Building a Service Resolution Function in Toronto:

Recommendations for Meeting the Needs of People with Complex Mental Health and Justice Needs

Provincial HSJCC Conference – Toronto, ON
Nov 18, 2015

Jaime Brown, PhD
Jason Newberry, PhD

TaylorNewberry
CONSULTING

About Us

Taylor Newberry Consulting

Taylor Newberry Consulting (TNC) is community based research and evaluation organization located in Guelph, Ontario. We have extensive experience in

- program and system level evaluations,
- needs assessments,
- program and system design,
- organizational capacity building, and
- facilitation and training.

We work in a number of theme areas, including: mental health and addictions, disability rights and supports, youth development, anti-poverty, collective impact, and community wellbeing.

Acknowledgements

We warmly thank our key informants for sharing their experiences and expertise, and the *Complex Care Sub-Committee of the Toronto HSJCC* for their guidance and insights.

Special thanks to the Project Leadership Team:

Charissa Levy, *GTA Rehab Network/ Toronto ABI Network/ Rehabilitative Care Alliance*

Steve Lurie, *CMHA, Toronto*

Paul Van de Laar, *Cota*

Today's Agenda

1. Background and context setting
2. Review project goals, key concepts
3. Research design and key questions
4. Overview of findings
5. Presentation of SR model options informed by the research
6. Recommended SR model for Toronto
7. Discussion, questions

Background & System Context

- Open Minds, Healthy Minds (Ontario Government mental health and addictions strategy, 2011)
  - Improve mental health and well-being for all Ontarians
  - Create healthy, resilient, inclusive communities
  - Identify mental health and addictions problems early and intervene
  - Provide timely, high quality, integrated, person-centered health and other human services.

- Requires “right mix” of supports; a transformed MH&A system that is seamless, coordinated, integrated
- Many ON communities have taken great strides in building integrated service systems that attend to SDOH; increasing cross-sectoral partnerships and collaborations

Background & System Context

Particular interest in how service systems meet needs of individuals with complex needs

- The "right mix" of supports for this subgroup is often hard to discern and, more concerning, the health and social service systems may not have the capacity to fully meet the need. People with complex needs often …
  - Experience housing instability, homelessness, income insecurity, elevated risk of harm to self or others
  - Tend to be high users of emergency, hospital in-patient, and ALC services
  - More likely to experience criminal charges

- Complex Care Sub-Committee of the T-HSJCC – established to address co-occurring cross-sectoral service needs of individuals 16 yrs.+ who are not adequately supported
  - Mental health, cognitive and/or physical disabilities, substance use and addictions, ABI, dual diagnosis, developmental disabilities, housing, criminal justice

Project Goals

- To engage with the cross-sectoral provider community in Toronto to gather feedback and input regarding the creation/adoption of a Service Resolution mechanism.
- To develop and propose several options for a service resolution mechanism in Toronto to meet the needs of…

…people in contact with the justice system

…who have complex mental health and addictions challenges

…often co-occurring with developmental disability, ABI, and other difficulties.

Defining Service Resolution

- A system-level promising practice found in a range of sectors.
- A higher-level case conferencing process for individuals with complex needs.
- Pulls together all the organizations/services/sectors that know the individual and have a potential role to play in solving core problems.
- Representatives are from multiple sectors – mental health and addictions, ABI, developmental services, justice services, child and family services, and others.

Defining Service Resolution

- There is shared organizational accountability to agreed upon service interventions and formal endorsement of responses to be carried out by front-line staff. A service resolution process enables:
  - collaborative solutions, service agreements and cross-organizational partnerships.
  - practice changes, accommodations, service exceptions, bending/flexing of policies.
  - e.g. of actions: Identify a worker, obtain a diagnosis, assess risk to self or others, prioritize the individual for service access, access other sectors, gain admission to programs, develop and coordinate a support plan.

Service Resolution vs. Case Conferencing

CASE CONFERENCING	SERVICE RESOLUTION
• Initiated by primary worker	• Initiated by a coordinating staff person behalf of partners.
• Typically composed of front-line workers	• When case conferencing is ineffective, SR is composed of high-level managers
• Effective if the primary worker is well-connected, dedicated, tenacious.	• Effective because workers in system are accountable, through their organizations, to SR.
• Falls short when system barriers are beyond the control of case conference.	• Has the power and position to "bend policies", make exceptions, change programs.
• Actions and outcomes are most often not captured by the system.	• Actions and outcomes are continually collected to inform system improvements.

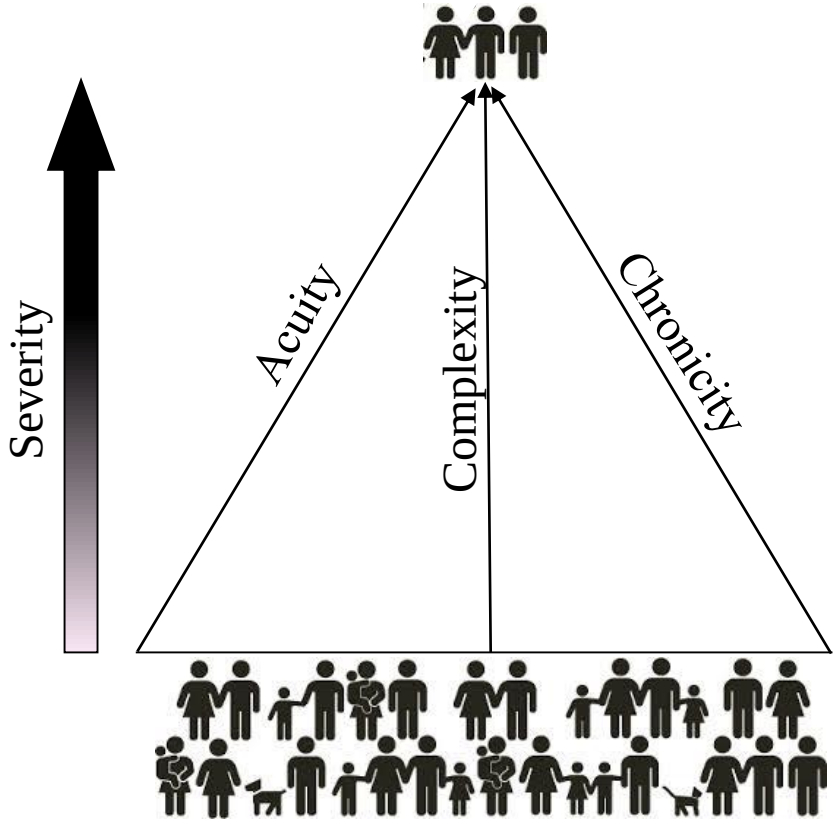
Service Resolution Targets People with Complex Needs

What do we mean by "complexity"

- **Combined challenges** associated with mental health, addictions, developmental disability, ABI, and/or physical health concerns.
- Risk factors in the context of **social determinants of health**: poor housing status, poverty, isolation, family breakdown, conflict with the justice system.
- **Risk of harm to self or others**; not imminent, but chronically high and elevated. SR is not a crisis response per se.
- High **acuity** of presenting problems.
- High **chronicity** of presenting problems.
- High **usage of EMS** and **justice services**.
- Repeated **challenges in accessing** supports and services.

What do we mean by "complexity"

Adapted from Rush (2009)



TaylorNewberry CONSULTING

What do we mean by "complexity"

Adapted from Rush (2009)

Eligibility to Services	Nature of Problems	Share of Population	Cost per Person	Specialization & Intensity	Integration with Community Life
Limited	Severe	Smallest	Highest	Highest	Lowest
Open	At Risk	Biggest	Lowest	Lowest	Highest

Local Data on Complexity

(Sirotich & Durbin, 2014)

- In Toronto, 87% of 2202 people receiving case management and 83% of 856 receiving supportive housing were considered "**complex**" using the definition of the TC LHIN:
  - Multiple chronic physical or mental health conditions; *or*
  - Psychosocial challenges (homelessness, poverty, isolation); *or*
  - Challenges accessing service and/or high emergency service use.

- **High health complexity**: Co-occurring conditions *and* high health care utilization or criminal involvement *and* low income or (risk of) homelessness:
  - 4.0% (69) of the case management sample
  - 3.4% (23) of the supportive housing sample

Our Methodology

- Web-based scan of services, organizations, initiatives, and partnerships.
- Local research, evaluation, and policy reports to shed light on the target population and local service pressures and gaps.
- Conducted 26 key informant interviews and 6 focus groups (~75 individuals) in the following sectors/service areas:
  - Mental health
  - Addictions
  - Developmental Services
  - Dual Diagnosis
  - Supportive Housing
  - ABI
  - Emergency shelters
  - Centralized MHA Access
  - Hospital Services
  - Psychiatry
  - Government (prov./mun.)
  - Police Services
  - Justice Services

Areas of Focus for our Primary Data Collection

- The **characteristics and circumstances** of the individuals served.
- Prevalent **barriers** in the system.
- **Similar initiatives** and examples of success in serving this population.
- Visioning **responsive and flexible** supports.
- The **support and buy-in** for service resolution
- **Ideas and feedback** regarding what a service resolution function could look like in Toronto.

Summary of Our Research Findings

Who could benefit from Service Resolution?

- Respondents aligned with common definitions of complexity.
- Co-occurrence of mental health and addictions with other health challenges.
- Unstably housed, homeless, living in poverty.
- Lack of awareness of needs/resistance to support.
- Failure of system to meet needs in relation to:
  - People with developmental delay and justice involvement
  - Addictions
  - Behavioural issues (e.g., aggression/risk of harm to others, sexual behaviours)
  - Significant trauma

Prevalent System Barriers

- **Ineligibility** due to presenting needs in relation to organizational policies, funding agreements, capacity, staff expertise/skills, and low risk tolerance. Creates service silos.
- **Fragmented system**: Too many gaps in continuum of care and lack of support to navigate the system. Poor coordination and communication across providers.
- **Inflexibility** and service bureaucracy doesn't match needs of complex clients – timely, responsive, and mobile services within small windows of opportunity.
- **Root problems heighten complexity**. Lack of housing and income, for example, exacerbate all other problems.

Prevalent System Barriers

- **Major gaps** in services **related to ABI and dual diagnosis**.
- Discharge from hospital without **appropriate discharge planning** and support.
- **Centralized access** slows down access and disrupts the effectiveness of front-line relationships among providers.
- People are **pooled in shelters and hostels** – inappropriate for individuals with complex needs
- **Long wait times** complicate things further
  - Client situation changes resulting in change in service need or eligibility; exposure to additional risk, e.g., in shelters while waiting .
  - Services that were intended as temporary/transitional to become long-term (and insufficient/inappropriate for complex needs)

Examples of Success

- **Bending eligibility** to pick up clients who wouldn't be eligible services because of diagnoses.
- **Service provider training** to expand capacity to address multiple/complex needs.
- **Services meet clients where they are** - flexibility in location of treatment; paperwork; etc.
- **Committed, multi-service teams**; flexible, continuum of care.

Building a Service Resolution Mechanism: Key Dimensions, Considerations, and Preconditions

Target Group

- Consistent with our definition of complexity.
- Current context: MHA with justice involvement, and acknowledgement of cross-over with developmental disability, ABI, and other issues.
- If SR is concerned with addressing needs of the most complex and difficult to serve then MH is always an issue and justice involvement is (virtually) always a risk.

Response Level and Committee Structure

Response Level

- SR models often have different response levels:
  - Front-line case conferencing
  - Interagency case conferencing (a mix of front-line staff and service managers)
  - System case conferencing

- More situations
- Less influence over system barriers

- Fewer situations
- Greater influence over system barriers

Response Level and Committee Structure

Committee Structure

- At different levels committees may be standing, ad hoc, or a mix.
- Ad hoc members are typically “rostered”.
- Some service resolution models attempt to have a mix of organizational levels (from front-line leaders up to executive directors) within one SR committee.
- What is essential is that committee decision-makers have control over high-level organizational decisions when required.
- System case conference committee may also serve as the governance structure (to be discussed).

Pathways into Service Resolution

Any SR model will need to consider how people come into service – how they are identified and protocol/process leads them into the service.

- **Open Service**: all providers can refer.
  - It is a function of the SR Coorindator (with guidance of governance committee) to educate providers on appropriate referral criteria.
  - We recommend providers refer with "home agency endorsement".

- **Localized Service**: clients hail from particular catchment area.

- **Streamed Service**: clients gain access through a particular service pathway (e.g., MH court, ALC discharge, etc.); internal providers refer to the table

Coordination with Existing Tables

- Forums and processes already exist that are designed to promote collaborative problem solving in relation to individual situations.
- A new service resolution model will need to consider how to **coordinate and integrate** with existing tables.
- Should **avoid duplication** and confusion and serve to enhance the response and practices of other initiatives (and vice versa).
- Other tables vary in mandate, structure, and reach thereby placing some constraints on SR function, flexibility, and governance.

Geographic Coverage

- A Toronto service resolution model will need to accommodate a large geographical area and complex sectors and systems. (e.g., there are over 70 funded MHA organizations in the Toronto Central LHIN alone).
- There a few obvious guidelines on how to parse the city geographically for this purpose. Some examples include:
  - LHINs
  - Quadrants: Etobicoke/York, North York, Toronto/East York.
  - Health Links (roughly neighbourhood divisions)
  - Police divisions
- Another option is to build geographic coverage inductively, by mapping presenting needs over time

Organizational Representation

- Effective service resolution requires cross-sectoral representation of organizations that have a direct role in services and supports.
- Essential to have a strong mix of MHA, developmental services, justice, housing, ABI, hospitals, primary care, etc.
- Some organizations are essential, due to mandate and reach, and are almost always needed around the table.
- Others are needed more occasionally.
- There will be an interplay between geography and organizational representation – different offices and personnel of single (but large organizations) may be implicated at different times.

Core Staff: SR Coordinator

- Service resolution relies very heavily on effective system coordination and networking.
- Without a dedicated position to facilitate inter-organizational, cross-sectoral communication, the mechanism will be very challenging to maintain.
- Existing SR models have central coordinators (navigators, facilitators).

Core Staff: SR Coordinator

The SR Coordinator Role

- A **unique system position** and central to the success of SR.
- Accountable to the system via a multi-organization governance committee.
- Provides **support, problem solving and education** to front-line workers and organizations.
- Promotes and **facilitates interagency case and system level conferences**.
- Gathers and **compiles information regarding common barriers and gaps** in system to inform SR and system improvement.
- Can be central point of access to SRM – the front door.
- A **system connector**: pulls together multiple organizations – has system endorsement and leverage to do so. Responsible for ongoing engagement and buy-in.

Governance

A SR model will need a governance structure to provide oversight and direction, ensure system-wide participation, and engage in system-level advocacy.

- Must be cross-sectoral, composed of high-level managers/executive directors.
- Same organizations that have most active members.
- Ideally will include governmental representation.
- Provides direct accountability to the SRC.
- Members may also be part of system case conferencing committee (a SR level).
- Analyses system barriers and innovations (rolled up from cases) to develop new policies, practices, and programs.
- Speak as one voice, representing the system.
- Could be assembled for this purpose or could be assigned to an existing system structure (e.g., the T-HSJCC).

Costs and Resources

- Cost outlays can and should be kept fairly low – SR is an alternative way for providers to do the work they are already tasked to do. SR should be seen as a more efficient and effective way to meet needs.
- Costs are associated primarily with staffing the service (i.e., a coordinator or coordinators).
- Each table will require a dedicated coordinator.
- Resource risks for organizations:
  - SR tends to implicate managers in more front-line operations – new roles require new or shifted resources.
  - Some organizations are called upon more than others and the volume can overtake capacity.

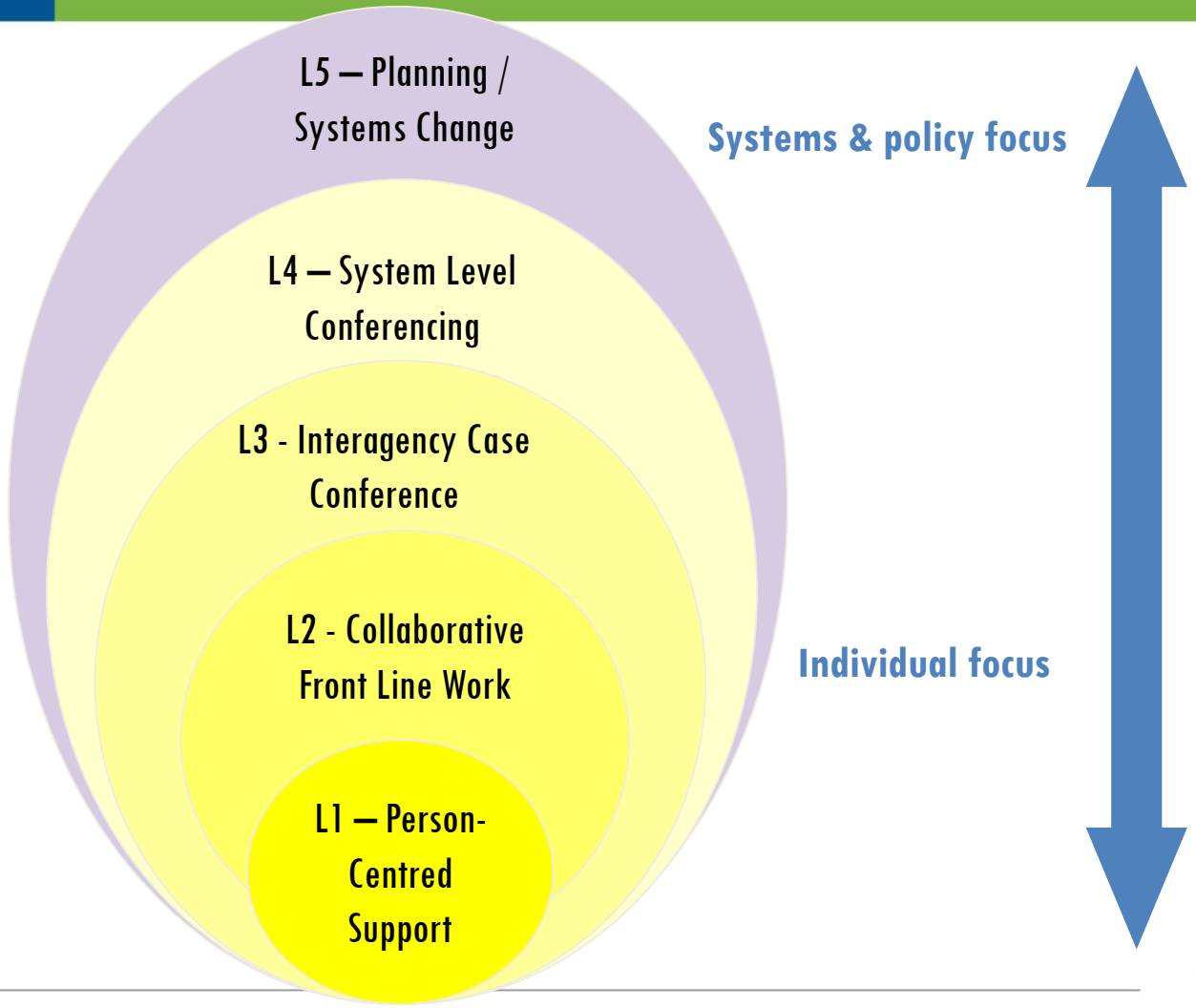
Service Resolution Model Options for Toronto

Model 1: Standing Committee Structure

- Two cross-sectoral standing committees each with additional ad hoc members as needed.
  - Interagency case conferencing committee of middle/high-level managers
  - System case conferencing committee of directors.

- A service resolution coordinator brings cases to the committees upon demonstrating that the issue cannot be resolved locally.
- Multiple tables would be required for full geographic coverage. Correspondingly, organizational representation would need to align with geography, across the core services/sectors.

Example Service Resolution Model



TaylorNewberry CONSULTING

Model 1: Strengths and Challenges

Strengths	Challenges
• Recommended in smaller systems with fewer organizations. • Full control over the mandate, structure, governance. • Standing committees provide continuity of participation. • Consistency of membership promotes ongoing collaboration. • Shared history of system innovations.	• Full representation of relevant organizations in standing committee is problematic. • Requires geographic parsing – but individuals are often transient and agencies cross borders. Decisions on divisions are ambiguous. • In complex system, the need for ad hoc members may be so frequent as to question the viability of standing committee. • Relatively high cost to cover city (i.e., multiple tables, with staff) • Does not integrate well with existing tables.

Model 2: Ad Hoc Roster Structure

- Fully ad hoc committee, not arranged by geographic divisions but by presenting circumstances of the individual.
- Local organizations nominate members to a roster that feeds an interagency case conferencing committee (front-line leaders and mid-level managers) that is assembled according to the needs of each case.
- System case conferencing committee has standing members who meet as needed for the smaller number of cases that cannot be resolved at lower level.
- A cross-sectoral governing committee would provide oversight and ensure organizational participation.

Model 2 Strengths and Challenges

Strengths	Challenges
• Provides greater flexibility to provide wide geographic coverage (goes to the person). • Promotes greater customization of services to match needs and immediate relevance of members' participation.	• Some members will be called upon so frequently they may become standing members *de facto*. • Solutions may default to organizations that have greatest capacity/interest to attend. • May be hard to maintain membership of members who are not frequently accessed. • Lack of continuity in membership, process, decisions, practices may limit shared vision and accountability

Model 3: Brokering Structure

- No distinct, separate service resolution mechanism. SR Coordinator role will:
  - formally connect to existing SR-type tables throughout the city (and may sit as members)
  - bring individuals to the tables via organizational referrals or are called upon by the tables to bring forward resources and representatives.
  - maintain an ad hoc roster (similar to model #2) of providers that can be attached to existing tables.
  - play a capacity building role.
- Depending on the table, an additional system case-conferencing committee may be required if cases cannot be resolved at the table level.
- We can begin to imagine a network of tables that have shared goals and representation within a governing structure.
- Governance structure would be similar, but would need to include representation of the other tables.

Model 3 Strengths and Challenges

Strengths	Challenges
• Takes advantage of existing infrastructure, resources, and commitments of other organizations. • Reduces duplication and confusion in the system; more efficient. • Builds capacity other tables by mobilizing resources and expertise of specialized services.	• Significantly less control over the structure, process, and mandate over the function. • Existing tables may not match geographic need. • Existing tables may not share (enough of) the same mandate as SR. • SRC role and influence could be diluted or downplayed.

Our Recommended Model

1. **Hire a dedicated SR Coordinator**.
2. **Establish a standing Interagency SR Committee** – composed of supervisors/managers of the network of MH&J service organizations
3. **Augment the Interagency SR Committee with ad hoc members** – from additional sectors (as needed)
4. **Adopt a networked referral approach** – only organizations from the MH&J service network bring clients to SR. This helps to focus on the mandate of the network, capitalize on existing buy-in/commitment, provides control over volume/flow of cases.
5. **Developing funding allocated to "Flex Funds"** – provide discretionary funding to individuals for housing, medication, specialized services, and daily living needs
6. **Begin to build alliances with other tables** - through outreach, education, partnership and referral.

Our Recommended Model

Other Key Considerations

- **Governance** - cross-organizational committee; must routinely connect into high level policy agendas and broad-based system discussions
- **Organizational Commitment** – orgs will be required to stretch their boundaries, take risks to explore innovation, genuinely engage in service partnerships that are expressed/supported on the ground – will require multi-org'l terms of reference
- **SR Coordinator Role –** this role is critical to coordinating the many moving parts involved in SR; should be established and resourced first and foremost
- **Need for member training** – cannot assume committee members have the requisite information/experience to engage in SR discussions
- **Evaluating SR** – evaluation/monitoring is critical to capture and reflect upon SR practices, system challenges, interventions, partnerships, innovations

Our Recommended Model

Other Key Considerations: Supportive housing and the cycle of risk

- SR cannot solve chronic homelessness or address problem of lack of housing options.
- Directing flex funds to housing is modest way for SR to improve housing status and important component of this service
- However, policy decisions to add, enhance, or improve health and social services are incomplete and far less effective without corresponding investment in housing.

Thank you!

Questions, Comments, Feedback?

Feel free to follow-up with us about this work or our other related projects.

Jaime Brown, Ph.D.
jaime@taylornewberry.ca

www.taylornewberry.ca