EVALUATION OF THE GRANDE PRAIRIE POLICE AND CRISIS TEAM (GP-PACT)

A Collaboration between:

RCMP Grande Prairie Detachment

Alberta Health Services Mental Health

City of Grande Prairie Community Safety

Grande Prairie Regional College

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Executive Summary

This report details an extensive evaluation conducted on the Grande Prairie Police and Crisis Team (GP-PACT), an emergency response unit that responds to mental health crises. Research has shown that conventional police responses to mental health crises have been problematic in the past, in part because police officers do not always have the necessary training to defuse a mental health crisis safely and effectively, which can lead to the unnecessary criminalization of mental illness (Lamb & Weinberger, 1998). Mishandling of mental health crises can put undue strain on the criminal justice system and potentially cause further trauma to a client already in distress (Boscarato et al., 2014). The Grande Prairie RCMP detachment has therefore begun deploying PACT as an alternative to the traditional police responses to mental health emergencies. GP-PACT comprises of one police officer and one psychiatric nurse who attend mental health calls together. This strategy has been used in other police detachments in Canada and elsewhere, and existing evidence suggests that the complementary skills of the police officer and the psychiatric nurse frequently enable safe de-escalation more effectively than a police officer responding alone (Watson, et al., 2008).

This program evaluation analyzes data from several different sources and respondents, including surveys of general duty RCMP officers, PACT team members, other first responders, community-based organizations, clients, and members of the public; data from mental health related 911 calls; and a calculation of the GP-PACT program's social return on investment (SROI). The evaluation found that the GP-PACT program experienced high rates of successful de-escalation, as well as generally high satisfaction from clients, community organizations, general duty RCMP officers, and other first responders. An SROI calculation revealed that the program had the potential to more than double its investment value through direct and indirect social value (including more productive community members, reduced strain on community resources, and increased access to stable housing and employment). The program could benefit from more concentrated efforts at public awareness and education, more hours of service, and stronger communication between GP-PACT and other first responders.

The evaluation's main recommendations include the following:

- Increase GP-PACT's service availability, ideally to 24/7 service.
- Launch a focused public education campaign on when and how to access PACT services.
- Broaden training opportunities for RCMP officers in assisting on mental health calls.
- Continue to track GP-PACT performance by maintaining call records and using a standardized tracking sheet to log client outcomes.
- Conduct formal program evaluations at least every two years to track long-term GP-PACT performance.
- Engage in ongoing collaborative and educational discussion between GP-PACT, community-based organizations, and other first responders to ensure role clarity and effective coordination of emergency services.

Contents

Introduction

Mental illness, which affects one's thinking, mood, and behavior, is estimated to affect as many as one in five Canadians (CMHA, 2011). Most people living with mental illness face relatively mild and manageable symptoms, but a sizable proportion deal with recurring or persistent symptoms that cause distress. From the 2012 Canadian Community Health Survey-Mental Health, it was revealed that one in 10 Canadians meet the criteria for diagnosis of a serious mental health disorder (Statistics Canada, 2012). Rates are even higher when substance misuse in included. Results also confirm that people of all educational and socioeconomic levels are directly affected, but that the distribution is neither random nor uniform. These disorders were found to be most common among younger Canadians. Social factors, such as having a weak sense of belonging to one's community and low educational attainment, and economic factors tied to work-related stress, unemployment and poverty also contribute to the formation or aggravation of symptoms.

Most individuals living with mental illness can reside, function and recover in their communities, so long as they are provided with sufficient mental health supports (CMHA, 2011). Demands on community-based support systems have been growing, however (Adelman, 2003). Some reasons for greater demands are tied to strain caused by social and economic factors such as those listed above (Boyce, et al., 2015). Even those with mild and manageable symptoms may require more community supports when faced with such strain (World Health Organization, 2012). Another reason for the increased need is deinstitutionalization; over the past few decades in Canada, patients with serious symptoms have been moving out of psychiatric hospitals and into the community (Sealy & Whitehead, 2004). Unfortunately, community-based support systems have not been sufficiently funded to grow continuously and proportionately with the mounting demands (Clifford, 2010). Resultant gaps in mental health services place people dealing with mental illness at greater risk of entering into a state of crisis and in need of intervention.

Police are frequently the first responders to crisis situations related to mental illness. Stigmatizing attitudes about mental illness contribute to the expectation of a police response

(Lurigio & Watson, 2010). In Canada, it is estimated that one in three people dealing with a mental health issue have had contact with police (Brink et al., 2011) and studies suggest the number of people who have police-contact is overrepresented in this population (de Tribolet-Hardy, 2015; Wilson-Bates, 2008). Police are called for three reasons: a) make an arrest due to actual or suspected criminal behavior, b) provide safe transport to a mental health care provider, and c) deal with the crisis itself (Canada et al., 2010; Ritter; et al., 2010). Relatively few crisis situations are criminal in nature; only 12.5% end in arrest (Butler, nd;). For 30% of cases, the police serve as gatekeepers to mental health care resources (Demir, et al., 2009; Durbin, 2010). In remote and in small communities, unfacilitated access to resources, such as hospital-based care, is particularly problematic (Compton et al., 2010). Inpatient psychiatric beds are limited in number and those in a mental health crisis are often turned away from emergency services because they are deemed to be "not sick enough" to be given priority (Cotton & Coleman, 2006).

For the majority of mental health crisis situations, police are called to de-escalate the crisis in order to reduce the probability that those in such a state will hurt themselves or others in the community (Adelman, 2003). In these circumstances, police serve as de facto front-end mental health workers (Teller et al.,2006). Most events are handled without much incidence, but these encounters can be unpredictable and dangerous for the person in crisis, the police, and others who are present (Chappell, 2014). This risk is particularly high for those who have severe symptoms, have lost contact with mental health services for regular care, rely on drugs or alcohol to self-medicate and have access to weapons (Van den Brink et al., 2012).

Background

Considerable research has been dedicated to investigating the short- and long-term impacts of "police-as-first responder" approaches to mental health crises. Arresting those experiencing a mental health crisis has been decried for contributing to the criminalization of mental illness (Lamb & Weinberger, 1998). With regard to facilitating access to hospital-based resources, there is room for improvement. Even when escorted by a police officer, people experiencing mental health crises face long wait times or are not seen at all (Baess, 2005). With regard to

dealing with the mental health crisis itself, findings indicate that officers are generally not well prepared to respond on their own due to insufficient training, time, or resources (Clayfield, et al., 2011; Hollander et al., 2012; Watson & Angell, 2007; Winters et al., 2015).

For an individual experiencing a crisis, an inappropriate response can cause or add to trauma, which in turn may negatively impact recovery (Boscarato et al., 2014). In light of such findings, several recommendations have been proposed. At the heart of many of these recommendations is the idea of "community policing" which focuses on improving problem solving of issues that arise on a day-to-day basis, including mental health issues (Adelman, 2003). Recommendations for improving officers' ability to solve these types of problems include providing education targeting various types of Knowledge, Skills, and Attitudes (KSAs).

Police responses to those in a mental health crisis are improved if officers are appropriately and sufficiently trained to recognize symptoms of mental illness, de-escalate and contain those whose mental state is compromised due to their mental illness, and recognize when a person in crisis should be referred to services in community, diverted immediately into treatment or arrested. Training that addresses officers' preexisting attitudes about mental illness is also important (e.g., Chopko, 2011; Compton et al., 2006, 2009, 2014; Cotton & Coleman, 2008). The same recommendations apply to other first (e.g., EMS) and second responders who may attend to individuals experiencing a mental health crisis.

Education of first responders is not a panacea in and of itself, however (Coleman & Cotton, 2010). Optimal responses include a more efficient and responsive approach using front-line responders from various sectors who can attend to the full continuum of mental health crises in communities while ensuring a safe response (Baess, 2005). Since the late 1980's, a common example of this approach has been the use of "Crisis Intervention Teams" (CITs) which involve integrated partnerships between police and health services. Each team typically includes an officer who has special training and/or special interests pertaining to assisting individuals who are dealing with mental health issues. The other member of the team is a mental health professional who has significant experience working with this target population, typically a psychiatric nurse, but sometimes a social worker or a psychiatrist.

Since their inception, many studies have been conducted on CITs to determine their effectiveness (Watson, et al., 2008). In part due to reported successes of these teams in the United States, and in part due to the mandate to move to community-based policing, CITs have been implemented in Canada. Depending on the location in Canada, CITs operate as first or secondary responders to calls involving an individual experiencing a mental health, addiction or psychosocial crisis, especially when the individual in question engages in behaviour(s) that are unpredictable or present a danger to him/herself and/or to the public. In locations where CITs operate as secondary responders, they attend calls only after first responders (e.g., general duty police) deem the situation safe enough for the CIT mental health professional to assess/attend to the client in question. CITS also provide consultative and follow-up supportive services to other first responders who attend a mental health related call.

Criteria for a CIT response varies with the location where CITs operate. For Canadian CITs, some criteria include the following:

- The client has a history of mental illness along with aggression, violence, and/or weapons use;
- The client is exhibiting suicidal ideation (sometimes in conjunction with mental disturbance and/or intoxication);
- The client has a history of substance misuse that impacts mental status and level of functioning;
- The client has a file with cautions;
- The likelihood of requiring e.g., Form 10 (e.g., in Alberta) is high; or
- The client is a threat to public safety.

Service goals of CITs in Canada also vary with the location that CITs operate, but typically include the following:

- Making an immediate on-site clinical assessment (when possible) of the person in crisis;
- Attempting to de-escalate and stabilize the crisis;
- Assisting in removing the client from serious harm to him/herself or others;

- Providing supportive counselling, as needed;
- Arranging appropriate mental health treatment by referring and connecting the client to an appropriate agency or by apprehending the client under the relevant Mental Health Act;
- Coordinating and facilitating transportation to the hospital emergency department or inpatient psychiatric unit if further psychiatric and medical assessment is required;
- Coordinating and facilitating transportation to cells if criminal charges are possible; and
- Following up and checking in on clients who received CIT intervention (at homeless shelter, agency program, Inpatient Psychiatric unit, cells, etc.).

In some locations, CITs also engage in community outreach as a way to proactively address the needs of high-risk clients before they go into crisis. One valuable service is outreach to street-involved/homeless individuals in order to engage them in CIT services, especially those who are in frequent contact with police and/or mental health services. CITs also often provide supports to community agencies that serve vulnerable individuals by engaging in drop-ins to the agencies, by responding to calls requesting assistance for a crisis, and/or by responding to consultation calls whereby agencies are seeking advice. CITs often contact community agencies for advice on how to respond to a client they know the client receives service from the agencies.

Advantages of having CITs available in communities are numerous. For the community at large, having CITs helps to free up police resources such that general duty police can attend to other calls. Mental heath related calls can be very time consuming, especially when attended by officers who do not have the training or experience to efficiently help those who are in a mental health crisis. Similarly, having mental health professionals on the teams helps free up hospital services; they help streamline hospital intake processes for clients who do need hospital service and frequently divert clients who do not need these services.

For the clients themselves, having CITs available is clearly very beneficial. For example, CITs provide mobile service to clients; that is, they go to the client in need of CIT intervention.

When attending to the client, the officer helps maintain the safety of persons on site while the mental health professional performs a mental health assessment on site (when possible). Another important advantage of having a mental health professional attend calls is that he/she has access mental health records (not available to officers) and thus can more quickly determine if the appropriate course of action is further psychiatric intervention. If so, the mental health assessment and other steps required for further intervention can be initiated or completed while on-site, thereby speeding up hospital (or other facility) in-take processes. CIT member's training on de-escalation also helps keep the client stable so that the in-take process is more efficient and safer. Transporting the client in specially outfitted unmarked vehicles, and avoiding the use of lights and sirens, helps ensures a safe transport to the hospital (or other facilities) in a manner that maintains the dignity of clients and that helps keep the client calm. In addition to keeping the site safer, other important advantages of having police officers attend these calls is that they have the ability to carry out apprehensions (e.g., Form 10 Apprehensions) when necessary. They are also able to enter homes in exigent circumstances or with a CTO Apprehension order.

Related benefits tied to CIT members' special training, and in many cases, personal knowledge of the clients (e.g., repeat client), is that CIT members can make better decisions, compared to other responders as to when a client DOES NOT need further intervention. In other words, they are able to make sounder recommendations as to whether a client should be diverted from medical or judicial services. Other benefits arising from law enforcement, justice system and mental health system collaborations is the increased ability to share information, thereby enhancing communication. Therefore, when a client DOES need further intervention, the team can help the client get the help they need more quickly.

Optimally, CITs work closely and collaboratively with community support services (e.g., shelters, addictions services, community agencies that run programs for vulnerable populations). Providing clients with coordinated responses from both CITs and community support services helps facilitate continuity of care, thereby reducing frequency of relapses (and in some cases recidivism) and helps facilitate successful community integration. For clients who have a history of high-risk behaviors and chronic contact with hospital and/or police services,

specialized follow up teams that include CITs, case workers, and other experts may be warranted (Dempsey, 2017). Unfortunately, there are many communities that do not have CITs, and many have community services that are over-taxed; clients dealing with mental health issues in those communities are either not served or fall through the cracks in the mental health care system.

In 2004, CITs, referred to as Police and Crisis Teams (i.e., PACT) in Alberta, have been set up in Edmonton, Alberta's centrally located capital city. Its large city police force and health care network enable the use of multiple PACT teams who provide 24-7 service to those in need. PACT teams have also been established in other Alberta cities, namely Calgary, Red Deer, Lethbridge and Medicine Hat. Due in part to reported successes of PACT in Alberta, Grande Prairie applied for and secured a grant from Alberta Government's Safe Communities Innovation Fund to run a 3-year pilot of PACT in Grande Prairie (i.e., GP-PACT) from 2009 to 2012.

An evaluation conducted on GP-PACT in 2011 (Hincks, Miller & Pauls, 2013) revealed GP-PACT's value to the community and led to the recommendation that the program be continued. There are a number of factors that challenge continual optimal operation of GP-PACT, however. Although the GP-PACT was expanded in 2017 with addition of a second team, 24-7 service still is not possible; additional teams are required for 24-7 service to become a possibility. Also, shortfalls in service are anticipated to intensify; Grande Prairie is a small but rapidly growing city. From 2011 to 2018, its population grew from approximately 55,000 to 69,088; a 26% increase over 7 years (2017 Vital Signs-GP, 2018 Grande Prairie Municipal Census). During boom years, shadow populations, mostly young single males, contribute greatly to this number. Additionally, Grande Prairie serves as a regional hub of services for a large rural area that has an estimated population of 250,000.

This growth, accompanied by a shortage of mental health care workers, translates into higher caseloads and longer wait-times. Shortage of available hospital beds and long wait-times to get into treatment centers is a chronic problem in Grande Prairie. Consequently, people in need of mental health care (or related care) often do not get the help they need when they need it; this situation puts them at even greater risk for going into crisis. Those at risk for going

into a mental health related crisis, or who are in crisis, cannot easily travel to another center. Grande Prairie is a northern city that is fairly remote; the closest large city is Edmonton, which is over four hours away. Furthermore, after the cancellation of Greyhound Bus service to Edmonton, those who do not have access to a vehicle and cannot afford the airfare simply cannot travel to Edmonton to get help.

Another factor that can affect GP-PACT's delivery of service is the nature of policing services. Services are provided by the RCMP, which compared to City Police services (e.g., EPS in Edmonton), has a high turnover rate. Unlike city police officers, RCMP officers are sometimes reassigned to other units within the RCMP and are often reassigned to other communities. Such high turnover rates may challenge officers' ability to know which individuals in the community are at risk for mental health crises and how they are at risk; it may also compromise officers' ability to form trusting relationships with these individuals. Finally, reassignment makes it difficult for officers to become knowledgeable regarding which types of community-based mental health services are available and which are not readily available (i.e., have long wait-lists) or not available at all.

Another policing challenge in Grande Prairie pertains to the number of officers who serve the large area. Although more officers have recently been assigned to the Grande Prairie detachment (total = around 97 officers in 2018), the detachment is responsible for covering 73 square kilometres for the city area and 14,562 square kilometres for the rural area (Shokier, 2018). The "number of officers" to "area of coverage" ratio is below the Alberta average and the national average. This pinch affects the number of calls that RCMP can attend and the speed with which a police response can be delivered; the pinch is felt even more strongly when a GP-GP-PACT team is not available to attend time-consuming mental health calls, leaving General Duty officers to take on the responsibilities.

Other challenges facing GP-PACT are related to the nature of Grande Prairie's residents. Grande Prairie is a city with a young median age (31.9 years-2016 Federal Census) and lower than average rates of high school completion; both factors are associated with higher vulnerability to mental illness. Furthermore, the city is slightly skewed to males, many of whom have come to the city for employment and earn higher than average incomes. These factors

make the city a particularly attractive market for drug traffickers and thus puts all residents at a higher risk for drug use or abuse. Furthermore, Grande Prairie's primary economy employs a large percentage of workers who are transient or are temporary foreign workers who are likely to have challenges connecting to their communities (Vital Signs-GP, 2015). Alberta's recent changes in government policies (e.g., carbon neutral/climate change polices, foreign worker polices) has created a heightened mood of pessimism for many Albertans and recent dramatic fluctuations in oil and gas prices have hit many Grande Prairians particularly hard. Finally, although Grande Prairie's Crime Severity index has dropped from 2016 (Stats Canada), the level of crime still keeps the RCMP very busy on these types of calls. All of these stresses can significantly impact the overall mental health of a community, which means that it is important GP-PACT be made available to citizens, that the program be adjusted to meet the changing demands placed on it, and that the program be evaluated for its effectiveness.

Evaluation of GP-PACT

Because individuals assisted by GP-PACT are vulnerable, and because of the importance of ensuring that the assistance is helpful rather than harmful, it is critical that GP-PACT undergo an appropriate evaluation. First, it is necessary to determine whether GP-PACT's service model is indeed appropriate for the city; models that have been shown to work well in one setting (e.g., a large urban center such as Edmonton) may not work well for Grande Prairie. It is important to conduct an evaluation that considers the unique challenges associated with being a remote, rural community (Skubby et al., 2013; Watson et al., 2011).

Second, because the factors that affect successful implementation of crisis teams are numerous and diverse and because the issues being addressed by the team are complex, it is critical that the evaluation of GP-PACT be comprehensive. Various types of information must be gathered from a variety of sources and must reflect the perspectives of all relevant players (e.g., clients, police, mental health staff, community agencies that work with PACT, hospital staff). Most evaluations that have previously been conducted on programs involving crisis teams provide only single snapshot views of their operation and thus fall short of reaching this particular goal (Compton et al., 2008; Kisely et al., 2010; Watson et al., 2008). Such evaluation

shortfalls appear to be an issue for other crisis teams in Alberta and across Canada (Coleman & Cotton, 2010).

First GP-PACT Evaluation

The evaluation of GP-PACT that was conducted in 2011 by Hincks, et al., (2013) faced a variety of problems; some indicators that were needed to assess different processes and outcomes were missing, some key stakeholders were inaccessible and the amount of time available to complete the evaluation was only four months. Despite the challenges, a Social Return on Investment (SROI) forecast analysis was completed; the SROI ratio was forecasted to be 2.04:1. This ratio indicated that the program was projected to more than double its investment through social value that it creates in the community and therefore should be continued. Upon completion of this 2011 study, what was still needed was a comprehensive evaluation of GP-PACT.

Current GP-PACT Evaluation

In 2015, the local RCMP detachment requested assistance from Grande Prairie Regional College (GPRC) to conduct another evaluation of the GP-PACT program. In order to conduct the current evaluation, a funding and operational partnership between the local RCMP, Alberta Health Services-Mental Health, City of Grande Prairie-Safe Communities, and GPRC was formalized. Partners met multiple times a) to define and agree upon the roles each partner would take on and b) to establish the project goals.

a) Partner Roles & Duties

1. Funding: GPRC applied for and was successful in attaining federal funding from the Tri-Council College and Community Social Innovation Fund (CCSIF). Significant funding was also provided by the City of Grande Prairie, the RCMP and Alberta Health Services.
2. Instrument Development: To develop the data collection instruments (i.e., surveys in the form of questionnaires or interviews), GPRC relied on the current research literature (on factors that affect mental health, crisis intervention teams and program evaluation), but also relied heavily on feedback from the partners or other representatives of their organization (e.g., RCMP Operations Support NCO, QEII Emergency Department Flow Nurse, EMS supervisor of Clinical Operations, CMHA staff, GP-PACT team members). The

partners and representative gave advice regarding which questions to include and exclude, the wording that should be used and the format of questions that should be used (e.g., open-ended, checklist, Likert scale).

3. Recruitment of Participants/Data Collection: Partners assisted with data collection in a variety of ways. To assist with the collection of information from RCMP officers, RCMP staff uploaded the RCMP questionnaire into a protected RCMP online platform. An email was sent to officers informing them of the opportunity to complete the questionnaire. After three weeks, RCMP staff consolidated the data into a spreadsheet format that could be imported into Excel and then SPSS for analyses.

To assist with collection of information from ER nurses, an Emergency Department flow nurse notified other ER nurses about the opportunity to do the survey, distributed hard copies of the survey (packaged in envelopes with a cover letter), collected completed surveys (sealed in the envelope) and returned the bundle to the GPRC researcher after a six-week period. Similarly, to assist with the collection of information from EMTs/Paramedics, a supervisor of Clinical Operations notified EMTs and Paramedics about the opportunity to do the survey, distributed hard copies of the surveys (packaged in envelopes with a cover letter), collected completed interviews (sealed in the envelope) and returned the bundle to the GPRC researcher after a two-month period.

With regard to data collection from clients and families/caregivers, the partners invited the researchers to attend two community stakeholder meetings (attended by representatives of various community agencies). Discussions were had about how to collect information from clients and from families/caregivers. The stakeholders informed the researchers about community outreach events hosted by various community agencies and the City of Grande Prairie; they also assisted with recruitment of clients. A space was set aside for the researcher to conduct interviews at the community outreach events. The stakeholders advised that accessing families and caregivers would be extremely difficult. Therefore, families and caregivers were not included in the study as originally planned.

To assist with recruitment and data collection for the public awareness survey, the City of Grande Prairie-Crime Prevention posted the online survey (SurveyMonkey) and advertised it on their Facebook page, website and newsletter.

In addition to assisting with recruitment and data collection via surveys, a RCMP Crime Analyst and a Clinical and Alberta Health Services Coordinator with ICAT provided call data (i.e., mental health calls to 911 for Grande Prairie from 2014-2017). The data was in the form of a spreadsheet that enabled statistical analyses.

Finally, the GP-PACT members agreed to meet and be interviewed by the GPRC researchers on a number of occasions and provided further insight into how the teams operate in the city. Alberta Health Services and the RCMP also provided permission for the researchers to participate in ride-alongs with the GP-PACT teams in order to witness GP-PACT in action.

4. Data analyses/synthesis, SROI analyses, and report writing: These duties were performed by GPRC researchers.

b. Project Goals

The partners agreed upon the following goals:

- describe the community demands placed on GP-PACT (number and nature of calls)
- acquire input (data) from multiple stakeholders to incorporate various perspectives for the evaluation
- develop recommendations regarding program delivery
- make recommendations regarding training that should be made available to GP-PACT members and other first responders (especially RCMP officers)
- develop recommendations for evaluation that allows for continued assessment (whether the above recommendations are implemented or not).

Results and Discussion

Presented first in this section are the survey results and, specifically, answers to questions pertaining to a) working with those experiencing mental health crises (professional groups including RCMP, EMTs/Paramedics, ER Nurses, Community Agencies), b) training (RCMP,

EMTs/Paramedics, ER Nurses), and c) general knowledge and/or experience working with GP-PACT (RCMP, EMTs/Paramedics, ER Nurses, Community Agencies, Clients, General Public).

Presented second are respondents' evaluations and/or recommendations of the GP-PACT program as they reported in the surveys. Some groups (RCMP, EMTs/Paramedics, ER Nurses, Community Agencies) provided answers to answers to open-ended questions: "What are the benefits of GP-PACT?" "What are the drawbacks?" "What recommendations do you have, if any, to improve GP-PACT?" Some groups (EMTs /Paramedics, Community Agencies, Clients) provided ratings of Key Performance Indicators (KPIs).

Also presented are findings from the analyses of RCMP/AHS call data.

Lastly, the Social Return on Investment Analyses will be presented (the process used and the calculated results).

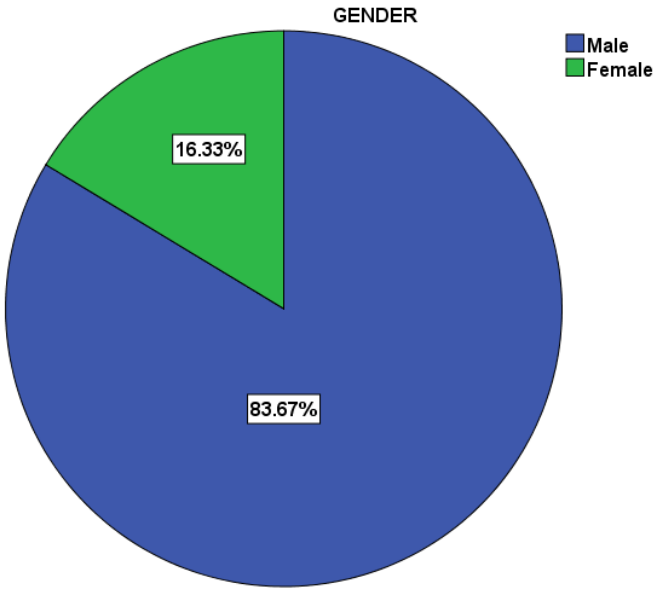
Survey Responses: Experiences, Training

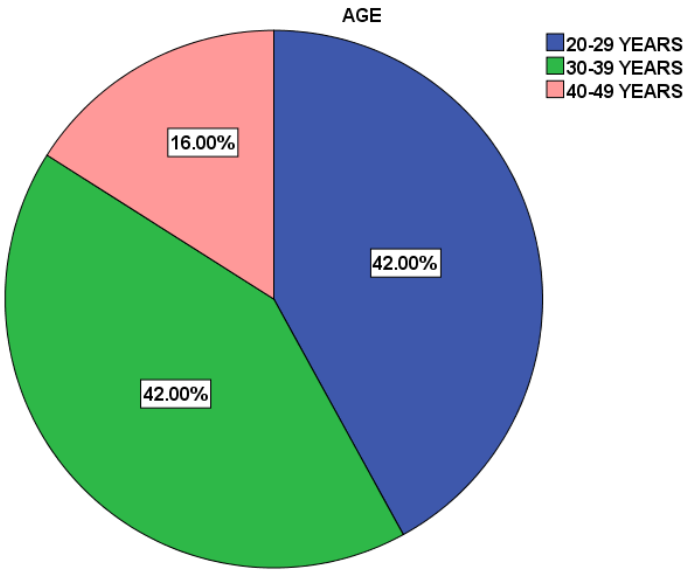
1. RCMP Officers' Responses

Fifty RCMP officers responded to a questionnaire whereby they provided a) demographic information and information about their RCMP work experience in general, b) their experiences attending to individuals who are experiencing a mental health related crisis (frequency with which they attend to such calls and how prepared, confident, stressed and safe they feel), c) ratings on how effective they believe they are on a variety of skills that are relevant when attending to those in crisis, d) information on the training (re: Knowledge, Skills, and Attitudes) that they believe would help them attend to individuals experiencing a mental health related crisis, e) current and preferred training method, and f) recommendations regarding the GP-PACT program (discussed later in this paper).

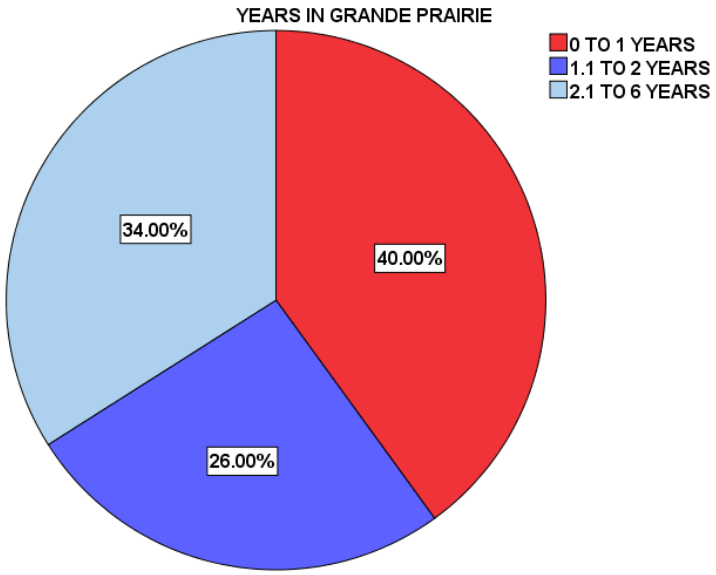
a. Demographic Information and Work Experience

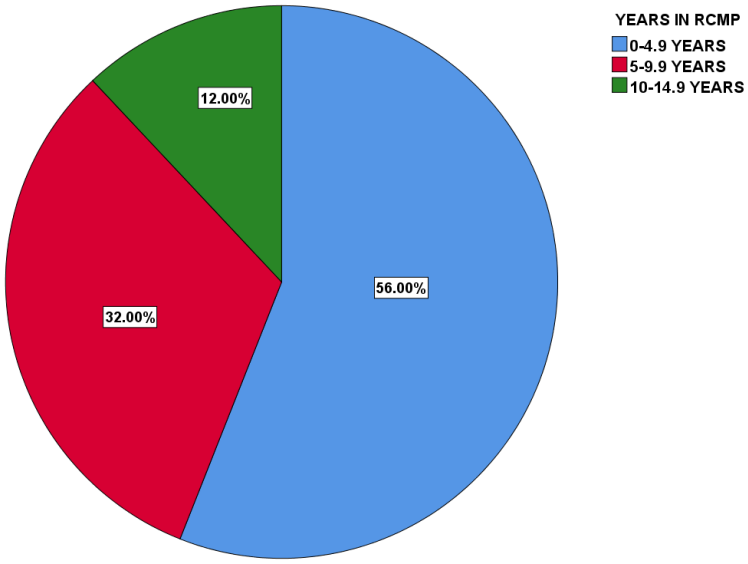
The majority (83.67%) of officers who responded to the questionnaire were male; 84% of respondents were between 21 and 39 years of age (overall average age = 31.8 years, SD=6.18 years), with the average age for male officers being 32.5 years (SD= 6.0 years) and for female officers being 28.1 years old (SD=6.25 years).





Approximately 88% of respondents served with the RCMP for less than 10 years, with one-third (34%) of officers serving less than 2 years. Male respondents served longer on the RCMP (average of 5.3 years; SD=3.9 years) than female respondents (average of 1.1 years; SD=.9 years). Overall, a sizable proportion of officers who responded to the questionnaire were relatively new to the field. Additionally, most respondents were relatively new to the community, with approximately two-thirds (66%) of officers working less than 2 years for the RCMP in Grande Prairie.

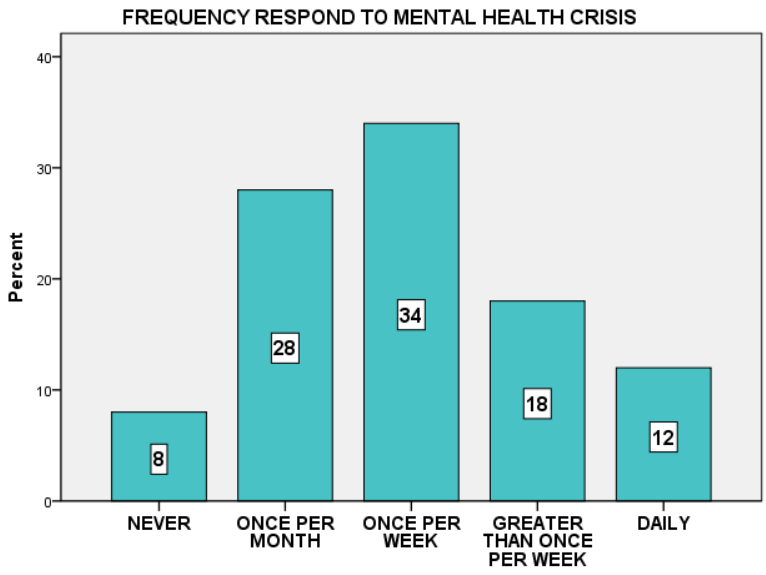




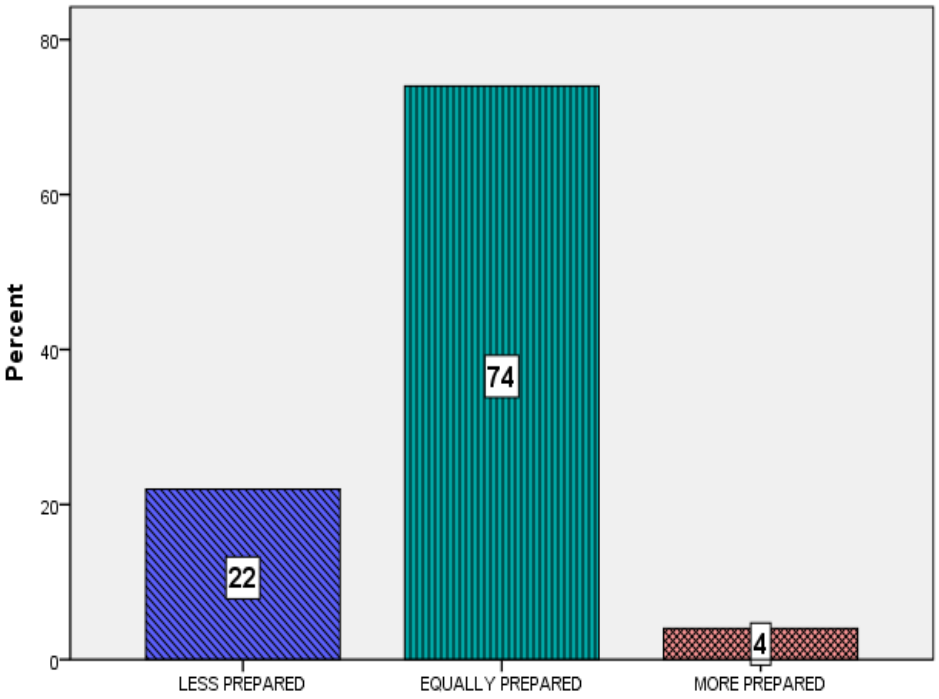
Given the recency with which many of these officers entered the RCMP, it is quite likely that several have not yet had the opportunity to acquire mental health training beyond what they received at Depot. Furthermore, officers who are new to Grande Prairie do not likely have extensive knowledge of which community mental health services and resources are available in the city and which services and resources are not readily available. It is important to keep these possibilities in mind. In Canada, it is estimated that one in three people dealing with mental health issues have contact with the police (Brink et al., 2011). This means that all RCMP officers in Grande Prairie will likely be called, at least on occasion, to attend to those experiencing such crises. As such, officers would benefit from general mental health training that improves relevant skills, knowledge and attitudes as well as from specific education on which mental health related services and resources exist in the community.

b. Experience-Responding Mental Health Crisis

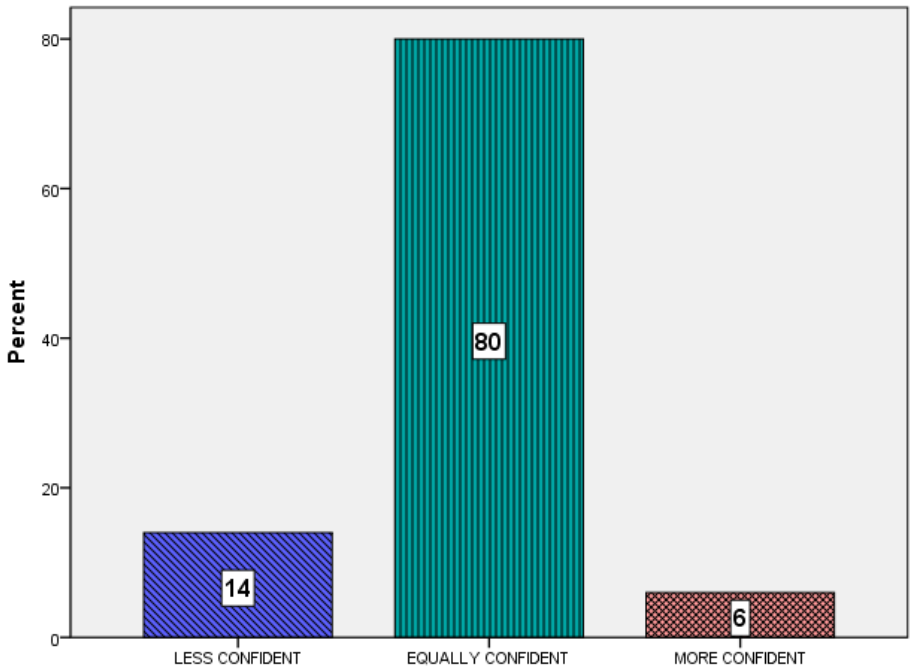
Officers who responded to the questionnaire were asked to report the frequency with which they respond to calls involving a mental health crisis, using a scale ranging from “Never” to “Daily.”. Only 8% of officers reported that they have never responded to a mental health call, whereas 64% of officers attended to those experiencing mental health-related crises at least once per week.



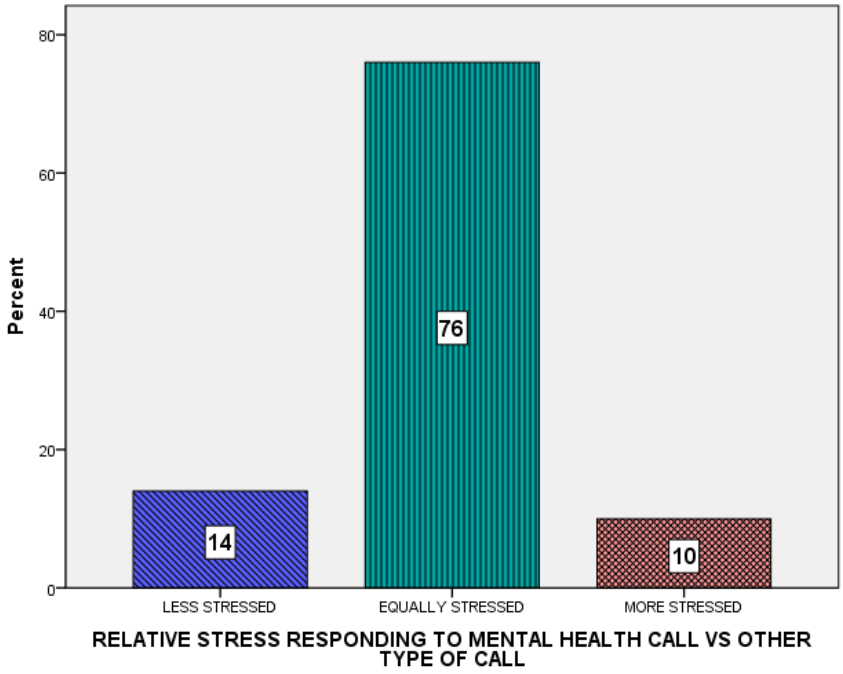
Officers were also asked to compare how prepared, confident, stressed and safe they feel when responding to mental health calls in comparison to other types of calls (which are challenging in their own right). While most officers (three-quarters or more) indicated that they feel that their preparedness, confidence, safety and stress are similar, regardless of they type of call they attend, it should be noted that a significant number of officers (22%) indicated that they feel less prepared when responding to a mental crisis compared to other types of calls. Furthermore, officers' ratings of preparedness were directly correlated with ratings of confidence ($r = +.39$, $p<.01$), meaning that as preparedness increases, so does confidence in responding to such calls (and when preparedness decreases, confidence decreases). Also, preparedness was negatively correlated with ratings of stress ($r = -.41$, $p<.005$), meaning that as sense of preparedness increases, stress decreases (and vice versa).



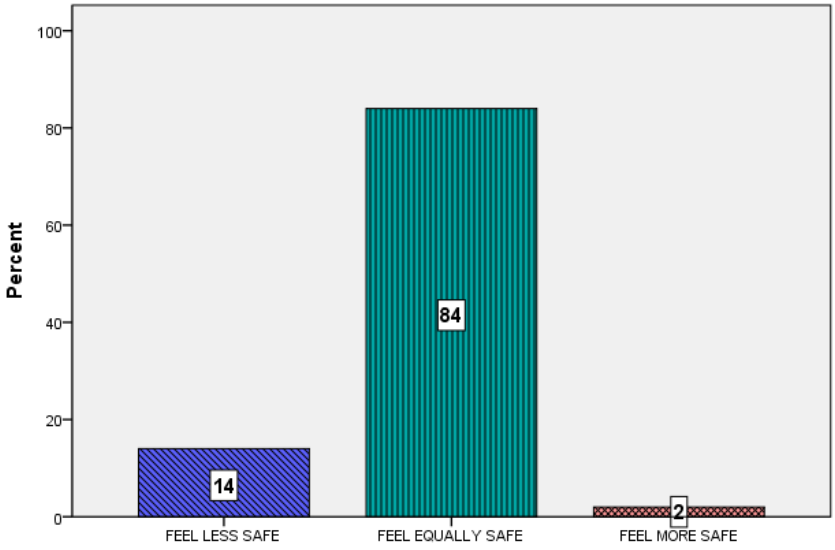
RELATIVE PREPAREDNESS RESPONDING TO MENTAL HEALTH CALL VS OTHER TYPE OF CALL



RELATIVE CONFIDENCE RESPONDING TO MENTAL HEALTH CALL VS OTHER TYPE OF CALL



RELATIVE STRESS RESPONDING TO MENTAL HEALTH CALL VS OTHER TYPE OF CALL



RELATIVE SENSE OF SAFETY RESPONDING TO MENTAL HEALTH CALL VS OTHER TYPE OF CALL

Officers' ratings of their preparedness to attend to mental health related crises did not vary with RCMP experience (i.e., number of years working as an RCMP officer) as expected, nor did it vary with their age (life experience). However, numerous studies do support the premise that officers' preparedness to respond to mental health related calls is related to amount and type of training received; specifically, with more training, preparedness improves significantly

(e.g., Bahora, Hanfi, Chien, & Compton, 2008; Bonfine, Christian & Munetz, 2014; Tully & Smith, 2015). It stands to reason that the positive impact of training has on preparedness would translate to positive impacts on confidence and stress.

It should be noted that training provided at Depot does help prepare RCMP officers deal with crisis situations and that several of the skills developed through such training is applicable to crises related to mental health problems (e.g., assessing the level of risk posed by a client, containing the risk that clients may pose to others, responding with sensitivity and maintaining the dignity of clients). However, it can be argued that additional specialized training is necessary to prepare officers to provide optimal responses to individuals experiencing a mental health related crisis.

For example, mental health crises can escalate or de-escalate based on the management of the crises by first and secondary responders (Compton et al, 2014; Dempsey, 2017). Before officers can effectively handle such situations and minimize escalation, they must be trained to conduct a preliminary assessment to determine the level of risk and to determine whether the risk is tied to mental illness (or other disorders). Further understanding is needed by attending officers that depending on the nature of the mental illness, individuals in crises may hold perceptions and beliefs (i.e., hallucinations and delusions) that are not based on reality and are frequently emotionally overwhelming. This situation is further complicated when clients dealing with mental health issues are also dealing with substance abuse problems. Thus, it is important for officers to do a preliminary assessment of whether the individual in question is also under the influence of a substance. Failure to engage in these preliminary assessments can lead to escalation and in some cases cause injury or further trauma for a client.

Another example that illustrates the importance of implementing a specialized response to reduce escalation pertains to the containment of individuals experiencing a mental health related crisis. One aspect of containment is the use of control. Officers operating from a "Forced Compliance" perspective (i.e., ask for compliance→order compliance→force compliance) may encounter difficulties using this approach when attending to those experiencing a mental health crisis for a variety of reasons. For instance, the client may not hear nor understand the request to comply. Furthermore, the client may not be able to control

his or her behavior and thus is not able to comply. Ordering and forcing compliance in these situations typically lead to escalation; training on appropriate containment of clients who are experiencing a mental health crisis help officers reduce escalation and, equally important, reduces the level of trauma and injury experienced by clients (Compton et al., 2014; Dempsey, 2017).

There are numerous other types of skills which come into play when attending to individuals experiencing a mental health crisis and which can be improved through training. One of these skills is the ability to determine the most appropriate response option (e.g., arrest vs hospitalization) for an individual who is experiencing a mental health crisis and is exhibiting harmful behaviors. In some cases, arrest is necessary and appropriate, but inappropriate arrest contributes to trauma and stigmatization. If more intensive medical intervention is necessary, transport to the hospital is necessary, while inappropriate transport to the hospital contributes to a waste of police and hospital resources. Other useful skills that help officers attend to those in crisis involve developing rapport with the client, establishing trusting relationships with the clients (especially repeat clients), providing assistance to other responders (e.g., Emergency Room staff, EMS staff) and/or caregivers, facilitating referrals to community services, following up with clients (especially repeat clients) and so on.

In order to get a better understanding of the type of training that Grande Prairie RCMP officers could most benefit from and the type of training that officers would be interested in pursuing, two groups of questions were included in the questionnaire. In the first group of questions, officers were presented with a list of various skills related to attending to someone experiencing a mental health crisis and were asked to self-rate their current skill level in terms of effectiveness. In the second group of questions, officers were presented with various topics (organized into categories of “Knowledge”, “Skills” and “Attitudes”) and were asked to indicate whether they would like further training on each topic.

c. Current Skill-Level—Self-Rated Effectiveness

A list of 20 skills were presented in this section of the questionnaire; each skill was followed by a self-rating scale of effectiveness (Very Ineffective, Somewhat Ineffective,

Somewhat Effective, Very Effective, Not Sure, Not Applicable). For ease of presentation in the table (next page), the "Very Ineffective" and "Somewhat Ineffective" ratings were collapsed and are reported as "Ineffective"; "Very Effective" And "Somewhat Effective" ratings were collapsed and are reported as "Effective". The table is organized from the highest percentage of respondents to the lowest percentage of respondents who indicated that they felt their current skill level was effective.

Overall, the largest percentage of officers who rated their skills as effective was seen in skill areas that are relevant to any type of call, namely the skills associated with assessing the level of risk, containing risk imposed on others, responding to clients with sensitivity, and maintaining client's dignity. A large percentage of officers indicated that they were effective in determining and delivering the best response options (e.g., arrest vs ER transport), though it is also important to monitor outcomes to be sure that the best options are in fact chosen and delivered.

A large percentage of officers also rated themselves as being effective at on-the-spot de-escalation. It is quite likely that the training officers received at Depot was sufficient to teach officers how to de-escalate a volatile situation, but it is also important that the de-escalated state is maintained. For individuals experiencing a mental health crisis and who have been de-escalated, re-escalation can occur fairly rapidly. Depending on the type of mental health issue, cognitive and emotional states can be unstable and triggered by seemingly innocuous behavior on the part of responding officers. At times, officers may unknowingly present "tells" (e.g., subtle facial expressions, change in tone of voice, tense body posture) that reveal their own unsettled emotional state and/or pre-existing biases and that might be detected and/or misinterpreted by the person who has just been de-escalated (Shook, n.d.). Furthermore, routine containment procedures may trigger a re-escalation. These situations can be minimized if officers are given special skills-based training on how to assess whether the escalation was originally triggered at least in part by a mental health issue and on how to reveal supportive behavior while conversing with and containing the individual. Attitudes-based training that increases officers' self-awareness and improves understanding about what individuals in a mental health related crisis are going through (e.g., empathy training) would also be beneficial.

EFFECTIVENESS RANKINGS AS A FUNCTION OF SKILL (% OF RESPONDANTS)

TYPE OF SKILL	SELF- RATED EFFECTIVENESS			
	INEFFECTIVE	EFFECTIVE	NOT SURE	N/A
1. Assessing level of risk while attending client	12	88	0	0
2. Containing client's risk to others while in crisis	6	88	4	2
3. Maintaining dignity of client during crisis	8	86	6	0
4. Responding with sensitivity	10	86	0	4
5. Determining response options (e.g., arrest, ER transport)	12	84	4	0
6. Manage risk: on-the-spot de-escalation	12	82	6	0
7. Delivering best response options that address crisis	12	80	8	0
8. Containing client's risk to them self while in crisis	18	74	6	2
9. Conducting an appropriate assessment re: nature of crisis	24	72	2	2
10. Providing assistance to caregivers during crisis	20	70	8	2
11. Forming a relationship with a client with recurring crisis	28	64	4	4
12. Providing assistance to ER staff who attend clients in crisis	24	56	10	10
13. Providing education to clients about topics re: mental health	34	44	8	14
14. Facilitating referrals/linking clients to outreach, agencies, etc.	34	38	14	14
15. Reducing inappropriate use of ER services	36	30	24	10
16. Reducing crime rates and repeat offences due to mental health	50	26	12	12
17. Being able to follow up with client—esp. repeat clients	44	24	12	20
18. Reducing number of arrests of clients who experience crisis	46	24	18	12
19. Reducing ER wait times	40	18	20	22
20. Reducing number of mental health relapses	50	18	12	20

Skill areas whereby there is noticeable drop in self-rated effectiveness are associated with attending to someone experiencing a mental health crisis. Two very important skills of note here are the ability to conduct an appropriate assessment to determine the general nature of the risk (vs level of risk) and the ability to contain the risk clients may impose on themselves while experiencing a crisis. These are skill areas that should be targeted for additional officer training. A large percentage of officers did indicate that they would like further training on different types of mental disorders, symptoms associated with mental disorders vs substance-use and about half would like training on reducing clients' risk to themselves (discussed in next section).

Other important skill areas that should be considered for additional training are areas that lead to better immediate results, such as a) knowing how to work with clients' caregivers (when applicable), b) forming a positive relationship with repeat clients, c) following up with repeat clients, d) assisting ER staff (knowing what information is important to record and to report) thereby reducing ER wait-times, e) helping educate clients (e.g., providing information) and f) facilitating community referrals. Strong skills in these areas also translate into better long-term results (e.g., reduction in mental health relapses, reduction in crime rate and arrests). Interestingly, when it comes to these skill areas, a significant proportion of officers were uncertain (i.e., not sure) of their skill level or believed that these skills are not applicable to their work as an RCMP officer. Perhaps these officers have not had the opportunity to apply and test these skills in their work, do not recognize the impact of these skills when they are applied, or feel that they do not have the time in their busy schedules to engage in this type of work. Further investigation would be warranted to determine the reasons for these ratings.

Generally speaking, strengths and weaknesses in one skill area may affect strengths and weaknesses in other skill areas. To determine which skill areas are related and how strongly they are related, correlational analyses were conducted.

Ratings on most skill areas were somewhat related, but only ratings with strong correlations (r = .70 or greater) are reported below:

- Conducting an appropriate assessment re: nature of crisis was strongly related to:
    - the ability to determine the best response option

- Reducing inappropriate use of ER was strongly related to:
    - Being able to facilitate referrals
    - Being able to reduce mental health relapses
- Reducing arrests was strongly related to:
    - Being able to facilitate referrals
    - Being able to follow up on a client
- Reducing recidivism was strongly related to:
    - Being able to follow up on a client
    - Being able to reduce mental health relapses
- Providing education to clients was strongly related to:
    - Being able to reduce arrests
    - Being able to reduce inappropriate use of the ER

d. Expressed Interest in Further Training

To determine the type of training that RCMP officers are interested in further pursuing, respondents were presented with various topics that were organized into the domains of Knowledge, Skills, and Attitudes (i.e., KSAs). Areas presented were selected from officer training handbooks (e.g., Coleman, T. G., & Cotton, D. (2014)). For each area in each domain, respondents were asked to indicate whether they would like further training (Yes vs No). They were also asked to pick the top 5 areas of interest for further training. Results below are organized from highest frequency (% or respondents) of expressed interest to lowest.

DOMAIN-KNOWLEDGE

AREA	% PARTICIPANTS WHO EXPRESSED INTEREST IN ADDITIONAL TRAINING	% PARTICIPANTS WHO PICKED AS TOP 5 AREA
How symptoms that appear to be due to a mental disorder may be due to substance use (intoxication, overdose, withdrawal)	82	52
Different types of mental illness that clients might present	80	50
How symptoms that appear to be due to substance use (intoxication, overdose, withdrawal) may be due to a mental disorder	74	38
Symptoms commonly associated with using various types of drugs	64	30

Symptoms commonly associated with various mental disorders	60	20
The types of forms that may be used when responding to a client experiencing a mental health crisis	58	22
How engagement in criminal activity is related to the type and severity of a client's mental disorder (when applicable)	58	6
Which agencies/other supports exist in Grande Prairie to help clients who experience mental health crisis	56	14
How symptoms that appear to be due to a mental disorder or substance use may be due to a medical crisis or chronic medical issue	54	14
How being in a mental health crisis can affect a client's ability to respond to or comply with instructions given by others	54	12
Relevant mental health legislation	54	12
Different classes/types of drugs that are commonly used/abused in GP	52	40
The ways substance use/abuse are in fact mental health issues and how these problems are classified by experts in terms of mental disorder types	52	16
How to contact agencies/other supports and how to make referrals for clients experiencing a mental health crisis	52	6
How a client's risk to self and others is related to the type and severity of the mental health crisis	52	4
RCMP's policies and procedures re: communicating and assisting a client experiencing a mental health crisis	50	8
How being in a mental health crisis can affect a client's ability to attend/understand information or instructions given by others	48	14
How suicidality is related to challenges associated with mental illness, substance use, and/or situational stressors	48	10
How engagement in criminal activity is related to the type and severity of a substance use (when applicable)	46	8
RCMP's professional code of conduct re: assisting a client experiencing a mental health crisis	46	8

How to access or register for relevant training workshops or courses to acquire more information about mental health crisis	46	2
How symptoms associated with mental health crisis can vary with sociodemographic factors associated with a client	44	12
How mental health may be compromised by aggravating situational factors	44	8
How suicidality is related to challenges associated with other sociodemographic factors (e.g., age, gender, history of suicide)	42	2

DOMAIN-SKILLS

AREA	% PARTICIPANTS WHO EXPRESSED INTEREST IN ADDITIONAL TRAINING	% PARTICIPANTS WHO PICKED AS TOP 5 AREA
How to conduct an assessment regarding suicidality of the client	66	32
How to conduct an assessment to determine the severity of the client's mental health crisis	62	30
How to calm the client and engage in conflict resolution to prevent an escalation, de-escalate a conflict or diffuse a crisis situation	60	46
How to conduct an assessment to determine the nature of the client's mental health crisis (type of mental disorder, whether substances used)	58	40
How to conduct an assessment regarding the risk imposed by a client to themselves or others while he/she is in crisis	58	26
How/when to respond to suicidal ideation/suicidal threats/suicidal behaviors expressed by the client	56	24

How to communicate with clients (before, during, after crisis) to acquire necessary information to provide best assistance	46	32
How to involve caregivers/other supports in deciding on treatment options	44	14
How to disarm a client who is experiencing a mental health crisis, stabilize the situation, encourage cooperation	44	24
How to provide client focused assistance to client experiencing crisis	42	12
How to develop/apply interpersonal skills that will enable you to build rapport with clients in crisis	40	14
How to apply use of force skills or similar models when assisting clients in crisis	40	10
How and when to intervene to contain a dangerous situation that may arise when a client is experiencing a mental health crisis	38	22
How to use non-violent crisis intervention skills as needed for clients in crisis	38	12
How to use technical and research databases to acquire more information about mental health crisis	36	8
How to access or register for relevant training workshops or courses to acquire more skills on handling mental health crisis	34	4

DOMAIN-ATTITUDES

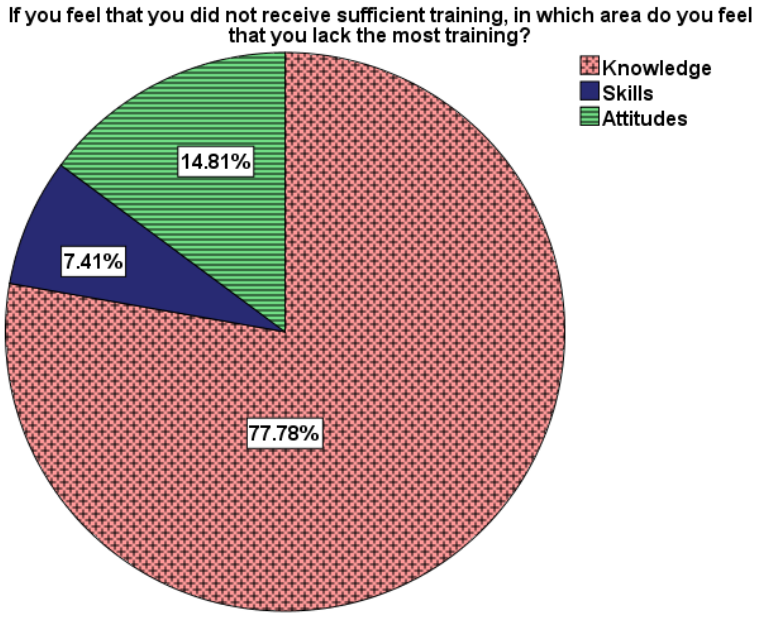
AREA	% PARTICIPANTS WHO EXPRESSED INTEREST IN ADDITIONAL TRAINING	% PARTICIPANTS WHO PICKED AS TOP 5 AREA
Training that encourages responders to better understand the perspectives of clients experiencing a mental health crisis (empathetic responding)	54	36
Training that provides hand-on opportunities designed to develop your confidence in your knowledge regarding mental disorders/substance use etc	50	34
Training that provides hand-on opportunities designed to develop your confidence in your skills regarding how to respond to a person in crisis	48	22
Training on why it is important to incorporate client/family/supporter feedback when appropriate	46	14
Training that challenges stigmatizing attitudes about people who have a mental disorder	42	20

Training on why it is important to make an effort to seek out and acquire background information on their clients	42	20
Training that challenges over-generalizations and/or over-simplifications regarding mental health issues	42	12
How to access or register for relevant training workshops or courses to learn how attitudes can impact the quality of RCMP services for clients in crisis	36	8

Overall, there appears to be enough expressed interest in almost every KSA to warrant the development of multiple training opportunities for officers; many of the topics could be packaged and offered together (e.g., "How symptoms that appear to be due to a mental disorder may be due to substance use (intoxication, overdose, withdrawal)" offered with "How symptoms that appear to be due to substance use (intoxication, overdose, withdrawal) may be due to a mental disorder"). Recording and tracking positive/negative outcomes of calls attended by officers (e.g., negative—client became more agitated and aggressive; positive—client is de-escalated and put into contact with community agency) over a period (e.g., 6 months) would help to prioritize areas for further training. Feasibility (e.g., ability to take officers off-duty so that they could pursue training) should also be factored in. There are various training methods available; officers prefer some methods over others.

e. Current Training/Preferred Training

When asked about their past training, almost all respondents (96%) indicated that they received their police training at Depot. Half of these respondents indicated that they felt that they were not sufficiently trained to attend to clients who are experiencing mental health crisis. The domain (i.e., Knowledge, Skills, Attitudes) that they felt was most lacking was "Knowledge".



It should be noted that despite this gap in training, almost two-thirds (62%) of respondents felt that they do not have enough time in their work schedule to pursue further training on the presented KSAs. Thus, if possible, work schedules would need to be adjusted to free up time so that interested officers can pursue this training.

Respondents were asked to indicate their preference regarding the method with which training is delivered. By far, formal face-to face training was preferred; this training would need to be scheduled to fit into work schedules. Furthermore, regarding formal training options (full course vs workshop), the choices were split with 46% preferring a full course and 48% preferring a workshop (6% did not answer this question).

PREFERRED METHOD OF TRAINING	MOST PREFERRED METHOD (1ST CHOICE) % OF PARTICIPANTS	LEAST PREFERRED METHOD (4th, or LAST CHOICE) % OF PARTICIPANTS
Formal Training-Face to Face	50	14
Formal Training-Online Delivery	14	30
Formal Training-Blended	18	6
Prefer to Learn On Own	18	42
Total	100	92*

*Not all participants picked a last choice (i.e., 4th choice), thus percentages do not add up to 100%

Respondents were also asked to indicate their preferred style of learning, and the frequency of training they prefer. The majority prefer to learn from experts with the opportunity to practice taught skills. It is important that new skills be practiced as frequently as possible to develop competence and for the new skills to "stick" and be applied smoothly in real life situations. Repeated practice of skills is particularly important for those that are used in high-stress real life situations.

PREFERRED STYLE OF TEACHING/LEARNING	*% OF PARTICIPANTS
Lecture—Expert Presents Information	76
Hands-On Learning—Learners Are Given Scenarios and Practice Skills That are Taught	70
Discussion Groups-Learners Share Information/Experiences	48
Gathering Own Materials (e.g., books) On A Particular Topic and Learn On Own	30

*Participants selected all options that applied

With regard to the preferred frequency of training opportunities, almost two-thirds (64%) of participants indicated that they wish to pace their additional training at a moderate rate (once a year/once every two years). This is a reasonable pace, as learners typically understand and remember best by learning and practicing manageable amounts of new material at a time.

RECOMMENDED FREQUENCY OF LEARNING OPPORTUNITIES	% of Participants
More than Once a Year	20
Once A Year	32
Every 2 Years	32
Every 5 Years	10
Never-My Organization Is Not Responsible for Providing Opportunities	2
Never-I Feel That the Training Staff Received Before Being Hired Is Sufficient	0
Other	2

As to when specialized training should be introduced, research has shown that training of new material is most effective after officers acquire some field experience. Some experts (e.g., Dempsey, 2017) have suggested that officers pursue specialized training after working at least

one year in the field. Field experience helps officers anchor the newly learned material to meaningful examples that they have personally experienced.

2. EMTs'/Paramedics' Responses

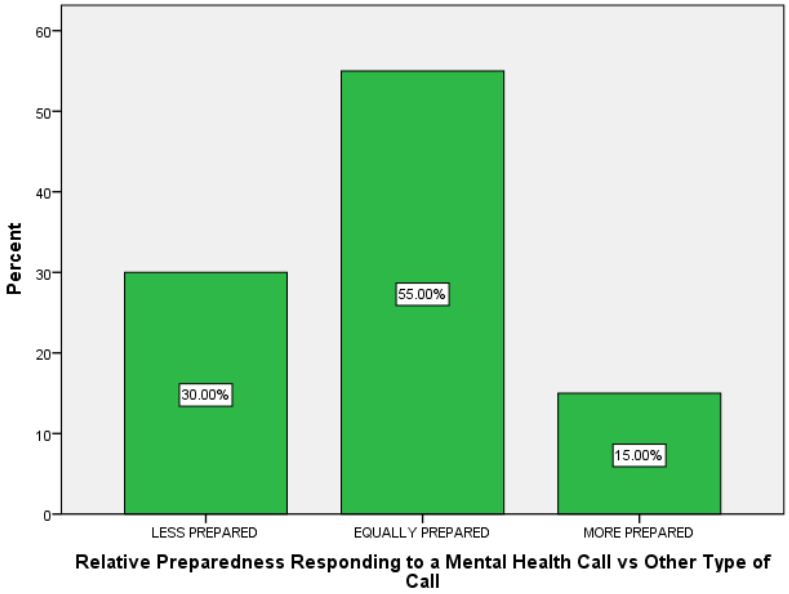
Because Grande Prairie EMTs and Paramedics are often first responders to 911 calls involving mental health crisis and at times attend calls along with GP-PACT and/or non-PACT RCMP officers, it was important to capture their perspectives. In the questionnaire, respondents were asked to provide information about their experiences working in the field, experiences working with patients exhibiting mental health issues and their experiences working with GP-PACT. Because they may witness GP-PACT in action, they were asked to evaluate the PACT program on various dimensions and to provide recommendations.

a. Demographic Information & Work Experience

Twenty EMTs/Paramedics completed the survey, 55% of whom were female and 45% were male. Number of years worked in the field ranged from 3 to 27 years (average = 10.39 years, SD = 6.31 years); number of years working in the field in Grande Prairie ranged from 1 year to 20 years (average = 7.32 years; SD = 4.92 years).

b. Experience-Responding Mental Health Crisis

All EMTs/Paramedics indicated that they have responded to calls whereby the patient was experiencing a mental health crisis and 80% indicated that they respond to such calls once a week or more (average weekly rate = 3.0 times, SD= .89). Like the non-PACT RCMP members who were involved in this study, EMTs/Paramedics were asked to compare how prepared, confident, stressed and safe they feel when responding to mental health related calls in comparison to other types of calls. Responses were as follows:


Percent
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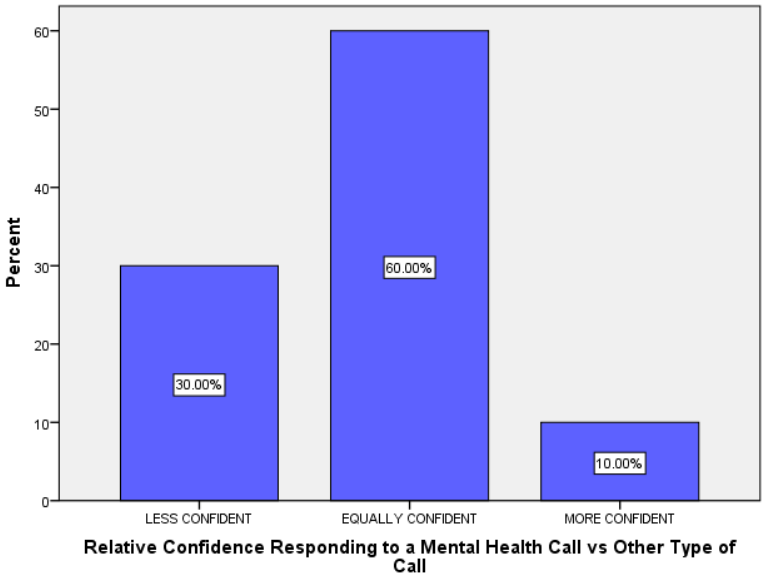
50
40
30
20
10
0
30.00%
55.00%
15.00%
LESS PREPARED
EQUALLY PREPARED
MORE PREPARED
Relative Preparedness Responding to a Mental Health Call vs Other Type of Call


Percent
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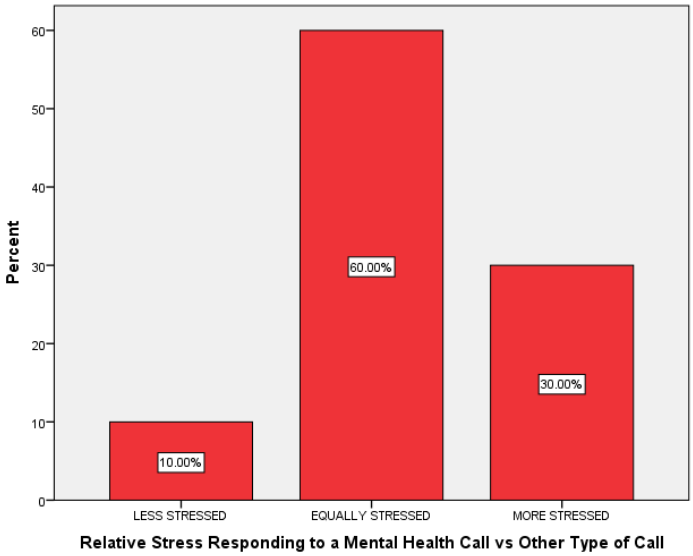
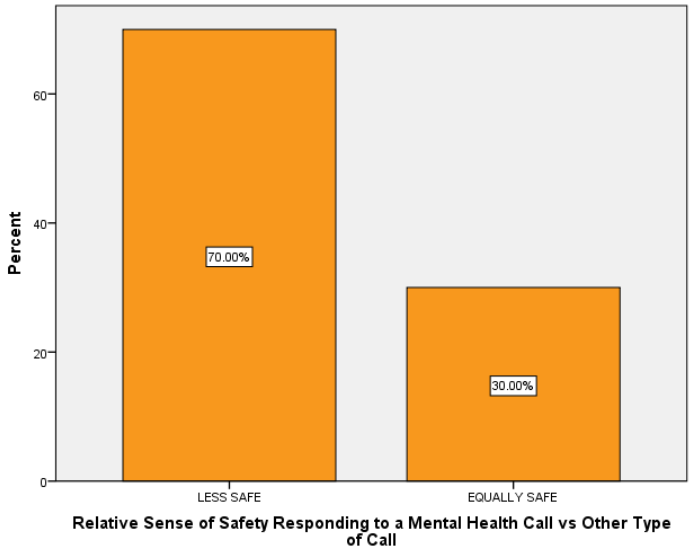
30.00%
60.00%
10.00%
LESS CONFIDENT
EQUALLY CONFIDENT
MORE CONFIDENT
Relative Confidence Responding to a Mental Health Call vs Other Type of Call





In comparison to RCMP members, more EMTs/Paramedics report feeling less prepared to attend to mental health related calls (compared to other types of calls), less confident, more stressed and much less safe. Reasons given for these responses include the unpredictability of clients who are in a mental health crisis. Only 35% of respondents indicated that they have received sufficient training to effectively assist someone who is experiencing a mental health crisis; those with sufficient training stated that they had to pursue this training on their own. Furthermore, 40% of EMTs/Paramedics indicated that the vehicles (i.e., ambulances) are not adequately set up to help a person who is experiencing a mental health crisis. In fact,

comments were made to suggest that ambulances compromise safety, especially for patients who are agitated and might become aggressive. They reported that ambulances are too confined, have only one exit, and are outfitted with sharp objects that could be used as weapons; sirens often further agitate patients. Thus, EMTs/Paramedics would benefit from some sort of assistance in addressing such calls, including having GP-PACT members attend these calls with them and transport the client if immediate medical attention is not required.

c. Experience working with GP-PACT

EMTs/Paramedics were asked if they had worked with GP-PACT over the previous year; all 20 respondents indicated that they had. A little over half (55%) indicated that, on average, they work with GP-PACT about once a month, whereas the remaining 45 percent worked with GP-PACT more frequently--about once per week (20%) or more than once per week (25%).

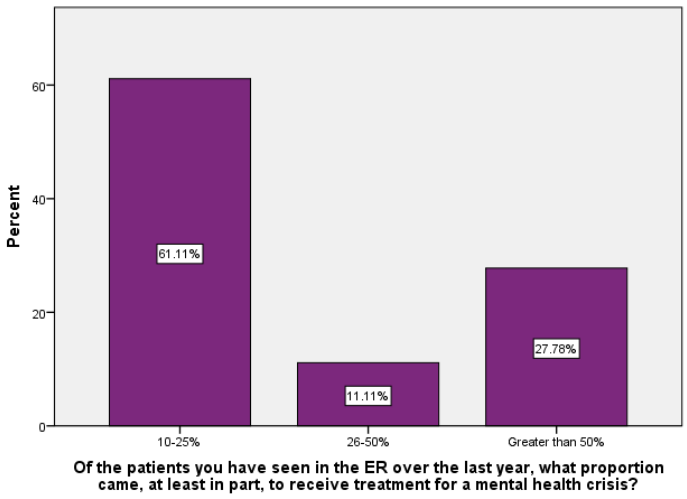
They were further asked whether they worked with GP-PACT on a variety of specific types of calls over that previous year (Yes vs No). The following percentages refer to the percentage of EMT/Paramedics who attended each type of call with GP-PACT at least once:

- 95% EMTs/Paramedics worked with GP-PACT re: suicidal attempted/threat to self
- 90% EMTs/Paramedics worked with PACT re: mental health. The breakdown is as follows:
  - Schizophrenia/Psychosis-85%
  - Depressive/Anxiety—80%
  - Bipolar-70%
  - Disruptive/Impulse control—40%
  - Trauma/Stress—15%
  - Eating/Sleeping Disorder—10%
- 85% EMTs/Paramedics worked with GP-PACT re: substance related issue (40% re: overdose/withdrawal)
- 35% EMTs/Paramedics worked with GP-PACT re: personal crisis (e.g., job loss)
- 15% EMTs/Paramedics worked with GP-PACT re: domestic violence

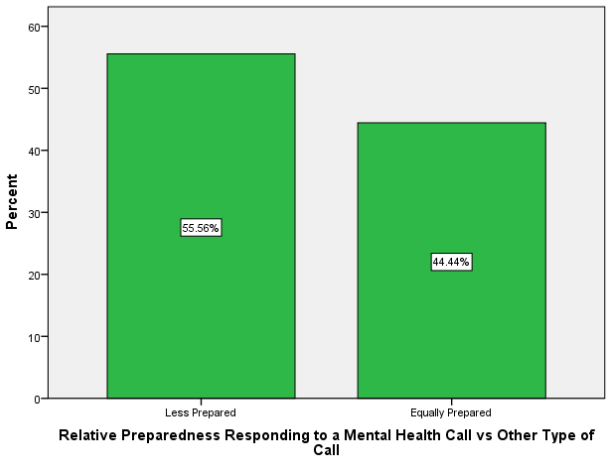
3. Emergency Room Nurses' Responses

Emergency Room nurses often attend to patients who are experiencing a mental health crisis that is severe enough to bring the patient to the ER. From time to time, these nurses work with the GP-PACT team. For these reasons, ER nurses were included in the study by answering a questionnaire. Eighteen nurses responded to the questionnaire. They were asked about a) their experience working in the field and their experience working with patients going through a mental health crisis. They were also asked to provide comments and recommendations regarding the GP-PACT program.

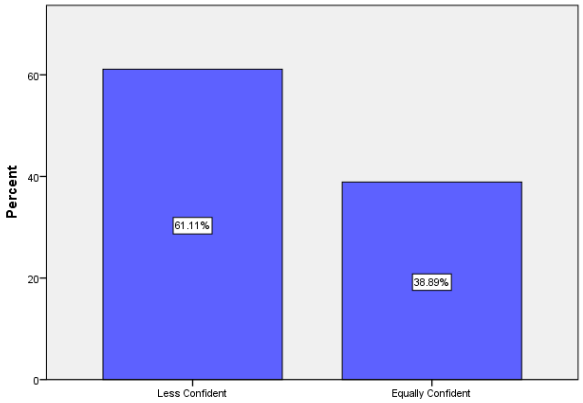
The nurses who answered the survey worked as an Emergency Room nurse in Grande Prairie for an average of 5.02 years (SD = 4.39 years; range = .5 to 15 years). In the previous year, 100% of the nurses had attended to a patient experiencing a mental health crisis; 94.4% of the nurses indicated that they attend to such patients on a daily basis. When asked to estimate the proportion of all ER patients they attended were at the ER in part due to a mental health crisis (options: none, less than 10%, 10-25%, 26-50% and over 50%) responses were as follows:



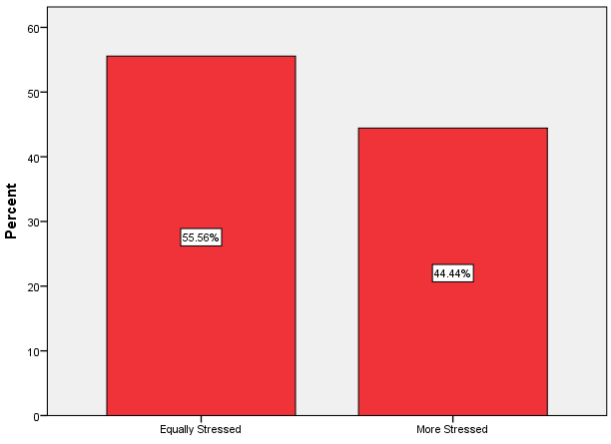
Overall, ER nurses very frequently are in a position whereby they need to attend to a mental health crisis. As with the RCMP and EMTs/Paramedics, nurses were asked to compare how prepared, confident, stressed and safe they feel when responding to mental health related calls in comparison to other types of calls. Responses were as follows:



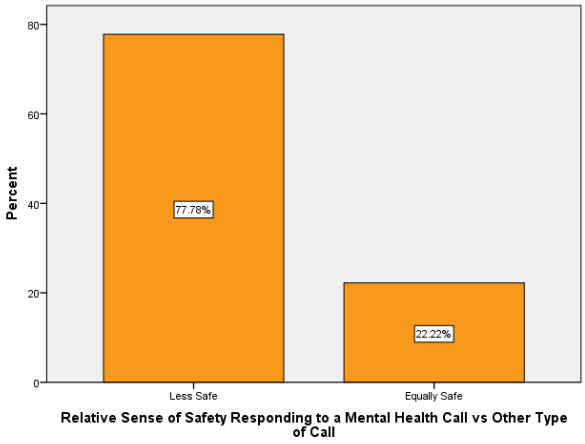
Relative Preparedness Responding to a Mental Health Call vs Other Type of Call



Relative Confidence Responding to a Mental Health Call vs Other Type of Call



Relative Stress Responding to a Mental Health Call vs Other Type of Call



Overall, a larger percentage of nurses feel less prepared, less confident, more stressed, and less safe attending to patients experiencing a mental health crisis compared to when they attend to patients dealing with other types of problems. Furthermore, nurses' ratings are quite alarming when compared to ratings given by the non-PACT RCMP officers and the EMTs/Paramedics. These ratings point to issues that could be addressed, either through additional training or through supports. Training needs highlighted by the nurses included learning how to identify mental health problems and how to choose treatment options, learning how to de-escalate a crisis situation, learning more about community resources and learning more about the mental health act.

One type of valuable support that could be made available to ER nurses is GP-PACT. Most nurses (83.3%) who responded to the questionnaire had heard of PACT. Only 33% of the nurses called GP-PACT while on duty and the frequency with which these nurses have called GP-PACT is low (once a month or less). It is quite possible that it does not occur to ER nurses that they could use GP-PACT as a resource when necessary and appropriate. Thus, education on this option would be beneficial.

Other supports mentioned by nurses included the need for a private and appropriate space to help those experiencing a mental health crisis. Such spaces help maintain the dignity of patients, reduce the likelihood that other patients become alarmed, reduce the likelihood of patients becoming triggered by others and helps keep all patients safer.

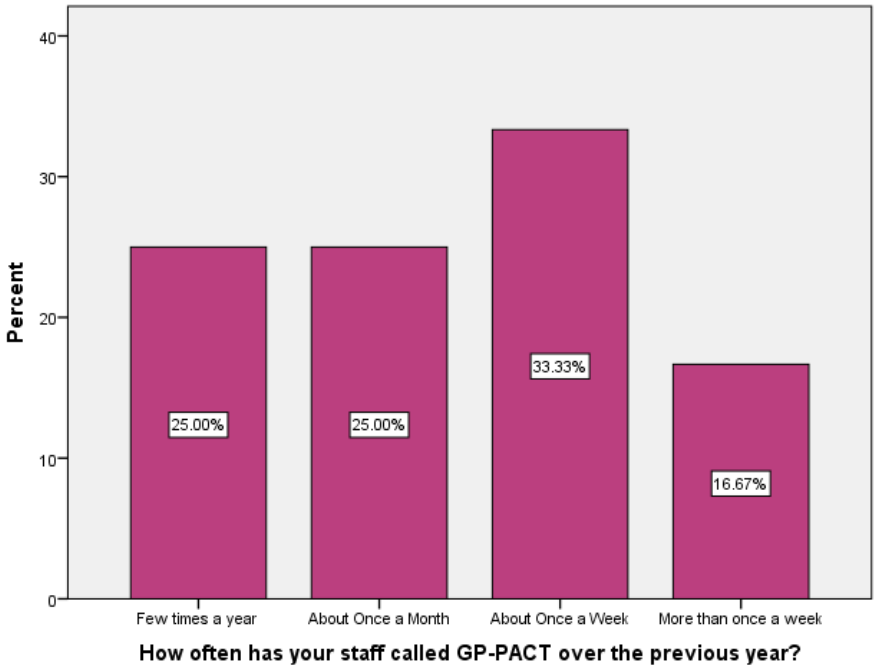
4. Community Agencies' Responses

A total of 28 agencies across Grande Prairie were initially screened via phone to determine whether they had sufficient knowledge of the GP-PACT program or contact with the GP-PACT team. Agencies that indicated that they had not heard of the program or GP-PACT team or had never encountered them were not included in the survey. Agencies that did not feel comfortable answering questions pertaining to the program/team/services also were not included. In the end, 12 agencies agreed to participate.

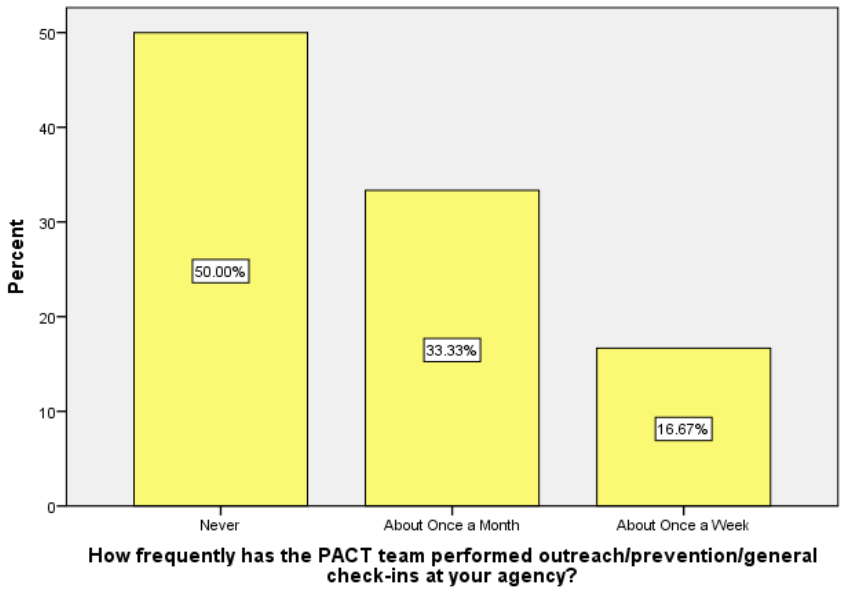
Representatives who could speak on behalf of the agency and who had experience working with GP-PACT were interviewed either face-to-face or via phone interviews, depending on the representative's preference. Upon attaining permission, interviews were digitally recorded and later transcribed. Respondents were provided with a copy of the questions prior to the interview.

The first half of the interview consisted of questions that pertained to the frequency with which the agency called GP-PACT and frequency with which GP-PACT engaged in outreach activities with them. In the second half of the interview, respondents were asked to rate the program on various Key Performance Indicators (discussed later in the paper).

All agency representatives indicated that their staff had called GP-PACT in the previous year, with 50% of agencies calling quite frequently (once a week or more) and 50% calling quite infrequently (once a month or less).



The reported frequency with which the GP-PACT team performs outreach, prevention, general check-ins at their agency is somewhat variable, with 2 agencies reporting weekly drop-ins and the remainder reporting a drop-in rate of once a month or less. Some agencies indicated that they would like to see GP-PACT at their agencies more often (in non-crisis situations). Representatives also rated GP-PACT on a variety of KPIs (reported later in the paper).

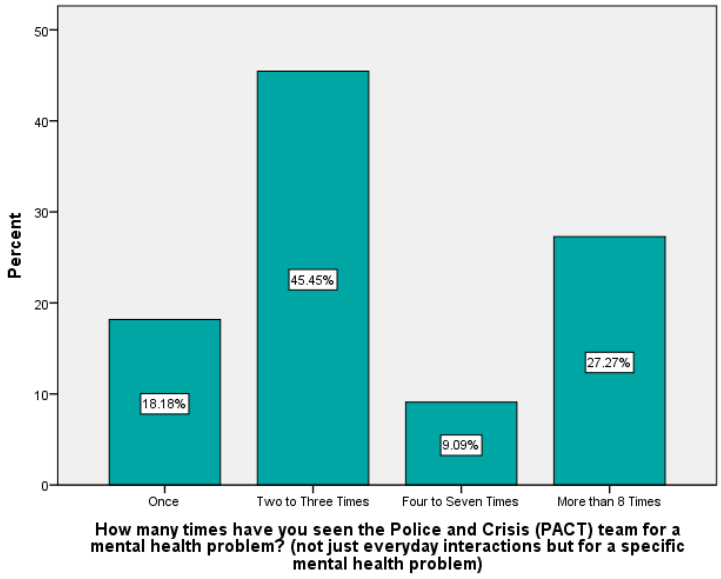


5. Clients' Responses

Community agencies were asked for advice regarding the best approach and avenue to recruit clients who had utilized GP-PACT services. Such clients are not only vulnerable; they also are frequently quite transient. The language used in the client interview was modified to suit an elementary school reading level; feedback was sought from case workers as to the appropriateness of the language and the questions asked. Clients were recruited at various community outreach events hosted by community agencies and the City of Grande Prairie. A table was set aside for the interviews.

An interviewer was present on site to explain any questions and offer assistance in reading the questions or filling out the survey. The interviewer asked for verbal consent from the participant before continuing with the survey. Potential participants were excluded if they indicated they had no knowledge of the GP-PACT program/services and were excluded if they did not have the ability to sufficiently understand the questions or the interview process. In the end, 11 clients were recruited to complete an interview.

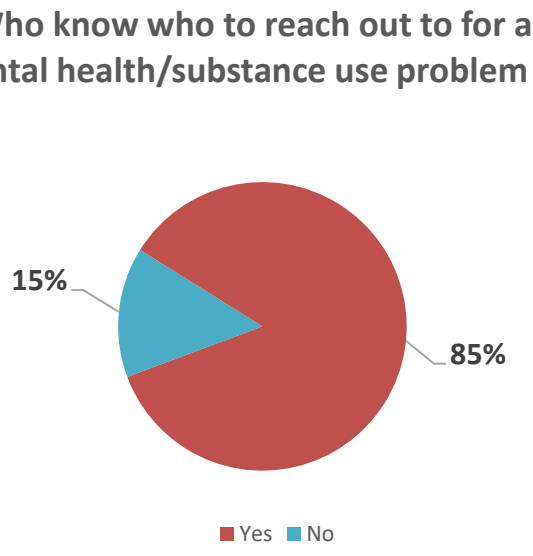
Because knowledge about GP-PACT was used to filter in clients as respondents, all respondents knew something about the types of problems that GP-PACT could help them with. When asked how many times they have seen GP-PACT for a mental health problem, about 82% indicated that they have repeatedly relied on the team. Responses to this question were as follows:



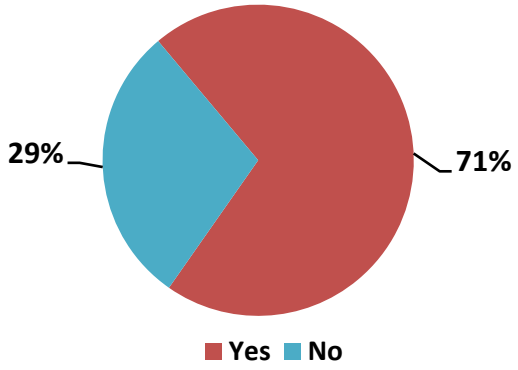
6. General Publics' Responses (Public Awareness)

To assess the level of community awareness of the GP-PACT program, input was sought from the general public. Grande Prairie Crime Prevention assisted with participant recruitment by advertising the survey on their Facebook page, website and newsletter. SurveyMonkey was utilized to collect responses to four questions, all of which were given in a "yes-no" format. The survey was open to the public for a period of one month. The recruitment message used was as follows: "Please participate in GPRC's 1 MINUTE mental health survey to inform recommendations for the Police and Crisis Team program and for a chance to WIN A $20 GIFT CARD of your choice." In the end, 48 members of the public answered the survey.

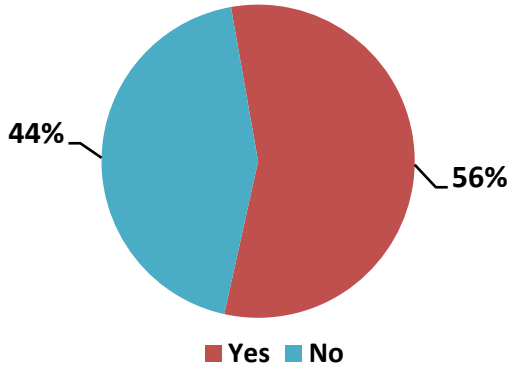
Questions asked were "Do you know who to reach out to when you/someone you know is dealing with a mental health or substance use/addictions problem?", "Have you heard of the Police and Crisis Team (PACT)?", "Do you know what types of problems the Police and Crisis Team (PACT) help people with?" and "Do you know how to contact the Police and Crisis Team (PACT) if you/someone you know needs them?" Responses were as follows:



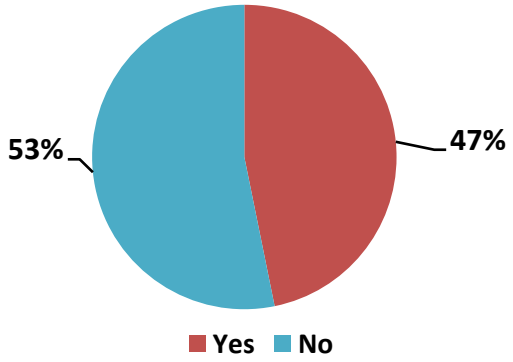
% Who have heard of the Police and Crisis Team (GP-PACT)



% Who know what types of problems the Police and Crisis Team (PACT) assists people with



% Who know how to contact the Police and Crisis Team (GP-PACT)



Generally, most members of the public reported that they know who to contact if they or someone they know experciences a mental health or substance-use related problem, but some individudals (39%) have not even heard of GP-PACT. Furthermore, a little over half (56%) of the respondents indicated that they know what types of problems GP-PACT can help them with and fewer than half (47%) reported that they knew how to contact GP-PACT. These findings reveal an opportunity for public education for Grande Prairie residents; an education campaign should be launched to educate the public about what GP-PACT does as well as when and how to reach the teams.

It should be noted that the GP-PACT members have indicated that it is better if callers use 911 to reach the team rather than calling the team on their direct numbers. This advice applies to the general public and to community agencies requesting service for an emergency. Using 911 guarantees a response (either from GP-PACT or other first responder) whereas using the direct GP-PACT line does not. PACT teams in Grande Prairie are not always available because they do not provide service 24 hours a day and they may be busy attending to another call when someone calls their direct line; the GP-PACT cannot answer a call to their direct line if they are attending to someone exhibiting high risk behaviors that requires focused attention.

The team members indicated that it may be appropriate for other first reponders (e.g., EMS, General Duty RCMP) to use the direct line in emergency situations, but if GP-PACT is not available, they should attend to the call to the best of their abilities and fill out a Community Referral Evaluation Form for the GP-PACT team to follow up when they are free. The team also invites community agencies to call the direct line if they are calling for a consultation or a request for a drop-in.

Research has shown that training the public (clients, caregivers, family) and others (e.g., community agencies) on proper telephone 911 communication significantly helps streamline the call-response process (e.g., Dempsey, 2017; NAMI, n.d.). All groups who make such calls would benefit if they were educated on when they should call 911 regarding a mental health issue, what information they should give the dispatcher (e.g., mental health history and current mental health status, access to weapons, ingestion of substances) what information they are allowed to give to the dispatcher, and what they should be prepared to tell the first responders

when they arrive. Some communities in the United States have created 911 checklists for family members and other caregivers to use when calling for assistance on a mental health crisis, including:

- name of caller
- address responder should come to
- list of weapons present
- information on person in crisis
    - age, gender, other physical descriptions as necessary (e.g., height, weight, hair color, clothing etc. if the person is on the move)
    - diagnosis
    - past and current drug/alcohol use
    - medications (on vs off)
    - prior violent behavior
    - past psychosis--delusions and hallucinations
    - triggers
    - things that have helped in the past
    - other relevant information (e.g., direction the person went if they left, whether there is a dog on the premises)

A public education campaign for the Grande Prairie public that includes such a checklist as a sort of tool would help streamline the 911 call-response process. Also important to include in such a campaign is information as to the location where 911 calls go and from where they get dispatched. For the city of Grande Prairie, 911 calls are dispatched from a centre in Sherwood Park, Alberta, which is over four hours away from Grande Prairie. Thus, it is important that the public knows that they cannot assume the dispatcher knows anything about Grande Prairie and that the 911-caller needs to communicate relevant information to enable a proper dispatch. Although the Sherwood Park dispatchers use a system that that dictates the order and type of questions to be asked (so that they can determine the caption and priority of each call), a prepared caller will greatly help the dispatcher with the process.

Targeted 911 education campaigns would also be of great value for other groups who do or could find themselves in a position to help individuals who go into mental health crises from time to time (e.g., staff who work at shelters, community agencies, schools, and community facilities). Furthermore, first responders (e.g., general duty police) who attend a mental health call and think GP-PACT should follow up on the client/sitution would communicate more fully

the nature of the need for follow-up if they used such a comprehensive checklist along with the Community Referral Evaluation Form they currently use.

GP-PACT Evaluation

Evaluation of the GP-PACT program was completed using four approaches. First, in each of their respective surveys, four groups of professionals, namely General Duty RCMP, ER Nurses, EMTs/Paramedics, and representatives from Community Agencies, were presented with open-ended questions whereby they were asked to describe what they believed to be the benefits and drawbacks of having the PACT program in Grande Prairie; they were also asked to provide recommendations as to how the GP-PACT program could be improved. Second, three groups of individuals, namely EMTs/Paramedics, Community Agencies, and Clients of GP-PACT, were presented with a series of Key Performance Indicators (KPIs) and asked to rate GP-PACT's effectiveness on each indicator. Third, call data was analyzed to determine the number and type of calls attended by GP-PACT and the outcome of the calls. Fourth and finally, a Social Return of Investment analysis was completed to determine the cost-effectiveness of the GP-PACT program. Results from each of these four approaches will be presented next.

Survey Responses-Open Ended Questions

1. Benefits of GP-PACT

Presented are the responses provided by General Duty RCMP members, EMTs/Paramedics, ER nurses, and Community Agencies when asked what they perceived to be the benefits of having a PACT program in Grande Prairie. Common themes across all groups pertain to the GP-PACT member's specialized training and expertise regarding mental health, their knowledge of the clients (e.g., medical history, personal background) and better use/reduced strain of community resources. Themes of responses were as follows:

a. General Duty RCMP Responses:

- GP-PACT have knowledge/expertise re: Mental Health
    - Know how to deal with bigger mental health issues
    - Know how contextual factors affect behaviors
    - Specialized standard of service to those in a mental health crisis

    - Higher standard of service to those in a mental health crisis
    - Knowledge allows for more consistent responses across clients and for repeat clients
- Has better working relationship with other health care professionals and with client's support network (e.g., case workers, family members, group home workers, etc.)
- Has better knowledge about repeat clients
    - Client is more comfortable with team if they know the team members→client has more positive relationship with team→fewer escalations
    - Much quicker understanding of what the client is going through because GP-GP-PACT knows the client's background and mental health history
- Has more efficient access to community-based resources
- Nurse on team
    - Has access to medical history
    - Allows for more accurate diagnosis
    - Diagnosis improves quality of response and quicker admission to hospital
        - Reduced wait times (e.g., don't have to wait for Form 10)
    - People in mental health crisis are more receptive to a nurse than to an RCMP officer
- Specialized RCMP officer on team
    - Has special interest in helping those in crisis
    - Handling of calls is safer due to officer training
- Alleviates strain on hospital resources
    - Less people taken to hospital unnecessarily
- Alleviates strain on General Duty RCMP
    - GP-PACT alleviates call volume—allows General Duty RCMP to attend to other calls

- General Duty RCMP—have less expertise re: mental health, community resources, appropriate resolution techniques
  - GD RCMP spend much more time trying to provide an appropriate response on such calls than GP-PACT would require
  - GD RCMPs' responses might not be as appropriate as GP-PACT response (e.g., erring on the side of caution: arrest person who claims to be suicidal and take person to hospital)

b. EMTs'/Paramedics' Responses

- GP-PACT members have more specialized training re: mental health and experience with clients→more efficient response
  - Having a psychiatric nurse attend to a mental health call makes a big difference
    - GP-PACT is helpful when need Form 10
    - Psychiatric nurses have more direct contact with physicians
    - Psychiatric nurses have access to pharmaceuticals not available to EMS
  - Efficiency reduces strain on other RCMP members
- GP-PACT response often leads to more effective response/better outcomes
  - Team is better at de-escalation; team is perceived as less threatening because of nurse presence
  - Knows when patient does/does not need an ambulance or hospital visit and knows when patient should/should not go to cells
  - Knows how to treat patient
  - RCMP presence is beneficial should the patient become agitated
  - Have more experience with repeat patients

c. ER Nurses' Responses

- More expertise/training of GP-PACT members
  - PACT members are calm and confident
    - De-escalation of patient occurs before patient arrives at hospital

- Psychiatric nurse on team enables better access/admission to hospital
- Psychiatric nurse enables better management of patient
- Defer patients from ER when appropriate→better use of community resources

d. Community Agencies' Responses

- GP-PACT has expertise on mental health issues (in general)
- Has in-depth knowledge about clients' medical and personal history
  - Better rapport with clients than other first responders
- Better use of resources in community

2. Drawbacks of GP-PACT

Of the four professional groups who completed the surveys, the General Duty RCMP members had the most consistent experience working with GP-PACT. Thus, they were able to identify some drawbacks of having a PACT program in the community. Basically, one theme emerged, which is the possibility of over-reliance on GP-PACT by both professionals and clients. Responses were as follows:

- GD RCMP may rely on GP-PACT too much and not pursue further education about mental health as a result
- Some clients may rely on GP-PACT too much; clients might
  - Expect a GP-PACT response at all times
  - Be disappointed when GP-PACT does not respond to call
  - Not cooperate if GD RCMP officer attends call instead of GP-PACT

3. Recommendations for Improved GP-PACT Service

Although all four professional groups indicated that GP-PACT is an invaluable resource in the community and highly supported the continued existence of the program, they all gave recommendations for even better service. Common themes involved requests to provide more comprehensive service, (i.e., providing 24-7 service and taking on other types of calls). It should be noted that making GP-PACT available 24-7 was by far the most frequently mentioned recommendation. Respondents also recommended that hours of service be more consistent,

that GP-PACT provide more education on the program (what they do, how to reach them, etc.), and that communication be improved between GP-PACT and other professionals who serve individuals dealing with mental health issues. Themes of responses were as follows:

a. General Duty RCMPs' Recommendations

- Need more comprehensive coverage
    - 24-7 coverage
        - More teams
        - More members (both officers and nurses)
    - Expand responsibilities of GP-PACT (e.g., involve GP-PACT in missing persons cases, as these cases often involve mental health/abuse problems)
- Need more consistent hours
- Add a psychiatrist to the team
    - As a doctor, a psychiatrist can admit someone to the hospital
- Provide more education
    - Need to educate public about GP-PACT and how to access→not enough public exposure
    - Need to educate other RCMP members about GP-PACT
    - Need to educate all community agencies about GP-PACT
- Need to choose an RCMP officer who will stay on team for a number of years
    - Possible high rotation of officers on team can be problematic
        - Try to avoid loss of knowledge
        - Try to avoid breaking relationship with clients
- Need to choose appropriate RCMP member; the member should have
    - a strong desire to help those with mental health issues
        - better if RCMP member volunteers due to interest
    - knowledge on mental health and how to address issues
        - Do not choose brand new RCMP members to be on this team
- Need to provide/enable more training about mental health for GD RCMP officers

b. EMTs'/Paramedics' Recommendations

- Need 24/7 availability---many calls occur when GP-PACT is not available
    - Increase availability to the public
    - Increase availability to EMS
- Improve communication
    - Better inter-agency communication
        - Need clearer procedures/training regarding GP-PACT capabilities
        - Need to educate EMS about GP-PACT services and when to call GP-PACT→provide information sessions rather than have EMS learn information while attending calls
    - Need clarity about roles and responsibilities when GP-PACT or RCMP and EMS attend a call together
        - Need to reduce confusion as to who treats patient
        - Need to reduce confusion as to who transports patient
        - Need to reduce confusion as to what GP-PACT expects from EMS when handling patient
- Reinforce relationship between GP-PACT and EMS
    - GP-PACT needs to be more responsive to EMS (i.e., reduce wait times)
    - Both groups need to develop an ongoing working relationship to enhance teamwork
    - Both groups could be more collaborative in developing treatment plans

c. ER Nurses' Recommendations

- Need 24-7 service
- Better communication between GP-PACT, ER staff, Psych staff
- Need to use the same forms

d. Community Agencies' Recommendations

- Need 24-7 service
- Need to educate agencies
    - What GP-PACT does
    - How to reach GP-PACT—we can't always access GP-PACT
    - Hours of service
        - should be consistent

Survey Responses-KPI Ratings

Via surveys, EMTs/Paramedics (EMS), Community Agencies and Clients were presented with various Key Performance Indicators (KPIs) and were asked to rate GP-PACT in terms of these KPIs. The KPIs cover two aspects of GP-PACT: Operations Effectiveness (8 KPIs) and Service Delivery Effectiveness (14 KPIs).

It was hoped that the General Duty RCMP Officers would also provide these ratings, as many see GP-PACT in action. However, it was advised that including this component would make the GD-RCMP questionnaire too long; RCMP officers are much taxed on time. ER Nurses were not asked to provide these ratings because they generally work with GP-PACT only occasionally.

It should be noted that the language used for Clients was altered. For example, EMTs/Paramedics and Community Agencies were asked to rate each KPI using the scale "Excellent", "Adequate", "Needs Improvement" and an option to answer "Not Sure". Clients were asked to provide ratings using "Very Good", "OK", "Needs Improvement" and an option to answer "Not Sure". Also, EMTs/Paramedics and Community Agencies were presented with all 22 KPIs whereas Clients were presented with 7 of the KPIs for which they could rate competently.

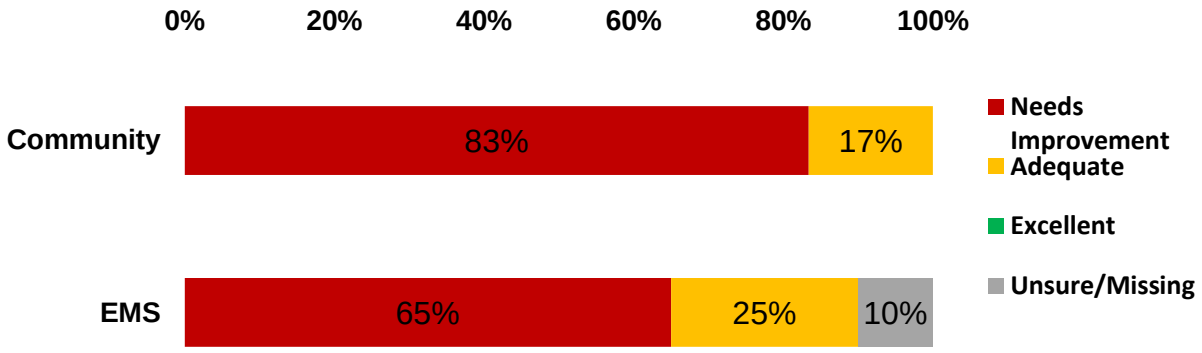
KPI ratings presented in the graphs below are organized into two categories: 1) Operations Effectiveness and 2) Service Delivery Effectiveness. In the graphs, "EMS" refers to EMTs/Paramedics; "Community" refers to Community Agencies.

1. KPIs-Operations Effectiveness

Eight KPIs targeting Operations Effectiveness were presented to EMTs/Paramedics and Community Agencies; Clients rated two of these KPIs (noted with an asterisk *).

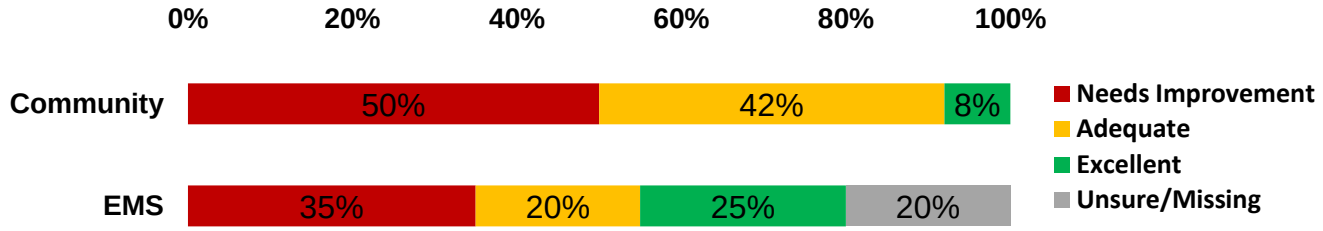
The eight KPIs were: 1) Hours are clear and offer sufficient coverage, 2) PACT program has community presence and awareness 3) Needs that PACT addresses are clear and easy to understand, 4) Types of services PACT provides are clear and easy to understand, 5)* the PACT team is easily accessible, 6)*the PACT team responds when called, 7) Response times are reasonable, and 8) PACT program procedures are clear and consistent. Ratings are presented below:

1. Hours are clear and offer sufficient coverage



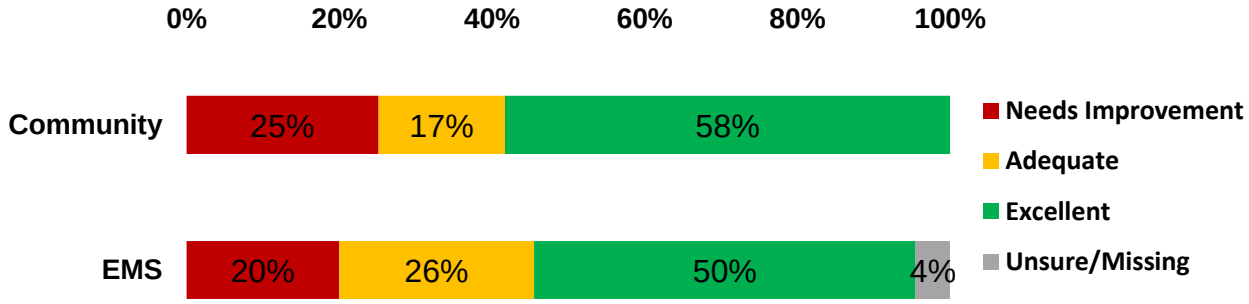
This is the KPI for which community agencies and EMTs/Paramedics found most problematic, with an overwhelming majority indicating that the program hours are unclear (variable) and do not provide sufficient coverage; none rated this KPI as excellent. This rating is supported by recommendations provided by the four professional groups regarding improved service; the most frequent recommendation was that PACT should be available for service seven days a week and 24 hours a day, and many stated that hours need to be more consistent.

2. PACT program has presence and awareness

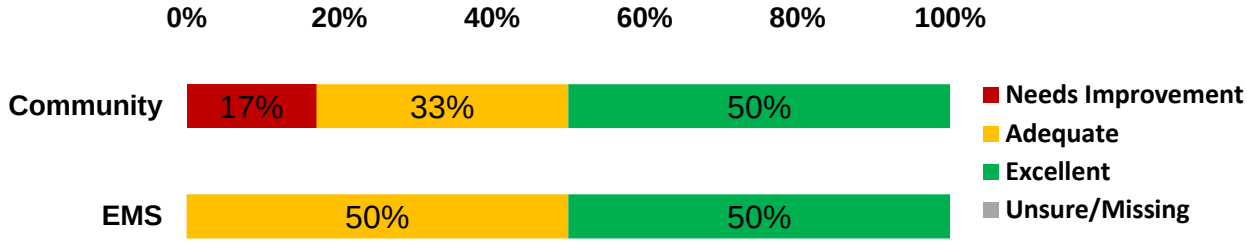


This is another KPI where PACT could be improved. Only a small percentage of Community Agencies and about one-quarter of EMS staff rated PACT's presence and awareness as "excellent"; the remainder thought that the program presence and awareness was just adequate or in need of improvement. These ratings are supported by the comments provided in the recommendation section of the interviews/questionnaire. The public's response to the community awareness survey contradicts this finding slightly, however, with 71% indicating that they heard of PACT. Having said that, 100% community awareness would be better.

3. Needs addressed by PACT are clear and easy to understand

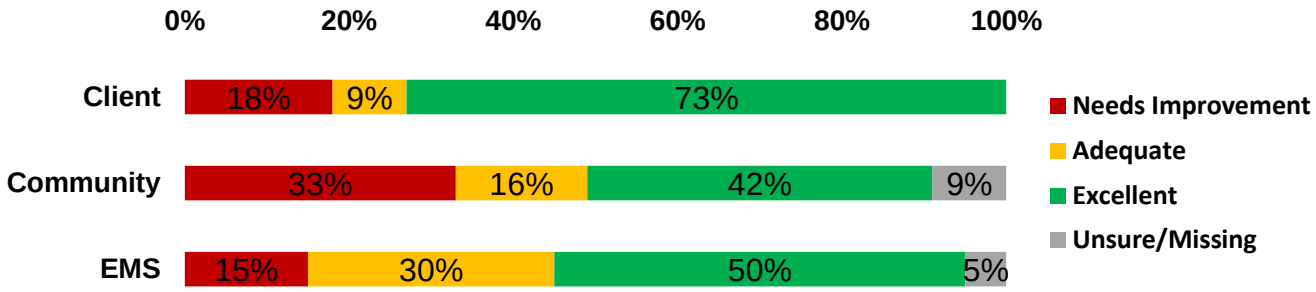


4. Types of services provided are clear and easy to understand



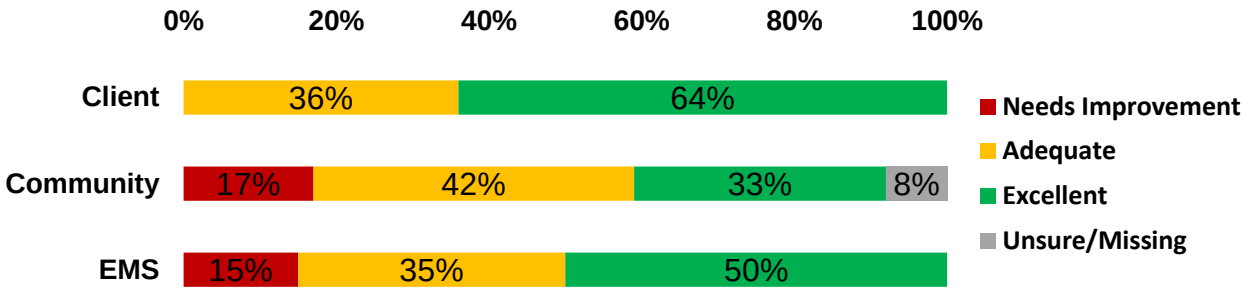
Respondents were split when rating KPI #3 and #4; approximately half of respondents from both Community Agencies and EMS found that GP-PACT is excellent in being clear as to the needs GP-PACT addresses (KPI #3) and the services PACT provides (KPI #4), but half thought that these KPIs are just adequate or need improvement. These ratings are supported by the trend seen in the community awareness survey; just over half (56%) of the public indicated that they knew what types of problems PACT assists people with.

5. The PACT team is easily accessible



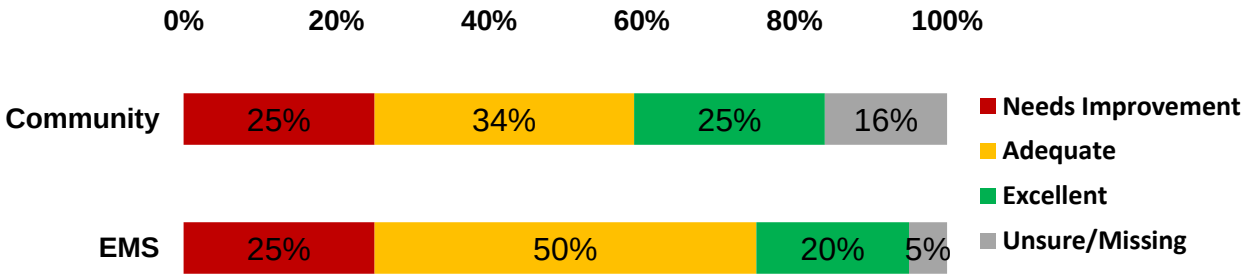
Clients were more likely to rate PACT highly on this KPI. Community Agency representatives were more likely to report that PACT needs improvement in this area, as reflected in a comment made that PACT cannot always be accessed as needed.

6. The PACT team responds when called



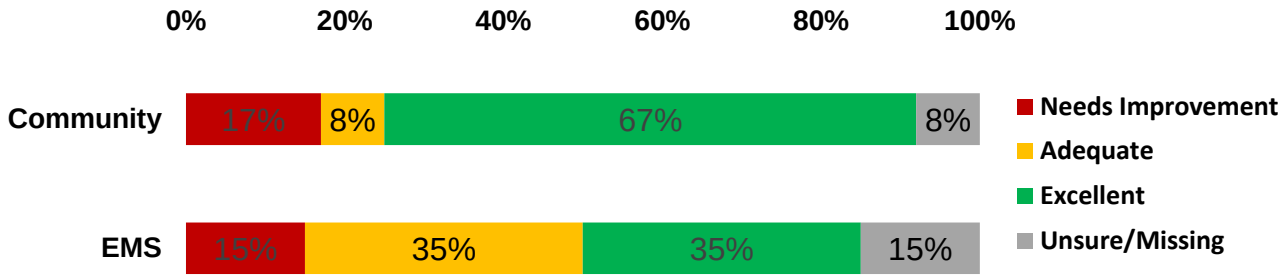
Again, Clients rated PACT on this KPI more highly than Community Agencies and EMTs/Paramedics. It is very likely that agencies and EMS staff call PACT much more frequently than Clients and have experienced frustrations when PACT is not on duty or is unable to respond because they are attending to another call.

7. Response wait times are reasonable



A relatively small proportion of respondents from Community Agencies and EMTs/Paramedics rated this KPI as excellent. Of course, when these professionals are attending to someone who is in a mental health crisis, especially if the client appears to be suicidal, any time required to wait for a GP-PACT response can seem too long; long wait times can be stressful and agonizing for both the client and those assisting the client. This situation could be ameliorated in one of two ways: 1) having more PACT teams on duty, and 2) training other first responders (EMTs/ Paramedics and General Duty RCMP) in mental health, particularly de-escalation and containment.

8. PACT program procedures are clear and consistent



EMTs/Paramedics were less likely to rate GP-PACT as being excellent for this KPI. This trend is supported by comments made in the recommendation section of the questionnaire whereby a number of EMS staff stated that they are unsure as to the roles and responsibilities of EMS vs GP-PACT when attending a call together. For example, it is not always clear as to who provides treatment, who transports the patient, etc. A comment was also made that it is not clear as to what GP-PACT expects from EMS. All of these issues could be resolved collaboratively between EMS and the RCMP by outlining the roles and responsibilities of each responder group and to clarify how roles and responsibilities vary according to the nature of the calls (e.g., whether the patient is aggressive/dangerous, or whether the patient needs immediate medical intervention).

2. KPIs-Service Delivery Effectiveness

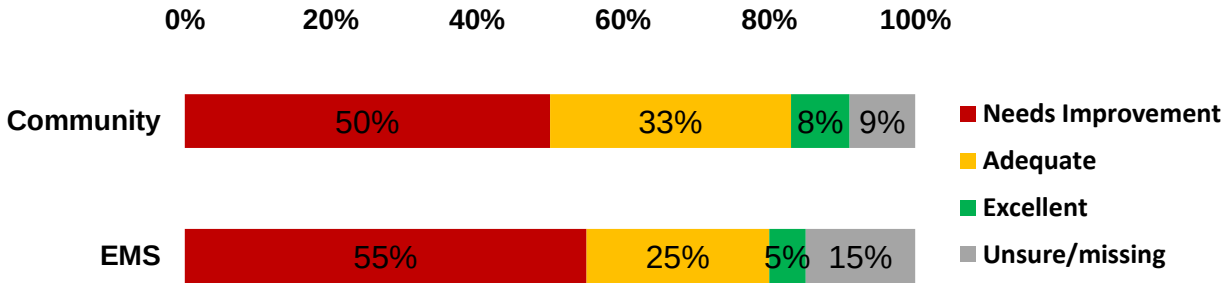
Fourteen KPIs targeting Operations Effectiveness were presented to EMTs/Paramedics and Community Agencies; Clients rated four of these KPIs (noted with an asterisk *).

The fourteen KPIs were: 1) Providing education about PACT to your agency 2) Providing communication to and from your agency, 3) Providing on-the-spot de-escalation 4)* Responding with sensitivity, 5) Conducting an appropriate assessment 6)*Delivering the best treatment, 7)Containing the risk a client can pose to him/her self, 8) Containing the risk a client can pose to others, 9)*Establishing trust and rapport, 10)*Providing referrals for clients to resources, 11)*Performing follow-up with clients, 12) Reducing arrests of clients, 13) Reducing relapses of clients, and 14) Providing education about the client to your agency.

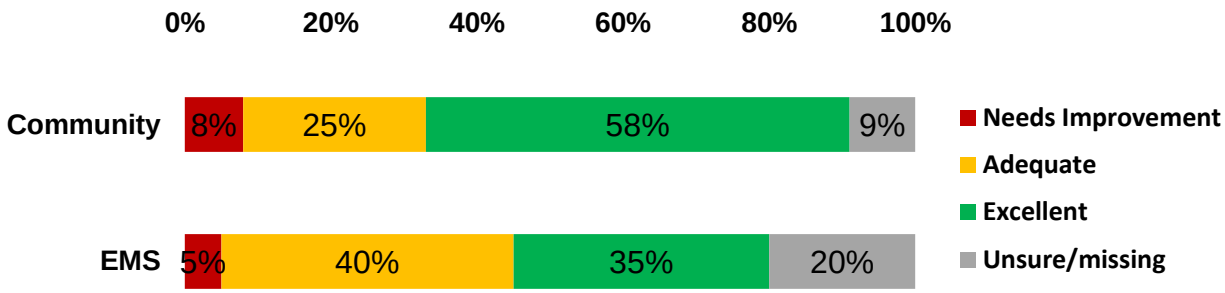
Overall, ratings on these KPIs were quite high, indicating that most respondents believed that the GP-PACT's performance on these KPIs was excellent or adequate. The only KPIs where there was clear room for improvement pertained to KPI #1: Providing education about PACT to your agency. Again, the rating on this KPI was supported by comments provided in the recommendation section of the interviews/questionnaires. Both Community Agencies and EMTs/Paramedics requested education pertaining to the GP-PACT program. For KPI #2, a significant number of EMTs/Paramedics indicated that communication could be improved—they also referred to this issue in their comments whereby they stated that roles and responsibilities need to be clarified.

Additionally, there were some KPIs whereby the respondents were unsure and could not provide a rating. These KPIs typically pertained to activities that occur after a call is completed (e.g., performing follow-up with clients) or pertained to long-term impacts that cannot be seen immediately (e.g., reduction of arrests, reduction of relapses). Responses to the 14 KPIs are as follows:

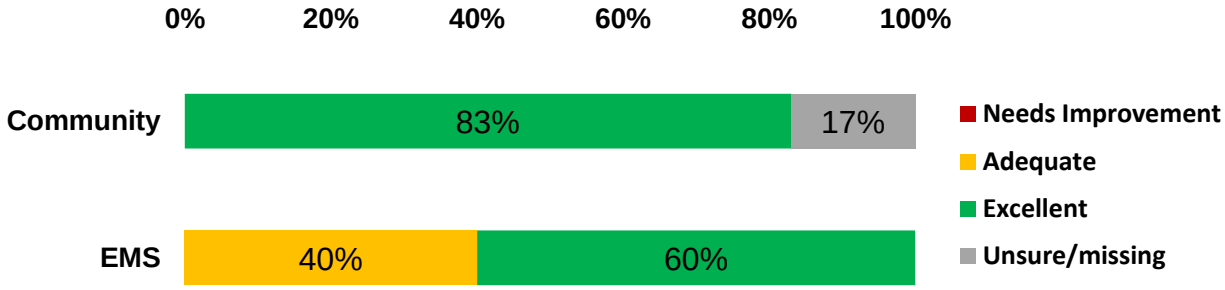
1. Providing education to your agency



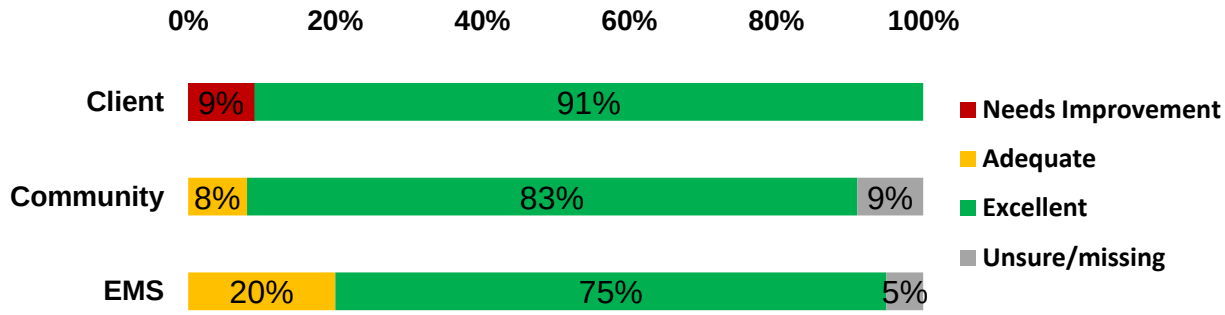
2. Providing communication to and from your agency



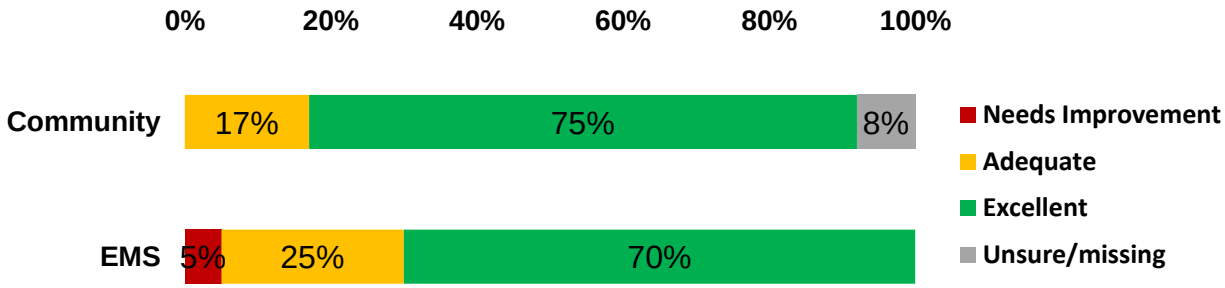
3. Providing on the spot de-escalation



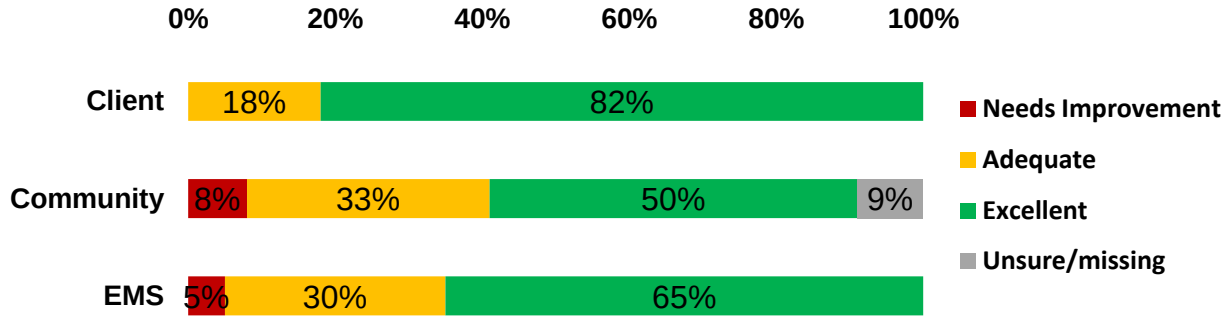
4. Responding with sensitivity



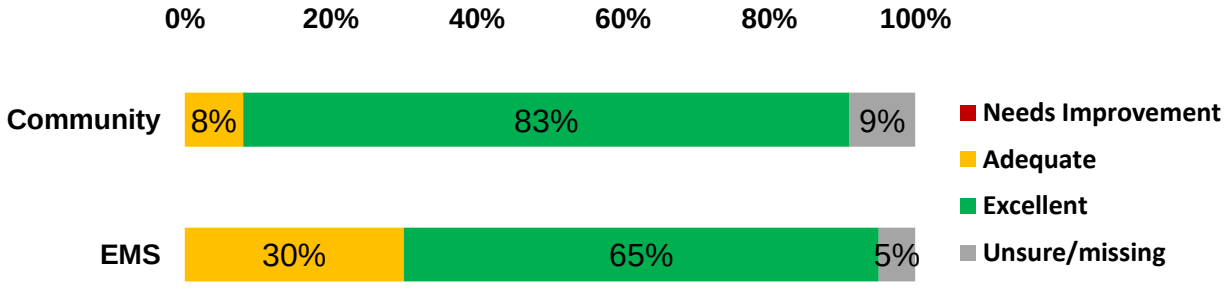
5. Conducting an appropriate assessment



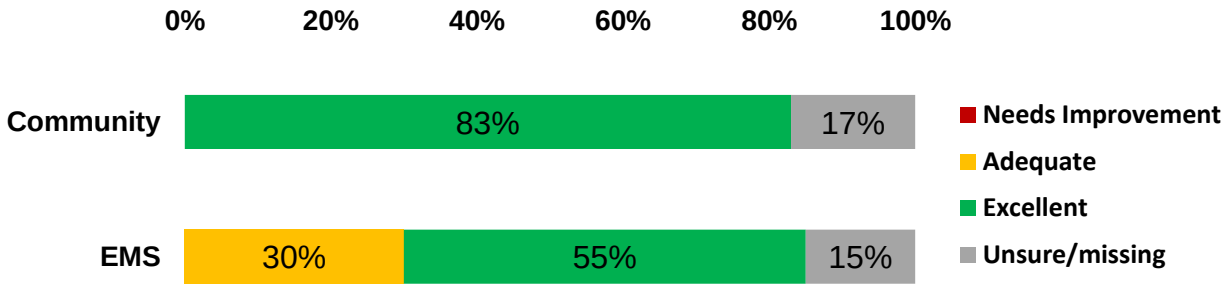
6. Delivering best treatment



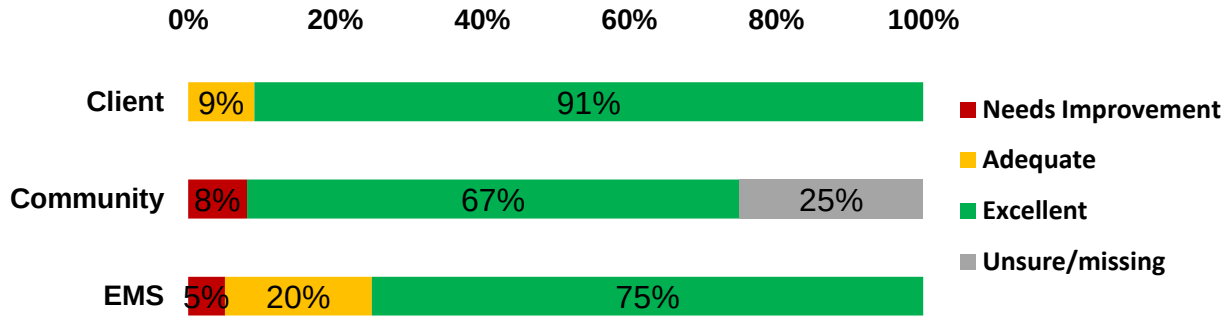
7. Containing client's risks to others



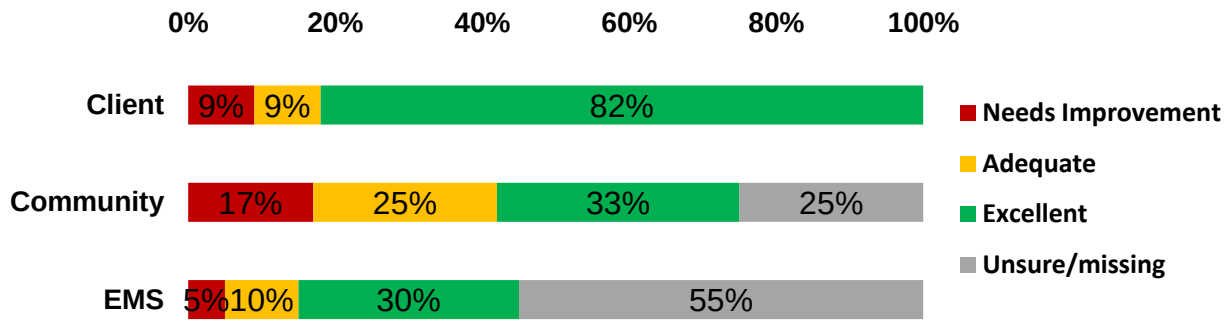
8. Containing client's risks to self



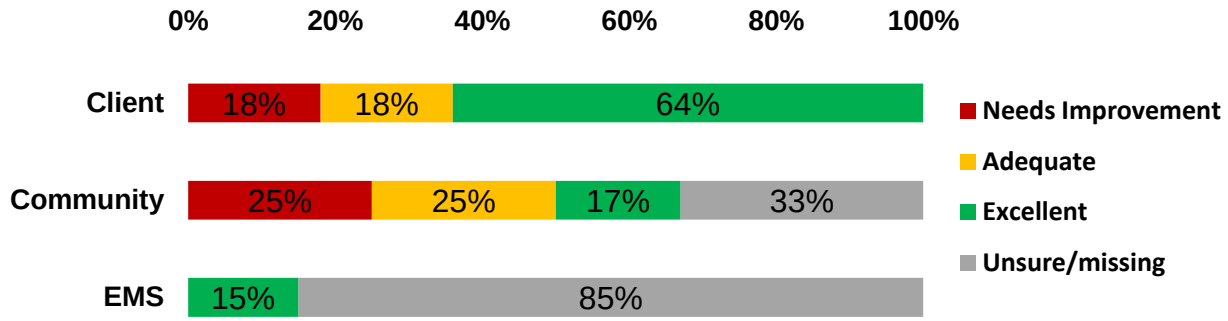
9. Establishing trust and rapport with clients



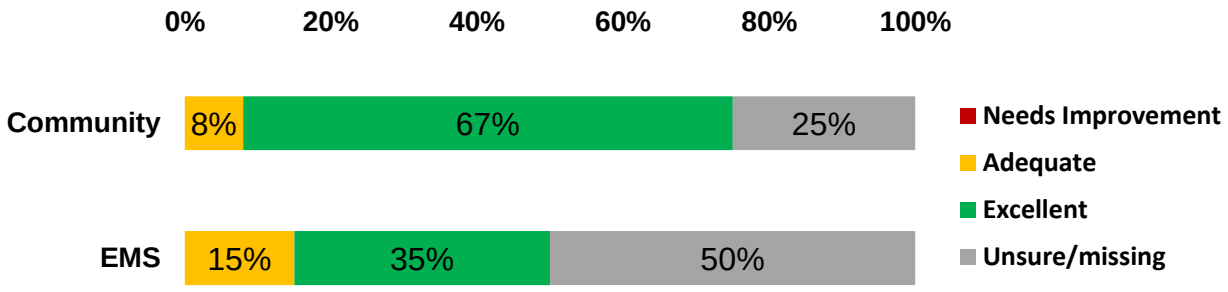
10. Providing referrals for clients to resources



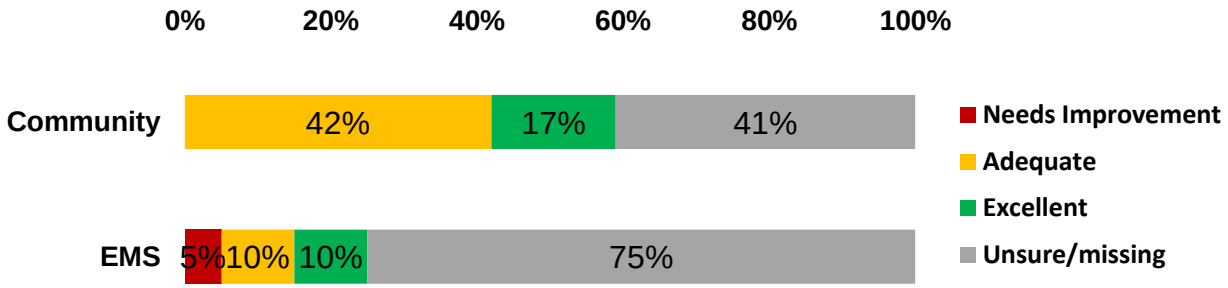
11. Performing follow-up for clients



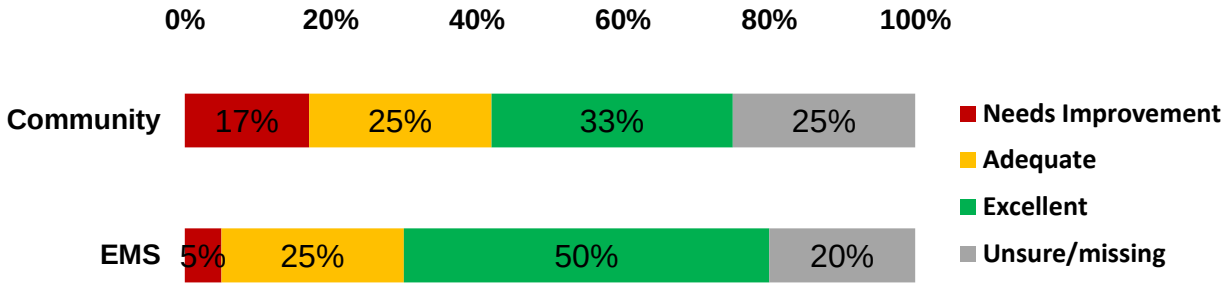
12. Reducing arrests of clients



13. Reducing relapses of clients



14. Providing education to your agency (specific to client)



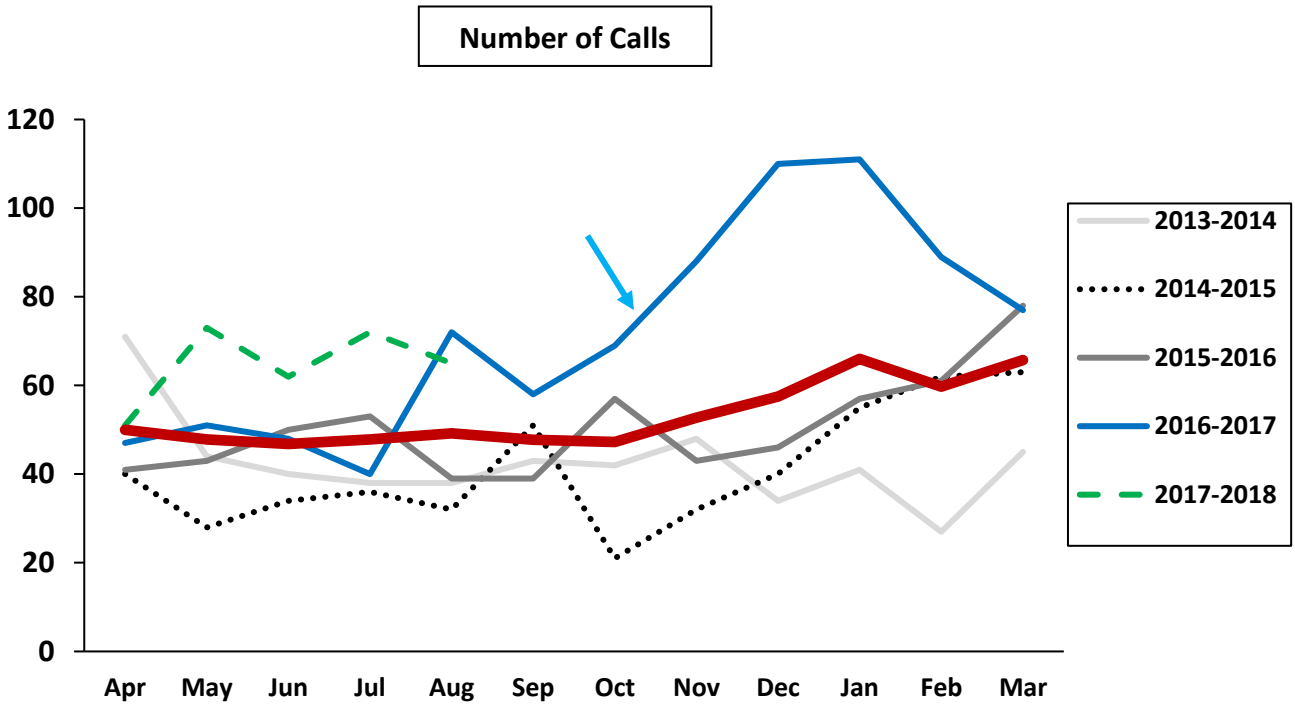
Call Data

Call data from RCMP and AHS were consolidated and analyzed to determine year-over-year trends regarding the number of calls attended by GP-PACT, how GP-PACT is contacted, the nature of the clients attended by GP-PACT, the nature of problems attended by GP-PACT and the outcomes of the calls. Although the GP-PACT program has been operating in Grande Prairie since 2009, available data for the analyses in the current study was from 2014 to 2017 (up to August).

1. How GP-PACT is Contacted/Number of Calls Handled

Most calls made to GP-PACT were via 911 (average = 76% of calls), followed by Health Services (12% of calls); the remaining 12% came from community agencies (6%) and repeat-clients (6%). The graph below reveals year-over-year increases in the number of calls attended to by GP-PACT; it is possible that this trend, in part, is due to the community's increasing

awareness of GP-PACT. Launching a public education campaign on what GP-PACT does and how to reach the team may lead to even more calls from the public for GP-PACT assistance.



The average number of calls per month were as follows:

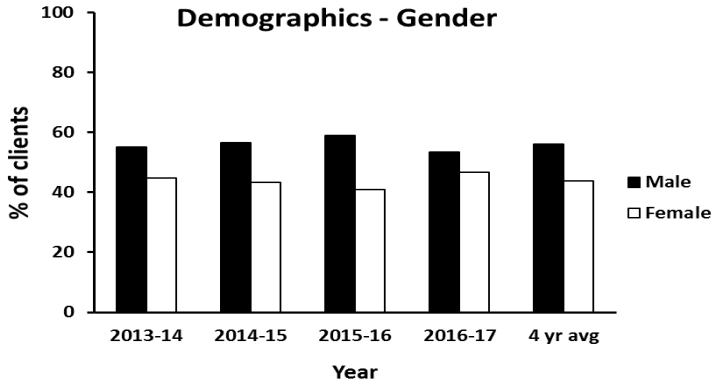
- 2014–2015: average = 41 calls per month
- 2015–2016: average = 51 calls per month
- 2016–2017: average = 72 calls per month
- 2017–2018: average = 75 calls per month (estimated average based on 5 months)

It is important to note that once the second GP-PACT team was introduced to Grande Prairie (indicated in the graph with an arrow), there was a noticeable spike in the number of calls that could be attended by GP-PACT. It is possible that the addition of more GP-PACT teams would reveal an even larger spike. As reported earlier, 92% of General Duty officers surveyed indicated that they have responded to mental health related calls, with almost two thirds (64%) responding to such calls at least once per week. All of the EMTs/Paramedics surveyed also indicated that they respond to such calls (80% once a week or more). Thus, there is a higher need for specialized service for those in a mental health crisis than what the GP-PACT program can currently meet and additional teams would help meet that need.

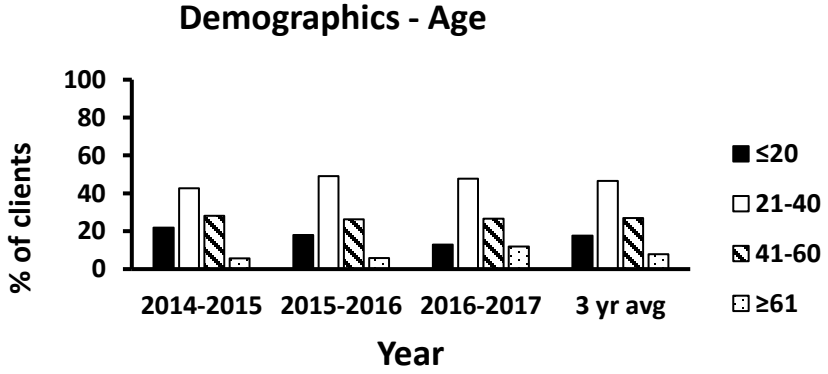
2. Nature of the Clients

Demographic information on each client was recorded in terms of gender and age. Also recorded was the client history (whether a repeat client, whether have an addictions history and/or psychiatric history).

Demographic Information



Across four years, males are slightly but consistently more likely to be attended to by GP-PACT; over a four-year period, 56.1% of GP-PACT's clients were male and 43.9% were female. Furthermore, although any age group may experience a mental health crises that requires intervention, clients who were served by GP-PACT tended to be younger, with 64.1 % of these clients being under 40 years of age and the most frequent age category being 21–40 years old (making up 46.5% of the clients when averaged over 3 years). This trend matches that which has been reported by the Canadian Mental Health Association (2011).



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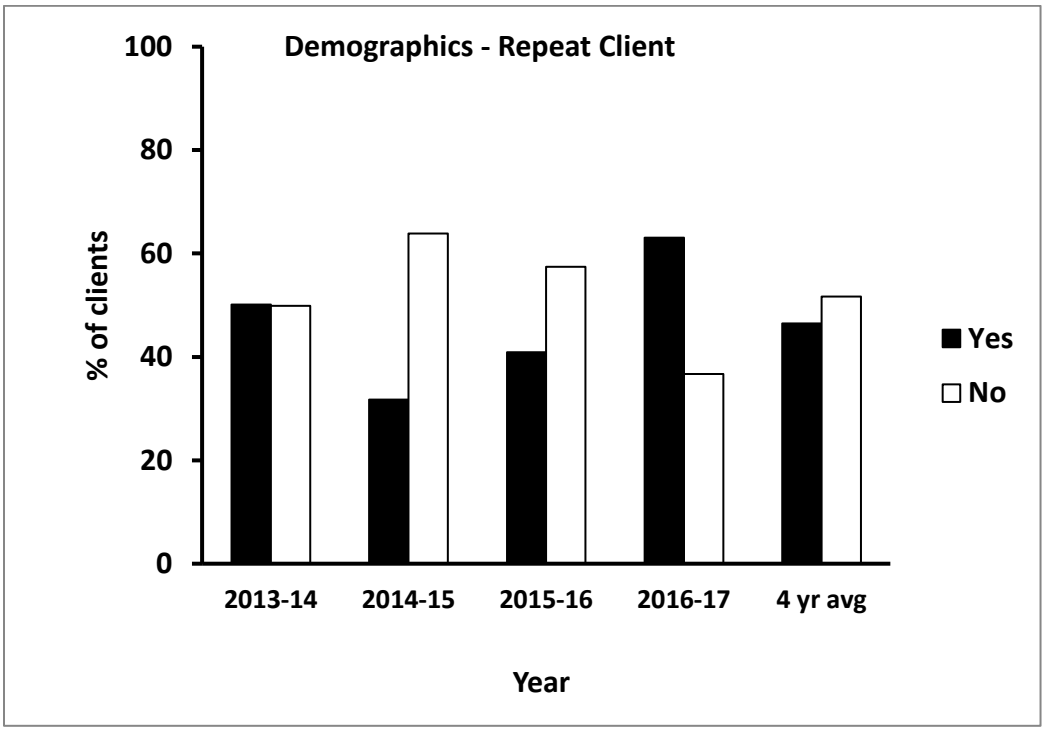
GP-PACT Client History

About half of clients (average = 46.6 % of clients across 4 years) attended to by GP-PACT have seen the team more than once (i.e., are repeat clients).



There are several benefits to having GP-PACT attending to repeat clients. First, this allows the same well-trained individuals to provide consistent assistance over time. Another important benefit of having GP-PACT respond to repeat clients is that members have more opportunities to establish a trusting relationship with the clients. Trust is critical in managing and helping a person who is in crisis and facilitates cooperative behavior from clients during and after crises. Also, by having particular responders attend to repeat clients, a better level of care can be delivered. GP-PACT members indicated that for repeat clients who are known to them, the members feel somewhat prepared to respond even before arriving on scene and thus can provide a more efficient response. Over time, they get to know what types of issues the clients are/are not dealing with (e.g., type of mental illness diagnoses, addictions history), which interventions are necessary, which interventions work best, which interventions do not work, what supports the client has/does not have, and which important aggravating or mitigating

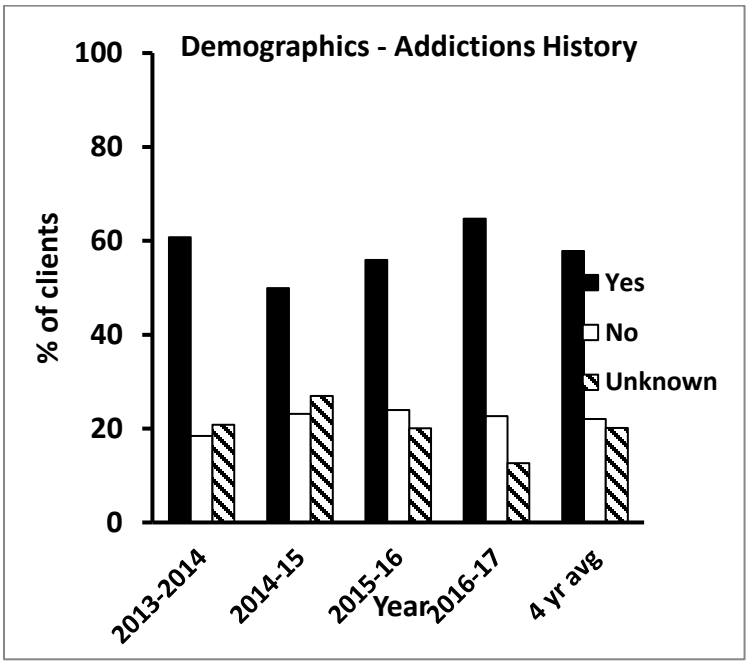
situational factors need to considered (e.g., access to weapons, dog on scene, client tends to take self off necessary medication, availability of calming caregiver).

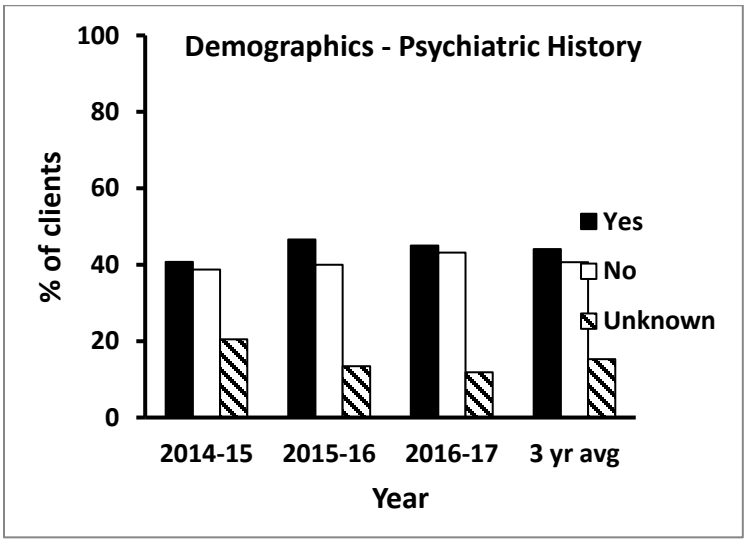
Finally, GP-PACT members indicated that through their work in the field, they come to know which repeat clients have a history of malingering (claiming that they have mental health issue when in fact they do not.) Some examples provided by GP-PACT members are clients (often with borderline personality disorder) who occasionally call 911 claiming to be suicidal when they are not; some have occasionally claimed that they are overdosing when they are not. (These behaviors are also sometimes exhibited by individuals held in cells). In these cases, the false claims are attention-seeking behaviors. Other first responders (who likely do not know the client's history of making such false claims) are understandably more likely to err on the side of caution and send these individuals to the hospital. Other examples of malingering include situations whereby a client is caught engaging in illegal behavior (e.g., shoplifting), falsely claims to have a particular mental health challenge and falsely claims that the mental health challenge compelled them to engage in the illegal behavior. Depending on the nature of these situation (e.g., whether someone else threatened the client to engage in illegal behavior), GP-PACT members may decide that charging the client is an appropriate decision. Other officers who may believe the client's false claims are more likely to send the client to the hospital.

GP-PACT team's extensive knowledge of repeat-clients also helps others (e.g., general duty officers, EMS, community agencies) attend to these clients should they seek GP-PACT's advice. Indeed, members of the PACT have indicated that they get calls from other professionals (especially general duty RCMP) for advice on repeat clients. General duty officers will also leave a Community Referral Evaluation Form for GP-PACT as a request for consultation and to do a follow-up with the client.

Other historical information captured in the call data was psychiatric and addictions history. Many clients had a history of issues that contributed to the crisis that resulted in response from GP-PACT, namely addictions and longstanding psychiatric issues. More than half of clients attended to by GP-PACT (57.8% average across 4 years) had a history of dealing with addictions and 44.4 % of clients had a longstanding history of dealing with psychiatric issues.

It should be noted that relatively few calls made to GP-PACT were due primarily to ingestion of substances (discussed shortly), but addictions certainly create situations that are complicated to manage. The same could be said for longstanding and difficult psychiatric problems. These are the reasons for why such calls require responses from those who have special training and expertise in areas pertaining to mental health (i.e., GP-PACT members).





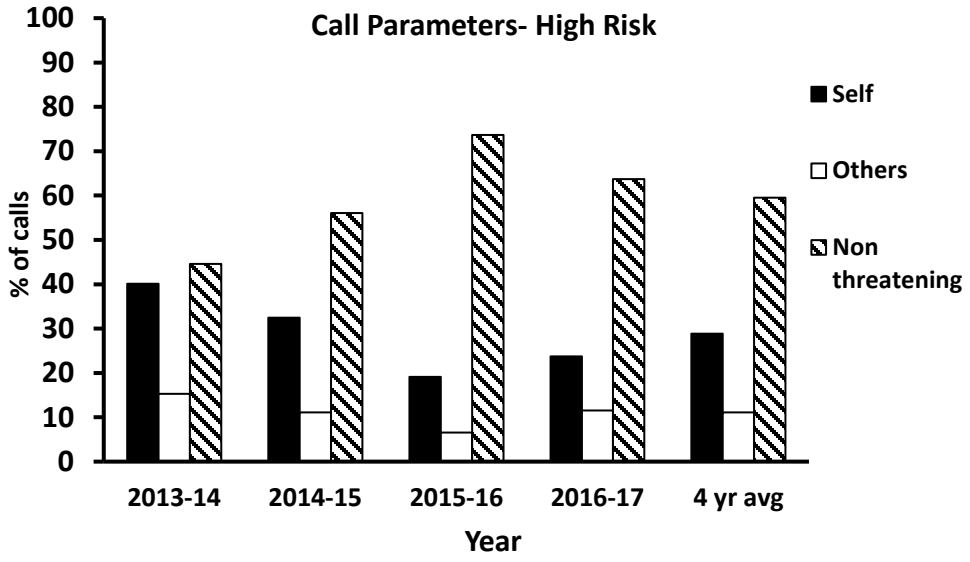
3. Nature of Calls

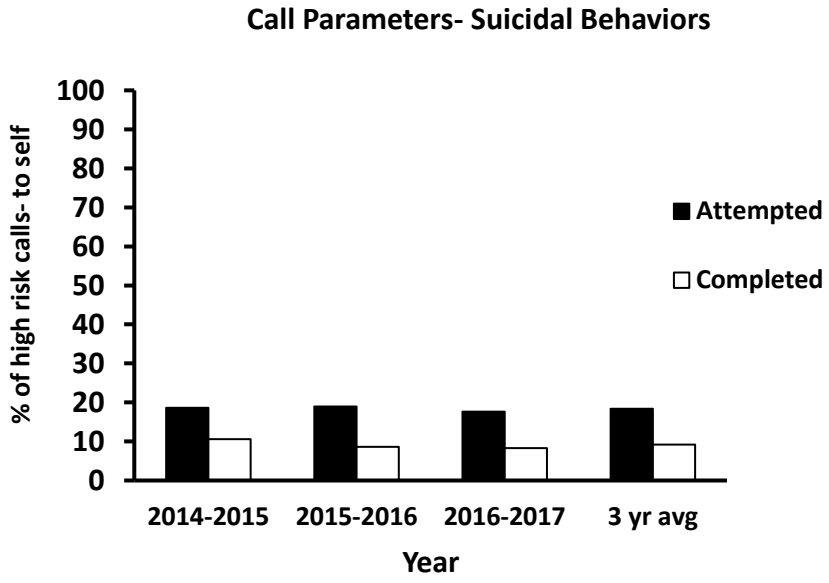
Across a 4-year period, about 60% of calls attended by GP-PACT were not high risk, but did involve issues (e.g., psychiatric and/or substance related issues) that contribute to the crisis; the remaining 40% of mental health calls attended to by GP-PACT were high risk.

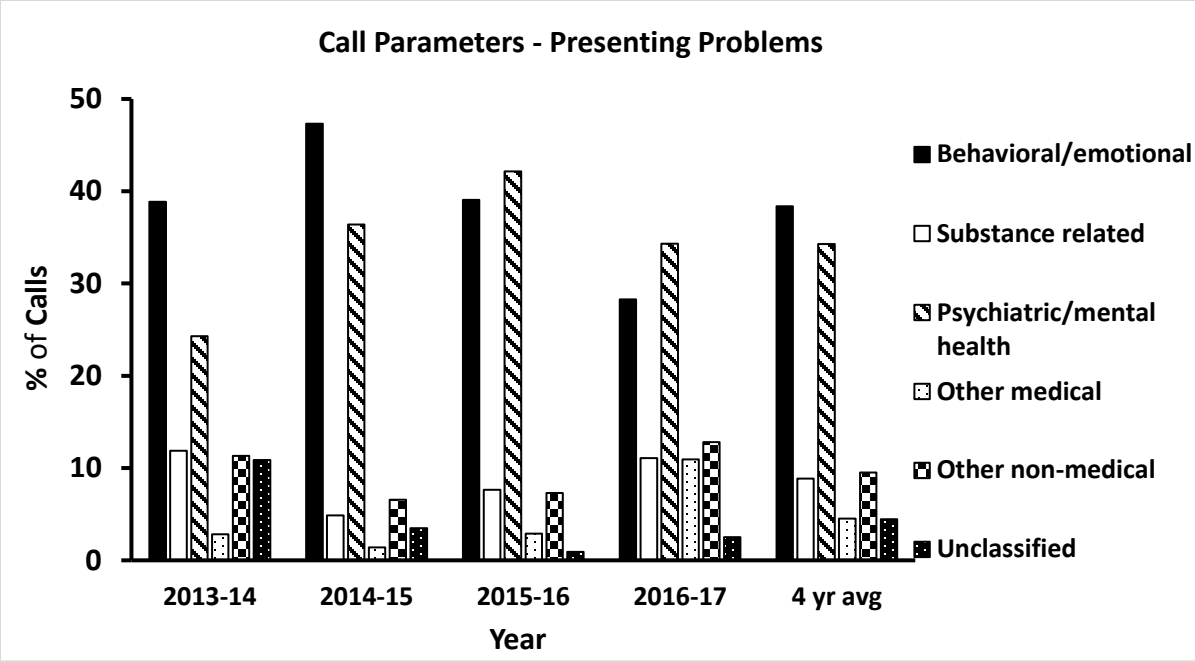
Approximately 11% of clients posed a risk to others (e.g., access to a weapon or vehicle). This pattern reveals the necessity of having an RCMP officer present to manage the safety of the attending nurse and other persons on the scene. In very high risk "Priority-One" calls, GP-PACT is backed up by other RCMP officers and a Watch Commander becomes involved to contain and manage the situation (e.g., deal with weapon) before the mental health issue is dealt with by GP-PACT. PACT members have indicated that this collaborative approach in dealing with actual Priority-One calls is necessary and effective, but quite expensive because of the number of RCMP staff involved. PACT members have also indicated that there have been times whereby a call is dispatched as Priority-One, but they happen to have extensive knowledge about the client and situation (e.g., they may know that the client doesn't have access to weapons) and have advised correctly that the call should not be given Priority-One status. When their advice has been heeded (which is quite frequent), they helped avoid the unnecessary costs tied to unnecessary involvement of other RCMP staff.

The call data also reveals that 29% of calls attended by GP-PACT involved clients whose behaviors put the client's own safety in jeopardy; a significant proportion of these calls involve suicidal ideation and actual suicidal behavior (with some behaviors resulting in completed suicide). GP-PACT members indicated that they have extensive experience with such calls and in fact, have dealt with multiple suicide-related calls simultaneously by "stacking" them according to priority. The way they go about stacking is quite fluid and is based on factors such as whether they know the client (if "no," assign a high priority), whether the client is alone (if "no," assign a low priority), if the client has made serious past attempts (if "yes," assign high priority) etc. Only if two or more high-priority suicide calls come in simultaneously does GP-PACT need assistance from other first responders. In these cases, GP-PACT will typically call for responder back up to "hold things together" until the team can arrive on scene. Back-up responders need sufficient training on handling suicide-related calls to be able to effectively

assist PACT. It should be noted that non-PACT responders do not typically have the needed experience to manage more than one suicide-related call at a time, which further highlights the value of having the GP-PACT team available 24-7.



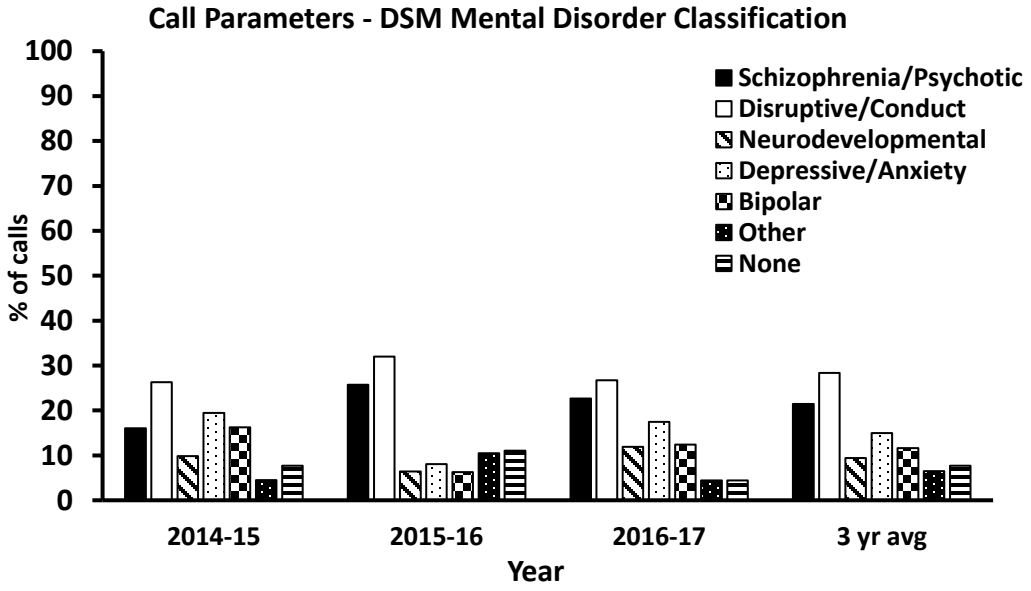




Over a 4-year period, the most prevalent type of call (38.4% average across 4 years) involved behavioral/emotional problems. The second most prevalent type of call (34.3% average across 4 years) involved psychiatric issues. While substances may be used by a number of the clients, and these substances may compound problems experienced by clients, substance use alone was rarely the primary reason a call was made to GP-PACT (average = 8.9% of calls over 4 years).

When digging further into the type of mental disorders that contributed to the crises, it was found that the most prevalent behavioral/emotional were disruptive/conduct disorders (28.3% average across 3 years). The most common psychiatric disorders were those involving psychosis (21.5% average across 3 years) with symptoms such as hallucinations and delusions (e.g., Schizophrenia). These types of disorders are associated with behavioral patterns that can escalate rapidly (American Psychiatric Association, 2013) and can be very challenging for first responders to manage, especially for first responders who are insufficiently trained on the disorders and who are unfamiliar with clients and how they exhibit the symptoms. First responders without adequate training would likely find it difficult to get clients with disruptive/conduct disorders to listen to them, especially those clients who are particularly hostile to people they perceive as pushing their authority. Untrained responders may not

understand that individuals experiencing a psychotic break (e.g., Schizophrenia) often cannot hear them and sometimes are not in full control of their behaviors. Similarly, untrained officers who encounter a client with a neurodevelopmental disorder (about 9% of calls) may not recognize when a client has this type of disorder and thus may not understand the behaviors exhibited. For example, people with autism often perceive and experience the world in very different ways than people without the disorder; sometimes these experiences are overwhelming (e.g., during a police response, sirens and radio calls seem excruciating loud and lights appear extremely bright). In such overwhelming situations, clients might not hear a first responder and/or might have problems communicating that they do not understand what is happening. In addition, they may start engaging in "stimming behaviors" that untrained first responders mistake for drug-induced behaviors. GP-PACT members have extensive training and experience managing such situations and providing proper referrals.

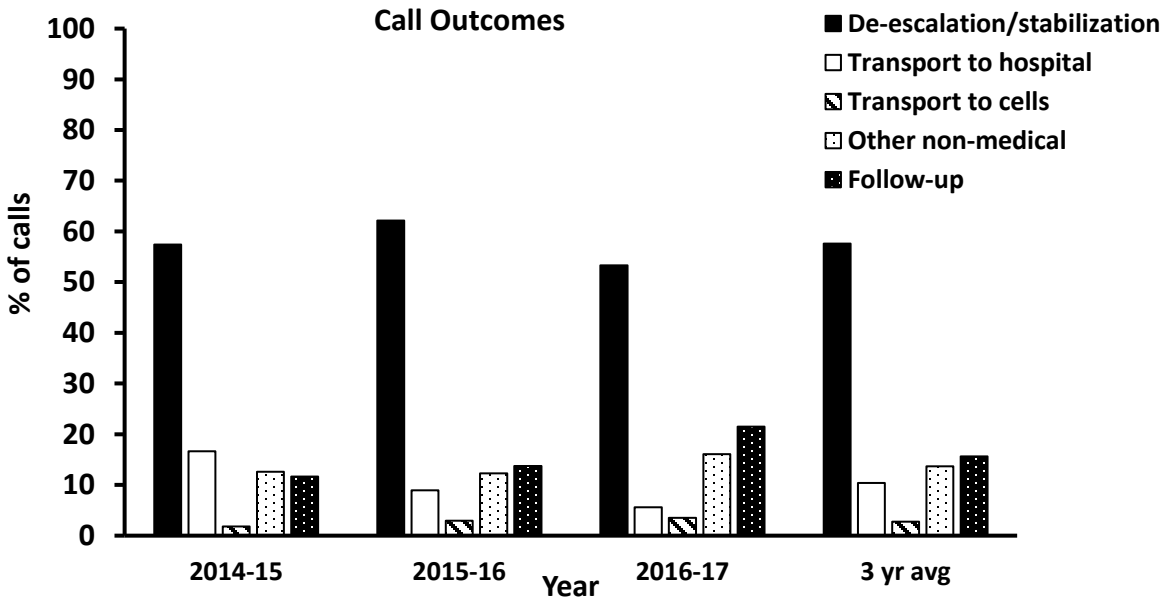


4. Call Outcomes

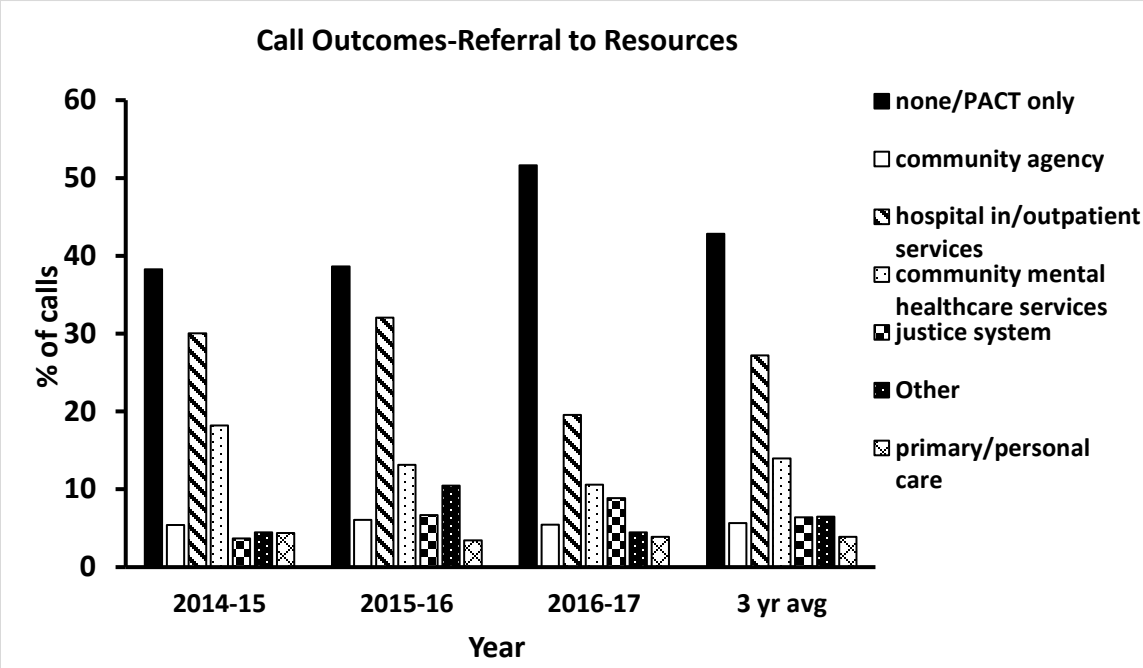
Over three years the GP-PACT team successfully de-escalated and stabilized 57.6% of their clients. Given the difficult behaviours associated with conduct disorders and psychosis, and the unpredictability of such behaviors, this rate is quite impressive. At times, it has been necessary to transport clients to the hospital for further treatment (average of 10.4% of calls

across a 3-year period); GP-PACT rarely sent clients to cells (average of 2.7% of calls across 3-years).

According to the information included in the call databases, GP-PACT followed up with 15% of clients (3-year average). It is worth noting that this percentage only reflects information that is recorded with a 911 call and likely significantly underestimates the actual extent to which GP-PACT members follow up with clients. For example, the researchers witnessed through ride-alongs the numerous drop-in visits GP-PACT members make at locations where clients reside (e.g., homeless shelter, psychiatric ward in hospital, group home) and where clients hang out. The purpose of these visits was to check in with clients and assist them however necessary. These follow-up visits were not initiated by calls to 911; thus, they were not included in the call databases.



In addition to following up with clients, GP-PACT members refer more than half of clients (57% average over 3 years) to various resources in the community. Referrals are based on assessed primary need (e.g., addictions, psychiatric services, community programs). The most frequent referrals were to hospital in/outpatient services (27.2% average over 3 years).



Social Return on Investment Analysis

Social Return On Investment (SROI) is "a principles-based method for measuring extra-financial value (such as environmental or social value) not typically reflected or involved in conventional financial accounts" (Wikipedia Encyclopedia, n.d.). SROI analysis provides a consistent quantitative approach to understanding the impacts of a program (Nicholls, Lawlor, Neizert, and Goodspeed, 2009); it puts financial 'proxy' values (i.e., dollar values) on all those identified impacts which do not typically have market values. In the case of the GP-PACT program, examples of social return include reduction in unnecessary use of ER resources, diversion away from the judicial system, reduced wait-times, reduced relapses, reduced injury, increased employability of clients, increased contribution by clients to the local economy, etc.

The steps in doing an SROI analysis involve identifying 1) program inputs (i.e., financial investment) into a program, including salaries (e.g., RCMP member, Psychiatric nurses) and equipment (e.g., specialized GP-PACT vehicle); 2) outputs that result from this investment, such as responding to mental health calls (crisis intervention), doing follow-up/check-ins with clients, engaging in community outreach, making referrals to community services, educating community about GP-PACT, etc.; 3) short-term positive impact of these activities (e.g.,

increased client well-being, reduced completed number of suicides, reduced number of days in shelter, increased community awareness, streamlined care, diversion from ER and cells and thus reduced use of ER and RCMP resources, reduced use of ambulance); and 4) long term positive impacts of the program (e.g., reduced relapses, development of effective policies, program scale-up).

After inputs and impacts are identified, financial proxies (dollar values) for both are established. The financial values of inputs are fairly straightforward and are documented (e.g., salaries, cost of vehicle). With regard to impact, some are tangible and can be assigned a financial proxy quite easily (e.g., Total reduced costs tied to reduced number of unnecessary ambulance rides = cost of each ambulance ride x number of ambulance rides avoided). However, some impacts are intangible (e.g., increased well-being of client, reduced number of relapses). These are the benefits that are more "social" in nature. Financial proxies assigned to intangible impacts are based on assumptions (e.g., "increase well-being" may translate into the client using fewer sick days at work, the client signing up to more fitness classes in the community, etc.). For the SROI analyses to be robust and convincing, the financial proxies assigned to intangible positive impacts must be very conservative. For example, in doing the calculation, an assumption can be made that that due to implementation of a program, an employed client used one less sick day at work (when in reality the client might have used 10 fewer sick days at work as a result of the program intervention). The impact is also discounted by incorporating assumptions that some positive outcomes (e.g., reduction in number of relapses) might have occurred even without intervention (i.e., some of the clients would have improved on their own even without intervention). In other words, steps were taken to ensure that the financial values assigned to intangible impacts was not over-inflated; if anything, the financial values assigned to intangible impacts were extremely conservative.

Indicators of Impacts and Financial Proxies used was similar to that used by Hincks et al. (2013), with the addition of economic contributions. Indicators and Financial Proxies are on the following table:

Indicator of Impact	Financial Proxy
Fewer emergency calls from clients with mental illness	Cost of Police call out
	Cost of EMS call out
Less escalation of situation at emergency call	Cost of emergency room visit
	Cost of criminal court case
	Cost of transportation to hospital, cells, court
Less suicidal ideation/completion	Cost per suicide
Fewer presentations to hospital ER with mental health complaints	Cost of emergency room visit
	Cost of incarceration
Less time spend in Emergency Room by both client and RCMP awaiting psychiatric assessment	Cost of time for police stay at emergency room
Less revolving door syndrome—less ER use and less re-admissions for inpatient care	Medical costs to treat undiagnosed mental illness
	Cost of Psychiatric admission/re-admission
Increased employment	Costs of short-term work loss due to mental illness (cost of sick day)
Increased stable housing	Cost to support homeless person
Increased economic contribution to local economy	Money spent on Eastlink pass

For the SROI calculations of the GP-PACT program, financial proxies were determined from a number of sources. The project partners provided financial information for inputs (e.g., salaries, equipment). Financial proxies for tangible and intangible impacts were based on published data (e.g., cost of an ambulance ride, cost of physician visit) and from local sources (e.g., drop-in fee at local gym, shelter cost per day). The SROI ratio is calculated as such:

SROI Ratio= (Tangible Impacts + Intangible Impacts) / Cost of Inputs

The SROI ratio indicates how many dollars are returned for each dollar invested into a program (i.e., return on investment) and is used to determine how long a program pays for itself (i.e., the break-even point).

Below are the calculated SROI ratios for each year between 2014 and 2017 and a 3-year average SROI ratio.

- 2014–2015 SROI = 2.08: 1 (for every $1 invested, the return was $2.08)
- 2015–2016 SROI = 2.09: 1 (for every $1 invested, the return was $2.09)
- 2016–2017 SROI = 3.17: 1 (for every $1 invested, the return was $3.17)—this is the period when the second GP-PACT team was added to the program
- 3-year average SROI = 2.44: 1 (for every $1 invested, the return was $2.44)
- 3-year average payback period = 5.2 months (for each year in service, the program pays for itself by 5.2 months (3-year average))

These SROI ratios affirm that which was forecasted in 2011 by Hincks et al. (2013) in their original assessment of GP-PACT and reinforces the fact that the GP-PACT program continues to bring tremendous value to Grande Prairie; the ratios indicate that the program more than doubles its investment through the social value it creates in the community. Furthermore, the SROI ratio patterns suggest that as GP-PACT service delivery increases (e.g., addition of a second GP-PACT team), so does the return in social value.

Summary of Recommendations

The recommendations listed below were derived from the data collected in the surveys, call data trends, SROI analyses, interviews with GP-PACT members and relevant literature.

1. GP-PACT COVERAGE:

- Hours of service: 24 hour per day-7 days per week

  The information gathered overwhelming converged to the conclusion that 24-7 service would be provide much social benefit and is necessary in order to provide adequate service to those experiencing mental health-related crises in Grande Prairie; comments made by various individuals were that the PACT program should include at least three, but ideally four PACT teams to provide sufficient coverage.

  - Currently the two GP-PACT teams are on duty 7 days a week from 10:00 a.m. to 9:00 p.m.
    - Additional team(s) are needed to cover 9:00 p.m. to 10:00 a.m. period

  - Call volume (for mental health calls) as a function of time of day and time of month (e.g., when cheques come in) should be tracked to determine peak hours/days; response rates and wait-times during these peak periods should be further investigated
    - Peak hours with long wait times should covered by additional GP-PACT team(s)
      - If additional coverage is needed during certain times, discussions should be had including PACT team members as to which scheduling options would work best (e.g., for peak hours--scheduling 2 teams with same start-end times

vs scheduling 3 teams with overlapping times to extend hours of double coverage)

- If adding 3rd /4th full-time GP-PACT teams is not possible, other ways to address the service gaps need to be investigated and implemented
    - Adding part-time GP-PACT teams
    - Designating at scheduling highly trained and highly experienced officers and EMS responders during gap/peak times

- <u>Types of calls handled by GP-PACT: More comprehensive</u>
    - Requests for GP-PACT assistance on other types of calls (missing persons, domestic violence) were made by officers who responded to the RCMP survey
        - Although the teams already do provide this assistance (e.g., domestic violence calls) through occasional consultation, providing more of this type of assistance is not feasible at this time. With only two GP-PACT teams, the team members are already over-taxed
        - Adding additional GP-PACT teams would enable GP-PACT assistance on other types of calls
            - If more teams are added, GP-PACT assistance on these calls is recommended; due to the team members' training and experiences, they would contribute valuable insights and would suggest sound courses of action

2. SCHEDULING OF TEAMS

- <u>Fill in gaps, more coverage for peak hours</u>
    - Schedule as necessary (see above recommendation)

- Consider impacts of scheduling on staff turn-over rates, burnout & performance
    - The members of GP-PACT have indicated that 5-day rotation schedules (especially 5 days on/2 days off) are too exhausting, is causing burn-out and can affect performance; the recommendation is to avoid this type of scheduling as optimal responding to those in crisis (especially high risk calls) would be significantly reduced. Furthermore, resultant burn-out contributes to higher staff turn-over rates of members, and consequently interferes with service continuity that is necessary, especially for repeat clients.
        - GP-PACT members recommended longer 12-hour shifts (e.g., 3 days on/3 days off rotation) or shorter shifts with more days on/off (e.g., 4 days on 4 days off). They also noted that 2 days off for rest is not sufficient.
            - the teams' comments about the effects of scheduling on burn-out for responders is supported by the literature of the effects of scheduling (e.g., Stimpfel, Sloane, & Aiken, 2012)
        - GP-PACT members suggested that the teams work together to work out the schedule
            - Should consider gaps, peak hours
            - Should consider how to best schedule for planned time off (e.g., vacations, training, etc.)

3. HIRING/ASSIGNING GP-PACT TEAM MEMBERS

- Self-selection to join the team is optimal (compared to assignment by supervisors)
    - nurses and officers with interest and a desire to help those who experience mental health crisis will be more likely to possess attitudes

that underlie patience and empathy and will more likely persevere through tough cases

- Commitment: Request that those who apply be willing to work for more than 2 years to enable continuity of service (allow them to stay longer than 2 years when appropriate)

- Training and/or Experience: should be weighted heavily in the decision-making process; however, comments from GP-PACT members indicate that training/experience may be less important in predicting performance on the team compared to interest and desire to help those who experience mental health crisis

- Varying perspectives:

    - Gender: Members of the GP-PACT team have found that teams being comprised of different genders has been helpful in that this composition brings in various perspectives sometimes needed when assessing a situation and making decisions; furthermore, in some cases, clients gravitate more to males while in other cases, clients gravitate to females—thus it is recommended to have both genders on teams

    - Background/experience: Assigning members of varying perspectives based on background/experience could also be beneficial and thus recommended

- Letters of Recommendation: Recommendation letters from current GP-PACT members who have experience working with applicants should be considered

and given significant weighting in the decision-making process when assigning PACT duties

4. CRISIS INTERVENTION TRAINING

- KSAs: Responding well to those who experience mental health crises requires specialized crisis intervention training in various Knowledge, Skills, Attitudes (KSAs) beyond that which is typically offered during initial training (e.g., Depot)

    - All responders should be provided with training opportunities and encouraged to pursue this training (especially GP-PACT team members)

    - Priority in specialized Knowledge areas based on relevance to mental health crisis and expressed interest by survey respondents include: a) symptoms associated with mental disorders, b) symptoms associated with drug use/abuse/overdose/withdrawal, c) how symptoms of mental illness may appear to be due to drugs and vice versa, d) community resources and services. Training in other knowledge areas should also be made available.

    - Priority in specialized Skill areas based on relevance to mental health crisis and expressed interest by survey responders include: a) responding with sensitivity, b) de-escalation/stabilization, c) use-of-force/containment. Training in other skill areas should also be made available

    - Priority in specialized Attitude areas based on relevance and expressed interest include attitudes that increase empathy and

empathic responding. Training in other attitude areas should also be made available

- Scheduling: GP-PACT members and other responders have indicated that they would like further training, but cannot fit extra training into their work/life schedule
    - When possible, time should be set aside during staff's work schedule to pursue needed training; because work demands are heavy and because time is needed to rejuvenate from these demands, responders will not likely pursue training on their own time
- Delivery: Preferences expressed by RCMP officers are for face-to-face lectures with opportunities to practice skills
    - GP-PACT members would be a good resource for face-to-face instruction, but given the current demands on their time, other experts should be sought out first
        - Inviting others responders who work with GP-PACT (e.g., EMTs/Paramedics, nurses, staff from community agencies, etc.) to these training sessions would be time/cost effective
    - A number of RCMP officers are willing to pursue online opportunities
        - Online opportunities available through elearning (AGORA) should be encouraged as these materials are standardized for all RCMP
        - All responders who take online training should attempt to gain first-hand experience and pursue opportunities to practice necessary skills
            - Enable ride-alongs with GP-PACT members for all responders so they can gain first-hand experience and witness well trained/experienced models in action

    - this opportunity should be made available when practical (e.g., not during peak hours)

- Enable opportunities for all responders to practice skills by attending calls along side GP-PACT (when practical)

- Enable all responders to practice skills in low-stress situations before moving on to real life situations

    - There are new virtual reality crisis intervention programs (e.g., AXON) that takes users directly into the perspective of an officer who is responding to a person in mental distress; these programs also enable users to go into the perspectives of distressed individuals as they are confronted by police (Francescani & Margolin, n.d.)

    - These programs enable responders to practice skills, and to see what happens based on actions they choose (e.g., Saying “Can we talk?” vs “Put down the weapon” when first approaching a person in crisis).

- Training opportunities should be paced regularly but at a moderate rate; all responders should be encouraged to pursue training after they have acquired some field experience (e.g., after one year in the field).

5. GP-PACT VEHICLE/UNIFORM

- Authoritative/non-threatening/practical: clients respond better when responders deliver care that is authoritative but non-threatening

    - Vehicle:
        - GP-PACT members have indicated that using an unmarked vehicle (no clear RCMP marking, but PACT sign is on vehicle on back window) works well in keeping clients calmer and reducing stigmatization
        - CMHA report similar findings (E.g., Canadian Mental Health Association - BC Division, n.d.)
            - If another GP-PACT vehicle is purchased, it should be unmarked
        - Split backseat in GP-PACT vehicle allows nurse to sit face to face with client while engaging the client and doing the assessment. Split backseat allows other responders to do ride-alongs with GP-PACT
            - If another GP-PACT vehicle is purchased, it should have a split back seat

        - Research has indicated that when possible, use of sirens and lights for all first responders should be avoided or minimized, especially for clients whose experiences deviate from reality (e.g., schizophrenia, autism)

    - Uniform: Recommended are continued use of clear “Police” and “Nurse” markings on the uniforms

- Clear markings on the RCMP's and Nurse's uniform/vest helps establish the nature of authority of both officer and nurse
- Clients in distress become calmer when seeing "Nurse" on the nurse's uniform

6. COMMUNICATION BETWEEN GP-PACT AND OTHER PROFESSIONALS

- Education-Roles and Responsibilities: A number of first responders have indicated that they are unclear as to what their role is and what their responsibilities are when attending to a mental health call along with GP-PACT
  - Recommended is collaborative discussion around which responder does what during a call (from arriving on scene to transporting the client to their destination)
  - Recommended are collaborative discussions as to what protocols respective groups all should be using when responding to particular types of calls to allow for more consistent responding and more consistent standard of care

- Education about GP-PACT services: A number of first responders and community agencies requested more information on what GP-PACT does, when to call GP-PACT, and how to call GP-PACT
  - GP-PACT has indicated that they have offered such workshops but that they have not been well attended
    - Recommended is that such workshops be advertised more widely and re-advertised and scheduled such that various groups can attend at the same time (with only two teams, GP-PACT is currently too busy to offer multiple workshops)

- Information systems: Shared approaches
  - Use of similar or standardized forms for RCMP/AHS record keeping would aid with tracking calls, ensuring all relevant information is

recorded (e.g., nature of call re: symptoms, outcome of call, what worked and didn't work, etc.) and that both groups could access comparable information from each of their respective systems.

7. PUBLIC EDUCATION

- It is recommended that an education campaign be launched that informs the public of what GP-PACT does, how to reach time and when to call them (i.e., types of calls that warrant GP-PACT intervention, hours of operation)
- Many people in need (i.e., people who are a potential client or the caregiver of one) are unaware of the specialized service, don't seek help and consequently suffer unnecessarily
- Including 911-call training/checklist will improve how the public communicates their needs to the dispatcher

8. ONGOING EVALUATION

- Recommended is regular assessment (e.g., every two years or when there is a significant change such as the addition of another team or change in hours of services)
- Recommended is assessment of effectiveness of Key Performance Indicators (KPIs) on Service Operations (e.g., sufficiency of hours of service, appropriateness of wait-times) and Service Delivery (e.g., ability to respond with sensitivity, ability to establish rapport and trust, ability to de-escalate crisis, ability to contain risk etc.) by getting feedback from relevant groups (GD –RCMP, EMS, Clients, Community Agencies, other groups who interact with GP-PACT)
- Outcomes-based assessments are recommended (e.g., continued gathering of information regarding hospitalizations, arrests, referrals, etc.); this information should be tracked by the GP-PACT team members
- Tracking calls is recommended to determine demands (amount and nature of demands) placed on GP-PACT program
    - Continued use of 911 call data is recommended

- GP-PACT should also track calls the teams attend to (type of crisis, duration of call, outcome, etc.)
    - This tracking is labour intensive; therefore, the teams should designate a representative time period (2–3 weeks in length, every year) to do this assessment.

A sample tracking system is on the following pages.

GP-PACT Tracking Sheet

Date: Time of dispatch (HH:MM):_____ Time on scene (HH:MM):_____

Program consumer demographics

1.) Type of Call
☐ Mental Health 911 Call ☐ Referral from GD officer ☐ Public Relations/Liaison
☐ Outreach to Clients ☐ other: _____

2.) Referral source
☐ client ☐ family member/caregiver ☐ friend ☐ community outreach worker
☐ RCMP ☐ EMS/hospital worker ☐ Community Agency
☐ other: _____

3.) Gender
☐ male ☐ female ☐ other ☐ unknown

4.) Age
☐ youth/minor under 18 ☐ 18-24 ☐ 25-35 ☐ 36-49 ☐ 50+

5.) Ethnicity ☐
Caucasian ☐ Indigenous ☐ Black ☐ Asian ☐ Other/Unknown

6.) Primary language
☐ English ☐ French ☐ other: _____

7.) Employment status
☐ stable employment ☐ unstable employment ☐ unemployed ☐ unknown

8.) Housing situation
☐ living with family ☐ own or rented place/room ☐ (shelter, public, other)
☐ unknown

9.) Educational background (FEEDBACK MAY OR MAY NOT INCLUDE)
☐ attended high school ☐ completed high school ☐ attended college/university
☐ completed university ☐ professional degree or graduate degree ☐ unknown

Call data Time Spent on Call (approximate # of minutes): _____

1.) Call status

☐ first encounter with client in crisis

☐ repeat encounter with client in crisis
- ☐ 2nd encounter
- ☐ 3rd to 5th encounter
- ☐ 6th to 10th encounter
- ☐ over 10 encounters

☐ follow-up call

2.) Nature of call

☐ Substance induced

☐ overdose ☐ withdrawal

☐ mental health

☐ Schizophrenia/Schizoaffective (psychosis) ☐ Delusions/hallucinations

☐ Bipolar Disorder ☐ Major depression ☐ Anxiety ☐ PTSD

☐ Fear/phobia/panic ☐ other_____

☐ personal crisis
☐ suicidal threat/attempted suicide
☐ personal harm
☐ other disability: _____
☐ Domestic Violence :

3.) Level of urgency

☐ priority 1 ☐ priority 2 ☐ priority 3 ☐ priority 4

Call outcomes

1.) **Resolution over the phone**: ☐ yes ☐ no agency referral: ☐ yes ☐ no

2.) **Resolution in-person**
☐ on the spot de-escalation ☐ transport to police station ☐ incarceration
☐ transport to walk-in clinic ☐ transport to ER ☐ transport to residence
☐ transport to community shelter ☐ transport to community agency: _____
☐ pickup from community agency/shelter: _____

3.) **Forms involved**
☐ none ☐ form 3 ☐ form 8 ☐ form 10 ☐ other: _____

Additional comments:

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