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**System Enhancement Evaluation Initiative --
Phase II Study**

An evaluation of an integrated crisis-case management service

**Terry Krupa, PhD, Principal Investigator
Heather Stuart, PhD, Co-principal Investigator
Alan Mathany, MSW, Co-principal Investigator
Jennifer Smart, Jill Lava and Shu-Ping Chen, Research Coordinators
Queen's University, Kingston, Ontario Canada**

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Key Messages

This study is the first of two Phase II System Enhancement Evaluation Studies conducted in Southeastern Ontario. The second study examined whether community mental health clients received more appropriate care and used fewer hospital resources following system enhancement funding. Results are available in a separate report.

This study evaluated the extent to which an integrated crisis-case management model resulted in improved service utilization patterns. In addition the study evaluated the experiences of both service recipients and community health and social services representatives with this new crisis model. Finally, a competency profile for the new Transitional Case Manager positions was developed. The following key messages are drawn from the results:

Key message 1: A model for crisis services that integrates both assertive mobile outreach and transitional case management has led to expected and desired changes in crisis service utilization patterns. This model has potential to be relevant and generalizable to other communities.

Key message 2: Traditional satisfaction surveys provide limited understanding of how clients experience crisis services..

Key message 3: Service recipients value crisis services highly but their experiences are influenced by several key tensions, in particular:

- uncertainty about what constitutes a legitimate use of crisis services;
- the extent to which expected standards for quality care can be guaranteed across service providers; and
- the extent to which consistent timely access to crisis services can be guaranteed.

Key message 4: Strategic outreach to the community service network should accompany major changes in service delivery resources and patterns in order to actively engage services in learning about specific changes in service delivery, and to promote ongoing dialogue and problem solving about the issues and challenges emerging.

Key message 5: Transitional case management is characterized by distinct competencies differentiating the position from both crisis worker and case manager.

Key message 6: The development of this new crisis model reflects innovation in program design and the potential for crisis service delivery to participate in crisis prevention, supporting community health and social services, and community development activities. The integration of a Transitional Case Management Program reflects improvements in the capacity to provide important follow-up services. It suggests the importance of ensuring that policies and funding governing crisis services promote responsiveness to service challenges and service innovation.

¹ Stuart, H., Krupa, T. and Koller, M. (2008). Do clients receive more appropriate care and use fewer hospital resources now that the system has been enhanced? System Enhancement Evaluation Initiative – Phase II study.

Summary of Results

This study provides an evaluation of a new integrated crisis-case management model of crisis service delivery. The evaluation was guided by four research questions:

- i) Is there a relationship between this new crisis model and the service capacity; access to mobile crisis service, and appropriateness of crisis services?
- ii) Are the crisis services acceptable to service recipients?
- iii) Are the crisis services acceptable to the local community health and social service network?
- iv) What are the key competencies for the new transitional case management positions?

Data from existing databases were used to compare the old model of crisis service delivery (individuals entering and exiting the crisis service between November 1, 2004 and October 31, 2005) and the new model (individuals entering and exiting the crisis service between March 1, 2006 and February 28, 2007). The study findings indicate that the new model of crisis services did indeed lead to the expected changes in service utilization patterns. Specifically the new model was associated with significantly greater service capacity, greater access to mobile crisis services, improvements in accessibility to crisis services across the broader community population, and more appropriate patterns of service delivery with respect to fewer days served within crisis and exit dispositions more consistent with crisis resolution.

The Transitional Case Management program (TCM) provided services to over 100 clients in the designated time period. Approximately 1/3 of the referrals to TCM came directly from the crisis service, while the remaining 2/3 came directly from local hospitals to facilitate discharge into the community and support stability and well-being in community living.

Key Message 1: A model for crisis services that integrates both assertive mobile outreach and transitional case management has lead to expected and desired changes in crisis service utilization patterns. This model has potential to be relevant and generalizable to other communities.

To evaluate the acceptability of the new crisis service to service recipients a client satisfaction survey (the CSQ-8) was offered to all service recipients who received face-to-face crisis services over a 4 month period. Thirty-five satisfaction questionnaires were collected, with 28 fully completed. The results of the satisfaction survey were biased towards the positive and open-ended comments offered by recipients offered no insights into possibilities for service improvements.

Key message2: Traditional satisfaction surveys provide limited understanding of how clients experience crisis services.

Qualitative data about how the crisis service was experienced by service recipients was obtained using a phenomenological participatory research approach. Four individuals who had received crisis services in the past participated as co-researchers and were involved in the design, data collection and analysis process. Thirteen service recipients participated in interviews about their experiences with the crisis services. The findings indicated that the crisis services are highly valued and that accessible, dependable, responsive and persistent services are key. The evaluation provided important information about the nature of crisis services received and highlighted the importance of the individual relationship with crisis workers. Three tensions, or elements of crisis that are experienced as potential weaknesses in service delivery, were identified. These tensions were related to clarity about what constitutes a crisis, vulnerability to the skill of individual workers, and challenges to timely access to services, particularly during periods of high service demand.

Key message 3: Service recipients value crisis services highly but their experiences are influenced by several key tensions, in particular:

- *uncertainty about what constitutes legitimate use of crisis services;*
- *the extent to which expected standards for quality care can be guaranteed across service providers*
- *the extent to which consistent timely access to crisis services can be guaranteed.*

To evaluate the acceptability of the new model of crisis services to the local network of community mental health and social services a survey questionnaire based on the Balanced Scorecard Framework of Kaplan and Norton² was used. Fifty-four local community mental health agencies were identified for inclusion in this portion of the evaluation and a total of 24 (44%) participated. Satisfaction levels among police, hospital and community health agencies were highest (with mean ratings ranging from 3.2-4 out of a possible 5), while lower ratings were received from non-profit and educational sectors. It may be that those service agencies providing higher rankings have the capacity to deliver crisis services as part of their mission and structure and are therefore less likely to be sensitive to perceived failures in crisis service delivery. Overall, respondents did not recognize improvements in service utilization patterns for crisis services (i.e. service capacity, access to mobile response and referral to follow-up services).

Key message 4: Strategic outreach to the community service network should accompany major changes in service delivery resources and patterns in order to actively engage services in learning about specific changes in service delivery, and to promote ongoing dialogue and problem solving about the issues and challenges emerging.

Finally, this study developed a competency profile for the transitional case manager positions within the new integrated crisis-case management model. The focus was on identifying the comprehensive range of competencies required for the job. The study used current principles in the field of competency profile development and aimed for a user-friendly competency

profile that organized distinct competencies into well-defined “clusters” with behavioural examples. The completed competency profile contained 14 domains with 130 competencies.

Key message 5: Transitional case management is characterized by distinct competencies differentiating the position from both crisis worker and case manager.

Systems enhancement funding provided the crisis service with an opportunity to address several ongoing issues and challenges in service delivery. This Phase II study provided the additional opportunity to explicate the nature of these service changes, to evaluate both processes and outcomes, and to disseminate these findings to a broad range of stakeholders in the community. In this way, the development of evidence-informed practices emerging from identified community needs was supported.

Key message 6: The development of this new crisis model reflects innovation in program design and reflects the potential for crisis service delivery to participate in crisis prevention, supporting community health and social services, and community development activities. The integration of a Transitional Case Management Program reflects improvements in the capacity to provide important follow-up services. It suggests the importance of ensuring that policies and funding governing crisis services promote responsiveness to service challenges and service innovation.

Project Report

This project was funded under Phase II of the Systems Evaluation Enhancement Initiative funded by the Ontario Mental Health Foundation. It is one of seven such projects looking at different aspects of community mental health functioning across Ontario following increased funding from the Ministry of Health and Long Term Care.

Context

This study was situated in Southeastern Ontario (LHIN 10). Frontenac Community Mental Health Services (FCMHS) is a multi-service agency located in Kingston, Ontario. In addition to housing, case management, Assertive Community Treatment and vocational services, they provide community-based crisis services. FCMHS applied for and received systems enhancement funding to refine and further develop their crisis services.

FCMHS identified four specific concerns in their delivery of crisis services. First they were concerned about their capacity to directly manage crisis calls received after regular business hours. Second, there was a concern that while the crisis service was meeting the needs of clients registered within the FCMHS group of programs, access by members of the broader Kingston community was constrained. Third, the crisis service had limited mobile response capacity. Fourth, the crisis service was having difficulty accessing appropriate follow-up services for clients served and this was creating a “bottle neck” – constraining the ability to meet new crisis needs as they emerged.

FCMHS used the enhancement funds they received to refine their services to address these issues. Specifically the funds were used to:

- Extend the hours of operation of the crisis service and to integrate after-hours crisis calls directly with the crisis service;
- Incorporate mobile crisis visits explicitly into the expectations of the crisis service. This mobile capacity included mobile responses to crisis calls. It also included regular and assertive community visits with a view to preventing crises, meeting the crisis needs of important community partners (for example, local shelters, the police and hospital services) and to increasing the profile of their services in the general public (for example, with local businesses).
- Develop a transitional case management (TCM) program. It was expected that this TCM program would provide case management services for up to 60 clients for 8-10 weeks. The transitional case management program would accept clients from the crisis service, and also direct referrals from the local hospitals to support the smooth transition from hospital to community (see Appendix A for a diagram of these service changes).

The research questions for this study focused on the service pattern changes expected with the delivery of this new integrated crisis-case management model. The following were the specific questions guiding this study:

- Is there a relationship between this new crisis model and service capacity, access to mobile crisis service, and appropriateness of crisis services?
- Are the crisis services acceptable to service recipients?
- Are the crisis services acceptable to the local community health and social service network?
- What are the key competencies for the new transitional case management positions?

Implications

The findings indicate that the service enhancements and modifications lead to the expected changes in service utilization patterns. The new crisis model was not fully implemented during the time of the study (for example, the full complement of Transitional Case Managers was hired mid-way through the study period), suggesting that improvements in service utilization patterns were underestimated. The crisis model has potential to be relevant and generalizable to other communities, particularly where crisis service issues of broad community access and the capacity for assertive mobile crisis response and issues related to lack of follow-up services are a concern.

The development of this new crisis model reflects innovation in program design and the potential for crisis service delivery to participate in crisis prevention, supporting community health and social services, and community development activities. The integration of a Transitional Case Management Program reflects improvements in the capacity to provide important follow-up services. It suggests the importance of ensuring that policies and funding governing crisis services promotes such innovation.

This evaluation provided limited information about the services provided by the Transitional Case Management service, although it did confirm that the Transitional Case Managers require competencies overlapping with, but distinct from both crisis work and case management. Future study of the nature of services actually delivered and outcomes achieved by Transitional Case Management would provide a more comprehensive perspective on this new integrated service model.

Satisfaction surveys completed by the recipients of the new model of crisis services were of limited usefulness. Although the responses to satisfaction surveys were overwhelming positive, they provided limited understanding of how the services were helpful. Qualitative interviews focusing on the experiences of recipients of crisis service users were more enlightening. They

supported the finding that, overall, the crisis service was highly valued and well received, but also revealed important knowledge about how services were experienced as helpful. In addition, these interviews revealed ongoing issues in service delivery, such as the possibility of separating “warm line” services from “crisis services” and developing service structures to ensure that individuals can always access crisis services – even during times of high demand.

Although the crisis service was refined to meet needs within the broader mental health and social support systems, the study indicated that such changes in service delivery should be accompanied by strategic outreach to the broader community support network. This outreach could include information and education about the nature of the service changes and subsequent changes in service delivery patterns. It could also include opportunities for ongoing dialogue about the crisis-related needs and issues emerging within this broader system.

Approach and Results

Five distinct study designs were developed to address the study’s core objectives. Each study design is presented separately, with the accompanying results.

Ethics approval was obtained from the Queen’s University Health Research Ethics Board for the entire study, and a separate ethics submission was approved for the participatory research study (Objective 3).

Approach: Objective 1 – To evaluate the extent to which the new integrated crisis-case management service lead to expected and desired changes in service delivery patterns.

To address this objective we compared the old crisis service model (individuals entering and exiting the crisis service between November 1, 2004 and October 31, 2005), with the new model (individuals entering and exiting the crisis service between March 1, 2006 and February 28, 2007). Existing databases of Frontenac Community Mental Health Services and local hospital data from Queen’s University affiliated hospitals were the primary sources for data. More detailed technical specifications of the study design are contained in Appendix B.

Results: Objective 1

a.) Service capacity

The new model demonstrated a significant increase in the number of unique individuals served over a one year period.

Table 1: Service capacity

	Number of unique individuals served over a 1-year period
Old model	108
New model	216

These estimates of unique individuals served are underestimates of the total numbers served by both the old and new crisis services since those situations where individual information was not identified (for example, some crisis calls and mobile response calls), were not included.

We completed a comparison of service recipients receiving the old and new model using Chi-square analysis and we compared the percentage change between old and new models on specific variables. Our comparisons indicated that there were no significant differences between the populations served on age, gender, marital status, residential status, legal status, principle income or diagnosis.

Differences in employment status were significant, with people served in the new crisis model more likely to be employed.

Table 2: Differences between the populations served on employment status

Chi-Squared **0.008**

VARIABLE	Percentage change	OLD MODEL Count	OLD MODEL Percentage	NEW MODEL Count	NEW MODEL Percentage
Employed	25	15	13.9	52	24.1
Not employed	7	92	85.2	152	70.4
Unknown, declined		1	0.9	12	5.6

Differences in living arrangements were approaching significance with new model participants more likely to be living by themselves or with a relative, while those served by the old model more likely to be living with non-relatives.

Table 3: Differences between on populations served on living arrangements

Chi-Squared **0.059**

VARIABLE	Percentage change	OLD MODEL Count	OLD MODEL Percentage	NEW MODEL Count	NEW MODEL Percentage
Lives by self	16	29	26.9	74	34.3
Lives with relative	13	41	38.0	96	44.4
Lives with non relative	2	33	30.6	41	19.0
Unknown declined		5	4.6	5	2.3

These findings suggest that the new model was more likely to reach individuals who would be considered to have moderate levels of mental illness or mental health problems, while the old model was more oriented to serving those with serious mental illness.

This interpretation is also supported by differences in hospital utilization patterns. A higher percentage of the clients served by the old model were more likely to be evaluated by crisis workers as having a presenting issue of previous psychiatric hospitalization. They also had, in the 6 months prior to receiving crisis services, significantly more days in hospital, more number of hospitalizations and more visits to emergency rooms compared to clients served in the new model.

Table 4: Comparison of hospital service utilization patterns for the period 6 months prior to receiving crisis services

*p<.001

	Old Model	New model
Days in hospital 6 mos. Prior – M/SD*	8.31/16.32	0.81/4.35
Number of hospital admissions - M/SD*	0.75/1.37	0.14/0.49
Number of emergency room visits – M/SD*	0.58/1.2	0.12/0.47

b.) Access to mobile crisis services

The new model demonstrated a significant increase in the number of mobile crisis visits conducted (old model number of mobile visits = 1; new model number of mobile visits = 72).

We compared those who did and did not receive mobile crisis services in the new model. Those receiving a mobile visit were significantly more likely to be unemployed and to have been referred through psychiatric hospital services. There was a trend towards those with no fixed address receiving a mobile response.

c.) Accessibility to crisis services

As expected, the new integrated crisis-case management model demonstrated referral source patterns reflecting a range of pathways to crisis services within the broader community. The new model received a significantly higher percentage of referrals from community organizations, self-referrals and referrals from other community members; while the old model received a greater percentage of their referrals directly from hospital services. It should be

remembered that in the new model, the local hospitals could directly access the Transitional Case Management Program to facilitate discharge and community support.

Table 5: Referral Source Patterns Old and New Model
Chi-Squared: 0.000

VARIABLE	Percentage change	OLD MODEL Count	OLD MODEL Percentage	NEW MODEL Count	NEW MODEL Percentage
General hospital, psychiatric hospital	3	21	19.4	27	12.5
Community mental health	26	11	10.2	40	18.5
Self, family, friend , teacher, clergy, others	14	63	58.3	149	69.0
Unknown		13	12	0	0.0

d.) Appropriateness of crisis service patterns

We measured the appropriateness of crisis service using two variables: length of time receiving crisis services and exit disposition. With regards to length of time, we considered a 3 week time frame as reaching the maximum expected for the “ideal” delivery of crisis service. This was based on the assumption that crisis is a potentially serious situation, but self-limiting and requiring resolution of the immediate problem. This assumption in no way negates the fact that some individuals require a longer period of formal mental health related support, but only that lengthy periods of direct service delivery is not the role of a crisis service.

Our comparisons of the old and new model indicates that there were significant differences in the number of days that people were served. The new model was significantly more likely to serve clients within a three week time period, while more than half of the old model clients were served for more than 3 months.

Table 6: Comparison of numbers of days served in old and new model
Chi-Squared: 0.000

VARIABLE	Percentage change	OLD MODEL Count	OLD MODEL Percentage	NEW MODEL Count	NEW MODEL percentage
1-21 days*	33	20	18.5	87	40.3
22-60 days	39	20	18.5	99	45.8
61-90 days	17	6	5.6	16	7.4
91 days and over	-8	62	57.4	14	6.5

With regards to exit disposition, we assumed that given the addition of the Transitional Case Management Service, clients of this new service would be more likely to have an exit pattern that reflected resolution of their problems, and this was indeed our finding.

Table 7: Comparison of exit disposition in old and new model
Chi-Squared: 0.000

VARIABLE	Percentage change	OLD MODEL Count	OLD MODEL Percentage	NEW MODEL Count	NEW MODEL Percentage
Completion without referral	92	9	8.3	92	42.6
Completion with referral	22	29	20.9	92	42.6
Withdrawal	-3	37	34.3	25	11.6
Other	-8	33	30.6	7	3.2

Our measures of appropriate service delivery were defined based on our assumption that the new Transitional Case Management service would provide the crisis service with quick access to follow-up services, thereby improving their capacity to provide outreach and mobile crisis services. In the year of study, the new crisis service referred 42 clients to the TCM service. In addition, the TCM received an additional 71 clients directly from the local hospital.

Our analysis suggests that referrals made to TCM were likely to have received a mobile visit, and be evaluated as presenting with issues of housing or previous psychiatric hospitalizations.

Approach: Objective 2 – To evaluate the acceptability of new crisis model to clients of the service

We surveyed all service recipients receiving face-to-face services between February 14, 2007 and June 27, 2007 to evaluate the acceptability of the new model.

Satisfaction was measured by the widely used Client Satisfaction Questionnaire – 8 (CSQ-8)³. The measure asks participants to self-rate on different aspects of satisfaction with services using a 4 point scale. Two open ended questions provided clients the opportunity to offer comments or suggestions about the service. The CSQ-8 is scored by summing the individual item scores to produce a range of 8 to 32, with higher scores indicating greater satisfaction. In addition, we added an open-ended item asking respondents to provide comments and/or suggestions at the end of the survey.

Measuring satisfaction of users of crisis services is notoriously problematic. Issues include: a response tendency towards social desirability; mobile crisis contacts in particular do not lend themselves to engaging clients in survey completion; perceived conflict of role of service providers collecting this information; and the acuity of emotional, mental and mental distress and instability in living conditions associated with crisis.

Results – Objective 2

Thirty-five satisfaction surveys were collected, but only 28 were fully completed. Information about the number of refusals, or the number of clients who were not approached to participate could not be collected, so it is impossible to know the extent to which the survey represents the total population served during this time period. Calculations of the expected return for this 4 month time period (as a proportion of the 216 served over the course of the entire year), suggest that approximately 72 individuals would have been served during this time period; offering an approximation of a 49% return rate. In addition the surveys provided no information about the elements of the crisis service that were actually received by the respondent making it difficult to understand the specific context of the ratings.

The results of the satisfaction surveys were biased towards the positive. Table 8 provides an overview of the frequency of responses to each survey item. All qualitative comments provided by service recipients were positive, and no suggestions for improvements or indications of issues in service delivery were noted. The limitations of satisfaction surveys in the evaluation of user satisfaction with health services have been noted in the literature^{4,5}.

Table 8: Responses to items on Client Satisfaction Questionnaire

N = 35	Rating 4 Excellent	Rating 3 Good	Rating 2 Fair	Rating 1 Poor	Unknown No Answer
How would you rate the quality of services received?	23	11	1	0	0
Did you get the kind of services you wanted?	20	13	2	0	0
To what extent has the program meet your needs?	17	10	5	0	3
If a friend were in need of similar help would you recommend our services?	24	9	1	0	1
How satisfied are you with the amount of services received?	22	8	2	0	3
Have the services helped you deal more effectively with your problems?	17	11	3	0	4
In an overall, general sense, how satisfied are you with the services you have received?	17	15	0	0	3
If you were to seek help again, would you use our Crisis Services?	27	5	0	0	3

Approach: Objective 3 – *To understand the experience of receiving crisis services*

Qualitative data about how the crisis service was experienced by service recipients was obtained using a phenomenological participatory research approach. Four individuals who had received crisis services in the past participated as co-researchers and were involved in the design, data collection and analysis process. Appendix C describes the technical aspects of this participatory study, the training to prepare co-researchers as interviewers and a summary of the participatory analysis processes.

This component of the study focused on the following research questions: 1) How do clients experience the crisis services? 2) How do the clients perceive the role of the crisis service, and; 3) How does involvement in the crisis service impact their life after the crisis or when the transition is over?

Thirteen clients who had a range of experiences with the crisis services were engaged in interviews (audiotaped and transcribed verbatim) focusing on their experiences of these crisis services in context of their intentions. Participants included 8 women and 5 men. Age was estimated by the interviewers with six participants aged 20-39, and seven 40 years or older. There was a fairly equal split between those who experienced the new model and those who had received services from both the old and new model. Nine of the participants indicated that they were involved in at least one other program offered through Frontenac Community Mental Health Services, the parent organization. Table 9 provides information about the nature of the crisis services they received:

Table 9: Nature of crisis service received by participants

Crisis service received	Number of study participants
Crisis telephone line	10
In-person crisis support	9
Mobile crisis visit	2
Seen by crisis service psychiatrist	6
Transitional case management	2

Results: Objective 3

Crisis was described as coming in many forms, from the “911” situation to needing to talk in order to prevent a crisis. Participants expected that crisis services would validate their distress and help them in the areas where they need help, but at the same time treat them as individuals and respect their capacities and strengths. Crisis was described as a very painful internal experience that feels overwhelming. It can be expressed outwardly through observable behaviours suggesting pain and internal chaos, or by a state of calmness. Some of the best support received was when the person was taken at their word, self-knowledge was recognized and respected, and when crisis services listened and guided the individuals to find their own answers or inner tools.

Crisis services were highly valued by participants, and the importance of these services to their well-being meant that when they worked well they “*saved my life*”, but when they didn’t work well “*it was very hurtful*”. Valued experiences of help from crisis services included services that were accessible, dependable and responsive:

“It’s always there. You can count on it, 24 hours a day, 7 days a week. You do not have to know what time it is, you don’t have to know when they are open, you don’t have to wait till somebody is there to work. 24 hours. I’ve only go one place to call, and that’s them”.

Participants valued crisis services that provided follow-up, were trustworthy in following through with expected actions (“*He says, ‘well I’m going to come and see you next week and he did, and he kept following up*”), and persistent in ensuring follow through on important actions by the client (*They brought me out.. they got me to class.. showed me through the network there that it would be to my benefit to go*). It was considered important for crisis services to recognize that crisis is both a universal and a unique experience (“*I don’t think he realized that that was a crisis for me*”). Crisis staff who would “get to know me” were able to ensure that needed information was gathered and that interventions and referrals matched specific needs. Related to these ideas, participants identified the importance of the opportunity to talk and vent, and providing the time to do so:

It’s not ever condescending you know ‘I have no time for that’ or anything like that. They always sit down and it could be a 2 minute thing or a 10 minute thing or whatever, they’re there...Every occasion is that occasion. You don’t find them looking at their watch all the time... so you don’t feel like you’re being rushed along”.

Participants expressed the importance of being helped to find their own solutions and to reconnect with their own inner strengths: “*the tools they gave me is just the ability to find my own tools*”. Specific strategies used by workers to support participants through their crises included: facilitating coping techniques and providing information; providing direct practical support, and; providing reassurance and hope. The value of the crisis service depended on the personal qualities, skill and ability of the individual worker. Participants depended on workers who were competent, trained, empathic, professional, compassionate and genuine. They expected crisis workers to demonstrate respect for them and to maintain a non-judgemental attitude:

“Compassionate, certainly not condescending...It’s individual. There’s eye contact. It doesn’t come across as a learned thing, it comes across as an instinctual thing.. [not] scripted.. The worker will be able to sense if there are any alarm bells going off... The person that you come to talk to has a diploma, has actually studied this, knows exactly how to identify a problem. And again, in doing so doesn’t give you the impression that it’s too big or too small”.

The analysis suggested three important “tensions” in crisis service delivery. Tensions are defined here as the interplay between elements of the crisis experience that are experienced as a potential point of weakness in service delivery:

The first tension is their sense of uncertainty about what constitutes the legitimate use of crisis services. Their sense of uncertainty extended to knowledge about the types and range of resources and supports they were entitled to, how the supports could be accessed, what defines a crisis, how severe or intense the crisis had to be to be accepted as a legitimate use of crisis services and whether the crisis service should be used to prevent further problems. The following quote is illustrative:

“I didn’t understand what was considered a crisis. I thought suicide was about where you start, so I never got the full scope of how much I could use it. I wasn’t sure about when to call. I didn’t know who would I call about what. I don’t have a clue what’s considered a crisis. Is it clothes? What kind of things? I have no idea what you would consider a crisis. Is it only mental health, like suicide or something?”

The second tension relates to the extent to which expected standards for crisis care can be guaranteed across all service providers. Although positive in their comments overall, the participants offered examples of specific situations when a crisis contact did not provide assistance in a way that was experienced as helpful. Specific examples included the mismatch in interventions when staff did not take the time to “know me” (“New people don’t know me and they suggest coping mechanisms that I’ve known for 10 years”), when interventions seemed to be prescriptive (“I’m not sure whether they kept data that would identify the person who was calling, and they’d just go, ‘Okay it’s [caller’s name] again, so tell her to read a book”), or when the participant perceived negative judgments:

“The worst or most difficult experience was being told that I was cutting to get attention. I called, and a person answered and I said ‘I’m really on the verge of cutting and I don’t want to do it. I need some help stopping myself’ and she said “Well you know, it’s a good way to get attention isn’t it? And I said “It’s not about attention”.

The third tension relates to the extent to which the crisis service structure is able to always meet immediate crisis needs. Timely access to crisis service was valued and access to this timely support could be compromised when an individual need occurred during a period of high demand for the crisis service:

“When the line is busy. When they say ‘can I put you on hold?...left me high and dry. That person at the other end should have got somebody to connect me to somebody else. So there’s five of us all having a crisis at the same time... and we’re all going to have huge problems and there’s going to be one crisis team member down there to help you. The networks got to be bigger than that. So get the technology, get it all together and help the patients.”

Specific suggestions for refinement to the crisis services were offered including: establish a warm line so that people can call to talk and vent and still receive more intense crisis services if needed; hire consumer survivors to operate a warm line and provide peer-to-peer support; provide personalized guidelines on how to use the crisis service; provide information about what the crisis service can offer; develop a system and structures that ensure people receive timely access to services.

Approach: Objective 4 – *To evaluate the acceptability of the ‘new model’ to the local network of community mental health and social services.*

This objective was addressed using survey questionnaire designed based on the Balanced Scorecard Framework of Kaplan & Norton² which is a strategic planning system and a performance measurement framework to give managers a more 'balanced' view of organizational performance. Three perspectives from this balanced scorecard applied to this survey were perceived helpfulness of the service, the perceived efficiency of the new model and ratings of the extent to which community partners understood the new model and their own capacity to manage crises. Additional details about this survey are included in Appendix D.

Fifty-four local community mental health and social agencies were identified for inclusion in this portion of the study. These agencies were recruited through a letter of invitation, informing them about the study and requesting that they complete the on-line satisfaction survey (between February 1 and March 7, 2008). Follow-up letters were sent to agencies and hard copies of the survey were mailed to participants upon request.

Results: Objective 4.

In total 24 (44.44%) surveys were completed; a 44% response rate. The majority of the 24 surveys were from the non-profit organization sector (n=8), followed by community mental health services (n=6) and hospitals (n=6). Responses were also received from educational institutions, the police, and community living services. All of the surveys were completed by individuals with some supervisory or management responsibility. These respondents were an experienced group, with the majority (70%) having more than 4 years of related work experience. All but four of the services participating indicated that they were familiar with the new crisis model and all the services indicated that they had made referrals or had served people who used the crisis service.

The mean overall rating of satisfaction across all programs surveyed was 2.95 out of a possible 5. The police, hospitals and community health agencies were the most satisfied with the new crisis model (means ranging from 3.2-4), while lower ratings came from the non-profit and education sectors (means ranging from 1.83-2.50).

Table 10: Means for satisfaction ratings according to service sector (total possible score = 5)

	Community health service (n=6)	Hospital (n=6)	Police (n=1)	Education institute (n=2)	Nonprofit organization (n=8)
The crisis service helps us do our jobs	3.63	3.27	4.40	2.80	2.46
The crisis service is efficient	4.20	3.33	4.00	2.93	3.13
The crisis service meets the needs of people with mental illness	3.66	3.06	3.83	2.75	2.17
Understanding of crisis service and capacity to deal with crisis	3.64	3.43	4.00	2.50	3.60
Overall rating of satisfaction	4.00	3.17	4.00	2.50	1.83
Average	3.85	3.28	4.03	2.73	2.88

A possible interpretation of the differences is that rankings need to be considered from the perspective of the capacity of any particular service sector to respond to crisis. This means, for example, the higher rankings from community health, hospital and police services might be expected; because they are less reliant on crisis services given they are in a position to deliver a mental health crisis intervention when needed, by virtue of their trained staff, service missions and structures. Non-profit organizations and other social service agencies, on the other hand, are likely to be more reliant on crisis services to deal with crisis situations, and experience negative situations if there is any perceived failure in crisis service delivery.

With regards to individual satisfaction items, the highest mean scores were obtained for the following items: My program/service is familiar with the procedures of this crisis service (Mean 4.09); This crisis service is timely during nighttime shift on weekdays (Mean 3.92); It is easy to make contact with this crisis service. (Mean 3.91); This crisis service is timely during daytime shift on weekdays. (Mean 3.89)

Respondents were least satisfied with the following items (mean score lower than 3.0): The service capacity of this crisis model is enough (2.20); This crisis service minimizes the amount of time my program/service spends on crisis situations (2.29); My program/service receives feedback from this crisis service about the disposition of people served (2.71); This crisis service

reduces the use of high intensity resources (2.76); This crisis model meets the needs of people they serve(2.80).

Table 11 provides information about the extent to which services in the local community network perceived the crisis service as improved, the same or worse over the past two years.

Table 11: Changes to crisis services as perceived by community agencies (Percentage of responses)

	Improved	The same	Worse
Accessibility	45.0	55.0	0
Service capacity	26.3	57.9	15.8
Service efficiency	22.2	61.1	16.7
Mobile crisis response	38.9	55.6	5.6
Referral to follow-up service	11.8	70.6	17.6

The responses indicate that the greatest area of perceived improvement was in accessibility to services. It is interesting to note that these agencies perceived the service capacity, mobile crisis response and follow-up services as mostly the same or worse over the past two years, while the results of our evaluation of the services indicate a significant improvement in each of these three areas.

Qualitative comments from community agencies indicated that they expected that the crisis service would provide immediate help to people with mental health problem who were in crisis or to prevent a crisis. They also expected the crisis service to assist clients with accessing psychiatric supports, and to refer people on to appropriate resources and to follow-up. Identified positive aspects of the crisis service included: 1) quick response; 2) easy to access; 3) information sharing; 4) mobile service; 5) spend time with clients; 6) appropriate referral or connection; 7) community based and community outreach; 8) staff professionalism; 9) staff energy and attitude; and 10) collaborative approach. Negative aspects of the crisis service included: 1) lack of feedback and follow up; 2) not offering services from some client's perspective; 3) limited access to psychiatrist; 4) restricted availability; 5) lack of flexibility about appointment times; 6) staff training/ability; 7) not having a mobile crisis unit during the night hours; and 8) lack of communication with agencies.

Comments suggested the recognition of many broader service-system issues constraining the work of the crisis service. These included: the need for more crisis beds; more attention to the needs of people with addiction problems who also have psychosis; difficulties associated with individuals refusing assistance; the need for more psychiatry services; and the need for more and better organized access to mental health resources in the community.

Certainly the results of this survey suggests the importance of strategic outreach to the network of community services to actively engage services in learning about specific changes in service delivery, and to promote ongoing dialogue and problem solving about the issues and challenges emerging.

Approach: Objective 5 – Development of a competency profile for transitional case managers (TCM) within the new integrated crisis-case management model.

Consistent with the emerging trends in competency based health-care this study defined competencies as measurable, human capabilities required for effective performance^{6,7}. Our focus was on identifying the comprehensive range of competencies required for the job, rather than on differentiating between levels of performance (for example exemplary, adequate, or inadequate performance). We were also interested in developing a user-friendly competency profile that organized distinct competencies into well-defined “clusters” with behavioural examples that would be meaningful to a wide range of stakeholders (providers, consumers, administrators, students, etc.). Technical details about the methods used are provided in Appendix E.

Results: Objective 5

Competencies of the transitional case managers include knowledge, skills, abilities and personal characteristics required to deliver quality, client-centred, time-limited, transitional case management services in the community for people with moderate to severe mental health issues in order to prevent or decrease; inappropriate use of emergency room services and hospitalization; and involvement in the criminal justice system. The competencies of the transitional case managers are directed to facilitating the transition of clients from crisis to an increased level of autonomy by promoting stability, empowerment and healthy living in the community.

Consistent with competency profile methodology, the competency profile includes domains (less than 20 recommended) and associated competencies. While there is considerable overlap between these competencies and those that have been identified for both crisis workers and case managers, they are specific to the job of the TCM in that they focus on transitioning people served from a position of distress and instability to one of well-being and reliance on personal resources.

The complete competency profile, containing 14 domains and 130 competencies, is presented in Appendix F.

Conclusion: Overview of key messages

The following key messages are drawn from the results:

Key message 1: A model for crisis services that integrates both assertive mobile outreach and transitional case management has led to expected and desired changes in crisis service utilization patterns. This model has potential to be relevant and generalizable to other communities.

Key message 2: Traditional satisfaction surveys provide limited understanding of how clients experience crisis services

Key message 3: Service recipients value crisis services highly but their experiences are influenced by several key tensions, in particular:

- uncertainty about what constitutes legitimate use of crisis services;
- the extent to which expected standards for quality care can be guaranteed across service providers
- the extent to which consistent timely access to crisis services can be guaranteed.

Key message 4: Strategic outreach to the community service network should accompany major changes in service delivery resources and patterns in order to actively engage services in learning about specific changes in service delivery, and to promote ongoing dialogue and problem solving about the issues and challenges emerging.

Key message 5: Transitional case management is characterized by distinct competencies differentiating the position from both crisis worker and case manager.

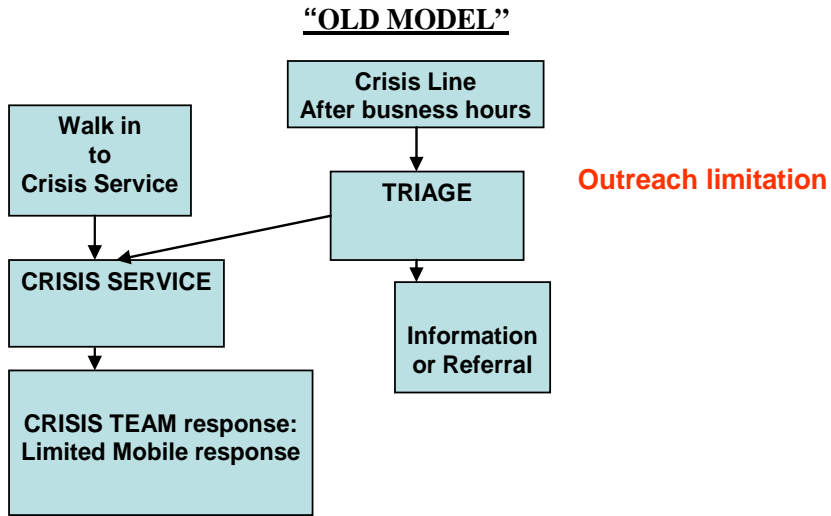
Systems enhancement funding provided the crisis service with an opportunity to address several ongoing issues and challenges in service delivery. This Phase II study provided the additional opportunity to explicate the nature of these service changes, to evaluate both processes and outcomes associated with these changes, and to disseminate these findings to a broad range of stakeholders in the community. In this way, the development of evidence-informed practices consistent with the local community needs was supported.

Key message 6: The development of this new crisis model reflects innovation in program design and reflects the potential for crisis service delivery to participate in crisis prevention, supporting community health and social services, and community development activities. The integration of a Transitional Case Management Program reflects improvements in the capacity to provide important follow-up services. It suggests the importance of ensuring that policies and funding governing crisis services promote responsiveness to service challenges and service innovation.

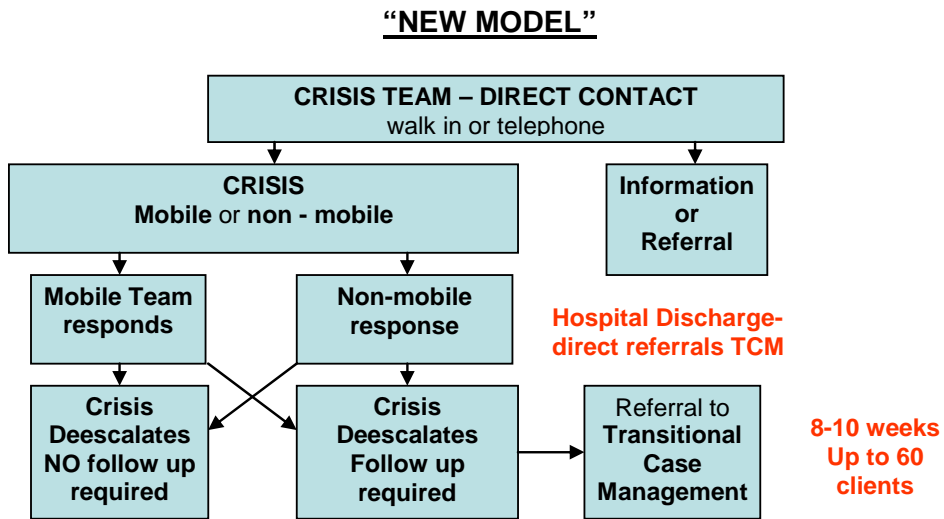
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**Appendix A: Service Changes: Old Model (before enhancement);
New Model (enhanced service)**



No built in follow-up



Appendix B: Technical aspects of the study design for objective 1: *To evaluate the extent to which the new integrated crisis-case management service lead to expected and desired changes in service delivery patterns.*

To address this objective, a non-equivalent group design was used. We compared the old crisis service model (individuals entering and exiting the crisis service between November 1, 2004 and October 31, 2005), with the new model (individual entering and exiting the crisis service between March 1, 2006 and February 28, 2007). Data were collected for all clients using the crisis services, with each client assigned a unique identifier. Existing databases of Frontenac Community Mental Health Services, the parent organization, were the primary source for data collected. This included data from: 1) Client Record Management System (CRMS); and 2) In-house Crisis Service Module logs and Client logs. In addition data about emergency room use and hospitalization was collected through the Psychiatric Administration Information Data Set (PAIDS), a local hospital records linkage system. Data was analyzed using SPSS version 16. Significance levels were set at $p < .05$.

Data from all sources were examined, evaluated, cleaned and finally entered into a new study database. Data were excluded when there had been major changes in data collection rules and processes over time, or where the number of “unknowns” for any data variable reached 20%. This latter situation can be particularly problematic with crisis services, given the often acute and transitory nature of the service delivered. For both the old and new models the actual number of clients served is an underestimation since many clients receiving services by telephone or in natural community contexts will never provide even the basic information necessary for registering with the service. Also recruitment and hiring for all of the jobs within the new integrated crisis-case management services was not completed until November 2006; therefore the new model was not in full operation for the entire period of this study.

Appendix C: Technical Aspects of the study design for objective 3: *To understand the experience of receiving crisis services.*

The participatory research process consisted of 3 planning meetings with client co-researchers to conceptualize the design of the study. These planning meetings consisted of: providing a background to the study and participatory research; brainstorming key issues; developing research questions and selecting information gathering methods. This was followed by the submission of a full proposal to the Queen's University Health Research Ethics Board.

Co-researchers engaged in interviewing completed one session of interview training. This training session provided the opportunity to review the interview guide, to review the "how to's" of interviewing, and interview practice opportunities.

Data collection and interviews were conducted over a 4 month period. This was followed by 2 meetings for data analysis and to reach consensus on interpretations. Co-researchers summarized interview transcripts following group practice in analysis. Key themes were identified. All transcripts were reviewed and coded by the principle investigator (Krupa) and the research associate (Lava) and themes were further developed. The co-researcher group completed a draft report of their findings and these are integrated within this report.

Appendix D: Technical aspects of objective 4- *To evaluate the acceptability of the “new model” to the local network of community mental health and social services.*

This objective was addressed using a survey questionnaire based on the Balanced Scorecard Framework of Kaplan & Norton² which is a strategic planning system and a performance measurement framework to give managers a more 'balanced' view of organizational performance. Three perspectives from this balanced scorecard applied to this survey were perceived helpfulness of the service, the perceived efficiency of the new model, and ratings of the extent to which community partners understood the new model and their own capacity to manage crises:

1. Customer Perspective (Perceived helpfulness): Customers were defined as local community mental health and social service agencies. The questionnaire posed 6 questions related to the extent to which these customers thought that the crisis service met the needs of people experiencing mental health problems and 5 questions asking customers if the service was helpful to them in doing their own job.
2. Internal Process Perspective (Perceived efficiency): Seven questions addressed the perceived efficiency of the new model's activities and how well these activities conform to customer requirements.
3. Learning and Innovation Perspective (perceived proficiency): Five questions asked these community partners about their perception of their own capacity to manage crisis situations and about the extent to which they believe they have adequate understanding of the new crisis model.

The Satisfaction with Crisis Service Questionnaire – Community Partners survey was organized into three parts: 1) Part One consisted of 5 multiple-choice demographic items; 2) Part Two consisted of 23 satisfaction using a Likert-style response format ranging from 1 (strongly disagree) to 5 (strongly agree) organized according to the Balanced Scorecard Framework; and 3) Part Three asked for an overall rating of satisfaction, general impressions and recommendations using a Likert scale, multiple-choice, and open-ended questions.

Simple descriptive statistics were employed to calculate a mean overall satisfaction rating, means for each distinct satisfaction perspective and means for each individual item. Responses to open-ended questions were analysed using a simple content analysis

Appendix E: Technical aspects of the study design for objective 5: *Development of a competency profile for transitional case managers (TCM)*

The competency profile was meant to facilitate fidelity to the approach to Transitional Case Management in dissemination of the service approach, and to inform employee selection, promotion, supervision, and training and development. The processes we used to construct the competency profile were guided by current principles in the field including: integration of proven interdisciplinary approaches (eg. organizational psychology, human performance technology, educational psychology); use multiple approaches for data collection; involve multiple groups with a range of interests in TCM in the development of competencies; the development of competencies closely linked to desired outcomes; establish that the competencies are present in routine practice; refine multiple drafts of competencies based on feedback from a range of stakeholders; and ensure transparency of the processes used to develop competencies^{7,8,9}.

We used the following step-by-step process to create the TCM competency profile: 1) Reviewed and compared job descriptions for all crisis and case management positions (i.e. crisis service, transitional case management, intensive case management); 2) Conducted literature review of competencies for community mental health services including, crisis, intensive case management, and assertive community treatment; 3) Observed TCM team meetings ; 4) Interviewed the Crisis Team Manager; 5) Conducted Focus Group with TCMs ; 6) Created Draft 1 of the TCM Competency Profile; 7) Draft 1 reviewed by TCM Team Manager and Principal Investigator; 8) Reconciled recommended changes and created Draft 2; 9) Draft 2 TCM Competency Profile provided to Transitional Case Managers and Team Manager for verification; 10) Held focus group with crisis workers to review Draft 2; 11) Created Draft 3 of the TCM Competency Profile; 12) Provided Draft 3 to crisis workers and Team Manager for verification; 13) Completed Draft 4; 14) Verified Draft 4 Competency Profile against all client interview data from participatory study focusing on client experiences of crisis; and finally 15) Created the final TCM Competency Profile.

Appendix F: Transitional Case Manager Competency Profile

Objective:

Develop a competency profile for the newly created Transitional Case Manager position at Frontenac Community Mental Health Services, crisis service, as part of an evaluation of the integrated crisis-case management service model.

Definition:

The Transitional Case Manager Competency Profile includes knowledge, skills and abilities, and personal characteristics required to deliver quality client-centred time-limited transitional case management services in the community, for people with moderate to severe mental health issues in order to: prevent or decrease inappropriate ER visits, hospitalization and involvement in the criminal justice system. With this in mind, TCMs facilitate the transition of clients from crisis to an increased level of autonomy by promoting stability and empowerment; transition clients from hospital to community and; support healthy community living.

Transitional Case Manager Competency Profile

1.0 Demonstrate a holistic understanding of the person experiencing mental health issues while in transition	<p>1.1 Demonstrate a holistic understanding of the client including basic needs, challenges, individual strengths, capabilities, and interests.</p> <p>1.2 Know the characteristics of moderate to severe mental health issues including substance use, signs and symptoms of serious persistent mental illness, and the behavioural and experiential dimensions of these issues.</p> <p>1.3 Know up-to-date reliable sources of information on types of medications, medication effects and potential side effects, and consider these in the context of the client's own experiences.</p> <p>1.4 Utilize knowledge of mental illness and substance use issues appropriately by differentiating between illness and personal characteristics, in order to effectively engage with the individual.</p> <p>1.5 Understand the impacts of serious mental illness/ mental health issues and substance use issues on the client transition and crisis stabilization process.</p> <p>1.6 Understand stigma and its impacts on people with mental illness.</p> <p>1.7 Understand how basic needs for food, shelter, security, clothing, finances, affiliation and dignity impact mental health.</p>
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<p>2.0 Engage the client relationship for short term intensive support during transition</p>	<p>2.1 Prioritize time and goals to identify critical areas of focus and need that can be realistically addressed in 8 weeks.</p> <p>2.2 Understand the importance of consciously building a relationship of trust with the client before moving forward to address issues of change.</p> <p>2.3 Use creative and non-judgemental approaches to identify personally meaningful ways of motivating and engaging a range of types of clients.</p> <p>2.4 Demonstrate the ability to engage in a meaningful relationship in a short time with a broad range of clients, including those who are resistant.</p> <p>2.5 Utilize interpersonal skills to adapt communication styles with different types of clients, based on an accurate assessment of the person and in the context of the working relationship.</p> <p>2.6 Demonstrate personal qualities of empathy, respect, active listening and supporting the client.</p> <p>2.7 Develop trust by maintaining regular contact with the client, responding to requests, keeping them informed and demonstrating consistent reliable follow-up on agreements and decisions.</p> <p>2.8 Utilize the information, resources and direct support of MCWs as joint members of the transitional client’s team, to assist client in reaching their goals and supporting the TCM-client relationship.</p> <p>2.9 Foster a smooth transition from crisis to TCM program by collaborating, coordinating and communicating with MCW staff and client.</p>
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	<p>2.10 Conduct active outreach and follow-up using a flexible approach to support/assist clients in remaining engaged and attending their scheduled meetings on time and as needed.</p> <p>2.11 Take measures to provide reasonable access for clients if they require support outside of scheduled appointments and ensure TCM clients understand how to access staff support (TCM or MCW) by phone or walk-in, whether it's by appointment or in an unscheduled crisis situation.</p>
<p>3.0 Use client centred approaches to foster dignity in the change process</p>	<p>3.1 Empathize with clients to understand their journey, how they arrived where they are, and to see it from their perspective.</p> <p>3.2 Demonstrate sensitivity to the impact of negative life circumstances on dignity, identity, comfort level and ability to manage new or changing situations.</p> <p>3.3 Remain non-judgemental and respectful of client behaviours, beliefs, life choices, views, values, hopes and chosen processes of change.</p> <p>3.4 Demonstrate patience in verbal and nonverbal communication, to allow change to occur in a way that fits for the client.</p> <p>3.5 Alter own behaviour to minimize negative impacts of stigma and maintain client dignity and confidentiality, for example when meeting in public places.</p>

	<p>3.6 Be flexible in offering a choice of locations for service which ensures maximum confidentiality and privacy as requested or appropriate for the client.</p> <p>3.7 Adjust plans and approaches to accommodate new learning and new preferences, respecting the competence of clients as collaborators in service planning, delivery and evaluation.</p> <p>3.8 Use neutral descriptive language as opposed to diagnostic labels and symptoms, to explain behaviours or describe the person.</p> <p>3.9 Engage with client as an equal partner to jointly assess the level of risk in decisions and choices.</p>
<p>4.0 Provide comprehensive individualized assessment for transitional needs</p>	<p>4.1 Participate cooperatively in the intake process with internal FCMHS staff and hospital outreach to determine if transitional case management is appropriate based on Ministry of Health criteria and the best outcomes for clients.</p> <p>4.2 Conduct broad contextual assessment to expand areas of focus and options.</p> <p>4.3 Accurately assess strengths, resources, needs and risks.</p> <p>4.4 Demonstrate an awareness of individual client sensitivities regarding boundaries and what helps them cope, and use this awareness to select the right approach for each person.</p> <p>4.5 Recognize subtle clinical changes that indicate that the client may be de-compensating or that the client’s stability and wellbeing may be compromised and communicate them to other members of the team (including MCWs) to ensure appropriate informed support can be provided if needed.</p>

	<p>4.6 Apply knowledge of the judicial system to assess how it impacts client stabilization and transition.</p> <p>4.7 Expand the assessment focus beyond immediate needs and crisis, to include the context of client’s life situation and goals/needs.</p> <p>4.8 Conduct ongoing assessment to monitor where client is at and where they’re going, and modify approach as needed.</p>
<p>5.0 Support client to work towards meaningful attainable goals within the transitional program</p>	<p>5.1 Match client and program resources with prioritized client needs, to develop realistic time-limited and meaningful goals.</p> <p>5.2 Offer support, options and choices to expand the client view of possibilities beyond the situation(s) of crisis.</p> <p>5.3 Develop and provide flexible individualized services and supports that meet client needs as they transition from crisis to increased stability.</p> <p>5.4 Utilize psychosocial rehabilitation approaches that are client centred and genuine.</p> <p>5.5 Conduct ongoing monitoring throughout the intervention and adjust focus and approach as needed.</p> <p>5.6 Address structural issues for longer term stabilization and resolution of stressors, for example, financial, housing and social supports.</p> <p>5.7 Foster hope and create a positive vision by demonstrating personal qualities of optimism and creative approaches to possibilities of the future.</p>

	<p>5.8 Address change explicitly by providing education about the change process and reassuring the client about the temporary or time limited nature of crisis.</p> <p>5.9 Focus on what’s worked for the client in the past and identify new areas of strength and success.</p> <p>5.10 Support client to understand how their behaviour impacts their ability to achieve their goals.</p> <p>5.11 Be flexible in providing the amount of time (frequency of meetings and length of time) needed to develop a relationship, provide support and, initiate and/or meet client goals within the approximate 8-week period.</p> <p>5.12 Focus on concrete issues related to housing, finances etc to establish stability in basic needs, while providing supportive counselling to support these goals.</p>
<p>6.0 Manage the transitional program completion process</p>	<p>6.1 Recognize when client needs or is ready to be exited from the TCM program.</p> <p>6.2 Prepare client well in advance for program completion or referral by providing information in advance regarding the time-limited nature of the service and jointly planning for or putting in place, the needed alternate client supports.</p> <p>6.3 Ensure the client has the necessary contact information for alternate resources and referrals, including both community support and FCMHS crisis support.</p> <p>6.4 Ensure sufficient resources are in place prior to the client exiting the program.</p> <p>6.5 Make any necessary information available to those who need it (including referral sources and MCWs) to ensure a</p>

	<p>smooth transition out of the TCM service.</p> <p>6.6 Reinforce client accomplishments, strengths, and successes achieved in the TCM program to foster confidence in new growth and learning.</p> <p>6.7 Notify clients of contacts made and the expected time frame and method of contact that the client can expect from those contacts or referrals.</p>
<p>7.0 Mobilize community resources for increased stabilization and support</p>	<p>7.1 Engage a broad range of external agencies and resources such as housing, legal, social assistance, mental health, vocational and educational services.</p> <p>7.2 Maintain a thorough understanding of community resources including eligibility criteria and referral requirements.</p> <p>7.3 Know where to find information about contacts and resources.</p> <p>7.4 Utilize an understanding of the collective impacts that community resources have on client support and plan in advance for changes in support needs due to service changes, for example, the end of a time limited program or changes in parole status.</p> <p>7.5 Assess programs and their eligibility criteria to determine appropriateness in relation to client goals and needs.</p> <p>7.6 Creatively problem-solve to locate or identify appropriate supports.</p> <p>7.7 Investigate possible leads to find new resources or update existing ones, including making cold calls to find or locate resources.</p>

	<p>7.8 Identify, develop and maintain good relationships and linkage with a wide range of community resources.</p> <p>7.9 Work collaboratively within and across programs, services and resource people for the benefit of clients.</p>
<p>8.0 Connect client with community resources and supports for increased stabilization and support</p>	<p>8.1 Provide information on available community resources with client.</p> <p>8.2 Make referrals appropriate to client needs and preferences.</p> <p>8.3 Directly assist and accompany client in accessing and attending services, programs and appointments, with dignity as empowered consumers.</p> <p>8.4 Support skill development in activities of daily living to build client capacity to seek out and engage independently with community resources.</p> <p>8.5 Refer and link clients directly to the appropriate staff at community support programs and social supports.</p> <p>8.6 Coordinate internal and external programs, services and resource people for the benefit of the client.</p> <p>8.7 Respect client’s decision to discontinue, change, or choose alternate more appropriate supports and services, based on an understanding of their experiences.</p>
<p>9.0 Advocate for client services and rights to support</p>	<p>9.1 Represent and promote the full range of client abilities and needs in the context of their environment, to community program staff.</p>

<p>transitional needs</p>	<p>9.2 Educate and encourage staff of community resources in the provision of strength-based client centred approaches to delivery of services in relation to specific individual client situations.</p> <p>9.3 Advocate for changes to policies, procedures and approaches that respect the individual rights and dignity, as well as their strengths and needs.</p> <p>9.4 Facilitate and support self-advocacy.</p> <p>9.5 Be assertive, persuasive and persistent in attaining needed resources for clients and when unsuccessful, let go and problem solve alternatives.</p> <p>9.6 Diplomatically challenge stigmatizing attitudes and beliefs about mental illness.</p> <p>9.7 Advocate for services and resources that meet specific individual needs.</p>
<p>10.0 Support interpersonal resources for crisis management and ongoing support</p>	<p>10.1 Assist clients to engage in positive supporting relationships in the community.</p> <p>10.2 Provide information and support to family members and/or personal supports as needed with the client's involvement and consent.</p> <p>10.3 Engage with the family and/or personal support network to understand their point of view, how the client's illness has impacted them over their lifetime.</p> <p>10.4 Engage with the family and/or personal support network to understand the level of involvement that is comfortable for them.</p>

	<p>10.5 Provide non-judgemental support to family members and/or personal supports regardless of the levels and types of support they can or will provide to the client.</p> <p>10.6 Provide support to the client’s landlord or other interpersonal supports, as agreeable to client and in a manner that demonstrates awareness of the differences between maintaining confidentiality in relation to giving versus receiving information.</p> <p>10.7 Develop strategies for resolving problems related to confidentiality in the process of engaging interpersonal supports.</p> <p>10.8 Facilitate the development of natural support networks.</p>
<p>11.0 Facilitate client empowerment and autonomy, from crisis to increased stability</p>	<p>11.1 Provide the appropriate amount and type of support in a way that respects the existing strengths and competence of the client.</p> <p>11.2 Work collaboratively with client to minimize risks.</p> <p>11.3 Provide non-judgemental support for harm or risk reduction, even if there is still existing risk, respecting the client’s right to choose based on informed decision making.</p> <p>11.4 Utilize a range of approaches to ensure informed decision making, for example, education and role play.</p> <p>11.5 Respect and assist the client to make her/his own decisions and choices even when TCM may not agree.</p>

	<p>11.6 Teach new skills and build on existing skills that assist the client in achieving goals and managing stress.</p> <p>11.7 Inform and educate to contribute to the client’s understanding and awareness of mental illness, medications, coping, resources, and the role of environmental supports.</p> <p>11.8 Identify and appreciate meaningful movement or change, no matter how small it may seem, and communicate this to clients to help them see and value their accomplishments.</p> <p>11.9 Reinforce client strengths, resources, skills, past successes, and all changes, no matter how small or large.</p> <p>11.10 Support the client in risk taking and managing potential consequences, in the move to self determination and their right to make their own mistakes.</p> <p>11.11 Encourage client to take responsibility for achieving their goals.</p> <p>11.12 Educate client on the program resources, supports and expectations of client responsibility for follow-up.</p> <p>11.13 Provide caring confrontations to support increased awareness of self-defeating behaviours or attitudes.</p>
<p>12.0 Manage the transition process</p>	<p>12.1 Understand the challenges and nonlinear processes of transition and change as involving growth and setbacks, and periods of rapid and little change.</p> <p>12.2 Demonstrate sensitivity to the types of support needed in life-changing circumstances that involve new experiences and require the learning of new skills.</p>

	<p>12.3 Understand the challenges and impacts of change on individuals.</p> <p>12.4 Accurately assesses the need for taking an active role in stabilizing a crisis versus a supportive role as the client self manages using their own coping strategies, and is able to move in and out of these roles as appropriate.</p> <p>12.5 Adjust the amount, type and intensity of support as needed depending on the stage of transition and individual circumstances, preference and needs.</p> <p>12.6 Balance hope and reality within self and client.</p> <p>12.7 Adjust approach from crisis management, risk management and stabilization to empowerment, self responsibility and self-determination, as needed and appropriate for the client in transition.</p> <p>12.8 Conduct outreach activities to assist clients leaving hospital to achieve a smooth transition to community without crisis.</p> <p>12.9 Trust in the person's ability to change, learn and grow.</p>
<p>13.0 Respond to clients in crisis</p>	<p>13.1 Teach skills and develop capacities to prevent or avoid crisis in the future.</p> <p>13.2 Knows and effectively uses a range of crisis prevention and intervention approaches in conjunction with knowledge of the client gained through engaging the client-TCM relationship.</p> <p>13.3 Act independently to calmly respond to unexpected crisis situations when occurring on a home visit.</p>

	<p>13.4 Take measures to prevent or minimize unexpected crises for example, by calling ahead to check-in before an upcoming visit.</p> <p>13.5 Actively monitor client needs and status for the prevention of further crisis.</p> <p>13.6 Be aware of environmental risks to TCM and others in the home, for example, physical surroundings and other people present in the client’s home.</p> <p>13.7 Manage potential triggers and sensitivities proactively to avoid unnecessary stress.</p> <p>13.8 Respond to contain crises and ensure safety.</p> <p>13.9 Assist the client to frame and use crisis as learning opportunities.</p> <p>13.10 Assess when hospitalization is the best solution given the available alternatives and need for safety or intervention.</p> <p>13.11 Work as a team with mobile crisis workers when responding in on-call weekend crisis support role.</p>
<p>14.0 Maintain current professional skills</p>	<p>14.1 Promote collaboration and coordination across services and programs.</p> <p>14.2 Identify training needs, participate in continuing education, apply new learning on the job, and self-evaluate.</p> <p>14.3 Ensure ongoing review of relevant policies and legislation (including but not limited to privacy and confidentiality) to ensure familiarity and to remain current on new developments.</p>

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| | <p>14.4 Actively participate in team supervision and team meetings to review difficult or challenging situations.</p> <p>14.5 Demonstrate integrity regarding client confidentiality when working with outside agencies.</p> <p>14.6 Enter and maintain up-to-date information about client services, supports and referrals according to Ministry of Health guidelines, ensuring accuracy and completeness.</p> <p>14.7 Work independently and take primary responsibility for a set client caseload.</p> <p>14.8 Manage time to meet caseloads and remain flexible with clients.</p> <p>14.9 Seek out and utilize peers and team manager for support and consultation as needed.</p> <p>14.10 Understand and act in accordance with relevant legal and health related laws, policies, regulations and procedures.</p> <p>14.11 Use self awareness to review and reflect on work with clients, and monitor and address stressors or potential issues.</p> <p>14.12 Maintain regular and ongoing communication with MCWs on pertinent TCM client issues related to TCM intake, crisis management, and discharge timing, needs and plans.</p> |
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