# CLIENT SATISFACTION WITH SERVICES DELIVERED IN A MENTAL HEALTH CRISIS CENTRE DURING ITS FIRST YEAR OF OPERATION

MARY B. DWYER

# CLIENT SATISFACTION WITH SERVICES

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# MENTAL HEALTH CRISIS CENTRE

## DURING ITS FIRST YEAR OF OPERATION

by

Mary B. Dwyer

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# DEDICATION

*To my husband*

*Bruce*

*and my daughter*

*Jessica*

*whose unfailing encouragement, humour, and tremendous belief*

*in my abilities are my mainstay*

# ABSTRACT

*Background*

   Client satisfaction with health care is important to ascertain from many standpoints. It is a useful measure in directing resources appropriately and providing direction for the improvement of health care delivery. Satisfaction is positively correlated with health care outcomes and it can be an important determinant of overall health status. The province's health system is faced with challenges of geography and the historical dominance of institutional provision of care. Mental health services in Newfoundland and Labrador have been evolving over the past two decades. Health system reform continues to occur in this province, as elsewhere across Canada.

*Design*

A cross-sectional study.

*Setting*

   A community-based mental health crisis centre established in June, 1996, by Health and Community Services, St. John's.

*Objectives*

   To determine general satisfaction with services, the extent to which clients were helped in addressing their immediate crisis and the long-term resolution of the crisis.

*Participants*

   A sample of 105 people over 16 years of age who visited or telephoned the crisis centre during the period June, 1996 to September, 1997.

*Methods*

   A telephone interview of clients who had consented to be contacted by researcher using a forty item survey comprised of Likert scale and narrative questions.

*Results*

   Eighty-five percent of participants indicated that they were satisfied or very satisfied with the service. More females indicated their satisfaction than did males (91.3% vs 78.6%). When the Centre was rated on such attributes as location, accessibility, waiting time and comfortableness of environment, the large majority of consumers reported being satisfied or very satisfied with all attributes. When satisfaction level was compared with the type of crisis that precipitated contact with the Centre, greater variability was observed. For example, 60% of individuals presenting with relationship problems were satisfied while 100% of individuals presenting with crisis codes of health concerns, bereavement/loss or mental illness expressed satisfaction. Eighteen percent of clients reported complete resolution of their crisis. Missing data and telephone numbers no longer in service reduced the number of clients available for interviews.

   Based on participant responses, recommendations for improvements and expansion of the services of the Mental Health Crisis Centre as well as integration of other mental health services were identified.

*Conclusions*

Participants in the study strongly supported community based crisis services and recommended expansion to other areas of the province. However, less than 10% of the clients contacting the Centre over the last 18 months could be reached for consent to participate in the study. Lack of adequate documentation on the client population prevented in depth assessment of how well the Centre is meeting the needs of its clients.

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# CHAPTER 1

## INTRODUCTION AND PURPOSE

*"Knowing that there's a place to go
is very helpful".*

*Crisis Centre Client*

## 1.1 Introduction

The provision of crisis intervention to persons with mental illness or mental health concerns is a necessary component of mental health services. Since the deinstitutionalization movement in the 1960s and 70s, persons with psychiatric illnesses have had an ever-increasing reliance on a range of community-based services (Bertsch, 1991; Ellison & Wharff, 1985; Neville, 1990; Stroul, 1988; 1989). Crisis centres and crisis response teams have become basic necessities to maintain persons with psychiatric disorders living in the community (Morrisey, Ridgely, Goldman, & Bartko, 1994; Sladen-Dew, Bigelow, Buckley & Bornemann, 1993; Velamoor & Mendonca, 1997).

The type of crisis resources available can mean the difference between remaining in the community or being admitted to hospital (Ruggeri & Tansella, 1995), or, in the absence of services, becoming involved in the criminal justice system (Solomon, Draine & Meyerson, 1994; Wasylenki, Goering & MacNaughton, 1992). The need for a mental health crisis centre in the St. John's region had been recognized for decades. It was only within the last two years that this identified need became a reality. Three major trends identified by Neville and Maddigan (1991) were the impetus behind the realization:

1. Reliance on inpatient facilities is decreasing. Professionals and consumers alike are moving toward community-based services geared to keeping persons in crisis out of hospital except in extreme circumstances. The financial cost of hospitalization along with the philosophy of treatment in the least restrictive environment is the motivation behind this move.

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2.   The chronically mentally ill continue to dominate the psychiatric emergency system. The literature abounds with articles on their use of community-based follow-up and maintenance services. Persons with mental illnesses tend to have a relapse remission pattern, and often require ongoing supports to maintain stability. Emergency services are one of the supports required.

3.   Psychiatric emergency services are a component of a wide array of mental health services needed in the community. Services geared to psychiatric emergencies have many components including, but not limited to, brief stay admissions, mobile response teams, referral to psychosocial rehabilitation services, and a range of vocational, housing and recreational services.

All too often health services are put in place with no mechanism for evaluation. Programs are started without a thorough assessment of the needs of those to be served or of the resources available, and the programs are often continued despite lack of evidence that they are making a positive contribution to health care (Brekke & Test, 1987; Munro, 1983). The Mental Health Crisis Centre, as part of its opening mandate, requested a process and outcome evaluation to determine its effectiveness in attaining its goals of providing in-person and telephone crisis intervention to persons in a mental health crisis.

## 1.2   Purpose Of Research

The Mental Health Crisis Centre (the Centre) in St. John's, Newfoundland and Labrador, operated as a 18-month pilot project (June 1996 to December 1997), with continued government funding contingent upon the results of an overall evaluation. A local

consulting firm, The Institute for Human Resource Development (IHRD) executed a two-phase evaluation of the project. The first phase focussed on the developmental aspects, structure, goals and objectives, and the place of the Crisis Centre in the overall mental health system in the province. Key informant interviews, document review and focus groups were used for information gathering. The second phase involved an evaluation of service delivery using interviews and focus groups. This client satisfaction survey is the third phase of the evaluation and is the topic of this thesis.

The specific questions to be answered through this research were:

1. Were clients generally satisfied with services at the Mental Health Crisis Centre?

2. Did clients get help in addressing the immediate crisis?

3. Has the help clients received at the Centre impacted on long term resolution of the crisis?

# CHAPTER 2

## LITERATURE REVIEW

*"The most helpful thing was the
staff's attitude, they were friendly
and understanding...treated me like a normal person"*

*Crisis Centre Client*

Persons with mental illnesses have probably been with us before recorded history. Depending on the beliefs and culture of the times, they were revered, feared, ignored, pitied, laughed at or tortured. This section briefly reviews the history of attitudes toward mental illnesses throughout the ages and highlights the kinds of procedures that were used to hide, subdue or treat the sufferers.

## 2.1    The Beginnings: Primitive Concepts

According to Wilson and Kneisl (1992) the era of preliterate times made no distinction between mental and physical illnesses and, consequently, no differentiation was made among magic, religion and medicine as treatments.

Early civilization differentiated between physical and mental illnesses. A medical concept describing the four body "humours" was summarized by Hippocrates who lived from about 460-370 B.C. He explained mental illnesses according to humoral pathology whereby good and bad bodily fluids or "humours" (black bile, yellow bile, phlegm and blood) influenced the body, and the body influenced the mind (Kolb & Brodie, 1982; O'Brien, 1989; Wilson & Kneisl, 1992).

The Middle Ages (1300-1600), alienated the mentally ill. 'Treatment' consisted of practicing mysticism and demonology. Troubled minds were thought to be influenced by the moon. "Lunacy literally means a disorder caused by the lunar body" (Wilson & Kneisl, 1992, p. 8). These people were left to wander aimlessly, sent on long pilgrimages or found participating in religious wars and crusades. Many women who suffered mental illnesses were thought by theologians of the time to be witches and were burned at the stake. Violent persons were shackled in prisons and "ships of fools" housed boatloads of people who were sent to sea to search for their 'reason'.

Whereas the Middle Ages excluded and abandoned the insane, the Renaissance confined them to 'mad' houses. The insane were part of a boarding house trade that sometimes housed as many as five hundred people in old abandoned mansions that were ill-fitted for the purpose (O'Brien, 1989).

It was during this period that some physicians began to consider that mental illnesses stemmed from natural causes. Johann Weyer (1515-1588), a German physician considered to be the first psychiatrist, stressed the needs of the individual over the institution. He espoused the necessity for careful clinical scientific observation, and the need for kindness and benevolence in the treatment of the mentally ill.

## 2.2    The Modern Era

The late eighteenth and early nineteenth centuries were referred to in psychiatry as the Era of Moral Treatment. Classification of mental disorders, rationalism and scientific observation occurred during this time. Philippe Pinel (1747-1826) in France, William Tuke (1732-1822) in England and Dorothea Dix (1802-1887) in the United States started what is known in psychiatry as the Reform Movement (O'Brien, 1989). These three people widely espoused the philosophy that kind, humane treatment of the mentally ill was necessary in order for people to improve. Hospitals were opened based on principles of hope and confidence rather than fear and force to subdue sufferers of mental illness.

The growth of public mental hospitals was not a coincidence in the nineteenth century. The outcome of moral treatment saw a rise in social awareness of the injustice of the treatment of the oppressed mentally ill. During this period, institutionalization itself was seen as a treatment. Psychiatrists held to the belief that mentally ill people could be cured nowhere else but in an asylum and that they would be cured by simply being in an asylum (Thompson, 1994). Grob (1994) observes that the nineteenth century was noted for its widespread use of institutional and state solutions for social problems rather than relying on familial or community solutions. Prior to 1800, there had been no systematic effort to restrict "lunaticks (sic) or distracted persons" (Grob, 1994, p. 542).

This was also the beginning of the mental hygiene movement. Clifford Beers (1876-1943), a Yale-educated businessman, in 1908 published *A Mind That Found Itself*, a book describing the profound anguish suffered while he was receiving custodial care at several private and state hospitals over a three-year period. In 1909, he organized the National Committee for Mental Hygiene. Its goal was prevention, early detection and treatment as well as research into causes of all mental disabilities (Kolb & Brodie, 1982).

In Canada, the beginning of the twentieth century saw the launching of evaluative surveys of care in hospitals in every Canadian province. The beginnings of research efforts and education for nurses, social workers and medical students in the field of normal personality development also occurred (Griffin, 1989).

## 2.3    Deinstitutionalization and the Community Mental Health Movement

The era of the asylum in the early 19th century, when mere admission to the asylum was thought to be a means of treatment gave rise to its own mental health problems — the social breakdown syndrome or institutionalization (O'Brien, 1989; Thompson, 1994). The symptoms were apathy; loss of individuality, interest and initiative; submissiveness and dependency. Extreme manifestations of these symptoms were impaired judgment and a characteristic posture and gait. These symptoms were originally attributed to the illness itself.

However, Barton (1959) in his book *Institutional Neurosis* proposed that these symptoms were possibly caused by or exacerbated by living in a mental hospital. Loss of contact with the outside world; loss of friends, possessions, personal events and outside prospects; loss of responsibility; enforced idleness; the ward atmosphere; the control by staff and drugs were factors associated with institutional neurosis.

A major shift in thinking occurred in where to best treat persons with mental illnesses at this time. Gerald N. Grob of Rutgers University has authored and co-authored over thirty books on the history of mental illness in America. In his book *From Asylum to Community* (1991) and subsequent publication *Mad, Homeless and Unwanted*, (1994) he outlines six major developments that resulted in reshaping the face of psychiatry during this period:

1. There was a shift in psychiatric thinking towards emphasizing the impact of life experiences and socioenvironmental factors on both the cause and the treatment of mental illness.

2. The experiences of World War II appeared to demonstrate the efficacy of community and out-patient treatments. Persons who suffered psychological distress and illness directly related to effects of the war were effectively treated without being hospitalized. Psychiatrists moved out of mental institutions into private and community practice. They promoted the effectiveness of out-patient versus institutional care.

3. The belief that early interventions in the community could be effective in preventing further hospitalization became popular.

4. A belief developed that psychiatry could promote prevention by embarking upon the amelioration of social problems in the community that allegedly foster mental problems.

5.    The introduction of psychological and somatic therapies, such as electroconvulsive therapy (ECT) and psychotropic drugs - promised patients a more normal existence outside the mental hospitals.

6.    An enhanced social welfare role of the government in providing a network of mental health professionals working in the community, and supports such as housing programs expressly for persons with mental disabilities hastened the move to community-based care.

Bachrach (1978) defines deinstitutionalization "as a process involving two elements: the eschewal, shunning or avoidance of traditional settings (particularly state hospitals) for the care of the mentally ill, and the concurrent expansion of community-based facilities for the care of these individuals" (p. 573).

In 1955, the United States had more than a half million patients in psychiatric facilities; in 1975 there were about 191,000 left, a decrease of 66% (Bachrach, 1978; Wilson & Kneisl, 1992). The discharge of psychiatric patients from Canadian hospitals from 1955-1970 resulted in a similar 62% decrease in the institutional population (Herman & Smith, 1989; Wasylenki, Goering & MacNaughton, 1992). Described as a "bold, new approach" by President John F. Kennedy in the 1960s, deinstitutionalization has been characterized by experts in the field of psychiatry in less flattering language: "A disaster by any measure used"; "an abdication of responsibility due to shortcomings in legislation; lack of funding and the unanticipated impact of discharged clients on communities"; "a single lousy

institution to multiple wretched ones" (Wilson & Kneisl, 1992). Deinstitutionalization has been widely described as a 'back wards to back streets' phenomenon.

In this period, the provision of community mental health services found its beginnings. Legislation in Canada and the United States called for the provision of community-based services as well as an increased emphasis on primary prevention, increased support for research in the area of mental illness, improved services to specialized and high-risk populations and public education.

In Newfoundland and Labrador, an innovative program called Community Care was officially started in 1955 and grew substantially after 1962. Persons who had spent extensive time in the provincial psychiatric hospital were discharged to supervised board and care homes. These were people who still received support from mental health professionals hired by the hospital. The program was one of the first in North America and is still viable today.

In the past decade and a half there has been a 30% decrease in the province's provincial psychiatry hospital beds. Community-based services are not yet fully developed to meet the needs of the mentally ill.

## 2.4    Post-Institutional Era

The 1980's were characterized by an emphasis on biologic etiologies of diseases (Minkoff, 1987; Wilson & Kneisl, 1992). Research in the area of schizophrenia, for example, has led to a greater understanding of the disease. Ventricular enlargement, cerebral atrophy and neurotransmitter disturbances are causally implicated in this disease and treatment. Treatment methodologies now tend to be evidence-based and more individualized. This is an era in which the chronically mentally ill may never be hospitalized. With improved pharmacology to treat primary symptoms, psychosocial interventions and the pressure of consumers to be treated in the least restrictive environment, the goal of this era should be "to help each patient attain the best possible adaptation to his or her illness over the course of a lifetime" (Minkoff, 1987).

## 2.5    History of Crisis Intervention

Crisis intervention came of age in the 1960's with the community health movement although the roots of crisis intervention began in the 1930's. Three milestones in the history of crisis intervention documented by Wicks, Fine & Platt (1978) were:

1. Querido's "psychiatric first aid station",

2. Lindemann's work with people suffering from grief reaction, and

3. Military psychiatry

Querido, in the 1930's in Amsterdam, set up psychiatric first aid stations whereby practical help was offered to people in crisis rather than totally relying on traditional therapeutic methods such as psychotherapy. As an example, if unemployment was the cause of the crisis, the focus of the intervention was getting the person employed. A wide range of community resources were used to restore equilibrium. He assisted people in their own homes, coordinated efforts with social welfare agencies and worked closely with the police. Working with the police was considered an important step in that the police dealt with people under stress on a daily basis and were therefore in a position to be a first line of referral. His efforts to get people to use their own psychological resources as well as utilizing community resources were classic examples of crisis intervention methodology.

Lindemann dealt with survivors of the tragic Coconut Grove fire in Boston in 1943. From this tragedy he noticed a sequential pattern of behaviour: problems in thinking; concentration on the past; desire and initial efforts to accept the loss; finally, normal or pathological grief reaction. He concluded that it was more helpful to intervene and foster bereavement rather than to try to repress it. This change in thinking highlighted the fact that people react to stressful situations differently, and some may lose their ability to cope if the

stress is overwhelming. The importance of intervening quickly so as to help avoid delayed and prolonged reaction was Lindemann's contribution to crisis intervention methodology.

During World War II and the Korean War, soldiers were treated for what was commonly known as combat and battle fatigue. The traditional method of treatment was to take the soldier out of the combat area. Elimination of most symptoms was often immediate, however, soldiers often suffered from long term guilt over "deserting" their unit. As well, too many men were being sent home for psychological reasons causing a shortage of men on the battlefields. In response a triage system was developed. This included treating the person as close to the battle as possible, maintaining a normal routine, and supporting and encouraging the men to express anger and fear about the situation while helping the person realize that their reactions were normal and expected. The goal was to revitalize the person's self-confidence and identification with his unit without removing him from the war environment.

## 2.6    Crisis Theory

Crisis intervention methodology is integral to community mental health practice – to provide help more quickly to a greater proportion of the population in an effort to prevent longer term problems. Caplan's (1964) approach to preventative mental health includes effectively dealing with crisis periods throughout a person's lifetime. He suggests that crises

therefore present a remarkable opportunity for health professionals to greatly influence the mental health of others.

A crisis is defined by Hoff (1978 p.7), as "an overwhelmingly stressful life event(s) to which a person is unable to find a solution." Stuart and Sundeen (1991) say a crisis is "an internal disturbance caused by a stressful event or a perceived threat to self. The person's usual way of coping becomes ineffective in dealing with the threat, causing a rise in anxiety" (p.272). Puryear (1979) outlines five characteristics of a state of crisis:

1.  Symptoms of psychological and physiological anxiety; (eg.) headaches, confusion, hopelessness, bleeding ulcer. There is always extreme discomfort.

2.  Attitude of panic or defeat. Attempts at solving the problem have failed and the person feels overwhelmed, inadequate and helpless.

3.  Focus on relief. The person is primarily interested in relief of the immediate symptoms of the stress (headache, depression, etc.). There is minimal effort focussed on problem solving at this point. Relief may be sought by attempting to discharge tension, withdrawing or turning to others for help.

4.  Lowered efficiency. The person may appear to function normally but his efficiency is lowered, especially in the problem-solving efforts directed at the crisis situation.

5.  Limited duration. People cannot exist in a state of crisis longer than six weeks (Aguilera & Messick, 1986, Puryear, 1979). A state of equilibrium which is the same as higher than or lower than the person's previous functioning level is attained.

The Chinese characters representing the word "crisis" mean both danger and opportunity (Aguilera & Messick, 1986). It is a danger in that it threatens to overwhelm the person or family. It is an opportunity because during times of crisis people are more receptive to therapeutic influences. New coping mechanisms may emerge that allow the person to attain a higher level of equilibrium than before the crisis.

The goal of crisis intervention is resolution of the immediate crisis with the restoration of the individual to a pre-crisis (or higher) level of functioning (Aguilera & Messick, 1986). According to the same authors there are four steps involved in crisis intervention:

1. Assessment of the individual and his/her problem

2. Planning of therapeutic intervention

3. Intervention which includes the following:

    (a) helping the individual gain an intellectual understanding of the crisis

    (b) helping the individual bring into the open his present feelings to which he/she may not have access

    (c) exploration of coping mechanisms and concrete steps to help resolve the crisis

    (d) reopening the social world which is especially important if the crisis has been precipitated by a loss of someone significant in the person's life.

4. Resolution of the crisis and anticipating planning for future coping.

The stressors associated with living in present day society are well documented: child and spousal abuse, crime, divorce, lone parenting, unemployment and poverty to name a few. The traditional supports of extended families and close knit communities are waning and crises are accepted in our culture as routine. The proliferation of self-help groups for diverse causes, the increase in public education related to mental illnesses and life threatening medical conditions and a myriad of social supports as well as twenty-four hour hot lines are examples of community responses to life crises.

On an individual level, seeking relief from conditions or situations that threaten to overwhelm us is adaptively controlling one's destiny and essential to maintaining health (Pinderhughes, 1983).

## 2.7    Empowerment and Consumer Participation

An underlying tenet governing the operation of the Mental Health Crisis Centre is that of client empowerment. Treatment for persons with mental health problems has traditionally been provided by mental health professionals trained in clinical diagnosis and treatment. The individual assumed a passive role which often led to feelings of powerlessness, loss of dignity and loss of self-esteem. This process was exacerbated by the stigma and discrimination against persons with mental health problems, which further

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prevented these individuals from demonstrating that they could actively contribute to their own health in meaningful ways. With growing consumer empowerment, there is an increased impetus to confront long held beliefs about mental illness (Wilson, 1996). Poverty, homelessness, limited social supports and lack of community acceptance are generic to persons with long term mental illness. The premise of consumer empowerment is that consumers want to be seen and supported as "valued members of the community as persons with abilities, potential and success" (Whyte, 1995, as cited in Wilson, 1996, p.73).

"There is an increasing recognition that consumers of services have the right to self-determination both individually and collectively, and that knowledge that comes from direct experience of mental health problems is vital to the provision of appropriate and effective mental health services" (Vandergang, 1996, p.153). "Client empowerment is a fundamental strategy for improving the effectiveness and responsiveness of human service organizations" (Hasenfeld & Chesler, 1989, p.501).

While social scientists do not all agree on the meaning of the term empowerment, many agree that it is both a process and a goal. The process of empowerment focuses on gaining mastery over one's affairs. Rappaport (1987) defines it not only as an individual psychological construct, but as an organizational, political, sociological, economic and spiritual one. "There is built into the term, a quality of the *relationship* between a person and his/her community, environment or something outside oneself" ( p. 129).

"Empower" is defined by Webster's New World Dictionary of the American Language (Guralnik, 1984, p 459): "to give power or authority to, to authorize, to give ability to, enable, permit". Empowerment refers to society's relationship to the individual and to the role that individual performs in society, as well as to one individual's role to another. (Freund, 1993). Empowerment, according to Rappaport (1987) may exist on three highly interactive levels: personal level, small group level and community level. Lord (1989) clarifies consumer participation at three different levels. The individual or service level actively involves the consumer in deciding treatment options and services. The second level involves the consumer in the agencies and organizations which provide mental heath services and may mean participation on committees, boards and in the day-to-day running of the organization. The third level involves consumers at the community, provincial and national policy and decision-making level. Each level of empowerment and consumer participation complements the other. Lord and Hutchinson (1993) suggest there are underlying assumptions to the concept of empowerment:

1.  individuals are assumed to understand their own needs better than anyone else and should have the power to act on them

2.  all people have strengths upon which they can build

3.  empowerment is a life-long endeavour

4.  personal knowledge and experience are valid and useful in coping effectively.

Lord (1989) suggests that the process of becoming empowered often begins in response to an external occurrence such as a crisis. The availability of practical support and resources, the presence of mentors, and the feeling that one is valued were found to be critical elements of the process.

The philsophy of empowerment is integral to a proactive approach to health. A new concept of mental health is emerging which also recognizes the major influences of the environmental factors. The World Health Organization's (WHO) most recent definition of health is:

> *The ability to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities* (Shah, 1994, p.3).

In the Health and Welfare Canada publication, *Mental Health for Canadians: Striking a Balance* (1988) a definition of mental health states:

> *Mental Health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the*

*achievement of individual and collective goals consistent with justice and the*

*attainment and preservation of conditions of fundamental equality p.(7).*

These socio-ecological definitions recognize the inextricable link between an individual and his/her environment. Satisfying interpersonal relationships embedded in a social network (Wilson, 1996) and safe, affordable housing (Stroul, 1989) are but two determinants of health. The Canadian Mental Health Association's *"A New Framework for Support"* (1993) outlines a Community Resource Base Model for persons with mental health problems. The model is based on primary resources of housing, income, education and work. The model suggests that action is required in the following two areas:

1.  Finding new ways of allocating financial resources for mental health.

2.  Finding new ways of distributing power and influence within the mental health system. When planning mental health services, consumers are of paramount importance in determining the parameters of the service.

To effect these changes, the framework suggests three basic elements are necessary:

1.  There must be a direct investment in the capacities of consumers and families to help themselves.

2.  Service systems need to be reformed to be more effective.

3.  It is necessary to provide opportunities for real work and education by developing strategies for accommodating people with mental illnesses.

In the mental health literature, the concepts of empowerment and consumerism are intimately linked. The groundswell of support for changes in the traditional mental health

system is coming from consumers themselves. Where, historically, persons with mental illnesses were unseen, unheard, and shepherded away from mainstream society, they are now moving to gain control over treatment choices.

## 2.8    Psychiatric Emergency Services

Since the deinstitutionalization movement of the 1960's and 70's, community based services have not grown in proportion to the demand. The majority of funding is still allocated to institutions for the treatment of mental illness (Report of the St. John's Metro Area Mental Health Services Committee, 1993; Renshaw, 1994). However, there is a commitment from the institutional sector to reallocate funds to develop community services. The opening of the Mental Health Crisis Centre is proof of the commitment; the provincial psychiatric hospital dedicated the majority of the financial and human resources required to operationalize the Centre.

The number and range of psychiatric emergency services are growing (Wellin, Slesinger and Hollister, 1987). The following is a brief summary of the types of services reviewed by Neville and Maddigan (1991) in the determination of potential components of psychiatric emergency services for the St. John's area.

1. *Residential Crisis Homes*. Montreal's Transition Communutative and Vancouver's Venture have non-hospital based crisis residential services staffed twenty-four hours a day with a maximum stay of up to one month (Frigo, 1988). Massachussett's Mental Health Centre has a time-limited residential crisis service open 24 hours a day and is part of a day hospital (Doherty, Mandersor & Carter-Ake, 1987).

2. *Hospital-based Crisis Beds*. Massachusetts Mental Health Centre's ICU has 30 beds for people who require 24 hour observation and intensive care. Once stabilized, they are returned to the day hospital for further treatment (Doherty, Manderson & Carter-Ake, 1987). Palo Alto Veteran Affairs Medical Centre is a brief admission program operating 24 hours a day, Monday to Friday (Bryson, Naqui, Callahan & Fontenot, 1990).

3. *Mobile Crisis Teams*. The Greater Vancouver Mental Health Emergency Service (MHES) is a mobile emergency service staffed by a nurse and a police officer seven nights a week from 5 p.m. - 3 a.m.. Montreal's Transition Communutative has a mobile crisis team staffed by paraprofessionals who go to the scene of the crisis and have access to housing and follow-up resources. Amsterdam's 24 hour mobile crisis intervention service is staffed by intern psychiatrists with back up by experienced on-call psychiatrists 24 hours a day (Reding & Raphelson, 1995).

4. *Available Professionals*. Assessment of persons who present with psychiatric disabilities in a general hospital emergency room is the primary function of these professionals (Borges, Summers, Karshmer, 1995; McIndoe, Harwood, Olmstead, 1994). The services range from one psychiatric nurse assigned to the emergency room on a rotational basis to the provision of mental health teams (usually a psychiatrist, psychiatric nurse and social worker).

5. *The Gerstein Crisis Centre*. This Mental Health Crisis Centre located in Toronto is staffed by consumers who have an academic background in the helping professions. It operates in the downtown area 24 hours a day, seven days a week. It has a mobile response team and short term stay beds (Frigo, 1988).

In June, 1995, the Mental Health Crisis Services Task Force submitted a report to Health and Community Services - St. John's Region and the Health Care Corporation of St. John's. The report identified the following parameters for a Mental Health Crisis Centre: twenty-four hour service, non-medical in nature, telephone and in-person intervention,

community-based in a safe, comfortable environment. Attaching the services to existing hospital services was rejected because of the stigma associated with institutional care and consumers' wish to have a dedicated community-based service. The Gerstein Centre model, staffed exclusively by consumers, was felt to be hard to duplicate in this province as there are a limited number of consumers with an academic background in the health professions (Interim Report, IHRD, 1997). However, the Task Force proposed that qualified consumers be considered for upcoming staff positions at the Centre.

## 2.9    The Importance of Evaluation

Evaluation is a vital and often mandated component of newly developed programs (Lebow, 1982). However, it is often neglected and programs continue despite lack of evidence of their positive contribution to health status (Brekke & Test, 1987; Johnson & Olesenski, 1995; Munro, 1983; Pyke & Lowe, 1996).

Approaches to evaluation include accreditation models, decision making models, system oriented models (Johnson & Olesenski,1995) organizational models, care process models, consumer evaluation models, efficacy models and community impact models (Lebow,1982).

Evaluations may be summative or formative. Formative evaluations focus on evaluating programs as they are being developed and implemented for the purposes of improvement, whereas summative evaluations are conducted once programs have been fully implemented to form the basis for decision making regarding final adoption and future funding (Forchuk & Voorberg, 1991).

Evaluation is important in improving health services. Quality of care and informed decision making (Donabedian, 1982; 1985; Johnson & Olesenski, 1995; Melum & Senoris, 1992), as well as appropriate resource allocation (Holdsworth & Guy, 1994) and cost containment (Johnson & Olesenski, 1995; Maynard & Bloor, 1995) are important considerations in health care.

In an era of increasing inflation and decreasing government spending on health care (Lorefice & Boris, 1984), the pressing need for evaluation is clear (Faulkner, Cutler & Middleton, 1982). Efficacy, the potential of a treatment under controlled or experimental conditions, and effectiveness, the results obtained in ordinary clinical practice are often difficult to ascertain, particularly in the area of mental health (Ruggeri & Tansella, 1995). Studies have shown that community-based treatment modalities are more cost effective and much better tolerated by patients and families (Bengelsdorf, Church, Kaye, Orlowski & Alden, 1993; Creed, Mbaye, Lancashire, Towenson, Williams & Holme, 1997; Ruggeri &

Tansella, 1995). Outcome measures, including client satisfaction, are important indications of the quality of care in the field of mental health (Donabedian; 1982; 1985).

## 2.10    What is Client Satisfaction?

The word "satisfaction", as a noun is defined by Webster's New World Dictionary 1984 (Guralnik, p. 1265) as: "anything that brings gratification, pleasure or contentment"... .The word "satisfactory" as an adjective is defined as: "good enough to fulfil a need, wish, requirement". Human satisfaction is a complex phenomenon involving life style, past experiences, future expectations and individual and societal values (Carr-Hill, 1992).

Lebow (1983) suggests defining patient satisfaction to include perceived adequacy of the treatment, accessibility, satisfaction with process and outcome of care, complaints or praise of treatment, and suggestions for improvement of care. Hall and Dornan (1988) in a meta-analysis of 221 patient satisfaction studies found that attributes commonly used to measure satisfaction were, in order of importance: overall quality, humaneness, technical competence, outcome, facilities, continuity of care, informativeness, cost, and attention to psychosocial problems. A study by Hardy and West (1994) found that satisfaction was related to patients' perceptions of quality of care, their satisfaction with their own health, and their level of well-being including their sense of control and feelings of anxiety. These and

other authors attest to the multi-dimensional nature of patient satisfaction and the challenges of elucidating a theory of patient satisfaction.

## 2.11   Why Measure Client Satisfaction?

The last decade has witnessed the growth of patient satisfaction research in the health care industry (Avis, Bond & Arthur, 1995; Cleary & McNeil. 1988; Elbreck & Fecteau. 1990; Linder-Pelz, 1982; Williams, 1994). This interest is based on a belief that patients are an essential source of data on service functioning and therefore have a right to input when planning and evaluating services. As well, other authors argue that satisfaction with care is an important influence in seeking medical advice, in compliance with treatment and in maintaining continuing relations with the practitioner (Carr-Hill 1992; Hildeman & Fergsuson. 1990: Linder-Pelz. 1982).

Patient satisfaction is viewed as an indicator of quality care (Cleary & McNeil. 1988: Donabedian, 1982; 1985; Johnson. 1996; Luther. 1996). When a health care agency focuses on consumer/patient satisfaction as an outcome of care, it helps counteract professional dominance by emphasizing the importance of the patient's perspective (Carr-Hill, 1992). Involving the public (the patient) in evaluating care provides opportunities to disseminate information about the service and create goodwill. Successfully canvassing the public for

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financial support is one positive result. The possibility of lawsuits is also reduced when staff understand and act on patients' perceptions (Campbell & Christopher, 1991).

The link between the consumer movement of the 70's and 80's and the growth of patient satisfaction research goes beyond the accountability of those providing service to a more fundamental right of citizen participation in health care (Kieffer, 1984). "In the context of consumerism, patients/consumers educate providers of health care as well as receive education from them" (Guzman, Sliepcevich, Lacey, Vitello, Matten, Woehlke & Wright, 1988, p. 226). Consumer involvement in decision-making about their treatment is seen as beneficial both from a provider and a consumer viewpoint.

## 2.12   Conceptual and Methodological Concerns in Measuring Patient Satisfaction

While many authors herald patient satisfaction as the ultimate validator of quality care, (Cleary & McNeil, 1988, Donabedian, 1982; 1985; Guzman, Sliepcevich, Lacey, Vitello, Matten, Woehlke & Wright, 1988; Hildeman & Ferguson, 1990;) others debate its usefulness. Avis, Bond & Aruthur (1995), Carr-Hill (1992) and Williams (1994) question what patients actually mean when they say that are 'satisfied'. As well, they argue that we need a clearer understanding of *how* patients evaluate their care to better interpret satisfaction survey results. Lebow (1983) identifies problems with measures used to assess satisfaction

such as ambiguity and oversimplification of response alternatives, failure to sufficiently probe and failure to include consumers in scale development.

Patient satisfaction surveys usually report high levels of satisfaction. Avis, Bond & Arthur (1995) suggest that this is often due to inherent weaknesses in such surveys, social desirability bias and a reluctance to express negative opinions.

Recent research is focussed on better articulating the concept of satisfaction (Fitzpatrick, 1991) as well as improving the measures of patient satisfaction (Elbreck & Fecteau, 1990). Satisfaction survey results are often a key determinant in continuing specific programs or adopting programs in new locations (Lebow, 1983). The strength of client satisfaction surveys lies in providing opportunity for consumer feedback, allowing patients to express their values (Carr-Hill, 1992; Hsieh & Kagle, 1991; Lebow, 1983; Perreault, Rogers, Leichner & Sabourin, 1996).

# CHAPTER 3

## METHODOLOGY

*"the (staff) kept me grounded,...started me on the right track"*

*Crisis Centre Client*

This chapter outlines the setting, definition of a mental health crisis and services offered by the Centre. Ethical considerations, the study design, development of the questionnaire, sample size, selection of participants, training of contact persons and analysis and reporting of results are also described in this chapter.

## 3.1    Crisis Centre Setting

*Location*

The Mental Health Crisis Centre, located in a city of approximately 150,000 people, opened its doors in June 1996 as the only such centre in Atlantic Canada. It is located near the downtown area of the province's capital city. It is a 24 hour, seven day-a week mental health crisis intervention service for persons of all ages. Clients refer themselves either in person or by telephone. The services are voluntary, confidential, non-medical and free-of-charge.

*Environment*

The two-storied physical structure of the service is wheel-chair accessible to the first floor level. It has separate, comfortable intervention rooms, a fully equipped kitchen, bathroom and bedrooms, and a large common living room. A smoking area is provided. The building resembles an older home, is located near one of the city hospitals and is

unobtrusively but clearly identified as the Mental Health Crisis Centre. The service ultimately implemented is a composite of some of the models of psychiatric emergency services and will be described in detail in the next sections.

*Security*

The building is locked at all times to ensure safety and security of staff and clients. Entry is gained by pressing a bell. There are emergency buzzers strategically placed within the building and linked directly to the police station. All staff have specialized training in intervening in threatening situations.

*Human Resources*

The Centre is staffed with a mix of professionals and para-professionals. The manager of the Centre is also the Community Mental Health Coordinator with a regional Health and Community Services board. Community mental health services are the mandate of this board. One half of the manager's time is dedicated to the Centre. Nine professionals, with backgrounds in health and social sciences, staff the centre twenty-four hours, seven days a week. In addition, trained volunteers are also present and are primarily responsible for responding to telephone crises.

Staff and volunteers are selected for their knowledge of mental health/illness, their ability to make independent decisions, display a non-judgmental attitude and validate the

experience of the person in crisis while intervening calmly and effectively. These skills are seen to be more important than having professional training in one of the health professions. Other important qualifications are the ability to quickly establish rapport and mutually agreeable goals, the ability to negotiate, broker and advocate on behalf of clients, and having a knowledge of the mental health system and how to access services.

*Development*

Planning for the Centre began in 1994, two years prior to its opening. A Mental Health Crisis Services Task Force determined its purpose through twelve public consultations with consumers and service providers. General citizens in the area of the Centre's location were also consulted in the planning phase. The consultative process identified the following needs: twenty-four hour a day telephone and walk-in services as well as a mobile crisis response team available seven days a week. The telephone and walk-in service have been established; the mobile team has been deferred.

*Philosophy*

The philosophy of the Centre is stated as:

"...committed to promoting the maintenance of good mental health by supporting individuals through mental health crisis. We encourage staff and clients to work together to identify needs and to agree upon a way in which these needs can be addressed. We accept each crisis as legitimate and we respect the individuality,

dignity, ability and autonomy of the people who use our service (A Model for the Operation

of a Mental Health Crises Service in the St. John's Region, June, 1995).

*Eligible Clients*

The proposed model targeted service to persons of all ages who sought help for a

mental health crisis, except the following:

a) Individual under investigation for child maltreatment
b) Psychogeriatric clients in long term care facilities
c) Individuals who have overdosed
d) Individuals under court ordered remands to determine psychiatric fitness to stand trial
e) Individuals who display aggressive behaviour
f) Intoxicated persons
g) Other individual situations as defined by the staff of the service.


## 3.2    Definition of a Mental Health Crisis

The Centre defines a crisis as any situation or change in an individual's life which

makes him or her unable to cope. It is a fluid concept in that the person may have been able

to deal with the situation yesterday, but not today.

Client empowerment is integral to the definition in that the crisis is defined as such

by the individual or family. If the client says it is a crisis, the staff respect that it is and assist

the person through the situation in a safe, non-judgmental environment.

The person in crisis must be willing to deal with the issues that are causing the crisis. A problem solving approach is used. Staff assist the person to generate as many helpful options as possible. The more options generated the more likely resolution will occur. (Personal communication, Karen McGrath, May 10, 1997).

## 3.3    Services of the Mental Health Crisis Centre

*In Person Crisis Intervention*

The service provides time-limited intervention to persons in mental health crises. Triage, intervention and discharge may be up to a maximum of seventy two hours per crisis episode. Two beds are available for persons who need to stay overnight for intervention. Ensuring that clients are linked to appropriate follow-up services is an important element of the service.

*Telephone Crisis Intervention*

Trained, crisis volunteers operate the seven day-a-week crisis line between 8 a.m. and 12 midnight. Paid staff resource the crisis line between 12 midnight and 8 a.m.. The mandate is to help callers effectively address their immediate problems. The centre has maintained an average of thirty volunteers on its roster at any one time.

*Mobile Crisis Response*

A mobile unit was viewed as a desirable element of the service. However, due to resource implications, it is not implemented at this stage. Discussions with the Chief of Police to set up a service similar to Car 87 in Vancouver have begun. Car 87 is a police car staffed with a plain-clothes police officer and a professional mental health service worker or nurse. They respond to psychiatric emergencies wherever they occur in the community. In support of mobile crisis teams, Bengeldorf and Alden, (1987), say that "the most effective emergency psychiatric treatment takes place before the patient ever reaches the hospital" (p. 663).

The proposal for a Crisis Centre and the Centre's eventual opening can be credited in large part to the voices of many consumers in the mental health system who were dissatisfied with the lack of community services available to them and became actively involved in the design and implementation of the service.

## 3.4    Ethical Considerations

Research involving human participants requires that high ethical standards guide the research, particularly in the sensitive area of mental health research. A number of safeguards were implemented prior to, during, and after completion of the research.

Prior to the start of the research, the investigator held meetings with the Chief Executive Officer, Health and Community Services, and subsequently with the Manager of the Mental Health Crisis Centre. The nature and scope of the research proposal were explained and permission for the research to be conducted was granted. The proposal was reviewed by the Human Investigation Committee (HIC) of the Faculty of Medicine, Memorial University of Newfoundland (Appendix A), the ethics review body for research conducted by faculty, staff and students of the medical school. Approval from HIC was granted (Appendix B). A series of meetings were held with the Centre's Manager and the agency conducting other parts of the Centre's evaluation to discuss the specific areas of consumer satisfaction that were being investigated in the thesis research and to avoid overlap with other evaluation components.

Prior to providing the researcher with the client list, the names of clients in exclusion categories were deleted from the list by Computer Systems Personnel. Only eligible participant names were given to the researcher as the initial contact list.

The Medical Research Council of Canada *Guidelines on Research Involving Human Subjects (1987)* suggest: "The cardinal principle of research on human subjects is that, to the extent that it is possible, a subject's involvement should be informed and voluntary. Ideally, subjects should be informed, and should make their decision on whether to participate at leisure and complete freedom from any pressure" (p. 21). Thus, in an effort to protect the

clients' privacy and right to refuse contact by the investigator, the Centre's volunteers were enlisted to make the first contact. When research involves human participants, the first contact should be by persons they know to be directly associated with the agency or organization. The Medical Research Council guidelines are very clear on this point: "The ordinary ethical requirement of confidentiality is reinforced by two principles of research: a) patients should not be approached by strangers who know their medical circumstances, b) the management of patients should not be influenced by their decision not to participate (p.37). Volunteers asked potential participants whether the investigator could call them to explain the study in detail and to obtain permission to be interviewed. Therefore, potential participants had two opportunities to refuse to participate - first, by not allowing the investigator to call and, second, by refusing to participate in the interview when the investigator made contact.

When completed, paper copies of interviews were kept in locked storage. Data were entered in an EPI INFO program (Epi Info Version 6.04A 1996) by the investigator and accessed by a password known only to the investigator.

Participants were offered a summary of results at the completion of the study.

*Summary of safeguards to protect the privacy of participant:*

1.  Permission to obtain access to the client list was sought and received from the Manager of the Crisis Centre.

2.  Clients in exclusion categories were deleted by Centre computer systems personnel prior to receiving the list.

3.  First contact of potential participants was made by volunteers of the Crisis Centre.

4.  Verbal informed consent was obtained by volunteers for the researcher to call and explain the research and obtain consent to be contacted by investigator.

5.  The investigator explained the research and obtained verbal consent to be interviewed. Participants were advised that they could end the interview at any time.

6.  Paper copies of completed questionnaires were kept in locked storage, computer access was safeguarded by an access code known only to the researcher.

## 3.5 Design Of The Study

The study is a cross sectional descriptive study, using two separate groups of participants at two different points in time. Potential survey participants were contacted by telephone by volunteers of the Centre for permission for the investigator to contact them. When permission was given, the investigator then called each potential participant, explained the research and obtained the participant's verbal permission for the interview.

The questionnaire was designed to obtain information on eleven variables. Five of the variables, namely age, sex, type of living arrangement, category of intervention, and how often participants availed of the services of the centre were obtained from client files with the express permission of participants.

The other six variables – awareness of the centre, comfortableness of the centre, satisfaction with help received, assistance in developing a plan, supports and services used in the past and suggestions for other services were variables on which information was sought during the interviews. Norman & Streiner (1994) suggest that "the number of data (patients, subjects, students) should be a minimum of 5 or 10 times the number of variables entered into the equation..." (p. 116). The final sample size was set at one hundred and ten, allowing for ten times the number of variables.

### 3.7 Proposed Selection Process with Revisions

The original proposal suggested three stages of data collection. In the first stage, a total of 50 randomized participants (25 in-person visits and 25 telephone calls) was to be interviewed in March and in stage two, reinterviewed in August, 1997, with 50 new randomized participants (25 in persons and 25 telephone calls) added at that time. In November, 1997, stage three, the participants from March and August would all be re-interviewed. The total number of interviews would be 250 interviews of 100 participants. The intent of re-interviewing one group of participants was to ascertain whether there was a long term positive effect from crisis counselling. As well, comparing general satisfaction in the early stages of the Centre's opening with satisfaction after a year of operation was believed to be worthwhile.

A look at the preliminary list of numbers of eligible participants provided a cautionary note with respect to the feasibility of, first, obtaining required numbers of participants, and, second, being able to contact those participants for re-interviews. Of the 1211 clients on the original list in the first phase only 420 remained after the exclusions requested by the researcher. Furthermore, a consultation with Dr. Veeresh Gadag, a biostatistician at the Faculty of Community Medicine (personal communication, April 16, 1997), led to further discussion regarding the relatively short time span between the data collection phases particularly the March to August interval; he felt that attempting to

correlate differences between satisfaction levels over such short intervals was questionable. Thus, in consultation with the researcher's thesis supervisor and the manager of the Mental Health Crisis Centre the proposal was revised from three to two points of data collection using separate groups of clients: the second data collection would take place among clients seen first after close to twelve months of full operation of the Centre.

The potentially accessible population were all 1759 clients who used the services of the Mental Health Crisis Centre between June 17, 1996 and August 31, 1997, the complete study period. Because 26.6% of the 105 people in the final sample both called and visited the Crisis Centre, these 28 participants were categorized as a call or a visit based on the last point of contact with the Centre, i.e. if the last contact was a telephone contact and the person had made a previous in-person (walk-in) contact, the participant was categorized as a telephone contact.

*Exclusions*

The following categories of clients were excluded:

1. Persons who called or visited the Centre because of violence
2. Minors (defined as persons under 16 years old)
3. Frequent Users (defined as persons who made 40 calls or 10 visits between June 17, 1996 and April 1, 1997, or 56 calls or 14 visits between April 12, 1997 and August 31, 1997.
4. Professional Calls (defined as calls from health professionals and police).

Persons who visited for reasons of family violence were excluded because of the extremely sensitive nature of the crisis and the danger of inadvertently breaching client confidentiality. A concern of the investigator was that the perpetrator of the violence might not know that the client contacted the Centre for services and could be present when either a volunteer or the investigator called. This could make it difficult or impossible for the participant to reply to the questions, and worse, could cause another episode of violence.

Minors under sixteen years were excluded based on confidentiality. Parents or guardians may not have known that the adolescent was in contact with the Centre with a mental health concern. The 16 to 19 year old group was included as 'mature minors'. As the law regarding consent is not exclusively reliant on age, persons in this age group were presumed to have the maturity to decide whether or not to participate in a research study.

Frequent users, defined as persons who contacted the Centre via telephone more than forty times or visited more than ten times between June 17, 1996 and April 1, 1997, respectively, were excluded. This definition was prorated for Phase II (April 2 to August 31, 1997) of the data collection; a frequent user for that phase was defined as a person who visited more than 14 times or called more than 56 times as of August 31, 1997. The definition of frequent users was developed with the assistance of the Manager of the Centre. There were 14 frequent users who accounted for 1449 of the calls and 115 of the visits during

the study period. The frequent users were excluded because they were a part of the larger evaluation being done by the Institute for Human Resource Development.

Professional calls were excluded. These were calls made by persons such as mental health professionals, hospital emergency staff or police to ask for information about Centre services or to inform the Centre that a client was being referred for services. Professional calls were identified by names recognized as colleagues in the field of mental health and were sometimes designated in the files as 'Information Calls'. Sixty-three professional calls were excluded. It is possible that some persons identified and therefore excluded as "professional" may have been using the Centre as clients, especially if the call was not designated as an Information Call. However, in an effort to be consistent, all known professionals currently working in the mental health field were excluded.

Clients for whom there was no name or telephone number on file were obvious exclusions because they could not be contacted.

Some people were excluded for multiple reasons. Table I gives the numbers in exclusion categories and overlaps.

TABLE I
Number of Excluded Contacts

| 1759 Clients | Total | No Phone | No Name | Violence | Minor | Freq. User | Professional |
|---|---|---|---|---|---|---|---|
| Total | 1873 | | | | | | |
| No Phone | 1169 | 1169 | | | | | |
| No Name | 433 | 407 | 433 | | | | |
| Violence | 156 | 87 | 33 | 156 | | | |
| Minor | 38 | 25 | 11 | 6 | 38 | | |
| Freq. User | 14 | 9 | 2 | 5 | 1 | 14 | |
| Professional | 63 | 0 | 0 | 0 | 0 | 0 | 63 |

After exclusions, 420 persons remained in Phase I and 101 in Phase II, for a total of 521 potential participants from which to draw the sample for the whole study. This list (n = 420 in Phase I and n = 101 in Phase II) was randomized using the ACCESS computer program (Access. 1996). However, with the substantial numbers of exclusions and persons unable to be contacted, ultimately all 111 clients of the Centre during the study period who could be contacted for consent to participate were included in the study.

## 3.8    Design of the Questionnaire

An extensive literature review on questionnaire development was undertaken prior to the development of the questionnaire. Texts by Hulley and Cummings (1988) and Polit and Hungler (1988) offer explicit principles governing questionnaire design and usage.

Methodological considerations in patient satisfaction (Lebow, 1983), discussions of a conceptual framework of patient satisfaction (Fitzpatrick & Hopkins, 1983), basic issues in questionnaire design and analysis (Ferber, Sheatsley, Turner & Waksberg, 1980; Fitzpatrick, 1991), and complexities of patient satisfaction surveys (Carr-Hill, 1992), were reviewed prior to the development of the instrument used to collect data for this study.

Client satisfaction questionnaires by Ware, Snyder and Wright (1976), the Barrett-Lennard Scale (Barrett-Lennard, 1962), and multi-dimensional descriptions of reactions to treatment, The Therapy Session Report (Orlinsky and Howard, 1975) were reviewed. Client satisfaction questionnaires evaluating mental health in-patient services (Hutchens, 1990), as well as the client satisfaction questionnaire evaluating the Gerstein Centre, a mental health crisis centre in Toronto, were also reviewed. Using the above named literature and her own experience in the mental health field, forty questions were developed by the investigator. The questionnaire was discussed with the manager of the Crisis Centre, representatives of the consultant agency, and the investigator's thesis supervisor to ensure comprehensiveness and to avoid duplication with the consulting agency's evaluation. The script incorporated a combination of qualitative and quantitative questions. The questionnaire was divided into five sections: Demographics, Crisis Centre Experience, Outcome of Crisis, Supports/Services used in the Past and Questions/Comments Section. A five point Likert scale was used. Answers ranged from (1) not satisfied/helpful (2) somewhat satisfied/helpful (3) neutral, (4) satisfied/helpful, (5) very satisfied/helpful. A series of open-ended questions provided an

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opportunity to clients to offer opinions, expound on their responses and offer suggestions (Appendix C).

The telephone script developed for volunteers who would make first contact (Appendix D) was pretested in volunteer training sessions. The questionnaire was pretested by the investigator on six mental health professionals as well as six consumers of mental health services known not to be clients of the Crisis Centre. Adjustments in wording and reordering of the questions resulted from the pilot testing. Section I, Demographics, required the collection of data from client files. As mentioned previously, this information was obtained from the files, where available, with the express permission of participants who were asked for their consent to access records at the beginning of the interview.

## 3.9    Training of Volunteers as Contact Persons

Prior to the recruitment of participants, an inservice session was prepared for the volunteers by the researcher entitled "Obtaining Consent to be Contacted" (Appendix E). A booklet outlined the purpose and content of the study, the background of the questionnaire and the importance of the volunteers' role in the study. The volunteers practiced the telephone script in small groups, suggested revisions and then practiced in pairs prior to being assigned two 'test' calls. The test calls were made to University faculty and staff or

colleagues of the investigator. The calls were completed over a two-day time frame. The test call respondents supplied feedback to the investigator on such things as voice tone, inflection and understanding the purpose of the call (Appendix F). All feedback was positive with suggestions of minor revisions in the script to allow for an easier conversational flow. Each volunteer was then given a list of names and telephone numbers of potential participants, telephone scripts and response sheets (Appendix G). Four separate inservice sessions were conducted for four different volunteer groups throughout the data collection process. The time frame for volunteer training, completion of calls and returning the responses to the researcher was 12 days. Appendix H outlines the design timeline, a listing of the events leading up to administration of the questionnaire. Prior to the investigator conducting the survey, volunteers of the Crisis Centre, using a standard script called each randomly selected potential participant to obtain consent for the investigator to call.

## 3.10  Efforts to Reduce Bias

To determine content or face validity, the interview questions were discussed with the thesis supervisor, manager of the Crisis Centre, and consultants from the agency performing other aspects of the evaluation. The questionnaire was also reviewed by colleagues in the mental health field. Test interviews were done by the investigator with both mental health professionals and consumers of mental health services. In each case, test participants were

asked for feedback on wording, ordering and clarity of questions. Feedback was incorporated into the final version of the questionnaire.

A standard script (Appendix I) was used by the investigator to introduce and explain the study to potential participants and to obtain consent. The questionnaire was administered to all participants by a single person, the investigator. The number of interviews was limited to a maximum of ten a day. Short breaks were taken between calls to reduce fatigue and the possibility of confusing one interview with another. Respondents' voice tone and clarity of responses were noted by the investigator as indicators of capacity to respond to the questions.

Social desirability bias – the tendency of individuals to give answers that are socially acceptable and not necessarily representative of how they feel is known to occur in studies eliciting satisfaction with services. Efforts to minimize this bias included informing the participants that the investigator was an independent evaluator i.e. not a staff member of the centre, in an effort to reduce the level of anxiety about criticizing the direct provider of the service. Responses to open-ended questions gave an opportunity to compare closed-ended responses.

### 3.11 Analysis and Reporting of Results

Data were entered into EPI INFO 6.04A (1996). Frequencies and proportions of responses were produced by individual variable and by cross tabulations of major categories of variables. Response four and five (helpful/satisfied, very helpful/very satisfied) were combined for the final analysis of Likert scale questions. Responses to open-ended questions were grouped by content category – services used previously, factors that were helpful and not helpful, suggestions and comments. A representative sample of responses was incorporated into the results section.

# CHAPTER 4

## RESULTS

*"Their (staff) tone of voice, language and kindness*

*validated my experience,*

*allowed me to open up and discuss my issues"*

<div align="right">

*Crisis Centre Client*

</div>

### 4.1 Number of Available Participants and Response Rates

The Crisis Centre opened its doors on June 17, 1996. Fifteen months after its opening, by August 31, 1997, the Centre had received 4,892 calls and 1,008 visits for a total of 5900 contacts (1759 clients). The first phase of data collection relied on clients who had used the service up to April 1, 1997. The second phase involved clients who used services of the Centre between April 2, 1997 and August 31, 1997; clients who had been contacted in Phase I were excluded in Phase II avoid to calling the same person twice.

*Available Participants: Phase I Part I*

The sampling frame in Phase I consisted of 420 people. Three hundred and thirty-four people were unable to be contacted due mainly to telephone numbers no longer in service. Of the 86 contacted by volunteers, ten refused permission for the investigator to call. Of the 76 who gave permission to be called by the investigator, one person refused to be interviewed. In the less than five days between the first contact by the volunteer 13 persons who had given verbal permission to the volunteer were unable to be re-contacted by the investigator as their telephones were no longer in service. Sixty-two were interviewed at this time, 32 individuals who had made telephone contact and 30 individuals who had presented themselves in person to the Centre.

*Available Participants: Phase I Part II*

The numbers obtained in Phase I met the minimum sampling requirements. However, the researcher was attempting to obtain the maximum requirements. In conjunction with the thesis supervisor and IHRD, it was decided to try to obtain telephone numbers for those clients for whom this information was missing. A request for telephone numbers was submitted to the consultants of IHRD, who had access to the OMNIFAX computer program; OMNIFAX is an on-line telephone directory of all published telephone numbers in the province. The source of the list was not identified. The original list was returned to IHRD who returned it to the researcher. Sixty-one telephone numbers were retrieved for the 1169 persons on the list (Table I). Twenty-five were able to be contacted by Centre volunteers and 20 persons agreed to be interviewed. The other 36 were incorrect telephone numbers or reported by telephone company as no longer in service. Of the 20 people who had given permission to be contacted, the investigator was successful in interviewing 15 people (Table III). Over a two week interview period five telephone numbers had been listed as no longer in service. After both parts of Phase I of data collection, 77 participants had been interviewed which included these 15 and the original 62 interviews.

*Available Participants: Phase II*

The sampling frame in Phase II of the study consisted of 101 potential participants. Interviews were done in September, 1997. Fifty-four people were unable to be contacted by volunteers mainly because telephone numbers were listed as no longer in service. The

remaining 47 were asked for permission to be contacted by the investigator; 43 agreed. Fourteen of the 43 could not be contacted by the investigator because telephone numbers were listed as no longer in service and there was no answer at one home despite calling in excess of twenty-five times over a two-week time span. Twenty-eight were interviewed by the investigator. There were no refusals in this phase.

Table II outlines a summary of the data collection process. This process is fully outlined in Appendix J.

**TABLE II**
**Summary of Data Collection Process**

| PHASE I          June 17, 1996-April 1, 1997 | |
|---|---|
| Number of clients between June 17, 1996 and April 1, 1997 | 1211 |
| Sampling frame after exclusions | 420 |
| Total number interviewed by investigator | 77 |
| PHASE II          April 2, 1997 -August 31, 1997 | |
| Number of clients between April 2, 1997 - August 31, 1997 | 548 |
| Sampling frame after exclusions | 101 |
| Total number interviewed by investigator | 28 |
| TOTAL NUMBERS FROM PHASE I & II | 105 |

*Response Rates*

This study involved a two phase consent process. In the first stage of consent, of the 111 people contacted by volunteers in Phase I, 96 agreed to be contacted by the investigator (86%). Of the 47 contacted by the volunteers in Phase II, 43 agreed to be contacted by the investigator (91.4%).

Second stage consent was obtained by the investigator. In Phase I, 77 of the 96 persons who agreed to be contacted were interviewed, a response rate of 80.2%. Twenty-eight of the 43 persons who consented to be contacted were interviewed in Phase II (65%). It is important to note that of those persons giving first stage consent who were able to be contacted by the investigator 99.5% completed the interview.

Table III outlines the actual data collection time frame.

***TABLE III***
*Data Collection Time Periods and Number of In-person/Telephone Clients*

| PHASE I | | PHASE II |
|---|---|---|
| **April, 1997** | **June, 1997** | **September, 1997** |
| n = 62 | n = 15 | n = 28 |
| 30 in person clients | 7 in person clients | 10 in person clients |
| 32 telephone clients | 8 telephone clients | 18 telephone clients |

## 4.2 Demographic Characteristics

The ratio of females to males in the sample was 2.5:1 (76 and 29 respectively). Information on demographic variables was not available for all participants. For example, 14 of the records gave no age, and 49 gave no data on living accommodations. The age group most frequently using the Centre was the 40–49 year olds (24%) followed closely by the 20-29 and 50-64 year old group (23%). Females were represented in these age groups in a 4.5:1 and 6:1 ratio respectively. Table IV outlines Centre use by age and sex for the 91 participants for whom this information was available. Appendix K gives detailed demographic characteristics of participants.

*TABLE IV*
*Crisis Centre Use by Age and Sex*

| Sex | 16-19 | 20-29 | 30-39 | 40-49 | 50-64 | 65> | Total |
|---|---|---|---|---|---|---|---|
| | n | n | n | n | n | n | |
| Female | 5 | 14 | 11 | 18 | 18 | - | 66 |
| Male | 2 | 7 | 8 | 4 | 3 | 1 | 25 |
| Total | 7 | 21 | 19 | 22 | 21 | 1 | 91 |

Table V outlines marital status by age and sex. The majority of participants were single, female and in the 40-49 age group.

**TABLE V**
*Marital Status by Age and Sex*

| Marital Status | | | | | | |
|---|---|---|---|---|---|---|
| Age | Sex | Common-Law | Divorced | Married | Single | Widow | Total |
| | | n | n | n | n | n | |
| 16-19 | f | – | – | – | 4 | – | 4 |
| | m | – | – | – | 2 | – | 2 |
| 20-29 | f | 1 | 1 | 3 | 7 | – | 12 |
| | m | – | – | – | 7 | – | 7 |
| 30-39 | f | 1 | 3 | 3 | 2 | – | 9 |
| | m | 2 | – | 2 | 3 | – | 7 |
| 40-49 | f | – | 4 | 5 | 7 | 1 | 17 |
| | m | – | 1 | 2 | 1 | – | 4 |
| 50-64 | f | – | 6 | 7 | – | 3 | 16 |
| | m | – | – | 1 | 1 | – | 2 |
| 65> | f | – | – | – | – | 1 | 1 |
| | m | – | – | – | – | – | 0 |
| Total | | 4 | 15 | 23 | 34 | 5 | 81 |

The majority of people lived in rented accommodations, 40.4% (n=52), followed by living with parents (27%). Fifty-seven percent (n =7) of the 16-19 year olds indicated that they lived with parents. Table VI outlines living arrangements by age and sex.

**TABLE VI**
*Living Arrangements by Age and Sex*

| Living Arrangements | sex | 16-19 | 20-29 | 30-39 | 40-49 | 50-64 | 65> | Total |
|---|---|---|---|---|---|---|---|---|
| boarding home | f | – | – | – | 1 | – | – | 1 |
| | m | – | – | – | – | – | – | 0 |
| group-home | f | – | – | – | – | – | – | 0 |
| | m | – | 1 | – | – | – | – | 1 |
| other | f | – | – | – | 1 | – | – | 1 |
| | m | 1 | – | – | – | – | – | 1 |
| own home | f | – | 1 | 2 | 2 | 6 | – | 11 |
| | m | – | – | – | 1 | 1 | – | 2 |
| living with parents | f | 3 | 3 | – | 1 | – | – | 7 |
| | m | 1 | 5 | 1 | – | – | – | 7 |
| rent | f | – | 2 | 4 | 4 | 5 | – | 15 |
| | m | – | – | 5 | 1 | – | – | 6 |
| Total | | 5 | 12 | 12 | 11 | 12 | 0 | 52 |

Geographic location was determined by telephone exchange numbers. Eighty-eight percent (n = 81) lived in St. John's; the majority were female and in the 30-39 age group.

Table VII shows geographic location by age and sex.

**TABLE VII**
*Geographic Location by Age and Sex*

| Geographic Location | | | | |
|---|---|---|---|---|
| Age | Sex | St. John's | Outside St. John's | |
| | | n | n | Total |
| 16-19 | f | – | – | 0 |
| | m | – | – | 0 |
| 20-29 | f | 11 | 2 | 13 |
| | m | 7 | – | 7 |
| 30-39 | f | 12 | 3 | 15 |
| | m | 6 | 2 | 8 |
| 40-49 | f | 13 | 1 | 14 |
| | m | 6 | 1 | 7 |
| 50-64 | f | 10 | 1 | 11 |
| | m | 5 | – | 5 |
| 65> | f | 1 | – | 1 |
| | m | – | – | 0 |
| TOTAL | | 71 | 10 | 81 |

## 4.3    Category of Contacts and Reasons for Calls and Visits

Tables VIII represents the categories of client contacts. Twenty-six percent (28 participants) had both a call and visit contact. For analysis purposes, the interview was coded on last point of contact, thus of the 28, 15 were coded as calls and 13 as visits.

**TABLE VIII**
**Category of Client Contacts**

| Contacts N = 105 | n | Percent |
|---|---|---|
| Number of clients who called | 58 | 55.2% |
| Number of clients who visited | 47 | 44.8% |
| Total | 105 | 100% |
| | | |
| Number who both called & visited | 28 | 26.6% |

Table IX gives the frequency of primary crisis codes by age and sex. Crisis codes were developed by a sub-committee of the Implementation Committee of the Mental Health Crisis Centre. Members of the sub-committee had clinical expertise and experience in mental health emergencies. A computerized data base of the Centre was developed for the crisis Centre to accommodate up to five crisis codes for each contact with the first code being the main reason (primary code) for contact. The second to fifth codes were problems that contributed to the primary reason for contacting the Centre. For example, a person may have

had a primary coding of addictions with a secondary coding of financial problems, a third coding of employment concerns and a fourth of family problems. Ninety percent and seventy percent of telephone and visit clients, respectively, had second and third crisis codes. Family crisis was the highest second code at 19.6%, parenting and suicidal thoughts were the two highest third codes at 16 % each.

Mental illness was the highest primary code for 15% of the participants. Most people with this code were female and distributed in age from 30 years onward. The next highest crisis code was addictions at 13%. This crisis code was distributed fairly equally among both sexes and ages including the 16-19 age group. Relationship (family) was the primary crisis code for 12% of participants. Family crisis was responsible for 10.5% of codes. Combined, these two similar codes, relationship (family) and family crisis were responsible for the majority of crisis experience by participants (22.5%). More females than males used the Centre for these two family crisis codes, at a ratio of 5.3:1.

The frequencies of crisis codes are found in Appendix L.

### TABLE IX
### Centre Primary Crisis Codes by Age and Sex

| Crisis Code | Sex | Age | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|
| | | 16–19 | 20–29 | 30–39 | 40–49 | 50–64 | 65> | |
| | | n | n | n | n | n | n | |
| Addictions | f | 1 | 2 | 1 | – | 3 | – | 7 |
| | m | 1 | 1 | 1 | – | – | 1 | 4 |
| Adolescent Issues | f | – | 1 | 1 | 1 | 1 | – | 4 |
| | m | – | – | – | – | – | – | 0 |
| Bereavement/Loss | f | – | – | 1 | 1 | 2 | – | 4 |
| | m | – | ~ | ~ | – | 1 | – | 1 |
| Family Crisis | f | – | 1 | 1 | 1 | 5 | – | 8 |
| | m | – | 1 | – | – | – | – | 1 |
| Financial | f | – | 1 | – | – | – | – | 1 |
| | m | – | – | – | – | – | – | 0 |
| Health | f | – | 1 | – | 1 | – | – | 2 |
| | m | – | – | – | 1 | 1 | – | 2 |
| Housing | f | – | – | – | – | – | – | 0 |
| | m | – | – | – | – | 1 | – | 1 |
| Isolation/loneliness | f | – | – | – | 3 | – | – | 3 |
| | m | – | – | – | – | – | – | 0 |
| Legal | f | – | – | – | – | – | – | 0 |
| | m | – | 1 | – | – | – | – | 1 |
| Mental Illness | f | – | – | 2 | 3 | 3 | – | 8 |
| | m | – | 1 | 4 | – | – | – | 5 |
| Non-Crisis | f | 1 | 1 | – | – | – | – | 2 |
| | m | – | 1 | – | – | 1 | – | 2 |
| Other | f | – | 2 | – | – | – | – | 2 |
| | m | – | – | 1 | – | – | – | 1 |
| Parenting | f | – | 1 | – | 3 | – | – | 4 |
| | m | – | – | – | – | – | – | 0 |
| Relationships (family) | f | 1 | 1 | 1 | 2 | 3 | – | 8 |
| | m | 1 | – | – | 1 | – | – | 2 |
| Relationships (other) | f | 1 | 1 | – | 1 | 1 | – | 4 |
| | m | – | 1 | 1 | – | – | – | 2 |
| Survivor Issues | f | – | – | 2 | 1 | – | – | 3 |
| | m | – | 1 | – | – | – | – | 1 |
| Suicidal thoughts | f | – | 1 | 1 | – | – | – | 2 |
| | m | – | – | – | 1 | – | – | 1 |
| TOTAL | | 6 | 20 | 17 | 21 | 21 | 1 | 86 |

## 4.4    Satisfaction with Physical Attributes of the Crisis Centre

Although 47 persons were categorized as "in-person clients" and 58 persons as "telephone clients" by their last contact, 28 of the total number of participants had at some time both visited and called the Centre. Eighty-six percent of those who responded found the geographic location accessible. Ninety four percent of these clients experienced no waiting time and were seen immediately by a crisis intervener. Eighty-eight percent of persons who visited found the environment of the Centre comfortable. Ninety-four percent of those who contacted the Centre by telephone found access easy. The range of values for those satisfied with physical attributes was from 86.4% to 94.1%. (See Table X).

**TABLE X**
**Satisfaction with Physical Attributes of the Crisis Centre**

| Criteria | n | Percent Satisfied |
|----------|------|-------------------|
| Location Accessibility | 66 | 86.4% |
| Waiting Time | 68 | 94.1 % |
| Comfortableness of Environment | 68 | 88.3% |
| Telephone Accessibility | 65 | 93.8% |

## 4.5    Satisfaction with Help Received at the Crisis Centre

Table XI compares satisfaction levels by sex, age group and marital status. More females were satisfied than males, 91% versus 79% respectively; overall 85% were satisfied. Fewer married men (66.7%) were satisfied; within this group no one reported complete

resolution of the crisis situation although 80% reported partial resolution. Two were in age groups 30-39 and 40-49 respectively; one person was in the 50-59 age category. Crisis codes assigned to this group were: employment (1); health (2), mental illness (1), and suicidal thoughts (1); one person was not assigned a code. Overall, a higher proportion of middle and older age groups were satisfied than younger age groups.

**TABLE XI**
**Comparison of Satisfaction Levels By Age, Sex and Marital Status**

| Sex | n | Percent Satisfied |
|---|---|---|
| Female | 69 | 91.3% |
| Male | 28 | 78.6% |
| Males and Females | 97 | 84.9% |
| **Age        n = 85** | | |
| 16-19 | 6 | 83.4 % |
| 20-29 | 21 | 85.7% |
| 30-39 | 17 | 76.5% |
| 40-49 | 20 | 95% |
| 50-64 | 20 | 85% |
| 65> | 1 | 100% |
| **Marital Status      n = 82** | | |
| Common-Law | 4 | 100% |
| Divorced | 15 | 91.3% |
| Married | 23 | 93.3% |
| Single | 35 | 82.8% |
| Widowed | 5 | 100% |

## 4.6    Satisfaction by Crisis Codes

The majority of respondents were satisfied regardless of the kind of crisis which brought them to the Centre. (Table XII). Those clients coded to the categories of relationship (other), adolescent issues and survivor issues were less satisfied. Of the people who had had previous experience with the Centre, 76% said that their last experience(s) was typical of other experience(s) at the Centre.

**TABLE XII**
**Comparison Of Levels Of Satisfaction By Crisis Code**

| CRISIS CODE | n | Percent Satisfied |
|---|---|---|
| Addictions | 14 | 78.6% |
| Adolescent Issues | 4 | 75% |
| Bereavement/Loss | 4 | 100% |
| Employment | 1 | 100% |
| Family Crisis | 11 | 90.9% |
| Financial | 2 | 100% |
| Health | 4 | 100% |
| Housing | 1 | 100% |
| Isolation/Loneliness | 3 | 83.3% |
| Legal Issues | 1 | 100% |
| Mental Illness | 12 | 100% |
| Non-Crisis | 5 | 100% |
| Other | 3 | 100% |
| Parenting | 4 | 100% |
| Relationship (family) | 11 | 90.9% |
| Relationship (other) | 5 | 60% |
| Survivor Issues | 4 | 75% |
| Suicide Thoughts | 2 | 100% |

## 4.7    Satisfaction with Interpersonal Dimensions of Care

Most clients, 93%, (n = 99) were satisfied that their privacy and confidentiality were protected and that they had been understood (n =97).

When people make contact with the Centre for crisis intervention as many options as feasible to resolve the crisis are generated by the client with the help of the crisis intervenor. The option(s) most likely to be followed is worked through and becomes "the plan" to help resolve the crisis. A positive relationship was evident between assistance in developing a plan and the helpfulness of the plan in dealing with the crisis. Eighty-one percent of the clients (n = 97) were helped in developing a plan. Eighty-seven percent of this group said that, in retrospect, the plan they were helped to develop was an appropriate plan (n = 88).

Table XIII compares the interpersonal dimensions of care and levels of satisfaction.

**TABLE XIII**
**Interpersonal Dimensions Of Care And Level Of Satisfaction**

| DIMENSION | n | PERCENT SATISFIED |
|---|---|---|
| Privacy/Confidentiality protected | 99 | 93% |
| Felt understood | 97 | 93% |
| Helped to develop a plan | 97 | 81% |
| Helpfulness of plan | 88 | 87% |

### 4.8    Resolution of Crises

Participants were asked about resolution of their crisis. Eighteen percent of participants who responded to this question (n = 99) indicated that their immediate crisis was now completely resolved and 54% said that it was partially resolved. Thirteen percent indicated no resolution of the situation which precipitated their crisis and 15% said they didn't know whether the crisis was resolved or not. Of the 19% who did not feel helped in developing a plan, there was no one who reported partial or complete resolution of the crisis.

Table XIV outlines percentages of clients who experienced complete, partial or no resolution of crisis, as well as those who said they did not know whether their crisis was resolved or not.

*TABLE XIV*

*Resolution of Crises*

| RESULTS | n | Percent |
|---|---|---|
| Completely resolved | 99 | 18% |
| Partially resolved | 99 | 54% |
| Don't know | 99 | 15% |
| Not at all resolved | 99 | 13% |

The following are a sample of client responses to open-ended questions.

*"I was listened to in an emphatic, compassionate way, and given the opportunity to speak."*

*"I wasn't treated like a nut-case".*

<div align="right">*Crisis Centre Clients*</div>

Most responses to the question of feeling understood were positive, with ninety-four percent responding affirmatively to the question.

The notion of being understood was exhibited in statements like:

*"clarified and reiterated what I was saying."*

*"sympathetic,"*

*"gave me hope and perspective."*

*"compassionate, listened well,"*

*"They seemed to know what I was going through,"*

*"They didn't offer advice,"*

*"let me make my own conclusions."*

Persons who did not feel understood eloquently voiced their perspectives:

*"...told me what was best for me and what to say"..*

*"I felt diminished after - it prevented me from seeking further help".*

*"They misjudged the seriousness of the situation, they didn't tune into how sick I really was."*

Sixty-nine percent attributed their ability to cope with their problem to the help they received at the Centre.

The most consistently positive attribute of the plan for 72% of people was appropriate referral to mental health services professionals, groups or agencies. This included, but was not limited to referral to psychiatry, case management, grief counselling, pastoral care, employment and financial counselling. This referral to other resources was considered a real strength of the Centre. Other helpful aspects of individual plans according to clients were:

*"I received validation and support".*

*"...helped me realize my strengths."*

*"education about the interactions between drugs and alcohol."*

*"The step-by-step guide was helpful in leading me through a confused and chaotic time."*

*"The visit helped me organize things in my mind, got me thinking about helping myself."*

*"options were presented, I had input..."*

The positive comments reflected staff's validation and support of clients. Threaded throughout the comments was the underlying theme of empowerment:

*"helped me help myself"*

*"didn't try to solve my problems for me..."*

*"let me come to my own conclusions".*

When hospitalization was necessary for one client, staff accompanied the client. This was viewed to be humane and caring. Giving clients a listening ear, treating clients like normal people were aspects of the interpersonal relationships that were reported to be beneficial. It appears that people are satisfied when treated with respect and dignity and allowed input into decisions that are made concerning their health.

## 4.9    Factors Clients would have found More Helpful

Responses to the question *"What would have been more helpful"* were categorized under the following headings: information needs, follow-up, sociodemographic factors and interpersonal factors. Some people wanted information on their specific condition or issue. Pamphlets and videos were requested but not available. A number of people (n=38) indicated that they would have been further helped if the Crisis Centre staff did follow-up and longer

term counselling. They had developed a comfortable rapport with the staff, had "told their story", and felt abandoned when they weren't able to avail of follow-up services from Centre staff. Several people (n=24) requested an intervener of the same sex but could not be accommodated. This had a negative impact on the course of the intervention. *"Someone closer to my age"* was a common theme in what would have been more helpful (n = 20). Comments pertaining to interpersonal issues ranged from needing to be taken more seriously and not wanting to be rushed off the phone to wanting more sincerity and caring by the staff.

## 4.10 Previous Sources of Help and Client Perceptions of Alternatives to the Crisis Centre

When asked whether they had experienced a previous crisis nearly two-thirds (60%) of participants responded in the affirmative. Sixty-three percent of these had sought help at a hospital emergency department at that time. Sixty-five percent indicated that the services at the Centre were more helpful than services they had received elsewhere. Clients were asked where they would seek help if the Crisis Centre was not available. The majority of people would have gone to a hospital emergency department if the Crisis Centre was non-existent. Some comments provided real insight into the differences between being helped at the Crisis Centre versus an emergency department. *"At an emergency department you're shoved in a back room and made to wait for hours,"* one respondent said. Another complaint expressed by a client was *"All they can do for you is give you pills, they don't have the time*

*to listen"*. The literature attests to validity of these statements. Long waiting times for psychiatric patients, long mental health interviews, and dealing with unmanageable behaviour of patients were common complaints of both staff and patients in emergency rooms. Long term planning to address this mental health problem is inadequate, resulting in an ongoing cycle of return visits.

# CHAPTER 5

## DISCUSSION

*"The staff were professional but human,*

*they didn't judge me, helped me work through my own solution"*

*Crisis Centre Client*

Factors associated with satisfaction with health care include patients sociodemographic characteristics, physical and psychological status, attitudes and expectations concerning health care as well as the process, structure and outcome of care (Cleary & McNeil, 1988). The results of these dimensions studied will be discussed in the following sections.

As well as actual experience with health care services, the expectations of service is a factor in satisfaction (Hsieh & Kagle, 1991). There were no questions asked in the survey to directly measure expectations. One might expect however, that in answering questions, participants expectations consciously or unconsciously weighed in their responses.

## 5.1　Limitations

There are a number of limitations that must be taken into consideration in this study. The major limitation was the number of clients who could be contacted. Unexpectedly, incomplete information in the data set severely reduced the number of persons available for the study. One hundred and five participants (6%) were interviewed for this study out of a total population of 1759 clients who made contact with the Centre during the study period. While the responses from the study group are interesting and provide useful information to the Centre, they cannot be said to represent the client population of the Centre.

The satisfaction levels of persons who could not be contacted and those in the exclusion categories were not ascertained through this research endeavour. Two of the exclusion categories were of interest but were omitted from the potential study population for reason of confidentiality and their inclusion in another component of the Centre's evaluation. The frequent user category had been of particular interest as they were a resource intensive group and their feedback could be expected to be very different from the sample of participants in the study. There were fourteen frequent users excluded by the definition used for this study. These persons generated 1449 calls and 115 visits of the total 5900 contacts, 26% of the Centre's overall utilization in the study period. This group had been included in the evaluation proposal of IHRD. Frequent users were to be given opportunity for input through focus groups; unfortunately this did not occur. According to the Institute for Human Resource Development Evaluation Report there were problems in obtaining pertinent data from the computer system as well as some staff misgivings about the focus group approach of interviewing clients. Two to three case studies of frequent users were also planned by the consultants. However because of limited staff response in identifying clients to be interviewed, only one case study was done (Second Interim Evaluation, Institute for Human Resource Development, 1997).

It was hoped that socioeconimic levels could be compared among users of the Centre. Educational level was not requested. Income range was collected on less than 20% of the client records.

The ambiguity of the crisis codes *relationship/family, relationship/other and family crisis as well as non-crisis and other* have prevented clear categorization of what brought persons to the Centre.

## 5.2    Age

Although some authors dismiss any reliable relationship between satisfaction levels and sociodemographic variables (Fox & Storms, 1981); other research suggests that age and sex are clearly associated to satisfaction with health care (Cleary & McNeil, 1988).

Age is thought to be the most significant demographic predictor of health care satisfaction (Fox & Storms, 1981). The predominant finding is that older people are more likely to be satisfied with their health care than are younger groups (Cleary & McNeil 1988; Corrigan, 1990; Hsieh & Kagle 1991; Perreault, Rogers, Leichner & Sabourin, 1996). In this study levels of satisfaction were high for all age groups. However, the groups aged 40 and over had higher levels of satisfaction overall than did the younger groups. One surmises many reasons for this; older people's expectations in all areas of life including satisfaction with health care are tempered by their life's experiences. They have probably come to the realization that instant gratification and quick fixes are not often possible. While it is difficult to clarify *why* age is a significant determinant of satisfaction, Fitzpatrick (1991) postulates

differences in expectations and the readiness of younger persons to express negative views, as well as actual differences in the quality of care received.

## 5.3 Sex

Females in the sample outweighed men by 2.5:1. This mirrors the frequency of males and females in total population of clients who availed of services of the Centre, where the ratio was 2:1. The higher frequency of female use of health services is supported in the literature. Lips (1993) suggests women tend to talk more openly about their problems, and seek professional help before men do. Men tend to stoically wait it out and seek help as a last resort.

One of the reasons women may be contacting the Centre more than men is that women may be more distressed. Mirowsky and Ross (1989) based their book *Social Causes of Psychological Distress* on findings of numerous community surveys of mental health. Reports of these studies found that women are more distressed than men. The explanation offered is the differences in the lives that men and women live. While employed women are less distressed than unemployed women, employed women are more distressed than employed men. Employment is associated with less distress among women whose husbands help; this contribution by husbands of employed women does not increase the husband's

distress. Husbands with higher education do more. They take more responsibility as the wife's earnings increase. Those whose earnings exceed the wife's take less responsibility for help in the home. It appears that economic equality in the workplace is an important factor in levels of distress in women. It is not known how many women worked or what the family income was in this study.

Females were more satisfied with health care at the Crisis Centre. This finding is supported by Hildeman & Fergsuson (1990) who find that males generally rate health services lower than do females. Cleary & McNeil (1988); Fox & Storms (1981); Perreault, Rogers, Leichner & Sabourin (1996) report similar findings. Another possible explanation is the impact of social learning. The influential conditions of gender identification and gender (sex) roles are thought to be as responsible for differences in gender response as genetics (Haas & Haas, 1993; Lips, 1993). The stereotypical behaviours assigned to females such as compliance, politeness, submissiveness and nurturing are thought to be learned from the cradle. It is therefore possible that these well-cemented attributes play a role in female response to questions of satisfaction with health services. According to social learning theory it is likely that women would err on the side of social desirability, the desire to present themselves positively (Hansburg, Nelson, Connors, Gill, Grande & Paley, 1996).

However, there were no discernible signs in the interviews that the respondents, particularly woman were telling the interviewer what she wanted to hear. Constructive, worthwhile feedback and suggestions were received from both sexes.

## 5.4    Marital Status

Somewhat fewer married men were satisfied (66.7%). The literature suggested that married persons tend to be healthier (Sherbourne & Hays, 1990), have greater longevity (Hu & Goldman 1990), have shorter lengths of hospital stay (Gordon & Rosenthal, 1995), enjoy a greater sense of well-being (Yates, Bensley, Lalonde, Lewis & Woods (1995), are more satisfied in general (Haas & Haas, 1993) and are less distressed than unmarried ones (Mirowsky & Ross, 1989). No reference could be found in the literature which discussed satisfaction with health care among married men compared to single, divorced or widowed men. It is possible that this group's overall health care outcome was perceived as less than ideal, or they may not have received the help they had anticipated.

Social supports that are inherent in the married status, as well as the functional supports that each partner gives the other, are reasons cited for marital status being a positive indicator of overall well-being and satisfaction.

<u>**5.5**</u>    <u>**Accessibility**</u>

*"I had no problem finding it, the cop took me right to the door"*

*Crisis Centre Client*

The above quotation illustrates the role of the police in dealing with persons with mental health problems and the partnership developed between the police and the Crisis Centre. The police are routinely involved in the transport of persons to hospital emergency departments and psychiatric facilities under the province's Mental Health Act. The police are often the first line of response to crisis calls to private homes and provide emergency assessment of family crisis, violence, substance abuse or altered mental states (Zealberg, Christie, Puckett, McAlhany and Durban, 1992). They also provide an informal crisis service in that police stations are often called by persons seeking help in a psychiatric emergency. This role was confirmed by several participants when they were asked about services and supports used prior to and since the opening of the Centre.

Notwithstanding the role of police in accessing services, 86% percent of people who visited found the centre easily accessible and 94% of people who called got through on the telephone without difficulty. Waiting time was non-existent for nearly all of the participants. The literature indicates that patient satisfaction is positively related to accessibility, availability and convenience of care; access being a very important determinant (Cleary and McNeil, 1988; Pascoe, 1983; Pickett, Lyons, Polonus, Seymour & Miller, 1995).

For the few people who had difficulty with telephone access, the wait was interminable. One respondent apparently waited for more than an hour before the telephone was answered. Because there was no recording, he was unsure if he had the correct number or whether the Centre was still operating. He felt a recorded message indicating that the lines were busy, etc., would have been helpful in this instance. Many people noted the lack of accessibility of the Crisis Centre telephone number. It is listed obscurely under Health & Community Services in the current telephone directory. Due to an oversight by the telephone company it was not available until this spring on the inside cover of the directory where most emergency numbers are located.


## 5.6    Satisfaction with Interpersonal Dimensions of Care

Satisfaction with interpersonal dimensions of care was ranked very high in this study. Protection of client privacy and confidentiality is an important element of health care from a consumer and a provider standpoint. It is an especially sensitive issue in the area of mental health; society is still labouring to rid itself of the stigma attached to having a mental illness. Mental illnesses or mental health problems continue to be viewed as a personality defect or a personal weakness and do not have the legitimacy of physical illness. People are often hesitant to associate themselves with receiving services; they need the reassurance of

protection of confidentiality. Satisfaction with this element of care would likely play a major role in whether clients sought services of the Centre in the future.

The vast majority of participants felt understood, attesting to the "connectedness" of the intervener in correctly identifying the person's concerns and responding appropriately.

Research in the area of interpersonal dimensions of satisfaction supports the benefits of a positive client/provider relationship; increased compliance with treatment is a major benefit. Interpersonal aspects of care are so influential that patients will keep seeing a therapist who is friendly but ineffective. Numerous studies have shown that patients are more satisfied if nurses and doctors appear to be caring and sensitive to their needs (Cleary & McNeil, 1988). Eisenthal & Lazarre (1976) found increased levels of satisfaction if patients were given opportunities to express their opinions. Sheppard (1993) reports significant differences in satisfaction levels when practitioners engage in open communication and, listen rather than closed perceived to understand. He postulates that failure to recognize the immediacy of clients' feelings is more detrimental than missing practical problems because it indicates lack of empathy, a failure to make contact with their very "self" (p. 254).

The minority of participants who did not feel understood clearly articulated why. It is obvious from statements like *"I felt like I was being tolerated"*, *"I was not taken seriously"*, *"they didn't know how to deal with my situation"*, *"they were too blunt and*

*unfriendly"* that the necessary components of a beneficial therapeutic relationship were missing for those clients.

## 5.7 Satisfaction with Help Received at the Centre

The Centre holds to a problem-solving approach in intervening in crisis situations. In 1910 John Dewy proposed the classical stages of problem solving which are still used today (Aguilera & Messick, 1986). They are:

(1)  a difficulty is felt

(2)  the difficulty is located and defined

(3)  possible solutions are suggested,

(4)  consequences are considered, and

(5)  a solution is accepted

Part of the Centre's approach is aiding in the development of a plan to assist persons through the immediate crisis. The plan includes putting steps in place to ameliorate future crises. The vast majority of people were helped by staff to develop a plan and were satisfied with it. The results indicate that help was received to deal with the immediate crisis, and the majority of participants were able to deal with the problem in the longer term because of help received at the Centre. This is very positive from any viewpoint. There is potential to prevent costly hospitalization where the client is more restricted and the cost far exceeds

community services. As well, the client is given control over his life and provided with a "success" experience in that the immediate crisis was successfully dealt with. The most helpful aspect of the plan for most people (72%) was appropriate referral to other services. Participants received much needed information on what services were available and were assisted in linking up to services. The Gerstein Centre's results were reviewed for the last four years and report similar findings regarding the helpfulness of their centre in dealing with crises (Paul Quinn, personal communication, May 4, 1998).

Principles of Crisis Intervention as outlined by Puryear (1979) were reflected in participant responses as to what was most helpful about their contact with the Centre. The first three principles of Immediate Intervention, Action and Limited Goal Setting were characterized by statements like *"They saw me right away"*, *"kept me grounded"*... . A crisis is a time of potential danger and time-limited opportunity for intervention and action. The immediacy of the situation directs a quick assessment with the client and formulation of a plan of action to avert catastrophe (Puryear, 1979). The principles of Giving Hope and Expectations and Giving Support are exemplified in statements like *"Showed me I could do things on my own to help"*, *"they were patient and understanding"*, *"they were concerned for me"*, *"reassured me."* The principle of Focussed Problem Solving, the backbone of crisis intervention, is identified in statements like *"helped me get my daughter to a hospital"*, *"helped with a step by step guide,"* *"referred me to a grief recovery group."*

The last two principles of crisis intervention, Protection of Self-Image and Preseverance of Self-Reliance are inherent in the Centre's problem-solving approach. The intervener attempts to convey by the entire approach the attitude that the client is a capable, decent person who has been temporarily overwhelmed by extreme stress; the intervener does nothing for the client that he can successfully do for himself. Client statements *"talked to me like a normal person"*, *"they were a catalyst in my seeking further help"*, *"gave me information"*, *"helped me help myself"* were indicative of this principle in action.


## 5.8    Resolution of Crises

There is a dearth of literature on long term resolution of the causes of mental health crises. Most Centres do not evaluate the importance of this aspect of crisis care. The Gerstein Centre asks: *"Did the staff give you the help you wanted in resolving the crisis?"* which pertains to help in the immediate sense, rather than overall resolution of the situation that precipitated the crisis. In this study they were specifically asked about long term resolution.

Eighteen people (18%) indicated complete resolution of their crisis (61% female, 39% male). The 18 were distributed across all age groups with more in 20-29 age group. The mental illness crisis category had the highest number of people who indicated complete resolution of their situation (5) followed by family relationship problems (4). Thus a likely

profile of persons in the sample who reported complete resolution was that of a young person with a mental illness or family relationship problem.

The finding that 18% of participants reported complete resolution provides reason for optimism. Mental health crises are often a long time in the making and a myriad of circumstances frequently make resolution very complex or at least far from simple. Poverty, child, spousal and elder abuse, inadequate housing, lack of knowledge of health care, unavailability of community and family supports, lack of education and life styles issues are some of the problems leading up to a full blown crisis. It is therefore rewarding that these participants had attained and maintained full equilibrium some time after the intervention. As well, 54% indicated that their crisis situation was at least partially resolved.

The Centre staff feel that they more successfully intervene with persons who have newly diagnosed mental illness, rather with persons who have a long-term enduring one (Karen Moores, personal communication, May 17, 1998). There continues to be a gap in service for the chronically mentally ill in this province. Mental illness was the primary crisis code for the exclusions and for the clients who were unable to be contacted because their telephone number was no longer in service.

Another gap in services that has been recognized is people between the ages of 15-21. An Adolescent Program is currently being developed by the institutional sector which is proposed to include services in the community.

As well, in a combined effort, a group from the institutional and community sectors is exploring alternatives to hospitalization for people with long term mental illness. Unfortunately, the initial intent of the Mental Health Crisis Centre to provide adequate crisis response to the chronically mentally ill has not come to full fruition. This resource intensive group who were responsible for 26% of the total Centre contacts of the study population will need continued community support. Sullivan, Bulik, Forman & Mezzich (1993) clearly state that "repeated use of emergency services is not an optimal treatment strategy: heavy users may drain staff and scarce resources, and patients' needs may not be met, increasing the risk of future repeat use" (p. 380). The crisis code for 10 of the 14 (71%) frequent users indicates a reoccurrence of mental illness. This suggests this group has extensive complex needs that may not be met by either the Crisis Centre or the services to which they were referred.

A day hospital where persons come for intensive treatment during the day but are not hospitalized allows the individual to continue living in the community. The use of crisis housing, an intensive residential rehabilitation model treating acute crises in chronically mentally ill patients, needs to be explored. The Crisis Housing Model has gained acceptance as an alternative to hospitalization. It is particularly effective in countering the strong

dependency needs of the chronic patient, which in hospital settings lead to institutionalization (Weisman, 1985). This model is less stigmatizing and less restrictive than admission to a psychiatric hospital (Stroul, 1988). Both the Gerstein Centre in Toronto and the Greater Vancouver Mental Health Service provide crisis housing services for the chronic mentally ill. The use of the overnight beds at the Mental Health Crisis Centre may have addressed a portion of this need, but these beds have not been used to capacity.


## 5.9    Recommendations

Two questions (37 and 38) of the questionnaire were designed to give participants opportunity for greater feedback. The clients were asked to give specific recommendations to the Crisis Centre and to speak to the need for other mental health services. Recommendations made by participants are listed in order of frequency of response with italicized comments by the investigator. These recommendations are divided into Improvements to Services and Expansion of Services.

The recommendations to maintain the Mental Health Crisis Centre was made by 88% of the total participants. Clients who were less satisfied with services received clearly expressed the need for crisis services even though they felt that the help they received was less than ideal. Most people were unreserved in this recommendation; they felt the Crisis

Centre was serving a worthwhile purpose. Their personal experience with the Centre was validating in that they did not feel stigmatized for having sought help and they were pleased that inroads were being made in community mental health services.

Seventy of the 105 participants suggested improvements to the existing service.

### *Improvements to Services of the Mental Health Crisis Centre*

- Increase public awareness of the existence of the Centre (81%).
  *Public service announcements on radio and television were recommended. The telephone number should be more easily accessible; listed on the front inside cover of the telephone directory. Some participants also advised a recorded message "You have reached the Crisis Centre, all lines are busy, please hold, etc."*

- Provide a non-crisis line for persons needing reassurance and support after dealing with a crisis (65%).
  *"Warm lines" are a feature of several crisis services (DeLeo, Carollo & Buono, 1995, Reid, 1977). A non-crisis line has several potential uses: information calls, non-crisis frequent user calls, calls from people who need confirmation and support, just to name a few.*

- Provide follow-up services (54%).
  *Many participants stated that follow up counselling would have been very beneficial. Short-term crisis counselling visits are a component of the Gerstein Centre and The Greater Vancouver Mental Health Services. Westchester Psychiatric Institute in Valhalla, New York has a mobile unit that responds to persons in their homes and the team schedule return visits as frequently as necessary up to a limit of eight (Bengelsdorf & Alden, 1987). Follow-up services are a feature of The Crisis Stabilization Program in Columbia, California (Ruffin, Spencer, Abel, Gaye & Miles, 1993) and The Community Crisis Intervention (CCIT) Team of Lake County, Ohio (Silver & Goldstein, 1992). In terms of follow-up counselling, some participants recommended evening and weekend sessions to accommodate persons who*

*worked during the day. Follow-up counselling to persons with persistent mental illnesses was recommended. Several participants with a mental illness diagnosis stated they had developed a rapport with a particular staff person and would have benefited by furthering a therapeutic relationship.*

- Make available same sex intervener (34%).
  *Several participants felt more comfortable if they were able to talk with an intervener who was of the same sex. Several participants had called when a same sex intervener was not available and felt less understood than previously. They attributed this to a same sex person having a better understanding of their reaction to the crisis.*

- Provide overnight stays (32%).
  *This was a recommendation by several participants who had specifically asked to stay overnight and were told that they could not. The centre has beds for the purpose of stays up to seventy-two hours. However, the policy regarding the use of the overnight beds is unclear. As well, having persons in crisis unsupervised at the Centre was felt to be a high risk issue and some staff were reluctant to have any overnight stays.*

- Obtain access to the client's hospital files (10%).
  *Several participants felt that the Crisis Centre should be able to access the client's hospital files. They viewed this as a means of verifying past episodes of illness and treatment.*

- Provide the name of the follow-up contact (5%).
  *When referred to outside agencies, having the actual name of the contact would have been helpful.*

- *Other suggestions included having more overnight beds, a hair dryer and night table.*

***Expansion of Services provided by the Mental Health Crisis Centre* (n = 70)**

- Expand the telephone service throughout the province with actual physical structures in larger geographical areas eg: (30%) Corner Brook, Grand Falls, Gander, Clarenville.
  *While the Centre has expanded its telephone services to other geographic areas, province-wide telephone accessibility is still not in place. There are no plans to open another Centre anywhere else in the province at this point in time.*

- Provide public education/awareness (48%) on:
  - menopause
  - suicide prevention
  - parenting normative as well as high risk teens
  - mental illness
  - alcoholism and drug addiction
  - anger and stress management
  - dispelling stigma of mental illnesses.

  *While not all people who indicated the need for increased education listed all the areas, most people addressed several areas of need.*

- Provide support groups (32%) for:
  - people who are lonely and socially isolated
  - people who need financial help
  - parents of adolescents

  *Ongoing support by way of support groups and follow-up counselling was clearly recommended. Commentary like "I could learn from people who have been through it", "It's comforting to know you aren't the only person who had this happen"... were often heard. This was particularly poignant in persons who suffered a recent loss and bereavement.*

- Provide mobile outreach programs for agoraphobic, depressed and suicidal persons (30%).
  *As previously indicated, mobile outreach is a component of other crisis services in Canada. This element is presently under discussion.*

- Provide crisis housing (14%)

  *In lieu of hospitalization, it was felt that this type of service would get persons out of the environment of the crisis situation and give a greater chance of looking at the situation objectively. Aligned with this suggestion was the proposal of a day hospital where persons would receive intensive counselling to assist in coping with their crisis, but would not actually be admitted to hospital with the inherent disruption that hospitalization entails.*

### *Other Mental Health Services (n = 52)*

The following are recommendations that speak to the need for increased services in the area of community mental health generally and are not directed specifically to the Crisis Centre.

- More community mental health services: crisis housing and a day hospital, social drop-in centres for depressed persons.
- Counselling services provided by social workers, nurses, psychologists should be covered by universal health coverage (eg. MCP).
- More employment programs for persons with mental illnesses. This was particularly supported by persons already availing of employment opportunities expressly designed for persons with psychiatric illnesses. They spoke eloquently of the benefits of such programs and wished there could be more of the same.
- Adolescent mental health services including a recreational drop-in centre for youth.

### *Researcher's Recommendations*

Based on the research literature and, particularly, client comments and recommendations, the researcher has recommended the following:

- Implement further research in the areas of:

(a)   telephone help versus in-person help.

Although it was not the objective of this study to determine differences in satisfaction levels between these two groups, the answer to this question has major human and fiscal implications, especially if expansion of services to other geographic locations is considered.

(b)   difference in satisfaction levels depending whether the counsellor was a volunteer or paid staff.

This is an extremely important research question in the area of crisis services. Another element of this question is whether staff or volunteers are themselves consumers of mental health services and difference in satisfaction whether they are consumers or not. The Crisis Centre had initially intended to use consumers as volunteers, however, it was not possible for the researcher to determine if any (and how many) of the volunteers were in fact consumers. The Gerstein Centre in Toronto operates on the model of hiring consumers with appropriate professional background as staff. The client satisfaction level for that agency is high. Fisher (1994) advocates this model of service delivery as the unique contributions that comes from the experience of "having been there".

These two research questions could have major impact on resource allocation. It is debatable whether it is in the interest of consumer empowerment to have consumers working as unpaid volunteers and have non-consumers as paid staff. It is imperative that the Centre fully endorse hiring qualified consumers as paid staff.

- Improve data collection and the data base of client information.

Results of care (outcomes) are particularly difficult to measure in mental health. Measurement is impossible if so many data items are missing that clients of the service cannot be categorized demographically or contacted for input. Service providers are accountable to collect as much information as possible in order that the service may be evaluated and continue to be developed to meet the changing needs of clients.

(a)   A number of clients in the sample were entered in the computer under several different identification numbers and several different spellings of their names. Inadequate data entry needs to be eliminated.

(b)     Demographic data are extremely incomplete especially for calls as opposed to visits. While it is entirely understandable that collection of demographic data is not the primary concern when a person is in crisis, the value of demographic information for purposes of research and evaluation cannot be over-emphasized.

(c)     The time of the call or visit should be recorded.
        This would be beneficial in terms of determining the busiest times and allocating human resources appropriately and would permit comparisons of volunteer/staff intervention.

(d)     The codes of *family crisis, relationships (family)* and *relationships (other)* are often used synonymously as well as the codes of *other, non-crisis* and *not applicable.*
        Some staff cannot differentiate when to use one of these codes as opposed to the others. Clearer definitions of these codes are needed. Educational sessions on crisis coding is essential for staff and volunteers.

- Develop criteria for each crisis code.
  The list of crisis codes was developed by an expert group. However, no criteria exist to assist with determining correct coding. Staff allocate the crisis code based on how they hear what the client tells them. This is very subjective and dependent upon how forthcoming the client is in articulating the crisis as well as the expertise of staff in extracting the crux of the matter. Specific criteria would be helpful in reducing subjectivity and variable coding.

- Explore the possibility of a client exit interview.
  Given the difficulty in reaching this population for evaluative purposes, a short exit interview for both in-person visits and call-ins would give some feedback on appropriateness and helpfulness of the service.

- Review the crisis codes at regular intervals and at least yearly to determine applicability.

- Clarify the policy on the use of overnight beds.
  There appears to be confusion on the part of clients as to how the overnight beds are used. Clear direction needs to be articulated in this area.

<u>5.10</u>    **Conclusions**

This descriptive study measured client satisfaction with services at a community-based mental health crisis centre during its first year of operation. Missing demographic data, data necessary for contact and exclusions greatly reduced the numbers of potential participants in the study. Data on file were very incomplete. Telephone numbers no longer in service were another drawback to contacting potential participants. In spite of these challenges, 105 participants were interviewed via telephone using a forty item questionnaire. Most clients in the study were satisfied and satisfaction levels in all areas were high.

The Crisis Centre has used some of the results of this research as well as results of an evaluation of other components of the Centre to successfully secure future government funding for the operation of the Centre.

Participants outlined recommendations for improved services at the Centre as well as for mental health services generally. Two research questions arising out of this study were formulated. In order to adequately study this group, an essential component for development of resources to address their needs, basic information needs to be collected and entered in the data base. Improving the data base is imperative for evaluating services and for supporting research which could contribute to improvement of community mental health services.

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**APPENDIX A**

**MEMORIAL UNIVERSITY OF NEWFOUNDLAND - FACULTY OF MEDICINE**

<u>HUMAN INVESTIGATION COMMITTEE - APPLICATION FORM</u>

This form is designed to cover as large a variety of proposals as possible: not all questions will apply to all projects;
however, please consider each question carefully before writing it off as "Not Applicable".

**<u>Please type your answers</u>**. If the space provided is not adequate and it is necessary to add further information, please submit this in **<u>single spaced typing</u>**, indicating clearly to which question the addition refers.

**\*\*YOU ARE ASKED TO FORWARD 13 COPIES OF APPLICATIONS AND CONSENT FORMS WHEN SUBMITTING TO THE COMMITTEE. ADD 3 ADDITIONAL COPIES PER HOSPITAL INVOLVEMENT.\*\***

1.  Name of Principal Investigator:  **Mary Dwyer**

    Mailing Address/Telephone No.:  **83 Beacon Hill Crescent, St. John's, NF, A1E 4S6**

2.  Name(s) of Co-Investigator(s): _____

3.  Name of supervisor, if Principal Investigator is a student:  **Dr. S. Buehler**

4.  Title of investigation:  (**<u>PLEASE HI-LIGHT KEY WORDS</u>**)

    *Client satisfaction* with *Services* delivered in a *non-medical mental health crisis centre* during its *first year* of operation

5.  What is the proposed starting date? (Must be <u>at least</u> 4 weeks later than date of receipt of this application by the H.I.C. Office.)

    **March 1997**

6.   What is the anticipated date of completion of the study?

| November 1997 |
| --- |

7.   Please fill in the appropriate information:

| Hospital/Community Setting Involved | Involves Patients / Residents | Involves Records | Involves Facilities | Submitted to Participating Hospital Ethics Committees |
| --- | --- | --- | --- | --- |
| Mental Health Crisis Centre | Yes | Yes | Crisis Centre | |

.   This application may be forwarded to participating institutions if requested.

8.   State, briefly, the objectives of the investigation:

> The crisis centre was established as a community service for those who find themselves in a mental health crisis; the crisis is defined by the client and not by mental health personnel. The goal of the Mental Health Crisis Centre and Crisis Line is to triage and intervene in mental health crisis situations.  The Centre opened in June 1996 as an 18-month pilot project between Community Health – St. John's Region, the Health Care Corporation of St. John's and the Department of Health. Following the pilot project, an outcome and process evaluation will determine if the Centre will continue.  (See attached brochure.)
>
> *As part of the overall* evaluation, **THE OBJECTIVE OF THIS STUDY is to** determine client satisfaction with services received at the Centre, whether these services were received via telephone or in person.  The client satisfaction survey is considered to be a vital component of the overall evaluation which was contracted to the Institute of Human Resource Development, (IHRD), a St. John's consulting firm which was awarded the contract to evaluate the Centre.
>
> * The student (investigator) is not a member of the staff of IHRD, however, has been granted permission by Community Health and IHRD to perform this particular component of the overall evaluation.

9.  What is the scientific background and rationale for the study? What benefits may be anticipated? Have any relevant human or animal studies already been conducted? Please specify. (Attach another sheet of paper, if required.)

> ▸ **Evaluation of services has been largely ignored in the area of psychiatric care. In the restructuring of health care it is imperative that we evaluate services. Ruggeri & Tansella (1995), Maynard & Bloor (1995).**
> ▸ **The lack of knowledge of the efficacy of psychiatric interventions has been outlined by Wright, G., Herman, J.R., Shupe, J., Olvera, G. (1989), Jenkins (1990), Mirin (1991), Attkisson, C., Cook, J., Karno (1992).**
> ▸ **The effectiveness of care needs to be evaluated from the client perspective - traditionally only clinicians have been involved in evaluation of services. Persons receiving services need to have a say in the development and implementation and evaluation of mental health services (Carter, Crosby,**
>
> ▸ **The concept of non-hospital, non-medical psychiatric intervention is relatively new, and we are charged with developing more effective and efficient methods of care, our first responsibility lies to the consumers of that care; it is imperative that we, as health professionals, involve them in the whole process, from development to evaluation (personal communication, Karen McGrath, Director of the Mental Health Crisis Centre, January 1997.**
> ▸ **Since the inception of the Crisis Centre in June 1996, as an alternative to hospital-based care, an evaluation scheme had been proposed. Client satisfaction has been deemed to be an important component of the evaluation framework, and the researcher will work closely with IHRD with this project. Of the half-dozen community based crisis services currently existing in Canada, none have been evaluated to date.**

10. Which of the following are to be employed in the investigation? List only those that are NOT part of normal patient care.

(a) Samples to be taken from subjects: State type of sample, frequency and amount.

N/A

(b) List the procedures and any tests or substances to be administered to patients: special diets, drugs (state dose and frequency), isotopic tracers, etc.

N/A

(c) Questionnaires: Attach copy of questionnaire to be used.

(d) Is this application for a clinical trial?                    ( ) Yes    (✓) No

If yes, what "phase" of the trial does this study represent?  What is the design of the trial (e.g. open, double blind, etc.)?

N/A

11.    Does the study involve the use of any radioactive material?    ( ) Yes    (✓) No
       If yes, specify.          N/A

       **A positive response to this question will be communicated to the Radiation Control Committee.**

12.    Give a brief description of the design of the study.  (Please also attach <u>one</u> copy of a protocol if available.)  This should include details of subject selection, sample size calculation (if applicable), outcome measurement and details of analysis.

**This is a descriptive study involving 100 clients of the Mental Health Crisis Centre.  The study will be carried out using telephone surveys of 25 clients who presented to the Centre in person and 25 clients who telephoned the Centre for help. (Phase I, March 1997).  The group (50 people in total) will be re-surveyed via telephone in five (5) months.  Fifty additional clients will be interviewed so that comparisons can be made with the first fifty participants in terms of differences/improvements in perceptions of satisfaction. (Phase II, August, 1997).  In November, 1997, (Phase III) the hundred clients from Phases I and II will be re-interviewed to determine longer term effectiveness of services provided.**

**Prior to the investigator contacting potential participants, personnel of the Mental Health Crisis Centre will call the randomly selected sample to apprise them of the study and to ask if they are willing to be contacted by the investigator.  If verbal consent is obtained by the investigator, a questionnaire will be administered by telephone.**

**Data Collection Time Frame:**

| | | | |
|---|---|---|---|
| Phase I | March 1997 – 9 months after Centre opened | 25 telephone interviews of persons who presented in person plus 25 telephone interviews of persons who telephoned for help | N = 50 |
| Phase II | August 1997 – 14 months after Centre opened | re-interview the 50 participants from Phase I; add an additional 50, {25 who presented in person and 25 who telephoned for help} | N = 100 |
| Phase III | November 1997 – 17 months after Centre opened | re-interview all participants from Phase I and Phase II | N = 100 |

---

Total: N = 250 interviews (100 participants))

Please Note: In consultation with IHRD and the Director of Mental Health Crisis Centre, Phase III was added after my first submission to HIC.

In the data analysis comparisons will be made between participants who presented to the centre in person and those who telephoned for help. The participants will all be re-interviewed in an effort to determine whether the lapsed amount of time made any difference to their perception of satisfaction. Comparisons will also be made by broad category of crisis, (i.e., addictions, financial crisis, bereavement/loss, family violence), by broad categories of age (young, middle and old), and by two or three categories of socioeconomic status and by "inside St. John's Metro" versus "outside St. John's."

---

| 13. | Number of subjects: 100 | Will pregnant women be excluded? No | State how subjects will be selected. Random selection of participants from lists of clients who availed of services at the Crisis Centre. |
|---|---|---|---|

14.  Number of controls:  State how they will be selected.

N/A

15.  What are (a) risks, (b) discomforts or (c) inconveniences are involved?

a.  **risks:** There is minimal, but potential risk of upsetting the participant by revisiting the experience of availing of the services of the Centre. The interviewer is a nurse with specialized training in psychiatry and would be sensitive to and would make appropriate referral if any (unexpected) untoward response were forthcoming. When contacted by crisis personnel, clients would be made aware that they will be asked questions about referral and made aware that they could refuse to answer questions.

b.  **discomforts:** No.

c.  **inconveniences:** The time required to respond to the questionnaire.

16.  Are there any immediate benefits arising out of the study for the subjects? (Specify)

In the experience of the investigator, persons with mental health concerns appreciate opportunities for input of their opinions.

17.  What steps will be taken to preserve confidentiality?

The only list of participants and phone numbers will be kept in locked storage. There will be no personal identification on the questionnaires. Any other identifiable data will be kept in locked storage.

18.  Explain procedure for obtaining consent.

Who will make the initial contact with the subject?

Personnel from the Mental Health Crisis Centre will telephone randomly selected participants to apprise them of the study and ask if they would be willing to be contacted by the investigator. Please seen Appendix "C" for script for Mental Health Crisis Centre personnel to contact participants.

Who will obtain the consent of the subject?

> **If participants are willing to be contacted by investigator, verbal consent will be sought at the time of the initial phone call from the investigator. Consent will be sought again at the time of the re-interview. See Appendix "D" for script for investigator obtaining consent.**
>
> *The consent signed by participants/clients who visited the Centre is not considered by the investigator to be sufficient for the purposes of this research project.*

Please provide 13 hard copies of the consent form as well as 1 soft copy either on 3 1/2" or 5 1/4" diskette.

19.  Will subjects include minors  **potentially**  (✓) Yes  ( ) No

    mentally incompetent persons  ( ) Yes  (✓) No

    legally incompetent persons  ( ) Yes  (✓) No

If so, what steps will be taken to protect their rights?  **Researcher will get verbal consent prior to asking any questions as well as stressing that participation is entirely voluntary.**

20.  What mechanism will there be for debriefing or feedback to subjects?

> ▸    **Summary of results will be offered to participants.**
> ▸    **Results will be presented to Crisis Centre Staff, Consultants and Internal Evaluation Committee.**
> ▸    **Results will be incorporated into the report of the IHRD Consultants Report.**

21.  (a)  Will volunteers receive reimbursement for expenses  ( ) Yes  (✓) No

            time lost from work  **N/A**  ( ) Yes  (✓) No

            payment for participation in the study?  ( ) Yes  (✓) No

\*\*  Please specify on separate sheet according to Guidelines for the Remuneration of Research Subjects.

    (b)  Will there be any third party remuneration for referral of patients?  ( ) Yes  (✓) No

**  AVAILABLE IN THE OFFICE OF RESEARCH & GRADUATE STUDIES (MEDICINE)**

22.    Please enclose a copy of the budget for this study, including an indication of source of funding.

Will the budget be administered through the University Finance Office?

( ) Yes    ( ) No

If no, specify.        **Attached Appendix D**

23.    Will the investigator accrue any benefits by virtue of participation
in this study?                                                        ( ) Yes    (✓) No

24.    Is this part of a multi-centre study?                          ( ) Yes    (✓) No

25.    Will data become the exclusive property of a pharmaceutical company or other outside agency? If yes, please elaborate.                         ( ) Yes    (✓) No

26.    It is the responsibility of the investigator to ensure that permission is obtained from clinicians, departments, institutions or communities whose patients/residents will be involved in the study.  Have the appropriate contacts been made?

> **Ms. Brenda Fitzgerald, Chief Executive Officer, Community Health - St. John's Region, and Ms. Karen McGrath have been contacted and are aware and supportive of the research proposal in this area.  Meetings with Ms. Karen McGrath and Rick Morris of IHRD were held to discuss major content areas of the study. The Institute of Human Resource Development personnel who have been hired to carry out a larger scale evaluation are supportive of this endeavour: A series of meetings will be held with this group over the course of study.**

26.    Have you read "Guidelines on Research Involving Human
Subjects" (MRC. 1987)                                             (✓) Yes    ( ) No

Date of submission:              **March 3, 1997**

Signature of principal investigator:        _____

Signature of supervisor, in case of student application: _____

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**APPENDIX B**

# Memorial
## University of Newfoundland

Office of Research and Graduate Studies (Medicine)
Faculty of Medicine
The Health Sciences Centre

1997 03 31

**Reference #96.191**

Ms. Mary Dwyer
83 Beacon Hill Crescent
St. John's, NF
A1E 4S6
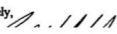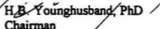
Dear Ms. Dwyer:

This will acknowledge receipt of your correspondence dated **March 2, 1997**, wherein you clarify issues and provide a revised application and questionnaire for the research application entitled **"Client Satisfaction With Services Delivered in a Non-Medical Mental Health Crisis Centre During its First Year of Operation"**.

At a meeting held on **March 27, 1997**, the Human Investigation Committee granted full approval of your research study.

We take this opportunity to wish you every success with your research study.

Sincerely,

H.B. Younghusband, PhD
Chairman
Human Investigation Committee

HBY\jglo

cc:   Dr. K.M.W. Keough, Vice-President (Research)
      Dr. E. Parsons, Vice-President, Medical Services, HCC
      Dr. S. Buehler, Supervisor

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ffice of Research and Graduate Studies (Medicine)
aculty of Medicine
he Health Sciences Centre

1997 03 31

**TO:**       Ms. Mary Dwyer

**FROM:**   Dr. Verna M. Skanes, Assistant Dean
Research & Graduate Studies (Medicine)

**SUBJECT:**   Application to the Human Investigation Committee - #96.191

////////////////////////////////////////////////////////////////////////////////////////////////////////////////

The Human Investigation Committee of the Faculty of Medicine has reviewed your
proposal for the study entitled **"Client Satisfaction With Services Delivered in a Non-
Medical Mental Health Crisis Centre During its First Year of Operation"**.

Full approval has been granted for one year, from point of view of ethics as defined in the
terms of reference of this Faculty Committee.

For a hospital-based study, it is **your responsibility to seek necessary approval from
the Health Care Corporation of St. John's**.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical
conduct of the investigation remains with you.

Verna M. Skanes, PhD
Assistant Dean

cc:     Dr. K.M.W. Keough, Vice-President (Research)
Dr. E. Parsons, Vice-President, Medical Services, HCC
Dr. S. Buehler, Supervisor

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**APPENDIX C**

**CLIENT SATISFACTION SURVEY**

## I. Demographics

*(INFORMATION FOR QUESTIONS 1-8 WILL BE COLLECTED FROM CLIENTS' FILES)*

1. *ID Number:* _____ *(dBASE)*

2. *Sex:* _____ *(dBASE)*

3. *Age:* _____ *(dBASE)*

4. *Income Range:* _____ *(dBASE)*

5. *Type of living arrangement: (dBASE)*

   i. *own house*           ☐

   ii. *apartment*          ☐

   iii. *boarding house*    ☐

   iv. *bedsitter*          ☐

   v. *living with relatives* ☐

   vi. *other*              ☐      _____

6. *Category of intervention:* _____ *(dBASE)*

7. *How often person used the Centre:* _____ *(dBASE)*

8. *Location: (dBASE)*

   i. *St. John's Region*      ☐
   ii. *Outside St. John's*    ☐

## II.   Crisis Centre Experience

9.   How did you learn of the Centre?

| | | |
|---|---|---|
| Word of mouth | ☐ | _____ |
| Mental Health Professional | ☐ | _____ |
| Advertising | ☐ | _____ |
| Mental Health Agency | ☐ | _____ |
| Hospital | ☐ | _____ |
| Doctor | ☐ | _____ |
| Other | ☐ | _____ |

10.   Have you visited the Centre in person?

Yes   ☐

No   ☐   *If No, go to #15.*

11.   How many times? _____

12.   Did you find the Centre easy to get to?

Yes   ☐

No   ☐

13.   About how long did you have to wait to see someone? _____

14.   How comfortable was the environment at the Centre, with 1 being Not Comfortable to 5 being Very Comfortable?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Not Comfortable | Somewhat Comfortable | Neutral | Comfortable | Very Comfortable |

15.	Have you called the Centre for help?

	Yes	☐
	No	☐

16.	*If Yes*, Were you able to get through on the telephone easily?

	Yes	☐
	No	☐

17.	How would you rate your satisfaction with the help you received at the Crisis Centre, with 1 being Not Satisfied to 5 being Very Satisfied?

	1	2	3	4	5

	Not	Somewhat	Neutral	satisfied	Very
	satisfied	satisfied			satisfied

18.	In what ways were the staff helpful?
	_____
	_____

19.	What, if anything, was not helpful?
	_____
	_____

20.	Did you feel your privacy and confidentiality were protected?

	Yes	☐	*If Yes, go to 22*

	No	☐	*If No, go to 21*

	Other	☐

21. *If No,* In what ways did you feel your privacy was not protected?_____

_____

_____

22. Did you feel you were being understood?

Yes ☐

No ☐

Other ☐

23. *If Yes,* In what ways did you feel you were being understood?_____

_____

_____

24. *If No,* In what ways did you feel you were not being understood? _____

_____

25. *If person visited or telephoned more than once,* Was your last experience typical of other experience(s)?

Yes ☐

No ☐

**III. Outcome of Crisis**

26. Did you feel you were helped in developing a plan to assist you with your situation?

Yes ☐

No ☐    *If No, go to #30*

Don't know ☐

27. What was most helpful about the plan? _____
_____
_____
_____

28. What would have been more helpful? _____
_____
_____
_____

29. Has the plan been helpful in dealing with the crisis, from 1 Not At All Helpful to 5 Very Helpful

| **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|
| Not Helpful | Somewhat Helpful | Neutral | Helpful | Very Helpful |

30. How much of your being able to deal with the problem would you say was because of the help you received at the Centre, from 1 Not At All Helpful to 5 Very Helpful?

| **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|
| Not Helpful | Somewhat Helpful | Neutral | Helpful | Very Helpful |

31. Looking back, do you think it was the right plan?

Yes ☐

No ☐

Other ☐ _____

32. Would you say your crisis situation is now resolved, from 1 Not At All Resolved to 4 Completely Resolved?

| **1** | **2** | **3** | **4** |
|---|---|---|---|
| Not at all | Don't know | Partially resolved | Completely resolved |

**IV.    Supports/Services Used in the Past**

33.    Where would you have sought help this time if the Crisis Centre was not available?

| | | |
|---|---|---|
| Emergency Department at a general hospital ☐ | Family Doctor ☐ |
| Waterford Hospital ☐ | Psychiatrist ☐ |
| Private Counsellor ☐ | Don't know ☐ |
| Friend ☐ | Other ☐ |
| Family ☐ | _____ |
| Community Counselling Agency ☐ | |

34.    Have you ever experienced a mental health crisis prior to the one you experienced when you *visited/telephoned* the Crisis Centre?

Yes     ☐

No     ☐      *If No, go to #37*

35.    *If Yes, where did you go to seek help?*

| | | |
|---|---|---|
| Emergency Department at a general hospital ☐ | Family Doctor ☐ |
| Waterford Hospital ☐ | Psychiatrist ☐ |
| Private Counsellor ☐ | Didn't seek help ☐ |
| Friend ☐ | Other ☐ |
| Family ☐ | _____ |
| Community Counselling Agency ☐ | |

36.    *If Yes, How would you compare the service you received at the Crisis Centre to the service you received in the past, from 1 Much Worse to 5 Much Better.*

| **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|
| Much Worse | Slightly Worse | About the Same | Slightly Better | Much Better |

**V. Questions/Comments**

37. Thank you very much for your time. I would be interested in any other suggestions or comments that you would like to make about the Centre. _____

_____

_____

_____

_____

38. What other services or programs do you think would be helpful in addition to the Crisis Centre?_____

_____

_____

_____

39. Would you like to have a summary of the results of this study?

Yes ☐          *If Yes, go to #41*

No ☐

40. Where shall I send the summary to?

Name: _____

Address: _____

_____

Again, Thank you very much for taking the time to respond to this survey.

*The investigator will note the general tenor of the interview, in terms of clarity of responses versus confused responses. It is necessary to be aware that some people may be psychiatrically unstable but may still want to respond to the questions.*

**APPENDIX D**

Client Name: _____     Phone #: _____

**Title: Telephone script for Volunteers of the Mental Health Crisis Centre.
Client Contact**

Hello, my name is _____. I am calling from the Mental Health
Crisis Centre. The purpose of my call is to tell you of a study being carried out about the
Centre and its services. The study is being conducted through Community Medicine at the
Memorial University of Newfoundland. Mary Dwyer is trained as a nurse and is completing
her Masters Degree in Community Medicine. She is interested in knowing how individuals
viewed the services they received so that they will be improved for the future. The study
will take about 15 minutes of your time to ask you some questions about the services you
received from the Centre. Your participation is strictly voluntary. If you do not want to
answer some questions, that's fine. Your responses will be completely confidential. You
will not be identified in the study.

| | | |
|---|---|---|
| Would you be willing to have Mary call you? | Yes ☐ | No ☐ |
| Would she call you at this number? | Yes ☐ | No ☐ |
| *If no*, Would another number be convenient? | Yes ☐ | No ☐ Tel. No.: _____ |

| *If no, and information not on list,* Would you give me the following information? | | | |
|---|---|---|---|
| Age Range: 16 - 19 years | ☐ | 20 - 29 years | ☐ |
| 30 - 39 years | ☐ | 40 - 49 years | ☐ |
| 50 - 64 years | ☐ | 65 years and over | ☐ |
| Community you live in: _____ | | | |

Thank You for your time.

*If yes,* Thank You. When is a good time to call?

Weekday ☐      Weekend ☐

What day is best? Monday     ☐

Tuesday     ☐

Wednesday   ☐

Thursday    ☐

Friday      ☐

Saturday    ☐

Sunday      ☐

What time is best for you?     Morning ☐ Time: _____

Afternoon ☐ Time: _____

Evening ☐ Time: _____

*Thank You very much for your time. Mary will be calling you within the next couple of weeks.*

**APPENDIX E**

**VOLUNTEER TRAINING BOOKLET**

**Obtaining Consent to be Interviewed**

**RESEARCH TOPIC:**  Client satisfaction with services delivered in a
Mental Health Crisis Centre during its first year
of operation.

**AGENDA**

1. Welcome and Introduction
2. Background of Study
3. Background of Questionnaire
4. How Sample was Obtained
5. The Importance of Your Role in this Study
6. Walk Through the Script
7. Practice in Small Groups - Read Script Aloud
8. Practice in Pairs
9. Assignment of Two Telephone Numbers Each - "Test Calls"
10. Deadline to Have "Test Calls" Made
11. "Test Calls" Give Feedback
12. Selection of Volunteers to Make "Real Calls"
13. Deadline for "Real Calls" Completion, Monday, April 21 at 5:00 p.m. (local calls from home, long distance from Centre)
14. Drop Points for Completed Calls Forms:
    - Health Sciences Centre Switchboard
    - Arts Building, Room 3056
    - Crisis Centre
    - Waterford Hospital Switchboard

    (Forms to be placed in <u>sealed</u> envelopes. Envelopes provided, addressed to <u>Dr. Sharon Buehler, "Confidential"</u>
15. Discussion/Questions

# NOTES

1. **Welcome and Introduction**

2. **Overview of Study**

   The Mental Health Crisis Centre opened in June 1996 as an 18-month pilot project. At the end of the pilot, a complete evaluation of the service will decide whether it continues to receive funding, and maybe expand to other regions of the Province. The Institute of Human Resource Development (IHRD), a consulting firm, is undertaking a major component of the evaluation. They are doing an operational review, focus group interviews, staff surveys, etc.

   I am doing the client satisfaction survey in partial fulfilment of the thesis requirement for an MSc degree.

   The title of the thesis is "Client perception of services delivered in a non-medical Mental Health Crisis Centre during its first year of operation."

   The questionnaire will be via telephone by me and another one will involve <u>two</u> data collection points: April 1997 and September 1997. It will involve a random sample of 200 clients (100 in April and 100 in September) who are equally divided between walk-ins and call-ins. **<u>The actual interviews will be done by me</u>**.

3. **Background of Questionnaire**

A series of meetings were held with Karen McGrath, Director of the Crisis Centre, Rick Morris and Mike Eagan of IHRD to determine what areas they wanted addressed in the survey. The questionnaire was developed through input from my thesis supervisor, Dr. Sharon Buehler and other questionnaires developed for similar purposes, eg. a Social Work Thesis and the Gerstein Centre Questionnaire (Ontario). There are 41 questions which will take about 15 minutes to complete.

4. **Importance of Your Role**

- Your role is crucial to the success of this study - you are the first point of contact, and will set the stage for the upcoming interview.
- You are the key to getting the required numbers for the study.
- Your contact will be instrumental in setting the tone for the upcoming interview.
- Because this is a random sample without replacement, it is really important not to get many refusals. We hope for an 85-90% response rate.

5. **Time Frame**

| Thursday, September 11, 1997 | Tuesday, September 16, 1997 | Thursday, September 18, 1997 |
|---|---|---|
| Volunteer training | All calls completed | I will pick up forms from Crisis Centre. |

## 6. Volunteer Information Sheet

| NAME | PHONE NUMBER HOME/WORK | FAX NUMBER | SELECTED DROP-OFF POINT* |
|------|------------------------|------------|--------------------------|
|      |                        |            |                          |
|      |                        |            |                          |
|      |                        |            |                          |
|      |                        |            |                          |
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|      |                        |            |                          |
|      |                        |            |                          |
|      |                        |            |                          |
|      |                        |            |                          |
|      |                        |            |                          |

**\*Drop-off Point:**

- Crisis Centre

**APPENDIX F**

## RESPONDENT FEEDBACK

## TEST CALLS

Name of Person calling you: _____

Please give your general impressions of the Test Call.

Voice tone/inflection: _____

_____

Rate of speech: *(normal, too rapid, too slow)* _____

_____

Clarity: _____

_____

Other comments: _____

_____

Name of Respondent: _____

Thank you for your time!

**Mary Dwyer**

**APPENDIX G**

**CLIENT RESPONSE SHEET**

Client Name: _____

Telephone Number: _____


**Comments:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____


*April 17, 1997*

**APPENDIX H**

## Design Timeline

| Date | Activity | Persons Involved |
|------|----------|------------------|
| **March, 1996** | Met with Thesis Supervisor to discuss area of interest for research | Researcher and Thesis Supervisor |
| **October, 1996** | Joint meeting with Institute of Human Resource Development (IHRD) and Thesis Supervisor to discuss proposal for Client Satisfaction Survey | Researcher, Personnel for IHRD and Thesis Supervisor |
| **November, 1996** | Joint meeting with IHRD, Manager of Crisis Centre, Thesis Supervisor to outline areas of interest in survey research | IHRD Consultants, Manager of Crisis Centre, Thesis Supervisor, Researcher |
| **December, 1996** | Meetings with Manager of Crisis Centre and IHRD to outline components of survey and get feedback on specific questions outlined in the questionnaire | Manager of Crisis Centre, Thesis Supervisor, Researcher, IHRD Staff. |
| **December–January, 1997** | Further meetings with IHRD Manager to discuss the start date, logistical concerns, confidentiality issues, data base information | IHRD Consultants, Manager of Crisis Centers, Thesis Supervisor, Researcher |
| **January, 1997** | Preparation and submission of HIC Proposal | Researcher and Thesis Supervisor |
| **March, 1997** | Approval from HIC | HIC Committee |
| **March, 1997** | Meetings with Volunteer Coordinator of Crisis Centre to set up inservice with volunteers | Volunteer Services Coordinator and Researcher |
| **April, 1997** | Inservice Volunteers | Six Volunteers, Volunteer Service Coordinator, Thesis Supervisor, Researcher |
| **June, 1997** | Inservice Volunteers | Four Volunteers, Researcher, Volunteer Service Coordinator |
| **June, 1997** | Completed first phase interviews | Researcher |
| **August, 1997** | Inservice for Volunteers, three separate sessions | Volunteers & Researcher |
| **September, 1997** | Completed second phase Interviews | Researcher |

**APPENDIX I**

**Title: Telephone script for Investigator**
        **Client Contact**

**Client Name:** _____        **Telephone Number:** _____

Hello, my name is Mary Dwyer. I am a Graduate Student at Memorial University of Newfoundland. Last week, one of the staff at the Mental Health Crisis Centre called you to ask if you would answer some questions about your experience with services at the Mental Health Crisis Centre. Thank you for letting me call you.

I am conducting part of the evaluation of the Mental Health Crisis Centre and I am interested in knowing how you feel about the services you received there. Your participation in this interview is completely confidential. Except for telephoning you, no names will be used in any part of the study. Your comments can provide a great deal of help in improving services of the Centre.

There are two parts to my study. The first is a short interview which will take approximately 15 minutes. You may choose not to answer any of the questions that you do not want to answer or end this interview at any time. The second part is to get some information from your file at the Centre, such as sex, age group, living arrangements, to be able to compare responses with different groups of people.

Are you willing to participate in this study?   Yes ☐          No ☐

Interview:                                    Yes ☐          No ☐

Look at files:                                Yes ☐          No ☐

*If no*, may I ask you a few more questions? *(Refer to demographics)*

*If no*, thank you very much for your time.

*If yes*, Fine, let's begin.

**APPENDIX J**

## Summary of Data Collection Process

| PHASE I April 1, 1997 | DECLINING NUMBERS |
|---|---|
| Numbers of clients up to April 1, 1997 | 1211 |
| Sampling Frame of clients after exclusions | 420 |
| Number of clients contacted by volunteers | 86 |
| Consented to be contacted by investigator | 76 (Response rate 88%) |
| Able to be reached by investigator | 63 |
| Consented to be interviewed by investigator | 62 |
| Total numbers interviewed at this time | 62 |
| **PHASE I CONTINUED JUNE 1, 1997** | |
| Telephone numbers obtained through OMNIFAX COMPUTER PROGRAM | 61 |
| Number contacted by volunteers | 25 |
| Consented to be contacted by investigator | 20 Response rate 80% |
| Able to be contacted and interviewed by investigator (No refusals) | 15 (Response rate 100%) |
| Total numbers in study at the end of Phase 1 | 77 (62 + 15) |
| **PHASE II SEPTEMBER 1, 1997** | |
| Number of clients between April 1 - August 31, 1997 | 548 |
| Sampling frame after exclusions | 101 |
| Number of clients contacted by volunteers | 47 |
| Consented to be contacted by investigator | 43 (Response rate 91%) |
| Able to be reached by investigator | 28 |
| Number of clients contacted and interviewed by investigator | 28 (Response rate 100%) |
| Total number in study from Phase II | 28 |
| **TOTAL NUMBERS IN PHASE I AND II** | 105 (77 + 28) |

**APPENDIX K**

*Demographic Characteristics Of Participants* (N = 105)

| SEX | FREQUENCY | PERCENT |
|---|---|---|
| Female | 76 | 72.4% |
| Male | 29 | 27.6% |
| N = 105 | | |
| **AGE** | | |
| 16 - 19 | 7 | 7.6% |
| 20-29 | 21 | 23.1% |
| 30-39 | 19 | 20.8% |
| 40-49 | 22 | 24.2% |
| 50-64 | 21 | 23.1% |
| 65> | 1 | 1.1% |
| n = 91 | | |
| **MARITAL STATUS** | | |
| Common law/living with | 4 | 4.4% |
| Divorced | 16 | 17.7% |
| Married | 27 | 30% |
| Single | 38 | 42% |
| Widowed | 5 | 5.5% |
| n = 90 | | |
| **LIVING ARRANGEMENTS** | | |
| Boarding home | 1 | 1.8% |
| Group home | 1 | 1.8% |
| Other | 2 | 3.6% |
| Own | 14 | 25.0% |
| With parents/family | 14 | 25.0% |
| Rent | 24 | 42.9% |
| n = 56 | | |
| **RESIDENCE** | | |
| St. John's | 93 | 88% |
| Outside St. John's | 12 | 12% |
| N = 105 | | |

**APPENDIX L**

| Crisis Codes | n | % |
|---|---|---|
| Addictions | 14 | 13.3% |
| Mental Illness | 14 | 13.3% |
| Relationship (family) | 12 | 11.5% |
| Family Crisis | 11 | 10.5% |
| Not indicated | 8 | 7.6% |
| Bereavement/Loss | 6 | 5.7% |
| Non Crisis | 5 | 4.8% |
| Relationship (other) | 5 | 4.8% |
| Adolescent Issues | 4 | 3.8% |
| Health | 4 | 3.8% |
| Parenting | 4 | 3.8% |
| Survivor Issues | 4 | 3.8% |
| Isolation/loneliness | 3 | 2.9% |
| Suicide thoughts | 3 | 2.9% |
| Other | 3 | 2.9% |
| Financial | 2 | 1.9% |
| Employment | 1 | 1.0% |
| Housing | 1 | 1.0% |
| Legal | 1 | 1.0% |