Building a Service Resolution Function in Toronto:

Recommendations for Meeting the Needs of People with Complex Mental Health, Addictions, and Other Challenges

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PREPARED FOR

Complex Care Sub-Committee,
Toronto Human Services and
Justice Coordinating Committee

Executive Summary

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In the City of Toronto, the Toronto Human Service Justice Coordinating Committee (T-HSJCC) recognized an acute need to examine service coordination for individuals with more complex needs. The Complex Care Sub-Committee was established in collaboration with the Toronto Acquired Brain Injury (ABI) Network to focus on individuals 16 years of age or older who are not adequately supported by the service system. These individuals often experience co-occurring needs across multiple sectors including mental health, substance use, acquired brain Injury, dual diagnosis, developmental disabilities, housing, and criminal justice. In 2014, the Sub-Committee began investigating the creation of a *Service Resolution* (SR) process to help meet the needs of this priority population. Taylor Newberry Consulting[1] was contracted to conduct a needs assessment to determine the scope, structure, and implementation of a SR mechanism in Toronto.

Project Purpose and Goals

The primary goals of the project were as follows:

1. To define the target population that would benefit from a SR process, including common presenting issues/needs and experiences/challenges in accessing services and supports.
2. To describe the characteristics, structure, processes, and intended outcomes of existing models of services resolution.
3. To provide recommended model or models of SR appropriate for the Toronto context, including recommended staffing roles, structure, governance, and coordination with other similar tables and initiatives in the city.

What Is Service Resolution?

Service Resolution is an approach to creative problem solving and customized service access for people with complex needs. While models can be structured in a variety of ways, the common feature is that a SR committee (often called a "table") is composed of high level managers representing a cross-section of organizations from multiple health and social service sectors. The function of the table is to engage in creative and collaborative problem solving centering on individuals who have continually experienced challenges in accessing services and getting their needs met.

For an overview of existing service resolution-type models, see Section 1.4.

Who is Service Resolution For?

A guiding principle of Service Resolution is that it is a last resort, after reasonable efforts of service access and collaborative problem solving have been made. Service Resolution must be narrow in its application to a proportionately smaller number of citizens with complex needs. Individuals accessing Service Resolution should typically experience the following co-occurring difficulties:

For a discussion of "complexity" in the context of service resolution, see Sections 1.3. and 3.1

- Challenges associated with **mental health issues, most often combined with other challenges** associated with addictions, developmental disability, ABI, and/or physical health concerns.
- Risk factors associated with **social determinants of health**: poor housing status, poverty, isolation, family breakdown, etc.
- Past or present **contact with the justice system** and ongoing likelihood of justice system involvement.

[1] Taylor Newberry Consulting engages in community based research and evaluation in the public sector. For more information, please visit www.taylornewberry.ca.

- A history of **risk of harm to self or others;** and a continued high risk in this regard. Note that Service Resolution is not for people currently in crisis or imminent risk.
- High **acuity** and **chronicity** of presenting problems.
- High **usage of EMS and justice services** and repeated **challenges in accessing** community supports and services.

Project Methods

The development of recommended options for Service Resolution in Toronto was based on a scan of the relevant practice literature, including local services, organizations, and partnerships, and existing system data. The project also consulted with the cross-sectoral provider community in Toronto to gather their input and feedback on the development and implementation of a SR mechanism. We conducted 5 focus groups and 26 key informant interviews a cross-section of providers. Over 75 unique individuals participated.

Circumstances of People Who Could Benefit Most from Service Resolution

Highlights from the feedback from project participants include the following:

- There was a general **agreement with the criteria of complexity** that would guide SR use.
- **Rigid eligibility criteria** that are set by organizational policies and funding agreements combine with complex needs in ways that disconnect and marginalize people from the supports that they need. Substance use, conflict with law, and challenging behaviours were highlighted as challenges that prevent service access.
- Barriers experienced by individuals with complex needs are not so much rooted in the severity and nature of their needs, but in the **inflexibility of the system** to accommodate them.
- **Lack of appropriate supportive housing** was resoundingly identified as a major gap in the service system, exacerbating existing challenges. Long wait lists for supportive housing are further complicated by the lack of availability of supportive housing options for individuals with highly complex needs (e.g., 24-hr support).

Key Dimensions and Considerations in Designing a Service Resolution Mechanism

The project reviewed a set of key dimensions that need consideration when designing Service Resolution. Based on the practice literature and feedback of project participants, the following findings and feedback were highlighted.

Dimension	Project Highlights
Response Levels of an integrated SR mechanism	• Front-line case conferencing needs to be supported in the community before moving up to a SR table. • If case conferencing is ineffective in creating a solution, then there is mechanism to provide a higher level SR intervention. • SR would also be responsible for identifying and cataloging specialized programs and services in the system that may not be widely known, identify gaps in the system, and serve as a lever for important systems level changes
Standing or ad hoc committee	• There are benefits and drawbacks of having ad hoc or standing SR committees. • *Ad hoc committees*: More flexible and customized to each situation, but may also lead to low participation and lack of shared ownership and cohesion. • *Standing committees*: provide consistency of shared practice and building of service relationships; however, standing committees may lead to a narrowing of participating organizations and lowered ability to

	customize the best response for a situation. • *Hybrid approaches* that combine the two committee types were seen as beneficial.
Organizational representation	• There is a vast number of potentially relevant organizations across the city that could participate. Sectoral representation may be more important and effective than organizational representation. • A mechanism should connect and build upon existing tables and initiatives that have similar mandates and objectives. • Representation of governmental funders at the governance level of SR was considered critical to increase buy-in and to communicate community needs. • Membership must be composed of organizational managers and leadership to ensure that decision-making has appropriate authority.
Geographic Coverage	• There are challenges in instituting a SR mechanism regionally (e.g., by city quadrants). Services across mental health and justices sectors operate differently in different areas of the city. Many individuals with complex needs are transient and may need to touch services across multiple places across the city. • There was endorsement for a hybrid approach wherein the SR table is less concerned with geographic placement but instead organized around an individual's particular needs (e.g., ad hoc meetings, drawing from a roster of relevant service providers).

Service Resolution Model Options

Based on our practice review and input drawn from our interviews and focus groups, three SR model options were articulated. The accompanying table describes the models and their strengths and weaknesses.

For details regarding SR model options, see Section 3.3.

Model	Description	Strengths	Weaknesses
Standing Committee Structure	• Two cross-sectoral standing committees each with additional ad hoc members as needed – an interagency case conferencing committee and a system case conferencing committee of directors • A SR coordinator brings cases to the committees upon demonstrating that the issue cannot be resolved locally. • Multiple tables would be required for full geographic coverage. Representation would need to align with geography, across the core sectors.	• Recommended for smaller systems with fewer organizations • Full control over the mandate, structure, governance. • Continuity of participation promotes ongoing collaboration. • Shared history of system innovations.	• Full representation of relevant organizations is challenging • Requires geographic parsing; decisions on divisions are unclear. • Relatively high cost to cover city (i.e., multiple tables, with staff) • Challenging to integrate with existing tables.
Ad Hoc Roster Structure	• Fully ad hoc committee based on presenting needs of each person; not organized by geography. • Organizations nominate members to a roster that feeds an interagency case conferencing committee. • System case conferencing committee has standing members who meet as needed for the smaller number of cases that cannot be resolved. • A cross-sectoral governing committee would provide oversight and ensure organizational participation.	• Greater flexibility within wide geography • Greater customization of services to match needs • Greater relevancy to member participation.	• Solutions may fall to agencies that have capacity and interest. • Difficult to maintain participation of members less frequently accessed. • Lack of continuity in membership, decisions, and practices.
Brokering Structure	• No distinct, separate SR mechanism. • SR coordinator formally connects to existing SR-type tables throughout the city (and may sit as members)	• Uses existing infrastructure, resources, and commitments of	• Less control over the structure, process, and mandate of the function.

	• Brings individuals to the tables via referrals or are requested 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. • An additional system case-conferencing committee may be required if cases cannot be resolved at the other level.	other organizations. • Reduces duplication and confusion in the system; more efficient. • Builds capacity of other tables by mobilizing resources and expertise of specialized services.	• Existing tables may not match geographic need. • Existing tables may not share (enough of) the same mandate as SR. • Coordinator's role and influence could be diluted or downplayed.

The Recommended Model of Service Resolution

For details regarding the recommended SR model, see Section 3.4.

The project drew upon the above model types and feedback from the T-HSJCC and ABI Network to formulate a recommended model of Service Resolution. This model capitalizes on the strengths of the previously discussed models and limits their weaknesses, while also incorporating some of the stated needs and concerns of the provider community.

The recommended model incorporates the following steps, structure, and process

1. **Hire a dedicated Service Resolution Coordinator.**
2. **Establish a standing Interagency Service Resolution Committee** composed of supervisors/managers of the network of mental health and justice service organizations (MHJS).
3. **Augment the Interagency Service Resolution Committee with ad hoc members** from additional sectors and organizations as needed.
4. Adopt a **networked referral approach,** such that only the organizations from the MHJS network bring forward clients to Service Resolution. This helps focus on the mandate of the network, capitalizes on existing buy-in and commitment, and provides control over volume and flow of cases.
5. **Developing funding allocated to "Flex Funds",** which provides 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. A key role of the SR Coordinator will be to educate other provider partnerships regarding the purpose and mandate of the service and how it may be seen as an important resource to other interventions. Specifically, SR should formally connect to local Health Links in order to reciprocally share resources and care planning roles for people with complex needs. Note that relationships with other tables may require expanding the boundaries of the referral network.

Other Key Considerations

For details on these additional considerations when implementing a SR model, see Section 3.5

The recommended model should be implemented with the consideration of other key factors, including the following:

Governance: Service resolution is a collaborative system level intervention and therefore requires system level governance. A cross-organizational committee that represents the organizational membership of the interagency SR committee is recommended. The governance of service resolution must routinely connect into high level policy agendas and broad-based system discussions.

Organizational Commitment: Service resolution is effective only insofar as the committee members have the authority to speak on behalf of their home organizations. Participating organizations are expected to stretch their usual boundaries, explore innovation by taking some risks, and genuinely engage in service partnerships that expressed and supported on the ground. A multi-organizational terms of reference is recommended to lay out expectations, responsibilities, and obligations of membership among the standing committee members.

The "Service Resolution Coordinator": There are many moving parts in the Service Resolution process, covering system engagement and promotion, training, support to front-line work, information gathering and provision, scheduling and communication, and monitoring of service resolution actions. This role should first and foremost be established and appropriately resourced.

The need for member training: It cannot be assumed that prospective committee members have the requisite information and experience to engage in service resolution discussions. Member training is recommended.

Evaluating Service Resolution: An evaluation and monitoring function is critical to capture and reflect upon Service Resolution practices, system challenges, interventions, partnerships, and innovations.

See Appendix B for an example SR evaluation framework

Supportive housing and cycle of risk: While it can achieve positive impacts for people with complex needs, Service Resolution cannot solve chronic homelessness or address the problem of lack of housing options. Directing flexible funds to housing is a modest way for Service Resolution to improve housing status and is an important component of the service. In general, however, we emphasize that policy decisions to add, enhance, or improve health and social services are incomplete and far less effective without corresponding investment in housing.

The Costs and the Cost of Doing Nothing

There are two major cost outlays for service resolution and a variety of smaller costs that may be required. First, is the hiring of a service resolution coordinator (1 FTE), with an expected annual salary of $65,000 to $80,000/year. The second major cost outlay is the provision of flex funds, an optional but recommended component. A pilot flex fund of $20-$30 thousand would allow the function to understand needs and impact. Note, however, that other jurisdictions have much higher annualized funds (e.g., Waterloo-Wellington recently approved $100,000 per year).

Significant service gaps and barriers combined with the complex challenges of the intended users of Service Resolution are associated with extremely high service costs. These are monetary costs are associated with frequent and long hospital stays, and high use of emergency services, the justice system, and a wide range community based services that have been largely inefficient and effective. Without a focused, flexible, and coordinated response to meeting the needs of people with complex challenges, the human cost is much higher. It is hoped that Service Resolution can fulfil this objective.

See Section 3.6 for a discussion of the system costs associated with complex populations.