Building a Service Resolution Function in Toronto:

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

May 2015

PREPARED FOR

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

PREPARED BY

TaylorNewberry
CONSULTING

At TNC, our goal is to help organizations and communities generate the information, tools, and resources they need to improve their work and create strategic change. At TNC, we believe that:

- Information should be useful and should inspire clear actions.
- We share responsibility in the change process.
- Complex social issues require collective action. Our projects build meaningful connections between individuals, organizations, and communities.

For more information, please visit www.taylornewberry.ca

Suggested citation:

Newberry, J. & Brown, J. (2015). *Building a Service Resolution Function in Toronto: Recommendations for Meeting the Needs of People with Complex Mental Health and Addictions Challenges*. Guelph, ON: Taylor Newberry Consulting.

Table of Contents

Table of Contents 3
Acknowledgements 5
Executive Summary 6
Part 1 – Introduction, Concepts, and Practice Review 11
1.1 Project Purpose and Goals 12
1.2 What Is Service Resolution? 12
1.3 Defining Complexity in the Context of Service Resolution 14
1.3.1 Complexity and the Toronto Population 15
1.4 Existing Models of Service Resolution 17
1.4.1. Developmental Services – Community Networks of Specialized Care 17
1.4.2 Housing and Homelessness – "Whatever It Takes", Waterloo Region 17
1.4.3 Mental Health and Addictions Service Resolution – Waterloo-Wellington and Peel Regions 18
1.4.5 Ontario's Collaborative Risk Driven Community Safety and Well-Being Projects 22
1.4.6 Durham Region's Collaborative for Children and Youth Mental Health 23
Part 2 – Project Findings 25
2.1 Project Methods 25
2.2 Summary of Findings 25
2.2.1 Defining the Target Population: Circumstances of Individuals Who Could Benefit Most from Service Resolution 26
2.2.3 Current Practices and Initiatives to Address Complex Needs 30
Initiatives utilizing interagency case conferencing and service resolution 30
Tables focusing on System Planning and System Level Change 32
Informal Strategies and Efforts of Service Providers to Address Complex Needs 33
2.2.4 Designing a Service Resolution Mechanism in Toronto: Key Dimensions and Considerations 37
Response Levels 38
Standing versus Ad Hoc Membership 40
Organizational Representation 41
Sectoral Representation and Accountability 41
Connecting to and Leveraging Existing Initiatives 42
Key Players to Engage 43

Geographic Coverage 44
Referral Pathways 46
Staffing Role in Service Resolution 47
Part 3 – Service Resolution Model Options 48
3.1 Intended Users of Service Resolution 48
3.2 Referral Pathways into Service Resolution 49
3.3 Service Resolution Model Options 50
Model #1: Standing Committee Structure 50
Model #2: Ad Hoc Roster Structure 52
Model #3: Brokering Structure 53
3.4 Synthesis and Recommended Model of Service Resolution 54
3.5 Other Key Considerations When Implementing the Model 56
3.5.1 Service Resolution Governance 56
3.5.2 Organizational Commitment and Terms of Reference 57
3.5.3 The Central Importance of the Staff Role 58
3.5.6 The Need for Member Training 58
3.5.7 Evaluating Service Resolution 59
3.5.8 Supportive Housing and the Cycle of Risk 60
3.5.9 The Costs of Service Resolution 61
3.6 Conclusion: The Costs of Doing Nothing 61
References 63
Appendix A – Key Informant Interview Guide 66
Appendix B – Service Resolution Coordinator Job Description 68
Appendix C - Example Evaluation Framework for Service resolution 69
Evaluation Planning Table for Levels 1 and 2 69
Evaluation Planning Table for Levels 3 and 4 72

Acknowledgements

Taylor Newberry Consulting would like to warmly thank the following organizations, networks, and individuals for their important contributions to this work:

Paul Van de Laar, Cota
Charissa Levy, Toronto ABI Network / GTA Rehab Network / Rehabilitative Care Alliance
Steve Lurie, CMHA Toronto

Katie Almond, Ministry of Community Safety and Correctional Services
Mohamed Badsha, Reconnect Mental Health Services
Claudia Brabazon, Ministry of the Attorney General
Sandra Bricker, Toronto Network of Specialized Care
Kathy Chau, Canadian Mental Health Association, Toronto
Dianna Cochrane, Centre for Addiction and Mental Health
Domenica Dileo, Toronto Human Service and Justice Coordinating Committee
Susan Davis, Gerstein Crisis Centre
Deputy Chief, Mike Federico, Toronto Police Services
William Gapen, Griffin Centre Mental Health Services
Dr. Omar Ghaffar, Ontario Shores Centre for Mental Health Sciences
Stephanie Gloyn, Centre for Addiction and Mental Health
Sue Goodfellow, City of Toronto
Robin Griller, Health Link, Mid-East Toronto
Lynn Hillman, Fred Victor
Alison Hunt, The Access Point
Jessica Lee, Canadian Mental Health Association, Toronto
Dr. Carolyn Lemsky, Community Head Injury Resource Services
Dr. Molyn Leszcz, Mount Sinai Hospital
Lori Lucier, Toronto Central Local Health Integration Network
Steve Lurie, Canadian Mental Health Association, Toronto
Susan Meikle, Toronto North Support Services
Tory Merritt, Health Link – North York General Hospital
Linda Mohri, Centre for Addiction and Mental Health
Judy Moir, Community Head Injury Resource Services
Jim Nason, LOFT Community Services
Linda Ngan, Toronto ABI Network
Julie Osbelt, Toronto ABI Network
Adair Roberts, Adair Roberts & Associates
Dr. Sylvain Roy, Inner City Family Health Team; Centre for Addiction and Mental Health
Patricia Pagnani, Toronto Bail Program
Frank Sirotich, Canadian Mental Health Association, Toronto
Vicky Stergiopoulos, St. Michaels Hospital

We would also like to thank the the following organizations for helping to organize our focus groups: Central Toronto Youth Services, Cota, Toronto Acquired Brain Injury (ABI) Network, Toronto Human Services and Justice Coordinating Committee, and Toronto Network of Specialized Care.

Executive Summary

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 or 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 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.

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

- 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.
- 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 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 geographically. • 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) • 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.	• Uses existing infrastructure, resources, and commitments of other organizations. • Reduces duplication and confusion in the system; more efficient. • Builds capacity of other tables by mobilizing resources and expertise of specialized services.	• Less control over the structure, process, and mandate of the function. • 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

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.

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

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.

Part 1 – Introduction, Concepts, and Practice Review

In *Open Minds, Healthy Minds,* the Government of Ontario (2011) advanced a mental health and addictions strategy with four priority goals:

1. Improve mental health and well-being for all Ontarians.
2. Create healthy, resilient, inclusive communities.
3. Identify mental health and addictions problems early and intervene.
4. Provide timely, high quality, integrated, person-centered health and other human services.

The last goal focuses on timely access to the "right mix of supports" and requires a transformed mental health and addictions system that is seamless, coordinated, and integrated. Many Ontario communities have taken great strides in building integrated service systems that attend to the interplay of social determinants of health. Organizational and sectoral boundaries are becoming far less rigid through planned cross-sectoral partnerships and collaboration. In a social determinants of health framework, health care is coordinated with a range of social and community-based supports to address housing, income security, justice services, education, employment, family context, and many other important factors affecting health and well-being (World Health Organization, 2008). In short, health outcomes are not solely impacted by health care but by varied social and environmental influences.

Provincial ministries have also been acutely interested in how health and social service systems meet the needs of individuals with particularly complex needs. Recent estimates suggest that about 5% of the population accounts for 61% of hospital and home care costs in Ontario (Rais, et. al, 2013). Among this 5% are individuals suffering from acute and chronic mental health struggles combined with other deleterious conditions and experiences. The "right mix of supports" for this subgroup is often hard to discern and, even more concerning, the health and social service systems do not have the capacity to fully meet the need. The outcomes are sobering – people with complex needs often experience housing instability and homelessness, income insecurity, and elevated risk of harm to self or others. They tend to be high users of emergency and hospital in-patient and Alternative Level of Care (ALC) services (Butterill, et al., 2009). They are more likely to experience criminal charges, the court system, and incarceration. These outcomes represent high costs for health care and justice systems; the human cost is much higher

Human Service and Justice Coordinating Committees (HSJCC) have been established in communities across Ontario to directly address the need to enhance the coordination of services to meet the needs of people with mental health and addictions struggles who are in conflict with the law. In the City of Toronto, the local committee (T-HSJCC) recognized an acute need to examine service coordination for individuals with more complex needs. To support this mandate the T-HSJCC Complex Care Sub-Committee (herein referred to as "the Sub-Committee") was established in collaboration with the Toronto Acquired Brain Injury (ABI) Network. The Sub-Committee's focus is on individuals 16 years or age or older with cognitive and/or physical disabilities and mental health needs who the service system has not been able to adequately support. These individuals often experience co-occurring needs across multiple sectors including mental health, substance use and addictions, acquired brain Injury, dual diagnosis, developmental disabilities, housing, and criminal justice.

In 2014, the Sub-Committee began investigating the creation of a *service resolution* process to help meet the needs of their priority population. Taylor Newberry Consulting[2] was contracted to conduct a needs assessment to determine the scope, structure, and implementation of a service resolution mechanism in Toronto. Part 1 of this report describes the project goals and provides a background review of the practice literature relevant to models of service resolution. Part 1 also discusses the concept of complexity and how it relates to service resolution. Part 2 reviews our findings from focus groups and key informant interviews with local providers and system leaders in Toronto regarding the need, scope, structure, and process of service resolution. Part 3 provides model options for a service resolution mechanism in Toronto, along with key issues associated with implementation.

1.1 Project Purpose and Goals

The purpose of this project was to engage the cross-sectoral provider community in Toronto to gather feedback and input regarding the creation of a service resolution mechanism. It was assumed that several different options for creating a service resolution model may be possible in Toronto's context, all of which needed exploring. Any chosen model would need to meet the needs of people with complex mental health and addictions challenges who are in conflict with the law. It was recognized that this population would be more likely to have co-occurring challenges, such as developmental disability, ABI, and other difficulties.

The Sub-Committee outlined the goals of the project as follows:

4. To define the target population that would benefit from a service resolution process, including common presenting issues/needs and experiences/challenges in accessing services and supports.
5. To describe the characteristics, structure, processes, and intended outcomes of existing models of service resolution.
6. To provide recommended model or models of service resolution appropriate for the Toronto context, including recommended staffing roles, structure, governance, and coordination with other similar tables and initiatives in the city.
7. To review potential models in the context of Toronto's service system with recommendations on how service resolution will promote cross-sectoral integration and align with the provincial and local priorities of health and justice.
8. An approximate cost estimate of adopting a service resolution process and evidence of impact should no action be taken to address the needs of people with complex challenges.

We begin with some key guiding definitions and concepts related to service resolution.

1.2 What Is Service Resolution?

Service resolution is an approach to creative problem solving and customized service access for people with complex needs. It has been adopted in a number of social service sectors including developmental services, child welfare, supportive housing, and more recently in mental health and addictions sectors.

While models can be structured in a variety of ways, the common feature is that a service resolution committee (often called a "table") is composed of high level managers representing a cross-section of organizations from multiple health social service sectors: mental health, addictions, justice, developmental services, ABI, child and family services,

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

and range of others. 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. Service resolution is efficacious because the members around the table are decision-makers. They have the power, leverage, and organizational endorsement to enact a range of customized decisions to meet the needs of the person in question. In turn, front-line providers are given direction and license to proceed with a support plan that they would not otherwise have the authority to carry out. Solutions are most often collaborative and cross-organizational and the table sets expectations on how their corresponding organizations will be expected to participate.

It should be emphasized that service resolution is not intended for the general population of people with mental health and addictions needs. It targets a smaller number of individuals with highly complex and exceptional needs that cannot otherwise be met by the existing service system. In the next section we go into more depth about what is meant by complexity and its relevance to service resolution models.

Service resolution is often confused with "case conferencing" and sometimes the terms are used interchangeably. There are important differences, however. Case conferencing is typically initiated by human service workers under circumstances when support and care are not effective and a more collaborative cross-organizational approach is necessary. The effectiveness of case conferencing largely relies on the relationships and partnerships that have been created, nurtured and sustained on this front-line level. It often only works to the extent that the primary worker is well connected, dedicated, and persistent. However, it can be limited by systemic barriers that the case-conferencing has little influence over. When the influence of case conferencing is limited, service resolution is capable of circumventing such barriers. Table 1 provides a comparison between both types of interventions to illustrate these differences.

Table 1 – A Comparison of Case Conferencing and Service Resolution

CASE CONFERENCING	SERVICE RESOLUTION
INITIATED BY PRIMARY WORKER.	INITIATED BY A COORDINATING STAFF PERSON ON BEHALF OF PARTNERS.
TYPICALLY COMPOSED OF FRONT-LINE WORKERS.	WHEN LOCAL CASE CONFERENCING IS INEFFECTIVE, SERVICE RESOLUTION IS COMPOSED OF HIGH-LEVEL MANAGERS REPRESENTING THE SYSTEM.
EFFECTIVE IF THE PRIMARY WORKER IS WELL-CONNECTED, DEDICATED, AND TENACIOUS.	EFFECTIVE BECAUSE WORKERS IN SYSTEM ARE ACCOUNTABLE, THROUGH THEIR ORGANIZATIONS, TO SERVICE RESOLUTION.
FALLS SHORT WHEN SYSTEM BARRIERS ARE BEYOND THE CONTROL OF CASE CONFERENCE.	HAS THE POWER AND POSITION TO ENTER ORGANIZATIONAL AGREEMENTS, BEND POLICIES, MAKE EXCEPTIONS, MODIFY PROGRAMS.
ACTIONS AND OUTCOMES ARE MOST OFTEN NOT CAPTURED BY THE SYSTEM.	ACTIONS AND OUTCOMES ARE CONTINUALLY COLLECTED TO INFORM SYSTEM IMPROVEMENTS.

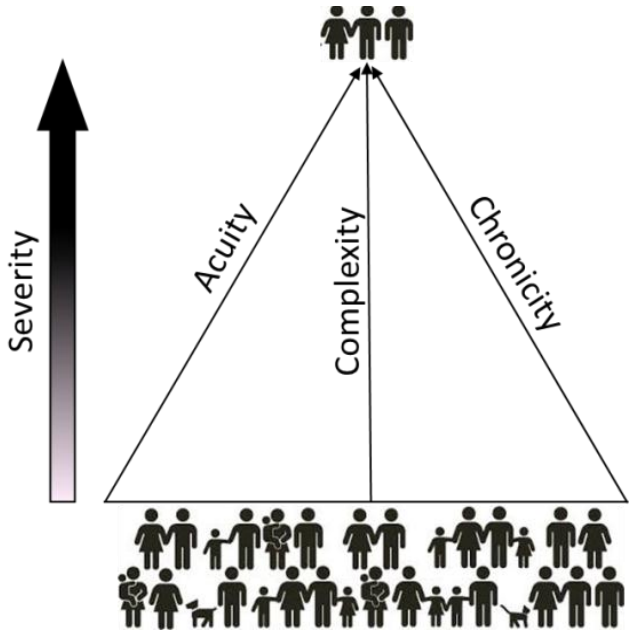
It should be noted that case conferencing remains a best practice and indispensable feature of a well-functioning system. Service resolution should be considered an option only after other avenues have been explored at the front-line, including problem-solving through case conferencing.

Another major difference between the two approaches is that service resolution is designed to "speak for the system." Service resolution is often misunderstood or misrepresented as an individualistic intervention. It is, of course, focused on customized, person-centred planning for users; however, it is effective precisely because it strategically mobilizes collaborative partnerships and innovative responses. Over time these responses begin to change practices *systemically* – interrelating organizations begin to do things differently. System change emerges organically as a result. The membership – high level managers and executive directors – represents a collective that not only directs flexible changes to services, but can enter into multi-organizational agreements to enhance the continuum of services. We have heard many examples of situations that would normally go to service resolution being managed within new practices and partnerships that evolved from service resolution actions.

1.3 Defining Complexity in the Context of Service Resolution

In mental health and addictions systems, and health systems more generally, complexity is a term that is used liberally by practitioners and policy makers. Generally, the intent of the concept is to distinguish individuals with higher and more challenging needs from the larger population of service users. But the concept is a moving target depending on the service context. The extent to which a person is complex is not easily separated from the capacity of the service system to meet their needs. An individual may be considered complex within a local community that lacks capacity, resources, expertise, and an integrated system of care; that same individual may have their needs met in another community that possesses such assets. While individuals may experience risk and vulnerability due to their presenting health conditions and social circumstances, such risk and vulnerability is similarly attributable to a system that fails to effectively respond. Complexity, then, must be understood in relation to individual needs in interaction with the array of supports that a person is able – or unable – to access.

Figure 1 – Complexity and Severity by Population (adapted from Rush, 2010)



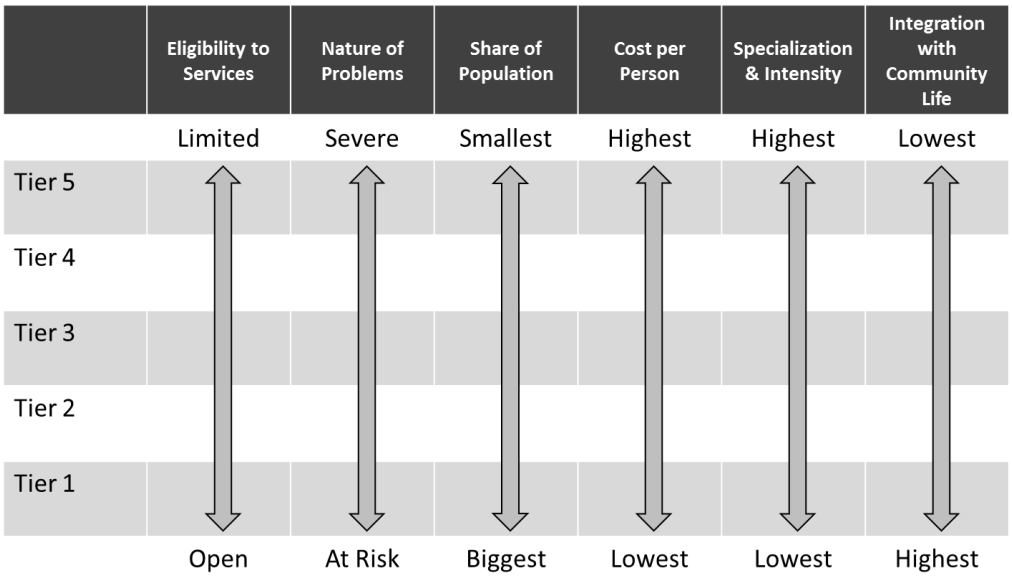
There have been a number of frameworks created to help clarify and define complexity. Typically definitions of complexity identify the co-occurrence of multiple health conditions, psychosocial challenges, and service access challenges as indicative of complexity. For example, Reist and Brown (2008) attempt to clarify the severity of health conditions by articulating three interrelated dimensions: acuity, chronicity, and complexity (see Figure 1).

Acuity refers to the short-term, punctuated risk and urgent negative consequences of a condition. Chronicity refers to the continuous, long-term, and often worsening burden of a condition. Complexity refers to the co-occurrence of acuity and chronicity in combination with deleterious social determinants of health, such as poverty, homelessness, family dysfunction, and so on. For example, a person may

have chronic diabetes punctuated by acute attacks that are not properly self-managed due to mental health and addiction challenges. If there is poverty and isolation in addition, this person's needs will be particularly complex. Emergency service use will tend to be high, while use of other health and/or social programs may be low.

Consistent with recent health policy, a definition of complexity should serve to narrow the population to identify citizens who need specialized care and who account for much more, proportionately, of health care expenditures. Rush (2010) reviews a number of frameworks designed to illustrate "tiered" models of health care, ranging from universal health interventions to highly specialized interventions, where the latter represent a relatively small number of people with complex needs. We draw heavily from Rush's review as it is comprehensive in laying out the key definitional issues surrounding complexity.

Figure 2 - Criteria for Defining Tiered Substance Use Treatment Responses (adapted from Rush, 2010)



Tiered health frameworks have their roots in the early language of primary, secondary, and tertiary interventions (Caplan & Caplan, 2000). They been since been refined and elaborated to describe severity, risk level, intensity of interventions, and other elements that together suggest different levels of care for different groups of people.

Rush presents a set of key criteria that helped to designate the tiers in a national treatment strategy for substance abuse services in Canada (see National Treatment Strategy Working Group, 2008). These are displayed in Figure 2.

The national treatment strategy described Tier 5 as "intended to address only the needs of people with highly acute, highly chronic, and highly complex substance use and other problems, for whom lower-tier services and supports are inadequate". Tier 5 appears to align with the expressed mandate of service resolution, where individuals with severe health difficulties have limited eligibility to services and require intensive levels of specialized support. They are often isolated and disconnected and represent a small proportion of the population.

1.3.1 Complexity and the Toronto Population

It is extremely difficult to reliably estimate the size of the population that would be appropriate for service resolution. Individuals with complex needs as described above are often transient and are connected to services systems in inconsistent ways. People with complex needs may also be adequately supported at any given time but their life and health circumstances can change dramatically and quickly, such that existing supports are no longer enough. The best we can do is attempt to assess needs at key juncture points in our health and social service systems.

The Toronto Central Local Health Integration Network (TC LHIN) has identified addressing the needs of complex health populations as a key priority (TC LHIN, 2013a) . In TC LHIN policy statements, complex health populations refer to individuals who have any of the following:

a) multiple, chronic physical or mental health conditions;
b) psychosocial challenges related to homelessness, poverty or social isolation; *or*
c) challenges accessing outpatient and community health care services and/or high utilization of emergency department and inpatient services.

This definition may be a little too inclusive as each criterion on its own constitutes "complexity."[3] Sirotich and Durbin (2014) found that 87% of adult case management users and 83% of housing support users in Toronto would be considered complex under such a definition. The authors utilized OCAN data to specify level of need (low, medium, and high) and the extent to which needs were met. They found that 72% of the low need group had all their needs met; 42% of the medium need group had all their needs met; and 25% of the high need group all their needs met. This latter group gets us closer to what we mean by complex needs. Again using OCAN data, the authors operationalized "high health complexity", defined as co-occurring mental health and other conditions; *and* high heath care utilization or criminal involvement; *and* low income or (risk of) homelessness. Those fitting this profile accounted for 4% (69) and 3.4% (23), respectively, of the total samples of case management and housing support users. These proportions clearly underestimate need; these numbers do not include individuals who are unconnected to formal services. However, it is nonetheless a useful proportional estimate among people with mental illness in the city.

Data from other juncture points can shed light on this population. Frequent emergency department visits for mental health and addictions issues is a useful proxy for complexity. Recent research has defined frequent ED users as those who have 4-5 or more visits to an ED annually[4] (Dawe, 2011; Newberry, 2014a). In a 3-month snapshot, 8.2% of emergency department (ED) visits in seven Toronto hospitals were associated with mental health and addictions (Dawe, 2011). Among these same emergency departments, about 2% (about 400 people) of frequent users made 21 or more visits. This group accounts for 20% of all ED visits among people visiting at least once for a mental health and addictions related concern (Stergiopoulos, 2014). According to Sirotich and Durbin (2014) cited above, 6.1% (126) of people receiving case management services met the criteria of frequent ED use.

Another relevant system pathway is the array of justice services that coordinate with the mental health and addictions system. People with mental illness are over-represented in the criminal justice system, with 45% of male inmates and 69% of female inmates receiving mental health services in federal prisons (Sapers & Zinger). The Ministry of Community Safety and Correctional Services (MCSCS, 2008) reports that 15% of inmates required a clinical intervention for mental illness within Ontario's provincial corrections facilities (for those awaiting sentencing or serving less than 2 years). MCSCS also reported that mental illness is prevalent among those in remand. Estimates of mental illness and addictions will tend to be underestimated in prison populations due to inadequate and inconsistent screening practices.

[3] While this inclusive definition appears in TC LHIN's IHSP for 2013-2016, a more refined and narrow definition was adopted in other planning documents (TC LHIN, 2013b), following the work of Schaink et al. (2012).

[4] [4] Lecalle & Robin (2009) suggest 4 visits per year as the minimum cut-off of "high ED use" based on the sample mode of several reviewed studies. Hunt et al. (2006) used 4 visits per year since this number accounted for 25% of all ED visits, which was considered an administratively significant number.

People living under particularly challenging and oppressive circumstances – like experiencing severe mental illness and addictions while homeless – are more likely to be come in contact with police and enter the justice system. If incarcerated, suitable supports are most often lacking and the prison environment can exacerbate mental health difficulties. When discharged from prison, former inmates often lack resources and connections to meet their needs and often are confronted with homelessness or housing instability, putting them at risk of contact with the justice system once again. Inconsistent (or absent) discharge planning makes it very difficult to estimate the prevalence of people re-entering the community who have mental health needs.

Complexity will be revisited in detail in relation to our key informant interviews and focus groups. Feedback from local providers along with concepts from the literature will help us generate a definition of complexity that can guide the priorities of service resolution (see section 3.1 *Intended Users of Service Resolution*).

1.4 Existing Models of Service Resolution

A selection of existing models of service resolution were reviewed in this project in order to better understand local practices and how they may inform the Toronto context.

1.4.1. Developmental Services – Community Networks of Specialized Care

A good place to start is the developmental services sector, which has been an early adopter of service resolution in Ontario. Four networks of specialized care (North, South, Central, and were established by the Ministry of Community and Social Services, each with a mandate to coordinate specialized service systems, enhance service delivery, and train and build capacity in their communities. Each network engages in training, education, knowledge transfer, service/system improvements, and policy analysis; and they also each engage in service resolution for individuals with developmental disabilities and their families who are unable to access the services they need.

We can use the Central Network of Specialized Care (CNSC) as an example. The CNSC is further subdivided into Central East (CE CNSC), Central West (CW CNSC) and Toronto (TO CNSC). All three of these networks promote local case conferencing to resolve challenging access issues. To illustrate, TO CNSC held 29 clinical conferences (2013-2014) that included family members, teachers, physicians, police services, justice services, social service providers. Systemic challenges included a lack of high support housing for transitions from treatment, hospitals, and prison; a lack of long-term clinical support;, and a lack of supports when transitioning from youth to adulthood (Community Networks of Specialized Care, 2014). When cases are particularly complex, each network has the option to bring cases to a higher level service resolution committee.

1.4.2 Housing and Homelessness – "Whatever It Takes", Waterloo Region

Service resolution-type models have also been developed in the housing stability sector. For example, Region of Waterloo Social Services and its community partners implemented a *Supports to End Persistent Homelessness* (STEP Home), a cluster of community programs that attempt to secure housing for individuals experiencing persistent homelessness.[5] This is part of larger "homelessness to housing stability strategy" that has federal, provincial, and regional funding contributions approaching $7.6 million per year (Social Planning, Policy, and Program Administration, 2012).

[5] See http://communityservices.regionofwaterloo.ca/en/communityPlanningPartnerships/homelessnesstohousing.asp

Whatever It Takes (WIT) Service Resolution, a program of STEP Home, regularly brings together a range of service providers to solve systems barriers to achieving stable housing.[6] It is a highly person-centred program that looks for creative and innovative solutions to homelessness experienced by a small number of individuals in the community (e.g., in 2010 the program served 34 people). If housing instability is particularly complex or entrenched, the strategy may move from front line coordination meetings to higher level interagency planning of system level planning meetings. WIT also utilizes flex funding, discretionary funds that can be utilized to securing housing. The annual flex funding pool is approximately $50 thousand per year (Social Planning, Policy, and Program Administration, 2011).

In addition to ongoing front-line partnerships and actions, WIT also brings ongoing information on barriers to a systems-level reference group comprising multiple programs, services, and organizations. This program has the resources and leverage to enact changes to organizational policies and practices to redress a host of systems/service barriers.

1.4.3 Mental Health and Addictions Service Resolution – Waterloo-Wellington and Peel Regions

With leadership from a multi-organizational committee of local providers, a service resolution mechanism for mental health and addictions was developed for Waterloo Region and Wellington County (which together forms the Waterloo-Wellington LHIN). This model was designed to:

- Promote and support service coordination among the service providers.
- Provide a point of contact for individuals/families and service providers who are having difficulty accessing services due to the complexity or uniqueness of a person's needs.
- Advocate for individuals at the system level when existing resources are not meeting their needs.
- Resolve service barriers and assist with transition to the appropriate level of service.
- Identify gaps in service and communicate this information to pertinent service system planning groups through program evaluation and quality monitoring.

A central component to the success of this model is the "Service Resolution Facilitator" (similar roles are elsewhere called "Coordinator" or "Navigator"). This staff role is a distinct and unique position accountable to the system in general and to the service resolution executive committee composed of cross-sectoral organizational leaders. The facilitator has multiple roles and functions, including:

- Serving as the central point of contact to service resolution.
- Providing education, training, and support to organizations and front-line workers.
- Building connections and relationships between providers.
- Bringing situations to the service resolution mechanism.
- Coordinating and managing interagency service resolution.
- Following up and supporting service resolution actions.
- Compiling ongoing case-level data regarding common service barriers and service resolution responses.

[6] See http://www.lutherwood.ca/housing/services/whatever-it-takes-wit-service-resolution

Importantly, the Service Resolution Facilitator (as originally envisioned in this model) is *not* to assume a short-term case management position, nor is it to function as designated navigator/advocate vis-à-vis local organizations. Rather, the role is to provide support to front-line providers, coordinate and manage the referrals and accompanying information into the mechanism, and to coordinate the committees so that decisions/solutions can be collectively generated. These roles are described in the next few sections.

In this model, there are five interrelated levels of response as pictured in Figure 3 below. This model is particularly important to our discussion since it very clearly articulates the different components of service resolution function. It is discussed in detail below.

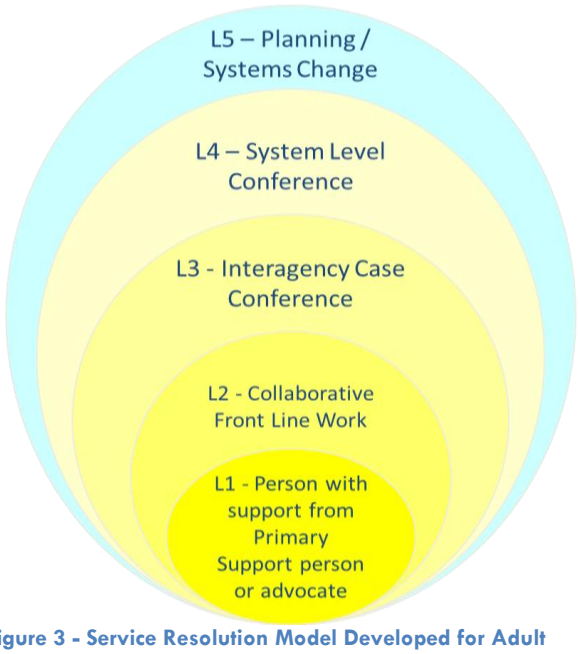


Figure 3 - Service Resolution Model Developed for Adult Mental Health and Addictions in Waterloo-Wellington

Levels 1 and 2 are not formal components of service resolution but are assumed as core activities of a well-functioning mental health and addictions system. Level 1represents a person-centred circle of support with a core individualized service such as case management or ACT focused on principles of recovery and wellness. The large majority of individuals with serious mental health issues can be supported in Level 1. When an individual experiences multiple or intensified needs beyond what can normally be supported, collaborative front-line work (Level 2) is required. Primary workers initiate connections with other providers to identify collaborative solutions, such as case conferencing. In the Waterloo Wellington model, Levels 1 and 2 are supported by the Service Resolution Facilitator, who ensures that local collaborative solutions are attempted first before moving to service resolution. Within these levels, the facilitator educates the provide community regarding the role of service resolution, and may help organizations pull together case conferences.

Level 3 – Interagency Case Conferencing represents the formal initiative of service resolution. When service barriers are too persistent and systemic for Level 2 to arrive at solutions, Level 3 is triggered. At Level 3, a committee of front-line providers and mid-level managers/supervisors is assembled to plan coordinated services and to address barriers to access. The Level 3 committee is in part a standing committee - to ensure there is continuity in decision making and ongoing system learning – and in part, ad hoc, with other members invited based on the presenting needs of the individual.

We find the use of "case conferencing" to label Level 3 to be somewhat confusing; case conferencing should be a term reserved for front-line collaborative problem solving, and not used to describe the activities of a service resolution committee. In the remainder of this document we instead use the term "**Interagency Service Resolution Committee**" or, in short-hand, "**Interagency SR Committee.**"

The Interagency SR Committee functions to organize resources and establish roles, responsibilities, and agreements of members to engage in a range of actions, including:

- Identify a worker (if one has not already been identified by the Service Resolution Facilitator).

- Obtain a diagnosis.
- Assess risk to self or others.
- Prioritize the individual for mental health service access.
- Access other service sectors and systems (e.g., housing, health, etc.)
- Gain admission to programs that have been difficult to access (due to past history, eligibility, or other barriers)
- Develop and coordinate a support plan.

The presence of supervisors/managers functions as a form of organizational endorsement of the plan, and therefore a greater degree of accountability to collective actions. It also allows for greater flexibility in securing needed resources, modifying procedures, and "bending" policy and practices as necessary. Just as important is the agreement among supervisors/managers to provide resources and accommodation to their staff to fulfill their roles on interagency service resolution and in relation subsequent action plans.

The role of the facilitator is to help identify to gather comprehensive information regarding the individual and their circumstances to bring to the table, including potential options to name a primary worker if none currently exists. The facilitator also identifies and connects to the range of relevant organizations that should be assembled given the person's needs. The role also includes chairing meetings, documenting shared information and decisions, following up on actions and their effectiveness and, if necessary, reconvening the group to modify and continue planning.

Level 4 – System Level Conferencing is enacted when Level 3 fails to yield workable and effective solutions to the presenting situation because service barriers persist. Relatively speaking, Level 4 is a rarely utilized component of the service resolution mechanism. The Level 4 committee is a standing committee of executive level leaders from a core partnership of multi-sector providers. This group has the organizational power and resources to stretch the mandate of their services, develop/modify programs to meet the individual needs, and enter into service agreements. Decisions are effective because they are formalized and introduce expectations and accountability within front-line programs. The role of the facilitator is to bring situations forward to this committee with a detailed rationale as to why this level of intervention is required. The Level 4 committee may also invite ad hoc members when relevant.

*In the remainder of this document, we refer to this Level as a "**system service resolution committee**" or, in short-hand, a "**system SR committee**"*

Level 5 – Planning and Systems Change is an executive level committee that provides governance and direction to the SR mechanism. It is the only level that is not focused on individual level situations but on addressing systemic challenges in the system. This committee functions as the collective "voice of the system" and thus plays a planning role in system policy development and advocacy, funding procurement, program and initiative development, research, and knowledge exchange. Where possible this committee connects to relevant policy tables and funding bodies connected to the system. It is noted that this high level mandate may be shared – or conceded to – other local system tables that are already doing this work and to which members of Level 5 are already connected. What is crucial is that the information from Levels 1-4 (especially 3-4) is captured, distilled, and synthesized so that the committee can use this information for system improvement purposes. A key role of the facilitator is to compile this information for this evaluative purpose.

And additional feature of the Waterloo-Wellington model is the availability of **Flex Funds**, a pool of money set aside for discretionary use to meet individual needs. Uses may be tied to addressing emergency circumstances such

as short-term accommodations, medication, food, and transportation; or to individual planning support, such as assistive aids and devices and the purchasing of uninsured social services.

The Peel HSJCC in Peel Region adopted the Waterloo Wellington model with little variation. Currently two service resolution coordinators are operating for adult mental health and transitional aged youth, respectively, and are housed at CMHA Peel. We spoke to representatives from both Peel and Waterloo-Wellington to gather their perspectives on how the models have evolved, where there have been challenges, and how practices have departed from the initial model.

- **Community education about the goals and process of SR**, especially to providers, is a crucial element to its success of service resolution. In Peel, many initial requests were inappropriate and represented a misunderstanding of the function. For example, some providers assumed service resolution was a referral option that would then "take over" the primary support for the individual, rather than understanding that the referring organization will typically play a central role. Organizational level education and buy-in to the function is necessary, from management down to the front-lines is necessary.

- **Facilitators spend the majority of their time providing education and support, and creating connections between providers.** Local providers very often need support in problem solving with existing resources and building case conferencing processes with their community partners before considering their situations for formal service resolution. In Peel, this type of local system support accounts for about 80% of the facilitators' role.

- In Peel, **some providers felt underused as standing committee members and began to wonder if regular meetings were an inefficient use of their time**. In response, they have shifted Level 3 to an "ad hoc roster" structure from the original standing committee. Providers commit to participate, be named to a larger roster, and set aside a regular meeting time in which they may be called to attend. In Waterloo-Wellington, this structural change has not be been formalized, but an ad hoc approach is beginning to happen by default.

- Facilitators recognized the risk of **slipping into a short-term primary worker role** in order to meet immediate needs and to enact table decisions. In Waterloo-Wellington, it was conceded that this can often happen and that the facilitator engaged in a significant amount of advocacy to get services into place. This suggests that the committee and oversight structure has become less active. The intended design of the model is for a cross-organizational management group to instruct the customization of services, rather than rely on the requests of the facilitator.

- **"Flex funds" are considered a key component of the SR** and are attractive to the community of providers, as discretionary funds are rare in social services. Funds can be used to purchase a range of assessment, treatment, and support services, which is often the first step in overcoming many system-level barriers.

- Planning and implementation of the service resolution model can be **challenging when there are other similar initiatives in the local community**. In Waterloo-Wellington, service resolution for mental health

operates alongside service resolution for developmental services, three tables focused on addressing elevated risk (the Prince Albert Hub model – discussed below), a table focused on people with concurrent disorders, and other collaborations that are attempting to provide enhanced wraparound care for people with complex needs. A similar context was observed in Peel and in response the community has since developed "System-Wise", a network which markets similar initiatives together, with protocols established to match inquiries to the right table based on presenting need and geography.[7]

- The facilitators are the "front-door" of service resolution – they receive requests for service resolution from providers and community members. In Peel, the narrowed the pathways into the service at the outset, starting with referrals only from a defined network of mental health and justice diversion services. This was to pilot the service resolution process and practices. Access has since been opened up to the broader community. Referrals in Waterloo-Wellington are similarly open.

The mental health service resolution functions in Waterloo-Wellington and Peel Regions are solely funded by their corresponding Local Health Integration Networks. However, we are aware of other cross-ministerial funding arrangements. For example, a service resolution position in Waterloo-Wellington focused on children with developmental disabilities and/or mental health difficulties, as well as adults with developmental disabilities, is co-funded by Ministry of Children and Youth Services and the Ministry of Community and Social Services.

The cost outlays are primarily associated with the salaries of the service resolution position, corresponding to 1 FTE position. Given the required qualifications of this position (see section 3.5.3 and Appendix B), yearly salaries can be expected to be between $70 and $80 thousand. Flex funds in Waterloo Wellington were initially annualized at $50 thousand and have recently been increased to $100 000. To our knowledge, flex funds are still in development in Peel.

1.4.5 Ontario's Collaborative Risk Driven Community Safety and Well-Being Projects

Prince Albert Police Services (in Saskatchewan) initiated partnership development with community-based organizations in order to forge a more coordinated response to manage serious, elevated risk among particularly vulnerable community members. In 2011, "Community Mobilization Prince Albert" – also known as the "Hub Model" was established and has since been adapted in Ontario by the *Ontario Working Group for Collaborative Risk Driven Community Safety and Well-Being*. A number of communities have recently developed this model (in Ontario, termed "situation tables") including Cambridge, Brantford, Guelph, Halton Region, Kitchener-Waterloo, North Bay, Peel Region, Rexdale, Sudbury, Guelph. It is a similar model as service resolution, with some minor but important differences. These initiatives have been resourced by one-year funding from the Ministry of Community Safety and Correctional Services *Proceeds of Crime Front Line Policing Grants*. Grants for situation tables vary but most communities receive approximately $100 000 to develop their local models and local engagement strategies.[8]

Like service resolution, situation tables have a multi-organizational and multi-sectoral membership of police services, other justice services, mental health and addictions, children and youth services, school boards, hospitals, emergency

[7] http://peel.cmha.ca/programs_services/systemwise/

[8] See http://news.ontario.ca/mcscs/en/2014/11/backgrounder---proceeds-of-crime-front-line-policing-grants.html for a listing of the initiatives.

shelters, housing, and others. Situation tables are standing committees with consistent membership that meet weekly; representatives tend to be a mix of front-line workers and supervisors.

The intentions of situation tables are slightly different from service resolution. Situation tables are concerned with the immediate alleviation of elevated risk (note that this is different from imminent risk, which is considered potentially dangerous and more properly addressed by crisis and/or emergency services). Committee members bring forth situations (cases) to the table directly, via their own front-line work, when individuals they serve are in particularly risky circumstances that could quickly degrade into crisis or harm. The committee then strategizes on ways to address the immediate risk and what organizations should be involved. The goal of situation tables is to connect the individual to services that can help meet their immediate needs and mitigate risks. Once this connection to services is confirmed the situation is "closed" – it then becomes the responsibility of the relevant services to provide their supports. For a detailed description of these practices see Nilson (2014).

In contrast, service resolution is not solely focused on mitigating risk, although that certainly is a component – it is focused of developing a fulsome wraparound service and support plan. In principle, service resolution builds a plan that the table – and the front-line workers – are accountable to, and which may require flexing eligibility requirements and other program policies. Situation tables, in contrast, are concerned with immediate risk mitigation and do not provide oversight to the development of subsequent service plans. Tables may not have representatives in positions that can make organizational level decisions that are often necessary at service resolution, primarily because front-line workers are needed to identify and bring forth situations.

The models are more similar than different however. Some tables (e.g., "Connectivity" in Cambridge and Kitchener) have expressed interest in moving beyond immediate risk reduction to more exploring more comprehensive health promotion planning.

1.4.6 Durham Region's Collaborative for Children and Youth Mental Health

Through an extensive community collaboration led by the Centre for Addictions and Mental Health (CAMH), Durham region identified service resolution as a promising model for addressing challenges of children, youth, and their families. The model, called the "Durham Collaborative Planning Process", is quite similar to other service resolution models we have described; however, some elements vary and are instructive.

An interesting departure is that the collaborative decided to dispense with the concept of complexity – or at least the label and its attendant definitions. The rationale was that the term was overused and defined in too many different ways. In lieu of using complexity as a criterion for the service, the collaborative focused upon the families' connection and experiences with the system, which serves as a sort of proxy indicating complexity. To qualify for collaborative planning, the child/youth must be under 18 years of age and a resident of Durham; but also must:

- Not be in immediate crisis.
- Already be connected to local services and has attempted to access the full continuum of available supports in the local system.
- Has attempted case conferencing to collaboratively meet service needs.
- Be likely to benefit from cross-sectoral community expertise and supports.

In terms of structure, the collaborative has named representatives from local cross-sectoral agencies – called "champions" – who bring situations to the table. A dedicated coordinator collects the information from champions and

forwards it to a "triage subcommittee" that vets the referrals. A core group of standing committee members is joined by ad hoc members who all sit on a roster that is called upon to participate based on the presenting needs of a given client. Members are mid-level managers from organizations that have committed to the collaboration.
Durham has also introduced a train-the-trainer element wherein champions receive 2-day training on the structure, function, and goals of the table. They are charged with training and communicating with their front-line workers to ensure that the criteria for referral are fully understood and that prerequisite steps are taken before a referral is made.

There are of course other examples of service resolution type initiatives and some of these will be discussed further in relation to the interviews and focus groups conducted in this project. The models just described were selected provide a foundation of service resolution concepts, structures and processes that can help inform model options for Toronto.

We now turn to a presentation and analysis of our interview and focus group findings, to elaborate on the need, scope, and potential structure of service resolution in Toronto, from the perspective of local providers.

Part 2 – Project Findings

2.1 Project Methods

The development of recommended options for service resolution in Toronto were informed by the following methods:

- A scan of the relevant practice literature; local services, organizations, and partnerships; and existing system data available to shed light on the target population and local service pressures and gaps.
- Primary data collection, which involved consultation with the cross-sectoral provider community in Toronto to gather their input and feedback on the development and implementation of a service resolution mechanism

We conducted 5 focus groups and 26 key informant interviews with managers, directors, and front line staff from organizations providing services related to mental health, addictions, developmental disability, dual diagnosis, acquired brain injury, criminal justice, and housing across the city of Toronto. The total number of unique individuals participating was over 75.

Some participants were identified by the Sub-Committee a priori on the basis of their level of expertise and familiarity with complex care provision in the relevant sectors within Toronto. Additional key informants with unique knowledge or experience related to service resolution (in Toronto and elsewhere) were identified through TNC's own networks as well during data collection through the interviewees.

Interviews and focus groups were structured around the following research questions:

1. Who are the individuals who could most benefit from service resolution? What are the circumstances in which people are experiencing barriers that could be rectified by service resolution?
2. What are some examples of success in serving these subpopulations that could inform a service resolution model?
3. What existing initiatives and capacities similar to service resolution would be important to consider in developing and implementing a service resolution function in Toronto (e.g., existing case conferencing tables, partnerships, or wraparound care models)?
4. What are the key recommendations and/or concerns from the field regarding developing and adopting a service resolution model in Toronto? Is there support for a city-wide service resolution model? What key roles need to be filled? Who would be key collaborators? How should a service resolution table be structured? How would it function best in Toronto?

See Appendix A for our interview and focus group guides.

2.2 Summary of Findings

Our consultation with key informants helped to gauge the level of need for coordinated cross-sectoral action and buy-in for a service resolution mechanism for individuals involved with the criminal justice system who have complex mental health and addictions needs. The consultation process helped us to refine our understanding of characteristics and circumstances of the target population for this mechanism, existing initiatives and practices of service providers across

the system to better address complex needs, the features of a service resolution mechanism designed, as well as important factors consider in the implementation of such a mechanism for the city of Toronto.

These findings are reported in the following sections and informed the service resolution models proposed in the Part 3 of this report.

2.2.1 Defining the Target Population: Circumstances of Individuals Who Could Benefit Most from Service Resolution

Our interviews and focus groups with Toronto service providers helped to identify common themes in characterizing complex populations who experience the greatest service barriers, or whose needs the system has not been able to adequately address. We were interested in the extent to which providers' perspectives on needs and complexity aligned with definitions and concepts in the literature discussed in Part 1. Together this information could help us define the target population of service resolution.

In our data, complexity was positioned by key informants as inseparable from challenges in addressing individual needs. **Individuals were viewed as having complex needs because they were challenging to service appropriately; and the system was unable to adequately address their needs because they were so complex**.

> *I think a helpful way of conceptualizing complexity, especially for this initiative, is where the system is unable to respond effectively to the person's needs. A lot of people with complex needs can be served effectively - they would never come here, right? It's those individuals where the doors are being shut and they're not able to get the service that they need the way the system is currently structured... It's usually people who have exhausted other services, so people who have gone through several different organizations and worked with them, and the organization feels like they've done everything that they can… and it's still falling short. And then, it's usually that something really detrimental is going to happen. -FG 19*

Key informants commonly described clients as **complex as a result of the severity of a particular condition** or need and/or as a result of having **a multitude of needs or co-occurring conditions** requiring services and supports that span multiple sectors.

> *Complex can, I think, involve one of two components, either extreme complexity in one area - it could be a single problem that is so complex that it requires, perhaps, service resolution or requires advice, and/or a multitude of problems [that are] inter-sectoral. -P16*

> *It can be about the myriad of needs, or it can be actually about the specific disability the individual has and whether in fact there are interventions that work…My hypothesis would be sometimes the reason why the person has to cross all those sectors is because what they need actually doesn't exist in the system, and so they are bouncing around, certainly in terms of the contact with the law piece. -P1*

> *It was often people who had mental health and addictions challenges but also had co-morbidities, physical health issues, often were homeless or at risk of homelessness. For sure, there were contacts with the criminal justice system, but it wasn't around any particular gap, it was the fact that there wasn't a system in place to respond to those kinds of individuals. There were separate services that never worked together. (P32)*

Key informants noted that a key service barrier is **rigid eligibility criteria** that are set by organizational policies and funding agreements to serve individuals with particular diagnoses. Eligibility barriers may also be due to limits in an organization's skills and expertise to address particular needs. The challenge is often (although not exclusively)

related to organizations with a mandate to serve clients with a mental health diagnosis, as described by one of our key informants in the excerpt below.

> *We have historically discharged all these folks to the shelter system and the municipalities have dealt with them because they've had no choice, and they have not dealt with them well and they looked at us and said to us, the mental health system, why don't you help us with these clients? And we say things like, well, they don't have a treatable mental illness. We've got to figure out a way through this. -P28*

> *So people with Asperger's, brain injury, seniors who have dementia - although some of the services accessible through our network would probably be helpful for those three groups, our partners aren't funded or mandated to work with those groups. All of our services are targeted towards individuals with mental health issues, so they often have to have a mental health diagnosis, so some of the providers would say that those things don't fall within their mandate. – P2*

Interview and focus group **participants identified a set of conditions and characteristics co-occurring with mental health needs and justice involvement** that may be particularly appropriate for service resolution. Acquired brain injury (ABI) and developmental disabilities were identified most frequently, with some participants also highlighting addictions and substance use, autism and Asperger's Syndrome, FASD, PTSD, and dementia (amongst older adults) as issues associated with significant service gaps or challenges in Toronto.

> *If we have people who need housing, they are not allowed mental health housing. If the referral is coming from [the ABI sector] and they have an identified brain injury, they say oh, we don't do brain injury, even if the presentation is more like mental health and they would be appropriate for mental health housing. On the other hand, what they don't realize is we're dealing with very similar patients. In an ideal world we'd be looking less at etiology and more at presentation, and we tend to get very stuck in what caused the problem and we tend to therefore miss opportunities for appropriate care. -P3*

> *Another group that we struggle with is people who have dual diagnosis, where their developmental disability sort of is on the lower end and so mental health providers feel like the developmental disability is the primary issue, so they don't feel like that they are equipped to deal with them. And anything in the developmental sector, it's very, very hard to get in. You have to have major psychological assessments, so even just trying to prove that you meet some kind of eligibility criteria is very hard… So that group kind of ends up in limbo a lot as well.. –FG17*

Service providers also noted that clients with **challenges that co-occur with addictions** commonly experience challenges in having their needs adequately addressed because eligibility criteria for some services prohibits active substance use.

> *The co-morbidities that were more common and that the system didn't seem to be doing very well with were substance use issues. - P3*

> *I think also a better understanding across all of the sectors of addictions and how that relates to all of these other barriers, because often they'll have addiction issues or active substance users are discriminated against in the services… they're just not eligible. It's just like, well, we deal with brain injuries, we don't know how to deal with a meth addiction. It's like, the two are connected, so how can we--how can there be some more education within the sectors to understand that and therefore bring down some of the barriers. -FG 17*

Additionally, **key informants identified presentation of challenging behaviours as a prevalent barrier to accessing and utilizing necessary services and supports**. Individuals who present safety risks where there is a threat of harm to themselves or to others are particularly challenging to serve. The more challenging issues are related to sexual offenses, arson, aggressive behaviours, and personality disorders. Additional challenges are experienced when clients are resistant to or non-compliant with services and supports. These behaviours pose significant challenges to service provision because they often result in burning out care providers, or in the need to discharge - in some cases barring or restricting clients from services altogether - to ensure the safety of staff and/or other clients.

> *The other challenge, of course, is in the justice system, mental health issues get defined as behavioral issues, and so it's really a question of what are the effective interventions for a given behavior? … in terms of the folks who end up in the justice system, you may have a percentage with schizophrenia or bipolar disorder, but you're more likely to have a high percentage with substance abuse issues, behavior management things, borderline personality disorder, which we know there just aren't a whole lot of resources for.- P32*

> *I think that certainly the group that's the most challenging… is clients who have histories of trauma and abuse and neglect that result in them having significant difficulty coping in any kind of productive way. They tend to be homeless, they get booted out of shelters, they have huge anger management problems, usually have concurrent disorder. Their mental health diagnoses tend to be softer - they aren't necessarily psychotic but they can be--you know, the range of personality sort of diagnoses, and they are really, really challenging because they burn staff out so quickly. - P28*

> [The client] *comes and she is harassing all of our other residents, so then we can't have her here because she's making it unsafe for the other residents. So where do you place her? She's been evicted, she won't make it in a shelter either because she's been banned…where do you place somebody who is has no insight into her mental illness? - P23*

Our respondents noted that the 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.** There are examples of success in treating individuals with very complex needs, but success often requires organizational commitment to flexibility in protocols, in broadening mandates, and a commitment to collaborating with community partners to serve individuals over a long period of time. Repeatedly, we heard that service providers have been allowed to refuse serving challenging, complex clients, thus leaving these vulnerable individuals unattached to supports.

> *I've been trying to go to our local community providers to say, listen - I have a partnership with the tertiary care. They will take him, you will not get stuck with him for a very long period of time, but in a crisis I need you guys. And the response there is, 'that's not what our hospital is supposed to be used for. He's just going to be taking up a bed', and I'm thinking, that is what your hospital is supposed to be for! It serves a good purpose - it keeps him safe until we can get him longer term care. – P3*

> *I would say the biggest gap is for the unattached patients, the patients that nobody wants or nobody feels they are able to treat. There is really nowhere to go with those ones... Particularly if you felt like you were going to have to manage on your own, you know? It's the hot potato, and I don't mean that in derogatory way, but nobody wants to take on a really, really tough patient because we don't have a particularly integrated system that allows you to get the help that you need. – P31*

Finally, **key informants resoundingly identified housing as a major gap in the service system** in Toronto that has powerful reverberating impacts on individuals with complex needs. Wait lists for supportive housing are excessively long, resulting in vulnerable individuals pooling in shelters and hostels – inappropriate settings for individuals with highly complex mental health. Excessively long waits complicate situations further for these individuals in a variety of ways. Vulnerable individuals residing in shelters and hostels while waiting for more appropriate housing are often exposed to additional risks to their health, safety, and wellbeing. Subsequently, while waiting for services, the individual may experience subsequent changes in the type and level of their needs or eligibility for certain services. We were also told that often, temporary supports individuals may have been connected to that were intended as transitional while waiting for more appropriate care tend to become longer-term and are insufficient and inappropriate for those individuals' needs.

> *Well, housing availability, and the types of housing. So there doesn't seem to be a lot. Some locations have maybe staff eight hours of the day, but you need staff 24 hours a day for some of the folks that have high complex needs. So there isn't a lot of that out there. They're all short term. They're all meant to be transitional, so either 30 days, or you have transitional housing programs which are up to six months to a year, and then what do you do at that point? So the person ends up coming back because they need the support more long-term. - P23*

> *For even a room at this point, you're looking at a year wait list for a shared room that you pay for, that the client pays for. So we're in a situation where people are pooling in the shelter system even while they're on a wait list. … by the time a year has passed, it is no longer the same client that applied for that housing: , "they're using meth now? Oh, they're doing sex work now? They're not eligible for these services". - FG17*

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 supervision/support).**

> *A gaping hole in the system is the difficulty people have in getting housing, and in particular…people who have been involved either in the hostel system or jail, and there's a smaller group that have security issues where you really couldn't put them in their own apartment and have an ACT team visit them every day. You'd need more support than the hour or two or the 45 minutes, or the two med drops a day. So there's a small group - it's not huge, but there's a group of people who need not only housing but they need higher levels of support than may be currently available. - P32*

To ground the discussion of these key system barriers and the service resolution models that we recommend to address some of these needs, we first highlight a selection of current efforts in Toronto across the mental health, addictions, and justice sectors to address complex service needs. In some cases, formal tables have been set to find creative service solutions for individuals with particular types of complex needs or for individuals tied to a particular service/discharge location. In other cases, we learned of service providers tooling up their own capacity to better serve individuals with complex needs through employee training initiatives and by nurturing partnerships with key organizations willing to work collaboratively and creatively.

2.2.3 Current Practices and Initiatives to Address Complex Needs

There are three important reasons to take stock of existing initiatives and efforts to address complex needs across Toronto. First, we want to ensure that in proposing a service resolution mechanism we are not duplicating existing initiatives. Second, we aim to leverage learnings from other existing, related initiatives to inform a strong design for service resolution in the complex geography and service landscape of Toronto. Finally, we want to have a clearer vision of the landscape of existing and emerging initiatives in order to gauge capacity of key leaders across the relevant sectors to participate in a mechanism such as this.

There are networks of service providers in Toronto who engage in inter-agency case conferencing to address challenges in addressing complex service needs of particular sub-populations. Many of these groups function as standing committees with regular membership and meetings. Although each table differs in focus, there is potential for overlap in their target populations because individuals with complex needs or at elevated risk often have co-occurring needs that cross sectors and may be relevant to multiple service providers.

Initiatives utilizing interagency case conferencing and service resolution

- **SPIDER** (*Specialized Program for Interdivisional Enhanced Responsiveness)*
    - SPIDER is funded by and based at the Social Development, Finance, and Administration Division of City of Toronto. The Mission of the program is to support participating divisions and agencies to develop coordinated responses to complex and unresolved health and safety risks that involve vulnerable Torontonians, their homes or property, and their neighbours. These risk situations may include, but are not limited to, possession of many animals, multiple property standards and fire code violations, dilapidated living conditions, accumulation of refuse, environmental and odour issues, bed bug and other pest infestations.
    - The SPIDER program includes a Situation Table with a mandate to develop fast-turnaround and coordinated front-line responses to specific risk situations. Member organizations include the Toronto Police Services, Fire Services, Municipal Licensing and Standards, Public Health, Shelter Support and Housing, and Community Housing.
    - Members of this table commit to participation on a regular basis, meeting bi-weekly. Member organizations must be directly or indirectly active with vulnerable residents, their homes, or their neighbours and in a position to arrange for individual situations to be expedited (to the extent possible and where appropriate). Responses target solutions to high risk housing situations, although individuals may become connected to other social services as a result.
    - The SPIDER program also includes a System Reform Table to champion relevant policy or legislative reforms. The System Reform Table includes senior policy leadership from within and outside the City of Toronto, representing major sectors that that have a role to play in addressing complex health and safety risks involving vulnerable residents, their homes and property, and their neighbours.
    - As of March 2015, SPIDER has addressed 19 situations originating from 5 different agencies. 14 agencies have provided support in the interventions, with an average of 4 agencies participating in each situation (City of Toronto, 2015).

- **Toronto Justice Collaborative**
  - As part of Ontario's *Open Minds, Healthy Minds* 10 mental health and addictions strategy, the Centre for Addiction and Mental Health developed 18 service collaboratives to improve accessibility and coordination of services. The Toronto Justice Collaborative (TJC) is one example of local initiative that has a service resolution-type focus.
  - Through a comprehensive system review[9], the TJC identified a number of key challenges and strengths at key junctures of the mental health and justice systems, including:
    - crisis support, pre-charge diversion, and arrest;
    - court appearance and make fit order;
    - remand or bail and post-charge diversion;
    - trial and unfit or "not criminally responsible" (NCR);
    - sentencing and disposition; and
    - discharge planning and release, as well as a focus on increasing access to the social determinants of health to prevent involvement in the justice system and reduce recidivism.
  - The TJC (2014) is an inter-sectoral, multi-agency group that convenes regularly to plan service and support needs of individuals with mental health and addictions issues who are transitioning through these key junctures of the system.

- **FOCUS Rexdale**
  - FOCUS Rexdale is a multi-service, cross-sectoral Situation Table (described in section 1.4.5) aimed to address acutely elevated risk in the Rexdale neighbourhood. Members meet once a week to review situations referred to the Table to assess the level of risk (and thereby eligibility for the Table's mandate) and prepare coordinated, collaborative immediate responses to mitigate the level of risk for individuals/families/ groups involved.
  - The table is funded through a grant from the Ministry of Community Safety and Correctional Services.
  - Complexity in regards to mental health, addictions, justice, and service needs is sometimes, but not always, inherent in situations of acutely elevated risk.

- **Health Links**
  - Health Links is an initiative of the Ontario Ministry of Health and Long-term Care and coordinated by the LHINs to provide more person-centred, wrap-around care via a multi-service health care team to individuals with complex health needs. There are 9 Health Links across the Toronto Central LHIN, and 3 more within the city's boundaries in the Central, Central-East, and Central-West LHINs. Each Health Link has a localized focus and approach to defining complexity based on community needs and priorities. Health Link teams are targeted to individuals considered to be high service users – individuals who disproportionately consume a high degree expensive health care services, most notably, hospital services.
  - Within the Toronto Central LHIN there are two Health Links with a particular focus on serving individuals with complex mental health issues – the Mid-East Health Link, hosted by the Regent Park Community Health Centre; and the South Toronto Health Link, hosted by St. Joseph's Hospital.

[9] For details, see http://www.criminallawyers.ca/pdf/CAMHTorontoJusticeCollaborativePresentationMay72014.pdf

- Health Links teams have been designed as a multi-service team that engages in regular inter-agency case conferencing for their patients as a means of providing health care services. Team members often represent health and allied health care professionals. However, in some cases, the team consults and collaborates with community mental health and social service providers to better meet their patients' array of needs. The Mid-East Health Link has initiated *Community Rounds,* sessions where community service providers are invited to share information about their services so that the Health Links team becomes more aware of referral options for additional supports and services in the community that may benefit their patients. These sessions also serve to inform community providers about how Health Links functions leading to increased understanding of the suite of services existing Health Links clients are connected to and to appropriate referrals of clients to Health Links in the future.

- **CAMH Table to Address Discharge Needs for Alternative Level of Care (ALC) Patients**

  - This is a multi-service table including CAMH staff and supportive housing providers in Toronto. There is a core membership but other individuals and service providers are invited to attend as appropriate to the needs of the presenting situation. The operation of the Table is linked to new LHIN funding for supportive housing dedicated to transition ALC mental health patients in Toronto out of hospital and into the community. The Table convenes when vacancies open up for one of the designated housing providers. The service providers at the Table work collaboratively to prepare a tailored set of supports and services to promote a safe and successful transition for these patients into the community.

- **Access Point**

  - The Access Point, the single point of access or 'front door' for connecting individuals to mental health, addictions, and supportive housing in Toronto, convenes an ad hoc table of service providers when the program experiences significant challenges in connecting individuals to appropriate services in the city. This typically takes the form of inter-agency case conferencing involving front-line staff and managers of community service agencies most appropriate to the presenting needs of the individual in question.

Tables focusing on System Planning and System Level Change

In addition to these efforts to address service issues for individuals, there are other networks that examine access barriers and service gaps in Toronto at a systems level. This includes the network of HSJCCs in Toronto, which focus on needs of individuals with severe mental health issues who are currently or are at risk of involvement with the criminal justice system. There is a provincial-level HSJCC, a regional Toronto-HSJCC (who commissioned this project), and 4 local HSJCCs across Toronto (Scarborough, West Toronto, North York, and Downtown).

The SPIDER initiative includes a System Reform Table, in addition to its case-focused Situation Table, with a mandate to drive system-level reform (e.g., legislative and policy change) to "increase the capacity of the City of Toronto and its partners to respond effectively to complex health and safety risks involving vulnerable Torontonians, their homes or property, and their neighbours."

Informal Strategies and Efforts of Service Providers to Address Complex Needs

Through our interviews and focus groups, we also identified a number of examples of how teams or individual service providers have exercised flexibility, creativity, resourcefulness, and persistence in order to address unmet and complex needs of the individuals they have served. These have been one-off, or isolated practices and efforts of particular teams or individuals rather than coordinated systematic approaches to addressing complex needs and have been utilized to address those very gaps and barriers across the service system.

Our key informants noted that eligibility criteria limited to particular diagnoses or etiology is a prominent barrier to service access for individuals with complex needs. They described **'bending' or 'flexing' eligibility criteria as a common strategy to connect individuals with complex needs to services they need** but may not otherwise be permitted to access. In some cases these efforts are driven by frontline workers or managers who push the limits of their own organization's mandate or eligibility standards in order to serve clients who they believe would otherwise not be served at all.

> *We're not funded to do this. The stuff that I've been doing with this one case, my ED is regularly saying to me, really? We spent that much? We really can't afford this. But you know? I feel badly for the family. What was the family going to do? We're serving the family here also, right? We do it, we do it. – P3*

> *There's no justice workers in the courts for people with developmental delays. There's no case managers. There's the mental health court workers that are in all the courts in Ontario, but there are actually no one-on-one workers like us, so we actually get a lot of these referrals and staff kind of BS us, or exaggerate. Sometimes I think they're just … "oh, there's some family history of psychosis here", and we're getting clients where the main thing is developmental. We've been talking more about accessing the DSO, and I probably have four clients who only have developmental delays. We're not really supposed to be picking up those clients. They're supposed to have some mental health pieces. - FG 17*

In other cases, service providers have **leveraged relationships with other organizations and advocated for those organizations to open up their services to individuals in need** who would typically fall outside of their eligibility. An example of this situation is described in the following quotation from one of our key informants:

> *It's relationships, right, so when someone comes to our door and is really critical--because a lot of the way that we fill vacancies is kind of like a pull model, so organizations pull an applicant from [the] wait list when they have capacity. But sometimes we'll push a person out to an agency by begging and pleading - you know, this person really needs you, kind of thing, if they're really urgent. But a lot of it is relationships and our history and knowledge with that provider and knowing that they are willing to be flexible or they'll be responsive if they really need to be. - P2*

Another less common example of service providers' efforts to better address complex needs included **exercising flexibility in the locations where services are offered** so that they meet clients where they are. Although a seemingly simple solution, service providers related that individuals with complex needs are often living in transient situations without regular access to a phone, computer, or other means of communication to book appointments, and experience significant physical, financial, and psychological barriers in accessing transit or other means to make appointments with service providers in their primary offices.

So we sort of do the whole gamut, and on average we support people for at least a year and a half - that's our average, is a year and a half. We're not location-based, we're not office-based. We're out in the community. We meet the clients where they're at. When we're first starting to work with them, that's on the street, and when they're in their housing, that means we go to their housing and visit them in their housing. And we accompany them, so it's a very intensive approach to working with folks that have, for whatever reason, disengaged from the regular system. – P13

Well, I think one of the things that we did, and we hugely benefited from, is that we have a day of a week of a psychiatrist who is attached to our case management team, and that 10 years ago would have been almost unheard of and now is becoming more and more common. I think if you're going to serve this population, you have to have those kind of supports in place. So that's been a huge support to us, absolutely huge. – P28

I think it's when they need a service but they don't want it and we're kind of stuck in the space with them, with program staff at the shelters or the drop-ins, and to get them physically from that point of service to get through all these hoops and sign forms, and get them on a good day where they're feeling ready to consent, it just takes so much labour on our side… We have psychiatrists in a lot of the shelters now, which helps a lot. We have doctors in a lot of the shelters now, which helps a ton, but I think it's about changing the way we're looking at service provision, where we're physically there and available as opposed to asking them to go somewhere new and scary. – FG17

Exercising flexibility extends beyond the physical location of services. Some service providers have tailored their services to better fit individuals' needs in terms of timing of appointments, duration of service, location of service, etc. Many of our key informants insisted that a flexible and responsive system requires a mindset shift; a different way of working that may involve tailoring services or service teams to an individual's needs and capacities rather than asking individuals to 'fit' into the organization's model of service provision. Our key informants noted examples of situations where an individual's needs were so complex that a service did not exist in the system that could appropriately address them. In some instances **we heard providers were able to advocate for resources and bring together multiple agencies to create a customized response**.

I'll use the term patient because at that time, she was in hospital, who was exceptionally complex. They ended up doing a multi-ministerial response and brought together a bunch of stakeholders to address this because she was just bouncing around from hospital to hospital and decisions were made and it was just an enormously complex, enormously expensive, enormously unsatisfying situation. What's likely is that there isn't a service that's going to assist this woman in the needs she has. - P1

In this particular case, I think the issue was, again, the lack of services that were available. So what he truly needed was 24-hour, around-the-clock support. He didn't have the cognitive capacity to be making rational decisions…He had been turned away or turned down from some homes, was my understanding. Places that could service him or that supposedly worked with and had those types of supports were still denying him. But I think the underlying issue was the support he needed didn't exist, and so basically the solution that we found was advocating with the ministries to get that exact funding, so they did. And because he was involved with the ombudsman, it was very political. And he got the money that we requested that gave 24-hour support. We developed a specific residential and support program for him. - FG19

"Working differently" as a means of addressing co-occurring and complex needs was a key theme that emerged from our interviews and focus groups with service providers in the mental health and justice sectors. Beyond flexing

eligibility criteria, where and how services are provided, and creating customized programs tailored to individuals' unique needs, **key informants called for service providers across the mental health, justice, and affiliated sectors to work in a more integrated, coordinated, and collaborative manner** that supports a multi-service, cross-sectoral continuum of care for people with complex needs.

> *Successes that we've had around individuals here are always interdisciplinary kind of collaborative teams where everybody is committed to the client and the success of the client. There needs to be commitment to be flexible, the ability to be flexible from management, and commitment to the process. – P4*

The need for collaborative care teams and a more continuous multi-agency approach to caring for individuals with complex needs extends from a few key issues described by our key informants. First, providers acknowledged that individuals with highly complex and co-occurring needs require long-term supports and services from different agencies and different sectors. They also asserted that although long-term supports are often necessary, that the specific nature or domain of an individual's needs and the acuity or intensity of those needs often changes over time. Connecting and re-connecting individuals to these varied services that are appropriate to their needs in a timely manner poses significant challenges for service providers (e.g. long wait lists for service, shifts in eligibility for services based on changes in presenting needs, and other bureaucratic processes that may pose access barriers for vulnerable individuals with highly complex needs).

Some service providers in Toronto have been able to establish longer-term partnerships with a few key community service providers and tertiary providers who have committed to share responsibility for a small number of particularly complex clients. They recognize that complex clients will need to flow in and out of their services as acuity and intensity ebbs and flows. Not only do such partnerships ensure services are in place to better meet the cyclical needs of complex individuals, they ensure that one particular service provider is not bearing the full weight of caring for the individual over the long-term.

> *It's not like they're going to come in the system one end and go out the other and live happily ever after. It doesn't happen. We need a way of following them that reduces the excess lengths of stay that are created... We knew that we needed a provider that was willing to accept the fact that this is a person who is going to need repeated hospitalizations and a community-based placement that can handle his psychiatric behaviors, that has the right level of demand and the right level of structure, that was willing to take education and support from our workers to help him to manage that situation – P3*

> *I think that quite often, one places discharges and the other person takes them on and there's no transition time and there's no working together. And it goes down to even doctor-wise, it goes down to billing. A client can't have two doctors on record, so I think that's the kind of thing that we need to get over. I think that we need to realize that clients need more than just what one service can provide, so to be flexible about maybe two agencies are providing the same service to somebody at the same time. – P4*

Our key informants emphasized that individuals should not be merely passed like a baton from one organization to the next. Collaborative practice demands that partners share their specialized expertise, educating team members at the other organizations as necessary, and creating capacity to better meet an individual's complex, co-occurring needs. This collaborative approach was described by our key informants as representative of a recent shift in the service system towards greater flexibility and creativity in addressing complex individuals' unmet needs. Providers we spoke with asserted that serving individuals with chronic health issues and problematic behaviours often leads to

burn out of case managers, intolerable risk to organizations, and premature service discharge, leaving individuals disconnected from the supports they need. This is gradually changing in Toronto through **incremental efforts of committed services providers** and, as descried by the key informant below, through **reinforcement of system leaders like the Toronto Central LHIN.**

> *One of the things that we learned… is that you don't have to discharge people who are out of control and safety risks to others. You can sometimes find ways to serve them by telephone, for example. We have two or three guys that we have maintained phone contact with the program manager, so that we didn't have to discharge them for periods of time when their behavior was so outrageous that it wasn't safe to meet with them. But it's a struggle, and this is the new frontier for mental health, from my perspective. We have historically discharged all these folks to the shelter system…. I think that certainly the Toronto Central LHIN is now saying, "these are our clients and we've got to figure out a way through this". – P28*

Collaborative service arrangements require trust and strong personal relationships amongst the providers involved. One service provider informed us that the successful multi-agency partnerships she has established to serve clients with complex needs are based "*almost entirely on our personal relationships… we have a trusting relationship between our programs" (P3).*

Providers also shared with us examples of their efforts to build capacity, internally within their own organizations, as well as across the sector, to better address complex and concomitant needs of individuals they serve. Minkoff and Cline (2004) have asserted the need for agencies working in the mental health sector to develop as complex or concurrent capable organizations. In their model, organizations should expect that individuals will present with co-occurring needs and be prepared to find ways to address these complex needs – for e.g., by building staff competencies through training, expanding service teams to include additional members with complementary specialized expertise, or through collaborative service agreements with agencies who can provide complementary services in other areas of expertise. Co-occurring needs should be an expectation rather than an exception.

In the following example, a key informant from a mental health agency attested to the powerful impact of specialized training provided to staff to better address clients' unique needs. In this case, specialized training provided to a mental health providers helped the team to better address a complex client's needs related to developmental delays and being Deaf.

> *They struggled. I think she was there for three years, and I think somewhere about a year, 18 months in, they found a resource, I think it was in the community, that was able to train their staff in how to deal with Deaf People with developmental delays. So all of a sudden,* [the care provider] *had sort of a shared care expertise internally to begin to work much more effectively with this person. - P 12*

In another example, below, a service provider describes how her organization has expanded the capacity of their staff team, working primarily with ABI issues, in order to better address psychiatric symptoms and other mental health and addictions needs of complex clients who have been increasingly referred to their program. As noted in the following quotation, the agency's effort to "tool up" internally expanded into **efforts to share expertise across the sector and build more collaborative partnerships with agencies specializing in other areas.**

> *Yeah, so we sort of said, "okay, we have to get better at dealing with mental health and brain injury". We've kind of tooled ourselves up to be that. I now have an addictions worker, but there are still cases where there's really need for more of a continuum of services that deal with people. So we've been trying to promote something that looks a little bit more like continuous integrated care…The number one thing that has helped us to break down the barriers is you screen for brain injury and then you feed back to the partner agency, "okay, so these are the people you're already dealing with. I'm not asking you to take on new work, I'm going to try and make your current work a little easier and more productive". And then they're like, "Yes! Please, give me the training" - P3*

There are limits to an individual staff person, team, or organization's capacity to flex their mandate continuously. Our key informants across the mental health, justice and other associated service sectors across Toronto informed us of a small but significant sample of successful strategies enacted by diligent and creative service providers to better serve individuals with complex needs. However, the amount of time and labour that has been required to address just one complex case is significant and not sustainable through singular efforts by individual service providers or agencies. A system-wide coordinated approach is necessary to effectively – and efficiently – address the complex mental health and justice needs in Toronto. Although a Service Resolution mechanism will not fully resolve the service gaps in the mental health and justice sectors in Toronto, our key informants emphatically endorsed the service resolution as key driver of a more collaborative, responsive, and coordinated service system in Toronto.

2.2.4 Designing a Service Resolution Mechanism in Toronto: Key Dimensions and Considerations

Through our review of existing models of service resolution in mental health and other sectors we identified a set of key dimensions that can help to shape and define a particular model or approach for Toronto. In designing a service resolution mechanism, the following must be considered:

- Levels of response by the service resolution mechanism
- Standing committee versus ad hoc membership structure
- Organizational representation
- Geographic coverage
- Referral pathways into service resolution
- Staffing roles

There are multiple ways of shaping and defining these dimensions. We asked key informants to provide input into how a service resolution model for complex mental health and justice needs should function and how it should be structured to address the complex geography and service context of Toronto. What levels of response are critical and how many levels are necessary? Who should be involved, and at which levels? What organizations should be represented and what key roles need to be filled? How would this mechanism be triggered and what are the appropriate pathways to access service resolution?

Feedback from our key informants about each of these dimensions is synthesized in the following sections. We have drawn upon these findings, balanced with learnings from our review of the practice literature and our own field experience, to develop the model options in Part 3 of this report.

Response Levels

Some service resolution models, such as the Waterloo-Wellington and Peel Region models described earlier in this report (see section 1.4.3, p. 13), contain multiple levels of response with varying levels of cross-agency and cross-sector involvement and participation of front-line workers and leadership. This multi-level model of service resolution ensures that all means of resolving service challenges and barriers an individual is facing are exhausted before a cross-sector group of senior leadership becomes involved. This preserves efficiency in expenditure of resources. The activities in Levels 3 and 4 – the interagency SR and system SR committees – reflect the typical activities of service resolution.

Our interview and focus group data revealed that Levels 1through 3 are enacted on a fairly regular basis in the mental health and addictions sectors. The systems planning function of Level 5 is addressed, to some extent, across the mental health and justice sectors by the T-HSJCC and other system planning committees. However, such planning committees do not receive the benefit of a systematic case-by-case examination of prevalent barriers and promising collaborative responses that would be continually yielded by service resolution work.

We invited our key informants to describe the components or levels that they believed would be useful for a service resolution mechanism for in Toronto. There was a degree of consensus, not in regard to the precise composition or number of levels for a service resolution model, but in the general concept of a leveled approach with at least two tiers: one level focusing on resolution of individual cases, and the other focusing on addressing system-wide barriers and gaps that may be a common root of individual challenges. Many providers noted the value of the T-HSJCC for their function in addressing system-wide issues related to the interaction of mental health and justice, and valued the efforts of existing networks that perform service resolution and inter-agency case conferencing functions for complex and vulnerable individuals. However, they noted that **there still exists a need for higher level system-case conferencing for individuals with highly complex mental health needs who are involved in the justice system**. Comments below from key informants highlight these reflections:

> *We will get calls from correctional facilities all over the place when people are finished serving their sentence but still have mental health problems and are being discharged and then coming back to settle in Toronto. Figuring out how to support those clients is a challenge. Again, it requires multiple agencies… And getting a table, I know no one has a table. There just isn't one. – P31*

> [Re: the relevance of the work of a local HSJCC to resolving individual case challenges] *It's too generic. It's too higher level, it's too broad. It doesn't actually help with frontline service delivery clients. It's from a systems perspective more than anything, which you have to have in order to get a sense of what's going on, because those are the people that are making the decisions. But you have to be able to operationalize it. – P23*

Service providers reported that **a key function of a service resolution mechanism would be to identify and catalogue 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**. Some acknowledged that this function may closely align with the work of the T-HSJCC and that they could perhaps integrate with this component of the service resolution model (see Level 5 in section 1.4.3, p. 15).

It will definitely identify gaps in the system, and those gaps will be real. It will be great to be able to document those. At the end of the day, somebody has to take responsibility for these clients, and to me, I don't know what the process is to compel people to do that. – P31

It would increase, I think, accountability, and I think it would also increase not so much transparency but [system leaders] *would have a better idea at an operational level where there are gaps between the sectors in terms of adequately addressing the needs of individuals. – P5*

I think one of the things that the service resolution table might do is identify where there are known gaps in the system… You could begin to catalogue, here are things either because the capacity exists but there's not enough, or there's no capacity, that we just can't find things for people, and then on the more positive side, are there ways of bringing people together and bringing services together on sort of a very ad hoc basis to meet needs. I think that's the challenge with service resolution - when you don't have your basic supply of services well distributed and widely available, certain things that should be part of a basket of services for anyone are going to become identified as service resolution issues because they're just not available…– P12

Beyond this, there was endorsement that there should be pre-conditions or a stepwise approach built into the model to conserve limited resources at the highest level of service resolution involving system leaders. This higher level should be reserved for the most complex cases. For example, **local case conferencing by organizations and their networks would be a pre-condition for service resolution in order to demonstrate that existing processes and opportunities had been exhausted** before tapping higher cost resources associated with system-level case conferencing.

There's got to be some kind of stepwise approach, and then maybe there's just situations that are just so urgent, where you would need to have service resolution accessible… Because then you're saving your specialized, your most important, your most limited resources… and service resolution really is the last resort for somebody for whom all the existing processes have not been able to address the issue. - P1

A critical point is that our key informants acknowledged that **local case conferencing processes already exist across the community service sectors in Toronto and should be utilized to their fullest extent prior to enacting a higher level of service resolution.** Health Links, for example, were identified as a primary place to attempt collaborative problems solving before enacting service resolution.

The main process on the health side of things is going to be this collaborative care planning process through the Health Links. Service resolution really is the last resort for somebody for whom all the existing processes have not been able to address the issue. So if you can tie it to Health Links, it helps with the flow. And individual doesn't get to service resolution unless you've been through collaborative care planning. … And maybe it's not through collaborative care planning once. Maybe there's levels of collaborative care planning – P1

Others informed us that although there are well-resourced collaborative teams who specialize in working with individuals with complex needs, such as Health Links and Flexible Assertive Treatment (FACT) teams. Because the situations these teams address are often so challenging, there still exists a need for broader, and higher level support to resolve extraordinary needs. In some instances there may be a need to connect an individual into different services that have been challenging to access, but in other cases it may simply involve accessing specialized expertise and advice from the high-level and cross-sectoral representation that a service resolution table could offer.

Standing versus Ad Hoc Membership

We also asked key informants for feedback about how a Service Resolution table should be structured. There is some debate about the merits of operating such a table as a standing committee with a core membership participating in standing meetings (e.g., once/week, once/month, once/quarter) versus an ad hoc approach with a rostered membership – i.e., scheduling meetings as needs arise and inviting participants based on their perceived relevance and potential contributions to the presenting needs of the case.

There were not strong opinions on which structure would be most appropriate or practical, but awareness of a variety of challenges in organizing such a table unique to the Toronto service context. These challenges were related to the expansive geography of the city, the large number of service providers across the city and multiple, inconsistent arrangements of catchment areas amongst them. Respondents also acknowledged the high number of related networks and initiatives service providers already commit their time to, which may impact participation in this new initiative.

Key informants noted the structure of a service resolution model and the frequency by which it would meet should be informed by available estimates of the expected case volume the table would be dealing with. This estimate is a moving target and likely has less to do with actual need and more to do with the case load volume the table decides to take on. Key informants reflected on participation in service resolution tables in other sectors and noted the **need to adapt their participation as they learned more about needs and capacity**.

> *The developmental sector, I think they initially tried to start off ad hoc but the numbers just grew, so they scheduled a regular meeting monthly and then would slot cases in as they came. I would picture [this initiative] being like that. – P4*

> *I think we'd probably need more information. Like in terms of meeting regularly, in terms of the frequency, that would probably be informed by the volume of the cases that we'd be anticipating, although I can appreciate you might want to sort of keep it on the agenda. In a particular month, you might not have any [cases], and then in another month you might have three or four, right? Whatever process we develop, I would look at it as a pilot, and you collect more data on and you either scale it up or plan to study, act, you modify it according to what our experiences are. – P5*

Another key consideration informing decisions on structure was related to perceived buy-in and endorsement of this approach by key players across the mental health and justice sectors. Key informants generally endorsed the concept of a service resolution mechanism and strongly voiced a need for an approach such as this to address prominent service barriers for individuals with complex needs. However, at an operational level, **key informants expressed concern about the merits and consequences of both a standing committee and an ad hoc structure in their ability to keep people engaged,** to develop a shared sense of ownership and responsibility, and to prioritize service resolution as a part of their work.

With regard to the standing committee model, commitment to a regularly scheduled meeting would help to ensure the work becomes enmeshed for members as part of their regularly scheduled work. A consequence of regular attendance at meetings is that not all cases may require the participation of all committee members; members may feel disconnected and feel time spent at the Table is not valuable. Key informants also suggested that it may be difficult to gain the commitment of the senior leaders necessary for this committee to attend regular meetings if they

were scheduled too frequently. Alternatively, key informants expressed that with an ad hoc approach members may not feel a strong sense of commitment and connection to the Table and thus, worried about waning engagement and accountability. The benefit, certainly, would be that it may be easier to recruit a roster of members because they would not be asked to commit to regular attendance and would be called to participate only when particularly relevant to their work and expertise. These concerns are reflected in the statements below from key informants.

> *I think it's hard to know. Having a standing table may be helpful so that people can expect it. It may not be monthly - it could be quarterly, but then have some working groups that look at specific issues, otherwise people would get tired if they're not particularly invested or the issue is not particularly relevant to them. – P16*

> *The time that it takes to get everybody to the table is a challenge. Because it's a robust multi-agency process, it takes a long time to get people there, and we've often run into problems with trying to discharge patients and the table wasn't ready to talk about them yet. So that's been a challenge for us – P31*

> *Part of what I base my hesitation or reservations around the notion of having a standing committee, because I think of existing committees that I've been involved with… but these are places where people are mandated to be, and it's still hard to get people there. So for me, I struggle with, okay, if this is a collaboration, let's come together as a community. When people aren't mandated, personally I think it would be hard to get people committed, especially when it's much more peripheral. So every single person who comes to the Toronto Network of Specialized Care has an intellectual disability, right, so if they had to deal with people with just an addiction issue, they'd be, like, why am I here? And same with other sectors, so mental health players are going to be, I don't know about ABI - what am I supposed to be doing here? I'm wasting my time. – FG19*

As was highlighted in the quotation above (FG19) a number of the providers we spoke with noted that, from their experience, that to gain commitment and participation in a particular initiative amongst the many demands on the time of service providers and sector leaders, it may be useful to create strong incentives for participation. Regardless of the precise structure of the model – standing committee, rostered ad hoc, or some combination of the these options - a number of key informants noted that the **engagement of key funders, such as the City of Toronto, provincial ministries, or one or more of the Toronto LHINs could provide enough incentive for key players in the sector to participate.**

> *To the extent that you can have a funder at the table, I think you're more likely to get buy-in on the part of organizations. You can go with a coalition of the willing and I think you'll probably have enough there. Certainly there is goodwill among most organizations, certainly within the broader mental health and justice sector, but you're not going to have complete buy-in by all organizations, and that's okay. I think you start with what you have. - P5*

Organizational Representation

We asked service providers if there were key organizations they felt should be represented on a service resolution table. Rather than naming particular organizations, key informants highlighted a number of key factors to consider in building membership for this table.

Sectoral Representation and Accountability

First, there was acknowledgement that **organizational representation may not be as important as sectoral representation.** This was rooted in the difficulty of balancing an appropriate membership size for operational purposes with the need to ensure the vast number of relevant organizations and institutions across Toronto offering

services related to mental health, justice interactions, addictions, housing, ABI, developmental disability, dual diagnosis, etc. However, it was also noted that because service resolution requires cross-sectoral system-level coordination, that accountability should exist at a sector level, as opposed to an organizational level. Organizations across a sector should work collaboratively in serving the table and sharing responsibility for system barriers, gaps, and required changes.

> *I think a key here, though, is in terms of the cross-sectoral -- you want key people at the table, but you don't need everybody at the table, right? Because sometimes the more cooks you have, the more complicated it can be. So for each of the different sectors, if there was an existing table, so where at that table is the representative of the sector?… Somebody would sort of be accountable for that particular sector, right. So if they don't attend, they can send somebody, but there needs to be an accountability mechanism for not only the organization but for the sector. – P5*

The benefit of this approach, as described by our key informant (P5), is that it also serves to leverage existing tables or networks, such that an individual could sit at the Service Resolution table to represent the other collaborative or cross-agency networks they are members of, not just their organization. This could add a layer of accountability to mitigate risk of redundancy in the work of various existing networks, while also building upon the shared learnings and assets of existing networks.

Connecting to and Leveraging Existing Initiatives

Many key informants endorsed the need for this emerging service resolution mechanism but strongly cautioned that this initiative **carefully connect to and build upon the existing service resolution mechanisms** and other collaboratives in Toronto with related aims.

> *I think if you tie it to existing kinds of priorities, then there wouldn't really be redundancies. I guess there's the potential that that redundancy is with some of the work of the Health Links, but you can figure out a way to involve them. I'm thinking with tables that are sort of cross-LHIN city-wide, the one that comes to mind just given the population is the Toronto Human Service and Justice Coordinating Committee. So if* [service resolution] *sort of sat there but there was the capacity to bring in different providers. - P5*

A number of the service providers we engaged in this research identified the T-HSJCC as a natural foundation to build upon in developing an appropriate cross-section of membership for this service resolution mechanism. There was recognition that conducting service resolution discussions around individual cases may lie beyond the mandate of the T-HSJCC, but referred to their membership as a model, or launch pad for the development of a service resolution table relevant to these sectors. Some suggested **the service resolution table could sit as a sub-committee of the T-HSJCC**, while others recommended the **T-HSJCC could serve as a governing, oversight committee for the service resolution committee**.

> *I have to say that the Human Services and Justice Coordinating Committees do offer a great opportunity to build upon an established network or an established body. I mean, I guess at some point you have to assess whether or not they're equipped and their mandate could expand into looking at individual client cases. But there's a lot of resources at these HSJCCs that might be a good foundation. – P8*

> *Another way to think about it would be you've got the downtown HSJCC, and are they a vehicle to convene others and bring them to the table on an as-needed basis around complex clients. So would it be that each local HSJCC*

sort of can call on this service resolution table, so you wouldn't necessarily create a separate service resolution table for each HSJCC that's local, but you've got four of them so you'd say, on Monday it's the Scarborough group that could call. So some way, because remember the local HSJCCs in fact are service networks of their own. – P12

Key Players to Engage

Beyond the importance of leveraging existing collaboratives and initiatives, key informants also noted the importance of involving two types of players whose endorsement and participation in a service resolution function could add clout, access to scarce resources, and compel action – hospitals and potential funders.

One key informant noted that **hospitals, in part because of their access to psychiatry, are key players** that are sometimes disconnected from community mental health collaboratives and need to be represented in at service resolution.

One of the things that I've been struck by [in work around access in the mental health and addictions sectors], *is the hospitals aren't always represented at the tables. And while I don't think the general hospital or specialized hospitals are necessarily the solution to everything, I think that they are partners because that's where all the psychiatrists are. And that piece, when it's all community mental health agencies, they all have some psychiatrists but they don't have as much as they need. So I think finding a way to pull the hospitals into this is really important. – P31*

Funders were implicated as a critical group to engage in this mechanism for two primary reasons: 1) their endorsement of the initiative may encourage, or even compel, other organizations to participate, share responsibility for the function, and propel systems change, 2) access to resources or information about funding that may support and sustain the work of the table.

To the extent that you can have a funder at the table, I think you're more likely to get buy-in on the part of organizations. – P5

I think to be successful, you need the buy-in of the funders, and so I think someone like [a representative from a LHIN] *could make it happen, right? So then if somebody doesn't engage, you can go back to* [the LHIN] *and say, we're having a hard time engaging. They could call that manager of that organization and say, what's going on? … A crucial piece is that oftentimes the services for the people with the more complex care needs, there aren't existing solutions, so you have to create something new and different to meet their unique needs, and you can really only do that with funding. There are times when you can piece together… But I think the ones with the truest needs, they go beyond this, and who needs to be sitting at the table are the funders. – FG19*

In terms of the level or status of individual members at the table representing their organization or sector, **there was a high degree of consensus that there must be participation from management and leadership – individuals endowed with decision-making power and clout** to authorize changes in practice, or bend eligibility criteria, policies or mandates found to be service barriers for individuals with complex needs.

Somebody who has enough authority to push through this stuff needs to be involved.– P31

I would think you would be way more likely to have success if you had a group of directors and managers and psychiatrists. You have to have somebody that knows 'that's not really going to work, at the frontline level that's never going to work'. - P23

I think that management needs to be involved. There needs to be people who are able to sign off on any kind of changes in funding… whether it's utilizing a resource in a different way or bringing in extra resources, I think the people that sign off on the money have to be at that table, otherwise I don't think you can move forward. Quite often when you have a difficult client, the clinicians… they call out to other clinicians, perhaps in another program in another hospital, and maybe at the clinical level there is agreement to work on it, but then when it gets up to who's paying for what and who's doing this and management gets involved, then it kind of falls apart. – P4

Together, the learnings from our key informants suggest that in building a membership for this Service Resolution mechanism, regardless of the precise structure and response levels, it will be important to engage funders (if not as active participants at the table, at a level of endorsing and promoting the initiative), hospitals and sector leaders who can represent the interests and capacities of other sector collaboratives as well as their home organizations. It will also be important to consider how this initiative can be mapped onto the network of existing service resolution tables and service collaboratives in the city in order to leverage existing assets and reduce the risk of redundancy. Although these considerations will be important to the continued development of the model, key informants recognized a growing urgency to develop and test a Service Resolution model with willing members and to fill gaps in membership as the mechanism evolves.

Geographic Coverage

We have been aware that a service resolution model will need to accommodate a very large, diverse geographical area and a complex interaction of sectors and systems. A key question overlying this work has been: what is the best way to design a service resolution model for the mental health and justice sectors in Toronto that can appropriately balance the needs across the expansive geography of the city? In smaller communities where service resolution models have been established in the mental health sector, there are fewer organizations covering smaller geographic areas; the sectors/systems tend to be less complex in a smaller geography although there are still prominent needs and service barriers. Toronto is larger and complex. The City of Toronto crosses the boundaries of 4 LHINs –Toronto Central, Central, Central East, and Central West. There are over 70 funded MHA organizations in the Toronto Central LHIN alone – each with differing ways of defining catchment.

Key informants discussed the potential of designing regional, or geographically based service resolution tables rather than one city-wide table, that aligned with the geographical boundaries of existing services/structures – e.g., LHIN boundaries, Health Links across the city, police divisions, or court divisions. The benefit of aligning with existing geographic boundaries would be the promotion of greater service alignment and integration.

In an argument for a regionalized or quadrant approach, some key informants expressed concerns that it would be too **difficult to manage the geography and regional diversity of the whole city through one service resolution table.**

I think that the whole city, or anything close to the whole city, would be way too big. I think that people would not feel a sense of responsibility if they were covering the whole city, so you may have an overarching governance model, but I think that you would have to pull people together on more of a neighbourhood kind of basis. I think

maybe four or five areas where people can identify with either the southeast or the northwest or whatever, so I think that there is some economy of scale there. P28

Another key informant noted **value in aligning with LHIN and Health Link geography,** not only as a means of simplifying service pathways across the city, but as a means of aligning to a structure that has buy-in and "teeth" across the service sector and may encourage greater engagement from organizations.

The Health Links really has a strong mandate and they have teeth to make people sit at those tables, right? This won't have teeth, right, so it's kind of like…How do you make people see the benefit in being there? I wonder whether there can be some sort of piggybacking on Health Links. So Health Links is there, the structure is there. Could that be a go-to kind of mechanism? The complex care people, there is a healthcare component, or usually, right? So if we can piggyback somehow on each Health Link and have them kind of motivated and see the benefit for them too, they may be willing to help the process, so we can almost divert to Health Links when possible and play a supporting role in that process. – FG19

The challenge with this regionalized approach is that **services across mental health and justices sectors operate differently in different areas of the city.** Key informants struggled to provide us with a clear direction on how to manage geography, noting that because of the variance across organizations in how they manage geography aligning with one of the existing approaches (e.g., LHIN or Health Links boundaries, or court divisions) may help to simplify but also may further complicate the map of Toronto services.

The issue is that the with mental health and addictions, the catchment areas are so haphazard of the various organizations. A lot of them serve the whole city and may or may not divide their teams geographically or service geographically. Others are micro and serve a tiny pocket. It's a dog's breakfast in terms of how they're organized now... – P1

I think it's really hard to know. It's really about where the client wants to live, so in a lot of ways, a lot of programs are based on catchment areas. If we have a client here that is interested in living downtown… it should be looked at in the area that the client needs the service. – P23

Some noted that regardless of the various service catchments across Toronto**, the reality for many individuals with complex needs is that they are transient and may need to touch services across multiple neighbourhoods and quadrants of the city**. There was a strong recognition that Service Resolution should be designed to match the needs of individuals – wherever they live and use services.

My gut reaction is to not create silos. I get that you need to draw a line somewhere… But from a resolution perspective, I don't know. Not to generalize, but I just feel like I can't imagine those patients just sitting in one quadrant and not engaging services across the city. I just think that if you--like, it would almost create more problems to do it in separate quadrants than to just try and do it all together. – P29

There was endorsement for **a hybrid approach – whereby tables are organized regionally or otherwise around an individual's particular needs (e.g., ad hoc meetings, drawing from a roster of relevant service providers), but feed up to a centralized oversight committee** where city-wide issues and learnings are shared. Some key informants noted that the current structure of the Toronto HSJCC may lend itself to managing this approach. This is described by a key informant below.

My initial thought is I would actually look at it at system level, or city-wide level. If the issue is in Scarborough, then you bring the providers that are providing service in that particular region together. So there'd be like a central repository for information, and also there could be certainly across learnings, or something occurs in Scarborough… then subsequently a year later it occurs in Etobicoke. Well, if it's looked at city-wide, then it could be replicated, right, so you're not recreating the wheel at a later point. The Human Services and Justice Coordinating Committee, given that they are really the impetus for this, that might be a logical place for it to be, like a subcommittee of the Toronto HSJCC. – P5

Referral Pathways

Any service resolution model will need to consider how people come into the service – how they are identified and protocols/processes leading them into the service. As discussed in an earlier section of this report (see section 2.2.4, *Response Levels*), there was a shared understanding amongst our key informants that service resolution should be triggered for only the most complex cases, and after other possible resources and options have been exhausted. Beyond this, a variety of perspectives were raised regarding the potential referral pathways to Service Resolution. Some individuals argued that the table should be open to referrals from service providers across the city through a central access point. Others agreed that an open referral process, managed by a central coordinator who would screen for appropriate cases, would be appropriate, but postulated that **the most likely source of referrals would be from the justice sector – particularly service providers connected to the Toronto HSJCC**.

I think because of the size of Toronto, it would be helpful to have a facilitator who does screening. Anyone can call. It will be primarily the people who sit on the HSJCC, who it will be, because they're already involved there. That's most likely the path. – FG19

Alternatively, other providers cautioned against an open referral process, suggesting that only active members of the service resolution committee should be able to refer cases. The rationale for this approach was that the service resolution committee should act as partnership, sharing responsibility and accountability for all cases that are referred to the table. From this perspective, **committee membership - as a criterion for referral - may safeguard against what may be perceived as unloading complex cases to the table**, and could promote collaborative problem solving across agencies and sectors.

I think any of the providers that are participants should be able to bring forward cases. I would like to make membership a requirement of referral, and I'll tell you why. There's a tendency for some agencies who may have a critical piece of the puzzle who will refer to get them out of their hair. I would like it to be more open than that, but I really do think that anybody who refers should have some role in the actual table, the actual ongoing services. – P3

Regardless of the direction the resulting model takes, a key message we have heard from key informants is that the referral pathways need to be clearly communicated across the sectors. Because there are so many service organizations in Toronto connected to mental health and justice sectors and a number of existing and emerging initiatives with mandates related to serving individuals with complex needs, there is a strong need for clarity in service pathways. **Service providers need to clearly understand what supports and resources are available, to whom they are eligible, and when/how they can be invoked, including the service resolution option**.

I think… there isn't a lot of knowledge of what else could or should be happening. So I think it's definitely making sure that people know the process to raise it to service resolution is important, because a lot of people don't even know that there's such a thing. – P4

> *The only thing that I think is particularly important is its going to have to be crystal clear when you would take somebody to some of the* [other collaborative planning processes] *that are being put in place* [in Toronto] *versus service resolution. Getting to a more specific level of detail in terms of the criteria that would be used to determine if somebody needs to get to service resolution and making sure that there is a lot of communication about that, otherwise people won't know where to take somebody to and it will all get muddy. – P1*

Staffing Role in Service Resolution

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 service resolution models have central coordinators (navigators, facilitators) who perform a number of functions central to the success of Service Resolution, including (but not limited to) managing communications, managing referrals and intake to the table, and facilitating interagency case and system level conferences.

Our key informants widely endorsed the need for a staff coordinator role, describing two primary functions for this position. First, the **coordinator was viewed as necessary to provide strong leadership and facilitation of the table.** Facilitation was described as extending beyond facilitation of case discussions at the table, but in skillfully engaging relevant organizations as needed to optimally address case challenges, and managing ongoing engagement and buy-in of committee members.

> *I like the idea of having a facilitator to gather the people when they need to and set meetings and facilitate meetings. I think you need someone to sort of take a leadership role to make it happen. If you don't, it's probably not going to happen. I have experience where even if you have a facilitator but not strong leadership, then people don't feel like it's worth their time and they're not going to not attend. So I think if you have focused meetings, specific goals to be accomplished during meetings, you have a strong leadership that can facilitate that and make sure that things are moving along, I think that would be helpful. – P25*

Second, **a critical role of the coordinator is related to their function as the gateway or front door to the service resolution mechanism.** This involves screening for appropriate cases to manage case load and educating and connecting front-line workers and organizations about local case conferencing processes and other problem solving resources.

> *I think if there's somebody to vet, that's the key, like a facilitator - they screen – "okay, this person is not eligible, you need to go back and do this, this and this". The gatekeeper… It is helpful to have somebody do some sort of assessment or screening process because Toronto is so big and there are so many people. There needs to be some sort of criteria so everybody just doesn't come, because there are lots of complex cases and sometimes it's around talking it out with different service providers and different resources… - FG19*

> *Part of the role of the coordinator would be to pull together the relevant tables. So for example, if the person doesn't have an acquired brain injury, then you're probably not going to bring CHIRS or an individual from those service providers to the table. – P5*

Regardless of the structure of the model, it is evident that there is endorsement amongst the initiative's key stakeholders for one or more staff coordinator roles. We discuss the role in more detail in Part 3 (see section 3.5.3).

Part 3 – Service Resolution Model Options

Based on our practice review and findings from our local interviews and focus groups, we developed the characteristics of three distinctive models of service resolution that could potentially be useful in the Toronto context.

Model #1 – Standing Committee

Model #2 – Ad Hoc Roster

Model #3 – Brokering Structure

These three models differ from one another on several of key dimensions but also share a number of elements. In the sections that follow, each model is assessed according to its relative strengths and weaknesses. We follow with a synthesis into a recommended model of service resolution in Toronto that attempts to maximize the strengths of the three basic models. This final synthesis is based on two high-level feedback sessions that were conducted with Toronto Acquired Brain Injury (ABI) Network and the Toronto HSJCC. These two groups provided very useful critiques of the three models and helped to articulate the resulting synthesized model in a way that was most compatible with the expectations and concerns of represented organizations. We felt it important to lay out the three basic models first – to elucidate key features, strengths, and weaknesses – to provide the reader with a more informed and clear assessment of the final recommended model.

It will be helpful to first comment on two dimensions of service resolution that are equally relevant across the three models: 1) Intended users of service resolution and 2) Referral pathways into service resolution.

3.1 Intended Users of Service Resolution

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. Based on the mandate of the Sub-Committee, our review of complexity definitions and frameworks, and input from the local provider community we recommend the following criteria to help specify the user group who would normally access service resolution in Toronto. Individuals accessing service resolution should typically experience the following:

- 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.
- 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** of presenting problems.
- High **chronicity** of presenting problems.
- High **usage of EMS and justice services**.
- Repeated **challenges in accessing** supports and services.

Note that these criteria should normally occur *together* for individuals to access service resolution. It is assumed that this set of criteria is relevant regardless of the model of service resolution that is adopted in Toronto.

3.2 Referral Pathways into Service Resolution

Independent of the characteristics and experiences of intended users is how referral pathways into service resolution are established. There are five useful pathway options that can be considered. These are described below, arranged from most narrow to most open.

1. **Streamed Service**: Users gain access upon entering or transitioning through an identified service pathway or pathways (e.g., discharge from hospital, discharge from prison, while in court remand).
2. **Networked Service**: A circumscribed network of organizations has access to service resolution. The front-line workers of the partnered organizations bring situations to service resolution as warranted.
3. **Localized service**: The service is available in a specified catchment or geographical area (by neighbourhood, borough, or other division). Users will therefore be residents of, or receive services from an organization within, the specified area.
4. **Open Service – System**: The service is marketed widely to the provider community (in this context, city wide). Providers access the service on behalf of individuals, with their consent. Referrals are not accepted directly from community members.
5. **Open Service – Community**: The service is marketed widely to the community (in this context, city-wide). Any individual, family, community member, or provider can request and apply for service resolution through a centralized access point (e.g. a phone number, website, etc.).

Open service pathways (#4 and #5) are typical of smaller communities with a smaller number of involved organizations or in communities that have started narrowly and then moved over time to a wider referral scope. Networked service pathways are often established in order to pilot a smaller, more manageable service and/or to stay within a particular service mandate (i.e., to serve a particular subpopulation of people).
In Peel Region, for example, service resolution began with a networked model of mental health and justice organizations (#2). Over time, once practices became consistent, they opened it up the broader community (#5).

The most narrow approach, streamed service pathways (#1), tend to evolve from needs identified by individual organizations or small partnerships, attaching service resolution to a particular service pathway that sees an inordinate number of individuals with complex needs. Localized service pathways (#3) tend to develop when there is a particular need identified according to geographic considerations (e.g., a particularly vulnerable neighbourhood) or when policy funding mandates require localization (e.g., Health Links are arranged geographically to serve specific catchments). In localized models, providers make the referrals to service resolution in order to ensure the service remains local.

We now turn to three model options for service resolution in Toronto. Each is described in relation to key dimensions that need to be considered when creating the service, based on our practice review and input drawn from our interviews and focus groups. Strengths and weaknesses of each model are also discussed.

3.3 Service Resolution Model Options

Model #1: Standing Committee Structure

Model Synopsis:	• This model follows the same structure as mental health and addictions service resolution in Waterloo-Wellington and Peel Regions. It has a standing 2-committee structure and a dedicated staff coordinator position.
Response Levels:	• A first level interagency SR committee is composed of cross-sectoral representatives in supervisor and management positions. If resolution is not possible, it is referred up a level. • A second level system SR committee is composed of cross-sectoral representatives of high level management and executive directors. This committee has greater influence over organizational policy, programs, and resources and can enter into service agreements with partners.
Standing versus Ad Hoc Membership:	• Both committees are primarily composed of standing committee members of cross sectoral organizations. Ad hoc members are invited based on the presenting needs of clients. • The interagency committee meetings are standing meetings. The system SR committee meetings may be ad hoc as needed.
Geographic Coverage:	• In the Toronto context, full geographic coverage would likely require multiple interagency service resolution tables feeding into a single system service resolution committee when required. • Decisions on geographic divisions would be required. SPIDER, for instance, divides the city into quadrants of north, south, east, and west. Other divisions are possible, e.g., according to Health Link designations, police divisions. • Concerns with geographic coverage may be mitigated by narrowing the referral pathways.
Referral Pathways:	• All referral pathway options are possible • If a streamed or networked pathway is adopted, geographic coverage becomes a secondary concern. • Localized referral, by definition, would narrow needed geographic coverage and would also condense the pool of standing committee members. • Open referrals would expand the coverage of service resolution city-wide.
Organizational Representation:	• Standing and ad hoc members are representatives from a cross-section of health, social service, and other agencies/sectors. • The core standing members represent organizational leaders in mental health, addictions, developmental services, primary care, justice, housing, emergency shelters, child and family services, and others. • Selection of standing members will vary based on decisions on geographic coverage and referral pathways. If particular geographic divisions are specified, representatives should be from organizations/offices within the specified area.

Staffing Role:	• A dedicated service resolution coordinator is responsible for the following roles:
	  ○ Education, outreach, and training to organizations regarding the purpose and process of service resolution.
	  ○ Building interagency connections and supporting local case conferencing to organizations as initial alternatives to service resolution.

	○ Taking referrals, assessing intake criteria, and assembling required information for uptake by the interagency service resolution table. ○ Following up and supporting service resolution actions and referring to the system SR committee when resolution is not possible. ○ Communication and scheduling of the two committees. ○ Collecting and compiling data on system barriers, service resolution actions, and impacts to inform service and system improvement.
Coordination with other tables and initiatives:	• Other tables, processes, initiatives, can access service resolution as a service option when a) their own practices fail to meet required needs, and b) the individual in question matches the eligibility criteria of service resolution. • The service resolution coordinator can also broker relationships between service resolution table members and other initiatives (e.g., key providers from service resolution can connect to other tables in an ad hoc manner to resolve issues before bringing a situation to service resolution). • Service resolution should forge strong connections to local Health Links, notably those that are beginning to specialize in mental health and addictions as an area of complex needs. This could be formalized by naming Health Links representatives as standing or ad hoc members on the interagency SR committee; and conversely, attach the SR coordinator to corresponding Health Links committees.

Model #1 Strengths:

- A standing committee structure supports a continuity of participation and commitment to the service resolution function, provided members have consistent opportunities for their organization to be involved. Thus, standing members should be from organizations that are often involved in resolution actions.
- Consistent standing membership is conducive to building strong interagency relationships and partnerships and leads to on the ground service solutions that make formal service resolution less frequent.
- A standing committee structure gives full control of the leadership over the mandate, structure, and governance of the function.

Model #1 Weaknesses:

- This model has shown to be effective in smaller communities with fewer organizations. In the Toronto context there is a large number of relevant organizations - making full representation quite challenging.
- Standing committee members are not always relevant to the issue at hand; for some members this can be common, leading to disengagement from the table.
- If city-wide coverage by the mechanism is desired, then multiple interagency SR committees are required to attach to designated geographic areas. Management of multiple tables would be complex and more costly.
- A complex system like Toronto would tend to require so many ad hoc invitations as to question the usefulness of a standing membership. This problem is mitigated, however, if referral pathways are narrowed.

Model #2: Ad Hoc Roster Structure

Model Synopsis:	• This model is a modified version of **Model #1**, but with a fully ad hoc interagency service resolution membership. The function is not tied to geography; the assemblage of members is driven by the presenting needs of the individual.
Committee Levels:	• ***As with Model #1***, a first-level interagency SR committee is composed of cross-sectoral representatives in supervisor and management positions. If resolution is not possible, it is referred up a level. • ***As with Model #1***, a second level system SR committee is composed of cross-sectoral representatives of high level management and executive directors. This committee has greater influence over organizational policies, programs, and resources and can enter into service agreements with partners.
Standing versus Ad Hoc Membership:	• The interagency SR committee is constituted each time, based on the individual circumstances and needs of the client. • Optionally: several standing committee members from organizations that frequently are involved in resolution actions can a) support the coordinator with intake and ad hoc roster decisions and b) provide a degree of continuity to the committee. • City-wide, cross-sectoral organizations commit to the participation of supervisors/managers on interagency SR committees. This forms an *active roster* of representatives. • Meeting times are regular and standing. Roster members set these times aside in their schedules so they are able to attend if called upon. • ***As with Model #1***, the system SR committee has a standing membership which meets as needed, based on referrals from the first level.
Geographic Coverage:	• The interagency committee and its membership are not organized around geographic areas. Rather, the ad hoc roster is assembled according to the needs of the individual. • The geographic reach of the service depends on referral pathway decisions.
Referral Pathways:	• ***As with Model #1***, all referral pathway options are possible. • Exception: A localized referral pathway is not relevant as the service is not organized by geographic areas.
Organizational Representation:	• Ad hoc roster members are representatives from a cross-section of health, social service, and other agencies/sectors, including mental health, addictions, developmental services, primary care, justice, housing, emergency shelters, child and family services, and others.
Staffing Role:	• See **Model #1** for a summary of roles and responsibilities of the service resolution coordinator. • Additionally, the coordinator is responsible for maintaining the ad hoc roster and inviting members according to the presenting needs of users. • Optionally: A smaller intake committee may be necessary to ensure there is a balanced and informed decision making process for inviting ad hoc members.
Coordination with other tables and initiatives:	• See **Model #1**.

Model #2 Strengths:

- The model is not hampered by considerations of geographic coverage and resources to ensure that form of coverage.
- Ad hoc rostering matches table members to presenting clients, which heightens involvement and relevance at each meeting.
- Ad hoc rostering is more efficient for participating organizations, who do not need to commit their time when unnecessary.

Model #2 Weaknesses:

- Inconsistent and varied membership, processes, decisions, and practices may reduce buy-in and ownership of the service and may limit shared vision and accountability. An ad hoc roster makes it more difficult to maintain the interest, energy and commitment of members who are less frequently accessed.
- Inconsistent and varied membership may make interagency relationships and partnerships less likely to form.
- By virtue of their organizational affiliation, 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.
- Maintaining, and communicating with, a large ad hoc roster is challenging and time-intensive.

Model #3: Brokering Structure

Model Synopsis:	• Model #3 recognizes and leverages other existing, service-resolution-type initiatives (herein referred to as "tables") in the city. Rather than building a new and independent committee structure, it attempts to insert principles and practices of service resolution into these existing processes, and to build their capacity to meet the needs of the intended user group.
Committee Levels:	• There is no independent interagency SR committee in this model. • Committee levels will depend on the initiative/table in question. Some may have memberships that resemble front-line case conferencing while others will have memberships with higher levels of organizational influence. • ***As with Model #1***, the model includes establishing a system SR committee that could receive cases that are not resolved at local tables.
Standing versus Ad Hoc Membership:	• A SR coordinator would serve as an ad hoc member of strategically selected tables. • An ad hoc roster, managed by the SR coordinator, is formed in order to attach members to existing tables as needed. The size and scope of the roster would depend on the needs of the tables in question.
Geographic Coverage:	• Will vary depending on how the tables have arranged themselves according to geography.
Referral Pathways:	• Referrals into tables will vary based on their internal practices. • Additionally, the SR coordinator refers clients to tables based on presenting needs. • Front-end referrals to the SR coordinator come from a network mental health and justice organizations.

Organizational Representation:	• Based on the membership of existing tables. • Ad hoc roster members fill in identified sector/service gaps as needed.
Staffing Role:	• The main role of the SR coordinator is to help build the capacity of existing tables to meet the needs of the priority group of service resolution; to help incorporate service resolution type practices into tables' mandates; and to broker relationships between existing tables and representatives from mental health and justice diversion focused organizations (including from ABI and developmental services). • The SR coordinator sits on tables that regularly serve individuals with mental health and addictions • The SR coordinator is responsible for maintaining a roster of ad hoc members who can contribute to table decisions and actions.
Coordination with other tables and initiatives:	• The primary function Model #3 is the coordination of service resolution practices with other tables, as described above.

Model #3 Strengths:

- Attaches to and leverages existing infrastructure, resources, connections, and commitments of local organizations.
- Reduces duplication and potential confusion in the system for providers and the community more generally.
- Builds the capacity of existing tables and attendant organizations by broadening their scope, access to expertise and specialization, and overall level of integration.
- Less resource intensive as it does not require the ongoing management of an independent table structure.

Model #3 Weaknesses:

- Significantly less control over the structure, process, and mandate of existing tables.
- Existing tables may not adequately match the mandate of the Sub-Committee.
- Presumes that the structure/practices of existing tables will accommodate additional ad hoc members.
- Difficult to ensure that the SR coordinator will have sufficient influence on existing tables. There could be resistance to the priorities of Sub-Committee (e.g., deciding that individuals are not appropriate for their table).

3.4 Synthesis and Recommended Model of Service Resolution

Based on our consideration of the strengths and weaknesses of Models #1-3 and feedback gathered from the T-HSJCC and the Toronto ABI Network, we recommend the following 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.

7. **Hire a dedicated Service Resolution Coordinator.** The functions of the coordinator match those described in Models #1 and #2. We provide additional details regarding this staff role in section 3.5.3.

8. **Establish a standing Interagency Service Resolution Committee** composed of supervisors/managers of the network of mental health and justice service organizations (MHJS). This standing committee should include organizational/program representation from:

    a. Mental health addictions justice-focused services (e.g., court support, justice case management)
    b. Safe Beds Network
    c. Developmental Services
    d. Dual Diagnosis
    e. ABI
    f. Probation and parole
    g. Access Point

    A standing committee structured is favored over a fully ad hoc structure because it creates greater consistency in developing the service resolution function, promotes greater commitment and ownership over the goals of the service, and is more effective at building collaborative interagency relationships and activities.

9. **Augment the Interagency Service Resolution Committee with ad hoc members** from additional sectors and organizations as needed. This could include Health Links that have prioritized (or intend to prioritize) people with mental health and addictions challenges.

    We recommend that ad hoc membership be developed as needed, i.e., through piloting the service resolution process with range of client needs and circumstances in order to determine membership gaps.

10. Adopt a **networked referral approach**. In the recommended model, only the organizations from the MHJS network can bring forward clients to service resolution. There are several benefits of this approach:
    a. It better enables a focus on individuals who fall within the expressed mandate of the Sub-Committee (individuals with mental health and addictions who have contact with the law)
    b. There is already awareness, buy-in and commitment to pursue a service resolution model among the affiliated organizations.
    c. It provides greater control over volume and flow of cases coming to service resolution.
    d. It reduces the complexity of representing a broader cross-section of organizations.
    e. It allows the mechanism to be piloted to ensure consistency and effectiveness of practice.

11. **Developing funding allocated to "Flex Funds."** Acknowledging limitations in funding for the service, discretionary flexible funds may not be possible. However, it is viewed as a critical component of other service resolution mechanisms in mental health and developmental services, allowing a greater flexibility in building an effective support plan for individuals.

12. **Begin to build alliances with other tables** through outreach, education, partnership and referral. We felt that Model #3 would be insufficient in effectively achieving the mandate of the Sub-Committee. The unique strength of Model #3 lay with its emphasis on coordination with other tables. It will be important for the service resolution function to build functional relationships with other tables. 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. The network of Health Links is a good example. Some may lack the capacity to meet the complex needs of those with mental health and addictions issues and may benefit from the expertise of service resolution, including referral into the mechanism. Conversely, Health Links may serve as important primary care destinations as part of individual service resolution plans. There could be cross appointments of members on an ad hoc basis and the Service Resolution Coordinator could broker these relationships. Note that relationships with other tables may require expanding the boundaries of the referral network.

3.5 Other Key Considerations When Implementing the Model

In addition to the above description of recommended structure and related processes, there are other considerations when planning and implementing the model. The leadership will need to specify the governance structure and required resources, and must consider governmental policy and funding directions. In closing, we discuss some of these issues with associated recommendations.

3.5.1 Service Resolution 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. Beyond that minimal expectation, governance could be organized in several ways and operate at multiple levels. Some service resolution models (e.g. Peel Region mental health and addictions) attach governance responsibilities to their system SR committee. This means that the system SR committee engages in system level service resolution (i.e., focused on resolving individual cases) but also is responsible for the governance function. This is an efficient approach that also ensures that governance is directed by leaders who are intimately aware of the service function.

The Waterloo-Wellington and Peel Region models (section 1.4.3) incorporate a "Level 5" in the model, which focused on "planning and systems change". Its effectiveness relies on consistent, comprehensive process data from the two SR committees below it. This is a governance function and is therefore also taken on by the system SR committee. However, it would make good sense to introduce key ad hoc members who are not part the system SR committee but are integral to planning and systems change discussions.

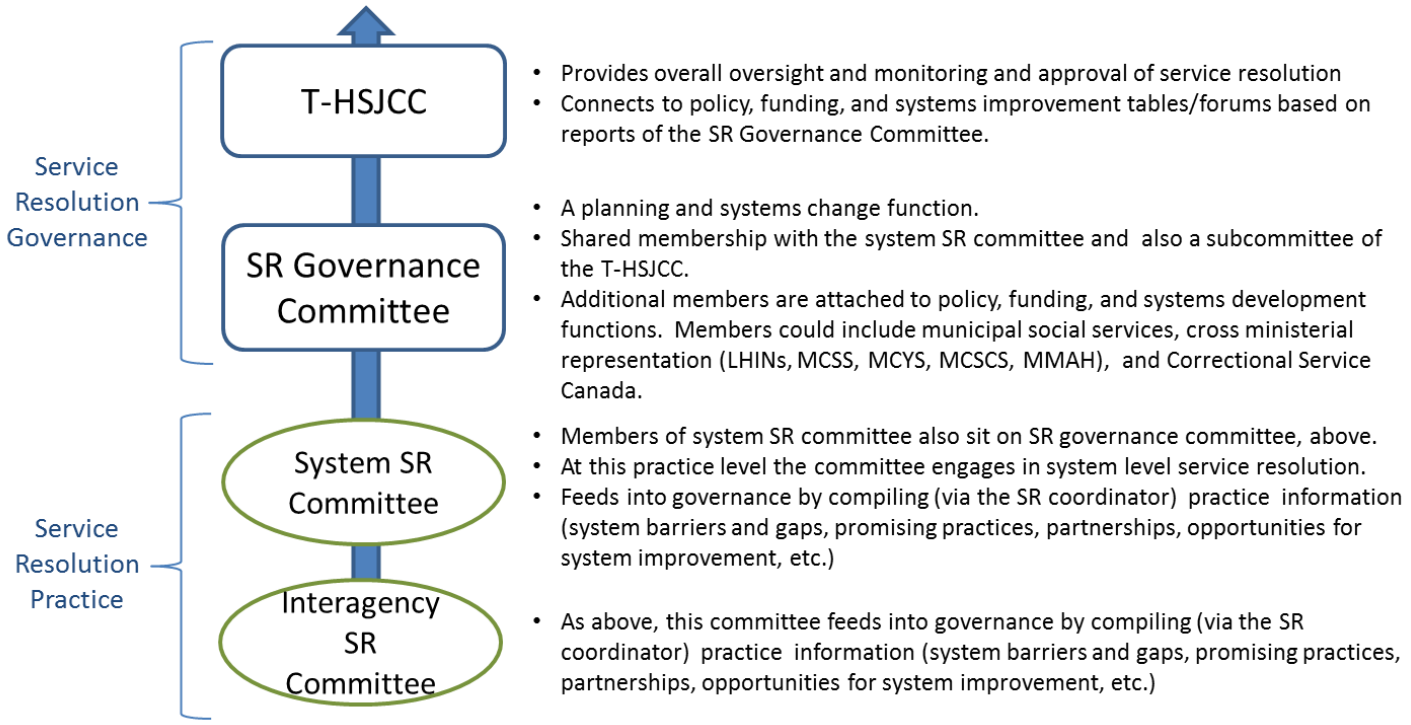
The governance of service resolution must routinely connect into high level policy agendas and broad-based system discussions. There is a natural connection with the Toronto HSJCC which, through the Sub-Committee, has directed the scoping and development of a service resolution model. The governance committee should report to the T-HSJCC, which should provide overall oversight over the service. The proposed governance structure appears in Figure 4 below.

Specific areas of governance oversight should include:

1. Review and development of the service direction.
2. Review and development of policies and procedures.
3. Review and approval of the annual work plan of the Service Resolution Coordinator.
4. Development and implementation of a marketing strategy.
5. Monitoring and evaluation of the service resolution model.

6. Reporting to the T-HSJCC regarding recommendations for system enhancements and improvements.

Figure 4 - Suggested Governance Model for Service Resolution[10]



3.5.2 Organizational Commitment and Terms of Reference

A first implementation step is gaining organizational commitment to the service resolution function. 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. It is the members' responsibility to set expectations and accountability among their front-line staff to engage in service plans. Service resolution is ineffective when committee members are operating without their organization's endorsement and commitment. If members are removed from the operations of the front-lines, service planning cannot be implemented.

A multi-organizational terms of reference is recommended to lay out expectations, responsibilities, and obligations of membership among the standing committee members. As new ad hoc members enter the fold, their home organizations may also enter in the terms of reference agreement.

Terms of Reference items could include:

1. Promote the principles and practices of service resolution model within home organizations.
2. Provide education and training to staff on the service resolution practices.

[10] MCSS=Min. of Community & Social Services; MCYS=Min. of Children & Youth Services; MCSCS=Min. of Community Safety & Corrections Services; MMAH=Min. of Municipal Affairs & Housing.

3. Ensure that relevant staff attend service resolution meetings at the levels appropriate to their role.
4. Commit to engagement in interagency planning and implementation to reach a resolution or until a decision is made to proceed to another level.
5. Commit to engaging in creative approaches to meeting service needs that may stretch normal service delivery boundaries and practices.
6. At the system SR committee, provide a representative with the authority to make decisions about organizational mandate, policies, programs, and resources.
7. Contribute data as required for advocacy, evaluation, or monitoring in relation to SR function.

3.5.3 The Central Importance of the Staff Role

Throughout this document, and most prominently in our discussion of model options, we have outlined the suggested roles and responsibilities of a Service Resolution Coordinator. We assert that this position is integral to the success of the service resolution function. A complex, cross-organizational, cross-sectoral function such as service resolution cannot operate effectively by a committee membership who are already busy with their own home organization positions. 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. A dedicated coordinating role is essential. When considering funding decisions to move forward service resolution, this role should first and foremost be established and appropriately resourced.

The Service Resolution Coordinator position is a unique role requiring certain qualifications. These include:[11]

- A minimum MSW or equivalent.
- Extensive experience in adult mental health and addictions systems.
- A strong working knowledge of the social service sector in Toronto.
- Advanced mediation and group facilitation skills.
- Clinical expertise in mental health and addictions.
- A systems orientation to social service interventions.
- Exceptional leadership skills.
- Exceptional interpersonal skills.
- Strong verbal and written communication skills.
- Independence and initiative.
- Information management and research skills.

A list potential roles and responsibilities of a service resolution coordinator is provided in Appendix B.

3.5.6 The Need for Member Training

Several representatives of existing SR tables emphasized the importance of training. It cannot be assumed that prospective committee members have the requisite information and experience to engage in service resolution

[11] Qualifications were in part derived from the SR facilitator job description in Waterloo-Wellington

discussions. The experience of one representative was that some members without training/experience fail to connect the work of service resolution back to their own organizational practices and that their contributions were limited to what they felt they could do within their own purview, rather than what the organization as whole could do. Sometimes members' colleagues, including the leadership, are unaware (or only vaguely aware) of the service resolution function and the expectations of the organization. This has as much to do with failure to gain organizational buy-in as it does with member training. That said, members are to be the champions and primary communicators of service resolution and for that reason member training is a helpful tool.

In Durham, for example, members of their service resolution collaborative are literally called "champions". A two-day training program is conducted with members to provide necessary information regarding the structure, process, policies, and roles and responsibilities of their collaborative. It is also a train-the-trainer model wherein members are expected to train their colleagues on service resolution and when/how to use it. Training is supplemented with a practice guide for service providers (Durham Collaborative Planning Process, 2014).

3.5.7 Evaluating Service Resolution

Failure to document and understand new service responses that emerge from service resolution a missed opportunity. Conversely, a failure to document and summarize persistent service barriers that repeat within service resolution situations is a missed opportunity for the system to improve. An evaluation and monitoring function is therefore critical. Information must be consistently collected at both interagency and system SR committees for summarization and use by the governance committee. Over time individual case information can be aggregated into a potentially powerful set of data about system needs and promising practices. A role of the governance committee is to meet several times a year to reflect on what has been collectively learned from a range of issues, system challenges, practices, interventions, partnerships, and innovations.

The following general information categories for evaluation and monitoring are relevant:

1. **Presenting primary issues**: Areas of need/risk associated with mental health and addictions issues, developmental disability, physical health challenges, etc.
2. **Social determinants of health**: Areas of need/risk associated with housing status, income, trouble with the law, etc.
3. **Service connections**: Current and past service use and connections, especially re: identification of a primary worker.
4. **Barriers**: Barriers to service access and reasons (e.g., ineligibility, perceptions of risk, past behaviour).
5. **Action Plan**: Description and monitoring of actions taken, such as main service connections, accommodations, and roles and responsibilities of providers/organizations.
6. **Outcomes**: The result of the intervention in terms of its resolution as described by health status, stability, urgency, acuity, opportunities, etc.
7. **Follow Up**: Adjustments or updates to the response as needed.

Each of these areas needs to be captured through a range of evaluation indicators. Parallel to this project, Taylor Newberry Consulting worked with Peel's service resolution function to build an evaluation framework (Newberry, 2014b). With their permission, we are attaching this framework in Appendix C. We have not customized it to Toronto's context specifically (i.e., it is has not be altered from the source); it is nonetheless contains information highly relevant to the evaluation of Toronto's service resolution model. It is not expected that all indicators for all

processes/outcomes of service resolution will be collected. Rather, we provide a menu of options and related issues that can help the service resolution leadership make some strategic choices about the information to collect.

3.5.8 Supportive Housing and the Cycle of Risk

We heard in our findings that the availability of affordable and supportive housing in Toronto is extremely low and that wait lists are exceptionally long. Addictions and Mental Health Ontario (2014) reported that 8000 people were on wait lists for supportive housing in Toronto and that over 9500 people receiving treatment for addictions had no fixed address. As of March 31st 2015, Toronto's Access Point had 10416 people on the wait list for supportive housing (8804 for mental health supportive housing; 590 for addictions supportive housing; 1022 for mental health and justice supportive housing). Of those on the wait list, 5408 have been determined to be homeless.[12]

A lack of housing options is a challenge in most urban centres in Ontario and it is particularly acute in Toronto. When considering the complex population that are the intended users of service resolution, the situation becomes increasingly dire. Individual profiles of complexity very often include homelessness and housing instability. People who are homeless have a greater rate of hospitalization due to mental health concerns (Adams, et al., 2007) . It has also been found that people with mental illness who are homeless have higher in-patient costs than those who are not homeless (Hwang, Weaver, Aubry, & Hoch, 2011). The authors surmise that people who are homeless present at admissions with greater severity than do those who are housed. Unstable housing and homelessness leads to risk and crisis at key transition points, such as discharge from prison or from hospital. This represents a cycle of risk in which a return to the streets and shelter system exacerbates mental health, addictions, and other challenges leading to repeated crisis and/or conflict with police and the justice system.

A perspective emerged from our interviews and our meetings with the T-HSJCC that the efficacy of service resolution was greatly reduced, or even thwarted entirely, without first addressing the housing shortfall problem. There was pessimism among some that putting resources toward a new community service was once again avoiding the primary root cause of distress and risk among this population. In this view, service resolution necessarily had limitations, and much good work could so easily be undone by the harsh effects of homelessness.

We remind the reader that this was not the consensus opinion, but a concern among some stakeholders. Others disagreed with the conclusion that strides could not be made in helping people with complex needs in the presence of serious housing barriers. Others felt that a service resolution mechanism was one route to expand the possibility and potential of achieving stability and attaining some form of housing. Among the disagreements, however, there was a strong consensus opinion:

- Service resolution cannot solve chronic homelessness or address the problem of lack of housing options for people with complex needs.
- Service resolution can achieve positive impacts for people with complex needs; but would be far more effective if individuals had access to safe, affordable, supported housing.

One modest approach to addressing housing needs of service resolution participants is the use of flex funds to secure housing or to prevent loss of housing. Flex funds do not address limited housing stock, of course, but they can help resolve certain housing challenges, especially those that require immediate and timely action.

[12] These recent figures were provided S. Lurie, CMHA Toronto via personal communication, April 16th 2015.

The principles and rationale of Housing First and health promotion are well established and understood, and advocacy efforts for improved housing in Toronto have been ongoing (e.g., see Addictions and Mental Health Ontario, 2014). These do not need to be summarized here other than to emphatically state that policy decisions to add, enhance, or improve health and social services are incomplete and far less effective without corresponding investment in housing.

3.5.9 The Costs of Service Resolution

Service resolution is cost efficient by design for participating organizations. Organizations that are already investing time in supporting particular individuals rearrange themselves in order to collectively and more effectively respond. It could be argued that service resolution requires more time from managers and supervisors to attend meetings and support implementation of plans. This may be true to some extent, but it nonetheless helps management better support their staff to improve their supports. Sitting on the service resolution committee is also aligned with the goals and principles of cross-organizational partnership and integration, which is a priority mandate for all organizations. In short, service resolution is about doing the work that is already being done, but differently.

This is not to suggest that service resolution does not, at times, exert new pressures on organizations. An organization that is well positioned to provide a particular area of support (e.g., mental health supports) may be called on more than others to participate in resolution and, over time, may find their capacity stretched and overtaxed. Some organizations that are a bit newer to serving this complex population may experience difficulties in properly resourcing and supporting their own role. These are expected growing pains in a new service such as this.

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), which we view as a critical role. Given the required educational background and professional experience, an annual salary of $70 000 to $80 000/year can be expected.

The second major cost outlay is the provision of flex funds. Flex funds are an optional but recommended component of the service. It is very difficult to specify a recommended funding amount in advance of fully understanding service flows and presenting needs. In Waterloo-Wellington, flex funds were originally annualized at a $50 000 base, with top ups becoming available with need. The pool of funds recently been increased to $100 000. A pilot flex fund of $20-$30 thousand would provide the function with an understanding of support and planning needs that are required for purchase, and the impact of having these monies available.

Other costs are quite minor in comparison. Marketing via pamphlets and a website presence could be a small additional cost. Training and resources (e.g., creation of a service resolution guide for members) would normally be a cost item; however, we view these as falling within job description of the salaried coordinator position.

3.6 Conclusion: The Costs of Doing Nothing

What are the costs of failing to introduce a new model of service resolution to meet the needs of people with complex challenges associated mental health and addictions, justice involvement and other difficult issues? The precise costs are difficult to estimate as we are uncertain at this juncture how many people the service resolution will be able to serve. What we do know is that the characteristics and circumstances of this population, combined with significant service gaps and barriers, are associated with extremely high service costs. A service resolution model will focus on individuals who are high users of emergency services, hospital in-patient and ALC beds, and who are more likely to experience incarceration and justice services in general.

These service types are indicative of needs that are urgent, acute, chronic and, without a range of intensive community supports, repeatable. Service costs for these groups are not only high, but cyclical. Service resolution provides a pathway to comprehensive supports that can reduce ongoing risk and a need for intensive, but very often temporary, interventions.

In Canada, mental health conditions and behaviour problems are among the top 10 most expensive in-patient conditions to treat (Canadian Institute for Health Information, 2008). Based 2004-2005 data, the average cost per stay for "mental and behaviour disorders" was $8,878; this increased to $10949 for "schizophrenia, schizotypal and delusional disorders". In Ontario, the in-patient cost per bed per day ranges from $500-$800; at the Centre for Addictions and Mental Health, the cost is reported as $579/day (Butterill, et al., 2009).

For the population of interest for service resolution, hospital costs are exorbitant. A report out of CAMH examined the factors contributing to long in-patient stays (over 90 days) or ALC designation, and the attendant costs, for people with mental illness and addiction (Butterill, et al., 2009). The analysis demonstrated that, compared to individuals with short stays, this group was more likely to have psychotic disorders, addictions issues, developmental disorders, and physical illnesses. The group was also characterized by involvement in the legal system, violent and disturbing behaviours, challenges with self-care, poor social networks, and persistent use of emergency and in-patient services. They were more likely to be admitted from institutional, assisted living, or shelter settings. In summary, long-stay users align closely with our definition of complexity and the recommended criteria for entry into service resolution engagement. This group also accounts for 51% of all long-stay/ALC days in Ontario.

Through the development of comprehensive, customized, wraparound supports, service resolution can help reduce hospital admissions - which is much more cost effective. High support housing per diem costs have been estimated at about $100 (with some exceptions that estimate a high cost, of about $230/day). Community based supports, of course, entail an additional cost, but still fall far below costs associated with hospital based care (Goering, 2004).

This report constitutes a synthesis of many different sources of information – the academic literature, technical practice and research reports, and interviews and focus groups from a diverse cross-section of Toronto's provider community. It aims to provide the rationale, concepts, structure, and process of an effective service resolution mechanism for people with complex needs. Service resolution is a best practice and there should be optimism that careful planning and open stakeholder engagement can yield an effective and practical approach to resolving complex difficulties. It is also aligned with stated priorities of system and government leaders. The Toronto Central LHIN, in describing their community transformation agenda and the needs of people with mental health and addictions clients, proposes the following coordinated approach:

> *To ensure effective and efficient care delivery, Teams will work with other providers under an integrated partnership model. Future implementation planning will define the structure and necessary supports for this arrangement (e.g., shared communication tools and client information; ability to negotiate a shared plan, problem solve and clear accountability for outcomes, and service teams that are multi-disciplinary to enable immediate care response as required).* (Toronto Central LHIN, 2013b, p. 2)

This approach is highly consistent with the goals of service resolution; and a service resolution mechanism would be a core resource and planning table for integrated partnerships. We hope that this document can provide the framework and roadmap to realizing this vision.

References

Adams, J., Rosencheck, R., Gee, L., Seibyl, C.L., & Kushel, M (2007). Hospitalized younger: A comparison of a national sample of homeless and housed inpatient veterans. *Journal of Health Care for the Poor and Underserved, 18*, 1, 173-184.

Addictions & Mental Health Ontario (2014). *The Case for Investment in Supportive Housing: A proposal from Addictions and Mental Health Ontario*. Toronto, ON: Author.

Butterill, D. et al. (2009). *From Hospital to Home: The Transitioning of Alternate Level of Care and Long-Stay Mental Health Clients*. Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health. Report prepared for the Ministry of Health and Long-Term Care. Toronto, ON: CAMH.

Canadian Institute for Health Information (2008). *The Cost of Acute Care Hospital Stays by Medical Condition in Canada, 2004–2005*. Ottawa, ON: Author.

Caplan, G. & Caplan, R. (2000). The future of primary prevention. *The Journal of Primary Prevention 21*, 2, 131–136.

City of Toronto (2015). *Program Update: The Specialized Program for Enhanced Interdivisional Responsiveness (S.P.I.D.E.R)*. Powerpoint presentation, Executive Director, Social Development, Finance, and Administration. Toronto, ON: Author.

Community Networks of Specialized Care (2014). *Central Region 2013-2014 Annual Report*.

CSDH (2008). *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization.

Dawe, I. (2011). *Toronto's Mental Health and Addictions Emergency Department Alliance*. Presentation at the 2011 National Health Leadership Conference.

Durham Collaborative Planning Process (2014). *Durham Collaborative Planning Process: A Service Provider's Guide* (Version 1). Durham Region, ON: Author.

Goering, Paula. (2004). *Making a difference: Ontario's Community Mental Health Evaluation Initiative*. Toronto, ON: Canadian Mental Health Association.

Government of Ontario (2011). *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Toronto, ON: Queen's Printer for Ontario.

Hunt, K.A., Weber, EJ, Showstack, J.A., et al. (2006) Characteristics of frequent users of emergency departments. *Annals of Emergency Medicine, 48*, 1-8

Hwang, S.W., Weaver, J., Aubry, T. & Hoch, J.S. (2011). Hospital costs and length of stay among homeless patients admitted to medical, surgical, and psychiatric services. *Medical Care, 49*, 4, 350-354.

Lecalle, E. & Robin, E. (2009). Frequent users of emergency departments: The myths, the data, and the policy implications. *Annals of Emergency Medicine*, *56*, 1, 1-8

MCSCS (2008). *A Safe, Strong, Secure Ontario: Strategic Plan 2008–2013*. Toronto, Ontario: Author.

Minkoff, K. and Cline, C.A. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America, 2*, 4, 727-43.

National Treatment Strategy Working Group (2008). *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*. Ottawa, ON: Author.

Newberry, J. (2014a). *Building Wraparound Supports for People with Complex Mental Health and Addictions Needs* Evaluation report submitted to Homewood Health Centre and the Top 40 Steering Committee. Guelph, ON: Taylor Newberry Consulting.

Newberry, J. (2014b). *Evaluation Planning Framework for Mental Health and Addictions Service Resolution in Peel Region*. Technical report submitted to CMHA Peel. Guelph, ON: Taylor Newberry Consulting.

Nilson, C. (2014). *Risk-Driven Collaborative Intervention: A Preliminary Impact Assessment of Community Mobilization Prince Albert's Hub Model*. Centre for Forensic Behavioural Science and Justice Studies, University of Saskatchewan. Saskatoon, SK: Author.

Rais, R. et al. (2013). High-cost users of Ontario's Healthcare Services. *Health Policy, 9*, 1, 44-51.

Reist, D. & Brown, D. (2008). *Exploring Complexity and Severity Within a Framework for Understanding Risk Related to Substance Use and Harm*. Paper presented at the International Symposium on Needs Assessment and Needs-based Planning for Substance Use Services and Supports. Toronto, Ontario: Centre for Addiction and Mental Health.

Rush, B. (2010). Tiered frameworks for planning substance use delivery systems: Origins and key principles. *Nordic Studies on Alcohol and Drugs*, *27*, 617-636.

Sapers, H. & Zinger, I. (2012). *Annual Report of the Office of the Correctional Investigator, 2011–2012*. Ottawa, ON: The Correctional Investigator of Canada.

Schaink, A. K., Kuluski, K., Lyons, R. F., Fortin, M., Jadad, A. R., Upshur, R., & Wodchis, W. P. (2012). A scoping review and thematic classification of patient complexity: Offering a unifying framework. *Journal of Comorbidity* 2, 1-9.

Sirotich, F. & Durbin, A. (2014). *Identifying the Needs of Complex Health Populations Receiving Community Mental Health and Addictions Services: An Analysis of Ontario Common Assessment of Need (OCAN) Data for Case Management and Supportive Housing Programs.* Final report, December 2014. Toronto, ON: Author.

Social Planning, Policy and Program Administration (2012). All roads lead to home: The homelessness to housing stability strategy for Waterloo Region – Policy framework. Waterloo, ON: Regional Municipality of Waterloo.

Social Planning, Policy and Program Administration (2011). *STEP Home flex fund report: June 2008-June 2010.* Waterloo, ON: Regional Municipality of Waterloo.

Stergiopoulos, V. (2014). *CATCH-ED: Coordinating Access to Care for Frequent Users of Emergency Departments.* Presentation at the 2014 Bridges Conference, Toronto, ON.

Toronto Central Local Health Integration Network (2013a). *A Plan to Transform Local Health Care for All: Integrated Health Services Plan 2013-2016.* Toronto, ON: Author.

Toronto Central Local Health Integration Network (2013b). *Enhancing Capacity to Connect Complex and At-Risk Clients to Services to Increase Access, Improve Coordination, and Enhance Care Management. Final Report.* October 2013. Toronto, ON: Author.

Toronto Justice Collaborative (2014). *System Improvement Through Service Collaboratives.* Presentation, May 77th 2014.

World Health Organization (2008). *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.* Final Report of the Commission on the Social Determinants of Health. Geneva: Author.

Appendix A – Key Informant Interview Guide

Introduction

Thank you for taking the time to speak with me today. I work with Taylor Newberry Consulting and we have been hired by the Complex Care Sub-Committee of the Toronto Regional Human Services and Justice Coordinating Committee (T-HSJCC) to engage local providers to help scope out a potential service resolution function in Toronto.

The Complex Care Sub-Committee (of the T-HSJCC) is committed to addressing service access issues for individuals with more complex needs who are currently involved with the criminal justice system and who are at risk of coming into contact with the law. We know that many people with complex needs are unable to get the services and supports they require, which heightens their risk of negative and harmful outcomes. We also know that the barriers people confront are often systemic in nature (many individual supports and services are not equipped to address a range of complex needs).

Service resolution is a strategic, coordinated approach to meeting the needs of people with these kinds of complex challenges – associated with mental illness, developmental disability, dual diagnosis, ABI, housing instability, involvement with the justice system, and other challenges.

Service resolution attempts to address systemic barriers to access by bringing together representatives of organizations from multiple sectors – mental health and addictions, ABI, developmental services, justice services, child and family services, and others. The key to Service resolution is that there is a committed *system-level* mandate to resolve complex individual challenges. It ensures there's organizational accountability to agreed-upon service interventions. That is – it brings together, not just front-line service providers (as is often the case in clinical case conferencing) but higher-level decision-makers in organizations so that there's high-level organizational endorsement and accountability for the table's decisions. This enables the system to make service exceptions, bend policies, enter cross-organizational partnerships, and formally endorse responses that are then carried out by front-line staff. This flexibility and **power** to change organizational practices is really what sets apart service resolution from traditional case conferencing approaches.

We're connecting with some key people across these sectors to get input into what a Service resolution model could/should look like in Toronto.

Consent -- All interviews are confidential and we will not be identifying you by name (unless you would like us to). If we have some quotes that may be at risk of being identifying, we will contact you to confirm if we can use them. We will be audio recording as a back-up. Do we have your consent to proceed?

Characteristics/circumstances/barriers of individuals served

1. First, let's hear about your organization your role within it, for some background.
2. In your experience, who are the individuals who could most benefit from service resolution?
    a. What are the circumstances in which people are experiencing barriers that could be rectified by SR?
    b. What services/supports do people try to use, but fail to? Or unable to access at all?

Examples of successes in serving this population

3. What are some examples of successes in serving these subpopulations that could inform a SR model?
    a. What is different? How is system responding differently?
    b. Are there examples of 'flexing and bending' in the system to create improved supports (of policies, practices, etc.)
4. What tables, groups, collaboratives, initiatives already exist that are similar to SR or would be relevant to a SR table?

What would a good SR model look like?

5. Given your own experience with SR or case conferencing approaches, do you have any recommendations on how a service resolution should be structured?
    a. Who should be involved and why? What are the roles to be filled?
    b. How should cases come to the attention of SR?
    c. Are there different decision making levels?
    d. How often would it meet? Is it ad hoc or is it regular prescheduled meetings?
    e. How could/should SR manage the geography and complexity of Toronto?

6. What concerns or advice do you have in developing and adopting a service resolution model in Toronto?
    a. Is there support for a city-wide service resolution model?
    b. Are there concerns about redundancy/overlap with other initiatives?
    c. Are there concerns about adding "new work" to the system?
    d. For a collaborative service/system designed to help individuals get comprehensive, appropriate, and timely supports what are the major things that would need to change in the system for it to work?

7. Other recommendations?

Appendix B – Service Resolution Coordinator Job Description

This list is adapted from SR coordinator job descriptions from the mental health and addictions systems in Peel and Waterloo-Wellington Regions. Please see section 1.4.3 for a description of their models. Note: the list below does not constitute the formal or finalized job descriptions of the coordinator positions in either region; it is merely a summary of common responsibilities, modified based on our professional consultations in the field in general.

- Provide support to all levels in the service resolution model and direct leadership in levels 3 to 5.
- Report to the executive director or designate of the sponsoring agency and the governance committee.
- Identify key system issues, and identify gaps in service at the local and regional Levels.
- Facilitate appropriate linkages and collaboration between the services and service sectors in the system.
- Provide reports as required by the sponsoring agency and governance committee.
- Promote, educate and inform agencies and the community on the service resolution model.
- Assist in the development of an annual operational plan, including an annual budget.
- Keep the governance committee informed on expenditures in relation to the annual operating budget.
- Assist in the identification and provision of any orientation or training needs in the system
- Promote shared services approach and philosophy in the development of system protocols and organizational structure, training, modeling and public awareness.
- Establish strong linkages to other systems and sectors.
- Actively participate in system planning initiatives, through planning groups, committees, at the local and regional level, (as appropriate) to further improve and enhance the system, and to build capacity within the system.
- Provide a point of contact for individuals and families who are having difficulty accessing services due to the complexity or uniqueness of their needs.
- Gather information on requests for service resolution and assess the extent to which requests are consistent with the eligibility criteria for service resolution.
- Schedule meeting of standing members and invite other participants as needed, including determination of consumer participation.
- Prepare and distribute meeting agendas and organize meetings.
- Chair the conference committee meetings, ensure that an achievable plan of services and supports has been developed, and complete minutes of the meeting.
- Maintain a record keeping system for cases that are reviewed at this level.
- Liaise with all necessary agency and Ministry contacts and advocate for identified service needs.
- Follow up with the family after the meeting for evaluation and support.
- Ensure confidentiality of consumer-related records used in the service resolution process.
- Provide evaluation, data collection, and recommendations for the continued improvement of the service resolution process.
- Liaise with other service resolution and other hard-to-serve mechanisms in the region.
- Work collaboratively with other services and teams within the community to ensure a coordinated and seamless approach to service delivery.

Appendix C - Example Evaluation Framework for Service resolution

Below are a set evaluation questions, indicators, data collection options, and related issues for service resolution in Peel Region. In their framework, Levels 1 and 2 refer to the collaborative person-centred front-line work that attempts to resolve issues prior to moving into formal service resolution. Levels 3 and 4 correspond to the interagency SR committee and the system SR committee of the recommended Toronto model. See page X for more detail on the Peel (and Waterloo Wellington) SR models.

Evaluation Planning Table for Levels 1 and 2

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
1. What are the main functions of the SCs within L1/L2? What proportion of time is spent engaged in each area?	Imp.	• # of consults for resources and information • # of local case conferences supported or initiated by SC • # of education events delivered • time spent on each category • time spent on system communication. • *Other* [add to SR-db as needed]	**SR-db** categorizes SC activities and records by date and time spent.	This first evaluation question focuses on the relative time that SCs spend on different tasks within the Levels 1 and 2. It will be up to the SCs and SR management regarding the level of detail desired. The design recommends using the SR-db to record *major* categories of activity – consults, local case conferences initiated by SC, educational events/workshops, and system communication. Other major tasks can be added as needed. System communication is a blanket term meant to a capture all the communication required within the SC role. Note time spent on each task category within Levels 1 and 2 can be compared, proportionately, to time devoted to Levels 3-4.
2. Who is accessing the system coordinator?	Imp.	• Primary contact name & position • Organization • Primary sector	Descriptive data recorded in **SR-db** from **referral form** or **contact tracking form** (see Table 1b).	It will be important to gather information regarding *who* is accessing the SR mechanism and for *what purpose*. These data will provide some indication of the reach and promotion of SR, the sorts of issues/barriers experienced in the community, and the appropriateness of referrals to the mechanism. The SR-db should be designed to capture basic descriptive and categorical

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
3. What are the primary requests and issues/barriers that are identified by providers seeking SR?	Imp./ Sys.	• Descriptive records of SC regarding the reasons providers are accessing the SR mechanism issues/barriers	Descriptive data recorded in **SR-db** from **referral form** or **contact tracking form** (see Table 1b).	information. Most of this information can be first captured on the SR referral form; however, we assume there are numerous instances where SCs are contacted with inquiries. These should also be tracked is possible. Recording this information and ensuring its accurate transfer to the SR-db can be tricky. It may be worthwhile to devise a simple *contact tracking sheet*, in lieu of a full referral form, that can capture who else is accessing SR.
4. What system connections are facilitated by the SC?	Out./ Sys.	• Descriptive records of: • Referrals made • "Warm connections" • Composition of case conferences.	**SR-db** captures the connection types made by SC to inquiring providers.	An important goal of SR at Levels 1 and 2 is to support collaboration and mutual problem-solving among local service providers to ensure that all options within the existing system are pursued before moving a situation up to Level 3. For each contact, the SC may create linkages to resources and services or may facilitate a local case conference. The SR-db should document if case conferences are occurring as result of the contact with the SC, including situations where the SC initiates and organizes a local

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
5. How often is local case conferencing used by agencies contacting service resolution.	Imp./ Out./ Sys.	• # of local case conferences supported or initiated by SC	• **Phone** or **email follow up** with providers will be required to see if case conferences actually occur (i.e., for those not attended by SC)	case conference. The SR-db should also capture the connections that are made by the inquiring provider as a result of their contact with the SC. This kind of record-keeping is potentially messy and challenging to manage. Part of the problem is how to operationalize the data that is being collected. For example, what will "count" as a connection? Does a referral by the SC to call another provider represent a connection? Does the connection need to be a "warm transfer"? Will the SC need to follow up to check on the result of the connection for it to "count"? Without clarity on the level of detail and corresponding definitions, data will be difficult to interpret. We recommend very simple data collection at this point. • Referrals made – i.e., referrals made to providers who need resources or linkages but not a case conference. • "Warm connections" made – i.e., where the SC brokers meetings, makes introductions, or otherwise facilitates a connection for a provider. • # of case conferences occurring after contact with SC. • Composition of case conferences – i.e., organizations represented at case conferences.

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
6. Does support provided at Level 1 and 2 lead to resolutions?	Imp./ Out.	• Self-reports of providers regarding result of SC support.	• **Phone** or **email follow up** with providers	This is a very important area for the evaluation of service resolution. It is a primary goal to divert situations from moving up to Level 3 when existing resources can solve the issue at hand. As part of general practice, the SCs will need to follow up with providers who have received support from service resolution to document a) what actions have been taken and b) what was the result and c) what next steps are necessary.

Key: Imp. = Implementation information; **Out.** = Outcome information; **Sys** = System Information; SC = System Coordinator; **SR-db** = Service resolution Evaluation Database.

Evaluation Planning Table for Levels 3 and 4

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
7. How often do inquiries for SR move up to Level 3?	Imp.	• # and % of inquiries at Level 2 that are moved up to Level 3.	Recorded in **SR-db**	The SR-db needs to code cases according to their status as those that are moved up to Level 3 versus those that are not.
8. Which organizations & sectors present cases that are served at Levels 3 and/or 4?	Imp.	• Primary contact name & position • Organization • Primary sector	Descriptive data recorded in **SR-db** from referral form or contact tracking form (see Table 1b).	For each L3 or L4 situation, the SR-db should have a corresponding "home" organization and primary worker that brought the situation forward

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
9. Who attends the interagency case conference? Who attends the system conference?	Imp.	• Primary contact name & position and SR table role (standing or ad hoc) • Organization • Primary sector	Descriptive data recorded in **SR-db**, drawn from meeting minutes of both Level 3 and level 4 meetings.	Service resolution is effective insofar as the people with influence and leverage over services and supports are active participants. A basic key indicator is organizational representation at each meeting (also according to "standing" or "ad hoc" status). This will help discern organizational and sectoral engagement.
10. What are the issues and circumstances that describe service resolution cases?	Imp.	• Demographic information of people in SR • Risk type and levels of people in SR • Barriers experienced and presenting needs	**SR-db** categorizes individuals served, collected via **referral forms** and **supplementary assessments.**	Much of this information should already be available via the referral form and other supplementary documentation. It should be entered into the SR-db as descriptive case information.
11. What decisions, actions, recommendations are made and who is involved?	Imp.	• Narrative documentation of actions recommended • Name of primary worker, home organization, and supporting organizations involved	This information is recorded in a **SR planning tool** with a unique number that is referenced in **SR-db**.	The SR Planning Tool should capture, at the time of the meetings, the range of actions that are recommended. Key information includes the determination of a primary worker, roles, communication, expectations, sequence of tasks, and timelines. This information should be given a unique (consumer) identifier that matches to the SR-db.

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
12. What actions actually take place? What challenges are confronting in carrying out plans?	Out.	• Narrative documentation of actions taken, including departures from recommendations, challenges confronted, and any new actions.		This area of inquiry requires follow up; this can be challenging to resource, but is essential to understanding the effectiveness of the mechanism. The SCs are the most appropriate staff to conduct this follow up, as new actions may be necessary. This narrative information can be captured using the SR planning tool, with a focus on actions taken, variances with plans, barriers confronted, and next steps.
13. How often do situations at Level 3 move up to level 4? What is the rationale for moving from Level 3 to Level 4? What system barriers warrant these decisions?	Imp.	• Narrative documentation of rationale and context of decision. • # and % of cases at Level 3 that are moved up to Level 4.	**SR planning tool** records rationale for moving from L3 to L4.	There is not a standardized analysis or set of criteria that can clearly specify that a situation is "ready" to be moved up to Level 4. In a general sense, the SC must feel confident that the actions in 11 and 12 above were faithfully pursued and met with serious barriers to service access. The information of interest focuses on systemic barriers that prevent a resolution or any other compelling reasons that a plan breaks down. This information can be captured narratively with the SR planning tool, and can be recorded alongside #12 above.

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
14. What is the system result of the intended resolution? What changes to policy, practices, and partnerships are observed?	Out.	• Self-reports of primary providers and related partners regarding changes to practice and observed benefits, challenges, etc. • Self-reports of Level 3 and Level 4 committee members regarding their perceptions of the impact of SR on organizational capacity, collaborations, changes to practices, etc.	SCs can collect this information in follow up with providers, either by **phone interviews** or **focus group debriefs**.	This component of the evaluation focuses on system outcomes and requires extra planning that lies outside the main day-to-day tasks of the SCs. There two primary sources of this information. First, are the local providers that are implementing the recommended plans. A follow up phone interview or group debrief with involved providers is recommended. Second, are the two committees of Level 3 and Level 4. A quarterly debrief for the Level 3 committee (with active ad hoc members invited) should be held to gather feedback. Feedback from the Level 4 committee can occur in combination with Level 5 meetings (which may be biannual or annual and are designed to reflect on evaluation information gathered by the SR function)

Key Evaluation Questions	Eval. Area	Suggested Indicators	Data Collection	Evaluation Design Considerations
15. To what extent to consumers (and significant others) engage with the suggested plan? What are the experienced benefits of consumers and others involved?	Out.	• Self-reports of consumers and their significant others regarding the experience of new services and supports. • Risk level, post-intervention	SCs or primary providers (on behalf of SCs) can collect **feedback from consumers** and/or supply an **updated risk assessment** after the plan has been put into action.	The evaluation of SR could benefit from gathering direct feedback from consumers and other significant people in their lives. This can be challenging given the often very difficult circumstances people are in. This automatically introduces a bias where the evaluation will tend to access people who are faring better and who consent to a conversation. Nonetheless, with the help of primary workers, it will still be useful to gather some feedback on how new interventions created or accessed out of SR have helped people. In absence of direct information, reports from providers and/or updated risk assessments can be valuable. It is of course challenging to know when to gather this information – we suggest accessing individuals when there is some evidence that they have participated meaningfully in the plan and had the identified needs addressed (successfully or not).