and because of the formative nature of the evaluation, the aim of crisis system enhancements is to reduce inappropriate contact with various criminal justice system components among people with lived experience, and to reduce pressures in hospital emergency departments. Accordingly, our investigative aims were to measure the extent to which various crisis system service components made progress towards the following:

1. *Increasing the Five Components of Continuity of Care[13]:*

Table 1: Definitions of the Five Components of Continuity of Care

Component	Definition
Coordination	Refers to the collaborative efforts, including communication and referral, amongst crisis system programs and other support services in efficiently delivering seamless services to the individual, taking into consideration the extent of family involvement.
Timeliness	Refers to the promptness with which services are received from

[12] Formative evaluation focuses on describing and strengthening service design and delivery, in support of improved outcomes (Scriven, 1967; Posavac & Carey, 2003). As a result, it looks primarily at processes of service/system design and implementation.

[13] These five components of care were first identified in the "Matryoshka Project", a Phase I project of the System Enhancement Evaluation Initiative. For details of this project see: Nandlal, J., MacDonnel, K., Ollenberg, M., & Dewa C. S. (2007). *Matryoshka project: Program perspectives from service users' points of view.* Toronto, ON: Community Support and Research Unit, Centre for Addiction and Mental Health.

	the crisis system. This refers to both (a) the initial intake process and how long it takes for individuals to be referred to services, and (b) how long it takes for individuals to receive services once they have been referred.
Accessibility	Refers to the ease with which an individual can obtain crisis system services and supports. This includes both initial eligibility criteria as well as how readily services can be accessed on an ongoing basis once the individual becomes a client.
Comprehensiveness	Refers to the breadth of services an individual receives from the crisis system.
Intensity	Refers to the frequency with which an individual receives services from the crisis system.

2. *Implementing system-level coordination activities consistent with best practices.*

3. *Increasing the appropriate use of hospital emergency rooms, police services, and crisis services.*

4. *Resolving presenting crises within a community setting.*

5. *Promoting practices consistent with principles of recovery.*

In May 2005 the Ministry of Health and Long-Term Care issued standards for mental health crisis response services[14], which were used as a conceptual framework for this evaluation. These standards were created by the Ministry to reflect the development of a "reformed mental health system that is focused on the delivery of comprehensive, coordinated and results-driven mental health services"[15]. The standards were also developed to ensure the consistent provision of mental health crisis services across the province. Provincial crisis services often differ based on the needs of the local population. The standards were developed to ensure that local crisis services reflect the broader principles of mental health reform in Ontario by setting expectations that reflect evidence-based best practices, thus increasing province-wide consistency. The standards are categorized under eight crisis response service performance domains: Acceptability, Accessibility, Appropriateness, Competence, Continuity, Efficiency, and Safety.

The standards were not directly measured in the current evaluation because (1) they relate more specifically to crisis service programs rather than to the crisis system as a whole, (2) the evaluation is primarily formative in nature and several of the standards are more aligned with outcome-based evaluation, and (3) they

[14] Ministry of Health and Long-Term Care. (2005).*Crisis Response Service Standards for Mental Health Services and Supports*.
[15] Ministry of Health and Long-Term Care. (2005).*Crisis Response Service Standards for Mental Health Services and Supports*.

do not apply directly to police services. Thus, they were used primarily as a conceptual framework to guide evaluation planning and data analysis.

The resources created to design and implement this evaluation included the following:

- A review of the relevant literature on evaluating crisis services and systems
- Development of a system-level logic model
- Development of an evaluation plan
- A template for data collection

3.0 Review of the Literature

Literatures were reviewed relating to (1) goals of an integrated crisis system, (2) best practices of an integrated crisis system, (3) evaluation findings regarding crisis systems, and (4) challenges and best practices in evaluating crisis systems. Each of these literatures is summarized in turn.

3.1 Goals of an Integrated Crisis System

Several goals of an integrated crisis system have been articulated. These include the following[16]:

- Facilitate stabilization of the individual to the point where (1) risk of harm to self/other is minimized, (2) the individual has returned to a level of functioning that does not require continued provision of an urgent/emergent level of care, and (3) the individual can follow through with a course of treatment in a community-based setting
- Provide a timely and appropriate initial response to individuals experiencing mental health crises
- Provide clinically appropriate crisis interventions for individuals who may not be appropriate for referral to other mental health services
- Provide a range of crisis response options which offer the least intrusive and most appropriate services to the client in crisis
- Promote clients' autonomy and mobilize coping skills
- Respond flexibly to the fluctuating and unpredictable level of demand for crisis/emergent response services
- Foster continuity of care among components of a crisis/emergent response system (i.e. promote seamless integration of services)
- Engage with the individual and with social supports and community service providers to create a viable follow-up care plan

[16] British Columbia Ministry of Health and Ministry Responsible for Seniors. (n.d.). *B.C.'s Mental Health Reform: Best Practices for Crisis Response / Emergency Services.*

3.2 Best Practices Related to Crisis System Integration and Collaboration

A variety of best practices have been identified in relation to crisis system integration and collaboration. The development of a collaborative and integrated system of care requires several components to facilitate flow of information, integrated service provision, continuity of care, and ongoing evaluation. These components include the following[17] [18] [19] [20] [21]:

- Commitment of all participating members and agencies to a collaborative approach and to its success, and to becoming familiar with the organizational culture of partner agencies.
- Establishment of and commitment to a shared vision, goals and objectives among all participating members and agencies.
- Multiple levels of involvement within organizations (i.e., front-line staff to senior management) and geographically (i.e., rural and urban representation at the local, regional and provincial levels).
- Efficient resource management leading to realization of system objectives.
- Development of a sustainable interagency policy and planning committee with clearly stated terms of reference.
- Development of clear agreements, protocols, memos of understanding, dispute resolution mechanisms, and operational guidelines to achieve close collaboration between groups and to resolve issues.
- Development of effective information sharing, integrated documentation, and common data collection systems. Data collection systems should focus on those elements critical to key performance indicators.
- Establishment of personal relationships and regular contact between system members, as well as constant improvement of these relationships.
- Incorporation of services (especially mobile crisis teams) into the formal mental health system to support appropriate service use.
- Inclusion of key intermediaries to navigate and reconcile issues of trust, sharing and conflict of interest.
- Stable and sufficient funding.

Several best practices have also been identified that specifically relate to the successful integration of police organizations and personnel into police/mental health liaisons[22] [23] [24]:

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[17] Atwal, A., & K. Caldwell. (2002). Do multidisciplinary integrated care pathways improve interprofessional collaboration? *Scandinavian Journal of Caring Science 16,* 360-367.
[18] Claiborne, N. & H.A. Lawson. (2005). An intervention framework for collaboration. *Families in Society, 86*, 93-103.
[19] Ferris, L.E., K.L. Shulman & J.I. Williams. (2001). Methodological challenges in evaluating mobile crisis psychiatric programs. *Canadian Journal of Program Evaluation 16*, 27-40.
[20] Gardiner, H., S. Polis, & R. Thomas. (2001).*Crisis and Emergency Services Evaluation.* Alberta Mental Health Board Research Program: Calgary, AB.
[21] Kates, N., S. Eaman, J. Santone, C. Didemus, M. Steiner & M. Craven. (1996). An integrated regional emergency psychiatry service. *General Hospital Psychiatry 18*, 251-256.
[22] Adelman, J. (2003). *Study in blue and grey, police interventions with people with mental illness: A review of challenges and responses.* BC: Canadian Mental Health Association. Retrieved on April 1, 2005 from http://www.crpnbc.ca/policereport.pdf

- Police organizations have one or more identified personnel who are responsible for issues related to people in the community with mental health issues.
- Police organizations identify and develop a relationship with a primary contact person within the local mental health system.
- Police organizations have an identified contact person in the emergency services department of all hospitals with which they do regular business.
- Hospital emergency departments provide timely responsiveness to police-escorted individuals presenting with mental health issues (i.e., short wait times).
- First responders, patrol staff, and all personnel who may come into contact with individuals in crisis (e.g., dispatch personnel, victim services personnel, etc.) have adequate knowledge, education and training regarding mental health issues
- Police have access to mental health consultation at the scene, and have clearly defined policies and procedures for accessing mental health expertise.
- Police have available a directory that provides descriptive and contact information for mental health agencies in the area.
- Police organizations participate in regional liaison committees comprised of members of the mental health system and criminal justice system.
- Police organizations establish a data collection system that captures the nature, quality and outcome of mental health related calls for service in order to facilitate ongoing monitoring and evaluation.
- Police organizations have a central location where general information regarding mental health issues, local resources, and legislation can be stored and easily accessed.
- The ongoing development and maintenance of police and mental health collaborations should be fostered, taking into account the differing organizational cultures and priorities of police and mental health agencies

3.3 Findings from Evaluations of Crisis Systems

A review of the literature uncovered very little research related to the evaluation of crisis *systems* as a whole. This underscores the uniqueness and value of the present evaluation as an opportunity to add to our understanding of crisis systems. The evaluations that have been conducted on individual crisis system service components suggest that:

[23] Canadian Association of Chiefs of Police Human Resources Committee, Police/Mental Health Subcommittee (2006). *Contemporary policing guidelines for working with the mental health system.;*

[24] Scott, R.L. (2000). Evaluation of a mobile crisis program: Effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services, 51*, 1153-1156.

- A number of evaluation studies[25] [26] [27] [28] [29] [30] [31] examining the relative success of community-based as compared to hospital-based crisis services indicate that community-based services are a cost-effective alternative to hospital services. The results concerning the outcomes of these services are mixed, but show some advantages of community-based services over hospital-based services.

- The majority of studies[32] [33] [34] [35] [36] examining the effectiveness of mobile crisis services report positive outcomes, particularly in terms of decreased hospitalization rates.

- While findings regarding the use of other forms of crisis services [37] [38] [39] [40] [41] [42] [43] [44]such as crisis housing and hospital-based services (e.g.,

[25] Fenton, W.S., J.S. Hoch, J.M. Herrell, L. Mosher & L. Dixon. (2002). Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives of General Psychiatry 59*, 357-364.
[26] Habibis, D., M. Hazelton, R. Schneider, A. Bowling & J. Davidson. (2002). A comparison of patient clinical and social outcomes before and after the introduction of an extended-hours community mental health team. *Australian and New Zealand Journal of Psychiatry 36*, 392-398.
[27] Hoult, J. et al. (1983). Psychiatric hospital versus community treatment: The results of a randomised trial. *Australian and New Zealand Journal of Psychiatry 17*(2), 160-167.
[28] Joy, C. B., Adams, C. E., & Rice, K. (2008). Crisis intervention for people with severe mental illnesses (review). *The Cochrane Library, 1,* 1-57
[29] Marks, I. M., J. Connolly, M. Nuijen, B. Audini, et al. (1994). Home-based versus hospital-based care for people with serious mental illness. *British Journal of Psychiatry 165*(2), 179-194.
[30] Merson, S., P. Tyrer, D. Carlen & T. Johnson. (1996). The cost of treatment of psychiatric emergencies: A comparison of hospital and community services. *Psychological Medicine 26*, 727-734.
[31] Ruggeri, M., G. Salvi, V. Perwanger, M. Phelan, N. Pellegrini & A. Parabiaghi. (2006). Satisfaction with community and hospital-based emergency services amongst severely mentally ill service users: A comparison study in South-Verona and South-London. *Social Psychiatry and Psychiatric Epidemiology 41*, 302-309.
[32] Buhrich, N. & M. Teesson. (1996). Impact of a psychiatric outreach service for homeless persons with schizophrenia. *Psychiatric Services 47*, 644-646.
[33] Fisher, W.H., J.L. Geller & J. Wirth-Cauchon. (1990). Empirically assessing the impact of mobile crisis capacity on state hospital admissions. *Community Mental Health Journal 26*, 245-253.
[34] Geller, J. L., W. H. Fisher, & M. McDermeit. (1995). A national survey of mobile crisis services and their evaluation. *Psychiatric Services 46,* 893-897.
[35] Guo, S., D.E. Biegel, J.A. Johnsen & H. Dyches. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services 52*, 223-228.
[36] Hugo, M., M. Smout & J. Bannister. (2002). A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian and New Zealand Journal of Psychiatry 36*, 504-508.
[37] Bond, G.R., T.F. Witheridge, D. Wasmer & J. Dincin. (1989). A comparison of two crisis housing alternatives to psychiatric hospitalization. *Hospital & Community Psychiatry 40*, 177-183.
[38] Breslow, R.E., B.I. Klinger & B.J. Erickson. (1993). Crisis hospitalization on a psychiatric emergency service. *General Hospital Psychiatry 15*, 307-315.
[39] Damsa, C., C. Hummel, V. Sar, T. Di Clemente, S. Maris & C. Lazignac, et al. (2005). Economic impact of crisis intervention in emergency psychiatry: A naturalistic study. *European Psychiatry 20*, 562-566

emergency room crisis units) are somewhat mixed, results generally point to the ability of these services to decrease hospitalization rates and to have a positive impact on other outcomes such as participant satisfaction and improved symptomatology.

It should be emphasized that while one of the goals of crisis intervention services is to reduce hospitalization, increased likelihood of hospitalization has been linked to a number of characteristics at the individual level[45] [46]. Specifically, research has found that:

- Individuals of a younger age are more likely to be hospitalized
- Individuals with severe mental health issues and/or disabilities, acute problems, problems with substance use, aggression, non-accidental self-injury, hallucinations and delusions are more likely to be hospitalized
- Social factors such as homelessness, occupational problems, lack of income, problems with activities of daily living and living conditions are linked to increased rates of hospitalization
- Referrals made from psychiatric hospitals, the legal system or other treatment facilities are likely to lead to higher rates of hospitalization

Hospitalization rates should also be interpreted with caution for some interventions (such as mobile crisis services) as these services may be preventing unnecessary hospitalizations while at the same time "discovering" individuals who require inpatient care.

3.4 Challenges and Best Practices Regarding System Evaluation

Several challenges and best practices for conducting process and outcome evaluations of various human service systems have been outlined that are

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[40] Gillig, P.M., J.R. Hillard, J. Bell, H.E. Combs, C. Martin, & J. A. Deddens. (1989). The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry 146*, 369-372.

[41] Lambert, L. (1995). Psychiatric crisis intervention in the General Emergency Service of a Veterans Affairs Hospital. *Psychiatric Services 46*(3), 283-284.

[42] Spooren, D., K. van Heeringen & C. Jannes. (1997). Short-term outcome following referral to a psychiatric emergency service. *Crisis: The Journal of Crisis Intervention and Suicide Prevention 18*, 80-85.

[43] Tschacher, W. & N. Jacobshagen. (2002). Analysis of crisis intervention processes. *Crisis: The Journal of Crisis Intervention and Suicide Prevention 23*, 59-67.

[44] Vingilis, E., Hartford, K., Diaz, K., Mitchell, B., Velamoor, R., Wedlake, M., & White, D. (2006). Process and outcome evaluation of an emergency department intervention for person with mental health concerns using a population health approach. *Administrative Policy in Mental Health and Mental Health Service Resolution, 34,* 160-171.

[45] Guo, S., D.E. Biegel, J.A. Johnsen & H. Dyches. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services 52*, 223-228.

[46] Hugo, M., M. Smout & J. Bannister. (2002). A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian and New Zealand Journal of Psychiatry 36*, 504-508.

relevant for evaluating crisis systems in particular. Some system characteristics that pose unique challenges for conducting evaluation include the following [47]:

- The nebulous nature of systems: The complex arrangement of shared processes and objectives can create blurred organizational boundaries, making it difficult to attribute outcomes directly.

- Perceptions of connectedness: By its very nature, a complex system will include organizations with weaker ties to the system as a whole. These organizations may not self-identify as system members, and decline to participate in data collection and evaluation efforts.

- Role confusion and diverging views of desired outcomes: Organizations may have differing views regarding how the overall work of the system should be defined and implemented, and what the desired outcomes should be. This can pose a challenge to evaluation efforts if there is lack of agreement on what should be evaluated and why.

- Identifying measurable outcomes: Historically, measured outcomes concerning individuals with mental health issues are often clinical in nature. Broader system-level evaluations will want to include outcomes based on broader definitions of health, as well as process outcomes.

A number of best practices for evaluating human service systems have also been identified that are relevant to crisis systems, including the following [48] [49]:

- A wide variety of stakeholders, including people with lived experience and family members, should be provided with the opportunity to inform evaluation planning to ensure the design is responsive to stakeholder interests.
- Evaluation of intended outcomes should be conducted at the level of the individual, the individual program, and the overall system.
- The evaluations should include an assessment of the individual service components, the contribution of each component to the overall system, and the interactions between each service component and the system.
- System-level performance measures should be included.
- Any individual service component evaluations should consider both the overall system evaluation plans and the needs of the individual service.
- Evaluation efforts require a dedicated and sufficient evaluation budget.

[47] Popp, J. K., L'Heureux, L. N., Dolinski, C. M., Adair, C. E., Tough, S. C., Casebeer, A. L., Douglas-England, K. L., & Morrison, C. C. (2005). How do you evaluate a network? A Canadian child and youth health network experience. *The Canadian Journal of Program Evaluation, 20,* 123-150.
[48] Boydell, K., D. Butterill, J. Cochrane, J. Durbin, P. Goering, J. Rogers, & J. Trainor. (1997). *Review of Best Practices in Mental Health Reform.* Publications Health Canada: Ottawa, Ontario.
[49] Jenks, C. L. (1998). Evaluating educational system designs. *Systems Research and Behavioral Science 15,* 209-215.

- Evaluation findings should be communicated to all participating members and agencies, and to the broader community.

4.0 System-Level Logic Model

A program logic model[50] [51] is a tool that maps the relationships between the activities of a service or intervention, and the anticipated outcomes of this effort. The term logic model is used because the tool lays out the underlying logic or rationale underpinning the intervention. Logic models show the linkages among clusters of activities and their intended outcomes or areas of impact. They can be used to assess whether or not these linkages make sense. In this way, a logic model can assist in making important decisions about how best to evaluate a service or intervention[52]. It can also be used by planners, and those charged with implemention, to "fine-tune" an intervention prior to more widespread implementation within or across organizations and communities. Of equal importance, logic models can equip stakeholders with a common language for communicating the purpose, activities, processes, and intended outcomes of an intervention. In addition to their role in evaluation, such models are also useful tools for training, planning, and awareness-building.

A system-level logic model (see Figure 1) of the Waterloo Wellington Regional Crisis System was created based on a review of program documentation, relevant literature, and input from the Waterloo Wellington Dufferin Regional Crisis Committee. It depicts the crisis system service components operating within the Waterloo Wellington crisis system, and the service delivery and system performance objectives that are expected to occur as a result of successful implementation of these components.

This logic model does not follow the conventional format advocated by researchers such as Rush and Ogborne[53], and instead follows the schematic format developed by Nandlal and Robinson[54]. The research team decided that the latter format was more appropriate in the context of the current evaluation because the main purpose of the logic model was to facilitate system-level conceptualizing and planning among key stakeholders. The schematic format provides an overview of a (highly complex) system that can guide this process.

[50] Rush, B. & Ogborne, A. (1991). Program logic models: Expanding their role and structure for program planning and evaluation. *The Canadian Journal of Program Evaluation, 6* (2), 93-105.
[51] Nandlal, J & Robinson, J. (2005). Evaluating police/mental health liaison initiatives. *The Canadian Journal of Police and Security Services, 3,* 149-159.
[52] Taylor, A., & Botschner, J. (1998). *Evaluation Handbook*. Toronto: Ontario Community Support Association.
[53] Rush, B. & Ogborne, A. (1991). Program logic models: Expanding their role and structure for program planning and evaluation. *The Canadian Journal of Program Evaluation, 6* (2), 93-105.
[54] Nandlal, J & Robinson, J. (2005). Evaluating police/mental health liaison initiatives. *The Canadian Journal of Police and Security Services, 3,* 149-159.

As indicated in the logic model, the following crisis system service components are in operation in Waterloo Wellington:

1. 24-hour crisis telephone lines
2. Mobile crisis teams (adult and child/adolescent)
3. Walk-in crisis services
4. Stabilization services (i.e., crisis respite beds, brief stay hospitalizations)
5. Community-based psychiatric consultations
6. Hospital-based emergency room psychiatric consultations
7. Police services
8. Service resolution services
9. Regional crisis system coordination

The logic model also identify long-term goals for the system. These are more properly investigated in an outcome-based evaluation and so are not included in the current evaluation.

5.0 Evaluation Plan

Based on the system-level logic model and existing documents, an evaluation plan was developed that included four components: research objectives, evaluation questions, indicators, and methods of data collection. Through an iterative process, the Waterloo Wellington Dufferin Regional Crisis Committee identified the evaluative criteria to be prioritized for inclusion in the evaluation. Priority was given to those evaluative criteria that (1) aligned most closely with the investigative aims described earlier, (2) aligned most closely with the service delivery priorities of participating organizations, and (3) were most measurable in terms of the system data that were available and could be collected. The full evaluation plan is included in Appendix B.

The evaluation plan adhered to several best practices related to sound system-level evaluation, including the following:

Best Practice: Provide a wide variety of stakeholders, including people with lived experience and family members, with the opportunity to participate in evaluation planning and data collection.

- Input was sought and interviews were conducted with representatives from all key stakeholder groups to inform both the evaluation planning process and data collection, as evidenced in the “Methods” section of the evaluation plan.

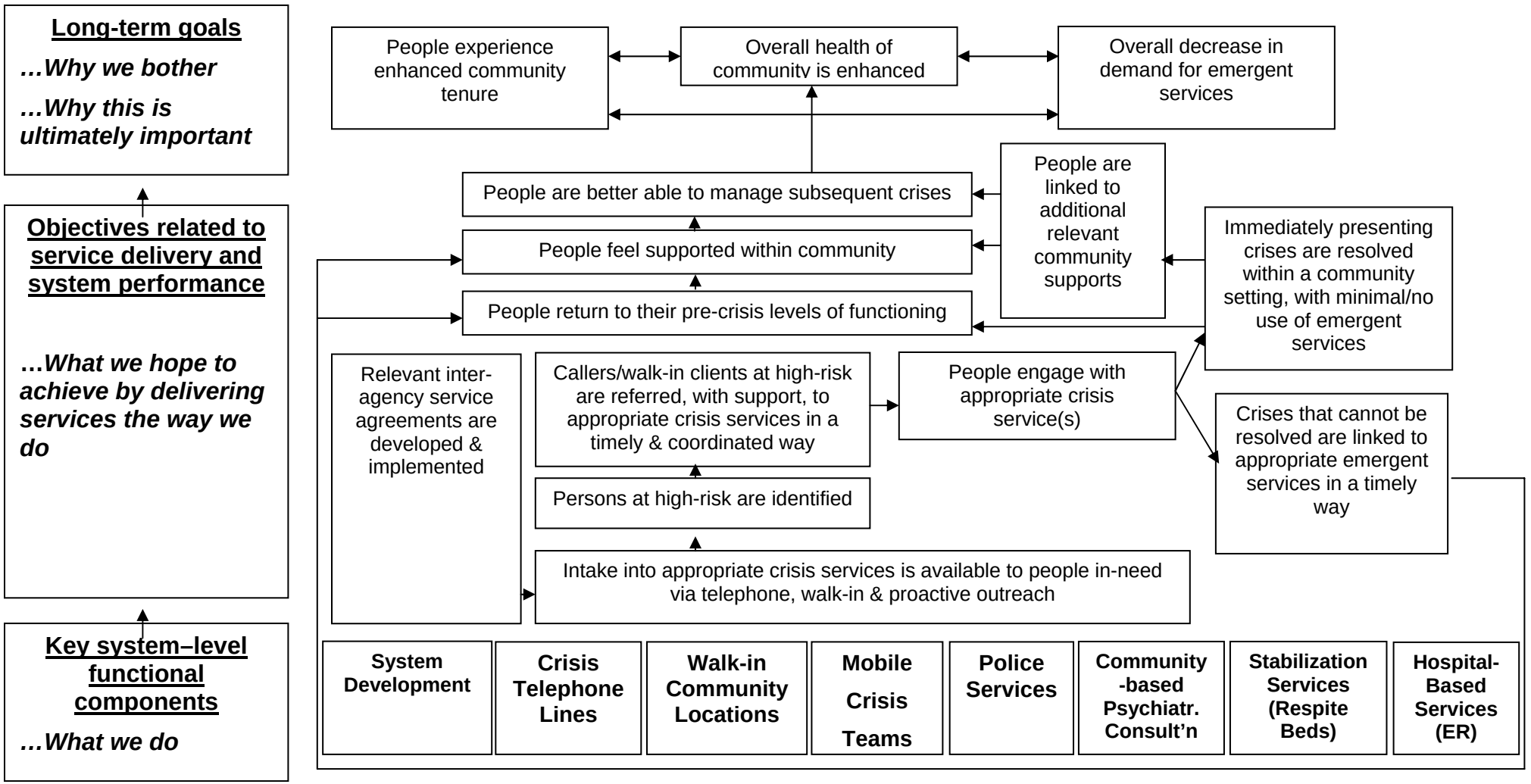
Best Practice: Include several system-level performance indicators.

- A number of system-level performance indicators were identified in the evaluation plan, as seen in the “Evaluation Questions” section, and these indicators guided much of the analysis.

Best Practice: Include an assessment of the contribution of each service component to the overall system, and the interactions between each service component and the system.

- The analysis contains a detailed assessment of how each service component (i.e., mental health agencies, police services, and hospitals) contribute to the overall system, and of the system-level relationships and coordination activities that take place between these service components.

Figure 1 – System Level Logic Model



6.0 Data Collection

Based on the literature review, system-level logical model, and evaluation plan, data were obtained from:

1. All hospitals[55], police organizations, and mental health organizations collecting organizational crisis system data within the Waterloo Wellington crisis system[56].
2. Interviews with people with lived experience and family members[57].
3. Crisis system staff via a staff survey[58].
4. Publicly available documents, reports, and statistics[59].

6.1 Organizational Crisis System Data

6.1.1 Staff Interviews

Interviews were conducted with crisis system staff in order to identify the crisis system data that could be applied to the current evaluation. Staff members were asked to comment on the data collected by their organization, how this data is collected and entered, and their confidence in the quality of the data collected. Based on these interviews, the research team was able to gain a better understanding of the data collection process across the entire crisis system[60]: (1) the type of data that is collected, including similarities and differences in the data collected by different organizations, (2) how data are stored and managed, and what data is accessible to third parties, (3) the quality of data currently available within the system, (4) how individuals are tracked within the system, (5) the resources available within each organization for data management, and (6) the funding and reporting requirements of each organization.

Subsequently, we were able to assess which data elements were collected by all organizations within a particular category (i.e., hospitals, mental health organizations, and police). This allowed us to determine which data elements could be collapsed, thus creating system-level variables. For example, virtually all the mental health organizations included in the current evaluation collect data regarding the number of individuals served. Thus, this data element could be

[55] Research Ethics Board proposals were submitted to the Centre for Addiction and Mental Health, Cambridge Memorial Hospital, Grand River Hospital, Guelph General Hospital, and the North Wellington Hospital Alliance (consisting of Groves Memorial Community Hospital, Louise Marshall Hospital, and Palmerston & District Hospital).
[56] For a complete list of these organizations, see Appendix C.
[57] In order to obtain informed consent, the nature and details of the interview process were fully disclosed, and all interviewees signed a project consent form. Recruitment advertisements provided details of the informed consent process as well.
[58] In order to obtain informed consent, a consent form was attached to the beginning of the survey.
[59] Permission was obtained from organizations and individuals to include various documents, reports, and statistics in the evaluation.
[60] An Excel spreadsheet was created representing all data collecting by all organizations within the system. For a copy of this spreadsheet, please contact Elly Harder, Co-Principal Investigator.

collapsed across all mental health organizations, permitting an analysis of numbers served at the system level (rather than at the level of individual organizations).

6.1.2 Data Variability

A key finding of this interview process is that there is a great deal of variability in the type and amount of data collected by various organizations within the regional crisis system. Because of this variability very few data elements could be collapsed across the crisis system and included in the present evaluation. There are several reasons for this variability:

1. Each organization has different mandatory reporting requirements as they are funded through different Ministries and other funding agencies, thus affecting the type and amount of data that are collected.

2. Each organization is resourced differently in terms of data management. For smaller organizations, information is entered by individual workers, either directly after an interaction with a client, at the end of the shift, or when time permits. For other organizations, data is initially entered onto a data form by front-line staff and is then entered by a single individual on a regular or ongoing basis. Finally, for some larger organizations such as hospitals and police services, data is initially entered onto a data form by front-line staff members and then later entered by dedicated data management staff. Thus, each organization varies significantly in terms of the resources they have available for data management.

3. Organizations use a variety of systems to store the data they collect, from Excel spreadsheets to complete information systems (such as Case Works or Client Record Management System). In fact there are few organizations that use the same system, creating additional variability in data management practices. Additionally, even though organizations have established systems for storing data, a significant amount of data remains in individual form only (either in paper form or in an electronic format that cannot be aggregated). This type of data is extremely time-consuming to both collect and to aggregate for evaluation purposes.

6.1.3 Data Quality

Most organizations have a review or audit process in place to check the accuracy of their data. This can occur in a variety of ways: (a) review on an ongoing basis as information is entered, (b) systematic data audits at specific intervals, (c) “spot-checking” the data (pulling a number of records and verifying their accuracy), or (d) identifying errors in monthly or quarterly reports.

Most organizations reported that the quality of their data is good or very good. There has been an adjustment period for most organizations as they familiarize

themselves with new systems and reporting structures (e.g., Common Data Set or CDS). There are likely some problems or inconsistencies in the data collected and entered for 2006. Most organizations indicated that they have worked hard to reconcile these problems by providing training to data entry staff and by improving the consistency of the data. As a result, agencies reported greater confidence in the validity and reliability of their data beginning in 2007 although the system as a whole has not fully verified the quality of the data.

6.1.4 Tracking Individuals Within the Crisis System

Generally, individuals cannot be tracked from one organization to another within the crisis system. The data systems employed are not linked in any way; therefore tracking an individual would require searching for that person by name and date of birth within each organization. Some organizations, such as Trellis Mental Health and Developmental Services, have a variety of documents within an individual file to show contacts with various services. Unfortunately, this information is not available in electronic format and would require examining each file individually. Both search methods would be an extremely time consuming process and would require individual consent. Some information systems (such as CaseWorks) have the capability to track individuals, but all organizations would need to be using this system in order to benefit from this feature.

6.2 Interviews with People with Lived Experience and Family Members

Interviews were conducted with people with lived experience and family members. For the current evaluation, a “family member” was broadly defined to include anyone who has provided support to a person experiencing a mental health crisis (or a mental health issue). Interviews followed a semi-structured format and asked a series of questions regarding (1) participants’ experiences with the crisis system, (2) their reflections on the quality of those experiences, (3) their experiences with recovery principles within the crisis system, (4) and changes to the crisis system that they have seen and/or would like to see[61].

The initial goal was to interview equal numbers of participants from Waterloo Region and Wellington County, and to recruit individuals from both urban (60% of the interviews) and rural (40% of interviews) areas. This 60/40 split was determined based on a combination of factors: (a) population statistics from the Waterloo Wellington Local Health Integration Network Integrated Health Service Plan[62] that shows that the population in Waterloo Region and Guelph/Wellington County is 85% urban and 15% rural, (b) the experiences of people working within the system, and (c) a desire to sufficiently represent individuals from both areas. Finally, it was proposed that 65 percent of participants would be persons with

[61] For a complete list of the interview questions, please contact Elly Harder, Co-Principal Investigator.

[62] Waterloo Wellington Local Health Integration Network (2007). *Integrated health service plan: Live and live well in Waterloo Wellington 2007-2010.* Guelph, ON.

lived experience and 35 percent of participants would be family members. The proposed numbers of participants for each group is provided in Table 2.

Table 2: Proposed Number of Interviews for People with Lived Experience (PLE) and Family Members (FM)

	Waterloo Region n = 20		**Guelph/Wellington County n = 20**		**Total**
	Urban	Rural	Urban	Rural	
PLE	8	5	8	5	26
Family Member	4	3	4	3	14
Total	12	8	12	8	40

A number of methods were adopted to recruit these individuals. First, advertisements were posted in free local newspapers[63] on two separate occasions, including the Guelph Tribune, the Waterloo Chronicle, the Cambridge Times, the New Hamburg Independent, Guelph Pennysaver Smart Shopper, and Kitchener Waterloo Pennysaver Smart Shopper. Second, members of the crisis system were asked to post flyers in appropriate locations within their organization. Third, an advertisement was posted to a local community forum (Craig's List). Fourth, members of the research team directly recruited community members to participate.

Selection criteria for interviewees included:

- Being a person with lived experience or a family member
- Residing in Waterloo Region or Wellington County
- Having accessed crisis system services and supports within the last two years
- Being 18 years of age or older

Table 3 shows the breakdown of the convenience sample that was gathered through these various recruitment strategies. A concerted effort was made to recruit a sample that was as representative of the region as possible, and that captured the perspectives of both people with lived experience and family members, and individuals from both urban and rural locales. All persons interested in participating who met the selection criteria were invited to

[63] All newspapers are delivered free of charge to residents.

participate. A total of 33 interviews were conducted with 35 individuals[64], which was very close to the proposed target of 40.

Table 3: Interviews with People with Lived Experience and Family Members

	Waterloo Region n = 17		**Guelph/Wellington County n = 18**		**Total**
	Urban	Rural	Urban	Rural	
PLE	10	1	13	2	26
FM	6	0	3	0	9
Total	16	1	16	2	**35**

As can be seen in Table 3, we had good representation from both people with lived experience and family members living in urban areas. We had less representation from individuals residing in rural areas so issues and concerns unique to rural residents may not be adequately represented in the evaluation. Additionally, although the interviews provided considerable feedback regarding the crisis system, the convenience sampling strategy used should be kept in mind when reviewing the findings of the evaluation. All interviews were conducted in English with individuals who had reached a point in their recovery process where they were able to access the methods used to recruit participants, and were comfortable talking about their experiences with the crisis system. This means that the interviews do not necessarily capture the experiences of individuals who are at an earlier point in the recovery process, or who have more diverse ethno-cultural backgrounds.

6.3 Staff Survey

A staff survey was made available to staff members from each organization within the crisis system. The purpose of the survey was to assess (1) staff members' familiarity with various components of the crisis system, (2) the changes that staff members have seen to the crisis system and how these changes have impacted their work, (3) additional changes that staff members would like to see and any perceived barriers to delivering crisis services, (4) the frequency and quality of working with staff members from other organizations, and (5) the extent to which staff members' crisis services are aligned with recovery principles. The survey consisted of both quantitative items rated on scales (see Appendix D for details), and open-ended qualitative items.

[64] Two of the interviews were conducted jointly with both a person with lived experience and a family member. 26 interviews were conducted in person and 7 interviews were conducted over the telephone.

The survey was offered both online using Survey Monkey, a web-based survey tool, and in paper format for those staff members who did not have direct access to a computer at their place of employment, or who otherwise preferred to complete the survey in this format. All individuals were provided a minimum of 60 days to complete the survey, and the deadline for the survey was February 22, 2008.

One representative within each organization was asked to make members from their organization aware of the survey and its purpose[65]. These individuals were also asked to track the number of people who they invited to participate in the survey so that we could calculate response rates. The research team requested that a minimum of 5 staff members from each organization be made aware of the survey. Based on this recruitment strategy, the following estimated response rates were calculated:

Table 4: Estimated Staff Survey Response Rates

Organization type	Number of organizations participating	Minimum number of participants targeted for recruitment	Actual number of participants	Estimated response rate relative to target
Hospital	6	30 (6 x 5)	15	50%
Mental Health Organization	4	20 (4 x 5)	33	165%
Police	3	15 (3 x 5)	25	167%

A total of 73 participants completed the survey. Tables 5, 6, and 7 summarize the distribution of survey participants according to type of organization and locale served (urban, rural, or both), and across geographical regions.

Table 5: Staff Survey Participants Serving Waterloo Region (n = 21)

	Waterloo Region			
Type of Organization	Urban	Rural	Urban & Rural	Total
Hospital	2	n/a	6	8
Mental Health Organization	4	1	4	9
Police	n/a	n/a	4	4
Total	6	1	14	21

[65] Although these representatives invited staff members to participate, they were not involved in the formal consent process and did not know if and/or which staff members participated in the survey.

Table 6: Staff Survey Participants Serving Guelph/Wellington County (n = 40)

	Guelph/Wellington County			
Type of Organization	Urban	Rural	Urban & Rural	Total
Hospital	1	3	1	5
Mental Health Organization	n/a	1	13	14
Police	9	n/a	12	21
Total	10	4	26	40

Table 7: Staff Survey Participants Serving Both Regions (n = 10)

	Both Waterloo Region & Guelph/Wellington County			
Type of Organization	Urban	Rural	Urban & Rural	Total
Hospital	n/a	n/a	2	2
Mental Health Organization	n/a	n/a	8	8
Police	n/a	n/a	n/a	n/a
Total	n/a	n/a	10	10

As can be seen from Tables 5, 6, and 7, there is representation for urban and rural service providers across the regional crisis system.

Table 8 summarizes participants' job roles across type of organization, again demonstrating good representation across type of job.

Table 8: Staff Survey Participants' Job Role Across Organization Type (n = 73)

	Type of Organization			
Job Role	Hospital	Mental Health Organization	Police	Total
Senior Administrator/Manager	5	3	5	13
Supervisor	4	6	7	17
Front-line worker	6	24	13	43
Total	15	33	25	73

6.4 Publicly available, accessible documents, reports, and statistics

In order to examine the development of the crisis system and the development of the coordination and integration amongst crisis system members, all publicly available and accessible documents, reports, and statistics were collected. These included documents such as memoranda of understanding and inter-agency protocols, Waterloo Wellington Dufferin Regional Crisis Committee meeting minutes and materials, planning documents, and any other documents relevant to the evaluation of the regional crisis system[66].

7.0 Evaluation Findings

7.1 Overview

The data collected for this evaluation were analyzed for common themes related to the extent to which various regional crisis system services and supports made progress towards the investigative aims discussed earlier:

1. Increasing the Five Components of Continuity of Care, including Coordination, Timeliness, Accessibility, Comprehensiveness, and Intensity[67].
2. Implementing system-level coordination activities consistent with best practices.
3. Increasing the appropriate use of hospital emergency rooms, police services, and crisis services.
4. Resolving presenting crises within a community setting.
5. Promoting practices consistent with principles of recovery.

[66] A complete list of the documents used in this evaluation can be obtained from Elly Harder, Co-Principal Investigator.

[67] Nandlal, J., MacDonnel, K., Ollenberg, M., & Dewa C. S. (2007). *Matryoshka project: Program perspectives from service users' points of view.* Toronto, ON: Community Support and Research Unit, Centre for Addiction and Mental Health.

Progress toward these investigative aims was examined in three domains, referred to as "Research Objectives" in the evaluation plan (see Appendix B):

- Process of Development: To identify the key inputs, principles, and mechanisms necessary to develop the crisis system in Waterloo-Wellington
- Process of Operation: To describe the operation of the crisis system in Waterloo-Wellington
- Early Impacts: To identify the early outcomes of the operation of the crisis system in Waterloo-Wellington

It should be emphasized that the findings reported here focus on the system as a whole, given the system-level nature of the evaluation. Thus, information that was inadvertently mentioned regarding individual services and supports during the course of the evaluation was not analyzed at the individual agency level.

In addition, evaluation participants (i.e., people with lived experience, family members, and crisis system staff members) largely conceptualized any identified *benefits* in direct relation to the analytic themes listed above. Thus, benefits are addressed in the current evaluation within the context of the appropriate theme.

Lastly, although the various themes have been conceptualized and analyzed separately for the sake of clarity and to highlight important issues, it should be emphasized that all the themes are interconnected and dependent upon one another. An effective regional crisis system requires that all the themes work in tandem, and the extent to which one theme is realized will have an effect on the others. The full extent of these interconnections would require a comprehensive outcome evaluation.

7.2 Data Analysis

All of the qualitative data gathered for this evaluation (i.e., people with lived experience and family member interviews; qualitative sections of the staff survey) were analyzed for common themes and categories that were aligned with the investigative aims of the evaluation. In addition, the inductive nature of the analysis allowed for the emergence of new themes and categories. All analyses were conducted using NVIVO 7, a commonly used qualitative analysis program.

Using SPSS v15.0, quantitative data gathered from the staff survey were subjected to analyses of variance where there was clear relevance to the evaluation research questions and sufficient sample size. Significance levels

were adjusted to control for the family-wise error[68] rate using the Bonferroni correction[69].

The organizational crisis system data were reviewed for those variables that were collected by all organizations within a particular category (i.e., hospitals, mental health organizations, and police). These variables were then collapsed to create system-level variables. From there, system-level averages were created for each of these variables for each of the seven reporting periods included in this evaluation, starting from April 1, 2004 to September 30, 2007. Where appropriate, system-level averages were reported in both raw form and indexed to a rate per 100,000 population. These reporting period averages were then descriptively examined for change over time as a way of substantiating or refuting the findings of the staff survey and the interviews conducted with people with lived experience and family members.

Lastly, publicly available documents and reports were used in order to contextualize the data analysis, and to provide a broader narrative structure for the findings of this evaluation.

7.3 Limitations of the Evaluation

The developmental nature of the crisis system in Waterloo Wellington posed some unique challenges for this evaluation. The enhancements in funding and subsequent service delivery and coordination activities were anticipated to benefit the overall quality of crisis services and supports in the region. However, the constantly evolving nature of the crisis system meant that we were faced with implementing an evaluation of a moving target. The nature and frequency of service delivery and coordination activities evolved and changed over the two-year course of this evaluation. Because aspects of the crisis system were changing as we evaluated it, we were required to make certain adjustments to the evaluation as it unfolded. For example, certain evaluation questions identified early on as priorities subsequently received less priority in the evaluation as new questions were identified that were more reflective of the changes that had occurred in the nature and goals of the crisis system.

The developmental stage of the crisis system also implies that it might be too early to see the full impact of the changes that have been made. Several of these changes are still in the process of being implemented or finalized, while others have only been in full operation for a short time. Thus, the findings of this evaluation, in particular those that indicate that no improvements have been seen as a result of crisis system enhancements, should be at least partially interpreted within this context.

[68] The family-wise error rate, or the probability of uncovering a statistically significant difference where there in fact is not one, increases with the number of tests conducted.
[69] The Bonferroni correction is a commonly accepted statistical method for controlling the family wise error rate.

The developmental nature of system-level evaluation design itself also posed unique challenges. Very little evaluation has been conducted on crisis systems as a whole. Thus, portions of this evaluation design were based on the extensive literature that exists on program evaluation, and then adapted for a system evaluation. Certain challenges that are often found in program evaluation are amplified when the evaluation is conducted at a system level.

One common challenge is the potentially diverging priorities of stakeholders. At the regional crisis system level, a large number of key stakeholders are involved, and they work for organizations that in several instances have different mandates and priorities. For example, a key priority for police services is to reduce police wait times in hospital emergency room departments for mental health-related calls for service, while a key priority for hospital emergency rooms is to reduce the number of mental health-related cases that present in the first place. Both of these priorities are important for mental health service providers, but only if they are related to their key priority, which is to provide effective and recovery-focused crisis resolution to the individual in crisis.

Thus, organizations involved in the crisis system may have differing views on how the overall work of the system should be defined and implemented, and what the evaluation should be measuring. As a result of this (and because it adheres with best practices related to system evaluation) we consulted with multiple stakeholders, and a great deal of up-front planning was conducted with key stakeholders for this evaluation (e.g., system-level logic model, evaluation plan) in order to ensure that there was broad stakeholder agreement regarding the goals of the crisis system and evaluation. Nevertheless, stakeholders work for a variety of organizations that in many instances will have different (a) mandates and priorities, (b) legislative and reporting requirements, and (c) target populations. Thus, it is unlikely that the goals of an evaluation will ever receive unanimous agreement across such divergent stakeholder groups. One of the strengths of an inclusive approach to evaluation is that points of disagreement are discussed up-front and throughout the evaluation, enabling a focus on those areas where stakeholders share common priorities and goals

Another challenge posed by system-level evaluation is the sheer amount of data that must be collected and analyzed. A large number of data sources must be targeted for this kind of evaluation, from the organizations that coordinate service delivery, to the staff members who deliver these services, to the people who receive them. Providing a succinct summary of these findings that decision makers can use quickly and effectively, while still remaining faithful to the numerous viewpoints and findings that emerge, is an ongoing challenge[70].

Regarding the crisis services and supports available in Dufferin County, it was noted that many of the crisis system components serving Wellington County

[70] For details of the data management strategy used for this evaluation, please contact Elly Harder, Co-Principal Investigator.

serve Dufferin County[71]. However, given the new Local Health Integration Network boundaries, this evaluation received funding to focus exclusively on the crisis services and supports serving Waterloo Region and Wellington County. Some input from Dufferin County was received through meeting held with key crisis service stakeholders, in light of the ongoing operational connection of services between Wellington and Dufferin Counties.

8.0 Evaluation Themes

8.1 Coordination of Services

Key Messages

Regional crisis system coordination activities and inputs are aligned with best practices.

System data collected from the regional crisis system are beginning to demonstrate a shift towards preferred service pathways regarding the delivery of crisis services and supports.

Additional coordination efforts are required between police, hospitals, and community-based agencies, especially according to the perceptions of people with lived experience, family members, and police services.

The key research question here is the extent to which collaborative efforts within the crisis system result in the efficient delivery of seamless services to the individual. Specifically:

- Are service providers aware of the services offered by other organizations and do they make appropriate use of them? Do service providers exchange information appropriately?
- Are new partnerships being established regarding crisis service delivery?
- Are police services involved in the crisis system in an appropriate way (e.g., are police able to efficiently coordinate with local hospitals and mental health organizations when they have responded to a crisis-related call for service)?
- Has the inappropriate use of hospital emergency and mental health services been reduced?
- Is regional decision-making coordinated?

[71] The Waterloo Wellington Local Health Integration Network replaced the Waterloo Region-Wellington-Dufferin District Health Council in 2005 and no longer includes Dufferin County. Dufferin County is now served by the Central West Local Health Integration Network.

8.1.1 Regional Crisis System Planning

Consistent with best practices regarding crisis system integration and collaboration, various inputs and activities between organizations and individuals involved in the delivery of crisis services have occurred over the last two years in order to create the structures and resources required for a more coordinated crisis system. These best practices and their related activities and inputs include the following:

Table 9 – Best Practices and Regional Crisis System Planning

Best Practice[72]	**Activity or Input**
Development of a sustainable interagency policy and planning committee with clearly stated terms of reference.	▪ Waterloo Wellington Regional Crisis Committee and its Terms of Reference[73] established in January 2006 ▪ Committee supported through funding provided for the Regional Crisis Coordinator
Establishment of and commitment to a shared vision, goals and objectives among all participating members and agencies.	▪ Core vision and set of principles formally adopted by the Waterloo Wellington Dufferin Regional Crisis Committee in October 2007 ▪ Objectives of the Waterloo Wellington Dufferin Regional Crisis Committee laid out in the Terms of Reference[74] ▪ Annual planning exercise held by Waterloo Wellington Dufferin Regional Crisis Committee to set priorities and an annual work plan ▪ Development of a work plan and key deliverables[75] in June 2008 by the Public Relations/Education Working Group (a sub-committee of the Waterloo Wellington Dufferin Regional Crisis Committee)

[72] See “Review of the Literature” section for specific references.
[73] Waterloo Wellington Regional Crisis Committee and its Terms of Reference may be obtained from Elly Harder, Co-Principal Investigator.
[74] Some of these objectives include: providing a venue for community input into crisis system implementation issues, developing and maintaining a centralized source of crisis system information for individuals, families, and service system employees, and developing templates for inter-agency protocols.
[75] The purpose of the work plan, developed in June 2008, is to increase coordination activities both within the Waterloo Wellington Dufferin Regional Crisis Committee and with other groups and agencies relevant to the crisis system. For details, please contact Elly Harder, Co-Principal Investigator.

Best Practice[72]	Activity or Input
Commitment of all participating members and agencies to a collaborative approach and to its success, and to becoming familiar with the organizational culture of partner agencies.	▪ High attendance at Waterloo Wellington Dufferin Regional Crisis Committee meetings demonstrated from all major stakeholders ▪ Through committee meetings, establishment of personal relationships and regular contact between system members, as well as constant improvement of these relationships ▪ Orientation session in development for new staff and volunteers to be held three times per year to provide an introduction to recovery principles, and the other crisis system partner agencies and their role in the system and the referral linkages (target start date is Fall 2008) ▪ Package of materials[76] developed by the Public Relations/Education Working Group for use by all partner agencies to deliver community presentations that introduce the range of crisis services available in the region ▪ High inter-agency participation and satisfaction in service resolution meetings for individuals in crisis, as evidenced by a survey conducted in early 2008[77]
Multiple levels of involvement within organizations (i.e., front-line staff to senior management) and geographically (i.e., rural and urban representation at the local, regional and provincial levels).	▪ Supervisory and service directors included in the membership of the Waterloo Wellington Dufferin Regional Crisis Committee, including from police and hospital services ▪ Links to the executive leadership maintained through the Regional Crisis Coordinator's attendance at the Waterloo Wellington Dufferin Mental Health and Addictions Planning and Advisory Committee
Development of clear agreements, protocols, memos of understanding, dispute resolution mechanisms, and operational guidelines to achieve close collaboration between groups and to resolve issues	▪ A total of 8 different inter-agency protocols between hospitals, police services and mental health agencies signed, or under development[78] ▪ A section on how to resolve issues contained in all inter-agency protocols ▪ Conflict resolution mechanism in place for the Waterloo Wellington Regional Crisis Committee, and relationships built through the committee are key contacts when there is an interagency issue to resolve ▪ System quality meeting, led by the Regional Crisis Coordinator, held on a quarterly basis in Wellington and Dufferin Counties to address local working relationships and issues

[76] The materials include a pamphlet, the crisis services flow chart and services by geographical region (see Appendix E), a DVD (under development), and a standard power point presentation and display board.
[77] For a copy of these survey findings, please contact Elly Harder, Co-Principal Investigator.
[78] For a full list of these protocols, please contact Elly Harder, Co-Principal Investigator.

Best Practice[72]	Activity or Input
Development of effective information sharing, integrated documentation, and common data collection systems. Data collection systems should focus on those elements critical to key performance indicators.	▪ Current evaluation supported by the Waterloo Wellington Dufferin Regional Crisis Committee as one means of developing information sharing and common data collection systems ▪ Standard police "Emotionally Disturbed Person" form in development for Waterloo Region Police Service to facilitate information sharing with Canadian Mental Health Association and regional hospitals ▪ Shared documentation form used jointly by Waterloo Region Police Service and the Canadian Mental Health Association as part of their Pre-charge Diversion Protocol ▪ Wellness Recovery Action Plan (WRAP) developed to facilitate information sharing amongst crisis system agencies

Incorporation of services (especially mobile crisis teams) into the formal mental health system to support appropriate service use.	▪ Linkages established with the following committees/groups through attendance by Committee members and the Regional Crisis or Service Resolution Coordinators:
	  ▪ Waterloo Wellington Dufferin Mental Health and Addictions Planning and Advisory Committee
	  ▪ Human Service & Justice Committee
	  ▪ Regional Support Coordination Management Committee
	  ▪ Concurrent Disorders Steering Committee
	  ▪ Waterloo Region Suicide Prevention Committee
	  ▪ Suicide Resource Group of Wellington-Dufferin
	  ▪ Planning Group – "The Walk" for Community Torchlight
	  ▪ Elder Abuse Inter Agency Case Review Committee
	  ▪ United Way Planning Focus Groups – Wellington-Dufferin
	▪ Regional Coordination Team meetings with other coordinators in the region (i.e., dual diagnosis, seniors, concurrent disorders) who, as a group, have a broad system planning perspective and a strategic role for service coordination

Police organizations have one or more identified personnel who are responsible for issues related to people in the community with mental health issues. AND Police organizations identify and develop a relationship with a primary contact person within the local mental health system	▪ Police services represented through membership on Waterloo Wellington Dufferin Regional Crisis Committee, and by attendance at system quality meetings held on a quarterly basis in Wellington and Dufferin Counties ▪ Individuals who present ongoing issues to police can be addressed through the regional service resolution mechanism

Best Practice[72]	Activity or Input
Police have access to mental health consultation at the scene, and have clearly defined policies and procedures for accessing mental health expertise	▪ Access formalized through several inter-agency protocols between police, mental health agencies, and regional hospitals

Police have available a directory that provides descriptive and contact information for mental health agencies in the area	▪ Descriptive and contact information available through the following materials:
	  ▪ "Open Mind" pamphlet in Wellington and Dufferin Counties
	  ▪ Orange resource cards and peer/family supports book mark available for all regions
	▪ Access to resource information available 24/7 through crisis lines staff and during business hours through Centres for Mental health (CMHA)

Police organizations participate in regional liaison committees comprised of members of the mental health system and criminal justice system	▪ Police services represented through membership on Waterloo Wellington Dufferin Regional Crisis Committee & Human Service & Justice Committees
The ongoing development and maintenance of police and mental health collaborations should be fostered, taking into account the differing organizational cultures and priorities of police and mental health agencies	▪ Collaborations fostered through membership on Waterloo Wellington Dufferin Regional Crisis Committee

Underlying these various coordination activities and inputs is a newly created flow chart that outlines the ideal movement of an individual in crisis through the Waterloo Wellington regional crisis system. The flow chart details the preferred service pathways among the various organizations involved in the crisis system In addition, a template has been created that outlines services by geographic area (see Appendix E for this flow chart and template).

Crisis system staff members were asked to rate their level of familiarity with these various activities, and were also asked to rate the frequency and quality of the interpersonal collaborations required for a coordinated crisis system. Analyses of these ratings revealed several important differences:

- Staff members working in Waterloo Region were more familiar with the activities and mandate of the Waterloo Wellington Dufferin Regional Crisis

Committee than staff working in Guelph/Wellington County (see Appendix D, Table 21 for details of the analysis).

- Staff members working in mental health organizations were significantly more likely than hospital staff or police to be familiar with the role of the Regional Crisis System Coordinator (see Appendix D, Table 22 for details of the analysis).
- Police staff members worked less frequently with members of other services than hospitals or mental health organizations (see Appendix D, Table 23 for details of the analysis).

Collectively, it is not surprising to uncover that police in general and staff members working in Guelph/Wellington County had less familiarity with certain coordination activities and worked less frequently with members of other services. Theoretically, we would expect that lower levels of familiarity with system-level coordination activities would be associated with a lower frequency of inter-agency collaboration. Additionally, these results are aligned with the perceptions of people with lived experience and family members, some of whom stated that more efficient coordination was needed between the organizations working within the crisis system.

However, it is important to highlight the unique role police hold within the crisis system. Except for those situations in which individuals present repeatedly to police, the role of police services is to provide front-line management and then to effect a “hand-off” to appropriate crisis services and supports. The ongoing collaboration of inter-agency mental health services may involve police in a minimal way, which would explain their lower reported frequency of inter-agency collaboration.

When asked to comment on the changes they have seen to the crisis system since 2006 and how these changes have impacted the way in which they do their job, several staff members across all organizations, locations and settings (urban and rural) noted an increase in partnerships and collaboration among various crisis system organizations. This finding may be initially surprising for police staff members in particular, given that they reported a low frequency in working with members of other services. However, this particular survey item also asked participants to report not on the frequency of inter-agency collaborations in general, but on the frequency of collaborations focused specifically on finding solutions for individuals dealing with a mental health crisis. Thus, police may believe that partnerships and collaborations among crisis system agencies have increased in general, but that solution-focused collaborations when it comes to assisting individuals in mental health crisis have not.

A significant number of mental health staff members, working in urban settings or both urban and rural settings, reported that improvements in system-level coordination have resulted in (a) an increase in their awareness of the services that are available in the region, and (b) an increase in their ability to make

seamless and timely referrals for individuals in crisis. Mental health staff members reported that this has resulted in quicker and more effective crisis resolution.

> *…Mental Health staff member working in both urban and rural settings: By increasing communication we are able to provide more detailed information to callers and help them access further services quicker and more smoothly.*

As coordination across the regional crisis system increases, one would expect to see an increase in the number of referrals made among the various organizations involved in the crisis system. System data regarding the number of referrals made and the source of the referral were available for the crisis line serving Wellington and Dufferin Counties, and for the mobile crisis teams serving the entire region[79].

Table 10 – Number and Source of Referrals Made to Crisis Line Serving Wellington and Dufferin Counties

	Reporting Period	
Referral Source	April 1 2006 to Sep 30 2006	Oct 1 2006 to March 31 2007
Self, Family or Friend	89 (43.4%)	136 (42.4%)
Hospital	46 (22.4%)	105(32.7%)
Criminal Justice System/Police	11 (5.4%)	27 (8.4%)
Community Mental Health Organization	59 (28.8%)	53 (16.5%)
Total	205 (100%)	321 (100%)

Table 10 summarizes the number and source of referrals made to the crisis line across two reporting periods. The majority of people with lived experience and family members contacted the crisis line on their own. There was a substantial increase in this category from the first to second reporting period, possibly indicating that more individuals and family members are aware of the crisis line and are willing to use it. This would be seen as a positive change, as the crisis line has been emphasized as one of the individual's ideal first points of entry into the crisis system. Table 10 also indicates considerable increases in the frequency with which both hospitals and police refer individuals to the crisis line, implying that they are more aware of the service and/or more likely to make a referral.

[79] Number of referrals has not been indexed to a rate per 100,000 population because the referrals provided in Tables 15 and 16 do not represent the total number of referrals made for each reporting period. Referral sources not directly relevant to current coordination efforts, such as Telehealth Ontario, family health teams, and employee assistance programs, were not included.

Table 11 - Number and Source of Referrals Made to Mobile Crisis Teams serving Waterloo Region and Guelph/Wellington County

	Reporting Period			
Referral Source	Oct 1 2005 to March 31 2006	April 1 2006 to Sep 30 2006	Oct 1 2006 to March 31 2007	April 1 2007 to Sep 30 2007
Self, Family or Friend	628 (88.5%)	723 (89.6%)	653 (89.0%)	656 (81.6%)
Hospital	39 (5.5%)	41(5.1%)	273 (3.7%)	21 (2.6%)
Criminal Justice System/Police	20 (2.8%)	29 (3.6%)	19 (2.6%)	78 (9.7%)
Crisis Lines[80]	17 (2.4%)	9 (1.1%)	23 (3.1%)	37 (4.6%)
Community Mental Health Organization	6 (0.8%)	5 (0.6%)	12 (1.6%)	12 (1.5%)
Total	710 (100%)	807 (100%)	734 (100%)	804 (100%)

Table 11 summarizes the number and source of referrals made to the mobile crisis teams in the region. Again, although people with lived experience and family members make the majority of these referrals, we can also see increases in other referral sources. Of particular note are the decreases in hospital-based referrals and the corresponding increases in crisis line-based referrals. It is possible that some individuals in crisis may have started to bypass hospital emergency rooms altogether by contacting the crisis lines first, and then receiving a direct referral to mobile crisis. This may indicate that the inappropriate contact with hospital emergency rooms is decreasing. Additionally, we see a overall increase in the number of criminal justice system/police referrals, indicating that this group is placing more calls to the mobile crisis teams working in the region.

A minority of staff members across all organizations and locations reported that they thought no changes had been made to the crisis system since 2006. This was especially the case for staff members working in rural settings.

8.1.2 The Coordination of Crisis System Services and Supports

The extent to which participants perceived crisis system services and supports as coordinated was mixed. Police services and hospital emergency rooms appear to be the initial point of contact for most individuals in crisis. Some people with lived experience and their family members thought that this was inevitable and, in the case of hospital emergency rooms, even appropriate, given the recent system improvements in the services and supports that individuals in crisis receive when they present to hospital emergency rooms. Other people with lived

[80] Data regarding number of referrals made by the crisis lines are only available for the mobile crisis services provided by Trellis Mental Health and Developmental Services.

experience and family members wondered why alternative community-based services were not more readily available, especially as a way of reducing inappropriate contact with police.

> *…Family member: …what the hospital has done with signing in for the mental health issues, that is awesome. I really like what they've done. Dave (pseudonym) gets in there fairly quickly. Maybe twenty minute wait and then Dave gets in or at least you get to go and sit in this little separate area. But usually they handle the situation fairly quickly and then they get you back to talk to a nurse and then a psychiatrist. I think what they've done is great.*

> *…Person with lived experience: Why don't you have respite in the first place, right because it's an alternative to hospitalization. The police have someone maybe and they don't know where to go with them. The only proper place is- they don't want to bring them to the hospital cause the know they're going to have to wait for five hours…the idea for a respite in the first place, it was supposed to be an alternative to hospitalization. And so I don't think the respite system is set up for that.*

In assisting an individual in crisis, the majority of police working across both urban and rural settings reported high levels of difficulty in coordinating with both hospitals and mental health organizations (e.g., lack of availability, lack of cooperation). This posed a significant drain on police resources.

> *…Police staff member working in urban setting: It has not happened yet, we are anxiously awaiting the opportunity to assess the impact (of crisis system enhancements) as the police still spend too much of the community's time on lengthy security duty.*

The difficulty that police experience in coordinating with other agencies is not surprising, given the developmental nature of the regional crisis system. Several inter-agency protocols between police and hospitals and mental health agencies are currently in development. Thus, we would expect to see a decrease in coordination difficulties experienced by police once these protocols have been finalized and implemented.

Some hospital staff working in either urban settings only, or both urban and rural settings reported that improvements in system-level coordination have resulted in increased inter-agency collaboration and coordination with mental health services, while other hospital staff working in both urban and rural settings reported difficulties in coordinating with mental health organizations

> *…Hospital staff member working in rural setting: It is more and more frustrating as we continue to say "they are working on improving access" but never see results. Barriers to access continue to seem to be created to protect mental health facilities from accepting patients for care they specialize in (and we do not in hospitals!)*

The availability of community-based crisis services and supports, such as mobile crisis teams, crisis lines, and crisis respite beds, were generally perceived as an effective means of coordinated service delivery. A significant number of staff members across all organizations and settings (urban and rural) reported the availability of mobile crisis teams as an important change to the crisis system. Table 12 summarizes the number of calls to mobile crisis from October 1 2005 to September 30 2007.

Table 12 – Number of Calls to Mobile Crisis Teams serving Waterloo Region and Guelph/Wellington County

Reporting Period	Number of calls to mobile crisis teams	Number of calls to mobile crisis teams indexed to a rate per 100,000 population
October 1 2005 to March 31 2006	1740	237
April 1 2006 to September 30 2006	1749	239
October 1 2006 to March 31 2007	1918	262
April 1 2007 to September 30 2007	2043	279
Average for total reporting period	**1863**	**254**

As seen in Table 12, the use of mobile crisis teams in the region is increasing, indicating that coordination between mobile crisis, police, and hospitals may be improving. System data provided by the two crisis lines operating in the region also show similar increases in overall use. Tables 13 and 14 summarize the number of calls to crisis lines by region and reporting period.

Table 13 – Number of Calls to Crisis Line Serving Waterloo Region

Reporting Period	Number of calls to crisis line	Number of calls to crisis line indexed to a rate per 100,000 population
April 1 to September 30 2004	563	118
October 1 2004 to March 31 2005	1103	231
April 1 2005 to September 30 2005	1348	282
October 1 2005 to March 31 2006	1913	400
April 1 2006 to September 30 2006	1707	357
October 1 2006 to March 31 2007	1328	278
April 1 2007 to September 30 2007	1756	367
Average for total reporting period	**1388**	**290**

Table 14 – Number of Calls to Crisis Line Serving Guelph/Wellington County and Dufferin County

Reporting Period	Number of calls to crisis line	Number of calls to crisis line indexed to a rate per 100,000 population
April 1 2006 to September 30 2006	793	311
October 1 2006 to March 31 2007	1043	409
Average for total reporting period	**918**	**360**

System data provided by the crisis respite beds operating in the region also demonstrate an increase in the number of individuals served as shown in Table 15.

Table 15 – Number of Individuals Served by Crisis Respite serving Waterloo Region and Guelph/Wellington County

Reporting Period	Number of individuals served by crisis respite	Number of individuals served by crisis respite indexed to a rate per 100,000 population
April 1 2006 to September 30 2006	57	8
October 1 2006 to March 31 2007	93	13
April 1 2007 to September 30 2007	81	11
Average for total reporting period	**77**	**11**

People with lived experience and family members reported mixed experiences with community-based crisis services. Some believed that these services assisted them in navigating the crisis system and avoiding inappropriate contact with police and hospital emergency departments, while others were not even aware that these services existed. Still others reported that they were aware of and used these services, but that more coordination was needed between community-based crisis services, police, and the hospitals.

> *…Interviewer: If it was your job to manage the crisis system, would you change anything? …Person with lived experience: I'd make it easier for the hospital emergency service, especially smaller hospitals to work with the crisis services- mobile unit and mental health clinic.*

The extent to which individuals are referred and linked to additional relevant community supports was mixed. Some people with lived experience and family members reported referrals that made them believe they were supported within the community, while others (especially family members) reported little or no

referrals, and high levels of frustration in trying to locate community services and supports.

> *…Interviewer: How did you feel that the communication worked between the different people that were involved. Between respite and April (pseudonym)?*
> *Person with lived experience: I think it was very efficient…everybody knew each other.*
> *Interviewer: So it seemed like they had good working relationships?*
> *Person with lived experiece: Absolutely. Yeah, yeah, very good.*

> *…Person with lived experience: Once I went to the emergency room, the system really worked for me. So it was pretty seamless as far as the time I spent in the hospital, and started doing group work.*

> *…Family member: From my experience though, to this very day, from having been in this system for the last four years and as deeply as I've been in it, I feel like I don't know what's in the system. I don't know what supports are there to this day…and I'm angry about that. I'm angry because this was so hard. And it was a dangerous game to play with my daughter's life and with our family. You know? It was at great personal cost. But we got her through. But it was with not a whole lot of help from the crisis system.*

8.2 Timeliness of Services

Key Messages

The timely delivery of crisis services has long been perceived as a key issue facing not just Waterloo Region and Wellington County, but the province of Ontario as well.

Delays in crisis services were perceived by most key stakeholders, and at most points of entry into the regional crisis system.

A minority of people with lived experience noted an improvement in hospital emergency room wait times.

Most participants reported long waiting lists for referrals to community based programs and services.

The key research question here is the promptness with which services are received from the crisis system. This refers to the promptness of the initial response, how long it takes for individuals to be referred to other support services, and how long it takes for individuals to receive services from these other support services once they have been referred.

Only a few documented benchmarks exist regarding the timeliness of services. The Ministry of Health and Long-term Care identifies three standards related specifically to wait times for crisis response services[81]:

[81] Ministry of Health and Long-Term Care. (2005).*Crisis Response Service Standards for Mental Health Services and Supports*.

- Upon identification of a crisis, the first contact with the consumer by the crisis response service must be established within 90 minutes
- A crisis requiring in-person contact will be responded to as soon as possible. Response time should be within 24 hours, with consideration for travel time, weather, etc.
- Crisis support lines must be configured to include a queuing system that lasts no longer than 15 minutes.

However, as has been noted already, these standards relate more specifically to individual crisis services rather than to the crisis system as a whole, and they do not apply to police services.

A May 2008 brief to then Minister of Health and Long-Term Care George Smitherman addressed emergency department wait times[82], noting that wait times are a significant issue across the province of Ontario and for all cases, mental-health related or not, that present to the emergency department. While not establishing specific benchmarks regarding timeliness of services, the brief does recommend increasing 24-hour community-based crisis services and enhancing the role of peer support in order to mitigate the number of mental health-related cases that present to the emergency department in the first place.

The timely delivery of crisis services has long been perceived as a significant issue in Waterloo Region and Guelph/Wellington County specifically. In the spring and summer of 2005, a community consultation to identify key issues was conducted with key stakeholders in the region. These stakeholders asserted that hospital emergency department delays were a serious issue for individuals in crisis, police, and service providers, and concluded that hospital emergency departments must receive the necessary resources to provide effective crisis services (such as rapid mental health assessments, psychiatric consultations, de-escalation and stabilization, etc.)[83].

The lack of resources has historically been seen as a more critical issue in Guelph/Wellington County than in Waterloo Region. For instance, the number of acute mental health beds available in Guelph/Wellington County for the 2004-2005 fiscal year the lowest among all several regions and counties in Ontario, even though the number of mental health presentations at Guelph General Hospital were the same or higher than other similarly sized hospitals across Ontario. Mental health presentations have continued to show a steady increase in Guelph/Wellington County since April 2003, consistent with the area's

[82] Addictions Ontario, Canadian Mental Health Association, Centre for Addiction and Mental Health, Association of Patient Councils, Ontario Federation of Community Mental Health and Addiction Program, Ontario Peer Development Initiative (2008). *Brief to the Honourable George Smitherman: Recommendations for addressing emergency department wait times and enhancing access to community mental health and addictions services and supports.*

[83] For a copy of this document entitled *Gaps and Priorities Presented by Theme and Geography*, please contact Elly Harder, Co-Principal Investigator.

increasing population, while the average length of stay in the emergency department of Guelph General Hospital has at times reached 8 to 9 hours[84].

In response to recommendations made in a formal review undertaken by Guelph General Hospital with support from the Ministry of Health and Long-Term Care, a Psychiatric Emergency Services Implementation Steering Committee, including Homewood Health Centre, Guelph General Hospital, and Trellis Mental Health and Developmental Services was established in June 2005. The Committee submitted a proposal to the Ministry of Health and Long-Term Care in June of 2006 for the implementation of an Emergency Mental Health Service, which includes a self-contained unit with crisis beds, to be located within Guelph General Hospital. In February of 2007, the Ministry of Health and Long-Term Care announced capital and operational funding in the amount of $3.1 million for the Emergency Mental Health Service. While still awaiting completion of the tendering process to begin construction of the self-contained unit, nursing and psychiatric services are currently being implemented within the emergency department space. A coordinator and approximately half of the nurses required have been hired and are onsite, and recruitment for psychiatric services is currently underway. On-call psychiatric services began on March 31, 2008. This service will offer 24-hour, 7 days a week emergency psychiatric assessments, and will work in direct partnership with Homewood Health Centre and Trellis Mental Health and Developmental Services to improve the timeliness of crisis services and supports. A unique feature of this collaboration is the legal agreement by which the Schedule 1 status of Homewood Health Centre is operationalized at the Guelph General Hospital facility. The Emergency Mental Health Service will also be linked to rural hospitals serving Wellington County, providing enhanced consultation and service to those sites.

The issue of timeliness was a recurring theme across all participants involved in the current evaluation. Overall, participants thought that there were significant wait times for a variety of crisis system services and supports.

The majority of participants perceived hospital emergency room wait times as excessive. Police expressed particular frustration with the length of time spent in hospital emergency departments waiting for an individual in crisis to be assessed. This was the case for police working in both urban and rural settings.

> *…Police staff member working in an urban setting: I've seen and heard a great deal of talk in regard to people getting help when they are in crisis. I've only seen very little action. Sometimes the crisis workers are able to assist the police but in most cases when we need to*

[84] Skimson, C., on behalf of the Psychiatric Emergency Services Implementation Steering Committee (2006). *Emergency mental health service for Guelph and Wellington County.* Confidential consultants report funded by Homewood Health Centre, Guelph General Hospital, and Trellis Mental Health and Developmental Services, with permission to use granted May, 2008.

transport people to the hospital, there is still a significant waiting period to get people assessed.

…Police staff member working in both urban and rural settings: (The changes that I would like to see to the crisis system are) police not having to wait hours (sometime days) with a patient at the hospital waiting for the mental health system to help. We do not have anywhere [near] the resources the mental health system demands of us.

System data provided by Wellington County Ontario Provincial Police showed that police officers spend an average of 8.9 hours[85] on each mental health related call for service[86].

System data provided by the six hospitals serving the region show the following average emergency room wait times for individuals presenting with a mental health-related issue, in hours:

Table 16 – Average Emergency Room Wait Times for Individuals Presenting with a Mental Health-Related Issue in Waterloo Region and Guelph/Wellington County[87]

	Reporting Period						
	April 1 2004 to Sep 30 2004	Oct 1 2004 to March 31 2005	April 1 2005 to Sep 30 2005	Oct 1 2005 to March 31 2006	April 1 2006 to Sep 30 2006[88]	Oct 1 2006 to March 31 2007[89]	April 1 2007 to Sep 30 2007[90]
Average ER wait time in hours	3.1	3.1	3.4	3.4	3.4	3.8	3.4

[85] This average is based on all the mental health related calls for service that occurred between April 1 2004 and March 31 2007. For each 6-month reporting period (e.g., April 1 2004 to September 30, 2004; October 1 2005 to March 31 2006) the average ranged from 6.5 hours to 10.6 hours.

[86] The time spent on a mental health related call for service is based on the time between the on-scene arrival of the police officer to the time when the call has been resolved and the police officer returns to active duty.

[87] The accuracy of these averages should be interpreted with some caution as the data provided by the various hospitals differed to some extent in how they were operationalized. The following variables were used to calculate average emergency room wait times: Hospital A – "Wait Time: Average hours from triage to initial assessment by physician"; Hospital B - "Wait time in ED" (these data were only available for patients who were seen in the ED and then admitted; wait times were not available for discharged patients); Hospital C - "Average time in ER: Time of registration to time of discharge from ED"; Hospital D - "Triage to visit disposition"; Hospital E - "Average time in ER: Registration to disposition"; Hospital F - "Average time in ER: Registration to disposition"

[88] Average emergency room wait time was not available from Hospital B at the time of this evaluation.

[89] Average emergency room wait time was not available from Hospital B at the time of this evaluation.

[90] Average emergency room wait time was not available from Hospital D at the time of this evaluation.

Wait times for people with lived experience and family members were often associated with feelings of self-consciousness and exhaustion, and often exacerbated the mental health crisis.

> *…Person with lived experience: How long we'd waited? Um, I'm really not good at remembering these things but it would have been a number of hours I think. And so my paranoia kind of increased.*

> *…Family member: But then, you're sitting in the emergency waiting room with all the kids with the flu and chicken pox waiting for average eight hours, eight to ten hours. Everybody's looking at you. You've got this kid who's crying, I want to die, I want to die.*

A minority of participants did report that hospital emergency room wait times had improved, and this was associated with higher levels of satisfaction with the crisis system, and increased benefits in terms of crisis resolution. This is an important finding, given the current challenges both in the region and across the province regarding emergency room wait times.

> *…Interviewer: So what generally happened when you when you went into the hospital, what was that like, was it easy to get into the hospital? Did you have long wait times?*
> *Person with lived experience: Well, with my doctor's help, it didn't take as long as it used to take*

> *…Mental health staff member working in both urban and rural settings: (The changes to the crisis system since the beginning of 2006 have resulted in) 24-hour access to services that reflects 24-hour occurrence of mental health crisis, thus clients will have reduced wait times in ER.*

Regarding police response times, family members in particular reported that the time between when police were initially called to respond to a crisis to when they intervened was too long, which was associated with an exacerbation of the mental health crisis.

> *…Family member: …they waited until like 7:00 in the morning before they actually started searching. They said they put out like an Amber Alert, but we didn't see nothing. And nobody came and talked to us that night, Nobody did anything. They just like you know, she's probably at a friend's place. They just assumed that and I was telling them no, she's suicidal and she's not at a friend's place. It wouldn't have made any difference, they wouldn't have found her alive, but you know we don't know, some other child they would have maybe. If they had listened right away and said okay and someone had come right away. Instead of waiting until that next morning.*

> *…Family member: First the fire department and the ambulance guys came and they kept sending me upstairs to her room to check on her because they wouldn't go into the house because she had a knife, until the police came. And it took a long time for the police to come.*

Participants generally reported quicker response times for community-based services and supports, such as crisis lines and mobile crisis teams, although some police and hospital staff members reported excessive wait times for these services.

…Interviewer: How do you find that process (referring to crisis line), does that work well for you?
Person with lived experience: It's excellent. You don't have to wait very long usually. Normally it's maybe fifteen minutes. It's not like it's three hours because someone's always on call.

…Mental health staff member working in both urban and rural settings: (The changes to the crisis system since the beginning of 2006 have resulted in) the ability to get a crisis worker on the phone 24/7 and less waiting (2 adult crisis workers on at all times after hours).

…Hospital staff member working in both urban and rural settings: (The changes that I would like to see to the crisis system are) mobile teams being able to get to the home within couple hours vs. "took all day" as one family said.

Participants' experiences with timely referrals to crisis system services were mixed. People with lived experience reported that referrals to crisis respite beds generally occurred in a very timely fashion, although they reported long waiting lists for community based programs and services (e.g., group therapy, counselling, etc.). Mental health workers and hospital staff also noted excessive waiting lists for community based programs and services.

…Mental health staff member working in a rural setting: (The barriers that make it difficult for me to provide the type of crisis services I would like to provide are) wait lists that make it difficult or impossible for people to access services in a timely manner.

A crisis response service standard identified by the Ministry of Health and Long-term Care states that:

> *Written protocols must be established for providing referral and transition to post-crisis services. Referrals to post-crisis services must be based on consumer-articulated needs.*

Protocols such as this do not currently exist at a system level, highlighting the need for development in this area for the regional crisis system. Long wait times for community based programs and services also speak to issues of capacity not for the regional crisis system but for follow-up services. A strong entry point is needed from the crisis system into these follow-up services in order to facilitate ongoing crisis resolution.

8.3 Accessibility of Services

Key Messages

Most people with lived experience and family members reported that they were aware of crisis lines and how to access them, indicating that crisis system promotion efforts, which have positioned the crisis lines as the ideal point of entry into the crisis system, may be having a positive impact.

The availability of crisis respite beds was seen as an important change to the accessibility of the regional crisis system.

More crisis respite beds are needed to divert people with lived experience from inappropriate contact with hospital emergency rooms.

The number of individuals accessing service resolution in the region has increased, indicating that more individuals have been able to gain access to the services they require during a crisis.

The key evaluation question here is the ease with which an individual can obtain crisis system services and supports. Specifically:

- Are individuals aware of the crisis services and supports available to them and do they know how to access them?
- Do the eligibility requirements of these crisis services and supports allow individuals to seamlessly access them?
- Are crisis services and supports readily accessed on an ongoing basis once the individual becomes a client?

Accessibility is also identified as a key performance domain by the Ministry of Health and Long-Term Care[91] and is defined as:

> Ability of people to obtain services at the right place and right time based on needs.

8.3.1 Accessibility of Services and Supports

The majority of people with lived experience and family members reported that they knew of the availability of crisis lines and how to access them. This finding

[91] Ministry of Health and Long-Term Care. (2005).*Crisis Response Service Standards for Mental Health Services and Supports*.

may suggest a positive impact of crisis system promotion efforts[92], which have positioned the crisis lines as the ideal first point of entry into the crisis system.

> *…Interviewer: So generally do you find it easy to access the crises line?*
> *Person with lived experience: Yes, they are usually right there*

The majority of people with lived experience and family members however, reported difficulty in navigating other crisis services and supports, which appeared to be a significant barrier to accessibility.

> *…Family member: You just feel very alone and you're in charge of the whole situation yourself. I can't imagine what people who don't know that they can try and access services- I mean I have spent so much time with all these mood disorder meeting and eating disorder and depressed and all these different situations we've run into and I've spent so much time on the phone with people. There must be a whole bunch of people who aren't doing that whose kids are just slipping through the cracks.*

Crisis system staff members echoed some of these concerns, although they also reported that some positive changes had occurred regarding the accessibility of the regional crisis system. Almost all police staff members reported that they perceived very few changes to the accessibility of the crisis system since 2006, in particular emphasizing that they had very little access to mental health services for individuals in crisis. This is not surprising, given that most of the inter-agency crisis service protocols involving police are still being completed.

> *…Police staff member working in both urban and rural settings: Nothing - essentially everything remains status quo*

A number of mental health staff members working in urban settings, or both urban and rural settings reported the availability of crisis respite beds in the region as an important change to the accessibility of the system.

> *…Mental health staff member working in both urban and rural settings: With the addition of respite beds, more people who are experiencing mental health crisis are able to access the help that they need, instead of using space at shelters, hospitals, or not being served at all.*

However, several staff members working across all organizations and settings reported that more beds were required for individuals in crisis. This included both hospital emergency room beds dedicated specifically to individuals in crisis, and crisis respite beds outside of a hospital setting.

> *…Police staff member working in an urban setting: We desperately need the construction of the Schedule 1 facility at the General Hospital. I also believe that there are not enough beds available at mental health facilities…new facilities or additions to current facilities need to be made.*

[92] A full list of these promotion efforts is maintained by the Public Relations/Education Working Group.

8.3.2 Regional Service Resolution

The primary goal of regional service resolution is to provide high-end support for individual/service resolution issues. This includes facilitation of planning meetings and resources to better respond to the needs of individuals when the capacity of the usual mandates of mental health services are not able to respond adequately. The Service Resolution Coordinator oversees service resolution. Specific purposes of service resolution include the following[93]:

- Promote a shared services paradigm among mental health service providers
- Provide a point of contact for individuals/families and service providers who are having difficulty accessing services dues to the complexity or uniqueness of a person's needs
- Advocate for individuals at the system level when existing resources are not meeting their needs
- Identify gaps in service and communicate this information to pertinent service system planning groups
- Liaise with the Regional Crisis Coordinator to assist in identifying systemic service issues

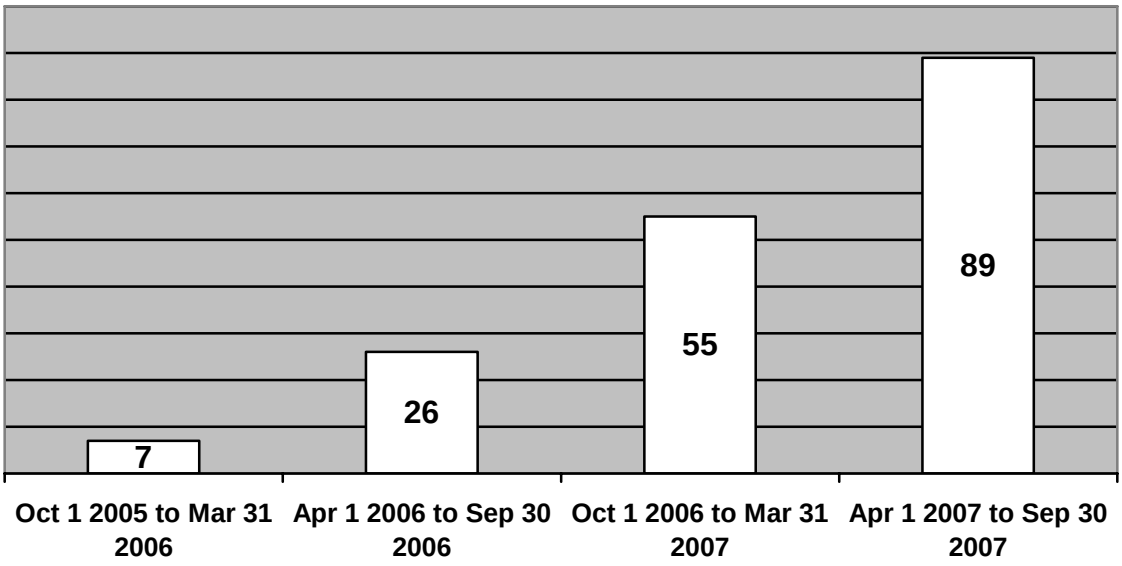
Service resolution varies in its level of intensity. Lower intensity interventions focus mainly on providing emergency funding through the Crisis System Flex Fund. The Flex Fund, implemented in the fall of 2005, is generally used for individuals and families in need of food, shelter, medication, or transportation in order to de-escalate a crisis situation. All other community resources need to be exhausted before the Flex Fund is accessed, and funding is only provided for short-term crisis resolution, not for ongoing use.

Higher intensity interventions consist of intense case conference meetings, involving multiple agencies, for individuals who have unique or complex needs that are not currently being met by available services in the region. The Flex Fund may also be used to support the service plans created at these meetings.

The number of individuals accessing service resolution has shown an increase since its inception, indicating that more individuals have been able to gain access to the services they require during a crisis.

[93] Full details regarding regional service resolution can be found in the Service Resolution Terms of Reference. For a copy, please contact Elly Harder, Co-Principal Investigator.

Figure 2 – Number of Individuals Served by Service Resolution for Entire Region



Individuals participating in case conference meetings (i.e., service providers and people with lived experience) are asked to complete an evaluation form at the end of the meeting. A recent summary of thirty-seven evaluation forms completed by service providers and seven evaluation forms[94] completed by people with lived experience indicated that[95]:

- 73% of service providers agreed or strongly agreed that their concerns/issues were addressed during the meeting
- 95% of service providers agreed or strongly agreed that the facilitation of the meeting was effective
- 86% of service providers agreed or strongly agreed that the recommendations provided at the meeting will assist in a more comprehensive plan for service
- 100% of people with lived experience were satisfied with the outcome of the meeting
- 100% of people with lived experience believed their concerns were understood during the meeting

A recent evaluation[96] of regional service resolution services (e.g., Service Resolution Coordinator, Crisis System Flex Fund) however, suggests that these services are not well understood across various service providers, and that more clarity, formality, consistency and visibility regarding the nature and role of these

[94] The number of people with lived experience who completed evaluation forms is low due to the relatively low number of individuals who receive intense case conference meetings.
[95] For a copy of this summary report, please contact Elly Harder, Co-Principal Investigator.
[96] Shields, C. (2008). *Review of Waterloo Wellington Dufferin service resolution function: Report on interview findings (draft).* Human Services Consultants.

services are required. The evaluation also found that more coordination is needed with other service resolution services operating in the region.

In the present evaluation, no significant differences were found among staff members in their level of familiarity with the Service Resolution Coordinator position. However in absolute terms, police had less familiarity with the role than both hospitals and mental health organizations, and Guelph/Wellington County had less familiarity with the role than Waterloo Region (see Appendix D, Table 24 for details of the analysis).

Staff members were also asked to rate their familiarity with the Flex Fund specifically. Staff members working in Waterloo Region were more likely than staff working in Guelph/Wellington County to be familiar with the fund, and staff members working in mental health organizations were more likely than hospital staff or police to be familiar with the role of the fund (see Appendix D, Table 25 for details of the analysis). This latter finding is not surprising given that initially, direct access to vouchers and funds (e.g., for medications, housing, etc.) was only available to the mobile crisis teams working in the region, which are operated exclusively by mental health staff members. In fall of 2007, access was expanded to other direct service partners such as hospitals and crisis respite beds. Thus, we should expect to see a corresponding increase in familiarity among these staff members over time.

A few staff members working in hospitals and mental health organizations reported that the creation of the crisis system Flex Fund has increased the accessibility of services to individuals who could otherwise not have afforded them.

…Hospital staff member working in an urban setting: I have been able to access resources/funds for resources critical to clients' functioning. e.g., payment for psychotropic meds. prescriptions when clients have no funds, coverage.

As of 2007, a total of $80,000 was allocated to the Flex Fund ($30,000 allocated to Guelph/Wellington County and $50,000 allocated to Waterloo Region). The most recent figures available on use of the crisis system Flex Fund indicate that a total of $37,876.70 in emergency funds was provided to individuals and families in crisis for the April 1, 2007 to September 30, 2007 reporting period. $15,152.44 of this funding was provided in Guelph/Wellington County (40%) and $22,724,26 was provided in Waterloo Region (60%).

Additionally, the April 1, 2007 to March 31, 2008 reporting period showed that a total of 42% of the Flex Fund (33% in Wellington County and 9% in Waterloo Region) was allocated to ‘emergency accommodations’, representing a total of 192 overnight hotel accommodations. This represents a significant improvement in the accessibility of crisis respite services as (a) it increases the chances that an individual in crisis will be diverted away from the inappropriate use of hospital emergency room beds, and (b) in the case of Wellington County, any barriers in

accessing crisis respite beds located in Waterloo Region (e.g., travel distance) is mitigated by access to emergency hotel accommodations in Wellington County.

8.4 Comprehensiveness and Intensity of Services

Key Messages

The regional crisis system needs to improve its ability to create and sustain mechanisms for tracking individuals through the crisis system.

The key research questions here are:

- The degree to which the individual received comprehensive services from the crisis system. Comprehensiveness is defined as the breadth of services received.
- The degree to which the individuals received intense services from the crisis system. Intensity is defined as the frequency of services received.

The interviews conducted with people with lived experience and family members were the primary data source for these two themes. The lack of available data from the other sources used in this evaluation (i.e., staff survey, system data, system documents) is an evaluation finding in itself, as it demonstrates a need to improve how individuals are tracked through the crisis system.

The vast majority of people with lived experience and family members who talked about the comprehensiveness and intensity of the crisis services they received discussed these issues in direct relation to the perceived appropriateness of the services they received. In other words, both comprehensiveness and intensity were simply the underlying processes that were used to articulate a broader discussion around appropriateness.

> *…Person with lived experience: My GP sees me every two weeks, my psychiatrist right now is seeing me once a month. It feels to me and I've felt this for a long, long time that it's only a matter of time for me before I'm gone because this is so persistent and I can't get any help…I don't feel like I'm going in a forward motion. I feel like I'm stuck and I've reached the point where the community and our health system there's just nothing there.*

As a result, a great deal of repetition was seen in the analysis of comprehensiveness and intensity on the one hand, and in the analysis of *Appropriateness* on the other. Thus, the themes of comprehensiveness and intensity, while included in the analysis, were embedded into the broader analysis of appropriateness, which follows in the next section.

In addition, intensity (or frequency) of services was a concept that did not lend itself readily to a comparative analysis because of the nature in which crisis services are typically delivered to the individual. In the mental health system in

general, the frequency of services received can be readily analyzed because the system is structured so that mental health services are ideally delivered a number of times over the course of a particular intervention or set of services. However, within the crisis system specifically, crisis services for many individuals are received through a single point of entry (either through the police, hospital emergency departments, or mental health organizations). From there, the nature of the crisis is assessed, and decisions are made about intervention (e.g., hospitalization, crisis respite, discharge, etc.). Thus, the range for intensity of services is quite limited, and did not provide a sufficient enough range to generate a varied analysis.

8.5 Appropriateness of Services

Key Messages

People with lived experience and family members perceived the appropriateness of the regional crisis system differently, depending on which service they were discussing. Crisis respite beds were viewed as the most consistently appropriate.

Mental health staff members reported that the greater availability of crisis services and supports had resulted in improvements in care.

System data did not indicate an overall decrease in the use of police and hospital services.

System data may be beginning to show a shift towards preferred service pathways in the delivery of crisis services and supports, as indicated by the decrease in the number of apprehensions under the Ontario Mental Health Act.

The key research question here is the extent to which individuals receive services that are appropriate to their situation. Appropriateness can be defined both from the perspective of the individual and from the perspective of the crisis system. Appropriateness from the perspective of the individual is defined as the perceived relevance of services received (i.e., did the individual perceive the services received as helpful and/or useful to their situation?).

Appropriateness from the perspective of the crisis system is defined based on relevant crisis response service standards and best practices. “Appropriateness” is identified as a key performance domain by the Ministry of Health and Long-Term Care[97], and is defined as:

[97] Ministry of Health and Long-Term Care. (2005).*Crisis Response Service Standards for Mental Health Services and Supports*.

Services provided are relevant to service users needs and based on established standards.

Logically, appropriateness of services can be seen to flow from the five components of continuity of care. In other words, the more timely, coordinated, accessible, comprehensive, and intense crisis services are, the more appropriate they should be perceived by both people with lived experience, family members, and crisis system staff members. At the same time, because appropriateness is also conceptualized as the degree to which services are helpful or useful (especially by people with lived experience and family members), it is also independent of the five components. In other words, services may be timely, coordinated, accessible, comprehensive and intense, but may not be perceived as useful by the individual in crisis.

The majority of people with lived experience and family members reported being released from crisis care too quickly, before the immediate crisis had resolved itself, resulting in services that were perceived as inappropriate to their situation. Crisis care included primarily in-patient hospital care. Some people with lived experience also reported too little interaction with mental health workers while hospitalized. A minority of people with lived experience provided highly positive feedback regarding their stay in community-based crisis respite care, which increased the perceived appropriateness of services.

…Interviewer: So do you feel that (the crisis service you received) was intense enough? Do you feel you were in long enough to get to the point where you were ready to leave and sort of go back to?
Person with lived experience: I'm glad you brought that up. I felt I would have been able to like to stay a couple of days extra. But I have to, you know, I have to appreciate that they need to have a constant change - you know other people waiting. I would have liked to have been able to stay for a couple more days. I think that would have been a little more helpful.

…Person with lived experience: I have to say it was a perfect solution for my situation (referring to crisis respite). I was in crisis and I was in despair… An alternative opportunity was wonderful. It did exactly what I needed to do was to get help to my environment. It took me from my environment. It was comforting. It was secure it was safe. It was ideal for what I needed at the time. It was an excellent opportunity.

Satisfaction ratings from people with lived experience were collected directly by crisis respite services from September to November 2006. The results showed that:

- 85% rated the quality of the service they received as "excellent"
- 91% indicated that the program was "good" or "excellent" in meeting their needs
- 94% reported that the amount of help they received was "good" or "excellent"
- 97% indicated that the services they received were "good" or "excellent" in helping them deal more effectively with their problems

Most mental health staff members working across both urban and rural locales believed that changes to the crisis system, such as the more coordinated delivery of services, resulted in improvements in care for the individual in crisis. This contrasted with a significant amount of feedback provided by people with lived experience and family members regarding the appropriateness of the services they received.

> *…Mental health staff member working in a rural setting: I am now able to provide the community and people accessing our services with resources that are appropriate to their specific situation. It decreases the amount of community agencies that I need to connect to and the "being bounced" around syndrome that occurs when people are not fully eligible for each service. It provides a more timely resolution for people and returns them to their pre-crisis state much quicker.*

Specifically regarding the impact of greater availability of services, two mental health staff members working in an urban setting and one hospital staff member working in both urban and rural settings reported that the availability of crisis respite either prevented inappropriate hospitalization, or assisted in community reintegration. This was aligned with most of the feedback from people with lived experience regarding the appropriateness of crisis respite.

> *…Mental health staff member working in an urban setting: I have referred the majority of the individuals I support to crisis respite. In each circumstance it has prevented a hospitalization. Several have also been able to use the house as a transition out of hospital to ensure they are fully stabilized prior to moving home or looking for a new home.*

Many people with lived experience and family members commented specifically on the appropriateness of the crisis lines. Approximately half indicated that the crisis lines were very helpful, providing both knowledge and emotional support. The other half indicated that the crisis lines were either unhelpful or extremely unhelpful, providing unsupportive responses and little or no knowledge of how to manage a crisis.

> *…Person with lived experience: But with this crisis line you get people that are genuinely concerned, they are good people, generally are concerned about the person and they take the time and make sure that you are all right before they let you go. And then they reassure you that if you are still feeling bad again, give them a call. They are available 24 hours a day.*

> *…Person with lived experience: She just answered the phone, hello and I was like hi and I just kind of started talking and I think the only words she said through the whole thing was uh huh. Uh huh, like absolutely no feedback no supportive words or anything. And I was just after I talked for a bit I was just like I'm going to go now. Okay. But nothing. And I haven't called since, cause why bother? I can talk to myself in the mirror.*

Several people with lived experience and family members reported being linked to crisis services and supports that were ultimately ineffective in improving their situation.

> *…Person with lived experience: Kind of like you're out in a little rowboat coming in, most people will bring that boat up to the dock, right? Well this system is wanting us to just jump out of the boat and sort of swim to the shore, and just you know, maybe we don't know how to swim.*

A minority of people with lived experience reported that different organizations seemed to define mental health crises in different ways, leading to potential gaps in service and/or the possibility of not being taken seriously (especially by hospitals). This was viewed as highly inappropriate.

> *…Person with lived experience: Finally I went to the hospital and I was wondering, why aren't people taking me seriously, what is going on? You know, I'm in a crises situation…you know I am in trouble, I can see the signs of what's going on with depression. I had a plan already to commit suicide.*

Several people with lived experience and family members commented on the appropriateness of police behaviour. Approximately half thought that police were supportive and helpful, while the other half thought that police used excessive force or inappropriate tactics.

> *…Family member: The police were awesome they were just amazing. Every time they came they were absolutely amazing. Very calm with him. Trying to talk him down.*

> *…Family member: They sent two squad cars with those plexi-glass shields and helmets and taser guns. Which was so inappropriate for someone who's in a manic state because you really want to keep things level. You try very hard to keep the stimulus down as low as you can and a lot of it, just grace of God, pure like, whatever you want to say, she heard the male voice downstairs. Curiosity got the better of, came downstairs and there's all these cops. And their guns pointed, drop your weapon, drop your weapon.*

One of the goals of the crisis system is to reduce the amount of inappropriate contact between individuals in crisis and police. In other words, community-based services and support should be increasingly available as a first-response alternative to police services. As their availability increases, we should expect to see a corresponding decrease in the number of the mental health-related calls for, and in the number of apprehensions under the *Ontario Mental Health Act.*

Table 17 – Number of Mental Health Related Police Calls for Service and Number of Apprehensions under the *Ontario Mental Health Act* for Waterloo Region and Guelph/Wellington County

Time Period	Number of mental health related calls for service	Number of mental health related calls for service indexed to a rate per 100,000 population	Number of apprehensions under the *Ontario Mental Health Act*[98]	Number of apprehensions under the *Ontario Mental Health Act* indexed to a rate per 100,000 population
April 1 2004 to Sep 30 2004	618	84	268	134
Oct 1 2004 to March 31 2005	680	93	255	127
April 1 2005 to Sep 30 2005	744	102	257	128
Oct 1 2005 to March 31 2006	723	99	228	114
April 1 2006 to Sep 30 2006	899	123	230	115
Oct 1 2006 to March 31 2007	874	119	236	118
April 1 2007 to Sep 30 2007	917	125	238	119

As can be seen in Table 17, system data regarding the number of mental health related police calls for service has shown a steady increase, indicating that police services are frequently called upon as the first response to a crisis situation. However, the number of *Ontario Mental Health Act* apprehensions has shown a decrease. One possible explanation for this decrease is that police officers, once they have arrived on the scene of a mental health related call for service, may be less likely to apprehend an individual under the *Ontario Mental Health Act*, and may be more likely to refer individuals in crisis to more appropriate community-based services and supports[99].

When asked to comment on changes to the crisis system since 2006 however, the majority of police officers reported that very few changes had been made, and that any impacts on the appropriateness of services were negligible. Two

[98] Data regarding number of *Ontario Mental Health Act* apprehensions was available for 2 of the 3 police services operating in the region.

[99] This could be due both to the increasing availability of these services in the region, and to the coordination efforts aimed at making police officers more aware of these services and how to access them.

police officers reported that opportunities for training police regarding mental health issues had increased.

> *…Police staff member working in an urban setting: It allows me to pass on information to the training branch so that younger police officers can have a better understanding of mental health issues and the services that are available to them and those suffering from mental health issues.*

Thus, it is possible that a decrease in apprehensions under the *Ontario Mental Health Act* is more directly related to police training initiatives that educate officers on the crisis services available in the region.

The appropriate use of police services can also be indirectly measured by the number of suicides and attempted suicides that police are called to in the region. A decrease in the number of suicides and attempted suicides could indicate that community-based crisis services and supports are being accessed more readily and are intervening more appropriately.

Table 18 – Number of Suicides and Attempted Suicides for Waterloo Region and Guelph/Wellington County

Time Period	Number of suicides	Number of suicides indexed to a rate per 100,000 population	Number of attempted suicides	Number of attempted suicides indexed to a rate per 100,000 population
April 1 2004 to Sep 30 2004	20	2.7	220	30
Oct 1 2004 to March 31 2005	29	4.0	272	37
April 1 2005 to Sep 30 2005	23	3.1	264	36
Oct 1 2005 to March 31 2006	24	3.3	273	37
April 1 2006 to Sep 30 2006	34	4.6	284	39
Oct 1 2006 to March 31 2007	31	4.2	291	40
Average for total reporting period	**27**	**3.7**	**267**	**37**

As can be seen in Table 18, the region has not experienced a decrease in the number of suicides or attempted suicides. However, the average regional suicide

rate of 3.7 is considerably lower than the province of Ontario's rate of 7.9 or the national rate of 10.8[100].

An equally important goal of the crisis system is to reduce the amount of inappropriate contact between individuals in crisis and hospital emergency departments. In other words, community-based services and support should be increasingly available as a first-response alternative to hospital emergency rooms. As their availability increases, we should expect to see a corresponding decrease in the number of mental health visits that present to emergency departments.

Table 19 – Number of Mental Health Visits to Hospital Emergency Departments serving Waterloo Region and Guelph/Wellington County

Reporting Period	Number of mental health visits to hospital emergency departments	Number of mental health visits to hospital emergency departments indexed to a rate per 100,000 population
April 1 2004 to Sep 30 2004	4057	553
Oct 1 2004 to March 31 2005	4116	562
April 1 2005 to Sep 30 2005	4299	587
Oct 1 2005 to March 31 2006	4369	596
April 1 2006 to Sep 30 2006[101]	4503	614
Oct 1 2006 to March 31 2007[102]	4529	618
Average for total reporting period	**4312**	**588**

Table 19 shows the number of mental health visits presenting to emergency departments for all the hospitals in the region. Overall, the region has demonstrated an increase in mental health visits, which is aligned with earlier findings that people with lived experience and family members reported difficulties in finding out what community-based crisis services are available and

[100] Statistics Canada (2007). *Canadian Vital Statistics for 2004.* Birth and Death Databases and Demography Division (population estimates). Retrieved May 2, 2008 from http://www.statcan.ca/english/freepub/84F0209XIE/84F0209XIE2004000.pdf

[101] Average emergency room wait time was not available from Grand River Hospital at the time of this evaluation.

[102] Average emergency room wait time was not available from Grand River Hospital at the time of this evaluation.

how to access them. As discussed in the May 2008 brief to then Minister of Health and Long-term Care George Smitherman[103], these difficulties are an issue not just for Waterloo Region and Guelph/Wellington County but for the province of Ontario as well:

> *Emergency department use and repeat ED visits are oftentimes the result of little or no communication between hospitals and community-based services…Lack of access to primary health care and community-based psychiatric care are two other reasons for unnecessary emergency department visits…Lastly, the lack of 24-hour crisis alternatives in most communities directly contributes to increased emergency department use. Options for crisis services on evenings and weekends are limited in many communities to emergency departments or the police (p.2).*

8.6 Crisis Resolution

Key Messages

Most people with lived experience reported that their crisis was not properly resolved, and/or that the immediate crisis was resolved but that they did receive necessary follow-up services and supports.

Most staff members perceived improvements in crisis resolution but that more follow-up services and supports were needed for the individual.

Participants' perceptions of crisis resolution were largely based on anecdotal evidence. As the ability to track individuals through the crisis system develops, it is anticipated that data regarding crisis resolution rates can be collected.

The key research question here is the extent to which crises were perceived as having been resolved (1) from the perspectives offered by people with lived experience and family members through the interview process, and (2) from the perspectives offered by crisis system staff members through the staff survey.

A minority of people with lived experience indicated that their crisis had resolved itself through the services they received from the crisis system (e.g., hospitalization, crisis respite, etc.). Others reported that the crisis had not

[103] Addictions Ontario, Canadian Mental Health Association, Centre for Addiction and Mental Health, Association of Patient Councils, Ontario Federation of Community Mental Health and Addiction Program, Ontario Peer Development Initiative (2008). *Brief to the Honourable George Smitherman: Recommendations for addressing emergency department wait times and enhancing access to community mental health and addictions services and supports.*

properly resolved itself, and that they believed they did not receive the proper amount of support, either from the crisis system, from the community or both.

> *…Interviewer: When they discharged her the first time do you think the crisis was over? Family member: No, no, I knew it wasn't over. They kind of, I don't know, when they discharged her they gave us like pamphlets and stuff you know make sure she gets into counseling, make sure she stays on her medication, and if you have any problems call the crisis thing that mobile. And that was about it. And then it was like bye, good luck. It kind of felt like you were shoved out and I was like okay so what are we supposed to do here?*

Still others were somewhere in between, reporting a resolution to the immediate crisis but believing that the crisis system needed to do more in terms of follow-up services and support.

> *…Interviewer: So the crisis had passed during the three days?*
> *Person with lived experience: The immediate emotional crisis that I was experiencing, but you're still in a state of crisis because you're on the verge of eviction probably. You don't have any food in the cupboard and you don't have any money to buy any. You don't have, you just don't have, don't have, don't have all the way down the list, right? And you're not going to get any because now you're on the punitive side, right? We have to punish this person because they have done wrong? You know what I mean? Mental illness or not, they have to learn right?*

Crisis system staff members were asked to rate the degree to which they believe changes to the crisis system have benefited individuals in resolving their mental health crisis. Mental health workers were more likely than hospitals and police to perceive that changes to the crisis system have benefited individuals (see Appendix D, Table 26 for details of the analysis). The majority of mental health staff members working across all regions and locales believed that the more appropriate delivery of crisis services (e.g., increased inter-agency coordination, increased accessibility) had resulted in more efficient, effective and consistent crisis resolution for the individual. Mental health staff members highlighted several specific system-level activities that had contributed to this increase in appropriateness including (1) 24-hour access to crisis services, (2) the availability of crisis respite beds, (3) the availability of the crisis system Flex Fund, and (4) increased community follow-up. These system-level activities were also perceived as contributing to a decrease in the inappropriate use of hospital emergency rooms and police services.

It should be emphasized that the perceived benefits regarding crisis resolution reported by mental health staff members is largely anecdotal and not based on any statistical data gathered by the system. In other words, their perceptions are based on their own experiences within the crisis system and may not coincide with actual crisis resolution rates. As the ability of the crisis system to track individuals develops, it is anticipated that data regarding actual crisis resolution rates can be gathered.

Police staff members working in urban settings only reported that they had seen no benefits to the individual as a result of changes to the crisis system. Reports from police working in both urban and rural settings were more mixed. They

indicated that increased coordination with mental health workers had resulted in improved crisis resolution for the individual, but that more community-based support and follow-up was required for more effective crisis resolution.

> *…Police staff member: Police as first responders now have more tools to use when dealing with mental health patients. By utilizing mobile crisis teams, etc. police now receive more assistance with patients…more patients are being referred and are obviously getting the help they need.*

Several hospital staff members working mainly in urban settings reported that changes to the crisis system had resulted in reductions in the inappropriate use of hospital emergency rooms and, through the crisis system Flex Fund, increased access to necessities such as food and medications. A few reported that more community-based support and follow-up was required for more effective crisis resolution. Two urban hospital staff members in particular noted that they had referred individuals they deemed to be in crisis to mobile crisis but were subsequently informed by mobile crisis that the "individual was inappropriate for service". This resulted in the necessity for a hospital-based crisis intervention rather than intervention in the community. The majority of hospital staff members working in rural settings indicated that no improvements had been made in the degree to which individuals are able to resolve their mental health crises.

> *…Hospital staff member working in a rural setting: As we are seeing an increase in the number of patients presenting and the number of patients we are holding under Form 1, there is very little benefit to the patient in attempts at resolving their mental health crisis. We are ill equipped and do not have the clinical expertise to deal with patients in crisis. Our role should be to be initial intake into the system and quick transfer to appropriate facility.*

8.7 Recovery Principles

Key Messages

Most people with lived experience reported not having developed an individualized crisis plan. An important priority for the regional crisis system is the implementation of standardized individualized crisis plans by Fall 2008. It is anticipated that this will result in increased usage and an increase in recovery principles within the crisis system.

Overall, the regional crisis system has made important advancements towards incorporating principles of recovery into its services and supports. However, the perceptions of people with lived experience and family members suggest that there is still work to be done towards developing a truly recovery-focused crisis system.

The key research question here is the extent to which recovery principles are being expressed in the operation of the crisis system. Crisis system services and supports that are recovery focused will:

- Be desired by the person with lived experience
- Demonstrate respect towards individuals in crisis and their family members
- Follow a holistic approach (e.g., informal supports will be consulted in crises assessment and intervention)
- Value empowerment so that the individual exercises control and power over his or her life
- Support individual and meaningful choice
- Value and respect individual diversity
- Be delivered in the least intrusive manner possible
- Encourage individuals to create individualized crisis plans

Two key outcomes of recovery implementation identified for the Waterloo Wellington Regional Crisis System are (1) the increase of peer involvement across all crisis system functions, and (2) the implementation of individualized crisis plans. Both the Waterloo Wellington Dufferin Regional Crisis Committee and the Self Help Alliance have articulated these as key outcomes[104]. Activities designed to increase these outcomes include:

- A Welcome Support Service: Designated individuals from the Self Help Alliance[105] meet one-on-one with individuals experiencing a mental health crisis either at one of the Self Help Alliance sites or out in the community. The objective is to provide peer support and/or introduce individuals to peer support services.

- Peer support to assist individuals with the development of their individualized crisis plans: Training is available to facilitators within the Self Help Alliance to support individuals in the design of their individualized crisis plans.

- The delivery of a Self Help Recovery Centre Peer Support Group on the topic of individualized crisis plans.

8.7.1 Individualized Crisis Plans

A minority of people with lived experience reported developing plans while the majority reported that they had never heard of them. Those who had developed a

[104] Self Help Alliance (n.d.) *Peer Support Involvement in Crisis Services*. For a copy of this document, please contact Elly Harder, Co-Principal Investigator.
[105] The Self Help Alliance consists of the following members: Cambridge Active Self Help, Mood Disorders Association Waterloo Region, Waterloo Region Self Help, and Wellington-Dufferin Self Help

plan reported that they were helpful in articulating the needs of the individual and navigating the crisis system in the event of a subsequent crisis.

> *…Person with lived experience: One of the counsellors there, one of the workers said okay, let's create a plan. A safety plan. You know? So to identify when you're feeling this way, thoughts are going through your head, who are you going to approach? Where's your safety net. Implement a safety net. A crisis plan. That's what it was. I thought that was very, very helpful. And it was good because it gave me, made me think. What would you need? What do you think you would like to help you through these? And it was a good process.*

Crisis system staff members were asked to rate their level of familiarity with individualized crisis plans. Staff members working in mental health organizations were more likely than hospital staff or police to be familiar with individualized crisis plans (see Appendix D, Table 27 for details of the analysis).

As mentioned earlier, the development and implementation of individualized crisis plans is an important priority for the region, as identified by the Waterloo Wellington Dufferin Regional Crisis Committee and the Self-Help Alliance. An important objective of this priority is to adapt the current format so that it clearly represents the needs and wants of people with lived experience[106]. In 2006, a common form, adapted from others already in use in each area, was introduced across Waterloo Region and Guelph/Wellington County in order to better integrate the regional crisis system. In June of 2007, the Public Relations Working Group, a sub-committee of the Waterloo Wellington Dufferin Regional Crisis Committee, partnered with the Self-Help Alliance to conduct an evaluation of this form. Focus groups were conducted with people with lived experience, family members, case management workers, mental health workers, and hospital staff, and a web-based survey was administered to crisis system staff members.

Results of the evaluation indicated that

- The vast majority of participants reported that they would like the name of current form entitled "Registered Individualized Crisis Plan" changed. Thirty-five percent preferred the name "Wellness Recovery Action Plan". (WRAP)
- People with lived experience reported that they want to be fully involved in the development and implementation of individualized crisis plans, and in any future evaluation processes related to the plan.
- People with lived experience reported that the plan should be in plain, person-centred language, not in clinical services language.
- What is useful information for crisis system organizations must be tempered with the needs of people with lived experience, especially as it relates to issues of privacy and informed consent.

[106] Self Help Alliance (n.d.) *Peer Support Involvement in Crisis Services.* For a copy of this document, please contact Elly Harder, Co-Principal Investigator.

- The plan should be accessible to anyone who is interested in it (e.g., mental health agencies, crisis services, hospitals, consumer survivor initiatives, mobile crisis teams, hospices, etc.)

Based on these evaluation findings, a process is currently underway across the region to update the individualized crisis plan. The name has been changed to "Wellness Recovery Action Plan" or WRAP, and implementation of the new form will begin in Fall 2008. Funding is being sought for two peer consultation positions whose role will be to conduct WRAP training and pre-/post-crisis follow-up.

8.7.2 Perceptions of Recovery Within the Crisis System

A minority of people with lived experience reported experiences that were aligned with the principles of recovery outlined above. Importantly, the analysis revealed that the term "recovery" and what it means is not generally discussed explicitly by the services and supports of the crisis system.

Instead, people with lived experience tended to report experiences and interactions in which recovery principles were more implicitly conveyed through politeness, respect for individual circumstances, etc. Virtually all of these positive experiences were based on interactions with the crisis lines or with crisis respite beds.

> *…Person with lived experience: And when I did get the call from the respite home it was such a nice - would you like to come spend some time with us? It was very nice the way she handled it. Yeah, just come on over, you know and? You're welcome you're welcome, come on over. It was very nice the way that was done. I felt very relieved when I knew that was happening.*

The majority of people with lived experience and family members however, thought that their interactions with the crisis system were not recovery focused, either implicitly or explicitly. Participants reported a range of negative experiences with crisis system service providers, from indifference to outright hostility. The majority of these experiences were based on interactions with hospital emergency rooms and in-patient treatment facilities. A few people with lived experience and family members specifically reported that the services they received from the crisis system were intrusive.

> *…Interviewer: Tell me you experiences with them when you were in crisis.*
> *Person with lived experience: Um, it was you know, it was almost a situation that they didn't want to touch it, you know what I mean? They were that- trained that it was a situation they felt something would crawl on them or something. Disgust. Open disgust, eh?*
>
> *…Family member: I'm just sitting there (in the hospital emergency department) with all these people around watching and it's, I mean it's, it's embarrassing for- it's degrading to her. It's embarrassing and it's stressful to the other people in the waiting room*

Only a few people with lived experience commented specifically on their perceptions of peer support in relation to the crisis system. Most referred to having heard about recovery only through peer support.

> *…Interviewer: Has anyone ever brought up the word recovery with you?*
> *Person with lived experience: Only other patients, former patients from the (local self help organization).*

Crisis system staff members were asked to rate their level of familiarity with recovery principles and practices. Police staff members were less likely to be familiar with these principles and practices than either mental health or hospital staff members (see Appendix D, Table 28 for details of the analysis). Moreover, mental health staff members were more likely than police to report that the services they provide are aligned with recovery principles (see Appendix D, Table 29 for details of the analysis).

All mental health staff members who provided comments reported that their organization firmly embraced principles of recovery. They indicated that the services they offer are client-focused, with a strong emphasis on empowerment, individual choice and self-determination, individual control, and non-intrusive services and supports. This aligns with most of the accounts from people with lived experience and family members regarding their experiences with community-based mental health services. Several mental health staff members also indicated they their organizations engage in ongoing staff training and education regarding recovery principles.

> *…Mental health staff member working in both urban and rural settings: All training with our organization focuses on non-judgemental, person-centred, respectful listening skills. We do not believe in telling someone what to do, but rather exploring different options and how the person feels about those options. In crisis situations, safety is the priority, but control is always returned to the person. Options and choices are discussed with anyone seeking support and the goal is to find the choice that is right for them. We like to focus on a person's strengths as well as being sensitive and assisting with any difficulties the person is dealing with. We see a whole person, and a diagnosis is a part of a person (not the definition of who they are).*

A few hospital staff members reported that their services were recovery focused, while two reported that their organizations were striving to incorporate recovery principles into their services. This contrasts with the hospital-based experiences of most people with lived experience and family members.

> *…Hospital staff member working in both urban and rural settings: The services provided by myself and my colleagues are very focused on providing a sense of hope, and of the individual's ability to effect change, to self-advocate as well as accept a community support system that offers very skilled, dedicated front line workers. Elimination of prejudice and discrimination is also a strong focus in our work. Considerable time is spent and every opportunity available is used to 'sensitize' fellow team members to the challenges of mental illness, particularly the systemic barriers (this is a huge challenge in our working environment, however, we persist!)*

The majority of police staff members reported that their organizations were receptive to principles of recovery but that recovery was not an explicit mandate of their services. Most indicated that because they are often the first point of contact for an individual in crisis (when there is a call for service), their primary objective is to ensure the safety of the individual and others involved, and then to refer the individual to appropriate crisis services and supports. Several police staff members reported that they treat individuals in crisis with respect and fairness.

> *…Police staff member working in both urban and rural settings: We provide assistance to patients to bring them to a facility or talk with crisis workers to empower them to continue to focus and work on their problems so that they can cope.*

8.7.3 Recovery-Focused System Activities

Several activities have been undertaken in the region to promote practices within the crisis system that are consistent with principles of recovery. As mentioned earlier, implementation of the new WRAP form and process will begin in Fall 2008, and funding is being sought for two peer consultation positions whose role will be to conduct WRAP training and pre-/post-crisis follow-up. In addition, several additional recovery-focused system activities have been implemented, including the following:

- The vision statement adopted by the Waterloo Wellington Dufferin Regional Crisis Committee in October 2007:

> *"A person in crisis will have access to a respectful and prevention-oriented, holistic service, integrated with their chosen community and support networks, when they need it, where they need it, and how they want it."*

- A set of recovery values and principles for a recovery-oriented mental health system[107] articulated by the Self Help Alliance, and adopted by the Waterloo Wellington Dufferin Regional Crisis Committee in June 2006

- Recovery principles foregrounded in all the work of the Waterloo Wellington Dufferin Regional Crisis Committee (e.g., Memoranda of Understanding, inter-agency protocols, etc.)

- Person with lived experience membership on the Waterloo Wellington Dufferin Regional Crisis Committee. Committee member is included in all the activities of the committee.

- The Peer-Family Roles Working group report[108], tabled to the Waterloo Wellington Dufferin Regional Crisis Committee in February 2007, which

[107] Self Help Alliance (n.d.). *Recovery values and principles in the mental health and addiction service system*. Guelph, ON: Self Help Alliance. Retrieved May 8, 2008 from http://www.wrsh.ca/Values_and_Principles

[108] For a copy of this report, please contact Elly Harder, Co-Principal Investigator.

outlined several proposed activities, including: (a) increasing the involvement of family members in the planning and evaluation of services, (b) attaching peer workers to specific service junctures such as crisis respite and hospitals emergency rooms, (c) submitting a proposal for a consumer-run safe house.

- Participation by persons with lived experience in all working groups, in particular the WRAP development process.

- A bookmark that lists contact information for various peer and self-help organizations in the region.

- Financial support from the Public Relations/Education Working Group (a sub-committee of the Waterloo Wellington Dufferin Regional Crisis Committee) for the creation and publication of "Journey of Recovery – A mental health guidebook for families in Waterloo Region".

- Inclusion, whenever possible, of the person with lived experience and family members in service resolution meetings. Upon conclusion of the meeting, feedback is gathered from the person with lived experience and family members regarding satisfaction with the meeting, the extent to which they were treated with respect, and whether their concerns were understood.

8.7.4 Realizing Recovery Principles Within the Crisis System

Overall, these findings indicate that the crisis system has made important advancements towards incorporating principles of recovery into its services and supports. At the same time, the perceptions of people with lived experience and family members suggest that there is still work to be done towards developing a truly recovery-focused crisis system. This development relies in part on a change in values for some organizations involved in the crisis system. As evidenced from the feedback received from staff members, this change is underway but is one that takes time to be fully realized.

8.8 Satisfaction with the Regional Crisis System

Key Messages

The vast majority of people with lived experience and family members reported on their satisfaction with individual service components rather than the crisis system as a whole, and these accounts are embedded in other evaluation themes.

Staff members working in mental health organizations were the most satisfied with the regional crisis system.

Staff members working in urban setting were more satisfied with the regional crisis system than staff members working in rural settings.

The key research question here is the extent to which services provided by the crisis system meet the expectations of the individuals who receive services and the individuals who provide them. The Ministry of Health and Long-Term Care identifies satisfaction as a key performance domain although it is referred to as "Acceptability":

> *Services provided meet expectations of service users, community, providers and government.*

The vast majority of people with lived experience and family members reported on their satisfaction with individual crisis system services and supports rather than the crisis system as a whole. These accounts of satisfaction are embedded in the previous sections regarding the five components of continuity of care, appropriateness of services, crisis resolution, and recovery principles. In general, people were somewhat satisfied with the crisis system because, as noted previously, their crises were not adequately addressed or in some instances were adequately addressed but without sufficient follow up support. Consistent with this finding, two of the six people who commented on their satisfaction with the crisis system as a whole were dissatisfied with the crisis system, while the other four people (two people with lived experience and two family members) were satisfied to very satisfied with the system.

> *…Interviewer: If it was your job to manage the crisis system, would you make any changes and if so, what would you do?*
> *Person with lived experience: No I wouldn't… I think it's a wonderful system.*

Crisis system staff member satisfaction ratings with regional crisis services and supports revealed that staff members working in mental health organizations had higher satisfaction ratings than either police or hospital staff (see Appendix D, Table 30 for details of the analysis). Additionally, staff members working in rural settings had lower satisfaction ratings than staff members working in urban settings, or staff members working in both urban and rural settings (see Appendix D, Table 31 for details of the analysis). Within rural settings, staff members working in mental health organizations had significantly higher satisfaction ratings than hospital staff members (see Appendix D, Table 32 for details of the analysis).

9.0 Key Findings and Recommendations

9.1 Summary of Key Findings

A number of notable findings emerged from the preceding evaluation of the development and operation of the Waterloo Wellington Crisis System.

Given the developmental nature of the crisis system, it is important to emphasize that several key accomplishments have been achieved within a relatively short-time frame.

Significant progress has been made in system-level coordination activities, including (a) the formation and ongoing work of the Waterloo Wellington Dufferin Regional Crisis Committee, (b) the development of several inter-agency protocols regarding the delivery of crisis services and supports, and (c) the more informal inter-agency coordination activities (e.g., referrals) that have occurred through a greater inter-agency awareness of the crisis services and supports available in the region. Several best practices of crisis system coordination and integration have also been followed through the various activities and inputs of the Waterloo Wellington Dufferin Regional Crisis Committee and the crisis system as a whole.

A significant accomplishment has also been the crisis system's emphasis on promoting practices consistent with principles of recovery. Recovery principles are typically not emphasized in the design and delivery of crisis services, so their inclusion here is an important step toward developing a mental health system that takes a holistic approach to recovery by including its principles at all possible points of entry into the mental health system.

An ongoing concern continues to be lengthy hospital emergency room wait times for people with lived experience, family members, and police officers. Shortening these wait times is an especially important priority for police services in the region. Given the early developmental stage of the crisis system, it might be too early to see the full impact of the system enhancements targeted toward wait time reductions. As inter-agency protocols between police and hospitals are finalized, and as the Emergency Mental Health Service at Guelph General Hospital is completed and fully operational, the crisis system should begin to demonstrate a reduction in emergency room wait times. Additionally, as coordination activities between organizations involved in the crisis system continue, one would predict an increase in levels of collaboration between police services and community-based services such as mobile crisis teams and crisis respite, thereby circumventing emergency rooms altogether (in those crisis situations where this is appropriate). The Waterloo Wellington Regional Crisis Committee has identified awareness building among police and hospitals regarding the community crisis services available in the region as a key public relations priority in support of enhanced service utilization.

The crisis system enhancements that have been implemented over the last two years appear to be most keenly experienced by staff members working for mental health organizations. In other words, mental health staff members were more familiar with various components of the crisis system, were most likely to report being satisfied with the crisis system, and were most likely to report that changes to the crisis system had resulted in more effective crisis resolution for the individual. This is not surprising given that these enhancements are largely

targeted toward community-based mental health services (see Appendix A). The rationale is that as community-based mental health services are enhanced, inappropriate pressures experienced by police and hospital services should begin to decrease. Thus, one would predict that mental health staff members should be more immediately satisfied, and that satisfaction levels among police and hospitals should start to increase as they become familiar with and begin to experience the benefits of these enhancements as well.

The crisis system enhancements that have been implemented over the last two years appear to be most keenly experienced by individuals working and living in urban settings. As discussed earlier, the evaluation experienced challenges in collecting data from rural sources, especially in relation to the interviews that were conducted with people with lived experience and family members. The data that were collected from rural sources (including crisis system staff members) generally demonstrated less satisfaction with the crisis system than data collected from urban sources.

More progress is required toward the development of practices consistent with recovery principles. The inclusion of recovery principles as a guiding framework for the regional crisis system is an important step toward a recovery-focused mental health system in Ontario. The findings of this evaluation indicate that while the crisis system has developed numerous practices that are aligned with principles of recovery, the perceptions of people with lived experience and family members indicate that these principles are not consistently experienced at the level of the service recipient. As already discussed, the incorporation of recovery principles into the crisis system, what this means and how to measure it, will continue to be an ongoing issue for both the Waterloo Wellington Dufferin Regional Crisis Committee and for the crisis system as a whole.

9.2 Recommendations

The evaluation findings have also highlighted important recommendations that can guide and inform the ongoing development and evaluation of the regional crisis system.

9.2.1 Recommendation: Refine System-Level Performance Indicators

A great deal of variability was found in the type of data collected throughout the system, which is to be expected given the developmental nature of the system. As already discussed, this meant that very few data elements could be collapsed to create system-level variables.

As the crisis system matures, a key activity should be the ongoing identification of system-level performance indicators and how to measure them reliably. Indicators should be identified based on a review of the logic model and then refined through a process of consultations with service providers and other key stakeholders. It is recommended that an Evaluation Sub-Committee (a sub-

committee of the Waterloo Wellington Dufferin Regional Crisis Committee) be formed to spearhead this process. For each particular performance indicator that is identified, the Evaluation Sub-Committee should consult all organizations involved in its collection so that each organization can make the others aware of the process by which an indicator is currently collected or can be collected. Through this consultation process, agreements can be made regarding how an indicator is defined, and what is reasonably feasible in terms of how it can be collected, given the resources of each organization.

At the same time, there are also conceptual and methodological challenges in incorporating and measuring recovery principles at the level of the system. What does it mean to have a recovery-focused crisis system? How can system-level recovery principles be operationalized and measured (e.g. what are the indicators of recovery)? These are issues that both the Waterloo Wellington Dufferin Regional Crisis Committee and within broader Ontario will continue to wrestle with as the whole system evolves towards a recovery focus. The table below lists examples of performance indicators which the regional crisis committee can use when developing plans for ongoing evaluation and monitoring[109]:

Table 20 – Examples of Crisis System Performance Indicators and Methods of Data Collection

Performance Indicator	**Method of Data Collection**
Joint proposals submitted by crisis system organizations	Count number of joint proposals and divide by total number of proposals to generate a percentage
Referrals to mental health agencies from hospitals and police	Mental health organizations record referrals made by hospitals and police and divide by total number of referrals to generate a percentage
Average time spent on mental health-related calls for service for police services & Average emergency room wait times for police services	Police officers record time spent in minutes on mental health-related calls for service: ▪ Gather organizational consensus on the call's start and end time ▪ Clearly demarcate any time spent in the hospital emergency room as part of the call
Apprehensions under the *Ontario Mental Health Act*	Police organizations record number of apprehensions under the *Ontario Mental Health Act*
Type and frequency of services received by the individual from the crisis system	Data regarding this indicator can be reliably collected once the ability to track the individual through the system has been developed and is fully operational

[109] Where possible the performance indicators should specify the direction (increase/decrease) of change and the specific amount of change.

Performance Indicator	Method of Data Collection
	▪ Privacy issues and informed consent must be a key consideration in the development of this indicator
Wellness Recovery Action Plans developed by the crisis system[110]	Mental health organizations count the number of plans developed across the region

9.2.2 Recommendation: Develop Outcome-based Evaluations

As already mentioned, the developmental nature of the crisis system meant that our evaluation was largely formative in nature. Accordingly, this meant we were not in a position to evaluate expected outcomes of crisis system enhancements, such as a reduction in the inappropriate contact with the criminal justice system.

As the system matures, another activity of the Evaluation Sub-Committee should be the submission of funding proposals for outcome-based evaluations of the crisis system.

9.2.3 Recommendation: Use Evaluation as a Guide for Crisis System Enhancement

The findings documented in this report, which are based on consultation with all key stakeholder groups, are ideally positioned to guide ongoing crisis system development. Consequently, these findings should form the basis for future discussions on the ways in which the services and supports of the regional crisis system may be enhanced, changed or improved. This discussion process then becomes the means by which actionable next steps are defined, prioritized, and implemented for the region.

Afterward

Ultimately, the purpose of any evaluation is to highlight the components and activities that are working as they should, and to pinpoint any areas that can be improved or enhanced. We hope that this evaluation report will be used by key stakeholders as a way to highlight the accomplishments that have been made in the last two years.

[110] As already discussed, one of the key tasks facing the regional crisis system will be to develop other recovery-focused performance indicators.

Appendix A: Mental Health Enhancements to Waterloo Region and Wellington County

Local Health Integration Network 3 - June 2007

NB: Shaded areas represent crisis funding.

*In some service areas funding was given to Trellis as lead agency and contracted to other agencies to deliver the service. Total allocation is noted under Trellis.

Reg = regional Wat = Waterloo Region W-D = Wellington-Dufferin

Agency	Program Funded	Date Funded	Amount	Date Operational
Waterloo Regional Homes (With Dunara) Reg	Respite beds #1 (two beds in total - one bed in Waterloo, one in Guelph)	2005 - 2006	$363878	October 2005
Reg	Crisis System Coordinator .5FTE		$42,122	Transfer to CMHC
Reg	Beds # 2 (4 beds funded – moved to one location)	2006 - 2007	$430,000	June 15, 2006
Reg	Beds # 3 (2 beds bring total Respite beds to 8)	2007 - 2008	$290,000 Crisis Respite beds total = $364,598.00	April 2007
Wat	ACTT	2006 - 2007	$1,.200,000	July 2006
Wat	Case Management (CM)	2005 - 2006	$80,000	July 2005
Wat	CM (through CMHC)	2006 - 2007	$270,000 4.5 FTE*	June 2006
Wat	Supportive Housing (Waterloo Region)	(this is for housing subsidy and support) 2006 – 2007	$1,593,600	August 2006 – Total – 80 units, gradual take-up of units – to date 18 units.
W-D	Supportive Housing (Wellington/	2007 – 2008 (annualized amount)	$1,843,000	Total 40 units – gradual take-up of units – pending start

Agency	Program Funded	Date Funded	Amount	Date Operational
	Dufferin)			
Homewood W-D	CM		.68FTE-Dufferin* + .32 HHC funds 1 FTE Well*	June 06
W-D	ACTT rural # 1	Jan 2001	$700,000	November 2001
W-D	ACTT rural #2 And South Well. ACTT	Aug 2005	$1.7 M	March 2006
Self-Help Alliance Reg	Recovery Coordinator Outreach		1.8 FTE*	
Trellis (Community Mental Health Clinic - CMHC) W-D	Mobile Crisis Team (MCT)– Phase I&II	2004-05	$769,000. MCT (not 24/7 =$419,000.00 Crisis Line $350,000*	Jan 05
Reg and W-D	Mobile Crisis – phase III	2005-06	$570,000 – 24/7 MCT=$257,000 Coordinator .5 FTE, Service Resolution 1FTE Flex fund W=50,000 +W-D =30,000 EMHS = 150,000	Jan 06 November 2005 November 2005 November 2005
Reg	CM	2005-06	$1,130,000- across region as per FTE noted by agency CMHC = 1 FTE*	Sept 05
W-D	Court support	2004-05	$252,000 across region CMHC =1FTE	
Reg	Pre-charge diversion	2006-07	$306,700 (to CMHC and CMHA, below)	In process- 1 FTE hired as of June 2007
Reg	Early Psychosis	2005-06 2006-07 2007-08	$420,000 $425,000 $361,000 (tent.)	October 2006
Reg	Special Populations (Concurrent, Seniors)	2006-07 2007-08	$336,000 -Senior Coordinator -Concurrent (1 FTE	July 07 Pending

Agency	Program Funded	Date Funded	Amount	Date Operational
			going to St Mary's) $504,000 pending	
Canadian Mental Health Association Wat	Crisis line	1996	$33,000	1996
Wat	Mobile Crisis Team	1996 Sept 2004	$106,440 $505,000.	1996 Sept 2004
Reg	CM		1 FTE Well* 2.5 FTE Waterloo*	May/June 06
Wat	Court support 1	05-06	$126,000 1.0 FTE* (CMHA added .5 FTE)	May 2005
Wat	Pre-charge	Jan 2007	$219,000* 2.5 FTE	In process- 1 FTE hired as of June 07
Distress Centre W/D W-D	Crisis line	November 2004	$350,000* 5.8 FTE	January 2005
Guelph General Hospital + partners W	EMHS #1 Accord $	Mar 2005	$150,000*	
	EMHS – capital	Feb 2007	$2.1 M	
	EMHS – operation	Feb 2007	$1.0 M	

Appendix B: Evaluation Plan

Research Objectives	Evaluation Questions	Indicators	Methods
A – Process of Development To identify the key inputs, principles, and mechanisms necessary to develop the crisis system in Waterloo-Wellington	**A1** Were key inputs identified? Did logical links exist between Ministry of Health and Long-Term Care (MoHLTC) policy, the Waterloo-Wellington service design, and the development and enhancement of crisis services?	• Key inputs necessary to develop the crisis system were identified (e.g., policies, data, funding strategies, existing protocols, guidelines, directives, funding, personnel) • Consensus among planners re required inputs and their necessary levels • Consistent priorities across MoHLTC policy, service design, and crisis services development and enhancement	• Review of documentation - Relevant MoHLTC documents - Original funding proposals for system and individual agencies - 2005 consultation notes and minutes from initial planning meetings - Planning and summary documents from Waterloo and Wellington - Job descriptions for key funded positions (for comparison with actual work • Interviews with staff - Staff involved in initial planning - Key players in front line delivery • Interviews with key stakeholders, including: - Regional Crisis Coordinator (RCCr) - Regional Support Worker (RSW) - Service Resolution Coordinator (SRC) - RCC Chair
	A2 Were all relevant (key) stakeholders identified in the development process? Were key stakeholders engaged in the development process?	• Key stakeholders identified and invited to participate the development process • Roles of key stakeholders in the development of the crisis system • Key stakeholders were engaged in the development of the crisis system	• Review of documentation - Original funding proposals for system and individual agencies - 2005 consultation notes and minutes from initial planning meetings - Planning and summary documents from Waterloo and Wellington - Job descriptions for key funded positions (for comparison with actual work - RCC meeting minutes • Interviews with staff - Staff involved in initial planning - Key players in front line delivery • Interviews with key stakeholders, including: - RCCr; RSW; SRC; RCC Chair

Research Objectives	Evaluation Questions	Indicators	Methods
	A3 Were key principles for the development of the crisis system determined and included in the system design?	• Key principles were determined • Peer groups were consulted • Key principles are identifiable in system design	• Review of documentation - Terms of reference - RCC meeting minutes and supporting documents
	A4 Were mechanisms necessary for decision- making and ongoing administration identified?	• Mechanisms necessary for decision-making and administration were identified • Mechanisms are being utilized	• Review of documentation - Terms of reference (structure and function of the committee) - RCC meeting minutes and supporting documents
B – Process of Operation To describe the operation of the crisis system in Waterloo-Wellington	**B1** Has coordinated planning been used to enable the operation of the crisis system? What is the relationship between system development, integration and collaboration and their impacts on service quality?	• Joint funding proposals are being developed and submitted (+ purposes of submission) • Service agencies are engaged in coordinated planning • System level information is being shared between service providers	• Review of documentation - Proposals submitted - Service agreements - Protocols and MOUs - Policies and procedures of affiliated agencies (where they exist)
	B2 What new resources have been developed to enable the operation of the crisis system?	• Joint policies and protocols have been developed (e.g., shared protocols re assessment, referral and intake) • Existing services reconfigured, new initiatives developed • Knowledge exchange events between participating agencies have been undertaken.	• Review of documentation - Protocols and MOUs - Policies and procedures of specific agencies - Public relations documents - Information from joint training and information events • Interviews with stakeholders - Public relations committee members • Interviews with staff - Program managers - Members of training branches
	B3 Is the system involving key stakeholders as participants in, and recipients of, service delivery?	• Characteristics of participating services • Characteristics of service users	• Review of documentation - Committee membership (both core and corresponding) - Participant characteristics, service provision information

Research Objectives	Evaluation Questions	Indicators	Methods
	B4 Were inputs that were in place sufficient to enable the operation of the crisis system?	• Relevant inputs were in place to sufficient degree to enable the operation of the crisis system (e.g., policies, data, funding strategies, existing protocols, guidelines, directives, funding, personnel)	• Review of documentation • Interviews with stakeholders • Interviews with staff - Key service delivery staff (what is the reality of the system?)
	B5 Were system features and practices consistent with MoHLTC Crisis System Standards?	• System structures, resources, and practices were consistent with relevant MoHLTC Crisis System Standards	• Crisis Standards checklists for: – Documentation review – Self-report surveys of service providers & PLEs – Field observations
C - Early Impacts (Outcomes) To identify the early outcomes of the operation of the crisis system in Waterloo-Wellington	**C1** Are services following the 'Continuity of Care' principles? 1. Timeliness 2. Coordination: ▪ To what extent has the system achieved the outcome of appropriate involvement of police services? ▪ To what extent has the system achieved the intended outcome of reducing the inappropriate use of hospital emergency and mental health services? 3. Accessibility 4. Intensity 5. Comprehensiveness 6. Appropriateness **C1 continued…**	• Service providers are aware of services provided by one another • Service providers are involved with one another as appropriate/ make use of one another's services (i.e., appropriate involvement of police services, mutual referral + joint delivery - e.g., crisis workers attend/assess in community jointly with police; refer people to each other) • Service providers exchange information as appropriate (e.g., ongoing consultation between emergency services and crisis team/hospital) • New partnerships are established re service delivery (purpose; mechanisms, e.g., MOUs, informal referrals, other) • Changing patterns of funding • Callers are referred to appropriate services in a timely way • PLE experience services as seamless	• Review of documentation - Original funding proposals for system and individual agencies - 2005 consultation notes and minutes from initial planning meetings - Planning and summary documents from Waterloo and Wellington - Job descriptions for key funded positions (for comparison with actual work - RCC meeting minutes and supporting documents - Terms of reference - Proposals submitted - Service agreements - Protocols and MOUs - Policies and procedures of affiliated agencies (where they exist) - Public relations documents - Peer Family Roles Working Group meeting minutes - RICPs - Referral patterns - Police data - Emergency room records • Interviews with stakeholders - System participants

Research Objectives	Evaluation Questions	Indicators	Methods
		and accessible • No. of emergent services calls in year preceding system implementation compared to no. of emergent services calls after system implementation • No. of repeat clients in year after system implementation compared to year preceding system implementation • Referrals to alternative options (e.g., various forms of respite beds) • Emergent services staff satisfaction	- System participant supporters - RCCr; RSW; SRC; RCC Chair Public Relations committee members • Interviews with staff - Front line workers - Program managers - Members of training branches • System participant feedback (e.g., CSQ, VSSS, BHRS)
	C2 Is regional decision-making coordinated?	• Joint policies and protocols are referred to by service providers (e.g., joint service agreements are used by service providers; registered crisis plans are developed and referred to by service providers). • Strategic planning and strategies complement each other (e.g., operating plans are planned jointly and are aligned). • Service mandates complement each other (e.g., service mandates are planned jointly and are aligned). • A mechanism exists for coordinated decision-making	• Review of documentation - Strategic plans from CMHC, Community Torchlight Distress Line, Regional Waterloo Homes - Operational Plans (crisis section only) of participating agencies for March 31, 2007 • Interviews with staff - Laura Hanley (MIS)

Research Objectives	Evaluation Questions	Indicators	Methods
	C3 Is the crisis resolved for the individual?	• Immediately presenting crises are resolved within a community setting in the least intrusive way (e.g., RICPs are utilized; crisis team responds in a timely manner) • Individuals feel services are recovery focused • Number of referrals by crisis system service providers to emergent services • Individuals are linked to emergent services when appropriate (e.g., ongoing consultation between emergency services and crisis team/hospital). • People are referred and linked to additional relevant community supports (e.g., service agencies contact each other to ensure appropriate community support is provided).	• Review of documentation - RICPs (new RICPs developed, number of RICPs activated, etc.) - CDS data captured by *Caseworks* software (referrals to community supports, referrals to emergent services) • Interviews with stakeholders - System participants - Participant supporters • System participant feedback (e.g., CSQ, VSSS, BHRS)

Research Objectives	Evaluation Questions	Indicators	Methods
	C4 Did the system work effectively as planned? To what extent have system enhancements achieved the expected outcome of greater system capacity?	• Immediately presenting crises are resolved within a community setting in the least intrusive way (e.g., RICPs are utilized; crisis team responds in a timely manner) • Number of RICPs activated • Number of referrals by crisis system service providers to emergent services • Individuals are linked to emergent services when appropriate (e.g., ongoing consultation between emergency services and crisis team/hospital). • People are linked to additional relevant community supports (e.g., service agencies contact each other to ensure appropriate community support is provided).	• Review of documentation - RICPs (new RICPs developed, number of RICPs activiated, etc.) - CDS data (referrals to community supports, referrals to emergent services) • Interviews with staff - Front line staff
	C5 Are key principles (i.e., recovery) being expressed in the operation of the crisis system? In what ways have system enhancements fostered and promoted recovery?	• Services are recovery-focused (i.e., client-focused and include attention to diversity; e.g., individuals direct creation/usage of RICPs) • Services are holistic (e.g., informal supports are consulted in crises assessment and intervention) • Individual choice supported in services (e.g., in planning RICPs) • Peer involvement across system functions/ Options/protocols developed to enable peer support	• Review of documentation - RICPs (review of a sample of plans) - Peer Family Roles Working Group meeting minutes • Interviews with stakeholders - Service participants (level of involvement and satisfaction) - Participant supporters • Interviews with staff • System participant feedback (e.g. Client/Consumer Satisfaction Scale – CSQ; Verona Service Satisfaction Scale – VSSS; Behavioral Healthcare Rating of Satisfaction – BHRS)

Appendix C: Waterloo Wellington Crisis System Organizations

In total, 13 organizations submitted crisis system data[111] for this evaluation. Specifically, the organizations that submitted were as follows:

Community Mental Health Agencies (n = 4)

- Trellis Mental Health and Developmental Services (mobile crisis and walk-in crisis data)
- Canadian Mental Health Association, Grand River Branch (mobile crisis, crisis line, and walk-in crisis data)
- Community Torchlight Inc. o/a Distress Centre Wellington Dufferin (crisis line data)
- Waterloo Regional Homes for Mental Health (crisis respite beds data)

Hospital Emergency Departments (n = 6)

- Guelph General Hospital
- Cambridge Memorial Hospital
- Grand River Hospital
- North Wellington Hospital Alliance (Groves Memorial Community Hospital, Louise Marshall Hospital, and Palmerston & District Hospital)

Police Organizations (n = 3)

- Waterloo Regional Police Service
- Guelph Police Services
- Wellington County Ontario Provincial Police

[111] Crisis system data was not requested from Homewood Health Care Centre because their crisis data is collected by an assessment nurse in the emergency department and is thus captured by the data submitted by Guelph General Hospital.

Appendix D: Staff Survey Analysis

A total of twenty-two scaled (i.e., quantitative) and open-ended (i.e., qualitative) items were included in the staff survey:

- Four items asked for demographic information related to organization, job role, geographical area, and locale (i.e., urban, rural, or both).
- Seven items asked staff members to rate their familiarity with various components of the crisis system. All items were rated on a 5-point Likert scale (1 = "not at all familiar", 3 = somewhat familiar", 5 = "very familiar")
- Four items asked staff members to comment on the changes that they have seen to the crisis system, and how these changes have impacted their work and benefitted individuals in crisis. Two of these items were open-ended, and two were rated on a 5-point Likert scale (1 = "no impact", 3 = "some impact", 5 = "a great deal of impact")
- Two open-ended items asked staff members to comment on additional changes they would like to see, and any perceived barriers to delivering crisis services
- One item asked staff members to comment on the frequency of working with members of other services, and was rated on a 5-point Likert scale (1 = "never", 5 = "always")
- One item asked staff members to rate the quality of their working relationships with other organizations, and was rated on a 5-point Likert scale (1 = "poor", 5 = "excellent")
- One item asked staff to rate the extent to which their organization is aligned with principles of recovery on a 5-point Likert scale (1 = "not at all", 5 = "extremely")
- One open-ended question asked staff members to comment on how their services are recovery focused
- One item asked for overall satisfaction with the crisis system and was rated on a 10-point Likert scale (1 = "very unsatisfied", 10 = "completely satisfied")

The quantitative data gathered through the staff survey were analyzed for statistically significant differences using SPSS v15.0. Analyses of variance were used to compare group means, sample size permitting. Significance levels were adjusted to control for the family-wise error[112] rate using the Bonferroni correction[113]. Only relevant analyses that clearly related to the research questions of the current evaluation were conducted.

The following tables show the group means and standard deviations for the findings highlighted in the report, as well as the corresponding significance level.

[112] The family-wise error rate, or the probability of uncovering a statistically significant difference where there in fact is not one, increases with the number of tests conducted.
[113] The Bonferroni correction is a commonly accepted statistical method for controlling the family wise error rate.

Table 21 – Familiarity with Activities and Mandate of the Waterloo Wellington Dufferin Regional Crisis Committee (1 = "not at all familiar", 5 = "very familiar")

Survey Item	Location	
	Guelph/Wellington County	Waterloo Region
Familiarity with the activities and mandate of the Waterloo Wellington Dufferin Regional Crisis Committee	1.9 (1.2)	*3.0 (1.2)*

*p <.007

Table 22 – Familiarity with the Role of the Regional Crisis System Coordinator (1 = "not at all familiar", 5 = "very familiar")

Survey Item	Type of Organization		
	Police	Hospital	Mental Health Organization
Familiarity with the role of the Regional Crisis System Coordinator	1.7 (1.1)	2.1 (1.1)	*3.5 (1.3)*

*p <.007

Table 23 – Frequency of Working with Members of Other Services (1 = "never", 5 = "always")

Survey Item	Type of Organization		
	Police	Mental Health Organization	Hospital
Frequency of working with members of other services to find solutions for individuals dealing with a mental health crisis	*2.7 (1.0)*	4.0 (0.7)	4.1 (0.8)

*p <.03

Table 24 – Familiarity with Role of Regional Crisis Service Resolution Coordinator (1 = "not at all familiar", 5 = "very familiar")

Survey Item	Type of Organization			Location	
	Police	Hospital	Mental Health Organization	Guelph & Wellington County	Waterloo Region
Familiarity with the role of the Regional Crisis Service Resolution Coordinator	1.7	2.4	3.6	1.9	3.2

*Descriptive analysis only; no statistically significant differences found

Table 25 – Familiarity with the Crisis System Flex Fund (1 = "not at all familiar", 5 = "very familiar")

	Type of Organization			Location	
Survey Item	Police	Hospital	Mental Health Organization	Guelph & Wellington County	Waterloo Region
Familiarity with the role of the Crisis System Flex Fund	1.8 (1.2)	1.8 (1.1)	*4.3 (1.0)*	2.5 (1.6)	*4.1 (1.0)*

*p <.007

Table 26 – Benefits of Crisis System Changes to the Individual (1 = "no impact", 5 ="a great deal of impact")

	Type of Organization		
Survey Item	Police	Hospital	Mental Health Organization
Degree to which changes to the crisis system benefit individuals in resolving their mental health crisis	2.0 (1.3)	3.1 (1.4)	*4.1 (1.1)*

*p <.03

Table 27 – Familiarity with Individualized Crisis Plans (1 = "not at all familiar", 5 = "very familiar")

	Type of Organization		
Survey Item	Police	Hospital	Mental Health Organization
Familiarity with the development and usage of RICPs in Waterloo Wellington	1.8 (1.3)	2.8 (1.3)	*4.2 (1.1)*

*p <.01

Table 28 – Level of Familiarity with Recovery Principles (1 = "not at all familiar", 5 = "very familiar)

	Type of Organization		
Survey Item	Police	Hospital	Mental Health Organization
Level of familiarity with the implementation of recovery principles and practices	*1.9 (1.2)*	3.3 (1.4)	4.1 (1.0)

*p <.01

Table 29 – Alignment of Crisis Services with Principles of Recovery (1 = "not at all recovery focused", 5 = "extremely recovery focused")

	Type of Organization	
Survey Item	Police	Mental Health Organization
Extent to which the crisis services you provide are aligned with recovery principles	2.5 (1.1)	*4.1 (1.1)*

*p <.01

Table 30 – Satisfaction with Crisis System Across Type of Organization (1 = very unsatisfied", 10 = "completely satisfied")

	Type of Organization		
Survey Item	Hospital	Police	Mental Health Organization
Overall how satisfied are you with the crisis services of Waterloo Wellington	4.5 (2.6)	4.7 (2.0)	*7.5 (1.0)*

*p <.05

Table 31 - Satisfaction with Crisis System Across Type of Locale (1 = very unsatisfied", 10 = "completely satisfied")

	Locale		
Survey Item	Rural	Both	Urban
Overall how satisfied are you with the crisis services of Waterloo Wellington	*4.3 (3.6)*	5.8 (2.0)	6.2 (2.2)

*p <.05

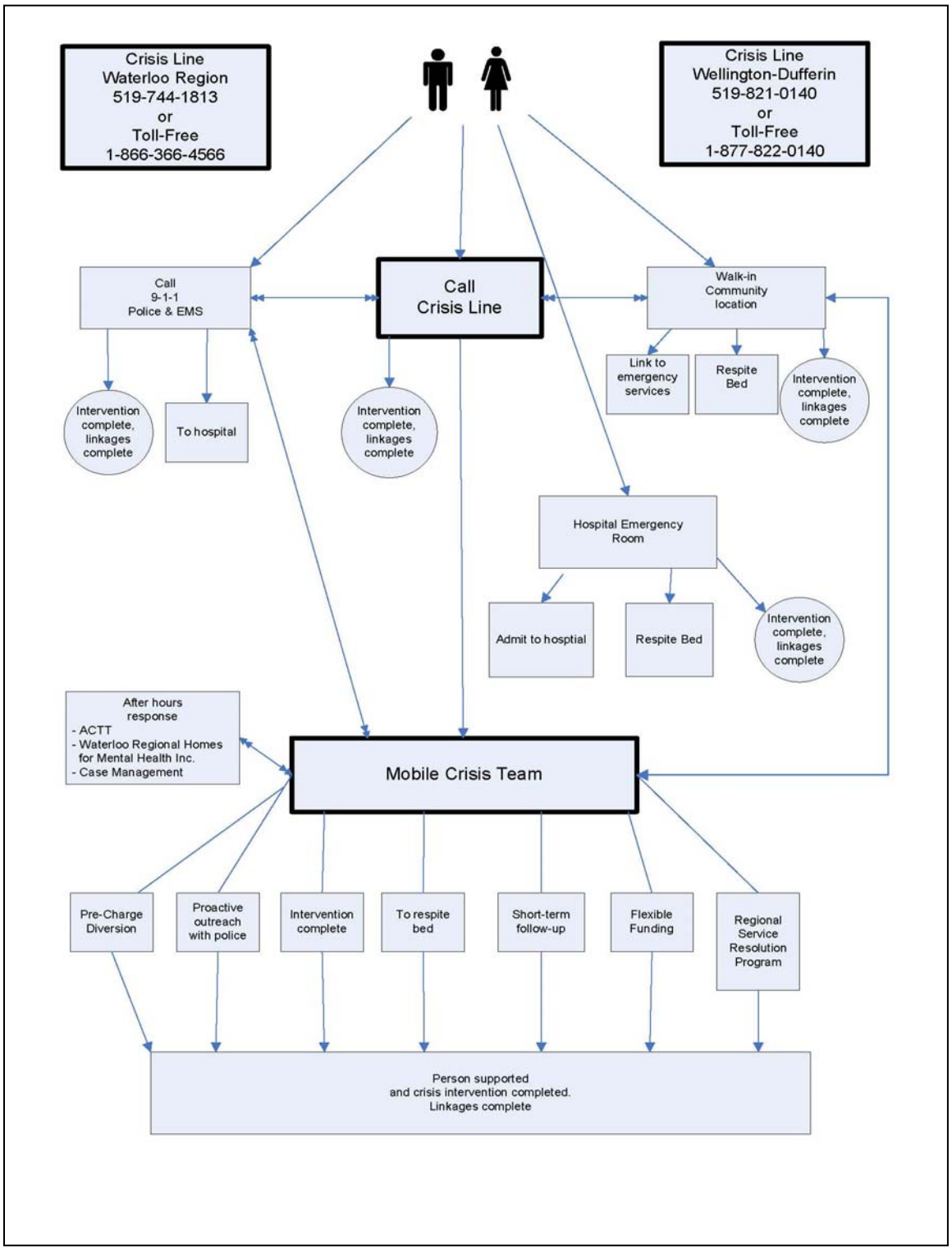
Table 32 – Satisfaction with Crisis System Across Type of Organization Within Rural Settings (1 = very unsatisfied", 10 = "completely satisfied")

	Type of Organization	
Survey Item	Hospital	Mental Health Organization
Overall how satisfied are you with the crisis services of Waterloo Wellington	1.0 (0.0)	*7.5 (0.7)*

*p <.05

Appendix E: Waterloo Wellington Regional Crisis System

Flowchart of Crisis Services and Crisis Services by Area



Services and Geographic Area

Regional Crisis System: Services and Geographic Area

CRISIS SERVICE COMPONENTS	Waterloo Region	Wellington-Dufferin Region
Crisis Line	Canadian Mental Health Association 1-866-366-4566 or 744-1813	Community Torchlight (operated by) 1-877-822-0140 or 821-0140
Mobile Crisis Adult	Canadian Mental Health Association 1-866-366-4566 or 744-1813	Trellis Mental Health & Developmental Services 1-877-822-0140 or 821-0140
Mobile Crisis Child & Adolescent	KidsLink/Lutherwood 9:00 am – 9:00 pm, reduced weekend hours Access through the Crisis Line (above) Children's Mental Health Access Centre: 519-749-2932	Wellington: 24/7: use Crisis Line (above) Dufferin Child and Family Services 7 days week: 519-941-1530
Walk-in Crisis	Canadian Mental Health Association- Centers for Mental Health Hospital Emergency rooms	Trellis Mental Health & Developmental Services offices Hospital Emergency rooms CMHA - Centers for Mental Health
Stabilization Services – Respite Beds	Waterloo Regional Homes for Mental Health crisis/respite home For inquiries/referral 519-576-7431	
Community-based psychiatric consult	Grand River Hospital – outpatient and Hazelglen process under development. CMHC at Cambridge Memorial Hospital.	Trellis Mental Health & Developmental Services HHC – Transitional Care
Psychiatric, Hospital-based Services: ER Consultation	Grand River Hospital Cambridge Memorial Hospital	At Guelph General Hospital with Homewood Health Centre
Hospital-based Services: Brief Stay	Grand River Hospital Cambridge Memorial Hospital	Guelph General Hospital (EMHU under development) Homewood Health Centre – Trillium units
Service Resolution Coordinator	Pam Howard c/o Trellis Mental Health & Developmental Services 821-8089, ext. 241	Pam Howard c/o Trellis Mental Health & Developmental Services 821-8089, ext.241
Regional Crisis System Coordination	Elly Harder c/o Trellis Mental Health & Developmental Services 821-8089, ext. 233	Elly Harder c/o Trellis Mental Health & Developmental Services 821-8089, ext. 233

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