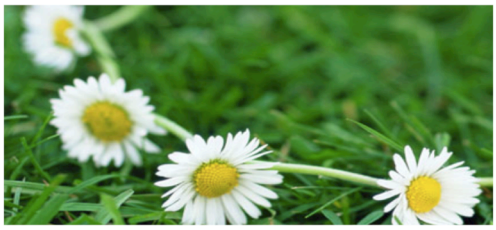

Making Links

Frequent Service User Project

Think Tank 3: Designing the Model

Notes

Part 1: Exploring

Introductions and welcome

Louise Richardson, AoD Health Services Planner, Odyssey and ReGen, acknowledged the traditional custodians of the land on which we are meeting and welcomed everyone to this third of three 'think tanks' for the Making Links Frequent Service User project. Louise reflected that in Think Tank 1: A Shared Understanding, George Hatvani presented on international research defining frequent service users and learnings about responses to them. In Think Tank 2 we heard from a number of other linked projects in order to consider their learnings.

Setting the scene

The organsing group has prepared 'evidence based decision cards' to document our discussions through the Think Tanks, identifying learnings and agreements to date and items requiring further consideration.

Kris Honey identified that this is the last Think Tank and we now have to 'land' a cross sector proposal to respond to frequent service users across our Sectors.

Evidence based decision cards

1. Target group/definitions:

Does the target group need to be frequent service users of all three systems?

Discussion:

In addition to the criteria established previously, this group of consumers are likely to have chronic health conditions, high risk behaviours. Some will have ABI and disabilities.

Should we compare the top 25 most frequent service users across each Sector?

Sue from EACH presented some figures on mental health intake across four catchments. Clients prioritised as Priority 1 match the target group we are talking about. EACH has 99 people of the total wait list of 600 identified as Priority 1. In the North there are 14 individuals listed as Priority 1.

Should the mental health needs be clinical/acute? Are we talking about acute trauma and the way it is impacting on day to day lives?

To what extent are we focussing on people whose needs are so complex that they are not engaging with any services and to what extent are we talking about frequency of use in at least one of the systems?

The Launch Top 25 are identified as 'complex' because of the extent of the impact of trauma/family violence on their day to day functioning. Launch clients don't feel safe with the current service system and may practice avoidance strategies. They require a different service approach.

Our target group would meet the threshold for all three service systems.

A key element is that the current service system doesn't work for them – every time they come to a service we can't do much for them.

Do we identify this group by the extent of system failure in the past – they are not getting good outcomes from contact with the service system.

The core business of each service system is to respond to trauma, complex needs.

There is a significant group of people who experience issues addressed by all three sectors (hence the Making Links initiative) but this group has been failed by all our systems.

One benefit of working with this target group is that we can work back to those whose needs are less complex because our improved response will have an impact that is broader than on those who have the most complex issues.

Our intake systems may not pick up this target group. The move to telephone based, centralised intake may have proven a deterrent for this target group.

Where are we likely to see people who meet these criteria? Emergency departments?

NB: Outcomes: Saving the service system money and keeping people alive with a better quality of life. Cost benefit to the whole system. Reducing inter generational impacts.

The responses that we are starting to discuss that is needed is not currently provided by the majority of our current service system models as they are currently funded.

Summary

The target group will:

- be experiencing complex issues across all sectors.
- Have a history of frequent service use without improvement.
- Have needs that have been long term.

In developing a response we will need to pick the top 'x' number of people who meet the target group across the service delivery partners (small number).

2. **Privacy**

Privacy becomes an issue if we are sharing data about frequent service users before one service makes contact with them. Once we make contact with an individual we can seek their consent to sharing information cross sectors.

The group questioned whether consumers will give consent to sharing of information across Sectors. Given that this target group have used services frequently, they are likely to be more comfortable with information sharing across systems. There may be specific services or service models that they don't wish for information to be provided to.

How do we manage responses to those target groups who practice high levels of avoidance? We may need to limit participation to those consumers who are engaging/prepared to engage, in the first instance.

There was acknowledgement that preparing an IUA will take significant time so we need to devise a project that, in the first instance, does not require an IUA. In Phase 2 we build in data sourcing that will require an IUA.

3. Funding and parameters

We do need funding for coordination. Data sharing comes with costs. Beyond this the costs depend on the model: ie. Participation in a panel, more intensive support.

We are likely to be able to negotiate with funding bodies for changes to durations of support and targets.

The process of social impact bonds has started. We have missed the first round of this development but there are likely to be more. Projects need to be very solid in order to participate in the social impact bonds projects. We could look at this in Part 2.

We could look to a major donor for seed funding. William Buckland may be interest and we could potentially acquire $300k over a few years. The Lord Mayors Fund may provide funding.

Louise had a conversation with Eastern Melbourne Primary Health Network (overlap with our catchment is Bunyule/Nillumbik). North West PHN has the same type of funding. PHNs have been allocated $1.5M per year through the ICE Task Force. The funding does not have to be used directly in response to ICE use. Eastern PHN is interested in funding something that is evidence based and is ready to go. PHNs have to prove outcomes by 1 January. Bringing our three Sectors together to work in response to this target group would be considered an outcome. The funding has an ATSI focus.

Some of the services at the table have a 30% use by ATSI people. About 10% of Launch clients are ATSI.

We will need funding for housing. We can promote the project through the Housing and Homelessness Reform but the only additional capacity for housing is built in through additional private rental brokerage.

Partner agencies could put money on the table.

DHHS amend targets/FASA conversations.

Proposal:
That we pursue:

- Seed funding through PHN
- Donor funding
- Government investment (meet with Ministers and Minister's advisors).
- Process to get 'buy in' at the CEO level within our organisations.

Whichever strategy we apply will require resources directed to the development activity. If we have a model/pitch we will need to direct capability to advocacy meetings and submission writing. The Planners/Networkers could coordinate this.

4. Evidence based interventions

Do we have a robust enough evidence?

We have strong evidence about the service system failures with this group – that we need to respond differently.

We have strong evidence about service interventions that are likely to work for this client group – particularly around housing first. Establishing connections for clients is critical.

We don't yet have strong evidence for a cross sector collaborative response.

NEAMI Willum model provides a coordinated response to Aboriginal clients experiencing homelessness, AOD and mental health issues. See notes from Think Tank 2 about other collaborative models.

There is agreement that we need to run a Housing First model but access to housing is the key challenge in the current environment. Private rental may be our only option. We need to find a way to find capacity in the private rental market to manage fluctuating tenancies and affordability.

Can we advocate that this group be allocated priority in public housing systems?

How do we frame the argument?

- Emergency department presentations.
- Family Violence Royal Commission – the housing requirement
- Current service use is costly – reduced cost to the service systems in the long term.
- Current Justice issues are costly – community safety issues reduced; call on the 'first response' systems
- Human Rights/social justice issues – improving quality of life for individuals
- Supports service system improvements: Addressing failings in the service system – reforms in all service systems have led to greater barriers for this client group. We need to adapt our systems to respond appropriately.
- We will impact cross generational issues.

- Effective use of Commonwealth/NDIS resources.

5. The model

Critical success factors – add:

- **Collaboration:** shared vision, philosophy/core values, training, shared approach, language and culture, mechanisms to grow shared practice/coordinate and resolve issues.
- Making Links has a focus on shared practice that we direct to this project.
- **The authorising environment is critical.**
- **Consumer voice** – build in to our evidence base: an understanding of clients, their view of impact – what the services means to them. Co design with consumers. Inclusion of a peer support worker.
- **Evaluation** – domains/meaningful activity (connection), service model design
- **Openness to reflect/develop/improve**.

Design: Are we going to be doing something differently or just doing what we usually do but doing it together?

See Three Broad Directions (p. 7 of learnings). Agreement to start with 2) Collaborative responses to this target group (new program/way of working).

Part 2: Landing

What is the service response?

We need to consider: Client services, Coordination and Governance/authorising environment

Proposal 1:

Establishing connections for clients is critical. **Key worker** – person with the best relationship with the client, who coordinates the other responses and starts the engagement and undertakes key contact with client. Other workers provide secondary consult, help negotiate access to service responses. The key worker would be the worker who has already interacted with the client and has the best engagement with them.

Other supports – other workers who are involved with the client or who are needed in response to client need participate in a coordinated, collaborative team around the client

Panel – coordinates the project, designs the proposed intervention, creates authorisation for participating agencies, case reviews.

Project coordinator – coordinates the whole project

How would it work?

Collective impact approach to supporting identified client group.

Once a client is identified as a frequent service user, the systems would identify who is already involved with that client. Those already involved become the core in the support system. The Project Coordinator brings the agencies together who are already involved with a client. Those agencies meet together with the client and discuss the ideal intervention for the individual and develop a response – bringing other agencies in if necessary.

A Panel with Team Leaders from each Sector could oversee the responses. The Panel could agree the service intervention and authorise the responses from within each sector.

Pros

- Driven by the engagement that the client already has with a worker
- Capacity building for all those involved in care coordination.
- Flexibility to set up a 'care team' that best fits the needs of individual clients.

Cons

- Potential for dependency
- How can we train all the workers who may be involved with a client.
- Managing authorisation and supervision is complex.
- It is harder for the team to undertake recreation and other diverse activities with the client.

Issues

- Buy in would be required at a high level in organisations. Authorisation would be required across organisations to enable workers involved to do this work differently.
- Would we need to target particular workers in each sector in order to ensure that have appropriate practice skills? This would reduce the flexibility to engage any worker in the sector already involved. (Although those workers who already have good engagement with this target group are likely to be those with the practice skill.)
- Different workers will surround different clients. How do we coordinate them?
- How do we manage support in to the long term?
- How does the coordinated response group work with people/services in the client's life outside the three sectors? We could use a 'Mirrors family model' – develop an ecomap with clients about who they have in their life.
- How do we avoid multiple data sets?
- A similar model was trialled in UK about five years that incorporated an online information sharing system that was controlled by the client. The client could choose who gets what information. This system can be used for both formal and informal supports.
- Launch Housing has access to SRS and could grant access to all participants. AOD has developed an online system that the client controls access to.
- The group debated whether or not the client controls the information.

Proposal 2:

Create a team of workers from across the services to form a co-located team.

Pros

- Easier to develop a shared understanding, supervision, management, peer support

Cons

- Loss of flexibility geographically and in terms of the client working with the worker in the system who has the best relationship with them
- Replicates other models such as HOMHS – we could just expand those programs.

Proposal 3:

Develop a core team but the client can nominate a different key worker to take with them in to the initiative.

Proposal 4:

We have a core team of support workers who will provide capacity building support for other workers who come in to support that client.

Discussion

Is our capacity to coordinate the key current issue? What is currently inhibiting workers from working appropriately in a coordinated way?

Why did housing breakdown for the top 25 frequent service users? Are we pre-determining what response would have assisted them to better outcomes initially in order to build that in to our model. Response: The reasons were not the same but a key factor was that people tend to be housed and then support ends.

What is currently not working with the Launch project? Noach is currently providing intensive case management but has little time for coordination.

How does this role differ from PIR? PIR is missing a level of authorising. Do we need a system that is appropriately authorised to adapt the service system responses to these clients?

We could argue to government that rather than adapting our current systems, these clients need a different response: housing first, coordination of services, social engagement, good clinical engagement and case management, ongoing support, key worker with a care team.

PIR/MACNI and Services Connect all provide learnings/links/elements for this initiative.

Could community visitors be trained to undertake the ongoing monitoring? Could GPs take a monitoring role? Neighbourhood houses?

AOD data shows that it generally takes people 6-7 attempts at recovery for good outcomes – fewer instances if residential rehab is part of the response.

Family violence data shows that a woman may need to leave 7 times before she leaves a violent situation permanently.

Changes to practice negotiated through the Launch project: maintenance of the same worker/continuity, direct access to crisis accom (ie 28 day wait is waived).

Changes to current service models and targets is identified a VERY LARGE sticking point. What is the likelihood of us getting authorisation to take away targets for this client group in all three sectors?

Developing a service model

Agreed design features:

- Outreach capacity
- Secondary consult capacity
- Build in to the model above a practice model that incorporates a predication on connectedness and built in redundancy of the key worker model.
- Key worker role is to model and facilitate other engagements
- Capacity to house
- Housing first model
- Meaningful engagement
- Long term step up/step down support if needed – need to ensure that an alert capacity is built in with capacity to respond in a timely way as needed (ie like chronic disease management)
- Establish a relationship to an agency, not a worker in the long term
- Create a sense of history/agency narrative
- Evaluation – intersect with a social return on investment practitioner or university
- Part of the work of the team would be to get the client an NDIS package if they are eligible

Two proposals are on the table in terms of where to next:

- Dedicated response – specifically funded – need to source funding first
- Collective impact response within current resources – need to incorporate authorisation to change targets

Are we talking about a place based pilot to develop an evidence base?

Next steps:

- Write up two models (one the dedicated and one on the collective impact approach)
- Write a PHN response
- Prepare a philanthropic submission
- Somebody/ies needs to write this up with some urgency, in order to make use of PHN and other funding opportunities.
- Seek Ministerial buy in.

Action:

- **The Frequent Service User Working Group coordinate write up of the models.**
- **George can write up a 2-3 page version of the collective impact response.**
- **Ian Symmons, Venetia, Leonie are all interested in joining the working group.**
- **Utilise the December forum to discuss the practice implications of this sort of work – to focus on how we can work differently together across sectors.**

Reflections

- The commitment to attend three sessions is difficult and it is tempting to pull out of one.
- Perhaps bringing everyone together for one day would work better.
- Working together collaboratively has been good.
- Really good progress has been made but the process is complex and hard.
- 'The proof will be in the pudding'
- There is a lot of wisdom in the room.
- Disappointment that we haven't yet achieved something solid- but there is a feeling that we are close.
- Balancing the desire to get a distinct project underway with the need to 'bring people along'.
- CEO and Ministerial engagement needs to be a core part of the next steps and will impact the success of the project.