EXPLORING GENDER-RELATED ISSUES IN MOBILE CRISIS PROGRAMS THROUGH A FEMINIST THEORETICAL FRAMEWORK

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science, Graduate Department of Community Health/ Collaborative Program in Women's Studies University of Toronto

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0-612-58755-X
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ABSTRACT

The current investigation analyzed gender differences among a cohort of clients who accessed the services provided by two Ontario mobile crisis programs and was guided by a feminist theoretical framework. Gender differences were examined in terms of client characteristics, mental health functioning, process of care, and outcome of care. The study was part of a one-year evaluation that took place at Sunnybrook and Women’s College Health Sciences Centre (SWCHSC) and reports on data collected between March 15, 1999 and August 31, 1999. Data was collected retrospectively through a chart review of clinical record forms and progress notes completed by mobile crisis workers during their initial visit with clients.

The results of the study found that women and men differed on a number of important factors. Specifically, women were older, were more likely to be married, and were less likely to be referred to the mobile crisis programs by a family member than their male peers. In addition, women were more likely to report having been diagnosed with an affective disorder while men were more likely to report having been diagnosed with schizophrenia. Other significant gender differences showed that women were more likely than men to report suicide intentionality and were less
likely to have had contact with a psychiatrist and to be referred to case management services. Finally, even after controlling for the effects of other variables, affective disorders were shown to be more common in female than male clients by a factor of about two. The implications of these findings, particularly as they relate to the sensitivity of mobile crisis programs to gender issues and women’s mental health needs, are discussed and recommendations for policy and practice are provided. Limitations and strengths of the study and directions for future research are also presented.
ACKNOWLEDGEMENTS

I wish to express my gratitude to my supervisor, Dr. Lorraine Ferris, who has helped shape my thoughts and ideas in the area of women's mental health. As well, I thank both Dr. Ferris and Dr. Shulman, co-principal investigators in the original evaluation, for giving me the opportunity to work on this study. In addition, I am grateful to my committee member, Dr. Janice Du Mont, who has been a source of incredible support and encouragement along this challenging journey. Thanks are also due to Dr. John Paul Szalija for his knowledgeable advice and expert statistical analyses. I also appreciate the support and encouragement provided to me by my friends, particularly Dina, Glenn, Valerie, Annie, Peter, and Sal.

I would also like to send out a special thanks to my family. I thank my grandparents, Guiseppina and Gaetano Gagliano, for dedicating their life to ensuring that their grandchildren have the material and financial resources to pursue higher education. I thank my parents for their years of undying love and support. Particular thanks go out to my mother, for instilling in me at a very young age the importance of education and for teaching me the value of persistence and dedication. I thank my sister Tonia for her generosity and my nephew Matthew for always listening intently to my stories. Finally, I thank my sister Michelle, for inspiring me and filling my life with joy and laughter.
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I dedicate this thesis to my sister Michelle, who is my best friend.
SECTION 1

INTRODUCTION

Traditionally, women’s mental health has been a neglected area of study. Feminist critiques have helped elucidate how women who sought the assistance of the mental health system were often ignored, disbelieved, and silenced (Chelser, 1972). In the past decade, there has been growing interest into understanding causes and seeking solutions to women’s mental health problems. More and more women are working together to identify and speak out against injustices within the mental health system. In 1990, for instance, representatives from women’s organizations across Toronto formed the “Coalition of Feminist Mental Health Services” in an effort to “critique traditional systems, identify gaps, and advocate for alternative feminist models” (p. i). Furthermore, in 1995, the Federal government set up five “Centres of Excellence” to promote much-needed research on women’s health in Canada and to address the insufficient attention which has been paid to the health concerns of women. More recently, the newly formed Canadian Institutes for Health Research (CIHR) established a “Gender and Health Institute” to direct more attention to issues relevant to women’s health. Despite these gains, the mental health system remains entrenched in patriarchal assumptions and practices. Women’s distinct needs continue to go unrecognized and have not been pursued as separate areas of concern. Although some alternative feminist models have been developed and implemented, they are not regarded as central components of the mental health system. Today, evaluating mental health services available to women remains a priority of feminist researchers, scholars, and activists.
One area of mental health service delivery that has received scant research attention in relation to women's mental health needs has been mobile crisis programs. Mobile crisis programs are a component of the system of care that emerged out of the community mental health movement. These programs typically provide 24-hour mobile support services to individuals with serious mental illnesses who are experiencing an acute or episodic crisis. They are distinguished by their ability to provide psychiatric intervention to clients who require the familiar environment of their homes or other community settings. Early intervention in the community is designed to quickly stabilize crisis situations and address the health needs of clients and their families. Mobile crisis teams provide the least intrusive resolution of the crisis and respect the individuals wishes whenever possible. Case management services, provided either by the program staff or partner agencies ensure that these individuals and their families are linked with ongoing support services. Overall, mobile crisis programs have been viewed as an effective and humane approach for dealing with people who have mental illnesses (Ferris, Shulman, & Williams, 1998).

Although there have been several descriptive studies about the benefits of mobile crisis programs, there has been little research regarding their impact (Ferris, et al., 1998). Moreover, no existing literature has focussed on an analysis of gender-related issues or on the mental health needs of women. In an attempt to improve upon this deficit in the literature, the present study seeks to analyze gender

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1 Serious mental illnesses are those that are the most clinically complex and persistent and are often associated with severe deficits in functioning. Although the specific diagnoses and illnesses that meet these criteria may be debatable, there is consensus that schizophrenia and bipolar disorders are among the most serious mental illnesses (McAlpine & Mechanic, 2000).
differences among a cohort of clients who accessed the services provided by two Ontario mobile crisis programs—Metro Integrated Community Crisis Program (MICCP) and Peel Integrated Crisis Response (PICR)—using a feminist theoretical framework. Gender differences are examined in terms of client characteristics, mental health functioning, process of care, and outcome of care. Rather than merely comparing differences between women and men who accessed the services offered by mobile crisis programs, a feminist interpretation will emphasize the diversity of women’s experiences and enable consideration of the role of social factors in the etiology, prevention, and treatment of their mental health problems (Mowbray, Herman, & Hazel, 1992; Repper, Perkins, Owen, Deighton, & Robinson, 1996).

Because a feminist approach will be critical to the development of coherent health and social policy and cost-effective intervention strategies, within the context of the current study, discussion will centre on the quality of care and appropriateness of services offered by mobile crisis programs for female clients.

The literature review that follows is divided into three sections. The first section introduces current conceptualizations of mental health and outlines the central tenets of feminism and feminist theories. An overview of feminism’s contribution to the field of mental health is then presented along with a look at historical trends in the treatment of women with mental health problems. Following this is an exploration of a few salient themes that have emerged from the literature on gender differences in mental health. The section concludes by examining two competing explanations for gender differences in mental health advanced from a feminist perspective—the social constructionist approach and the social causation
approach. The social constructionist perspective considers gender biases in diagnosis while the social causation perspective argues that something inherent in the individual's social position contributes to the onset of mental disorder. It is shown that considered together, both these approaches contribute to a comprehensive feminist perspective on gender differences in mental health.

In the second section, the emphasis shifts from feminism and mental health to an examination of mobile crisis programs. In order to provide the landscape in which to understand mobile crisis programs, an overview of the community mental health movement is first presented. This is followed by an examination of the limitations of the community mental health movement and the emergence of mobile crisis programs as a way to manage some of the problems. Next is a discussion of the advantages and disadvantages of mobile crisis programs, policies and procedures followed by a description of mobile crisis teams, and a review of the mobile crisis literature that has been conducted to date. Finally, using the review of the literature as a base, section three outlines the rationale for the present study and the formulation of the research questions. The central goal of the study is to illuminate some gender-relevant issues in clients who access the services offered by mobile crisis programs.
SECTION 2
REVIEW OF MENTAL HEALTH AND FEMINIST LITERATURE

2.1 Conceptualizing Mental Health

The question of how to define mental health is a difficult one. Despite longstanding interest in the field, there is no one definition of mental health agreeable to all (Ontario Advisory Council on Women’s Issues, 1990). One aspect that has been fairly consistent, however, has been the emphasis on identifying people’s weaknesses and abnormalities as opposed to their strengths and abilities (Caplan, 1995). It is without surprise, therefore, that terms such as “illness” and “disorder” appear in the literature with far greater frequency than do terms such as “health” and “well-being.” The current preoccupation with “abnormal” behaviour raises a crucial question, namely, how is such behaviour defined? The concept of illness, whether it be physical or mental, implies deviation from defined norms or standards. Who decides when a particular kind of behaviour deviates sufficiently from a norm to warrant its definition as illness, and who ultimately decides which behavioural norms are acceptable indicators of mental health? To answer these questions, it is necessary to direct attention to the field of psychiatry.

Psychiatry has played a critical role in shaping current conceptualizations of mental health and illness. Psychiatric classifications and ideology powerfully shape mental health practice as they determine the official definition of the problem, as well as the parameters of treatment (Jimenez, 1997). Of particular influence has been the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM). Commonly referred to as the “bible” among mental health
professionals, the DSM is a formalized diagnostic system used by psychiatrics, psychologists, nurses, and social workers. The purpose of the manual is to facilitate and standardize the classification of mental illness and to generate reliable statistics regarding the epidemiology of psychiatric problems. The latest edition, DSM-IV (APA, 1994), consists of 397 different diagnoses with descriptions of symptoms that characterize the disorders (Caplan, 1995). The manual has become commonplace in the mental health community, even to the point of surpassing the use of other classification systems, including the World Health Organization's (WHO) International Classification of Diseases, tenth edition (ICD-10, 1992). One of the frequently cited strengths of the DSM is that categorizing clients into discrete diagnostic categories allows for the accumulation and integration of psychiatric knowledge and experience over time, permitting generalizations to be drawn (Hare-Mustin & Marecek, 1997). Moreover, diagnostic categories provide clinicians and researchers with a common language so that they can communicate more meaningfully with one another which, in turn, theoretically enhances treatment and research initiatives (Thakker & Ward, 1998). The DSM has also been credited for its everyday use in offering a consistent set of definitions and criteria to insurers, courts, and other agencies that deal with individuals who have mental illnesses (Horwitz & Scheid, 1999).

Despite these strengths, critics have asserted that because of the DSM's association with the medical profession, mental disorders tend to be conceptualized as being analogous to physical disorders (Mechanic, 1999). Accordingly, categories of mental illness are often thought of as having biological etiologies. This rather
reductionist view obscures the larger social, political, and economic context in which people live and in which mental health problems are experienced. Psychiatric diagnoses are also historically and contextually specific. Categories of mental illness reflect and reinforce the dominant values and beliefs of Western culture (Caplan, 1995). In fact, several of the mental disorders listed in the DSM are rarely found outside Western society (Thakker & Ward, 1998). Moreover, the DSM presents a descriptive rather than a theoretically based approach to diagnostic entities (Mechanic, 1999). A psychiatric diagnosis does little by way of explaining how the disorder came into being (Carson & Butcher, 1992), and this is especially true of personality disorders. Therefore, it can be argued that using the DSM for diagnosis and treatment involves a high degree of subjectivity and bias. As cogently put forth by Paula Caplan (1995), the process of assigning an individual a diagnostic label “has always involved far more ‘art’ than science” (p. 38).

2.2 Feminism and Feminist Theories

The term “feminism” gained widespread usage in the western world in the late 19th century. It emerged as a way to identify individuals who supported not merely an increased public role for women, but also women’s right to define themselves as autonomous beings (Elliot & Mandell, 1998). In the past few decades, feminism has come to embrace political, cultural, economic, sexual, racial, and ethical dimensions. Despite increased interest in feminist theory and research, there has been a lack of consensus concerning its very definition. According to Adrienne Rich (1986), feminism implies that women can recognize fully the inadequacy of male-centered
ideologies. To Barbara Smith (1990), feminism is the political theory and practice to free all women—women of colour, working-class women, poor women, physically challenged women, lesbians, old women, as well as white economically privileged heterosexual women. Moreover, bell hooks (1984) defines feminism as a social, economic, and political commitment to eradicating race, class, and sexual domination and to recognize society so that individual self-development takes precedence over imperialism, economic expansion, and material desires.

Notwithstanding definitional differences, feminism seeks to understand basic features of social life and human experience from a woman-centered perspective. The purpose of feminist analysis is to understand how and why women come to be subordinate and to elucidate the social and cultural processes through which social change can be realized. Key questions that have occupied feminist theorists include: How is male dominance sustained?; How is gender difference constituted?; How do we account for the diversity of women's experiences arising from differences of class, race, or sexual orientation? In addressing these questions of dominance, difference, and diversity, it is important to recognize that feminist theories do not offer a unified approach. There are four basic frameworks or theoretical orientations within the feminist perspective, each differing in terms of their general philosophical orientation and their explanation of women's oppression. Liberal feminism views women's oppression as a result of institutionalized sexism and argues that women should have access to the same rights and privileges as men (Lengermann & Niebrugge-Brantley, 1992). Radical feminism locates the source of gender inequalities and women's subordination in patriarchy (Fee, 1982). Marxist feminists
have also drawn on the concept of patriarchy, but tend to focus more on women's historical relationship to the means of production (Abbott & Wallace, 1997). Finally, feminist post-structuralists seek to destabilize gender as a hierarchical binary opposition and find the ground in between so that men can no longer be easily associated with all that is valued and women with all that is devalued in society (Annandale & Clark, 1996). Despite their distinct philosophical orientations, feminist theories are avowedly political in their advocacy for social and political change (Wilkinson, 1998), seek to understand the gendered nature of virtually all social and institutional relations (Elliot & Mandell, 1998), and challenge the dominant patriarchal ideologies that claim women's subordination is natural, universal and therefore inevitable (Abbott & Wallace, 1997).

2.3 Feminism and Mental Health

Women's mental health is a significant area of feminist theory, research, and activism. Feminist critiques have helped elucidate that psychiatry has generally held misogynous and male-biased assumptions about appropriate female behaviour and about the nature of femininity (e.g., Chester, 1972; Ehrenreich & English, 1978; Showalter, 1985). Such views are manifestations of the dominant ideology regarding the superiority of men, with women being looked upon as less valuable than men, as objects existing for male pleasure, and as passive and needing to be dominated and controlled. Such an ideology reflects and reinforces the differential power of women and men in society and has rendered invisible the efforts of women toward self-definition (Canadian Mental Health Association, 1987). Indeed, within
the mental health field, women have generally been looked at—rarely have they done their own looking or been asked their opinions concerning their own experiences. Certain groups of women have been doubly disadvantaged because discrimination due to race, ethnicity, disability, and socioeconomic status has rendered them invisible within the mental health field. The labeling of women as “mentally ill” has also served the function of maintaining women’s position as outsiders within patriarchal society—justifying their exclusion from entry into higher positions within the social structure and from obtaining higher social power (Canadian Mental Health Association, 1987). Feminists move away from pathological explanations for women’s mental health problems, presenting a different view and alternative treatment approaches. That which is defined as “illness” by psychiatry is seen by feminists as the result of women’s social structural position and misogynist beliefs and assumptions (Ussher, 1991). Thus, feminist scholarship looks to oppressive social institutions and structures in explaining women’s mental health problems.

In addition to calling attention to the misogynous and male-biased assumptions that are embedded within the institution of psychiatry, feminists have highlighted the paucity of research, thought, and sensitivity to gender issues in health-related research. Historically, large-scale epidemiological studies eschewed attention to gender differences. For instance, Hollingshead and Redlich (1958), in their widely cited study *Social Class and Mental Illness*, only made reference to gender differences in an appendix and offered no interpretation of the figures they provided. While today it is considered “standard good practice” to present and
analyze data separately for women and men, there is still little systematic analysis of
gender differences being made (Riska, 2000). A recent study by Vidaver, Lafleur,
Tong, Bradshaw, and Marts (2000) found that although 80% of research published in
four major medical journals between 1993 and 1998 included women, only one-
quarter to one-third of the studies analyzed the data by gender. Without adequate
research attention to gender differences in presentation, treatment, and
interventions, mental health services will continue to be ill-equipped at meeting the
diverse needs of its female clients. The most significant contribution that feminists
have brought to the study of mental health, therefore, has been their focus on
gender as a major object of enquiry (Busfield, 1996).

The concept of gender emerged out of the second wave of feminism in the
1960s as a way to challenge biological determinism. While the precise definition of
the term gender is often disputed, it generally refers to the social and cultural
expectations for femininity and masculinity that cannot be reduced to matters of
biology. Gender, then, is contrasted with sex—the latter referring to the
physiological aspects of being female or male (Busfield, 1996; Lips, 1993). Some of
the core features of gender that have been established by feminist scholars include
the assumption that differences between women and men are a social product rather
than a biological given and that they are culturally, historically, and politically situated
(Busfield, 1996). Similarly, nature and culture are inextricably intertwined, so that
ostensible biological explanations for differences between women and men must be
closely examined for ideological and determinist biases (Love, Jackson, Edwards, &
Pederson, 1998). In addition, while sex is often conceptualized as a binary and
mutually exclusive category, gender can be viewed as a continuum of degrees of maleness and femaleness, of masculinity and femininity (Yoder, 1999). Finally, gender is a marker of hierarchy which, in concert with other markers such as age, class, race, and ethnicity, determines relations of power (Marecek, 1995).

2.4 Historical Trends in the Medical Treatment of Women

Throughout history, the mental health problems of women and men have been regarded as arising from different causes. Disturbance in women has been considered emotional in nature, emanating from physical causes, while abnormality in men has been more likely to be described as an intellectual aberration. This is related to a longstanding belief according to which men have been associated with the mind and women with the body (Greenglass, 1982). In the Middle Ages, prior to the regulation of society through medical discourse, the mind and body were regarded as the domain of religion and all disease, madness, and unexplained misfortune were assumed to be the result of evil spirits, inhabiting the body of the victim (Ussher, 1991). A common belief during this period was that psychologically disturbed people, supposedly in league with the demon world, were involved in witchcraft. As such, hundreds of thousands of "witches," the vast majority of whom were women, were subjected to trial, torture, and then to death by burning or hanging for their "crimes". Among these crimes included causing illness in adults and children, fornicating with the devil, rendering men impotent, tearing unborn babies from the womb of their mothers, ruining crops, and poisoning livestock (Ehrenreich & English, 1978). It has been argued that the witch-hunts evolved in
response to the demise of feudalism and threats to the church (Ussher, 1991). Agricultural misery, plague, civil war, and religious changes resulted in a disruption to society. Since explanation for misery or infection could not be found in religious discourse, which was changing and uncertain, witches functioned as scapegoats for all social ills (Dworkin, 1981).

The eighteenth and nineteenth centuries marked a turning point in the history of women’s madness. During this period, the male-dominated medical profession, who took control of the diagnosis and treatment of mental illness, established the view that the explanations for women’s “abnormalities” lay in the female reproductive system (Ehrenreich & English, 1973). Physicians pointed to menstruation, childbearing, and menopause as being the causes of mental illness. As put forth by the president of the American Gynecological Society in 1900, those women who were not “crippled on the breakers on puberty” might be “dashed to pieces on the rock of childbirth” or “ground on the ever-recurring shallows of menstruation, and… the final bar of menopause” (Englemann, 1900, quoted in Ehrenreich & English, 1979, p. 110). Many women suffered scalding, branding, and surgical manipulations or removal of their reproductive organs in an effort to “cure” them from a variety of maladies (Canadian Mental Health Association, 1987). The most severe and disabling of these surgical interventions included clitoridectomies, hysterectomies, and ovariectomies (Ehrenreich & English, 1979; Ussher, 1991).

During the latter half of the nineteenth century, hysteria came to be the most common female diagnosis. Hysteria, named for the Greek word meaning uterus, was a mysterious disease marked by fainting or fits and a variety of symptoms such
as loss of voice or partial paralysis, without any apparent physiological basis (Ussher, 1991). It was believed to be caused by the uterus wandering to various parts of the body, the result of over-indulgence in intellectual pursuits which served to upset a woman’s “natural” balance (Ussher, 1991). A number of cures were offered for hysteria, including some of the physically intrusive ones described above. A very popular form of treatment was the rest cure devised by the American psychiatrist Salas Weir Mitchell (Ehrenreich & English, 1978; Ussher, 1991). The “cure” consisted of total isolation and sensory deprivation. For six weeks, the woman was instructed to lie on her back in a dimly lit room. She was not permitted to engage in any sort of intellectual activity and was to see no one except a nurse and physician. During this time, the woman’s diet consisted of bland food and she was given a daily massage. The cure became immensely popular largely because, unlike the gynecological treatments, it was painless (Ehrenreich & English, 1978). The active “cures” for psychological disorders were reserved for middle and upper class women; working class women in emotional distress were more likely to be warehoused in mental asylums amid conditions of incredible filth and cruelty (Ussher, 1991).

While it is arguable that today there are more enlightened attitudes towards women’s mental health and more humane treatment options, psychiatry continues to reflect a general devaluation of women. The view that mental health problems can be attributed to a biological or genetic phenomenon, rather than to social factors, has persevered. This is evident in the large numbers of women being prescribed psychotropic medications and who may be undergoing treatments such as
Instead of helping women challenge the social, economic, and political factors which are intimately connected to their mental health problems, psychiatry has been engaged in a process of helping women “adjust” to their existing social reality (Lepischak, 1992). The mental health profession has individualized and pathologized women's mental health problems by failing to see them as expectable and appropriate responses to oppressive social conditions. While not as overt as in the past, the mental health system remains unresponsive and insensitive to women’s specific needs.

2.5 Gender Differences in Mental Health

In the present investigation, gender differences are examined in an effort to determine whether women’s special needs and concerns are being adequately addressed in the mental health field. It is important to recognize that the issue of studying gender differences has been challenged in recent years (e.g., Hare-Mustin & Marecek, 1994; Hyde, 1994; Lips, 1993; Marecek, 1995; Wilkinson, 1997). One of the problems frequently cited is that studies only report gender differences where they are found to be significant, giving the illusion that there are more differences between women and men than there are similarities (Lips, 1993). Moreover, in the interpretation of gender differences, there is a tendency to apply male behaviour as the norm against which to measure females. In other words, gender differences are exaggerated and interpreted in a general context of women being inferior to men.

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2 According to Carson and Butcher (1992), ECT is a procedure used to treat individuals who are severely depressed and/or suicidal. It involves passing an electric current of approximately 150 volts through a patient's head. ECT is highly controversial and its use has somewhat subsided in the wake of the widespread use of psychotropic medications.
Another problem is that biological bases for observed gender differences are often postulated, even in the absence of appropriate data. Finally, reports of gender differences can be used in a way that is harmful to women (Hyde, 1994). For instance, because of the preponderance of men with alcohol and substance abuse disorders, men with these disorders have been studied more extensively (Nadelson, 1993). Limited understanding of substance abuse disorders in women has led to the development of treatment methods that are ineffective and inappropriate for women (Nadelson, 1993). In light of these problems, feminist scholars have been inclined to focus attention only on the lives and experiences of women. While women certainly need to be made visible and their experiences described and explored, without attention to men, it is difficult to advocate for changes to the structure of mental health services (Busfield, 1996). Therefore, while the current investigation places women's concerns at the forefront of analysis, it focuses on gender—that is, on differences between women and men.

2.5.1 Gender and Diagnosis

Gender differences in rates of mental illness have been the focus of research and debate across various academic disciplines, including medicine, psychology, sociology, public health, and epidemiology. Historically, studies estimating the number of people with psychiatric illnesses in the community showed that, overall, women suffered from greater mental illness than did men. For instance, Gove and Tudor (1973), in a comprehensive review of studies in Western industrial nations after World War II, found that women uniformly had higher rates of mental diagnosis
compared to men. In recent years, the conclusion that women suffer from greater mental health problems has been challenged (Dohrenwend & Dohrenwend, 1976; Greenglass, 1982). One of the arguments used to demonstrate that the gender difference in mental illness may not be as clear cut as it first appears comes from the inconsistency from study to study in the definition of mental illness that is employed. In their analysis, Gove and Tudor (1973) defined mental illness as "a disorder which involves personal discomfort (as indicated by distress, anxiety, depression, etc.), and/or mental disorganization (as indicated by confusion, thought blockage, motor retardation, and, in the more extreme cases, hallucinations and delusions), that is not caused by an organic or toxic condition" (p. 812). Excluded from this definition are personality disorders, substance-related disorders, and psychotic disorders—all of which predominate in men. Considering that most of the early community-based studies focused solely on depression and anxiety—disorders which predominate in women—it is not surprising that women were reported to have higher global rates of mental illness than men.

Although the literature looking at gender and the overall rate of mental illness is inconclusive and replete with methodological inconsistencies, epidemiological data obtained from large-scale community surveys provide convincing evidence that women and men suffer from different types of mental illnesses. The widely acknowledged Epidemiological Catchment Area (ECA) study was designed and conducted by the National Institute of Mental Health (1981). Its goal was to assess baseline rates of mental illness within treated and untreated populations. This involved a new type of research technique, the Diagnostic Interview Schedule (DIS),
which consisted of structured interviews based on DSM-III diagnostic criteria (Robins & Regier, 1991). The DIS assessed the presence, duration, and severity of a wide range of psychiatric symptoms and could be administered by non-clinicians. The ECA study was distinguished from previous epidemiological efforts in that it encompassed a greater range of diagnoses, including personality and substance abuse disorders. Moreover, the use of trained lay interviewers in administering the DIS increased the numbers of research participants that could be processed and maintained research costs within reasonable limits. The ECA study surveyed over 20,000 randomly selected people in five communities in the United States (i.e., New Haven, Baltimore, St. Louis, Durham, and Los Angeles) and produced estimates of incidence of mental illness, as well as one-year and lifetime prevalence rates.

The ECA found that overall, 32% of adults had experienced one or more psychiatric disorders at some time in their lives and that 20% had an active disorder, defined as having a mental disorder within the past 12 months (Robins & Regier, 1991). In terms of gender, more men than women had a psychiatric disorder over their lifetime (females 30.0%, males 36.0%), but women and men ranked the same in terms of their current experience of mental disorder (20.0% in both groups). The difference in lifetime prevalence can be explained by the significant overrepresentation of men diagnosed with substance-related disorders (females 4.6%, males 23.0%) and antisocial personality disorder (females 0.8%, males 4.5%). Women, on the other hand, had significantly higher rates for major depression (females 7.0%, males 2.5%), dysthymia (females 4.1%, males 2.2%), generalized anxiety disorder (includes agoraphobia and simple and social phobia; females 5.0%,
males 2.4%) obsessive-compulsive disorder (females 3.0%, males 2.0%), and somatization disorder (females 0.2%, males 0.1%) (Robins & Regier, 1991). The ECA study found that women and men had equivalent rates for schizophrenia and bipolar disorder; however, women seemed to have a later onset of schizophrenia and a briefer course than men. These findings suggest the need to examine rates of specific disorders rather than global measures to determine differences between women and men. As concluded by Robins and Regier (1991):

The ECA results have overturned some erroneous views of the nature of psychiatric disorder in the community. Based on earlier studies, it was thought that women were particularly liable to psychiatric illness... The stereotypic person with psychiatric disorder was a middle-aged anxious or depressed woman. The ECA has shown that disorders in men are as common as or slightly more common than in women and that most begin in early adult life. (p. 365)

In Canada, a major epidemiological investigation in Edmonton, Alberta, which also used the DIS (Bland, Orn, & Newman, 1988), corroborated the findings of the ECA study. In this study, 3,258 households residents 18 years of age and older were surveyed to determine the lifetime prevalence of a mental disorder. Overall, 33.8% of the population met criteria for one or more of the covered disorders at some point in their lives. Similar to the ECA study, men had a higher rate of psychiatric disorder over their lifetime compared to women (females 26.8%, males 40.7%). Women had higher lifetime prevalence rates for the group of affective disorders (females 13.2%, males 7.1%) and the group of anxiety/somatoform disorders (females 13.8%, males
8.7%). Specifically, women had higher rates of major depression (almost twice the rate for men), dysthymia (almost two and a half the rate for men), agoraphobia (almost three times higher in women), and simple phobia and panic disorder (twice as high in women). Men, on the other hand, showed a clear predominance in substance-related disorders (females 8.6%, males 32.5%) and antisocial personality disorder (females 0.8%, males 6.5%). Disorders without significant gender differences included schizophrenia, social phobia, and bipolar disorder.

While the ECA study and the Edmonton-based study represent an improvement of past research that excluded substance-related and personality disorders (i.e., Gove & Tudor, 1973), they still failed to provide a comprehensive listing of psychiatric diagnoses in their investigation. An expansion of the epidemiological data base is necessary in light of the fact that disorders such as posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) were not among those studied (Nadelson, 1993). Both PTSD and ASD are DSM classifications that have been proposed for people exposed to traumatic events, including violence and abuse. In recent years, there has been increased awareness of the enormous incidence of physical and sexual violence in the lives of women. To understand the psychiatric repercussions of violence against women, it is necessary to consider both PTSD and ASD when examining gender differences in mental health (Nadelson, 1993). Another problem with these studies is that they involved interviews with household residents only. The absence of individuals who are homeless or living in nursing homes, shelters, or correctional facilities may have the
effect of reducing the actual rates of mental illness which would have been found in the total population.

2.5.2 Gender and Mental Health Service Utilization

Research suggests that women and men seek mental health care differentially. However, gender differences in use of mental health services depend upon the type of treatment setting studied. Specifically, utilization rates reported by gender vary within psychiatric hospitals, outpatient mental health services, and community-based care facilities. Focusing first on psychiatric hospitalizations, research has shown that men have higher treatment rates than women. For instance, data from the National Institute of Mental Health in the United States revealed that in 1980, there were 369,049 admissions to state and county mental hospitals (Rosenstein, Steadman, Milazzo-Sayre, MacAskill, & Manderscheid, 1986). A total of 64.9% of the admissions were male. Gender differences were also reported for the primary diagnoses upon admission to state and county mental hospitals. Men were more likely to receive diagnoses of alcohol or drug-related problems, while women received diagnoses of schizophrenia and affective disorders. Rosenfield (1982) surveyed several emergency rooms in New York City and found that men were more often hospitalized for mental disorders more common among women, such as neuroses and psychotic depression. Women, on the other hand, were more likely to be hospitalized if they suffered from mental disorders more common among men, such as personality and substance abuse disorders. The results of the study suggest that for both women and men, behaviour which does not
conform to their ascribed gender is more likely to result in psychiatric hospitalizations.

In terms of outpatient mental health services, research has shown that women have consistently higher utilization rates (Greenley, Mechanic, & Clearly, 1987; Kessler, Brown, & Broman, 1981; Leaf & Bruce, 1987; Rhodes & Goering, 1998). Outpatient mental health services are defined as those provided in a clinic or office to ambulatory clients. There are two types of outpatient mental health services: primary and specialty care. Primary care usually incorporates general practitioners or family doctors whereas specialty care includes psychiatrists, psychologists, social workers, and other trained mental health professionals (Rhodes & Goering, 1998). With respect to the type of services used, the issue to have captured the attention of many researchers is the preponderance of women using primary care services for mental health problems. Leaf and Bruce (1987), using data from the New Haven ECA site, found, for instance, that 11.3% of women versus 6.6% of men sought mental health care. Although women and men did not differ in the likelihood of seeking specialty mental health care, women were more likely to seek mental health care from their family doctor or other general medical practitioners. It would appear, therefore, that while women are more likely than men to utilize outpatient services for their mental health problems, they do so outside the formal mental health service sector.

Women who use the primary care sector for their mental health problems may not be receiving care appropriate to their level of need (Rhodes & Goering, 1994). For instance, the National Ambulatory Medical Care Survey (NAMCS), a
sample survey of visits to nonfederal office-based practitioners, found that general practitioners performed more diagnostic evaluations and procedures, prescribed more psychotropic drugs, were less likely to provide psychotherapy, and spent less time with their patients than psychiatrists (Schurman, Kramer, & Mitchel, 1985). These results suggest that primary care physicians over prescribe psychotropic medications for the treatment of mental health problems. Similarly, the Medical Outcomes Study (MOS), an observational study of individuals who receive care either in a group practice, a large multi-specialty group practice, or in a single-specialty solo or small group practice, found that at least half of the patients with depression did not have their symptoms detected by general medical providers and received no psychosocial care (Mechanic, 1990). Moreover, among those whose symptoms were recognized, inadequate or inappropriate care was often provided. Specialty care practitioners, on the other hand, increased the numbers of visits in response to increased levels of patient distress (Mechanic, 1990).

In terms of community-based care, gender differences in service utilization have not been widely studied. The few studies that have been conducted suggest that women and men have different utilization patterns and are not being provided with equivalent services. Perkins and Rowland (1991), for example, found significant differences in the services received by women and men in community-based rehabilitation and continuing care services. While 60% of the clients were men, women had been in contact with the services for a longer period of time, had received less intensive input from the services, and were engaged in less demanding activities. The results of the study raise questions concerning whether
the needs of female clients are adequately being met in rehabilitation and community care. Test, Burke, and Wallisch (1990) examined gender differences in the lives of young adults with schizophrenic disorders who were participants in a long-term community treatment program. The results suggest that women have different characteristics and experiences than their male counterparts. Specifically, more women were caring for children, lived with a male partner, and were involved in a sexual relationship. These researchers concluded that these differences create specific needs among the female clients of community teams and that these needs are very rarely addressed (Test, et al., 1990).

2.5.3 Gender and Psychotropic Drug Use

Psychotropic drug utilization is another area where there has been significant research attention focussing on gender differences. Psychotropic drugs are chemical substances which are thought to ameliorate abnormal mental states by acting on one or more of the many neurotransmitters of the brain (Silverstone, 1998). Some drugs have a stimulating effect, while others have a tranquilizing one. Psychotropic drugs are classified into four different categories according to their pharmacological effect and their treatment of a particular symptom: (1) antidepressants which are prescribed for depression; (2) antipsychotics or neuroleptics which are prescribed for a range of psychotic symptoms, including schizophrenia; (3) anxiolytics or tranquilizers which are prescribed for anxiety; and (4) sedative-hynotics which are used to treat insomnia (Ettorre & Riska, 1995; Silverstone, 1998). The two former drug categories are prescribed for more severe
psychiatric symptomatology, whereas the latter two are prescribed for minor symptoms of anxiety and insomnia (Ettore & Riska, 1995). Anxiolytics and sedative-hypnotics, however, have greater abuse and dependency potential than do antidepressants and antipsychotics (Simoni-Wastila, 2000). The use of psychotropic drugs is relatively new in the treatment of mental disorders, having become commercially available in the mid-1950s. In fact, the availability of psychotropic drugs provided the impetus for the community mental health movement (Ettore & Riska, 1995; Prior, 1999).

Research has consistently shown that women throughout the Western world are prescribed approximately twice as many psychotropic drugs as men (Ashton, 1991). For example, in a study of 133,081 patients of general practitioners in the United Kingdom, the prescription rate was 20% for women and 10% for men (Parish, 1971). In a study of 24,633 patients admitted to general medical and surgical wards in the Boston area, the findings were even more startling, with 25% of women and 15% of men receiving psychotropic drug prescriptions (Greenblatt, Shader, & Koch-Weser, 1975). The majority of epidemiological studies focus on anxiolytics, and many investigations have confirmed the greater use of these drugs by women than by men. For example, a cross-national study in 1980-1981 of the use of anxiolytics found that in all the countries studied, the female to male ratio was approximately 2:1 (Balter, Manheimer, Mellinger, & Uhlenhuth, 1984). Moreover, Simoni-Wastila (1998), in a study examining how women and men differ in psychotropic drug use, found that women were 55% more likely to receive prescriptions for antidepressants and anxiolytics than men but were equally likely to receive prescriptions for
antipsychotics and hypnotics. This gender difference persisted even after controlling for diagnosis, demographic variables, insurance status, and physician specialty.

2.5.4 Summary and Conclusions

There is increasing evidence that there are gender differences in certain types of mental disorders, although overall rates of mental illness in men are as common or slightly more common than in women. Women have been reported to have higher rates of depressive, anxiety, and somatization disorders, whereas men show more substance abuse and antisocial disorders. In terms of service utilization, research shows that women and men differentially seek mental health care but that these gender differences are dependent on what treatment setting is examined. One of the more substantial findings has been that while women are more likely than men to seek outpatient mental health care, they do so within the primary health care sector. Finally, research has consistently shown that women are more likely to be prescribed psychotropic medications than men. To date, a number of competing theories have been offered to account for these gender differences in mental health. In the following section, those explanations advanced from a feminist perspective are presented.

2.6 Feminist Perspectives on Gender Differences in Mental Health

Feminist scholarship has generally been concerned with two distinct, yet complementary, endeavours when it comes to understanding gender differences in mental health (Pugliesi, 1992). The first mode of thought, referred to as the social
constructionist perspective, involves critical analyses of methodology and conceptions of mental health and illness and contends that gender differences are the result of institutionalized sexism and misogyny (Busfield, 1988; Pugliesi, 1992). The social causation perspective, on the other hand, examines features of social life that enhance or undermine a woman’s sense of well-being. According to this perspective, the disadvantaged position and low status of women in society makes them more vulnerable to mental health problems and more willing to seek psychiatric help (Busfield, 1988; Pugliesi, 1992). While critics have claimed that these two approaches are at odds with one another, together they contribute to a comprehensive feminist perspective on gender differences in mental health. Indeed, it is the case that women are subjected to stresses unique to their structural position that do cause distress. At the same time, however, concepts of mental disorder are tied to gendered notions of behaviour and mental health professionals do treat women and men differently. Both bodies of literature warrant further discussion.

2.6.1 Social Constructionist Perspective

The social constructionist perspective questions the validity of categories and conceptions of mental illness. This perspective maintains that women are more likely to be labeled “mentally ill” because of their relative powerlessness in society. For the most part, women have been excluded from positions of power and authority within the medical profession and have been denied the opportunity to view health and illness from their own perspectives. Conceptions of mental health and illness have been created by men, are laden with patriarchal values and assumptions, and
do not speak to the experiences and realities of women (Busfield, 1988; Pugliesi, 1992). Mental illness is a label inappropriately and incorrectly applied to women as a means of social control. Women who diverge from gender-specific cultural norms are particularly at risk of being labeled mentally ill. Rather than being biological in origin, mental illness is socially, politically, and legally defined (Busfield, 1988; Prior, 1999). The social constructionist perspective, therefore, is primarily concerned with uncovering the extent to which conceptions of mental health and illness are fundamentally gendered and the ways in which the practices of mental health professionals are inherently sexist. More specifically, this approach asks, what is it about psychiatric theory and practice that gives the illusion that women are more prone to mental disorder than men?

Chesler (1972), in her influential book *Women and Madness*, argues that women’s behaviour is typically devalued, rejected, and pathologized. She contends that women are in a catch-22 like predicament, that is, they are subject to the label of madness both when they conform too closely to their socially prescribed role and when they deviate from it. The extent to which femininity itself is seen as pathological was skillfully demonstrated in a classic study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970). In this study, the standards of mental health for women and men were examined in clinically-trained psychologists, psychiatrists, and social workers. The results showed that clinicians held different ideals for mentally healthy functioning adult males and females. Their ideal of a healthy man was similar to that of a healthy adult (gender unspecified), but their ideal of a healthy woman was quite different from both. The ideal healthy
woman was described as being submissive, dependent, excitable, easily influenced, emotional, and sensitive. These findings suggest a clinician’s perception of healthiness or unhealthiness is determined by the extent to which a client conforms or fails to conform to gender-role stereotypes. Replications of Broverman, et al.’s (1970) work over the past three decades have suggested that while there have been significant changes in standards of mental health for women and men, clinicians continue to be guided by gender-role stereotypes (Beckwith, 1993; Kaplan, Winget, & Free, 1990).

Feminists have also demonstrated how gender biases are built into the diagnostic categories of several disorders described in the DSM (e.g., Caplan, 1995; Jimenez, 1997; Loring & Powell; 1988; Kaplan, 1983). According to Kaplan (1983), masculine-based assumptions are codified most explicitly in personality disorder diagnoses. Consider dependent, histrionic, and borderline personality disorders—all are more commonly diagnosed in women because aspects of these disorders represent caricatures of the traditional female gender role (Jimenez, 1997; Kaplan, 1983). The essential feature of the dependent personality disorder is “a pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation” (APA, 1994, p. 284). Histrionic personality disorder (formerly known as hysterical personality disorder) is marked by “a pervasive pattern of excessive emotionality and attention seeking” (APA, 1994, p. 281). Finally, borderline personality disorder is characterized by “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity” (APA, 1994, p. 650). The aforementioned
diagnoses demonstrate that behaving in a feminine stereotyped manner will increase the likelihood of being diagnosed as having a mental illness. As concluded by Kaplan (1983), "... not only are women being punished for acting out of line and not only are traditional roles driving women crazy, but also male-centered assumptions—the sunglasses through which we view each other—are causing clinicians to see normal females as abnormal" (p. 791).

The extent to which the DSM is filled with gender biases was further elucidated in the controversy surrounding the revision of its third edition (DSM-III-R, 1987). The controversy centered on the proposed inclusion of two new diagnostic categories: late luteal phase dysphoric disorder (LLPDD) and self-defeating personality disorder (SDPD). LLPDD is characterized by "a pattern of emotional and behavioural symptoms (e.g., depressed mood, anger or irritability, fatigue, change in appetite, etc.) that occur during the week before, and within a few days after, the onset of menses" (APA, 1987, p.368). LLPDD is exclusively a female diagnosis and is merely a fancy label for what is more commonly referred to as "Premenstrual Syndrome." The inclusion of this diagnostic category in the DSM-III-R would have resulted in vast numbers of previously healthy women to now be considered "mentally ill." The essential feature of the second misogynist diagnostic category, SDPD, is "a pervasive pattern of self-defeating behaviour" (APA, 1987, p. 371). More specifically, "the person may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her" (APA, 1987, p. 371). Although theoretically applicable to both women and men, SDPD is primarily a "woman's
disorder" as women have traditionally been socialized to put other people's needs ahead of their own. According to Caplan, this diagnostic category "blinds people to the true causes of women's unhappiness" (p. 189). Instead of identifying, understanding, and promoting changes in the factors that make women unhappy, they are blamed for their own misery. Because of strong opposition from many feminist and professional groups, neither of these two diagnoses were included in the main text of the DSM-III-R; instead, they were listed in the appendix as "Proposed Diagnostic Categories Needing Further Study."

Feminist scholars working within the social constructionist paradigm have also argued that women are prescribed more psychotropic drugs than men because doctors are more likely to proffer drugs to women without medical justification (Fidel, 1980). According to Cooperstock (1971), the cultural beliefs of male physicians make them more likely to assign psychiatric labels to women's than men's emotional distress and, hence, to prescribe drugs to women. In addition, medical advertising often shows women in advertisements for psychoactive drugs. Not only do women appear in advertisements more frequently, but they tend to be portrayed in stereotypical gender roles. Mant and Darroch (1975) observed that these advertisements depicted men as working and women as minding the home or in glamorous poses. Finally, the social constructionist perspective would maintain that psychotropic medication is more socially acceptable for women than for men. According to Cooperstock (1971), "Women are permitted greater freedom than men in expressing feelings. Because
of this women are more likely to perceive or recognize their feelings and more specifically to recognize emotional problems in themselves" (p. 241).

2.6.2 Social Causation Perspective

The social causation perspective contends that women are more vulnerable to distress, depression, and other mental health problems than are men (Pugliesi, 1992). Thus, this approach conceptualizes gender differences in mental health as being real. According to this perspective, mental illness is a condition which reflects the inequalities and exploitation that exist in contemporary society (Busfield, 1988). Within psychiatry, distress and suffering are seen as a result of some inherent pathology within women, while the effect of women's daily experience of living out their expected role in the family and being subjected to stresses generated by present social structures is seldom considered (Penfold & Walker, 1983; Ussher, 1991). Critics of psychiatry have long argued that the term "mental health" is erroneous and that symptoms of distress might better be captured by the phrase "problems in living" (Szasz, 1961). Rather than looking at genetic predisposition or intrapsychic processes, the social causation approach asks, what is it in the life experiences of women and men that leads them to different kinds of psychopathology? In explaining women's poorer mental health status and greater use of mental health services this perspective looks at the conditions of oppression in women's lives. There are several factors associated with being a woman that may have deleterious implications on mental health, including marriage, poverty, and violence (Pugliesi, 1992; Russo, 1990).
Gove and Tudor (1973) were among the first to examine gender differences in mental health in relation to social structural variables. These researchers found that while married people in general fared better than their unmarried counterparts in terms of mental health, the specific effect of marital status was contingent upon gender—married women had higher rates of mental illness than married men. Gove and Tudor (1973) argued that their results suggest an explanation in which roles are central. They cited a number of features of the role of married women which they believed would engender psychopathology: (1) restriction to a single major social role; (2) activities of the homemaker are frustrating; (3) the role of homemaker is relatively unstructured and invisible; (4) even when married women work, they typically experience a lack of status and the additional burdens imposed by the dual role; and (5) the expectations confronting women are unclear and diffuse. Gove and Tudor (1973) concluded that because of the lack of power and control and conflicting expectations that accompany the marital role for women, more married women than men experience mental health difficulties.

One of the most well established research findings in psychiatric epidemiology has been the positive correlation between poverty and mental health problems (Belle, 1990). Research shows that women are overly represented among the poor, a phenomenon often referred to as the “feminization of poverty” (Belle, 1990). The feminization of poverty can largely be explained by the rise of single-parent families headed by women, women’s relegation to low-status and low-paying jobs, the unavailability of decent and affordable childcare, and the erosion of governmental economic assistance to low-income families (Paltiel, 1988; Perry,
According to Statistics Canada (1995), 56% of those living in low-income situations are women. While women have moved into the labour force in greater numbers, their earnings are consistently lower than men's. In 1993, the average annual income of women was $16,500, just 58% the average income of men ($28,600). Even women who have graduated from university earn only 75 cents for every dollar made by their male colleagues. The circumstances of single mothers are even more dismal. In 1993, families headed by female lone parents had an average income of $23,300, compared to $59,700 for two-spouse families. In addition, 60% of all single parent families headed by women had incomes which fell below the Low Income Cut-offs (Statistics Canada, 1995). Women also constitute a growing number of those facing homelessness. Approximately one-fifth of all homeless adults in North America are women and at least one-third of the homeless population is composed of families with children, headed predominately by a female lone parent (Buckner, Bassuk, & Zima, 1993).

The social causation model would posit that the aforementioned social and economic realities of women's lives have profound consequences for their mental health. For instance, research shows that women who live in financially strained circumstances and who have responsibility for young children are more likely than other women to experience symptoms of depression (Brown, Bhrolchain, & Harris, 1975; Radloff, 1975). High levels of depressive symptoms are particularly common among women without a social support network, child-rearing assistance, or employment. Weissman, Leaf, and Bruce (1987) found that lack of employment, single parent status, and lack of a university education were all associated with
chronic, mild depressive symptoms, although income level itself was not found to be a predictive factor. A longitudinal study that assessed depressive symptoms in the community found that inadequate income was associated with an elevated risk of depressive symptoms (Kaplan, Roberts, Camacho, & Coyne, 1987). A recent study conducted by Bassuk, Buckner, Perloff, and Bassuk (1998) compared the prevalence of DSM-III-R axis I disorders among homeless and low-income mothers with the prevalence of these disorders among women in the general population. These researchers reported that homeless and low-income mothers had similar rates of psychiatric and substance abuse disorders and that both groups had higher rates of major depression, substance abuse, and posttraumatic stress disorder compared to women in the general population (Bassuk, et al., 1998).

Violence against women compromises the personal health and safety of millions of women annually and is now being recognized as a leading public health concern. Worldwide, one of the most common forms of violence against women is abuse by their husbands or other intimate male partners. Woman abuse can take a variety of forms, including physical, sexual, psychological, economic, and spiritual acts of violence (MacLeod, 1995). Statistics Canada's National Violence Against Women Survey (VAWS; Rodgers, 1994), which involved telephone interviews with 12,300 women 18 years of age and older, found that 29% of women who had ever married or lived in a common-law relationship reported experiencing physical or sexual violence at the hands of a male partner. Another form of violence against women, sexual assault, exists along a continuum, from forcible rape to nonphysical forms of pressure that coerce women to engage in sex against their will (Population
Reports, 1999). Recent prevalence studies report that between 13% and 25% of women have been sexually assaulted at some point in their lives (Koss & Boeschen, 1998). Much sexual abuse takes place against children or adolescents. Between one-quarter and one-third of all female children suffer sexual abuse before their eighteenth birthday (Browne & Fikelhor, 1986). Clearly, violence, in its many forms, is ubiquitous in the lives of women.

Recent research overwhelmingly supports the conclusion that violence is an important factor effecting women's mental health. Women who have experienced violence in their lives have higher rates of clinical depression, somatization, generalized anxiety disorders, and obsessive compulsive disorders (Golding, 1999; Kilpatrick, et al., 1985). Abused women are also reported to have higher rates of alcohol and drug abuse (Rodgers, 1994), eating disorders, and personality disorders (Kilpatrick, et al., 1985). In addition, Koss (1990) has pointed out that most women who have experienced violence exhibit an immediate post-victimization distress response, which, if not resolved, can develop into posttraumatic stress disorder (PTSD). PTSD is an acute anxiety disorder that can occur when people have been exposed to a traumatic event which "involved actual or threatened death or serious injury, or a threat of physical integrity of self or others" (APA, 1994, p. 427). The symptoms of PTSD include recurrent and intrusive distressing recollections of the event through images, thoughts, perceptions, and dreams; efforts to avoid anything that would remind one of the trauma; becoming emotionally numb and detached from others; experiencing difficulties in sleeping and concentrating; and being easily alarmed or startled (APA, 1994, p. 428). Studies show that between 50% and 95%
of women who have been sexually assaulted develop PTSD (Bownes, O'Gorman, & Sayers, 1991; Breslau, et al., 1998; Darves-Bornoz, 1997). For some women, the burden of abuse is so great that they take their own lives or attempt to do so. A strong correlation between a history of violence and suicidal ideation or deliberate attempts to self-harm has consistently been found (Abbott, Johnson, Kozioi-McLain, & Lowenstein, 1995). Battered women who develop PTSD appear to be the most likely to attempt suicide (Thompson, et al., 1999).

In addition to elucidating the intolerable constraints that women face in their daily lives, feminists working within the social causation paradigm have attempted to explain why women are more likely to access outpatient mental health services compared to men (Prior, 1999). Gender differences in help-seeking behaviour can be seen as a product of women and men's differential gender role socialization. The traditional feminine gender role allows and even encourages vulnerability to problems, thus resulting in greater reporting of symptomology and greater willingness to engage in help-seeking behaviour. The traditional masculine gender role, conversely, discourages men from seeking help for their mental health problems as to do so would jeopardize their image as strong and invulnerable (Prior, 1999). It is also possible that health care providers are responsible for gender differences in help-seeking behaviour (Leaf & Bruce, 1997). Physicians may respond differently to indicators of positive or negative attitudes in their patients depending on whether the patient is female or male. Research would seem to suggest that general practitioners feel more comfortable questioning women about their mental health than they do questioning men (Verbrugge, 1984).
To this point, an overview of gender differences in diagnosis, utilization of mental health services, and psychotropic drug prescriptions has been discussed along with a feminist interpretation of these differences. The intention has been to illustrate that women and men have distinct needs when it comes to their mental health. In the following section, an overview of mobile crisis programs is provided as well as a critique of the research that has examined mobile crisis programs to date. This will be followed by the objectives of the current study and the formulation of the research questions.
SECTION 3

REVIEW OF MOBILE CRISIS LITERATURE

3.1 Community Mental Health Movement

The last 40 years have witnessed a dramatic change in the delivery of services to individuals suffering from mental illness (Wayslenksi, Goering, & Macnaughton, 1992). The Canadian mental health system has shifted from a centralized, hospital-based model to a decentralized, community-based model. Initially, care for persons with mental illnesses was transferred from provincial psychiatric hospitals to psychiatric units in general hospitals. As such, several thousands of individuals suffering from mental illnesses were moved from mental hospitals to general hospitals (Wayslenksi, et al., 1992). Unfortunately, the new general hospital psychiatric units did not provide adequate services for individuals suffering from chronic mental illnesses; rather, they were better aimed at treating individuals with acute or mild mental health problems. Provincial psychiatric hospitals, on the other hand, continued to care for those diagnosed with chronic mental illnesses despite diminished resources (Wayslenksi, et al., 1992). In response to the need for additional support for these individuals, provincial governments started to fund community mental health programs in the 1970s. These programs were initially developed to provide assessment and treatment, rehabilitation and maintenance, accommodation and other necessary services to those individuals living in the community who had severe and persistent mental illnesses (Wayslenksi, et al., 1992). By 1990, there were more than 4000 community mental health programs in Ontario.
Community mental health programs are differentiated from clinical or medically-based services on a number of levels, the most notable being their humanistic service philosophy (Bachrach, 1983) and their emphasis on comprehensive care. Community mental health services are based on the assumption that communities have the potential to provide a full range of essential services to clients with severe mental illnesses and that treatment in the community is highly therapeutic (Bachrach, 1983). In addition, community mental health services are part of an integrated system of care that encompasses medical, legal, and social services (Canadian Mental Health Association, 1998). Indeed, individuals with chronic mental illnesses often present a multiplicity of needs, including medical treatment, income maintenance, education, housing, health care, employment, social supports, and so forth. Mental health services have traditionally been organized on a single-problem basis. Accordingly, they have had their own specific purpose, their own sources of funding, their own eligibility requirements, and their own individual modes of operation. Community mental health services, alternatively, work collaboratively with other health and service sectors to ensure that the overall needs of people can be addressed in a planned, integrated, and accountable manner (Canadian Mental Health Association, 1998).

While the community mental health movement has had successes, it has also encountered problems. Perhaps its most significant shortcoming lies in its treatment of those individuals with chronic mental health problems. While community mental health services were originally intended to provide care to individuals with severe mental illnesses, many are no longer doing so. Instead, community mental health
services often deal with problematic behaviours that are more manageable in nature. Where they do provide services to individuals who have serious mental illnesses, community mental health programs are poorly coordinated and services are either non-existent or overlapping (Mechanic, 1987). As a result, many individuals with chronic mental illnesses are scarcely getting by in the community, generally living in social isolation and dependent on welfare for subsistence (Toews, 1986). Many have become part of the revolving door syndrome—going in and out of psychiatric hospitals with excessive frequency (Brooks, 1987). While in the community some individuals deteriorate and become dangerous to themselves and others partly because of the inadequacy of available services. They are then hospitalized, treated with psychotropic medications, and released back into the community only to destabilize once again. As suggested by Bachrach (1983), those individuals who have chronic mental illnesses have become the victims rather than the beneficiaries of community mental health programs originally designed for their benefit.

3.2 Mobile Crisis Programs

Out of the need to make community mental health services more widely accessible to individuals with severe and persistent mental illnesses, the idea for mobile crisis programs emerged. While it is difficult to determine precisely when mobile crisis programs were first implemented, descriptions of such programs began to appear in the literature in the early 1970s (Geller, Fisher, & McDermeit, 1995). Mobile crisis programs have been designed to work within a network of partner providers to offer a comprehensive range of support services along a crisis
continuum that includes a 24-hour crisis response line; pre-crisis and ongoing supports; support to family members, significant caregivers, and friends; emergency respite housing; follow-up support; short-term case management; linkages to other community services; inpatient psychiatric care; and innovative in-home treatment/support service. The major goals of mobile crisis programs are to provide crisis services in the client's natural environment, to assist or respond to the client's immediate dilemma, to provide support and structure in an unstable situation, to provide services to individuals who are difficult to reach, and to reduce hospitalization by mobilizing treatment resources and environmental support systems (Gillig, 1995; Zealberg & Santos, 1996). By assessing the client on site and beginning treatment immediately, mobile crisis programs are thought to increase accessibility and lead to enhanced delivery of services.

Stroul (1991) reviewed 69 mobile crisis programs within the United States and Canada and found that while their mission, scope, and approach often vary, they have similar characteristics (as cited in Zealberg, Hardesty, Meisler, & Santos, 1997). Mobile crisis programs exist in communities of 90,000 people or more, serve individuals of all ages, and provide services in diverse settings, including in the client's home, on the street, and in shopping malls, homeless shelters, jails, and residential care facilities. The mobile crisis programs themselves may be housed in hospital emergency rooms, mental health centres, and specifically designated mobile crisis walk-in centres. Most programs have 24-hour mobile response capability and most perform pre-hospital screening. The team composition often varies, ranging from mental health professionals with master's degrees and above to
specially trained volunteers. Programs are typically licensed and have 24-hour telephone capability. Client populations may include those with serious and persistent mental illnesses, those with substance-related disorders, those who are responding to acute situational stressors, and those who are suicidal or homicidal.

Mobile crisis teams respond to psychiatric emergencies wherever they occur, making it important that a set of policies and procedures guide their work (Zealberg & Santos, 1996). During the initial telephone encounter, a mental health professional or a trained volunteer asks a series of structured questions to carefully screen the request for mobile crisis services. Many calls will not require a mobile visit as phone counselling or referrals to community resources are often sufficient. If the client is extremely dysphoric, depressed, suicidal, homicidal, or psychotic, then a mobile crisis visit is warranted. Prior to the actual visit, crisis workers must determine whether the client in question poses a risk either to her or himself or to others. If the client is armed or potentially dangerous, police should accompany the crisis workers to the client’s location. Similarly, if the client has engaged in self-harm behaviour, emergency medical services should be called to the scene. In cases where the client is not in any imminent danger, crisis workers typically need the client’s permission before proceeding with the intervention.3 If consent is obtained, crisis workers interview the client and/or family members regarding the client’s current status, the onset of the problem, and precipitating events. In addition, questions about the client’s mental health history, chronic medical problems, current medication, past and present psychiatric treatment, and family and social history are

3 Consent is needed only in cases where client is 18 year of age or older. In cases where the client is younger, it is necessary to obtain the consent of a parent or guardian.
asked and a brief mental status assessment is conducted. If the client requires hospitalization or needs to be linked to community resources, these arrangements are made. In the event that the client refuses to meet with team members, crisis workers may visit with family members instead, counselling and educating them regarding the client’s mental health difficulties and providing them with referrals to appropriate community supports. Crisis workers typically provide follow-up calls or visits to clients within 48-hours of the initial mobile crisis visit.

3.3 Advantages and Disadvantages of Mobile Crisis Programs

Several researchers have documented the benefits associated with mobile crisis programs (Redding & Raphelson, 1995; Zealberg & Santos, 1996; Zealberg, Santos, & Fisher, 1993). For instance, many individuals experiencing psychiatric emergencies often resist efforts of family and police to bring them to a hospital. If they do comply, they will often have to wait in the emergency room for lengthy periods of time which can increase their anxiety and agitation. An individual who becomes increasingly agitated in an unfamiliar environment may distort their natural clinical presentation and be less able to provide accurate historical information (Zealberg, et al., 1997). By responding at the site of a crisis, mobile crisis teams are better equipped to understand how clients function in their natural environments (Gillig, 1995). In addition, a community-based mobile crisis team is in a unique position to access and initiate referrals to community agencies. Formalized linkages with housing services, police, hospital, and community mental health services ensure a coordinated system which responds to mental health emergencies.
(Zealberg, Santos, & Fisher, 1993). Treatment of clients in the early stages of
decompensation may also prevent them from needing emergency hospitalization,
ultimately reducing health care costs. Finally, for clients with limited finances,
accessing mental health services may prove to be especially problematic,
particularly in areas where public transportation is not available (Zealberg, et al.,
1993). Thus, mobile crisis teams provide access to mental health care for even the
most under-served populations.

Although it is a worthwhile goal to provide mental health services to clients in
their natural settings, this is not always feasible or even desirable (Zealberg &
Santos, 1996). While strict adherence to safety and security protocols and
guidelines ensure the safety of crisis workers, anxiety and stress levels can run high
in dealing with clients who are suicidal or homicidal. Results from several recent
surveys suggest that mental health professionals experience high levels of burnout
compared with other occupational groups which can negatively impact on the
delivery of high-quality mental health services. Mobile crisis workers are at particular
risk as they tend to work away from the support of an institution (e.g., Prosser, et al.,
1996; Wykes, Stevens, & Everitt, 1997). To prevent burnout, mobile crisis workers
must know their own internal motivations and conflicts, have appropriate methods for
managing anxiety and stress, and be open to ongoing supervision and feedback
around issues of client care and clinical management (Zealberg & Santos, 1996).
Another disadvantage is that mobile crisis teams may be limited in number or
availability. Requests for assistance need to be triaged so that the most important
and urgent ones are handled first. In cases where the crisis team is not able to visit
a client, arrangements should be made to link the client to alternative services until the team becomes available (Zealberg & Santos, 1996). Finally, while there are several advantages to being located in the community, because the mobile crisis team does not belong to an institution per se, they can be seen as outsiders, which can be stressful for staff. Regular meetings with referral sources, police, emergency department directors, mental health clinic directors, and others enhances the working relationships that are so necessary in diminishing any sense of separateness from the clinical care structures (Zealberg & Santos, 1996).

3.4 Descriptions of Mobile Crisis Programs

Myriad mobile crisis programs have been described in the literature. Tamayo, January, Peet, and Benditsky (1990) describe a mobile crisis team which began operation in April of 1986 in Bridgeport, Connecticut. While psychiatric emergency services are available 24 hours a day, seven days a week, the program only has mobile capacity from 8:30 a.m. to 10:00 p.m. It is staffed by a multidisciplinary team, consisting of one psychiatrist, one psychologist, two social workers, four psychiatric nurses, and one paraprofessional. The program is located in a community mental health centre and offers a 24-hour crisis line. Calls are received from clients, potential clients, and family members who are experiencing some degree of acute psychiatric distress. Callers identified to be in crisis are encouraged to come to the centre immediately. If they are unable to do so, a community visit is arranged. The community visit is always performed by a two-person team. A family member or other concerned individual must be present during the visit. Police are requested to
back up teams if the situation is deemed to involve risk of imminent danger. The mobile crisis team provides intensive 6-week crisis-intervention services to those clients who have experienced a recent identifiable crisis, with treatment focusing on the immediate crisis and its resolution. Families and significant others are strongly encouraged to participate in the treatment process.

The Emergency Psychiatry/Mobile Crisis Program (MCP), described by Zealberg and Santos (1993), was established in 1987 in Charleston, South Carolina. The MCP is based in a community mental health centre and serves a catchment area of approximately 300,000 people. The team is available 24 hours a day, 365 days a year and is staffed by an interdisciplinary team of psychiatrists and psychiatric residents, nurses, and master-level clinicians. Emergency calls requesting outreach services come from numerous sources within the community, including emergency departments, probation and parole boards, families, landlords, health professionals, and the clients themselves. Calls are carefully screened by clinicians who ask a series of structured assessment questions before responding to a request for mobile crisis services. Team members work closely with law enforcement agencies and always alert police dispatch of their destination via cellular telephones so that officers can reach them rapidly if needed. Because the team functions out of a community mental health centre, it is equipped with the capacity to link clients with continuing outpatient care and long-term treatment programs that help prevent hospitalization. Since the program’s inception, over 10,000 clients have accessed the service, with approximately one-third of these individuals suffering from chronic mental illnesses.
Bengelsdorf and Alden (1987) describe a mobile crisis unit established in 1979 in Westchester County, New York. The crisis team is based in the emergency department of a county hospital and provides services to a population of 870,000 residents. While the majority of the population are affluent, well-educated suburbanites, the team tends to serve the less affluent segments of the population. The team is comprised of 30 health professionals, including psychiatrists, psychologists, social workers, and nurses. Although some clients do walk into the psychiatric emergency room, most are seen in the community. Clients are screened with a crisis triage rating scale and assigned to either the crisis intervention team or to the hospital. If crisis intervention is selected, the team provides up to eight follow-up visits. The team psychiatrist has the authority to make emergency commitments of "dangerous" clients to the medical centre. In such cases, the team arranges transportation by ambulance. Sometimes, however, treatment by the crisis team is the only intervention required. The mobility of the crisis intervention team increases the chances for treating clients without having to resort to hospitalization. The crisis model includes the patient’s family, community therapists, residential agencies and staff, and the crisis services themselves.

A limited number of investigators have systemically examined mobile crisis programs. Gaynor and Hargreaves (1980) surveyed the emergency services of 33 federally-funded community mental health centres (CMHC) in California. Four aspects of service organization were examined: (1) the availability of various response styles (telephone service, walk-in service, follow-up home visits, mobile initial response); (2) the types of staff providing the service; (3) the location of the
programs; and (4) the organizational setting of the CMHCs. These researchers found that 11 of the CMHCs offered some form of scheduled outreach and nine others provided 24-hour mobile services. Fisher, Geller, and Wirth-Cauchon (1990) assessed the impact of mobile crisis capacity on state hospital admission by comparing the 20 catchment areas in Massachusetts that had mobile capacity with the 20 that did not. Controlling for differences in community resources and demand for hospitalization, they found that mobilization per se had no impact on psychiatric admission rates. Finally, Geller, Fisher, and McDermitt (1995) examined the prevalence and effectiveness of mobile crisis services in the United States. These researchers found that while most states had developed some form of mobile crisis services, few service systems collected evaluative data on the effectiveness of these services.
SECTION 4
RATIONALE FOR STUDY

This study was part of a one-year evaluation that took place at Sunnybrook and Women's College Health Sciences Centre (SWCHSC) between September 1, 1998 and August 31, 1999 (Ferris, et al., 2000). The larger evaluation was primarily concerned with identifying how often the mobile crisis programs were used, describing client-related characteristics; and determining whether the programs were serving people originally identified as the target population. The current study reports on data collected during the second phase of the original investigation, which began March 15, 1999 and ended August 31, 1999.

Upon perusal of the mobile crisis literature, it is evident that the research conducted to date has been limited to single program descriptions. The few systematic studies that have been conducted have invariably ignored gender as a significant category of analysis. As discussed previously, women have distinct needs when it comes to their mental health and these needs can only be recognized through consideration of gender-related issues. The primary objective of the current investigation, therefore, is to examine gender differences in a sample of clients who accessed the services provided by two Ontario mobile crisis programs—Metro Integrated Community Crisis Response (MICCP) and Peel Integrated Crisis Response (PICR)—using a feminist theoretical framework. Gender differences are examined in terms of client characteristics, mental health functioning, process of care, and outcome of care. A secondary objective of the study is to ascertain if
certain variables can assist in distinguishing clients who reported affective disorders.

The investigation will be guided by the following set of questions:

1. **Are there gender differences in the characteristics of clients who access mobile crisis services (i.e., age, marital status, referral source, living arrangements, socioeconomic status, language, location of visit, and legal history)?**

2. **Are there gender differences in mental health functioning of clients who access mobile crisis services (i.e., reported diagnoses, psychotropic drug utilization, previous hospitalization, connection to family physicians, psychiatrists, caseworkers, and other professional supports, severity of crisis, urgency of the visit, and reported reason(s) for the visit)?**

3. **Are there gender differences in the care offered to clients by mobile crisis programs (i.e., interventions and referrals)?**

4. **Are there gender differences in the outcome of care provided to clients by mobile crisis programs (i.e., what happened to client immediately following the mobile crisis visit)?**

5. **What variables predict having an affective disorder among clients who access the services offered by mobile crisis programs?**
SECTION 5

METHODOLOGY

5.1 Source of Data

The data were obtained from an audit of 396 clinical record forms and the accompanying progress notes of clients who accessed the mobile crisis services offered by the Metro Integrated Community Crisis Program (MICCP) and the Peel Integrated Crisis Response (PICR) between March 15 and August 31, 1999.

The mobile crisis programs made three types of visits: (1) crisis visits; (2) follow-up visits; (3) visit attempts and visits where there was no direct contact with the client. Crisis visits resulted from a call requesting service from the client, a family member, or from a mental health professional. Follow-up visits were typically made within 48 hours of crisis visits if deemed necessary by the crisis worker and if agreed to by the client or family member. Visit attempts occurred when the mobile crisis team responded to a call requesting a visit but was unable to complete the visit because nobody was at the given address at that specific time. No direct client contact occurred when a caller, who was not the identified client, requested a mobile crisis visit. In these cases, the mobile crisis team met with the caller in the client’s absence (e.g., request for the crisis team to accompany a family member in obtaining certification under the Ontario Mental Health Act).

During the study period, the mobile crisis programs made a total of 513 visits. Of these visits, 396 were recorded as crisis visits (77.2%), 48 as follow-up visits (9.4%), and 69 as visit attempts or visits where there was no direct contact with the
potential client (13.4%). The current study focused solely on crisis visits as the documentation for the other visit types was of poorer quality.

5.2 Program Descriptions

Metro Integrated Community Crisis Program (MICCP) began in October of 1997 and has partnerships with St. Elizabeth Health Care (SEHC), New Dimensions in Community Living (NDCL), Sunnybrook and Women’s College Health Sciences Centre (SWCHSC), Canadian Mental Health Association (CMHA), and other community agencies. The program is located in Toronto and serves the areas of Etobicoke, North York, Scarborough, and East York. Service is available 24-hours a day, seven days a week and requests for mobile crisis visits come in through a 24-hour central intake number. Peel Integrated Crisis Response (PICR) began in November 1997 and has partnerships with the law enforcement agencies of Peel as well as with most relevant social, health, and community agencies. PICR is located in Mississauga, serves individuals living in the Peel region, and is equipped with a 24-hour crisis response line and mobile crisis response team.

Both MICCP and PICR provide 24-hour, early intervention, mobile support services to individuals with serious mental illnesses who are experiencing acute or periodic episodes of crisis. This includes transitional age youth, the elderly, and individuals who have a dual diagnosis of a mental disorder and substance abuse and/or a developmental disability. In addition to those with mental illnesses, the programs provide services to the homeless and to individuals who are socially isolated or experiencing situational crises. Services are provided in the client’s
home or in a meeting place of their choice. The philosophy embraced by MICCP and PICR is that individuals who have a serious mental illness and who do not pose a threat to themselves or others are best treated in their natural environments. The major goals of the programs are to: (1) reduce the frequency of crisis events in the lives of individuals and their families; (2) reduce the use of inappropriate hospital services provided in the emergency departments and inpatient unit; (3) reduce the rate of arrests for persons in crisis; (4) refer clients who are homeless to partner agencies for housing; and (5) improve the psychological and social well-being of clients and their families.

There are a number of differences between MICCP and PICR. The first concerns their agreements with other agencies and services. PICR has signed a formal agreement with six other community agencies to enhance the effectiveness and efficiency of mental health services for individuals with serious mental illness who are in crises. A similar arrangement is not a part of MICCP and the administrators at MICCP believe that this type of service agreement will not occur for them in the future. A second difference between the two programs concerns psychiatric involvement. MICCP has back-up psychiatric consultation whereas PICR does not. In MICCP, it is possible to have consultation with a staff psychiatrist or a visit by a psychiatric resident supervised by a staff psychiatrist. The involvement of these professionals during the initial visit varies depending on the availability of residents, the decision of the case worker(s) to consult a psychiatrist by telephone, and the geographic area of the city. A third, more minor, difference between the programs is arrangements made with police services. Police are involved with both
PlCR and MICCP; however, PICR has a formal agreement with Peel Regional Police, whereas MICCP does not. In PICR, police become involved in one of three circumstances: (1) they request the mobile crisis team attend a police-call; (2) they “stand-by” in the case of an emergency at the request of the mobile crisis team; or (3) they attend a mobile crisis visit at the request of the crisis team.

5.3 Mobile Crisis Workers

According to official program documentation, mobile crisis workers at both MICCP and PICR provide timely mobile crisis response and follow-up services to individuals experiencing a mental health crisis. Among the clinical responsibilities that mobile crisis workers are charged with include: (1) providing crisis assessment and planning to clients via telephone and/or in-home; (2) developing a plan of action to resolve the crisis and assessing the need for follow-up intervention in collaboration with the client; (3) providing the client and/or family members with support, counselling, practical assistance, and a range of appropriate resources and supports available to assist in resolving the crisis; (4) identifying the need for and providing access to medical/psychiatric assessment/intervention including hospitalization; (5) providing access to safe, short-term accommodation including hospital, shelter, or hostel; (6) linking clients to appropriate resources and ongoing supports once the crisis has dissipated; and (7) educating clients and/or family about crisis prevention and intervention and about community services, resources, and supports. Crisis workers also provide community outreach and mental health
education and are responsible for a host of administrative and quality assurance tasks.

In terms of educational background, most crisis workers at MICCP and PICR have completed an undergraduate degree, while several others have either completed or are in the process of completing graduate work in psychology, nursing, social work, and other mental health-related disciplines. In addition to their formal education, crisis workers are expected to have clinical experience working with individuals who have mental illnesses, to know how to recognize the signs and symptoms associated with various mental disorders, and to be familiar with their corresponding treatments. When first hired, all crisis workers are required to go through a training program which covers topics such as CPR and basic first aid, non-violent crisis intervention techniques, suicide prevention and intervention, cultural and ethno-racial training, role playing, self-defense, conflict mediation, and team building. New workers are typically paired with an experienced worker, at which time they observe how calls are responded to, how visits are conducted, and have an opportunity to become familiarized with resources, polices, and procedures.

5.4 Measures

5.4.1 Clinical Record Forms

Standardized data collection forms were developed by the evaluation team in collaboration with the program directors (see Appendix A). Crisis workers used these forms immediately after the time of the mobile crisis visit and it was anticipated that they would complete them again 48 hours later. These forms had the dual
purpose of meeting the programs needs and providing standard data collection forms for evaluation studies. They contained confidential client information including demographic information (i.e., age, gender, marital status, referral source, living arrangements, socioeconomic status, language, location of visit, and legal history), mental health functioning (i.e., reported diagnosis, psychotropic drug use, previous psychiatric admissions, professional support network, severity of the crisis, and urgency of the crisis), process of care (i.e., interventions and referrals) and outcome of care data (i.e., what happened immediately after the crisis visit).

5.4.2 Progress Notes

Attached to the clinical record forms were progress notes written by the crisis workers after visiting with the clients. The progress notes were the original method of note taking used in these programs. The progress notes included a description of what happened during the visit and what interventions and referrals had been offered to the client. Some included only a brief statement while others were several pages in length. Any ongoing contact with the client was also noted, including follow-up phone calls or visits with the clients or their relatives or other service personnel. Because the progress notes often contained detailed information about what occurred during the visit, the information in them was used to supplement the information contained in the clinical record forms. In cases where the clinical record forms were incomplete, information concerning the visit was generated solely from the progress notes.
5.4.3 Crisis Triage Rating Scale

The Crisis Triage Rating Scale (CTRS; Bengelsdorf, Levy, Emerson, & Barile, 1984; see Appendix B), which was used to assist crisis workers in determining whether clients required hospitalization, was included as part of the clinical record form. The CTRS was developed specifically for use by a mobile crisis intervention service to rapidly screen clients. It focuses on three areas: (1) dangerousness; (2) support system; and (3) ability to cooperate. Five descriptive statements are given as examples for each of the possible scores in each area. Crisis workers trained in using the scale assign a grade of 1 to 5 for each of the three categories. Summing the three scores provides the crisis triage rating. The possible range of scores extends from 3 to 15, with low scores indicating high levels of dangerousness, absence of support systems, and inability or refusal to cooperate. Early trials by others using the CTRS demonstrated that most of the individuals who scored 8 or less were referred for admission to hospital, while those who scored 10 or higher tended to be treated in the community (Bengelsdorf, et al., 1984). Turner and Turner (1991) also studied the relationship between the suggested CTRS cut-off score and the decision whether to hospitalize, independently of these scores. The results of this study suggested that using a cut-off score of 9, the CTRS could be an additional assessment aid in determining whether patients require emergency psychiatric hospital admission.

5.5 Definition of Study Variables

Variables chosen for inclusion in this study were classified into five groups and their selection was guided by the reviewed literature on gender and mental health:
1. **Client-related characteristics** – included socio-demographic variables (age, marital status, referral source, living arrangements, employment status, income source, language, and location of visit) and information pertaining to legal history (previously arrested, time spent in prison, parole/probation, violent towards others).

2. **Mental health functioning** – included reported mental diagnosis, medication use, previous hospital admissions, connections to mental health professionals, urgency of the crisis, scores on the CTRS, and reported reason(s) for the mobile crisis visit.

3. **Process of care** – referred to the interventions and referrals provided to the client by the mobile crisis team and included supportive counselling and education provided to client, family, or another support person, liaisons with other professionals, referrals or reconnections to the hospital emergency department, psychiatrists, physicians, counsellors, case management, specialty mental health services, community and/or social services, mobile crisis program, crisis follow-up treatment, and others.

4. **Outcome of care** – referred to what happened to the client immediately following the mobile crisis visit and included having the client remain in their natural setting, having police intervention, being taken to the hospital emergency department, being taken to some other location (e.g., shelter), and pursuing certification under the Ontario Mental Health Act.
5. **Affective disorders** – included major depression, a unipolar form of disorder in which only depressive episodes occur, bipolar disorder, in which both manic and depressive episodes occur, and dysthymia, variation of major depression which is considered less severe. This variable was selected for analysis because the literature suggests women are twice as likely as men to suffer from affective disorders (Bland, et al., 1988; Robins & Regier, 1991). In addition, with the exception of schizophrenia, affective disorders were the only group of mental disorders that had a large enough sample size to conduct a multivariate analysis.

### 5.6 Study Procedures

Two methods of data collection were used in the original evaluation: (1) an audit of the clinical record forms (i.e., chart review); and (2) semi-structured interviews with crisis workers and stakeholders. The current study reports only on data obtained through the chart review, since the interviews did not consider gender-related issues. Chart review is widely used as a data collection method in studies examining the incidence, prevalence, clinical course, and prognosis of specific conditions and in studies examining the determinants and outcome of the use of health services and offers several advantages (Wu & Ashton, 1997). For instance, the clinical data contained in the chart is unequaled in its richness. Charts are also relatively accessible, and the chart review process, while labour-intensive, does not involve significant expense beyond review costs and data entry. In addition, clinical data recorded in charts is felt to be reasonably accurate. To ensure that data in the clinical record forms was abstracted in a systematic manner, a data abstraction tool
was developed (see Appendix C). This data abstraction tool contained explicit criteria that reviewers used at the time of chart abstraction. To address the issue of inter-rater reliability, three independent reviewers were trained in using the data abstraction tool until 100% agreement was obtained.

At the program sites, an administrative support person photocopied and removed all patient identifiers from the clinical record forms. Clinical record forms were shipped monthly from the mobile crisis sites to the study office. Once received, a unique identifier was assigned to each clinical record. All data necessary for the evaluation were abstracted from the clinical record forms and the progress notes by the chart reviewers using the data abstraction tool. In instances where the progress notes and the clinical record forms contained conflicting information, the information in the progress notes was considered to be the "correct" version, since they generally contained more detailed information. Data was entered into Epi Info, a statistical program used for handling epidemiological data in questionnaire format. After each of the clinical record forms had been entered into the program, 10% of the forms were randomly selected and re-entered to ensure that the data had been entered accurately. Before proceeding to the analysis stage, frequencies were run on all the variables to examine their distribution. As several of the cells had small expected frequencies, they were re-coded by collapsing some of the categories (e.g., marital status was collapsed so that "married" included common-law and "single" include divorced, separated, and widowed). Missing data were excluded from all statistical analyses. The Statistical Package for Social Sciences (SPSS-PC), Version 10 for Windows was used to analyze the data.
5.7 Statistical Analyses

5.7.1 Bivariate Analyses

Frequency counts and proportions were calculated for categorical data and means and standard deviations for continuous data. The two-way chi-square ($\chi^2$) test and the independent samples $t$-test were used to determine in which ways women differed from men in terms of demographic profile, mental health functioning, process of care, and outcome of care. In each of these tests, gender was the independent or predictor variable. A one-way chi-square ($\chi^2$) test was used to determine gender differences in the rate of mobile crisis service utilization. Results were reported significant at the $p < .05$ level of significance.

5.7.2 Multivariate Analysis

A logistic regression model was used to identify factors associated with affective disorders among clients accessing mobile crisis services. The dependent variable of interest in the logistic regression analysis was constructed from the variable affective disorders, which included major depression, bipolar disorder, and dysthymia. Affective disorders was coded positive if a client reported having been diagnosed with an affective disorder at some point in their lifetime ($n=152$). Cases coded “no affective disorders” were those where the client did not report being diagnosed with an affective disorder ($n=160$), but who may have reported being diagnosed with another mental illness. Selection of independent variables for the model was guided by the reviewed literature. Predictor variables were divided into two groups: (1) client-related characteristics (gender, age, marital status, living
arrangements, referral source, employment status, and income source); and (2) mental health functioning (previous hospitalization, psychotropic drug utilization, and CTRS scores).

To determine whether or not there was a relationship between affective disorders and each of the independent variables of interest, variables were screened using the two-way chi-square ($\chi^2$) test and the independent samples t-test. Any variable whose bivariate test had a p-value < 0.10$^4$ was included in the logistic regression model. Pearson correlations were also used to assess the selected independent variables for problems of multicollinearity (there were no problems identified). The independent variable of interest in the logistic regression model was gender, with male as the reference category. Other explanatory variables incorporated into the final model included age, marital status (single as reference), living arrangements (living with others as reference), psychotropic drug use (no psychotropic drug use as reference), and client referred themselves (client referred by family or professionals as reference). These variables were entered into a forward stepwise logistic regression model and their association to affective disorders was examined. Variables in the final model were reported significant at the p < .05 level. Odds ratios and 95% confidence intervals were calculated as a measure of the magnitude of the association between the independent variables and affective disorders.

$^4$ Use of the 0.10 level as a screening criterion for selection of candidate variables increased the likelihood that variables known to be important based on the reviewed literature would be included in the model.
5.6 Ethical Considerations

The Research Ethics Board of Sunnybrook and Women's College Health Sciences Centre (SWCHSC) reviewed the original research protocol and approved the study. A copy of the protocol submitted to SWCHSC was also submitted to the Ethics Review Committee at the University of Toronto. Since this study concerns a secondary data analysis and all client-identifiers were removed prior to the client record forms arriving at the research office, it was decided that a formal ethical review procedure at the University of Toronto would not be necessary (see Appendix D).
SECTION 6

RESULTS

6.1 General Description of the Sample

Between March 15 and September 31, 1999, the mobile crisis programs made a total of 396 crisis visits. Overall, statistically significant gender differences were found in terms of the rate of mobile crisis service utilization as more visits involved female than male clients (females 63.1%, males 36.1%; \( \chi^2 [1, N=396] = 27.31, p=.000 \)). Table 1 outlines other client-related characteristics for the total sample. Clients ages ranged from 15 to 91, with the mean age being 39.76 years (SD=17.79). In the majority of visits, clients were single (79.3%), unemployed (84.6%), and were receiving financial assistance (49.2%). In addition, most clients lived with family members (68.9%) and spoke English as their primary language (89.3%). The most common mobile crisis call-initiator was a community or health care professional (44.4%), followed by a family member (28.3%), and the client themselves (27.3%). Visits occurred in the client’s home or apartment (76.3%) and in various community or institutional settings (23.7%). Data on legal history revealed that 14.9% of visits involved clients who reported having a history of violence, 11.3% involved clients who had previously been arrested, 2.9% involved clients who were on parole or probation, and 4.4% of visits involved clients who had spent time in jail.

Information pertaining to mental health functioning is summarized in Table 2. Overall, 84.6% of the sample reported having been diagnosed with one or more mental disorders in their lifetime. The most common diagnoses were affective disorders (48.7%), schizophrenia (22.1%), personality disorders (4.5%), and anxiety
disorders (3.5%). Three-fifths of the visits (60.4%) involved clients who were taking medications. Further, in 61.5% of visits, clients had a history of psychiatric

TABLE 1

Client Characteristics for Total Sample (N=396)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (N=396)</td>
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</tr>
<tr>
<td>Female</td>
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</tr>
<tr>
<td>Male</td>
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</tr>
<tr>
<td>Age (N=381)</td>
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<td>17.79</td>
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<td>Client</td>
<td>108</td>
<td>27.3</td>
</tr>
<tr>
<td>Family</td>
<td>112</td>
<td>28.3</td>
</tr>
<tr>
<td>Professional</td>
<td>176</td>
<td>44.4</td>
</tr>
<tr>
<td>Living Arrangements (N=379)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>111</td>
<td>29.3</td>
</tr>
<tr>
<td>With others</td>
<td>268</td>
<td>70.7</td>
</tr>
<tr>
<td>Employment Status (N=350)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>54</td>
<td>15.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>296</td>
<td>84.6</td>
</tr>
<tr>
<td>Income Source (N=295)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government assistance</td>
<td>195</td>
<td>69.2</td>
</tr>
<tr>
<td>No government assistance</td>
<td>100</td>
<td>30.8</td>
</tr>
<tr>
<td>Language (N=393)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>351</td>
<td>89.8</td>
</tr>
<tr>
<td>Other</td>
<td>42</td>
<td>10.7</td>
</tr>
<tr>
<td>Location of Visit (N=393)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home/Apartment</td>
<td>300</td>
<td>76.3</td>
</tr>
<tr>
<td>Community/Institutional setting</td>
<td>93</td>
<td>23.7</td>
</tr>
<tr>
<td>Legal History (N=295)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previously arrested</td>
<td>35</td>
<td>11.3</td>
</tr>
<tr>
<td>Spent time in prison</td>
<td>13</td>
<td>4.4</td>
</tr>
<tr>
<td>On parole/probation</td>
<td>14</td>
<td>4.9</td>
</tr>
<tr>
<td>Violent to others</td>
<td>43</td>
<td>14.9</td>
</tr>
</tbody>
</table>

* Excludes missing data
hospitalization. Of the clients who had been previously hospitalized, 53.1% had been discharged more than a year ago. In terms of professional support, clients reported being connected to family physicians in 72.3% of visits, to psychiatrists in 55.4% of visits, and to case managers in 30.4% visits.

The reported reasons for the visit included harm ideation (60.8%), safety (40.9%), treatment noncompliance (39.9%), previous attempt to harm self or others (33.5%), threat of harm to self or others (26.8%), shelter (25.3%), hygiene (20.7%), plan or intent to harm (20.6%), inadequate nutrition (13.6%), violence or harm committed (15.5%), and financial issues (11.1%). In 72.6% of the visits, the crisis was described as urgent, indicating that a visit was needed immediately. Scores on the CTRS ranged from 3 to 15, with the mean score being 10.99 (SD=2.85). To determine whether the client was in need of hospitalization, scores on the CRTS were divided into those who scored 9 or less (hospitalization required) and those who scored 10 or more (hospitalization not required). Results revealed that for 20.4% of the sample, the crisis was severe enough to require hospitalization.

Table 3 summarizes the care offered to clients by mobile crisis programs. In 95.6% of the visits, clients were provided with supportive counselling and education. Supportive counselling and education were provided to others (including family and other caregivers) in 52.4% of visits. Additionally, during 52.2% of the visits, crisis workers made contact with other professionals, including family doctors, psychiatrists, social workers, and other community and mental health workers. Referrals to crisis follow-up treatment were made in 48.0% of visits. Another 33.2% of the visits involved referrals to psychiatrists. Referrals were also made to social...
service or community agencies (25.1%), specialty psychiatric services (23.3%),
hospital emergency departments (18.4%), physicians (12.1%), caseworkers (17.2%),
the mobile crisis team (12.4%), and counsellors (10.6%).

TABLE 2
Mental Health Functioning for Total Sample (N=396)

<table>
<thead>
<tr>
<th>Reported Diagnosis (N=312)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental illness</td>
<td>264</td>
<td>84.6</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>152</td>
<td>48.7</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>69</td>
<td>22.1</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>11</td>
<td>3.5</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>14</td>
<td>4.5</td>
</tr>
<tr>
<td>Developmental disability</td>
<td>4</td>
<td>1.3</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>4</td>
<td>1.3</td>
</tr>
<tr>
<td>Mental disorder due to medical condition</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Dementia</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>Specific disorder of childhood</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Other mental illness</td>
<td>6</td>
<td>1.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Currently Taking Medications (N=338)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>204</td>
<td>60.4</td>
</tr>
<tr>
<td>No</td>
<td>134</td>
<td>39.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Psychiatric Admissions (N=351)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>216</td>
<td>61.5</td>
</tr>
<tr>
<td>No</td>
<td>135</td>
<td>38.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Most Recent Admission (N=179)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; One year</td>
<td>95</td>
<td>46.9</td>
</tr>
<tr>
<td>&gt; One year</td>
<td>84</td>
<td>53.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Connected To: (N=258)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family physician</td>
<td>206</td>
<td>72.3</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>158</td>
<td>55.4</td>
</tr>
<tr>
<td>Case manager</td>
<td>62</td>
<td>30.5</td>
</tr>
<tr>
<td>Other</td>
<td>140</td>
<td>62.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgency of Crisis (N=372)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit immediately</td>
<td>270</td>
<td>72.6</td>
</tr>
<tr>
<td>Visit within 24 hours</td>
<td>102</td>
<td>27.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Triage Rating Scale (N=358)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization required (≤8)</td>
<td>73</td>
<td>20.4</td>
</tr>
<tr>
<td>Hospitalization not required (&gt;9)</td>
<td>285</td>
<td>79.6</td>
</tr>
</tbody>
</table>
TABLE 2 (continued)

Mental Health Functioning for Total Sample (N=396)

<table>
<thead>
<tr>
<th>Reported Reason(s) for the Mobile Crisis Visit (N=365)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danger to self</td>
<td>99</td>
<td>27.1</td>
</tr>
<tr>
<td>Danger to others</td>
<td>25</td>
<td>6.8</td>
</tr>
<tr>
<td>Deterioration in self-care</td>
<td>169</td>
<td>46.3</td>
</tr>
<tr>
<td>More than one reason</td>
<td>72</td>
<td>19.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Danger to Self and Others (N=194)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat</td>
<td>52</td>
<td>26.8</td>
</tr>
<tr>
<td>Ideation</td>
<td>118</td>
<td>60.8</td>
</tr>
<tr>
<td>Plan/Intent</td>
<td>40</td>
<td>20.6</td>
</tr>
<tr>
<td>Previous attempt</td>
<td>65</td>
<td>33.5</td>
</tr>
<tr>
<td>Violence/Overdose</td>
<td>33</td>
<td>17.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deterioration in Self-Care (N=198)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>81</td>
<td>40.9</td>
</tr>
<tr>
<td>Shelter</td>
<td>50</td>
<td>25.3</td>
</tr>
<tr>
<td>Hygiene</td>
<td>41</td>
<td>20.7</td>
</tr>
<tr>
<td>Treatment non-compliance</td>
<td>79</td>
<td>39.9</td>
</tr>
<tr>
<td>Inadequate nutrition/Hydration</td>
<td>27</td>
<td>13.6</td>
</tr>
<tr>
<td>Finances</td>
<td>22</td>
<td>11.1</td>
</tr>
</tbody>
</table>

TABLE 3

Process of Care for Total Sample (N=396)

<table>
<thead>
<tr>
<th>Interventions (N=389)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive counselling/ education of primary client</td>
<td>239</td>
<td>96.4</td>
</tr>
<tr>
<td>Supportive counselling/ education of other support persons</td>
<td>122</td>
<td>49.2</td>
</tr>
<tr>
<td>Liaison/discussion with other professionals</td>
<td>126</td>
<td>50.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals or Reconnections (N=331)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
<td>35</td>
<td>17.0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>61</td>
<td>29.6</td>
</tr>
<tr>
<td>Physician</td>
<td>24</td>
<td>11.7</td>
</tr>
<tr>
<td>Counsellor</td>
<td>20</td>
<td>9.7</td>
</tr>
<tr>
<td>Case management service</td>
<td>28</td>
<td>13.6</td>
</tr>
<tr>
<td>Specialty mental health service</td>
<td>44</td>
<td>21.4</td>
</tr>
<tr>
<td>Community/Social service</td>
<td>55</td>
<td>26.7</td>
</tr>
<tr>
<td>Mobile crisis team</td>
<td>29</td>
<td>14.1</td>
</tr>
<tr>
<td>Crisis follow-up treatment</td>
<td>103</td>
<td>50.0</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>16.0</td>
</tr>
</tbody>
</table>
A summary of the outcome of the mobile crisis visit is presented in Table 4. Following the mobile crisis visit, the majority of clients remained in the setting where the mobile crisis visit was made, whether their home, a hospital, or some other community location (66.5%). Another 25.7% of visits resulted in a hospital emergency department visit. In 10.5% of visits, mobile crisis workers assisted family members in obtaining certification under the Mental Health Act. Additionally, police were called to intervene and either took clients to the police station or assisted the mobile crisis team in transporting clients to the hospital (7.3% of visits).

TABLE 4
Outcome of Care for Total Sample (N=382)

<table>
<thead>
<tr>
<th>Mobile Crisis Visit Outcome (N=382)</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remained in natural setting</td>
<td>164</td>
<td>67.2</td>
</tr>
<tr>
<td>Brought to hospital emergency</td>
<td>63</td>
<td>25.8</td>
</tr>
<tr>
<td>Brought to other service or location</td>
<td>14</td>
<td>8.1</td>
</tr>
<tr>
<td>Police contacted</td>
<td>19</td>
<td>7.8</td>
</tr>
<tr>
<td>Certification under the Mental Health Act</td>
<td>27</td>
<td>11.1</td>
</tr>
</tbody>
</table>

6.2 Bivariate Analyses

6.2.1 Are there Gender Differences in the Characteristics of Clients who Access Mobile Crisis Services?

Table 5 outlines the client characteristics by gender. Frequency counts, proportions, means, standard deviations, the independent samples t-test, and the two-way chi-square (χ²) test were used to determine whether there were any gender differences in client characteristics. Results indicated statistically significant gender differences in age, marital status, and referral source. Age was a continuous variable of the clients' age at their last birthday. Overall, female clients
were more likely to be older than male clients (females M=41.85, males M=36.12; t[306.10, N=396] = -3.12, p=.002). Marital status was categorized into married (including common-law) and single (including widowed, separated, or divorced). Female clients were more likely to be married compared to male clients (females 24.0%, males 15.2%; χ²[1, N=396] = 4.28, p=.025). Referral source was divided into client, family, and professional. Women were less likely than men to have a family member call requesting a visit on their behalf (females 23.6%, males 36.3%; χ²[1, N=396] = 7.33, p=.007).

As well, statistically significant gender differences were found for legal history. Specifically, women were less likely to report being previously arrested (females 5.8%, males 19.7%; χ²[1, N=286] = 14.24, p=.000), on parole or probation (females 2.9%, males 8.0%; χ²[1, N=286] = 3.78, p=.052), and to have a history of being violent to others (females 11.6%, males 20.0%; χ²[1, N=286] = 3.874, p=.049). No statistically significant gender differences were found for living arrangements, employment status, income source, language, location of visit, and having spent time in prison.

TABLE 5
Bivariate Analyses of Gender Differences in Client Characteristics (N=396)

<table>
<thead>
<tr>
<th>Age</th>
<th>Women n=242</th>
<th>Men n=139</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>41.85</td>
<td>18.07</td>
<td>36.12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Women n=242</th>
<th>Men n=145</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Single</td>
<td>184</td>
<td>76.0</td>
<td>123</td>
</tr>
<tr>
<td>Married</td>
<td>58</td>
<td>24.0</td>
<td>22</td>
</tr>
</tbody>
</table>
TABLE 5 (continued)

Bivariate Analyses of Gender Differences in Client Characteristics (N=396)

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Women n=250</th>
<th>Men n=146</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>59 23.6</td>
<td>53 36.3</td>
<td>7.33 1 .007</td>
</tr>
<tr>
<td>Professional</td>
<td>116 46.4</td>
<td>60 41.1</td>
<td>1.05 1 .305</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Women n=237</th>
<th>Men n=142</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>Alone</td>
<td>77 32.5</td>
<td>34 23.9</td>
<td>1.18 1 .183</td>
</tr>
<tr>
<td>With others</td>
<td>160 67.5</td>
<td>108 76.1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Women n=214</th>
<th>Men n=136</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>Employed</td>
<td>31 14.5</td>
<td>23 16.9</td>
<td>0.38 1 .540</td>
</tr>
<tr>
<td>Unemployed</td>
<td>183 85.5</td>
<td>113 83.1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Women n=184</th>
<th>Men n=111</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>Government assistance</td>
<td>126 68.5</td>
<td>69 62.2</td>
<td>1.23 1 .267</td>
</tr>
<tr>
<td>No government assistance</td>
<td>58 31.5</td>
<td>42 37.8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th>Women n=248</th>
<th>Men n=111</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>English</td>
<td>221 89.1</td>
<td>130 89.7</td>
<td>0.03 1 .867</td>
</tr>
<tr>
<td>Other language</td>
<td>27 10.9</td>
<td>15 10.3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location of Visit</th>
<th>Women n=248</th>
<th>Men n=145</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>Home/Apartment</td>
<td>194 78.2</td>
<td>106 73.1</td>
<td>1.33 1 .249</td>
</tr>
<tr>
<td>Community/Institutional setting</td>
<td>54 21.8</td>
<td>39 26.9</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal History</th>
<th>Women n=180</th>
<th>Men n=115</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq. %</td>
<td>Freq. %</td>
<td>χ² df p</td>
</tr>
<tr>
<td>Previously arrested</td>
<td>11 5.8</td>
<td>24 19.7</td>
<td>14.24 1 .000</td>
</tr>
<tr>
<td>Spent time in prison</td>
<td>6 3.3</td>
<td>7 6.1</td>
<td>1.33 1 .250</td>
</tr>
<tr>
<td>On parole/probation</td>
<td>5 2.9</td>
<td>9 8.0</td>
<td>3.78 1 .052</td>
</tr>
<tr>
<td>Violent to others</td>
<td>20 11.6</td>
<td>23 20.0</td>
<td>3.87 1 .049</td>
</tr>
</tbody>
</table>
6.2.2 Are there Gender Differences in Mental Health Functioning of Clients who Access Mobile Crisis Services?

Table 6 shows the rates of mental health functioning by gender. Frequency counts, proportions and the two-way chi-square ($\chi^2$) test were used to determine whether there were any differences between women and men in mental health functioning. In terms of psychiatric diagnosis, results indicated statistically significant gender differences in overall rates of mental disorder, affective disorders, and schizophrenia. On the whole, female clients reported lower rates of mental disorder compared to male clients (females 81.5%, males 90.2%; $\chi^2 [1, N=312] = 4.15, p=.042$). In terms of specific diagnoses, women had statistically significantly higher rates for affective disorders (females 54.5%, males 38.4%; $\chi^2 [1, N=312] = 7.46, p=.006$). Men, on the other hand, were overrepresented among those with schizophrenia (females 15.0%, males 34.8%; $\chi^2 [1, N=312] = 16.38, p=.000$). Before concluding this analysis, another avenue was taken to further explore the relationship between gender and schizophrenia. Looking specifically at the effects of age, the study found that women who reported schizophrenia were significantly older than their male peers (females $M=38.93$ (SD=14.64), males $M=30.11$ (SD=7.84), $t[66, N=68]= -3.187, p=.002$). Anxiety disorders, personality disorders, developmental disability, substance abuse disorders, mental disorder due to medical condition, dementia, and posttraumatic stress disorder were all quite uncommon and demonstrated no pattern by gender.

---

5 Due to small expected frequencies, the relationship between schizophrenia and other variables of interest were not examined.
Statistically significant gender differences were found in terms of connection to other psychiatric and/or health services. Specifically, less women than men were connected to a psychiatrist at the time of the mobile crisis visit (females 49.7%, males 64.2%; $\chi^2 [1, \text{N}=258] = 5.19, p=.023$). Statistically significant gender differences were also found in reported reason(s) for the mobile crisis visit. Female clients were more likely to have a plan or intent to self-harm compared to male clients (females 25.4%, males 13.8%; $\chi^2 [1, \text{N}=194] = 3.92, p=.048$). None of the other reported reasons for the mobile crisis visit were found to have significant gender differences. Similarly, scores on the CTRS, psychotropic drug utilization, previous psychiatric admissions, and connections to physicians, case managers, and other mental health professionals were not found to differ significantly by gender. There was also no statistically significant gender difference in the urgency of the crisis.

### TABLE 6

Bivariate Analyses of Gender Differences in Mental Health Functioning (N=396)

<table>
<thead>
<tr>
<th>Reported Diagnosis</th>
<th>Women n=200</th>
<th>Men n=112</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Any mental illness</td>
<td>163</td>
<td>81.5</td>
<td>101</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>109</td>
<td>54.5</td>
<td>43</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>30</td>
<td>15.0</td>
<td>39</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>4</td>
<td>2.0</td>
<td>7</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>13</td>
<td>6.5</td>
<td>1</td>
</tr>
<tr>
<td>Developmental disability</td>
<td>1</td>
<td>0.5</td>
<td>3</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>2</td>
<td>1.0</td>
<td>2</td>
</tr>
<tr>
<td>Mental disorder due to medical condition</td>
<td>1</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Dementia</td>
<td>4</td>
<td>2.0</td>
<td>1</td>
</tr>
<tr>
<td>Specific disorder of childhood</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>1</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Other mental illness</td>
<td>2</td>
<td>1.0</td>
<td>4</td>
</tr>
</tbody>
</table>

*Due to small expected frequencies, the $\chi^2$ test could not be performed for these variables.*
TABLE 6 (continued)

Bivariate Analyses of Gender Differences in Mental Health Functioning (N=396)

<table>
<thead>
<tr>
<th>Currently Taking Medications</th>
<th>Women (n=210)</th>
<th>Men (n=128)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Yes</td>
<td>133</td>
<td>63.3</td>
<td>71</td>
</tr>
<tr>
<td>No</td>
<td>77</td>
<td>36.7</td>
<td>57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Psychiatric Admissions</th>
<th>Women (n=217)</th>
<th>Men (n=134)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Yes</td>
<td>129</td>
<td>59.4</td>
<td>87</td>
</tr>
<tr>
<td>No</td>
<td>88</td>
<td>40.6</td>
<td>47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Most Recent Admission</th>
<th>Women (n=106)</th>
<th>Men (n=73)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>&lt; One year</td>
<td>60</td>
<td>56.6</td>
<td>35</td>
</tr>
<tr>
<td>&gt; One year</td>
<td>46</td>
<td>43.4</td>
<td>38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Connected To:</th>
<th>Women (n=173)</th>
<th>Men (n=85)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family physician</td>
<td>134</td>
<td>73.2</td>
<td>72</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>90</td>
<td>49.7</td>
<td>68</td>
</tr>
<tr>
<td>Case manager</td>
<td>36</td>
<td>28.1</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>91</td>
<td>62.8</td>
<td>49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgency of Crisis</th>
<th>Women (n=234)</th>
<th>Men (n=138)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit immediately</td>
<td>164</td>
<td>70.1</td>
<td>106</td>
</tr>
<tr>
<td>Visit within 24 hours</td>
<td>70</td>
<td>29.9</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Triage Rating Scale</th>
<th>Women (n=224)</th>
<th>Men (n=134)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization required (( \leq 8 ))</td>
<td>42</td>
<td>18.8</td>
<td>31</td>
</tr>
<tr>
<td>Hospitalization not required (( &gt; 9 ))</td>
<td>172</td>
<td>81.3</td>
<td>103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reported Reason(s) for the Mobile Crisis Visit</th>
<th>Women (n=226)</th>
<th>Men (n=139)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danger to self</td>
<td>63</td>
<td>27.9</td>
<td>36</td>
</tr>
<tr>
<td>Danger to others</td>
<td>12</td>
<td>5.3</td>
<td>13</td>
</tr>
<tr>
<td>Deterioration in self-care</td>
<td>110</td>
<td>48.7</td>
<td>59</td>
</tr>
<tr>
<td>More than one reason</td>
<td>41</td>
<td>18.1</td>
<td>31</td>
</tr>
</tbody>
</table>
### TABLE 6 (continued)

**Bivariate Analyses of Gender Differences in Mental Health Functioning (N=396)**

<table>
<thead>
<tr>
<th>Danger to Self and Others</th>
<th>Women (n=114)</th>
<th>Men (n=80)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Threat</td>
<td>29</td>
<td>25.4</td>
<td>23</td>
</tr>
<tr>
<td>Ideation</td>
<td>73</td>
<td>64.0</td>
<td>45</td>
</tr>
<tr>
<td>Plan/Intent</td>
<td>29</td>
<td>25.4</td>
<td>11</td>
</tr>
<tr>
<td>Previous attempt</td>
<td>36</td>
<td>31.6</td>
<td>29</td>
</tr>
<tr>
<td>Violence/Overdose</td>
<td>19</td>
<td>16.7</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deterioration in Self Care</th>
<th>Women (n=129)</th>
<th>Men (n=69)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Safety</td>
<td>56</td>
<td>43.4</td>
<td>25</td>
</tr>
<tr>
<td>Shelter</td>
<td>28</td>
<td>21.7</td>
<td>22</td>
</tr>
<tr>
<td>Hygiene</td>
<td>29</td>
<td>22.5</td>
<td>12</td>
</tr>
<tr>
<td>Treatment noncompliance</td>
<td>52</td>
<td>40.3</td>
<td>27</td>
</tr>
<tr>
<td>Inadequate nutrition/Hydration</td>
<td>20</td>
<td>15.5</td>
<td>7</td>
</tr>
<tr>
<td>Finances</td>
<td>16</td>
<td>12.4</td>
<td>6</td>
</tr>
</tbody>
</table>

### 6.2.3 Are there Gender Differences in the Care Offered to Clients by Mobile Crisis Programs?

Table 7 shows the care offered to clients by the mobile crisis programs by gender. Frequency counts, proportions, and the two-way chi-square ($\chi^2$) test were used to determine whether there were any differences between women and men in terms of process of care. Statistically significant gender differences were found in referrals made to case management. Specifically, fewer women compared to men were referred to case management (females 13.6%, males 23.2%; $\chi^2 [1, N=331] = 5.04, p=.025$). No significant gender differences were found in supportive counselling and education of client, supportive counselling and education of family members, liaising with other mental health professionals, and referrals to the
emergency department, physicians, psychiatrists, counsellors, specialty mental health services, mobile crisis teams, crisis follow-up treatment, and other sources.

TABLE 7

Bivariate Analyses of Gender Differences in Process of Care (N=396)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Women (n=248)</th>
<th>Men (n=141)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Supportive counselling/ education of primary client</td>
<td>239</td>
<td>96.4</td>
<td>133</td>
</tr>
<tr>
<td>Supportive counselling/ education of other support persons</td>
<td>122</td>
<td>49.2</td>
<td>82</td>
</tr>
<tr>
<td>Liaison/discussion with other professionals</td>
<td>126</td>
<td>50.1</td>
<td>77</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals or Reconnections</th>
<th>Women (n=206)</th>
<th>Men (n=125)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Emergency department</td>
<td>35</td>
<td>17.0</td>
<td>26</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>61</td>
<td>29.6</td>
<td>49</td>
</tr>
<tr>
<td>Physicians</td>
<td>24</td>
<td>11.7</td>
<td>16</td>
</tr>
<tr>
<td>Counsellors</td>
<td>20</td>
<td>9.7</td>
<td>15</td>
</tr>
<tr>
<td>Case management service</td>
<td>28</td>
<td>13.6</td>
<td>29</td>
</tr>
<tr>
<td>Specialty mental health services</td>
<td>44</td>
<td>21.4</td>
<td>33</td>
</tr>
<tr>
<td>Community/Social service</td>
<td>55</td>
<td>26.7</td>
<td>28</td>
</tr>
<tr>
<td>Mobile crisis team</td>
<td>29</td>
<td>14.1</td>
<td>12</td>
</tr>
<tr>
<td>Crisis follow-up treatment</td>
<td>103</td>
<td>50.0</td>
<td>56</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>16.0</td>
<td>14</td>
</tr>
</tbody>
</table>

6.2.4 Are there Gender Differences in the Outcome of Care Provided to Clients by Mobile Crisis Programs?

Table 8 shows gender differences in outcome of care. Frequency counts, proportions, and the two-way chi-square \(\chi^2\) test were used to determine whether there were any differences between women and men in terms of outcome of care. Overall, no statistically significant gender differences were found.
TABLE 8

Bivariate Analyses of Gender Differences in Outcome of Care (N=396)

<table>
<thead>
<tr>
<th>Mobile Crisis Visit Outcome</th>
<th>Women (n=244)</th>
<th>Men (n=138)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Remained in natural setting</td>
<td>164</td>
<td>67.2</td>
<td>90</td>
</tr>
<tr>
<td>Brought to hospital emergency</td>
<td>63</td>
<td>25.8</td>
<td>35</td>
</tr>
<tr>
<td>Brought to other service or location (e.g., shelter, friend’s home)</td>
<td>14</td>
<td>8.1</td>
<td>11</td>
</tr>
<tr>
<td>Police contacted</td>
<td>19</td>
<td>7.8</td>
<td>9</td>
</tr>
<tr>
<td>Certification under Mental Health Act</td>
<td>27</td>
<td>11.1</td>
<td>13</td>
</tr>
</tbody>
</table>

6.3 Multivariate Analysis

6.3.1 What Variables Predict Having an Affective Disorder Among Clients Who Access the Services Offered by Mobile Crisis Programs?

A logistic regression model was used to identify factors associated with affective disorders among clients accessing mobile crisis services. Variables were screened for inclusion in the model using the two-way chi-square (χ²) test and the independent samples t-test (see Table 9). Those variables that were significant at the p < 0.10 level during the variable screening process were entered into a final logistic regression analysis (gender, age, living arrangements, marital status, psychotropic medication use, and self-referred). Results of the logistic regression analysis are presented in Table 10. The final model correctly predicted 58.4% of the 152 cases where affective disorders were reported. Only one independent variable, gender, was found to be a significant predictor of affective disorder. Female clients were found to be two times more likely than male clients to report affective disorders.
## TABLE 9

**Selected Independent Variables by Affective Disorders**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Affective disorder</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>109 (73.7%)</td>
<td>69 (43.1%)</td>
</tr>
<tr>
<td>Male</td>
<td>43 (28.3%)</td>
<td>91 (56.9%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>41.47</td>
<td>37.88</td>
</tr>
<tr>
<td>SD</td>
<td>17.06</td>
<td>16.85</td>
</tr>
<tr>
<td>t</td>
<td>-1.84</td>
<td>297.5</td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td>.067*</td>
</tr>
<tr>
<td>p</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>110 (73.8%)</td>
<td>25 (15.9%)</td>
</tr>
<tr>
<td>Married</td>
<td>39 (26.2%)</td>
<td>132 (84.1%)</td>
</tr>
<tr>
<td>Referral Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td>51 (33.6%)</td>
<td>40 (25%)</td>
</tr>
<tr>
<td>Family</td>
<td>41 (27.0%)</td>
<td>48 (30%)</td>
</tr>
<tr>
<td>Professional</td>
<td>60 (39.5%)</td>
<td>72 (45%)</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>32 (22.1%)</td>
<td>52 (33.3%)</td>
</tr>
<tr>
<td>With others</td>
<td>113 (77.9%)</td>
<td>104 (66.7%)</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>21 (15.8%)</td>
<td>21 (14.8%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>112 (84.2%)</td>
<td>121 (85.2%)</td>
</tr>
<tr>
<td>Income Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government assistance</td>
<td>76 (61.8%)</td>
<td>81 (70.4%)</td>
</tr>
<tr>
<td>No government assistance</td>
<td>47 (38.2%)</td>
<td>34 (29.6%)</td>
</tr>
<tr>
<td>Currently Taking Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98 (70.5%)</td>
<td>83 (39.4%)</td>
</tr>
<tr>
<td>No</td>
<td>41 (29.5%)</td>
<td>54 (60.6%)</td>
</tr>
<tr>
<td>Previous Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>93 (66.4%)</td>
<td>97 (68.3%)</td>
</tr>
<tr>
<td>No</td>
<td>47 (33.6%)</td>
<td>45 (31.7%)</td>
</tr>
<tr>
<td>Crisis Triage Rating Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization required (&lt;8)</td>
<td>26 (22.4%)</td>
<td>36 (29.3%)</td>
</tr>
<tr>
<td>Hospitalization not required (≥9)</td>
<td>90 (77.6%)</td>
<td>87 (70.7%)</td>
</tr>
</tbody>
</table>

* Variables selected for logistic regression analysis
TABLE 10

Logistic Regression Analysis of Factors Associated with the Probability of Reporting Affective Disorders

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>p</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>0.72</td>
<td>0.26</td>
<td>.006</td>
<td>2.06</td>
<td>1.23, 3.44</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Model chi-square = 7.759; df=1; p= .005; B=coefficient; SE=standard error; OR=odds ratio; CI=confidence interval.
SECTION 7

DISCUSSION

7.1 Overview

This study examined gender differences in a sample of 396 clients who accessed the services provided by two Ontario mobile crisis mental health programs. Gender differences were explored in terms of client characteristics, mental health functioning, process of care, and outcome of care. The purpose of the study was to add to the body of knowledge on mobile crisis programs by looking at gender-related issues. To date, systematic evaluation of mobile crisis programs has been scarce. Although there have been several descriptive studies about the benefits of such programs, there has been little research regarding their impact (Ferris, et al., 1998). Moreover, none of these studies have focussed on an analysis of gender differences or have examined issues of concern to women. The fact that previous research has left issues of gender virtually unexplored may be seriously hampering the ability of mobile crisis programs to deal with clients, particularly women, in the most effective way.

Research shows that women are more likely than men to use outpatient mental health services (Greenley, Mechanic, & Clearly, 1987; Leaf & Bruce, 1987; Kessler, et al., 1981; Rhodes & Goering, 1998). Indeed, this was the case in the current study as women comprised more than three-fifths of the clients who accessed mobile crisis services during the study period. Given this marked gender difference in the rate of utilization, one possible explanation is that women are not seeking help for their mental health problems until they are experiencing a crisis. A
second explanation could be that women are not as well connected to the formal mental health system as men and have no other option but to seek the assistance of mobile crisis programs when in crisis. A final consideration is that while women may already be connected to the mental health system, they are not receiving care appropriate to their level of need, and accordingly, are seeking the assistance of additional mental health services. Therefore, mobile crisis programs may be in a unique position to help women as they are equipped with the capacity to bridge the gap and attend to the their immediate needs while locating appropriate services.

The gender differences in patterns of mobile crisis service utilization in this study provide the impetus for further exploration of gender-related issues. Ultimately, any discussion of mobile crisis services would be incomplete without considering the gender of the individuals who access these services, as it cannot be assumed that the same service will equally benefit women and men. This chapter provides a summary of the significant gender differences found in this study, examines their convergence with past literature, and explores some of their broader implications. In addition, the study’s limitations and strengths are discussed and key recommendations for policy and practice are highlighted. The chapter concludes with some directions for future research initiatives.

### 7.2 Summary of Findings

The results showed that women and men who accessed mobile crisis services differed on a number of important client-related characteristics. As a group, women were significantly older than men and were more likely to be married. Similar
findings have been reported in the literature. For instance, Perkins and Rowland
(1991) and Test, et al. (1985) found that female clients seeking community-based
treatment for mental health problems were older compared to male clients.
Correspondingly, Gove and Tudor (1973) were among the first to report gender
differences in marital status among persons with mental illness in a variety of
outpatient mental health care settings. The results of the study also found that
female clients were less likely than male clients to have a family member call
requesting a mobile crisis visit on their behalf. This finding is difficult to compare to
the literature as no published studies looking at gender differences in referral source
could be located. Finally, the study found that compared to men, women were less
likely to have been arrested, on parole or probation, and to have a history of being
violent toward others. This latter finding concurs with research by Test, Burke, and
Wallisch (1990) who found that among individuals with schizophrenia, men had
higher arrest rates and had spent more time in jail than women.

In terms of gender differences in mental health functioning, the results
obtained in this investigation corroborate the findings of large-scale epidemiological
studies. In accordance with both the Epidemiological Catchment Study (Robins &
Regier, 1991) and Bland et al.’s (1988) Edmonton-based study, the current research
found that women who accessed mobile crisis programs reported lower global rates
of mental disorder compared to men. Looking at the specific types of disorders,
women had higher reported rates of affective disorders and men had higher reported
rates of schizophrenia. Women’s higher rates of affective disorders are well known
in the literature (McGrath, Keita, Strickland, & Russo, 1990; Nolen-Hoeskema,
1987). While studies have not generally found gender differences in the prevalence of schizophrenia, there is clear evidence that women and men experience schizophrenia in different ways. The most consistent finding has been the later onset of the disorder among women (Angermeyer & Kuhn, 1988; Bachrach & Nadelson, 1988; Goldstein, 1988). A similar trend was found in the current study—while the age of onset was unknown, women who reported schizophrenia were older than their male counterparts.

Another significant gender difference in mental health functioning was that women compared to men were less likely to have been connected to a psychiatrist. This finding is supported by the literature looking at gender differences in outpatient mental health service utilization rates which has demonstrated that women are more likely to seek care for their mental health problems within the primary care sector (i.e., family physicians and other general practitioners) rather than within the specialty care sector (i.e., psychiatrists, psychologists, and social workers; see Greenley, Mechanic, & Clearly, 1987; Kessler, et al., 1981; Leaf & Bruce, 1987; Rhodes & Goering, 1998). In the current study, female clients were also more likely to report suicidal intentions compared to their male peers. Previous research has not looked at suicide intentionality with gender as a fundamental unit of analysis, once again making it difficult to compare this finding.

In terms of gender differences in the care offered to clients by mobile crisis programs, the study showed that women were less likely than men to be referred or reconnected to case management services. Case management is a systems and services intervention designed to coordinate, access, and provide the full range of
care that a person with a severe mental illness needs to maintain their independence within the community (Harris, 1998). Research has generally found that case management services benefit those individuals diagnosed with schizophrenia, schizoaffective disorder, and other psychoses (Begley, 1994). While a few studies have examined gender differences in demographic factors, functioning level, and social network among case management clients (Goering, Wasylenki, Onge, Paduchak, & Lancee, 1992; Solomon & Draine, 1993), no studies have reported differences in utilization rates or patterns of referrals.

The results of the logistic regression found that gender was a significant predictor of affective disorders. Affective disorders are conceived of as being heterogeneous, as there are several variations recognized in the DSM-IV (APA, 1994). The constellation of disorders included under the umbrella of "affective disorders" are major depression, bipolar disorder, and dysthymia. Research has shown that women make up a significantly higher proportion than men of those diagnosed with major depression, typically at a ratio of 2:1 (Bland, et al., 1988; McGrath, et al., 1990; Nolen-Hoeksema, 1987; Robins & Regier, 1991). Rates of dysthymia have also been found to be higher among women while bipolar disorder has revealed a more balanced gender ratio (Bland, et al., 1988; Robins & Regier, 1991). Looking at the group of affective disorders as a whole, data obtained from large scale epidemiological studies has consistently revealed that women are twice as likely to report symptoms associated with affective disorders than men (Bland, et al., 1988; Robins & Regier, 1991). The results of this study substantiated these
findings as affective disorders were shown to be more common in female clients compared to male clients by a factor of about two.

7.3 Implications of Findings

The aforementioned findings have a number of important implications. That female clients were older than male clients may be indication that women experience mental health crises later in their lives. Another possibility is that women are seeking mental health care at later stages in their illness or when circumstances in their lives have become inordinate. Further research is needed to explore both of these possibilities. In the event that women are seeking mental health care at later stages in their illness or when stressful events have escalated into crises, it is necessary to identify the barriers which may be preventing them from accessing care earlier. The older ages of women also suggests that mobile crisis programs should be attentive to the special concerns of women across the life span. Research has shown that middle-aged women are responsible for providing informal caregiving to immediate and extended family, carry a greater burden of housework and paid work hours, face greater practical constraints on personal employment and advancement, and get less autonomy, authority, recognition, and pay when employed (Mirowsky, 1996). Just at the time in life when gender differences in family responsibilities and employment subside, the differences in the probability of widowhood rise sharply, making grief, loneliness, social devaluation, and economic insufficiency more common among older women (Mirowsky, 1996). Problems of younger women—including violence and discrimination—may plague older women as well. All these
factors may have profound implications on women’s mental health and need to be considered by mobile crisis programs in service delivery planning.

That married women were more likely to access mobile crisis programs compared to married men could be further indication that events in women’s social and personal lives contribute to the onset or exasperation of their mental health crises. Women who are married often have to balance the demands of paid employment, informal care giving, and responsibilities in the home. Results from the National Violence Against Women Survey (NVWS; Rodgers, 1994) showed that a substantial number of women who have been married or in common-law relationships have lived in situations characterized by violence and abuse. In light of the unfavorable social conditions that married women often must confront, it may not be surprising that they would seek the assistance of mobile crisis programs more frequently than married men. While marriage appears to have deleterious implications for women, the present study found marriage to have a protective effect for men. As a group, married men were the least likely to access mobile crisis services (as compared to married women and single men). This finding may be related to the fact that men who are married and experiencing mental health difficulties are provided with the support and care needed to subdue any impending crises by their female partners. Further, having a supportive partner may prevent the onset of certain types of mental health problems in the first place.

Knowing who referred the client to the mobile crisis program may provide valuable information about the social network and functioning of the client. The finding that women were less likely than men to be referred to mobile crisis programs
by family members could be taken as indication that women have less supportive
family networks. In fact, there was a general trend in the present study, albeit not
statistically significant, whereby men were more likely to be living with family
members while women were more likely to be living alone. Living with family
members increases the likelihood that mental health crises would be detected and
that family members would call requesting assistance on behalf of the client.
Another explanation may be related to men’s higher reported rates of schizophrenia
compared to women. Schizophrenia is considered a severe mental illness with
marked disability and impaired level of functioning, making it possible that family
members would be more likely to call requesting a mobile crisis visit because of the
impact that disability has on their own lives. Family members, therefore, may be
experiencing caregiver overload and may be calling the mobile crisis program for
help not available elsewhere in the community. Conversely, women’s mental health
problems may be more subtle and/or manageable in nature, making it less likely that
a family member would call requesting assistance. An interesting point worthy of
mention is that research has shown that family members charged with caring for
individuals with mental illnesses are most often women (Hooyman & Gonyea, 1995).
Whether or not this is the case for clients seen by mobile crisis programs is a
question which requires further investigation. In the event that women are the
primary caregivers, mobile crisis programs need to recognize the contribution
women make to the care of individuals who have mental illnesses in the community
and need to offer services specifically designed to alleviate the burden of care that
they may be experiencing.
The finding that women were less likely to have had contact with a psychiatrist may also be related to the preponderance of men in this sample who reported schizophrenia. Schizophrenia has traditionally been treated with a combination of anti-psychotic medication and psychotherapy, both of which are most often offered by psychiatrists. As this study focused on women's current connection to a psychiatrist, another possibility may be that women had sought the assistance of a psychiatrist in the past and found the experience to be ill-suited to address the true nature of their mental health difficulties. That women in this sample were less likely to be connected to psychiatrists is encouraging. Psychiatrists are trained in detecting and treating mental illnesses with physical and psychosomatic etiologies, not necessarily those with a social etiology. As noted previously in this study, the mental health problems experienced by women are often associated with social factors, such as violence, discrimination, and economic insufficiency. Exclusive focus on matters of biology and the use of psychotropic medications for women, therefore, might only serve to derail long-term solutions and true healing. The finding that women were less likely to be referred to case management services can also be understood in terms of men's higher reported rates of schizophrenia.

Individuals diagnosed with schizophrenia often require intensive case management services because of their inability to function in the community alone.

While research on suicidality in women is limited, epidemiological research has shown that attempted suicides occur primarily among women, while completed suicides occur primarily among men (Moscicki, 1994). The reasons for this are complex but stem in part from the fact that men select more lethal methods,
including the use of firearms and strangulation. Because male mortality from suicide is substantially greater than female mortality, suicidality among men has been studied more extensively. This has led women’s suicidal behaviour to be framed with a distinctly male bias (Stark & Flitcraft, 1995). For instance, suicide behaviour among women has tended to be viewed as “acting out” and “attention seeking,” while suicidal behaviour among men has been taken more seriously (Canetto & Lester, 1995). This has had the effect of minimizing the risk of suicidality among women and has led to problems in identifying warning signs. In reality, unless women are psychotic or acting violently, they are unlikely to be defined as “high risk” (Canetto & Lester, 1995). A growing body of literature is now drawing attention to social conditions as being intricately related to female suicidality (Hawton, Fagg, & Simkin, 1988; Platt, 1984; Stark & Flitcraft, 1995). Focus on traditional risk factors, such as the severity of the attempt, previous attempts, and the concurrence of mental disorders is likely to discount women’s experiences, perhaps placing them at increased risk.

The current study did not find any statistically significant gender differences in terms of outcome of care. While it may be the case that differences between women and men simply do not exist, one alternative explanation is that the mobile crisis programs do not operate from a model of care which differentiates clients on the basis of gender. In other words, both women and men may be offered the same interventions and referrals without regard for their distinct needs and concerns. Further research is needed to determine if this is indeed the case. In the event that the programs are not gender sensitive, they may be failing to provide care that is
appropriate for and responsive to women's mental health problems. Another possible explanation for the relative lack of gender differences in outcome of care could be the historic neglect of gender as a variable, and of females as study participants, in research on mental illness. The measures of outcome used in the present investigation may not have been sensitive enough to detect gender differences. For instance, referral to community and/or social services does not identify the actual service clients were referred to (e.g., shelter, foodbank, family services, etc.). This illustrates the need for broader, descriptive research, with more gender sensitive measures.

Many of the significant findings discussed are compatible with a feminist social causation paradigm. This paradigm contends that women are more vulnerable to distress, depression, and other mental health problems because of the greater number of adverse social conditions that they must contend with, including violence, poverty, and social isolation (Pugliesi, 1992). Indeed, that women who are married are more likely to access mobile crisis services draws attention to the link between social factors and women's mental health. On the other hand, the finding that gender is the only variable associated with affective disorders lends credence to the feminist social constructionist approach. The social constructionist perspective argues that women's behaviour is more likely to be assigned a psychiatric label because of women’s relative powerlessness in society. Throughout their lives, women are conditioned to display help-seeking behaviour and emotional distress—both of which are devalued in a patriarchal society and linked to definitions of mental disorder. Behaviour which deviates from the female gender role is also closely
associated with definitions of mental disorder as such behaviour is viewed as threatening to the existing social order. The social constructionist paradigm, therefore, posits that women are labeled “mentally ill” both when their behaviour conforms and departs from the female gender role. While women are not a homogeneous entity and social and economic conditions can have varying influences on their mental health, the mere fact of being a woman appears to be a risk factor for mental disorder given the sexist and misogynous assumptions that are embedded within the mental health system. Framed in this light, it is not surprising that gender remains a significant predictor of affective disorders even when controlling for other factors.

7.4 Limitations and Strengths of Study

Several limitations should be noted in this study as they relate to the interpretation of the findings. There were concerns about the validity of the reported diagnosis as this information was obtained directly from clients and/or family members and was not assessed by mental health professionals. Moreover, because of the small expected frequencies in most of the diagnostic categories examined, it was difficult to determine with any degree of certainty if patterns of mental disorders found in this sample were a reflection of patterns found in the general population. Methodologically, the use of chart reviews in the current investigation was also problematic because the clinical record forms often contained missing data. Charts may have been incomplete because the crisis workers failed to elicit important information from the clients or events occurred at times and in places that were
difficult to capture. The amount of incomplete documentation was so severe that the focus of the study had to be restricted to those visits that were classified as "crisis."

Another limitation was that because the data used were collected for the purposes of the larger evaluation study, some information that would be of particular interest to this analysis was not collected (e.g., data pertaining to abuse history, race, ethnicity, sexual orientation, and parental status). While the available data did afford an opportunity to assess gender differences among clients who accessed mobile crisis services, it was limited by its lack of comprehensiveness.

A final limitation was related to issues of confidentiality. In order to ensure confidentiality, all client identifiers were removed from the clinical record forms at the mobile crisis program sites. To identify repeat service users and track clients over time, the research team requested that crisis workers assign each client a unique identification number. Regrettably, this method was not consistently adopted. Even where programs were more consistent in providing unique identification numbers, it was difficult to discern whether two clinical record forms were connected to the same client as the unique identifier often varied on pages of the same form. Due to the absence of reliable client-identifiers, the research team was unable to estimate with any degree of certainty how many clients had accessed the services on multiple occasions. The valid use of both the chi-square test and the logistic regression analysis require that observations be independent of one another. A violation of independence occurs whenever a single subject contributes more than one pair of observations. In this study, it is likely that some clients were included more than
once in each of the statistical analyses performed. In order to compensate for this violation, the study spoke of “visits” as opposed to “clients.”

Despite the aforementioned limitations, the results generated from this study can be viewed as establishing the groundwork for enhancing the quality of care offered by mobile crisis teams to women and for developing coherent health and social policy in relation to women’s mental health needs. Moreover, the study is unprecedented as it represents the first attempt to examine gender-related issues with respect to mobile crisis service delivery. In addition, the study contributes to the existing literature on mobile crisis programs as it goes beyond merely describing the features of such programs by providing a systematic analysis of gender differences. Finally, the results of this study have important theoretical contributions as they support the feminist literature on gender differences in mental health. In particular, they speak to the importance of drawing on the knowledge generated within both the social causation and social construction paradigms in developing a more comprehensive understanding of women’s mental health.

7.5 Recommendations for Policy and Practice

The following is a list of policy and practice recommendations for mobile crisis programs which has emerged from the findings of the current investigation. A secondary set of recommendations, stemming from the feminist theoretical framework which has served to guide this study has also been included. While it is important to recognize that further research in the area of mobile crisis programs is required before any policy and practice changes can be implemented, these
recommendations represent a starting point for increasing sensitivity to gender-related issues and to women's mental health needs.

1. **Broadening Mandate** - The current mandate of the Metro Integrated Community Crisis Program (MICCP) and Peel Integrated Community Response (PICR) is to provide a timely response to individuals with mental illnesses who are experiencing an acute psychiatric crisis. As women's mental health problems may not be related to a "mental illness" per se, the mobile crisis programs should consider expanding their mandate so that they can provide crisis support which is appropriate for the women they work with. Broadening the mandate would ensure that crisis workers receive education and training on issues which are related to women's mental health problems. Furthermore, it would enable mobile crisis programs to become more accountable to female clients. In the event that MICCP and PICR do not want to broaden their mandate, alternative services for women in the community need to be developed.

2. **Assessment of Suicide Risk Among Women** — It is necessary for mobile crisis workers at both MICCP and PICR to be trained to routinely assess suicide risk among female clients and to be sensitive to female-associated risk factors for suicidal behaviour, which may include social isolation, violence and abuse, and economic insufficiency. Once it has been established that a woman has a plan or intention to engage in suicidal behaviour, intervention may include counselling, follow-up, and referrals to appropriate community services.
3. **Meeting the Needs of Women Across the Life Span** – MICCP and PICR should be sensitive to the distinct needs of women across the life span, particularly those who are middle aged and elderly, since these women comprise a substantial proportion of the clients who access mobile crisis services. Given the demographic projections of explosive growth in the over-65 age group, of which women are a clear majority, there is good reason to believe that the need for mental health services for older women will increase in subsequent years. Older women face disproportionate economic losses, a greater likelihood of widowhood, of living alone, and social devaluation—all of which need to be incorporated into mobile crisis service planning and delivery. Being situated in the community, both MICCP and PICR have better opportunities to recognize and assess these social factors and to take steps to alleviate them, such as arranging practical help with poor accommodation or helping older women to increase their social networks.

4. **Screening for Woman Abuse** – As indicated previously, neither MICCP nor PICR formally screen clients for woman abuse. An understanding of victimization is critical to the provision of services offered by mobile crisis programs. The American Psychological Association (1996) recommends that routine screening for abuse histories be included in standard medical and psychological examinations and should be extended to mobile crisis programs. Mobile crisis workers at MICCP and PICR must be educated and trained about the dynamics of abuse and the safety and autonomy of abused women. They must also learn how to screen for abuse and intervene with identified victims of abuse. Screening questions should be included on
the clinical record forms and should be asked of all women 16 years of age and over in a non-judgmental, non-threatening, and sensitive manner. Further, women should be interviewed alone or with a support person present. Identifying women who have abuse histories will allow mobile crisis workers to devise treatment plans and make referrals that are truly relevant to their experiences.

7.5.1 General Recommendations for Planning Mobile Crisis Services

Other ways that mobile crisis programs can become more sensitive to the distinct needs of women is through the establishment of an Advisory Committee for Women's Mental Health. This committee would be responsible for overseeing that important changes are made that enable mobile crisis programs to take into account the diversity and complexity of women's needs and experiences. Members of such a committee could include women in the community, mental health consumers, service providers from various women's mental health services, frontline workers at grassroots organizations, feminist therapists, survivors of violence, representatives from women's organizations interested in women's mental health, and members of women's advocacy groups. Not only would this committee ensure sensitivity to women's mental health needs, it would also increase women's participation in all stages in the development and implementation of a community mental health program designed for their benefit. In order to meet the needs of all women, mobile crisis programs should also consider the effects of the multiple characteristics that distinguish subgroups of women. Women do not constitute a unified and homogenous group and women's diversity with respect to ethnicity, age, ability,
socioeconomic status, and sexual orientation must be taken into account when addressing their mental health issues. Discovering and understanding this plurality is of critical importance for mobile crisis service delivery and planning.

Mobile crisis programs should also be involved in social action and advocacy in areas that impact on the lives and well-being of women with mental health problems. Social action can take on myriad forms, such as engaging in primary prevention efforts and leading public education within the community; altering organizational climate to serve female clients more effectively; incorporating antisexist and antiracist activities within educational workshops; influencing public policy in the area of childcare, pay equity, homelessness, and violence against women; and working with grassroots organizations to promote day care, adequate housing, and non-violent attitudes. In addition, mobile crisis programs should collaborate with other service sectors, such as the judicial system, psychiatric services, community and social services, voluntary services, and the private sector in developing an integrated and coordinated network of mental health services that would be sensitive to the distinct needs and concerns of women. There needs to be a unified strategy to meet women's needs and agreed upon standards to ensure a high quality of care and a comprehensive approach to the treatment of women's mental health problems.

Finally, even though mobile crisis programs are community-based, they function from a biomedical perspective insofar as traditional psychiatric diagnoses and methods of treatment are used. To minimize the power differential that exists between provider and recipient, mobile crisis programs should adopt a woman-
centered approach to treatment. This approach involves shared responsibility of the team members and clients in working together to identify solutions and treatment options. Women are acknowledged to be the experts about their own lives and experiences. The focus of mobile crisis intervention should be to provide safety, respect differences, facilitate women's ability to make informed choices, and to empower women to achieve more control over their lives. In addition, mobile crisis programs should move away from diagnostic labels since they tend to be biased against women and should incorporate a health rather than a disease focus.

7.6 Directions for Future Research

Further research is needed to advance understanding of the experiences and special needs of women who access mobile crisis services. The data presented in the current investigation suggest that there are significant differences in female and male clients who access mobile crisis services, in terms of service usage, client-related characteristics, mental health functioning, and in the process of care provided. The nature of these differences raises questions about whether the needs of female clients are being adequately met. Clearly such questions and the reasons for the differences found require further research investigation. With respect to research methodology, there has been concern that quantitative research methods alone fail to capture the full complexity of women's mental health problems, leading to a call for the use of a wider range of research methods and the increased participation of clients at every stage of the research endeavour. The use of qualitative methods of inquiry, which focus on the subjective experiences and
meanings of those being researched, may prove to be an effective way to determine sensitivity and appropriateness of services from a woman’s perspective. These methods might include in-depth interviews, participant-observation, and focus groups which would allow for the exploration of the meanings associated with mental illness and the experiences of accessing mobile crisis services. Such approaches would not only ensure sensitivity to the importance of gender, but would also make the important links between gender, culture, ethnicity, sexuality, and socioeconomic status. In addition, such approaches would draw on the actual experiences of women as the basis for taking action.

Further research exploring gender differences and experiences of women from the perspective of the mobile crisis workers is also needed. Such research would seek to identify the particular problems and needs of women; elicit views on the appropriateness of locally provided services and how they might be improved; and gain an understanding of the attitudes held by mobile crisis workers toward the women in this client group. Studies should also explore the different ways that women and men may experience mental health crises and should identify the antecedents to such crises. To date, there is little existing literature exploring the effects of gender on psychiatric crises. In addition, future research should investigate whether the course or quality of care offered to women with histories of abuse is fundamentally different from that provided to clients with no abuse history. Since abuse is intertwined with women’s experience of mental illness, researching abuse within the context of mobile crisis services would be advantageous in terms of service delivery and planning. Finally, studies should focus on the caregivers who
have called requesting a mobile crisis visit on behalf of a family member. This would be useful in determining whether mobile crisis programs are recognizing the difficulties informal carers may be experiencing and might generate ideas about how existing services can be improved or expanded so that their needs are better met in the future.
REFERENCES


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APPENDIX A

CLINICAL RECORD FORM
Confïnned form: March 26/99

Integrated Community Mental Health Crisis Response Program

MOBILE CRISIS VISIT ASSESSMENT FORM

I. BACKGROUND DATE

Date (d/m/y): __/__/__
Initial visit/Follow-up visit (circle)

Time of incoming call to Mobile Unit:__________________________
Time visit booked for:__________________________
Time of departure to crisis:__________________________
Workers Name:____________________________________

Primary CLIENT name:____________________________________
Address:______________________________________________
Postal Code:__________________________ Tel #:____________

Age (yrs):____________ DOB:______________ Sex: M F
Marital status: Single M CL D Sep W
Preferred Language:____________________________________

II. INFORMATION PROVIDED BY CALLER

Caller’s name: ______________________________________
Phone:______________________________________________

<table>
<thead>
<tr>
<th>Was the caller the</th>
</tr>
</thead>
<tbody>
<tr>
<td>client</td>
</tr>
<tr>
<td>family</td>
</tr>
<tr>
<td>friend</td>
</tr>
</tbody>
</table>

Description of crisis by caller

<table>
<thead>
<tr>
<th>☐Danger to self / ☐Danger to others</th>
<th>☐Deterioration in self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐Threats</td>
<td>☐Safety</td>
</tr>
<tr>
<td>☐Ideation</td>
<td>☐Shelter</td>
</tr>
<tr>
<td>☐Plan</td>
<td>☐Hygiene</td>
</tr>
<tr>
<td>☐Intent</td>
<td>☐Clothing/exposure</td>
</tr>
<tr>
<td>☐Previous attempts</td>
<td>☐Treatment noncompliance</td>
</tr>
<tr>
<td>☐Access to weapons</td>
<td>☐Inadequate nutrition/hydration</td>
</tr>
<tr>
<td>☐Violence committed</td>
<td>☐Finances</td>
</tr>
</tbody>
</table>
Please describe the situation that has prompted the call (2 - 3 sentences):


Urgency rating (as suggested by caller): (check one only)

☐ Visit immediately
☐ Visit within 24 hours
☐ Urgency unknown without further information

III. INITIAL ENTRY

Others in attendance at visit:

<table>
<thead>
<tr>
<th>☐ Family</th>
<th>☐ Health care professional</th>
<th>☐ Employer</th>
<th>☐ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Neighbour</td>
<td>☐ Police</td>
<td>☐ Community personnel</td>
<td>☐ Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Location of visit:

<table>
<thead>
<tr>
<th>☐ Private home, apartment</th>
<th>☐ Community-based programs (eg food banks/shelters/clubs etc.)</th>
<th>☐ Institutional settings (eg hospitals/ schools/ nursing homes/ correctional facilities etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Workplace</td>
<td>☐ Public access/thoroughfare (eg malls/ subway/ bus/ parking lot etc.)</td>
<td>☐ Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the client agree to talk with the Crisis workers?

☐ Yes If yes, continue
☐ No If no, do not continue with form
IV. ASSESSMENT OF CURRENT HEALTH STATUS & HISTORY

REPORTED DIAGNOSIS (source: ____________________):

Select 1 or more:

<table>
<thead>
<tr>
<th>Disorder Type</th>
<th>Disorder Type</th>
<th>Disorder Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>Substance Related Disorder</td>
<td>Specific Disorder of childhood/adolescence</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>Mental Disorder due to medical condition</td>
<td>Unknown</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Delirium</td>
<td>Other: Specify</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>Dementia, other cognitive disorders</td>
<td></td>
</tr>
<tr>
<td>Developmental Handicap</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CURRENT MENTAL STATUS:

Identify problems where intervention may be needed (✓):

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Thought content (describe preoccupations and/or delusions):</th>
</tr>
</thead>
<tbody>
<tr>
<td>malnourished</td>
<td></td>
</tr>
<tr>
<td>inappropriate clothing</td>
<td></td>
</tr>
<tr>
<td>other (describe):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Hallucinations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>suspicious</td>
<td>auditory</td>
</tr>
<tr>
<td>non compliant</td>
<td>visual</td>
</tr>
<tr>
<td>other (describe):</td>
<td>other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychomotor</th>
<th>Orientation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>agitation</td>
<td>time</td>
</tr>
<tr>
<td>slowing</td>
<td>person</td>
</tr>
<tr>
<td>other (describe):</td>
<td>place</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of Consciousness</th>
<th>Memory:</th>
</tr>
</thead>
<tbody>
<tr>
<td>sedated</td>
<td>impaired recent</td>
</tr>
<tr>
<td>other (describe):</td>
<td>impaired past</td>
</tr>
</tbody>
</table>

NPI
<table>
<thead>
<tr>
<th>Speech:</th>
<th>Slurred</th>
<th>Rapid</th>
<th>Other (describe):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention/concentration:</td>
<td>Unable to focus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal:</th>
<th>Ideation</th>
<th>Intent</th>
<th>Suicidal act/self harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement:</td>
<td>Poor</td>
<td>Fair</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Homicidal:</th>
<th>Ideation/intent</th>
<th>Violent act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insight:</td>
<td>Poor</td>
<td>Fair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mood:</th>
<th>Depressed</th>
<th>Angry</th>
<th>Euphoric</th>
<th>Other (describe):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Thought process:</th>
<th>Rambles</th>
<th>Looseness of association</th>
<th>Perseveration</th>
<th>Other (describe):</th>
</tr>
</thead>
</table>

**ILLNESS HISTORY:**

- Source: ____________
- Date of onset of current episode: ____________ (d/m/y)
- Previous psychiatric admissions: □ Yes □ No
- Most recent? ____________ Where? ____________
- (d/m/y)
Confirmed form: March 26/99

<table>
<thead>
<tr>
<th>Professional Support Network:</th>
<th>Is client connected to this type of professional?</th>
<th>Name:</th>
<th>Phone #:</th>
<th>Contacted (y/n)?:</th>
<th>Last seen (d/m/y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family doctor</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
<td></td>
</tr>
<tr>
<td>Case manager</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
<td></td>
</tr>
<tr>
<td>Home care (CCAC)</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
<td></td>
</tr>
<tr>
<td>Public Guardian/Trustee</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>□ yes □ no</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
<td></td>
</tr>
</tbody>
</table>

PHYSICAL HEALTH & MEDICATIONS (during last 9 months):

Please rate the consumer’s physical health problems:

□ No physical health problems
□ Minor health problems (e.g. colds, non-serious falls etc.)
□ Mild restriction on activity due to physical health problem
□ Moderate restriction on activity due to physical health problem
□ Severe restriction on activity due to physical health problem

Specific Diagnosis: ________________________________

Medications:

<table>
<thead>
<tr>
<th>Name:</th>
<th>dose &amp; frequency:</th>
<th>Compliant (y/n)?:</th>
<th>Name:</th>
<th>dose &amp; frequency:</th>
<th>Compliant (y/n)?:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**HOUSING STATUS:**

<table>
<thead>
<tr>
<th>Client CURRENTLY lives with (all those that apply):</th>
<th>CURRENT Location</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>Private home/apartment</td>
<td>□ Approved home</td>
</tr>
<tr>
<td>Parents</td>
<td>Hostel/shelter</td>
<td>□ Ontario Housing</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>Homes for special care</td>
<td>□ Institution (specify):</td>
</tr>
<tr>
<td>Other family</td>
<td>Non-profit housing</td>
<td>□ On the street</td>
</tr>
<tr>
<td>Non-family</td>
<td>Boarding/rooming house</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>Retirement home</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>Housing program (staff on site)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYMENT STATUS:**

<table>
<thead>
<tr>
<th>Employed (y/n)</th>
<th>Status (full time/part time):</th>
<th>Occupation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Earnings (spouse and/or self)</td>
</tr>
<tr>
<td></td>
<td>General welfare assistance</td>
<td>Employment Insurance</td>
</tr>
<tr>
<td></td>
<td>Ontario disability support program (Family benefits allowance)</td>
<td>Workman's compensation</td>
</tr>
<tr>
<td></td>
<td>Gains - D</td>
<td>Old Age supplement (OAS), GIS, SPA</td>
</tr>
<tr>
<td></td>
<td>CPP disability</td>
<td>Allowance/income from family</td>
</tr>
</tbody>
</table>

**LEGAL:**

<table>
<thead>
<tr>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past 9 months, has the client...</td>
</tr>
<tr>
<td>...been arrested (yes/no) ...been on parole/probation (yes/no)</td>
</tr>
<tr>
<td>...spent nights in prison (yes/no) ...been violent to others (yes/no)</td>
</tr>
</tbody>
</table>

Coping Skills/strengths:

Additional Information:
Instructions: score 1 to 5 in each category using descriptive statements as guidelines.

A. Dangerousness (circle number)
   1. Expresses or hallucinates suicidal/homicidal ideas or has made serious attempt in present illness. Unpredictably impulsive/violent.
   2. Same as 1, but ideas or behaviour are to some degree ego-dystonic or history of violent or impulsive behaviour but no current signs.
   3. Expresses suicidal/homicidal ideas with ambivalence or has made only ineffective gestures. Questionable impulse control
   4. Some suicidal/homicidal ideation or behaviour, or history of same, but clearly wishes and is able to control behaviour
   5. No suicidal/homicidal ideation or behaviour. No history of violent/impulsive behaviour.

B. Support system (circle number)
   1. No family, friends, or others. Agencies cannot provide immediate support needed.
   2. Some support might be mobilized but its effectiveness will be limited.
   3. Support system potentially available but significant difficulties exist in mobilizing it.
   4. Interested family, friends, or others but some question exists of ability or willingness to help.
   5. Interested family, friends, or others able and willing to provide support needed.

C. Ability to cooperate (circle number)
   1. Unable to cooperate or actively refuses.
   2. Shows little interest in or comprehension of efforts to be made on his/her behalf.
   3. Passively accepts intervention manoeuvres.
   4. Wants to get help but is ambivalent or motivation is not strong.
   5. Actively seeks outpatient treatment, willing and able to cooperation.

Subscale Score _________

D. Alcohol Use Scale (circle number)
   1. Client moderately to severely intoxicated
   2. Client mildly intoxicated
   3. Client admits to recent abuse of alcohol but is not clearly impaired
   4. Client shows no signs of intoxication and reports no recent use of alcohol but has past history of alcohol abuse
   5. No history or evidence of alcohol abuse

Subscale Score _________

E. Drug Use Scale (circle number)
   1. Client moderately to severely impaired
   2. Client mildly impaired
   3. Client admits to recent abuse of drugs but is not clearly impaired
   4. Client shows no signs of impairment and reports no recent use of drugs but has past history of drug abuse
   5. No history or evidence of drug abuse.

Subscale Score _________

TOTAL SCORE:_________
VI. INTERVENTION & OUTCOME

Brief Description of Crisis Plan (one paragraph)

INTERVENTION OFFERED:

<table>
<thead>
<tr>
<th>Please describe which intervention strategies were offered:</th>
<th>Time spent: (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Supportive counselling &amp; education of primary client</td>
<td></td>
</tr>
<tr>
<td>☐ Supportive counselling &amp; education of others:</td>
<td></td>
</tr>
<tr>
<td>If so, what were their relationships to primary client?</td>
<td></td>
</tr>
<tr>
<td>☐ Spouse/partner</td>
<td></td>
</tr>
<tr>
<td>☐ Parent</td>
<td></td>
</tr>
<tr>
<td>☐ Child(ren)</td>
<td></td>
</tr>
<tr>
<td>☐ Friends</td>
<td></td>
</tr>
<tr>
<td>☐ Others</td>
<td></td>
</tr>
<tr>
<td>☐ Liaising/discussion with other professionals involved in the crisis (e.g. police etc.)</td>
<td></td>
</tr>
</tbody>
</table>

Client taken to:  
☐ hospital emergency  ☐ Mobile Crisis team  
☐ psychiatric hospital  ☐ family/friends  
☐ police station  ☐ police  
☐ hostel  ☐ others (describe:  
☐ other (describe):  

Client provided with information about following service agencies/professionals:  
New / ☐ Re-connection  
☐ Hospital emergency  ☐ Day program  
☐ Psychiatric hospital  ☐ Community/social services  
☐ Gerstein Centre  ☐ Western Focus  
☐ Correctional facility  ☐ Drop-in Centre  
☐ Physicians  ☐ Foodbank  
☐ Psychiatrists  ☐ Griffin Safe bed  
☐ Counsellor  ☐ Hostel  
☐ Caseworker  ☐ Shelter  
☐ Crisis follow-up  ☐ Other (describe):  
☐ Public Guardian and Trustee (PGT)
## INTERVENTION OUTCOMES:

<table>
<thead>
<tr>
<th>Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client remained in location of visit</td>
</tr>
<tr>
<td>Client accepted &amp; complied with interventions offered</td>
</tr>
<tr>
<td>Client taken to:</td>
</tr>
<tr>
<td>hospital emergency department</td>
</tr>
<tr>
<td>psychiatric hospital</td>
</tr>
<tr>
<td>police station</td>
</tr>
<tr>
<td>hostel</td>
</tr>
<tr>
<td>other (describe):</td>
</tr>
<tr>
<td>Client declined information re: recommended service</td>
</tr>
<tr>
<td>Client refused to accompany workers to recommended service agency provider</td>
</tr>
<tr>
<td>Police contacted: (time):</td>
</tr>
<tr>
<td>Badge #’s:</td>
</tr>
<tr>
<td>Public Guardian &amp; Trustee Investigation Unit contacted</td>
</tr>
<tr>
<td>Psychiatric backup contacted (time):</td>
</tr>
<tr>
<td>Mental Health Act Form/Action</td>
</tr>
<tr>
<td>Form 1 completed</td>
</tr>
<tr>
<td>Direct to Justice of Peace</td>
</tr>
<tr>
<td>Form 2 completed</td>
</tr>
<tr>
<td>Form 14 completed</td>
</tr>
</tbody>
</table>

## SUMMARY OF VISIT

<table>
<thead>
<tr>
<th>Time spent (mins):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone assessment of crisis (including clarification of situation or ongoing monitoring)</td>
</tr>
<tr>
<td>Travel</td>
</tr>
<tr>
<td>Duration of visit (excluding travel time)</td>
</tr>
<tr>
<td>Documentation</td>
</tr>
<tr>
<td>Follow-up phone contact</td>
</tr>
</tbody>
</table>
Confirmed form: March 26/99

Unique Identifier ____________

Other (describe):

Mobile crisis team follow-up visit indicated? (yes/no):
If yes, when?:

Signature of crisis worker: ____________________________

Date: ____________________________

24 hour follow-up

Crisis Triage Rating Scale:

Subscale 1 score:
Subscale 2 score:
TOTAL SCORE:

Follow-up recommendations:
APPENDIX B

CRISIS TRIAGE RATING SCALE
V. CRISIS TRIAGE RATING SCALE

Instructions: score 1 to 5 in each category using descriptive statements as guidelines.

A. Dangerousness (circle number)
1. Expresses or hallucinates suicidal/homicidal ideas or has made serious attempt in present illness. Unpredictably impulsive/violent.
2. Same as 1, but ideas or behaviour are to some degree ego-dystonic or history of violent or impulsive behaviour but no current signs.
3. Expresses suicidal/homicidal ideas with ambivalence or has made only ineffective gestures. Questionable impulse control.
4. Some suicidal/homicidal ideation or behaviour, or history of same, but clearly wishes and is able to control behaviour.
5. No suicidal/homicidal ideation or behaviour. No history of violent/impulsive behaviour.

B. Support system (circle number)
1. No family, friends, or others. Agencies cannot provide immediate support needed.
2. Some support might be mobilized but its effectiveness will be limited.
3. Support system potentially available but significant difficulties exist in mobilizing it.
4. Interested family, friends, or others but some question exists of ability or willingness to help.
5. Interested family, friends, or others able and willing to provide support needed.

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1. Unable to cooperate or actively refuses.
2. Shows little interest in or comprehension of efforts to be made on his/her behalf.
3. Passively accepts intervention manoeuvres.
4. Wants to get help but is ambivalent or motivation is not strong.
5. Actively seeks outpatient treatment, willing and able to cooperation.

D. Alcohol Use Scale (circle number)
1. Client moderately to severely intoxicated
2. Client mildly intoxicated
3. Client admits to recent abuse of alcohol but is not clearly impaired
4. Client shows no signs of intoxication and reports no recent use of alcohol but has past history of alcohol abuse
5. No history or evidence of alcohol abuse

E. Drug Use Scale (circle number)
1. Client moderately to severely impaired
2. Client mildly impaired
3. Client admits to recent abuse of drugs but is not clearly impaired
4. Client shows no signs of impairment and reports no recent use of drugs but has past history of drug abuse
5. No history or evidence of drug abuse.

Subscale Score ________

TOTAL SCORE:_______
APPENDIX C

CHART ABSTRACTION TOOL
Mobile Mental Health Crisis Programs

CHART ABSTRACTION TOOL

I. BACKGROUND DATA

ID SOURCE: ___ (1=Peel, 2=Metro)
ID NUMBER: ________ (as indicated on the R upper corner of file)
UNIQUE ID: <A > ________ (if not filled out, put XXX 9999)

VISIT TYPE): __
1=crisis
2= follow-up
3=visit attempt - Ax not possible (i.e. not home, refused)
4=other (eg. JP visit, form pick up, meetings, etc.-
   no direct contact with SMI person/client)

VISIT (NUM)BER: ___ (1=visit 1, 2=visit 2, 3=visit 3, 4=visit 4, 5=visit 5)
(DATE) of (VISIT) (d/m/y): <dd/mm/yyyy>

(Age) (yrs): ________ (777=unknown, 999=no response provided by worker/refused)

(Sex): ___ (1=M, 2=F, 7=unknown, 9=no response provided by worker/refused)

(Marital) status: __
1=Single
2=Maid
3=CL (common law)
4=divorced
5=separated
6=widowed
7=unknown
8=not applicable
9=no response provided by worker/refused

Preferred (Language): ___
01=English
06=Russian
11=Yiddish
17=unknown to worker
02=French
07=Punjabi
12=Tamil
22=not applicable
03=Italian
08=Somali
13=Farsi
32=no response provided by worker
04=Spanish
09=Cantonese
14=Polish
05=Portuguese
10=Hebrew
15=other

II. INFORMATION PROVIDED BY CALLER

Caller/(referral (source)): ___
01=client
14=health care personnel
77=unknown
02=family
16=employer
38=not applicable
11=friend
21=community personnel
99=no response/refused
12=policeman
24=educational facility
13=neighbour
35=other

DESCRIPTION of CRISIS by caller/(NATURE) of (CRISIS): ___
01=Danger to self
77=unknown to worker
02=Danger to others
88=not applicable
03=Deterioration in self-care
99=no response provided by worker
04=Danger to self & others selected
05=Danger to self & deter. in self-care selected
06=Danger to others & deter. in self-care selected
07=all 3 types of crises selected

For the following information, code:
1=if selected by worker
0=if not selected by worker
9=if none selected by worker/no response in this category

1) if Danger to self and/or others, how did the worker record the following?:

[threats]: ___
[ideation]: ___
[plan]: ___
[intent]: ___
[previous attempts]: ___
access to [weapons]: ___
[violence] committed: ___
2) if Deterioration in self-care, how did the worker record the following?:

(safety): __    (shelter): __
(hygiene): __    (clothing)/exposure: __
treatment (noncompliance): __  inadequate (nutrition)/hydration: __
(finances): __

(Urgency) rating (as suggested by caller): __
1=Visit immediately  3=Urgency unknown without further information
2=Visit within 24 hours  9=no response by worker

III. INITIAL ENTRY
For the following information, code:
1=if selected by worker
0=if not selected by worker
9=if none selected by worker/no response in this category

OTHERS in ATTENDANCE at visit:

(Family) attending __  (Health Care professional) attending __
(Employee) attending __  (Unknown) attending __
(Friend) attending __  (Neighbor) attending __
(Police) attending __  (Community/Personnel) attending __
(Others) attending __

(LOCATION) of visit: __
01=Private home/apartment
02=Institutional setting (eg. hospital, schools, nursing homes)
03=Police station/correctional setting (eg. court house, jail)
04=Community setting (eg. community-based programs, foodbanks, shelters)
05=Workplace
06=Public access/thoroughfare (eg. malls, subway, buses, parking lots)
07=Other
77=unknown to worker  99=no response provided by worker

Does the (CLIENT AGREE) to talk with the Crisis workers? __
1=Yes  (If yes, continue)  2=No (do not continue)  9=No response by worker

IV. ASSESSMENT OF CURRENT HEALTH STATUS & HISTORY
REPORTED (DIAGNOSIS): __
01=Mood Disorder (eg. Depression, Bipolar)
02=Anxiety Disorder (eg. panic)
03=Schizophrenia
04=Personality Disorder
05=Developmental Handicap
06=Substance Related Disorder (eg. alcoholic, drug abuser)
07=Mental Disorder due to medical condition
08=Delirium
09=Dementia, other cognitive disorders (eg. Alzheimers)
10=Specific Disorder of childhood/adolescence
11=Schizophreniform/Schizoaffective Disorder
12=OCD (Obsessive Compulsive Disorder)
13=PTSD (Post Traumatic Stress Disorder)
14=other
15=more than 1 diagnosis
77=Unknown to worker
88=Not applicable
99=No response provided by worker
CURRENT MENTAL STATUS

MENTAL STATUS assessment: ___

(Review mental status assessment sections & any relevant progress notes, then choose the most appropriate description of mental status assessment)

01 = Mental status assessment completed IN FULL with client & documented by worker (i.e. all boxes addressed/ no evidence 3rd party report)
02 = Mental status NOT ASSESSED by worker (e.g. client absent/refuses)
03 = Mental status PARTIALLY assessed by worker (i.e. some areas not addressed)
04 = Worker uses 3rd PARTY report to complete mental status assessment (i.e. parent, sibling, physician)

For the following information, code:
1 = if selected by worker
0 = if not selected by worker
9 = if none selected by worker/no response in this category

APPEARANCE: [NPI appearance] ___ (malnourished) ___
[inappropriate clothing/apparel] ___
[other apparel] ___

THOUGHT CONTENT: [NPI delusions/preoccupations] ___
(client is delusional/experiencing preoccupations) ___

ATTITUDE: [NPI attitude] ___ (suspicious) ___
[non compliant] ___ (other attitude problems) ___

HALLUCINATIONS: [NPI hallucinations] ___ (auditory) ___
(visual) ___ (other hallucination problems) ___

PSYCHOMOTOR: [NPI psychomotor] ___ (agitation) ___
(slowing) ___ (other psychomotor problems) ___

ORIENTATION: [NPI orientation] ___ (disoriented to time) ___
(disoriented to person) ___ (disoriented to place) ___

LEVEL OF CONSCIOUSNESS: [NPI LOC] ___ (sedated) ___
[other LOC] problems ___

MEMORY: [NPI memory] ___ (impaired) (recent) ___ (impaired) (past) ___

UNRELIABLE (HISTORIAN): ___ (extra category not on form)
1 = yes, worker indicates that client was unreliable historian
2 = no, worker did not document that client was unreliable historian

SPEECH: [NPI speech] ___ (slurred) ___ (rapid) ___
(other speech pattern problems) ___

ATTENTION/CONCENTRATION: [NPI attention/concentration] ___
(unable to focus/no focus) ___

SUICIDAL: [NPI suicide] ___ (ideation) ___ (intent) ___
(suicidal act/self harm) ___

JUDGEMENT: [NPI judgement] ___ (poor judgement) ___
(fair judgement/limited judgement) ___
For the following information, code:
1=if selected by worker
0=if not selected by worker
9=if none selected by worker/no response in this category

HOMICIDAL: (NPI homicide: __ (homicidal (idea)tion/intent: __
(violent act): __

INSIGHT: (NPI insight): __ (poor insight/none: __
fair insight/(limited insight: __

MOOD: (NPI mood): __ (depressed): __ (angry): __ (euphoric): __
(other mood) problems: __

THOUGHT PROCESS: (NPI process): __ (rambles): __
(looseness) of association: __ (perseveration: __
(other) thought process problems: __

ILLNESS HISTORY:
1: Was the (source) identified by worker: __ (1=yes, 2=no)
2: Were there (previous psychiatric) (admissions): __
1=yes, 2=no, 3=unknown to worker, 9=not reported by worker
3: When was the (most recent) admission, prior to this episode?: __
1=was discharged under a week ago 2=discharged under a month ago
3=discharged over a month ago 4=discharged over a year ago

PROFESSIONAL SUPPORT NETWORK
(PROFESSIONAL SUPPORT: __
(after review of the professional support section & any relevant progress
notes, choose the most appropriate description of this section)
1=section suggests that CONNECTED to 1 or more support professionals
2=the worker was able to contact at least 1 of them
3=this section was NOT COMPLETED at all by the worker
3b=the worker was CONNECTED to partially completed, but worker did not contact
or was not able to reach professionals

IS THE CLIENT CONNECTED TO A:
1a) (Family (doctor): __
1b) Did the worker (contact) the (family (doctor)?: __
1c) Did the worker (contact) the (family (doctor)?: __
2b) Did the worker (contact) the (psychiatrist): __
3a) (Case manager): __
3b) Did the worker (contact) the (case) manager?: __
4a) Home care/{CCAC}: ___
  1=yes, 2=no, 7=unknown, 9=no response by worker

4b) Did the worker (contact) the {CCAC}/home care?: ___
  1=yes  2=no  3=tried but unable to reach  8=not applicable  9=no response

5a) Public Guardian/Trustee ({PGT}): ___
  1=yes, 2=no, 7=unknown, 9=no response by worker

5b) Did the worker {contact} the {PGT}?: ___
  1=yes  2=no  3=tried but unable to reach  8=not applicable  9=no response

6) Other connections: ___
  1=yes, 2=no, 7=unknown, 9=no response by worker

PHYSICAL HEALTH & MEDICATIONS (during last 9 months):
Please rate the consumer's {PHYSICAL HEALTH} problems: ___
1=No physical health problems
2=Minor health problems (e.g. colds, non-serious falls etc.)
3=Moderate restriction on activity due to physical health problem
4=Severe restriction on activity due to physical health problem
5=unknown to worker
6=not applicable
7=no response by worker/refused

Specific Diagnosis/{DX} of {PHYSICAL} health problem: ___
01=diabetes  02=thyroid  03=heart/cardiac/BP
04=respiratory  05=cancer  06=head injury/CVA
07=HIV  08=hepatitis  09=orthopaedic{eg. fractures etc.}
10=other  77=unknown to worker
88=not applicable  99=no response by worker to section/refused

{MEDICATIONS}: ___  0=none/non-compliant, 1=1-5 meds, 2=6+ meds,
7=unknown, 9=no response by worker/refused

HOUSING STATUS

Client currently lives with/ {LIVING} {ARRANGE}MENT: ___
1=alone,  2=spouse/partner, parents, children or other family
3=non-family/sharing accommodation, 4=homeless,  7=unknown by worker
8=not applicable,  9=no response by worker/refused

Client's current {HOUSING} location: ___
01=Private home  17=respite
03=Private apartment  18=eviction pending/evicted
04=Boarding/rooming house  19=Approved home
06=Hostel/shelter  20=homeless/on the street
08=Retirement home  21=other
10=Ontario housing  77=unknown by worker
11=Non-profit housing  88=not applicable
12=Housing program (staff on site)  99=no response by worker/refused
15=Homes for special care
EMPLOYMENT STATUS:
Is client (employed)?: ___ (1=yes, 2=no, 7=unknown, 9=no response by worker)
If yes, is their working status: ___ (1=full time, 2=part time)

What is the (Source) of (Inc)ome: ___
01=General welfare assistance
02=Ontario disability support program (Family benefits allowance)
03=Gains - D
04=CPP disability
05=Earnings (spouse and/or self)
06=Employment Insurance
07=Workman's compensation
08=Old Age supplement (OAS), GIS, SPA
09=Allowance/income from family
10=more than 1 source selected
77=unknown to worker
88=not applicable
99=no response by worker/refused

LEGAL:
In the past 9 months, has the client been...
a) (arrested): ___ (1=yes, 2=no, 7=unknown, 9=no response by worker)
b) spent nights in (prison): ___ (1=yes, 2=no, 7=unknown, 9=no response...)
c) on (parole)/probation: ___ (1=yes, 2=no, 7=unknown, 9=no response...)
d) (violent) to others: ___ (1=yes, 2=no, 7=unknown, 9=no response...)

V. CRISIS TRIAGE RATING SCALE
SCALE (COMPLETION): ___
1=Scale completed in full (i.e. each category given rating).
2=Scale not completed at all
3=Scale partially completed

A. (Dangerousness): ___ (please enter score (1-5) indicated by worker)
   7=unknown to worker, 9=no response by worker

B. (Support) system: ___ (please enter score (1-5) indicated by worker)
   7=unknown to worker, 9=no response by worker

C. Ability to (cooperate): ___ (please enter score (1-5) indicated by worker)
   7=unknown to worker, 9=no response by worker

(Subscale A) Score: ____ (total A, B & C - if all 3 provided [excluding 7,8&9])
   (99 if not completed)

D. (Alcohol Use) Scale: ___ (please enter score (1-5) indicated by worker)
   7=unknown to worker, 9=no response by worker

E. (Drug Use) Scale: ___ (please enter score (1-5) indicated by worker)
   7=unknown to worker, 9=no response by worker

(Subscale B): ____ (total D & E - if both completed [excluding 7,8&9])
   (99 if not completed)

(CTRS TOTAL) SCORE: ____ (total all sections if completed, excl. 7,8 & 9)
   (99 if not completed)
VI. INTERVENTION & OUTCOME

For the following information, code:
   1=worker indicates that this intervention was offered
   0= this intervention was not selected by worker
   9=no interventions were offered/no response to entire category

1) (Supportive counselling & education of primary {client}): ___
   {Time client}: ______ (in minutes, 999 if no response)
2) (Supportive counselling & education of {others}): ___
   {Time others}: ______ (in minutes, 999 if no response)
3) {Liaising)/discussion with other professionals: ___
   {Time liaise}: ______ (in minutes, 999 if no response)
4) Client {taken to}: ___
   1=hospital emergency  3=polic e station  5=friends/family
   2=psychiatric hospital  4=hostel  6=other
   8=not applicable/remained in visit location 9=no response
5) Client {taken by}: ___
   1=mobile crisis team  4=ambulance/911  8=not applicable
   2=family/friends  5=others  9=no response by worker
   3=p olice  7=unknown
6) Mobile crisis team {accompany} others in transporting client?: ___
   (1=yes, 2=no, 9=no response)
   {Time accompany}: ______ (in minutes, 999 if no response)

For the following information, code:
   1=if selected by worker
   0=if not selected by worker
   9=if none selected by worker/no response in this category

Client provided with information/ plans made re: agencies/professionals:
   {Hospital emergency} ___ {Day program} ___ {PGT} ___
   {Psychiatric hospital} ___ {Community/social services} ___
   {Gerstein} Centre ___ {Western Focus} ___
   {Correctional facility} ___ {Drop-in} Centre ___
   {Physicians} ___ {Foodbank} ___
   {Psychiatrists} ___ {Griffin} Safe bed ___
   {Counsellor} ___ {Hostel} ___
   {Caseworker} ___ {Shelter} ___
Crisis {follow-up} ___ {Other referrals} ___
INTERVENTION OUTCOMES:

{Outcome}/Summary section completed: __
1=yes, 2=no, not included in documentation/no completed by worker

If yes, For the following information, code:
1=if selected by worker
0=if not selected by worker
9=if none selected by worker/no response in this category

Client remained in location of visit/{natural setting}: __
Client accepted & {complied} with interventions offered __
Client {admitted} to {hospital} emergency department __
Client {admitted} to {psychiatric} hospital __
Client {detained} at police station __
Client {admitted} to {hospital} __
Client {declined} information re: recommended service __
Client {refused} to {accompany} workers __

Public Guardian & Trustee Investigation Unit {PGT} {contacted} __

{Psychiatric backup} {contacted} __
Mental Health Act {MHA} {Form}/Action __
{Form 1} completed __
Direct to Justice of Peace {JOP} __
{Form 2} completed __

{Form 14} completed __

SUMMARY OF VISIT

(phone time) spent on assessment: ______ (total mins, 999 if not included)
{Travel time}: ______ (total mins, 999 if not included)
(Duration) of visit {excluding travel time}: ______ (total mins, 999 if not incl).
(Documentation): ______ (total mins, 999 if not included)
Follow-up {f/u} phone contact: ______ (total mins, 999 if not included)

Mobile crisis team {follow-up} visit indicated? __ {1=yes, 2=no, 3=no response}
Did {24 hr} follow-up {f/u} occur? __ {1=yes, 2=no, 7=unclear, 9=no response}
if yes, was Crisis Triage Rating Scale {CTRS} {used}? __
{1=yes, 2=no, 9=no response}
if yes, was there a {reduction} in any of the scores? __
{1=yes, 2=no, 9=no response}
APPENDIX D

ETHICS REVIEW
Dear Ms. Desiato and Dr. Ferris:

Re: Your research protocol entitled “An Evaluation of Two community Mobile Crisis Programmes for the Chronically Mentally Ill”

Thank you for your submission for ethical review of the above-referenced study. Our review of your application indicates that the study qualifies as exempt from REB review under the Tri-Council Policy Statement (Articles 1.1, 2.3, 3.1, 3.2, and 3.3), and therefore does not require review.

During the course of the research, any change that disqualifies the study as exempt from REB review under the Policy Statement articles listed above should be brought to the attention of the Ethics Unit in the Office of Research Services.

If you have any questions, please feel free to contact me at 946-3389 or by email at tom.fleming@utoronto.ca.

Yours sincerely,

Tom Fleming
Ethics Review Officer

TF/pp