Psychiatric Crisis Services in Three Communities

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ABSTRACT

This study compared communities with three models of crisis service: (a) police as part of a specialized mental health team, (b) mental health worker as part of a specialized police team, and (c) informal relationship between police and mental health crisis service. Rural and urban areas were examined and compared. Data included focus groups and participant observation. Analysis revealed that while all communities valued their crisis services, all identified limitations in responsiveness, access, and systems-related issues. Quick access to psychiatric beds was important to services. Rural communities had no public transportation, and an important police role was safe transportation. In rural communities, mental health workers were generalists because they had to be able to address situations on their own. In urban areas, transportation was more readily available, and more specialization developed among mental health team members.

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In psychiatric crises, both police and mental health workers have important roles in providing assistance. However, how these two groups work together can vary considerably. This study examined different models of crisis services and the relationship between police and mental health crisis workers in each model.

In recent years, the number of contacts between police and persons with mental illness has increased in Canada (Adelman, 2003; Matheson et al., 2005). Ironically, deinstitutionalization—a movement that aimed to improve quality of life—has contributed to these contacts and the subsequent criminalization of individuals with mental illness (Matheson et al., 2005; Morabito, 2007; Watson, Corrigan, & Ottati, 2004). Both safety and ethical concerns arise from this phenomenon (Patterson, 2004; Teller, Muntez, Gil, & Ritter, 2006; Vancouver Police Department, 2008). To address the complexity of issues related to interactions between police and individuals with a mental illness, efforts have been made to identify effective interventions and services. Police mobile crisis services have become increasingly popular in the Canadian province of Ontario since the introduction of the Crisis Outreach and Support Team (COAST) program in the city of Hamilton in 1997, which was modelled after the Vancouver Car 87 Program (Landeen, Pawlick, Rolfe, Cottee, & Holmes, 2004).

Specialized training for police officers and the development of collaborative linkages between police and the mental health sector are believed to reduce inappropriate arrests and improve access to appropriate mental health services when crises arise (Morabito, 2007; Steadman, William Deane, Borum, & Morrissey, 2000; Strauss et al., & Rybakova, 2005; Teller et al., 2006; Vancouver Police Department, 2008). Surprisingly, there is limited understanding of the essential components, processes, and outcomes for crisis services to date. Extensive literature searches uncovered few published Canadian studies pertaining to crisis services and mental health (Cotton, 2004; Jarvis, Kirmayer, Jarvis, & Whitley, 2005; Matheson et al., 2005). However, this issue has received substantial attention from other Canadian sources (e.g., "grey" literature produced by the Ontario Ministry of Health and Long-Term Care, 2005; Champlain District Mental Health Implementation Task Force, 2002; and Community Resource Connections of Toronto, 2006). There is consensus in the available research that police are commonly the first point of contact for individuals experiencing a mental health crisis in the community; however, only a few formal evaluations of crisis service models have been carried out. These evaluations found that crisis services are an invaluable tool for helping individuals with mental health issues in both urban and rural areas. As new crisis teams are emerging that vary in structure and organization, there is a growing need to better understand these services to inform practice and policy.

This project examined three different models of crisis services with varying relationships between police and mental health workers at three sites in southern Ontario. While the crisis services differed, each site included some component of crisis delivery as identified by the Ontario Crisis Response Service Standards (Ontario Ministry of Health and Long-Term Care, 2005). Site A partners a police officer with the mental health team and offers mobile crisis services to a primarily urban population. The police officer and a mental health worker address mental health crises in the community together. Site B provides service to a largely rural population and offers a separate but collaborative approach between mental health and police teams. In this model, the police bring individuals experiencing a mental health crisis to the emergency department where a mental health nurse is on duty to assist with the crisis situation. At Site C, police officers receive specific training by mental health professionals to increase awareness and sensitivity to mental health issues

and crises, and to facilitate access to mental health services. The team at Site C delivers service to a mixed urban and rural population. When a mental health call comes in through police dispatch, an officer who has received this special training is assigned to the call whenever possible. During the course of this research study, Site C implemented a pilot project whereby a psychiatric registered nurse who could admit individuals directly to the ward was paired with a trained police officer to attend mental health crisis calls and conduct follow-up assessments of individuals with mental health issues who had recent contact with police. Both approaches employed at Site C were captured during the data collection phase.

The purpose of this study was to compare these three different models of crisis programs related to the role of police and mental health crisis workers, how the programs operate, and their impact on the perceived needs of mental health consumers, their families, and service providers. Specific research questions were

1. What are the perceptions of strengths and limitations of the crisis service from the perspectives of consumers, families, and service providers?
2. What are the differences and similarities in service delivery between models?

METHODOLOGY

An ethnographic case-study approach was used to compare and contrast crisis service models in three Ontario communities. The ethnographic approach included both focus group interviews (to address research question 1) and participant observation (to address research question 2).

Focus groups were organized to include police, emergency/crisis staff, community and hospital service providers, consumers of the crisis service, and family members. Posters were placed in various locations (e.g., mental health programs) in each city of interest to recruit consumers and family members, and letters were emailed to recruit service providers. The consumer/survivor groups assisted with recruitment in each community by distributing posters. These groups also provided the space for the consumer and family focus groups. Individuals who had experienced mental health issues and had accessed crisis services (mental health service provider and/or police) were eligible to participate as consumer participants; family members must have had a family member access a crisis service; service providers and police had to have direct experience with people experiencing mental health crises in the community. The focus group questions addressed issues related to both police contact and mental health service provider contact during a crisis. Participants were asked about their perceptions of the services, what aspects of the programs they considered important or useful, problems with the current approach, and suggestions for improvement. Focus group interviews were facilitated by a member of the investigative team and were audiotaped, transcribed, and validated by team members. Field notes were taken by experienced research staff. The sample size was determined by saturation of themes (Germain, 1993; Leininger, 1985). In total, 20 focus groups were conducted across the three sites. The study sample consisted of 143 focus group participants: 46 consumers; 47 family members; and 50 service providers linked to the police, crisis/emergency, or mental health sector. There were six focus groups at Site A (two consumer, two family, and two service provider); seven focus groups at Site B (two consumer, one family, and four service provider); and seven focus groups at Site C (two consumer, three family, and two service provider).

Research team members, who are also trained mental health professionals, were participant observers. They shadowed a team in each of the three communities for a minimum of two shifts per site. In total, they observed 10 shifts across the three study sites. One research assistant completed shifts at all three sites to ensure consistency in data collection and interpretation. Field notes were kept to record key processes and observations, and focused on discussions and interactions among mental health crisis staff, emergency room staff, police, clients, and families in each environment. Efforts to preserve client confidentiality and anonymity were maintained at all times.

An Advisory Group was formed composed of service providers and police officers linked to the three study sites, as well as investigators. Through regular meetings and teleconferences, this group sought to better understand the critical components, processes, implications, and outcomes of crisis services. The Advisory Group helped identify key stakeholders in each community, and assisted with system entry and dissemination of results.

Ethics approval was obtained through the University of Western Ontario and a hospital research ethics board.

ANALYSIS

A matrix method of ethnographic analysis was used in which each site was first analyzed separately and themes were then compared and contrasted across sites. The specific ethnographic stages of analysis developed by Leininger (1985) were used; the researchers developed descriptors, patterns, and then themes that were tested against the raw data. To implement this approach, each member of the research team read through all transcripts and field note materials and developed initial descriptors. Through discussion and consensus, the team further developed the list of descriptors and identified patterns. Through continued review of transcripts and field notes, patterns were combined and synthesized to obtain broad themes. The themes were then tested again against the raw data from focus groups and participant observation field notes. Data from each stakeholder focus group (consumer, family, and service provider) were first analyzed separately and a grid of themes was developed, with the sites in columns and each stakeholder group with its set of themes in rows. Themes were then compared to distinguish larger patterns and variances across groups and sites.

RESULTS

Brief Community Comparison

In order to understand the differences between the crisis programs, it is important to understand some of the differences between the communities and the specific mental health resources in each community. Key differences are summarized in Table 1.

The site-specific variances with respect to community resources, shown in Table 1, contribute to different strengths and limitations within each community. For example, at Site A, there are tertiary and acute care services available and a wide range of psychiatric and addiction services. Site B offers detoxification services and an addiction program, but no psychiatric beds. Site C has no detoxification or addiction treatment services; however, there are acute care psychiatric beds. These differences are important, as the role and function of each crisis mobile team are affected by the context in which the care is provided.

Table 1

Comparison of Community Characteristics and Crisis Programs at Three Sites

Characteristics	Site A	Site B	Site C
	• police officer is partnered with mental health team • police officer & mental health worker address mental health crises in community together	• separate but collaborative approach between mental health & police teams • police bring individuals to the emergency room where a mental health nurse is on duty to assist	• an officer with special training is assigned to mental health calls that come in through police dispatch • officer facilitates access to mental health services • a pilot project paired a psychiatric RN who could admit individuals directly to the ward with a trained police officer to attend crisis calls & to conduct follow-up of people with mental health issues who had recent contact with police
Population no. (2006 census) and density	531,000 Urban	112,100 Rural	109,600 Urban and rural
Police assigned to mental health crises	4 full-time officers 4 back-up full-time 75 Crisis Intervention Team (CIT) officers	No police assigned	24 front-line officers in pilot Mobile Crisis Intervention Team (trained as CIT officers)
Mental health crisis program staffing	29 staff, full- & part-time	4 full-time RNs (on one at a time) and 7 part-time RNs assigned to 24-hour crisis line & face-to-face ER assessments; 1.5 (full-time equivalent) short-term crisis counsellors who offer clients 6 sessions of solution-focused counselling	1 crisis nurse in ER (works on the inpatient psychiatric ward when not needed in ER)
Psychiatric and acute care beds	Approximately 80 psychiatric beds at Schedule 1 facility; 140 tertiary care beds	No psychiatric beds – inpatient treatment requires transfer to another community; 6 acute care beds located in 2 separate communities	21 acute care (adult)
Crisis beds	10 (safe bed program)	Proposed 1–2 bed mental health crisis unit in ER	No beds open at time of study, but planned with funding from Canadian Mental Health Association
Other mental health services	Tertiary & acute care psychiatric services	—	—
	Mobile crisis service	No mobile service	Mobile crisis intervention team piloted
	Crisis hotline	Crisis hotline	Crisis hotline
	Detoxification and withdrawal management	Detoxification and withdrawal management	—

Note. ER = emergency room; RN = registered nurse.

What are the perceptions of strengths and limitations of the crisis service from the perspectives of consumers, families, and service providers?

The first research question was addressed through focus groups with the key stakeholder groups in each community. The following are consistent themes that emerged:

- all communities value their crisis services,
- problems arise due to a lack of public transportation,
- need for immediate assistance when an individual is in crisis,
- all crisis programs have peak periods when they cannot handle volume,
- improved access to psychiatric inpatient beds is essential,
- consumers want peer support as part of their crisis care,
- crisis services require interagency collaboration, and
- specific gaps are unique to each community.

Communities value their crisis services. Within this study, participants from all three sites confirmed that the communities value their crisis services. Before these types of services were initiated, many consumers had expressed concerns about the lack of services. When programs were implemented, community members perceived differences in emergency room diversions, decreased use of the criminal justice system, decreased time in hospital, and decreased time in the emergency department. As well, an increased sense of accomplishment in service provision was reported in all three communities. These services benefit each community economically and socially and, in turn, enhance the morale of those served by the program.

> I found it really, really good … following the time that I met them [officers]; they already had some history, which was really good. But yeah, I've met other officers before that haven't had the team training and they were just working within their job or whatever, who, it's kind of hard to, umm, for them to determine how much of the problem here is illness and how much is criminal act or whatever, so I had really good responses from the … [team]. (mental health consumer, Site C)

> I think it's nice when the crisis team intervention starts earlier before the problem really escalates. By the time you get to the crisis nurse, even though there is still a problem, it hasn't got as severe as it could have got. (mental health consumer, Site A)

> You know one thing I really like with [Site B] is it's linked with a small enough system with adult mental health that people get tied in really quickly.... If it's identified that this person needs to talk to somebody, they've at least got that six visits feature built in. (family member, Site B)

> I think they provide a tremendous support network to the community. I mean I think that, some individuals, ah, I think are very reassured to know that [Site A] is there and that they can call. I hear they have saved lives on many occasions and know that because they were available to help people. Otherwise, there wouldn't have been anything. (service provider, Site A)

Problems due to lack of public transportation. Public transportation in rural areas is lacking, which is problematic for people needing crisis services. Without transportation, people might not be able to get to a crisis service or return easily for follow-up appointments. This problem was consistently identified in the

rural communities but not mentioned in the urban settings. In the rural areas, the police frequently served as a means of transportation to crisis or emergency services.

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

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

A consumer from Site B described being driven to hospital by two separate police forces because the hospital with a psychiatric unit was so far away: "So they drove half way, and then I sat and waited in the [town 1] police car for the [city 2] police to get there and then got switched and taken from [city 2] police back to the … hospital, and you already feel like shit." In another example, a consumer described being taken by police 80 km to a general hospital with a psychiatric program. She had no coat (it was winter), and no money for a taxi. When she was not admitted, she felt she had no choice but to hitchhike home in the middle of the night.

When people are in crisis they need help immediately. It may seem self-evident that a crisis is a crisis. However, family members and consumers at all sites gave examples of situations when they felt that they were not treated with the desired urgency. Examples included calling the crisis phone line but receiving a busy signal or an answering machine, and waiting for long periods for help to arrive.

> But if you're at home, in crisis and you've probably built yourself up to that level where, okay, now I'm going to call because it's so bad, and then you get an answering machine … (consumer, Site B)

> And my situation, ah, was pretty similar. Ah, they had an attitude. When we phone it my [family member] was in distress, ah, so I called the [Site A] for her and they gave me an attitude.... They said they will come down and they never showed up. (family member, Site A)

Crisis programs need the capacity to handle volume. The counterpoint to the previous theme is the programs' ability to handle volume. Crises are often unpredictable. Sometimes several people will be in crisis and mental health staff may have trouble handling the volume, while at other times things can be much slower. Mental health staff at Sites A and B said that staffing shortages prolonged client waits. This was less of an issue at Site C because it was the police who responded, and there was only one mental health worker on the pilot project.

> I think just going along with more resources… Sometimes quicker response would be … and it's just not possible. I know that they have limited ability to go out in the night 'cause there is only one staff and it would be great to be able to have that kind of [service] all night, but I think these are tied to funding issues. (service provider, Site A)

Easy access to psychiatric beds is essential. During a psychiatric crisis, the person might need a hospital bed. Without a system to access beds, much time can be spent waiting in the emergency services. This was particularly a concern at Site B where there were no psychiatric beds in the county. Site A and Site C had psychiatric beds in the region and clearer systems for accessing those beds.

> One thing is, that when we go to the hospital, we can't keep them [people in crisis] there because there's no beds in this area. (police, Site B)

> Because … the people you bring in have to be medically clear. Then we have challenges accessing beds or psychiatric … even just psychiatric assessments, when we try to make sure … try to get the police out of here as soon as possible, but you know there are some limitations. (crisis staff, Site B)

Consumers want peer support as part of crisis care. Peer specialists are regarded by consumers as a critical resource during crises. Consumers described the difference between a "hotline" that provides immediate attention and a "warm line" that provides support. Consumers indicated that peers are the ones who should provide the "warm" support. Consumers also described follow-up peer programs as essential and as a positive experience. Peer support was raised as an issue by all consumer groups, as well as by several staff and family groups.

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

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

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

> I think they need more people working there that have actually been through, umm, crisis or something—someone that will understand. Like you said, they don't take you seriously. (family member, Site A)

Crisis services require interagency collaboration. Crisis response often requires collaboration between multiple agencies and systems. Many focus group participants commented on the collaborative interaction between health care providers and police officers. The collaboration also needs to include clients and their families.

> I like the connection between mental health and the police and a sense that the [team members] are assisting them in the training of the police in terms of how to better work with, or handle, psychiatric offenders in crisis, because obviously for years a lot of police officers didn't have that training and really didn't know how to respond. So I think that it's an excellent service. (family member, Site B)

> I think over the years [Site A] has become well integrated into the existing system. I don't think it's seen as a separate entity so much as one part of a continuous chain of services. I think that has been a really good development. (service provider, Site A)

> I think some of the patients as well, they've actually been able to have successful tenure in the community, because their phone calls are never turned away…. I'm aware of clients who will phone [Site A] at least once a day and that becomes their, like, their follow-up in the community and has kept them out [of hospital]…. Prior to that, they'd have been in emerg, but to have that contact—and you know you have someone at the other end of the phone—keeps people successful in the community. (service provider, Site A)

Specific gaps are unique to each community. Focus group participants identified gaps in the crisis service model in their community, and made suggestions for improvement.

Site A. At Site A, service providers had difficulty meeting all consumer and family expectations about urgency care. Many family members viewed the stringent admission criteria as a gap in service.

> People can be concentrating on well, triaging as far as where, you know, do you need somebody sent out, a team sent out, or do you just need a crisis plan or what? Umm, but they need to have more lines so that we can talk and, umm, then they need to start introducing a better suicide protocol. (consumer)

> Most of the feedback that I have ever got about [Site A] has always been positive. The only time you ever get negative feedback is when you have frustrated families who want their family member admitted, but they don't meet the admission criteria or they don't, they're not formable [under the Mental Health Act], so then they get frustrated … for that reason. (service provider)

Site B. Site B offers a 24-hour crisis line. People who need immediate face-to-face assessment are asked to go to the emergency room. However, in this county there is no mobile crisis program. Since the community is largely rural, consumers have difficulty reaching the service.

> The solution—if we're back to dreaming—is the mobile unit. [If] they had a mobile crisis team, that would solve a lot of problems. (consumer)

> It sounds like people are generally happy with the program but that in a perfect world there'd be augmentations such as having more accessibility … more peer support … and mobile services…. People [who experience mental health crises are] having difficulty not only because of access to transportation but because they just don't exist in the same number, because there is not the same critical mass. (consumer)

Site C. At Site C, service providers and consumers expressed concerns related to capacity to service the entire region.

> We have a population of well over a 100,000 within our municipality and one police officer and one nurse.… It's not going to cut it for the moment for the municipality. (consumer)

What are the differences and similarities in service delivery between each model?

Participant observation revealed how each crisis service addressed and managed crisis situations, and how teams responded to gaps and deficits within the mental health system in their community. The amount of time that teams spent in outreach versus intake varied between programs. Systems that provided quick access to psychiatric beds saved prolonged waiting by staff and consumers alike.

Summary of observations. Key differences became evident in observing the crisis programs at the three sites in the following areas: outreach versus intake approach for service delivery; access to transportation; access to inpatient psychiatric beds; specialists versus generalists on staff; and the availability of other services in each community, for example, resources for interpersonal violence, addiction, and seniors.

Moreover, each site had a different model of crisis response. Site A had a mobile crisis intervention team with specialized services geared to children and teens, in addition to adult services. This site also had a crisis hotline.

The mental health program at Site B was not mobile. The mental health program had a service agreement with police who served as the mobile unit, but the mental health workers and police were separate teams and services. Access to mental health assessment and intervention was coordinated through the emergency room. This site also had a crisis hotline component to their service.

At Site C, specially trained police officers provided crisis assessment and intervention. The focus was to establish safety and make referrals to a mental health service. Acute mental health assessment, when indicated, was coordinated through the emergency room, where assessment was provided by a psychiatric registered nurse and/or an emergency room physician. A pilot project, a mobile team pairing a trained officer with a mental health nurse to complete follow-up and facilitate connections with mental health services, was initiated during the course of this study. Officers with this mobile team were non-uniformed and drove an unmarked car. This community had a crisis hotline available, but it was run by a separate organization and had an informal relationship with this crisis program.

Observations of crisis care. From observing the programs in operation, it became apparent that each program had adapted its service to address the unique gaps in mental health services in that community. For example, at Site C where there were very few addiction services, a large number of addiction-related crises occurred; at Site B, where psychogeriatric services were in short supply, there were more psychogeriatric crises. In other words, the service needs that are not met in the community will be disproportionately dealt with by the crisis program.

Limited access to beds created a major backlog of work and a ripple of deficiencies throughout the system. Clearly, one goal of crisis programs is to reduce unnecessary hospital admissions; however, when psychiatric admission is indicated, improved access to inpatient beds is necessary. Inadequate security staffing in rural hospitals (Site B had no in-hospital security staff, and Site C had two security guards to cover the entire hospital) meant that police were obliged to remain with clients in the emergency department while awaiting transfer to an inpatient psychiatric bed. This could take from several hours at Site C to several days at Site B. During one observation period, a police supervisor arrived at the emergency room to determine why all but one police car in the entire region were at the hospital. All of the involved police were with people awaiting psychiatric services, leaving few policing resources available for two counties.

The sites had different interpretations of "mobile." Sites B and C lacked the capacity to offer mental health service and crisis intervention in the consumer's setting. At these sites the "mobile" unit actually transported consumers to another location for intervention. In contrast, at Site A the mobile service was provided in the consumer's environment, and the person was moved only if necessary for safety.

Differences in service capacity between rural and urban communities were also apparent. Crisis services in urban settings tended to be more specialized. For example, individual staff or teams specialized in adolescent or addiction issues. The ability to specialize is related to the size of population served and the subsequent number of staff available. Public transportation is also more readily available in urban areas, making it easier for clients to get to the service. In rural settings, mental health services were more generic because there was often only one worker on at a time. Transportation was a major concern. However, all programs experienced challenges related to human resources, specifically difficulties in staffing crisis services and handling several calls at once.

DISCUSSION AND RECOMMENDATIONS

The findings were discussed with the Advisory Group to assist in identifying recommendations. The Advisory Group had representation from all the involved communities. In addition, open meetings were held

in each of the three communities and a dissemination conference was held in London, Ontario. The conference presentations included the results of this project as well as two other studies related to mental health crisis services. These events had strong representation from consumers of the services, family members, staff from mental health and addiction programs, and police.

Mobility of Crisis Programs

Many differences were observed in the approaches to mental health crisis services offered in the three communities studied. Of critical importance was the fact that not all programs had a true mobile service. The organization and delivery of services must take into account the context of the community in which the services are offered. For example, lack of public transportation in rural communities means that clients often cannot readily access crisis services. Thus, outreach programs that are not dependent upon clients having or finding transportation are particularly important for these communities. The crisis model for rural settings must include a mobile component if universal access is a goal. As one hospital worker commented during a focus group, "In an ideal world there would be something available 24/7 at the hospital and something more mobile to allow people to go out." Of course, even in an urban community, clients in crisis may not be able to access public transportation, and thus mobility is a key attribute of any mental health crisis service.

Presently, there is no integrated policy on transportation and access to mental health services in Ontario. Consumers need to be able to get safely to services and then safely back home, particularly when they come to the emergency room but are not admitted to hospital. Thus, the Ontario Public Hospitals Act should be revised so that, following a psychiatric assessment that does not lead to hospitalization, people can be offered a safe means of transportation home, especially when they live in another community.

Access to Beds

Ideally, crisis services will reduce the reliance on hospitals. However, when hospital care is required, there needs to be ready access to psychiatric beds for effective functioning of the crisis programs, hospital emergency rooms, and police officers who have a broad range of community safety and security responsibilities. Where access is problematic, there are long waiting times in the emergency room for the clients, families, community health workers, and police. Crisis staff were observed spending an inordinate amount of time attempting to locate a bed for one client, and were thus unable to respond to another client in crisis. One solution would be the development of a centralized registry of available psychiatric beds, similar to that which exists for other specialties such as labour and delivery, and emergency rooms.

Staffing

Crisis programs require highly educated and experienced personnel. This need is most acute in rural areas. There is usually only one staff member working at a given time. To successfully perform the role, the worker must become an "expert generalist" in mental health. Within a single shift, crisis calls can be related to addictions, adolescents, geriatrics, psychosis, suicidal behaviour, family violence, family problems, psychogeriatrics, and any other issues within the broad scope of mental health. The practitioner must be able to appropriately assess and triage the situation. In urban settings, the population is larger and denser,

and the volume of service is much greater. In these settings, a team approach with increased specialization of team members can occur; there may be an addiction specialist, a youth team, and/or a geriatric team to respond to different crisis situations.

Crisis services are in need of increased funding to recruit, support, and retain appropriate staff. The salaries of crisis team staff members should be comparable to the wages of hospital staff who do similar work. Crisis staff members who are highly trained and experienced should be paid according to their expertise; this would ensure recruitment and retention of appropriate staff.

Another important issue identified in the study is the need for more timely responses. When in crisis, consumers and their families wanted immediate help and became very frustrated when their phone calls went directly to an answering machine. Staffing issues gave rise to this type of situation at busy times when staff members could not respond to all the calls they were receiving. This finding suggests the need for the development of a coordinated telephone service between crisis services, so that neighbouring areas can serve as back-up for each other.

Models

The need for mobile crisis services and generalists in rural communities suggests that police crisis teams supported by mental health staff may be a more appropriate approach for this setting. In contrast, the larger volume of service and the ability to specialize in larger urban centres suggest that a mental health team supplemented by police officers would be more appropriate.

The specific education of police officers on mental health matters is critical in all communities. As well, it is important to have a specific assignment of police officers to respond appropriately to mental health issues. Without this assignment, situations can become crises or emergencies that require a police response, and opportunities to prevent some crises may be lost. Information on mental health issues should be included in the basic curriculum at the Ontario Police College. This information should also be included as part of ongoing professional development programs once officers are assigned to a detachment, as their role will vary depending upon the community which they serve.

Assessment of Gaps

The type of crisis situations commonly encountered in each community reflected the gaps in psychiatric services. Each program observed in this study had evolved to respond to the impact of these gaps and had adapted to the missing pieces within their community's health and social services. For example, where there were few or no addiction or withdrawal management services, the crisis services had an increased responsibility in responding to substance abuse emergencies. Where there was difficulty accessing seniors' services, the crisis service had more calls relating to the older population. A good strategy for assessing the gaps in a given community is to examine the nature of the crisis calls that are received. However, crisis programs run the risk of "mandate drift" as they struggle to respond to gaps in the service system.

Peer Support

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

Limitations

One limitation of this study is that only three communities were observed and compared. While this is an improvement over past evaluations of a single site, there is a possibility that unique community factors have unduly influenced the findings.

CONCLUSION

Crisis services are a critical component of the continuum of mental health care. Although all communities valued their crisis services, gaps and concerns were identified. Different solutions are needed to address the unique characteristics of rural versus urban settings. Attention to the recommendations can improve access to care and the quality of care provided.

RÉSUMÉ

Cette étude canadienne a comparé des communautés utilisant 3 modèles différents du service de crise: (a) la police faisant partie de l'équipe de crise spécialisée en santé mentale; (b) un travailleur ou une travailleuse en santé mentale faisant partie de l'équipe spécialisée de la police; (c) un rapport informel entre la police et le service de crise en santé mentale. Les régions tant rurales qu'urbaines ont été examinées et la comparaison a été fait entre les deux. Les groupes de discussion et l'observation participante ont servi d'outils de collecte de données. Les analyses ont révélé que même si toutes les communautés évaluaient positivement leurs services de crise, des limites reliées à la réceptivité, à l'accessibilité et aux problèmes systémiques ont été identifiées. L'accès rapide aux lits psychiatriques était important pour la livraison des services. Les communautés rurales n'ayant pas de transport public, le transport sécuritaire était un rôle important de la police. Dans les communautés rurales, les travailleurs et travailleuses de santé mentale était des généralistes, étant donné qu'un seul membre du personnel devaient adresser des situations diverses. Dans les zones urbaines, le transport était plus disponible, et les membres des équipes de santé mentale se spécialisaient davantage.

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