

**“Enhancing Community Capacity to Respond to Crisis  
Among People with Disabilities and their Carers”**

**A Workshop Collaborative between the Interim  
Authority and the South Fraser Community**

**Workshop Final Report**

**May 3, 2004**

## Table of Contents

---

<b>Introduction</b>	<b>2</b>
<b>Purposes of the Workshop</b>	<b>3</b>
<b>Workshop Invitees</b>	<b>4</b>
<b>Workshop Method</b>	<b>4</b>
<b>Workshop Findings</b>	<b>5</b>
<b>Morning Work: Defining a Crisis</b>	<b>5</b>
<b>Key Themes from Discussion of Crisis Stories</b>	<b>6</b>
<b>A Discussion of Values and Assumptions</b>	<b>8</b>
<b>A Synthesis of Key Elements to the Crisis Response</b>	<b>9</b>
Who is key in strengthening the crisis response?	9
Figure 1: Crisis Network	10
What are the objectives of the crisis response system?	10
What is the best structure for organizing a crisis response?	11
How does a crisis response system achieve continuous improvement?	12
Policies to support improved crisis response	12
<b>Evaluation of Workshop</b>	<b>13</b>
<b>Proposed Next Steps</b>	<b>14</b>
<b>Appendix 1: Workshop Invitees</b>	<b>15</b>
<b>Appendix 2: Best Practices Crisis Response</b>	<b>17</b>
<b>Appendix 3: Detailed Workshop Evaluation Responses</b>	<b>19</b>

## Introduction

---

On April 14, 2004 a workshop took place involving families and service providers who work with people with developmental disabilities in the South Fraser Region, which involves the communities of Langley, Surrey, White Rock and Delta. A photo of participants is included below.



The impetus for the workshop came from a meeting of four community living service providers who knew that in the current environment they needed to improve crisis response and two Interim Authority consultants who understood the need to develop policies and supports for Community Living British Columbia (CLBC)'s crisis response plan for the whole province.

The Planning Group included:

- Nancy Hall Interim Authority [IA],
- John Talbot Facilitator

- Melinda Heidsma IA
- Dan Collins Langley Association for Community Living
- Paul Wheeler Semiahmoo House Society
- Glenn Reid Surrey Association for Community Living, and
- Sharon Rose Delta Community Living Society

All seven worked to develop a guest list, an agenda and a series of workshop questions presented in a “Workbook”.

Staff from the Interim Authority (Brian Salisbury, Avril Harkness, Lisa Tedford) and the Provincial Tertiary Working Group on Crisis (Jan Wood) facilitated the small groups.

The report reviews the purpose of the workshop, identifies the people who attended the workshop and some whose presence was missed, describes the work done at the workshop and concludes with evaluation comments by the participants. It is presented as a beginning step with community ideas to develop an improved community based crisis response.

As with the Workshop Workbook, a Best Practices approach is used to stimulate dialogue on specific points relating to establishing a new network to do a very important task. We don’t have to reinvent the wheel when we can learn from other’s work.

This report was written by Nancy Hall. For any follow up information, please contact Nancy at [nancy.hall@shaw.ca](mailto:nancy.hall@shaw.ca).

## **Purposes of the Workshop**

---

- To convene a group of families, service providers, health professionals and law enforcement officers from the communities of Surrey, White Rock, Delta and Langley (South Fraser) to examine the region’s capacity to respond to crises involving individuals with developmental disabilities.
- To identify the current kinds of crises experienced by individuals with developmental disabilities, their families and service providers.
- To identify stakeholder responsibilities during a crisis and to brainstorm strategies that might be implemented to improve an effective resolution to specific kinds of crises.
- To provide the Interim Authority with information on key elements of a model for an improved community crisis response system for CLBC.
- To identify potential policies and/or protocols that might need to be developed between CLBC, Fraser Health and the RCMP to enable a better response to crises.
- To determine if this network is interested in meeting again.

## Workshop Invitees

---

The workshop facilitators invited representatives from families, community living service providers, Ministry of Children and Family Development staff, the Interim Authority, the health authority service providers and the RCMP. The names of individuals are included as Appendix 1 of this report.

During the Workshop, other people were identified to invite to another meeting of the South Fraser group. They included:

- A self advocate or group of advocates who received crisis support
- School personnel
- After Hours Crisis Team (They were contacted but couldn't attend).
- Hospital Social Workers (Their health service area managers were contacted but likely did not have enough time to respond).

## Workshop Method

---

The workshop planning group met once in person and once by teleconference. The Interim Authority supported logistics and workshop costs including facilitation fees. The group of 28 worked in four cross sector groups throughout the day.

The workshop began with a presentation of four different “stories” of individuals, families and service providers in crisis presented by Dan Collins, the Executive Director from the Langley Association for Community Living, in consultation with some of the families he works with. Each group discussed a different “story” and made some summary observations about key elements of a crisis response.

The afternoon small group discussions started with a discussion of values and assumptions. This was followed by a structured series of questions identifying more specific parameters of a crisis response:

- Who needs to be involved?
- What are objectives of an enhanced crisis response?
- What is the most desirable structure for a crisis response service in a community?
- How can the new service be structured to support continuous learning?

Several times through the day the facilitators worked to synthesize the comments of the four groups into one “analysis”. The larger group also considered barriers to implementing an improved crisis response that should be considered by the provincial Working Group and the Tertiary Capacity Committee. Next steps were briefly discussed.

## Workshop Findings

---

Workshop findings are presented in two parts: the findings from the morning and those from the afternoon.

### Morning Work: Defining a Crisis

---

People were divided into four small groups and discussed the “stories” which served as a starting point to define a crisis.

The groups began their work with a widely accepted definition of crisis: A **crisis** occurs “when a stressful life event overwhelms an individual’s ability to cope effectively in the face of a perceived challenge or threat<sup>1</sup>.”

At the end of the morning, the following phrases from the four working groups were seen to be key elements of a definition of a crisis:

**Group 1:** Elements of a crisis include one or more of the following:

- Situations of urgency
- Situations of powerlessness
- Situations of fear
- Situations of life and death

**Group 2:** Situations where the family feels out of control with a situation involving their family member and they have:

- No supports
- No one to listen or help

**Group 3:** A crisis can be defined as a situation where the system is unable to meet the needs of an individual or carer. A crisis is an overwhelming individual experience, which can be multi-dimensional and has the potential to impact the person/and or family.

**Group 4:** “A crisis occurs when our failure to be a community has resulted in an instance of spontaneous combustion.” – Paul Wheeler

**Other key elements:**

Crises are highly individualized. What is a crisis for one is not always a crisis for another.

---

<sup>1</sup> Raymond Flannery & George Everly (2000) Crisis Intervention: A Review. International Journal of Emergency Mental Health 2(2) 119-125.

No consensus definition was arrived at in the workshop. It is assumed that the Tertiary Crisis Working Group will take this information as a place to start and will work to a consensus definition as any policy must have a definition that can trigger action.

## **Key Themes from Discussion of Crisis Stories**

---

There were a number of key themes that emerged from the discussion of definitions and the stories. It was felt that these were central issues to be addressed if implementation of a crisis response system was to be successful.

They are presented below, grouped around three particular themes: Working with Community, Qualities of the System and Qualities of the Crisis Intervention.

### **❖ Working with Community**

- **Community Action.** Situations that give rise to crises must be seen as the responsibility of the community and go beyond the individual and his or her family. Any new system must take a proactive approach to building community inclusion and community connectedness.
- **Listening.** Individuals and families are the experts of their lives. Any crisis response must excel at listening and problem solving. Service providers must also be available at hours when families can contact the system (i.e. at lunch hour and after 4:30 pm. This inaccessibility often makes crises more difficult than necessary.
- **Isolation.** Isolation of individuals and their families predisposes an individual to having a crisis. One long-term prevention strategy is to proactively address isolation. Some participants spoke about working with different cultures to address isolation.
- **Values tension.** The rhetoric of community living speaks of self-determination but with certain individuals the need is to feel interdependent and receive support and services. There is a natural tension between independence and dependence that a crisis response has to manage.
- **Make the rules clear.** A number of service providers and families mentioned that the rules for accessing service and even the process of being on a wait list were not clear. Several workshop participants work with individuals with significant challenges and have developed cross system crisis management plans. We could learn from them.

### **❖ Qualities of the system:**

- **Continuous learning.** Many participants had heard of these types of crises before and noted that the system had been unable to adjust to prevent the crises from reoccurring. Any new system must provide for continuous learning of the crisis network.
- **Education.** Families have a great deal to educate the service providers about what helps (and what doesn't) in a crisis situation. Families of people with disabilities, and

service providers, have much work to do to educate the community so that the community can move beyond understanding to welcoming and safeguarding people with disabilities.

- **Leadership.** Many crises situations involve multiple jurisdictions. A key question in a crisis is, who will take the leadership role, both immediate and long term. The leader can be a self-advocate or a family member or he or she can be a service provider, but having an identified lead facilitates coordination of the different resources. People need to know who to call and who will be available consistently to coordinate action.
- **Transitions.** There are certain predictable life transitions such as turning 19 or the death of a parent who is the primary caregiver. It was a source of frustration for participants that planning for these transitions wasn't as proactive as it needed to be. Funders and community members will have to decide where the mandate for crisis response begins and ends.
- **Crises require a layered and individualized response.** It is best if the intervention can be thought of as a series of steps beginning with the least intrusive and moving to a more intensive response. Appendix 2 has a layered response from the Best Practice literature that could be used for future planning.
- **Service users are continuously involved in satisfaction feedback.** The discussions revealed that many families and service providers do not contact specialized providers such as the mental health system or the police because they are afraid of the kind of interventions that will result. People reported being concerned about inappropriate and often overly restrictive interventions from crisis responders. Still others decide not to contact after hour crisis support because they are ashamed of their family member's disability and fearful of the labeling that follows being identified as a person with a diagnosis. However, one respondent expressed that the response from After Hours Support was a pivotal first step in the management of a very serious crisis for the person and ultimately the family. The initial response AND the clear lead by MCFD in this situation aided in an eventual resolution. Mental Health involvement may have led to a possible restrictive outcome.
- **Legal Mandates.** A crisis for someone with a developmental disability can evoke concerns about guardianship, legal status under the Mental Health Act and the Forensic Psychiatry Act, privacy and confidentiality, and a person's rights as a citizen. Any crisis response strategy needs to reflect an understanding of the current legislation and identify specific ways to approach this. In particular, protocols for insuring information sharing across jurisdictions when the situation requires it need to be worked out.
- **Safety.** A crisis can invoke fears of safety for both the individual and the caregiver. A need was identified to require a specific individualized crisis plan so that when family and specialized providers need to be contacted it is easy to move forward. It was also identified that safety needs do not disappear with the temporary resolution of the crisis response. Many individuals, post crisis, require continuing follow-up or a different

configuration of staffing or residency. This is where having one person, as a point of contact, is key.

## **A Discussion of Values and Assumptions**

---

Using the Workbook to start discussion, the groups discussed a series of values and assumptions that each had about the crisis response system. There were certain values that people could endorse with consensus: community living, person centered planning, community capacity and fiscal responsibility.

Groups stated these shared values in different ways:

“An individualized approach that will lead to proactive, supportive services.”

“Individuals and families are experts of their own lives and should be key decision makers”.

“Collaboration, and living what that means, is the only way we will get to an integrated crisis response.”

There were other values and assumptions where group members differed. For example, the groups had difficulty with discussing mental illness as a consistent part of crisis.

Groups also differed as to the predictability of crises. One group thought you needed to assume every crisis is avoidable while another group assumed that crisis is inevitable.

The solution to this tension came from one of the groups, who commented, “We need to be sharing with each other constantly”.

Specific assumptions that were discussed that could be used to guide new service development included:

- Assume that every crisis can be averted. Or assume crisis is inevitable.
- People involved in the crisis have important information to help stabilize the situation.
- An immediate response for the individual does not always address the ongoing crisis for the family or service provider.
- Assume that de-escalating a crisis does not solve the crisis.
- We need to create a crisis response that will work for both adults and children with developmental disabilities.
- Families want flexible supports.
- “No wrong door” is an important philosophy of an effective network.

## **A Synthesis of Key Elements to the Crisis Response**

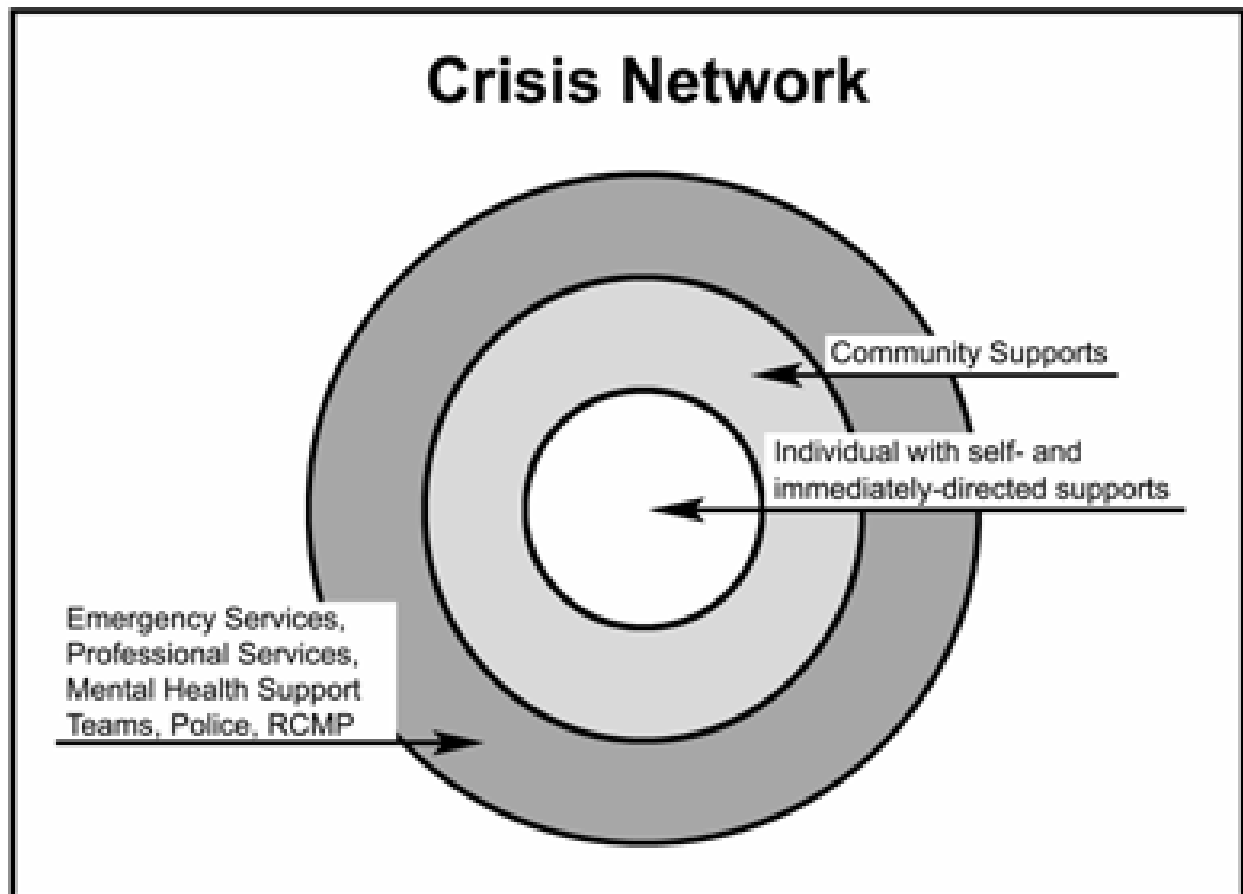
---

The working groups provided feedback on the key elements of a crisis response. They followed a structured set of questions that are listed below. What follows is a synthesis of the discussion of the four questions by each group.

### **Who is key in strengthening the crisis response?**

- **Community Responsibility.** Several groups identified responding to crisis as a community responsibility to people with disabilities living in our midst. Several times throughout the day, workshop participants explored the idea of a network for people within the region who work to support individuals with disabilities and their families.
- **Individuals and Families.** The group discussion identified that often families did not know the rules about how to access service and that there was limited straightforward communication about how to access help or how one qualified for service. The Family Support Institute was identified as a resource that could be tapped. Improved wait list management and informal supports to families would also help.
- **One person to facilitate the larger network.** The crisis response system needs a central point of contact. This person in turn works to keep the network connected. There was general discussion that this sort of multi-systems communication only works if there is a champion or a network coordinator.
- **One person to coordinate the person with disabilities' access to supports.** In a crisis, someone has to work directly with the person and his or her supports. It can be a family member, a guardian and/or a care provider. This work doesn't cease with the crisis resolution as some group members identified that the key crisis support person would often have follow-up to do. For example, the person may require changes in his or her housing situation. The lead responder would be different depending upon different needs but it would be clearly identified in the person's crisis plan.
- **A province wide access to local service.** Discussion identified that CLBC is planning to have a provincial 1-800 number so that anyone, anywhere in the province, will be able to access crisis support. This will require that CLBC has a network of individuals at the local level that can provide direct support.
- **Coordinated access to health services.** Discussions identified that some individuals require access to complex diagnostic and treatment services. As many people with disabilities experience mental illnesses, it would be key to have the person's lead mental health service provider identified where that is relevant.

Figure 1: Crisis Network



### What are the objectives of the crisis response system?

The groups were asked to discuss the potential objectives of a community crisis response. The objectives suggested by the groups had several common elements and a couple of tensions to balance. The following objectives represent a synthesis of the group discussion:

- **To take a preventive approach to community crisis.** This could be achieved by a variety of strategies including: developing clearer guidelines of what is available to families to support specific needs, strengthening access to peer support through already existing vehicles such as the Family Support Institute's Regional Resource Parents network, improving access to flexible family supports and providing more proactive supports for people in life transitions.

- **To maintain communications and support continuing role clarification** as the network changes. Phone and email lists need to be maintained with relationships clearly identified!
- **To develop creative, collaborative, community-based strategies** that provides a range of options to respond to crisis<sup>2</sup>.
- **To provide a timely<sup>3</sup> and respectful coordinated response** to individuals, families and service providers.
- **To provide an accountable and listening service that is committed to continuous learning** from the experiences of individuals, families and paid caregivers.
- **To provide better practice information and cross system education** that is based on the feedback of individuals and families.
- **To ensure that legal mandates are exercised in relation to safety and protection.** One group called this the responsibility of service providers to keep in the loop and exercise “due diligence” with regards to their community and people in need.

A central challenge to the discussion was the tension between a preventive approach and an urgent approach. Ideally, a crisis response system would work on a 24/7 basis and “priority needs” would be those who experience a specified degree of urgency. Much of the group discussion focused on the need to provide more preventive outreach and to have fewer people on wait lists for services. Each community will need to balance the tension of providing required core services with specifying the “target group” of a crisis response service.

### **What is the best structure for organizing a crisis response?**

The groups discussed a structure that would have the following qualities:

- Community based service with the ability to cross service system boundaries. There would be 24/7 access to support and a spirit of “no wrong door” would prevail among service providers.
- Local budget with accountability to CLBC.
- Educate and inform the community of the available supports as well as responding or triaging the crisis response.
- Group processes designed to work with members with divergent values.
- Formal collaboration agreements between the different agencies and organizations.

---

<sup>2</sup> Two groups suggested the importance of collaboration in better enhancing and coordinating what already exists. Still others suggested the pooling of resources in more of a consortium model as a potential way to achieve effective collaboration.

<sup>3</sup> Other descriptor words were timely, flexible, person centered, listening, proactive

The network model was most commonly mentioned as the best structure for the organization of the crisis response. Participants identified qualities of the network they thought were important such as: “team, connections, take a break, relationships, support, working together, influence, communications, resources and diversity”.

Participants also recognized that the network would exist by agreement on the use of shared resources. Networks appear to be strengthened by a healthy tension of personal relationships and formal agreements and protocols about who will do what.

Assuming a crisis response network is going to be supported, the group might look to the best practices literature on the network as a structure for innovation and service delivery. If CLBC were to contribute to funding a network, we would need a more precise definition of a network. For example, there are a number of strategic rural health networks in existence. In this situation the funders defined a rural health network as “a formal organization arrangement among rural health care providers (and possibly insurers and social service providers) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved.”<sup>4</sup>

### **How does a crisis response system achieve continuous improvement?**

The groups discussed that the current system does not learn from crises and they wish to see a system that is committed to continuous improvement. They also expressed an interest in seeing regular reviews anchored in data that give some independent assessment of whether we are making a difference.

Discussion around data was general and as a next step, would have to be tied to the indicators required to assess performance on the network’s stated objectives. This in turn would require the group to do some work defining measurable objectives beyond the general “reduce the number of crises”. For example, one best practice example cited in the workshop identified reducing the number of crisis hospitalizations as a measurable objective<sup>5</sup>.

### **Policies to support improved crisis response**

If crisis response is to be enhanced it will require intentional action by individuals, families, CLBC, community living service providers, health authority staff and the RCMP. The four groups identified the following as key policy areas to be recommended to the Tertiary Capacity Working Group:

- **Endorsement.** There must be highest-level endorsement within CLBC and the health authorities for a more systematic approach to crisis response. By agreement, CLBC and the health authorities could mandate that each of the proposed 17 community

---

<sup>4</sup> <http://www.ahrq.gov/news/ulp/ulpstren.htm>

<sup>5</sup> Griffin Community Support Network. Paper to be posted on CLBC web site.

living areas have a crisis response network. They could also mandate that individuals have their own crisis response plan where this is deemed appropriate.

- **Preventive Supports to Families.** Many group members identified the need to improve supports to families not receiving formal disability services, and not just consider how to improve the crisis capability of those in licensed or contracted resources.
- **Resources.** The endorsement must be accompanied by the provision of resources both from CLBC and other network members. This includes resources for an individual to coordinate the network and money to enable more flexible responses from service providers. There must be a specific budget line for family support.
- **Time.** Local managers within the various services would have to make it a priority to improve crisis response and support their staff to rethink current practices.
- **Leadership.** A more systematic response to crisis requires leadership: at the provincial level within CLBC and within the Community Living Centre Areas as well. “Who will take the lead?” was a question repeated many times in the Workshop.
- **Commitment to a Cross Sector Approach.** The crisis response network can be limited to families and service providers but it can also reach out to support those in the greatest difficulties whose needs have required the participation of emergency health services and/or the police. The Provincial Tertiary Capacity Steering Committee could mandate this approach and request that both the health and community living sectors commit to this collaboration.
- **Education.** It takes time and effort but cross system learning involving feedback from service users would add great value to the current supports. This needs to be organized and agencies have to agree to channel their continuing education money to support this activity. Again, the Provincial Tertiary Capacity Steering Committee and more specifically CLBC and the health authorities could mandate that as a condition of membership, network participants commit to creating a joint education fund.

## Evaluation of Workshop

---

The Workshop Evaluation consisted of responses to five questions. The aim was to assess whether the planners had met their objectives and to stimulate feedback from participants.

Generally speaking, the workshop met its objectives and the workshop participants enjoyed the process and were eager to get on with the real job of enhancing a crisis response. A consistent theme throughout the workshop and the feedback is the relative emphasis on mental health crises relative to other crises and the quality of the mental health interventions currently available to some individuals and their families. The group differed on their willingness to include serious mental illness and/or serious medical conditions as representing crisis.

The detailed responses to the Workshop Evaluation Form are included as Appendix 3.

## Proposed Next Steps

---

Before the workshop finished, group members identified the following as next steps:

- Write up a report from today. Nancy Hall to do this within three weeks.
- Nancy to circulate the report to the review committee composed of Lori Emanuels, Jan Wood, Brian Salisbury, Avril Harkness, Dan Collins and Sharon Rose.
- Circulate the final report to all participants, the Tertiary Capacity Steering Committee and post the report on the Interim Authority's website. Nancy Hall to do this.
- Tertiary Capacity Committee to discuss the provincial approach towards rolling out an enhanced crisis response capacity. The Tertiary Working Group (Melinda Heidsma Chair) will be charged with this work. Nancy Hall to circulate this information. It is assumed for instance, that as provincial CLBC policy this group would work in a combination of synthesis and feedback with local community groups such as the group assembled for this workshop.
- South Fraser Group to meet to follow up. Group to be convened by Dan Collins. Additional volunteers were: Lori Emanuels, Leah Lacey, Glen Reid, Debbie Jackson, Muriel Hansen, and Brian Salisbury.

## Appendix 1: Workshop Invitees

### Attended

Person, Agency or Program	Individual	Contact Information
Families	Donalda Madsen	604-534-6962 <a href="mailto:donaldamadsen@shaw.ca">donaldamadsen@shaw.ca</a>
Families	Lori Emanuels	604-575-2588 <a href="mailto:lemanuels@shaw.ca">lemanuels@shaw.ca</a>
Family Support Institute	Angela Clancy	604-875-1119 <a href="mailto:aclancyfsi@bcacl.org">aclancyfsi@bcacl.org</a>
Families	Helen Connolly	
Langley Association for Community Living	Dan Collins Teresa Griffiths	604-534-8611 local25 <a href="mailto:dcollinslacl@shaw.ca">dcollinslacl@shaw.ca</a> <a href="mailto:tgriffithslacl@shaw.ca">tgriffithslacl@shaw.ca</a>
Delta Community Living Society	Sharon Rose Cheryl Anne Hendy	604-946-9508 <a href="mailto:srose@dcls.ca">srose@dcls.ca</a> <a href="mailto:cahendy@dcls.ca">cahendy@dcls.ca</a>
Semiahmoo House Society	Paul Wheeler Wendi McIntosh	604-536-1242 <a href="mailto:p.wheeler@shsbc.ca">p.wheeler@shsbc.ca</a>
Surrey Association for Community Living	Glenn Reid Debbie Evans	604-584-4424 <a href="mailto:greid@commliv.com">greid@commliv.com</a>
Mainstream Association for Community Living/Tertiary Capacity Working Group	Jan Wood	604-299-4001 <a href="mailto:jwood@mapcl.org">jwood@mapcl.org</a>
Ministry of Children and Family Development	Muriel Hansen	604-501-3139 <a href="mailto:Muriel.Hansen@gems8.gov.bc.ca">Muriel.Hansen@gems8.gov.bc.ca</a>
MCFD	Jane Holland	604-775-1238 <a href="mailto:jane.holland@gems6.gov.bc.ca">jane.holland@gems6.gov.bc.ca</a>
MCFD	Debbie Jackson	604-501-3139 <a href="mailto:debbie.jackson@gems2.gov.bc.ca">debbie.jackson@gems2.gov.bc.ca</a>
MCFD	Jean Nakamura	604-501-3139 <a href="mailto:jean.nakamura@gems1.gov.bc.ca">jean.nakamura@gems1.gov.bc.ca</a>
Provincial Disability Consultant	Dr. Brian Plain	<a href="mailto:Brian.Plain@caphealth.org">Brian.Plain@caphealth.org</a>
Vinge Nursing	Gus Kops	<a href="mailto:augustus@vinge.bc.ca">augustus@vinge.bc.ca</a>
Applied Psychology Group	Trudy Merritt	604-543-8488 <a href="mailto:tmerritt@appliedpsychologygroup.com">tmerritt@appliedpsychologygroup.com</a>
RCMP	Inspector Janice Armstrong; Sgt. Trish Pinkewycz	Janice Armstrong 604- 598-4389 Pager 604-915-8353 <a href="mailto:janice.armstrong@rcmp-grc.gc.ca">janice.armstrong@rcmp-grc.gc.ca</a> <a href="mailto:trish.pinkewycz@rcmp-grc.gc.ca">trish.pinkewycz@rcmp-grc.gc.ca</a>

<b>Person, Agency or Program</b>	<b>Individual</b>	<b>Contact Information</b>
Fraser Valley Mental Health Support Team	Tina Donnelly	604-598-4389 <a href="mailto:Tina.Donnelly@fraserhealth.ca">Tina.Donnelly@fraserhealth.ca</a>
Fraser Valley Mental Health Support Team	Dr. Robin Friedlander	604-660-0792 <a href="mailto:friedlander@cw.bc.ca">friedlander@cw.bc.ca</a>
Health Services for Community Living	Fran Kain Lea Lacey	604 541-6800 <a href="mailto:fran.kain@fraserhealth.ca">fran.kain@fraserhealth.ca</a> <a href="mailto:lea.lacey@fraserhealth.ca">lea.lacey@fraserhealth.ca</a>
Surrey Health Service	Lois Dixon Referred: Crystal Mihelic	604 587-3901 <a href="mailto:lois.dixon@fraserhealth.ca">lois.dixon@fraserhealth.ca</a> 604-592-4987 <a href="mailto:chrystal.mihelic@fraserhealth.ca">chrystal.mihelic@fraserhealth.ca</a>
Fraser Health Authority	Pam Whiting	604-519-8523 <a href="mailto:pam.whiting@fraserhealth.ca">pam.whiting@fraserhealth.ca</a>
Interim Authority	Avril Harkness	604 660-3356 <a href="mailto:avril.harkness@gems2.gov.bc.ca">avril.harkness@gems2.gov.bc.ca</a>
Interim Authority	Lisa Tedford	604-660-0086 <a href="mailto:Lisa.Tedford@gems1.gov.bc.ca">Lisa.Tedford@gems1.gov.bc.ca</a>
Interim Authority	Brian Salisbury	604-897-1856 <a href="mailto:Brian.Salisbury@InterimAuthorityCLBC.ca">Brian.Salisbury@InterimAuthorityCLBC.ca</a>
Facilitator	John Talbot	604-513-8403 <a href="mailto:JohnTalbot&amp;Associates@telus.net">JohnTalbot&amp;Associates@telus.net</a>
Workshop Convener: Advisor Tertiary Capacity Project Interim Authority	Nancy Hall	604-660-3355 <a href="mailto:Nancy.Hall@shaw.ca">Nancy.Hall@shaw.ca</a>

### Invited but unable to attend

<b>Person, Agency or Program</b>	<b>Individual</b>	<b>Contact Information</b>
Mental Health/RCMP After hours service (Car 67) 3pm to 1am	Insp. Colin Blake	604 592-4927 Direct v.mail: 604-599-7777 Loc 3587 <a href="mailto:colin.blake@rcmp-grc.gc.ca">colin.blake@rcmp-grc.gc.ca</a>
Adolescent Crisis Response Service –South Fraser area	Munir Velji Senior Clinician	604 585-5561 <a href="mailto:munir.velji@fraserhealth.ca">munir.velji@fraserhealth.ca</a>
Kindale/IA CLBC Crisis Response Working Group	Henry Sundquist	250-546-3005 <a href="mailto:kindale@sunwave.net">kindale@sunwave.net</a>
Pacific Community Resources	Chris Thomas	

## Appendix 2: Best Practices Crisis Response for People with Disabilities and their Carers

Best practices involve different areas of focus. Some focus on the family supports; some focus on the community living sector specifically and finally, others work across the health and community living sector.

Every family or caregiver needs to have a crisis response strategy. Who calls whom about whom, is a good series of questions to have worked out in advance if it is at all possible. Currently there are various respite options open to family but it is unclear how they are individualized or networked locally. Flexible family support can be organized in small groups where parents together find a respite worker who works for them<sup>6</sup>.

Some of the best practice models are restricted to the developmental services sector. For example, the Vermont Crisis Intervention Network has three levels of action<sup>7</sup>.

1. **A Network.** These cover all of the agencies that deliver service to individuals with developmental disabilities within a particular region. They meet twice a year to reflect on practice issues and learn new skills and appreciations.
2. **On Site Consultation.** Expert clinical services are provided to the families or agency staff at their location and in reference to a specific individual. A referral can come from anywhere and depending upon the need, an expert mentor responds. The request for support may require medical, psychiatric and/or behavioural supports. Level 2 support almost always provides follow up support at the person's home.
3. **Crisis Residential Services.** In order for a community crisis system to work there has to be in an alternative setting, safe beds that offer safe housing, evaluation and treatment.

Other best practice models quite specifically involve *both* the health and the developmental sectors. The Griffin Community Support Network in Toronto has five levels of action:

1. **Telephone triage to the appropriate provider.** The network is organized so that jurisdictions and responsibilities are clear and respected. If you find a person with a

---

<sup>6</sup> "Family Governed Flexible Family Support: The Massachusetts Small Project Example". A paper sponsored by the Massachusetts Families Organizing for Change and Uniting Families for Change, Western Massachusetts. By Michael J. Kendrick, January 5, 2001 posted at: [http://interimauthorityclbc.ca/Tertiary\\_Articles.htm](http://interimauthorityclbc.ca/Tertiary_Articles.htm)

<sup>7</sup> From Concept to Practice: Building a Continuum of Supports for those with Complex Needs Carson, Neil and Dart, Laurie. Presentation to "Making Gains Conference" Niagara Falls, September 2003. Posted at: [http://interimauthorityclbc.ca/Tertiary\\_Articles.htm](http://interimauthorityclbc.ca/Tertiary_Articles.htm)

developmental disability in crisis, people know to call Griffin Community Support Network.

2. **On site supports.** The network coordinator has money to support families or agencies to consult about the challenges and if necessary, to bring in additional staff.
3. **Safe beds.** Sometimes people need a different environment or quite simply, their housing situation has broken down. The network coordinator manages access to ten short-term safe beds in the Greater Toronto Area.
4. **Expert diagnostic and treatment support.** If people are stuck and a solution to the challenging behaviour is not impacted by environmental strategies, individuals can be referred to a specialized mental health service that offers both outpatient and inpatient support. This health service is provides both out patient consultation and inpatient stays when necessary.
5. **Research:** The network was set up with a position so that someone could collect statistics about how individuals continue to present with crises and how the system needs to learn how to respond to meet the need.

The Griffin Community Support Network, ranging from telephone support to inpatient care is organized along the different levels discussed in Health Canada's Best Practices in Mental Health Reform<sup>8</sup>.

---

<sup>8</sup> [http://www.hc-sc.gc.ca/hppb/mentalhealth/pubs/bp\\_review/pdf/e\\_revsec1-2.pdf](http://www.hc-sc.gc.ca/hppb/mentalhealth/pubs/bp_review/pdf/e_revsec1-2.pdf). Crisis Response Systems in Mental Health Emergencies in Best Practices in Mental Health Reform

## Appendix 3: Detailed Workshop Evaluation Responses

What follows are the responses to the six Workshop Evaluation questions.

1. *As a workshop participant today, I learned something useful about a more effective way to approach crisis response.*

**Yes: 21**                      **No: 1**

*Comments:*

- The range of experiences should be very useful
- Thinking of crises other than mental health
- Who are the other potential stakeholders?
- Really like the concepts of no door is a wrong door while recognizing importance of sharing information and strong coordination/collaboration
- Very valuable ideas/sharing; diversity of people was excellent
- Systems and process may be available; however, under-utilized, inappropriately utilized – need coordination
- Networking was great.
- Not really sure that I “learned” anything new but benefits were many in regards to involvement in planning needs for crisis

2. *The workshop was well facilitated.*

**Yes: 22**                      **No: 0**

*Comments:*

- Very nicely tied elements of the process together and demonstrated a genuine valuing of the input from participants
- Very good!
- Strongly agree – very well done and maintained timelines, clarified issues, kept group focused. Well done!
- Well organized, really felt the table arrangements allowed for good discussions and networking
- Table arrangement excellent

- John & Nancy did a great job of moving us through the day

3. *The “case study” discussions were effective.*

**Yes: 21**                      **No: 1**

*Comments:*

- Would have liked more dealing with mental health/behavioral issues
- Could have perhaps spent less time discussing case (1/2 hr – 45min)
- Excellent examples. All could relate.
- More detailed scenarios, I think
- A few more details required
- A medical crisis covering issues of No family, DNR orders etc. would have been a good issue
- They certainly got us talking
- Differentiating between an emergency crisis and prolonged crisis
- Case studies of an effective Community Response System. Show us the Best Practice

4. *The workbook was an effective tool to initiate discussions and develop a beginning approach.*

**Yes: 18**                      **No: 3**                      **No Response: 1**

*Comments:*

- Plan to read it afterwards
- Nicely done
- A little wordy in places, but otherwise, very good
- Tended to focus on a specific kind of crisis
- Great to meet/re-connect with others/share info
- Excellent to bring together so many valuable persons in the CLS field
- Examples provided tended to shape thinking
- Mental health
- Too mental healthy and behavioural
- Useful to provide something to respond to. Helpful structure
- But people felt they needed it sooner

- Great tool!
- Excellent
- Interesting tool to get ideas flowing

5. *The workshop was a first step towards enhanced ability to respond to people with disabilities and their crises in South Fraser.*

**Yes: 21                      No: 0                      No Response: 1**

*Comments:*

- Plan to make a response resource
- What are the next steps?
- Very good discussion surrounding a more collaborative approach. Liked the approach of discussing values/assumptions – models
- Hope so! Keep it going
- Next Steps – what is our collective capacity

6. *The workshop met my needs.*

**Yes: 20                      No: 0                      No Response: 2**

*Comments:*

- Excellent facilitation – where do we go from here? What do you plan to do with the information – I'd like to hear back via email – Jean Nakamura
- Important sharing and process took place – would have condensed a bit more
- Great job and very timely!
- I wasn't sure what to expect, but thought it was excellent
- Great day, well organized, planned, went really fast, excellent facilitators.