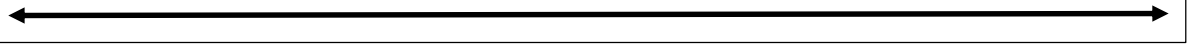
Introduction

Collaborative approaches with working with individuals identified as 'Frequent Services Users' can be conceptualised as operating along a continuum of resources and cooperation.

This document proposed two models at either end of this spectrum.

Continuum

Existing resources, multi-disciplinary team(s) ---------- Fully-funded, dedicated service response



The models are informed by the research synthesis undertaken by Launch Housing in its Frequent Service Users Annotated Bibliography, its Frequent Service Users Pilot Project and the consultations that took place over 3 'Making Links' forums during 2016.

The research and forums highlighted a number of evidence based approaches, including 'Collective impact', outreach support and Critical Time Interventions, as well as the Victorian Multiple and Complex Needs Initiative, Family Violence 'RAMPS' and Taskforce 1000.

Key learnings from these approaches are found in the models described.

The models proposed are also grounded in the evidence supporting the Housing First philosophical approach to ending homelessness, and a shared understanding by forum participants that safe, secure, affordable housing is a foundation from which the work of all the sectors involved in 'Making Links' is at its most effective.

The core philosophy of Housing First:

- Housing as a human right
- Housing not conditional on behaving in a certain way
- Housing First service users should have the same level of security and rights as anyone renting a home or an apartment.
- Harm reduction and choice
- Flexible, non-judgemental and open-ended support

Model 1: Existing resources model, collective impact based on virtual, multi-disciplinary team (s)

Underpinning commitment to collaboration

Agreement is reached among the CEO's of agencies representing the following sectors to work with 'frequent service users' who fit the agreed criteria (see notes from that part of 'Making Links' forum #3 on the agreed criteria).

The sectors (initially) are:

- Homelessness
- Mental Health: Clinical and Community
- Alcohol and other Drugs
- Primary Health: Hospitals, RDNS and Community Health
- Housing: Community and Public

Referrals into the program

These could happen in a number of ways:

- Using an existing list of 'frequent service users',
- Comparing lists from different sectors and agreeing on a list of clients to focus on,
- Using the agreed criteria and then the *FSU panel* uses this to agree on clients to work with

Getting started

- Settle on a small group to get started and seek their consent
- In parallel seek information usage agreement

The Model

The model has the following elements:

1. Virtual teams built around each FSU and based from the outset on:

- Sound assessments using existing client information;
- Workers already involved with the client, multi-disciplinary wherever possible;
- Led by the worker identified as having the best relationship with the client (go with the relational energy),
    - This person plays the role of *care coordinator*, but the arrangement is utilitarian; it is only used to facilitate initial engagement in the model;
    - If another worker is identified as better placed to be care coordinator then that role can sit with the individual identified as having the necessary skill;
- Team members meet before the offer is made to the client and plan their initial approach, the likely path of the intervention, including critical transition points, risk assessment, and likely case plan goals. They also make agreements as to how they will work with one another and how often then will catch up and discuss the client;
- One member seeks the consent of the client to participate in the model, with the explicit aim of ending the persons homelessness and ensuring they never experience long term homelessness again;

- Consnet process seeks consent to participat in the project and could explain the model and the fact that there are potentially mutltiple service who can provide epxtertise (plain language statement – sell it as a holistic, resourced project rather than opt out and choose who you work with and don't)
- If there is no engagement with the other sectors in person, there is still the background support provided via secondary consultation and the panel always there
- Team members remain in regular contact and participate in case planning meetings at regular intervals, ideally involving all team members and the client, but also sensitive to changing circumstances. As a result, case planning sessions may sometimes need to be 1:1 with the client, at other times they may involve the entire care team;
- Case management is strengths based, client centred and long term, but informed by the history that the service (s) hold with the client;
- The care coordinator is expected to produce regular case summaries for team members (in tandem with the *FSU program coordinator*) and ensure a continuous shared narrative, ideally involving the client in its generation.
- Engagement by the client should be with the team, but the team must have sufficient sensitivity to be able to adapt to the changing needs of the client and withdraw visibility to only 1 or 2 members if circumstances demand it;
- The team may need to change over time and it is the system which has responsibility for engagement with the client. If the client will not engage the collective must try other workers and other strategies to the ultimate satisfaction of the panel and then the collective of agencies, that every avenue of engagement has been exhausted. Engagement can then be put on hold for an agreed period (say 6 months) before renewed attempts to engage are made;
- Team members are in regular contact with each other but this is largely dependent upon the needs of the work - more intense at times, less at others;
- The duration of the work is open-ended;
- The intensity of engagement will fluctuate from many moments of contact at certain times to monitoring at others; however, there is always a level of monitoring, even if it is simply that a direct debit remains in place and is being honoured;
- The work also has a strong quality of life component as a way of securing housing in the long-term.

2. Support to each team provided by:

- The **authorising environment** provided by the collective agreement that each agency has entered;
- The **FSU panel** which is made up of senior management and clinicians, whose role is operational and to provide regular review, advice, consultation and service access, as well as to assist in the creation of a shared narrative and ongoing monitoring of each FSU;
- The model also has a **high level strategic (executive level) steering committee** made up of either CEO's or GM's of participating agencies. Their role is to oversee strategic collaborative relationships across the model and working closely with funders. By including Government funders in the high level steering committee we can modify the targets as needed and

flexibly, but also a high level panel meeting as needed to work through 'stuck' system level problems.

- An **FSU coordinator** whose role is to act as a liaison between the virtual teams and the FSU panel and to provide support to both. This will include:
    - Arranging clinical group supervision to each FSU team when requested;
    - Arranging access to specialist secondary consultations for each FSU team when requested, ideally through contacts on the panel;
    - Supporting the creation and updating of client summaries from teams and for the panel;
    - Monitoring data quality;
    - Monitoring and reporting on outcomes;
    - Supporting the maintenance of a shared client narrative;
    - Ensuring that client monitoring post-housing (long-term, safe and sustainable) continues and is part of regular outcomes reporting;
    - Creating annual review reports, quality improvement plans and structures for celebrating success for the project.

The model operates under *'collective impact'* with the following elements

Collective Impact under five key conditions

1. Common agenda

A common agenda for change forms part of that agreement including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.

- The problem is as described in the presentations from Launch Housing;
- The joint approach is this model;
- The agreed actions are those required to implement the model with the top 50 agreed FSU's;
- A collective approach to advocacy for an authorising environment from funding bodies in support of the collective impact approach (Allowing each participating agency some leeway in its agreed targets to accommodate long-term work with FSU's).

2. Data and Results

The partners agree to collect data and measure results consistently across all the participants. They will do so by using one client management system and an agreed process and templates for reporting information to each other and to the wider community.

3. Mutually reinforcing plan of action

The participants to the model agree to a plan of action that outlines and coordinates mutually reinforcing activities for each of the member agencies.

These include:

- Setting aside a proportion of potential EFT to allow existing staff to participate in the collective impact model described herein;
- The development of a program logic for the model;

- The recruitment of staff for the panels and for the role of FSU coordinator;
- The provision of regular training and support events to ensure a culture of cooperation and open learning is fostered across the related sectors;
- The development of rules and resources which support the creation of long-term structures of cooperation between the sectors who participate in the model, ensuring the continuous transfer of learnings to the wider sectors;
- Partnerships with academia for the purpose of evaluation and model development (philanthropy for action research evaluation)

4. Open and continuous communication

The creation of social structures (rules and resources) that support open and continuous communication between the following levels:

- Level 1: Between team members and between the team and the client (s)
- Level 2: Between teams and the FSU coordinator
- Level 3: Between teams and the FSU panel
- Level 4: Between the FSU panel and the member agencies ('the collective')
- Level 5: From 'the collective' to the funders
- Level 6: from 'the collective' to the wider community

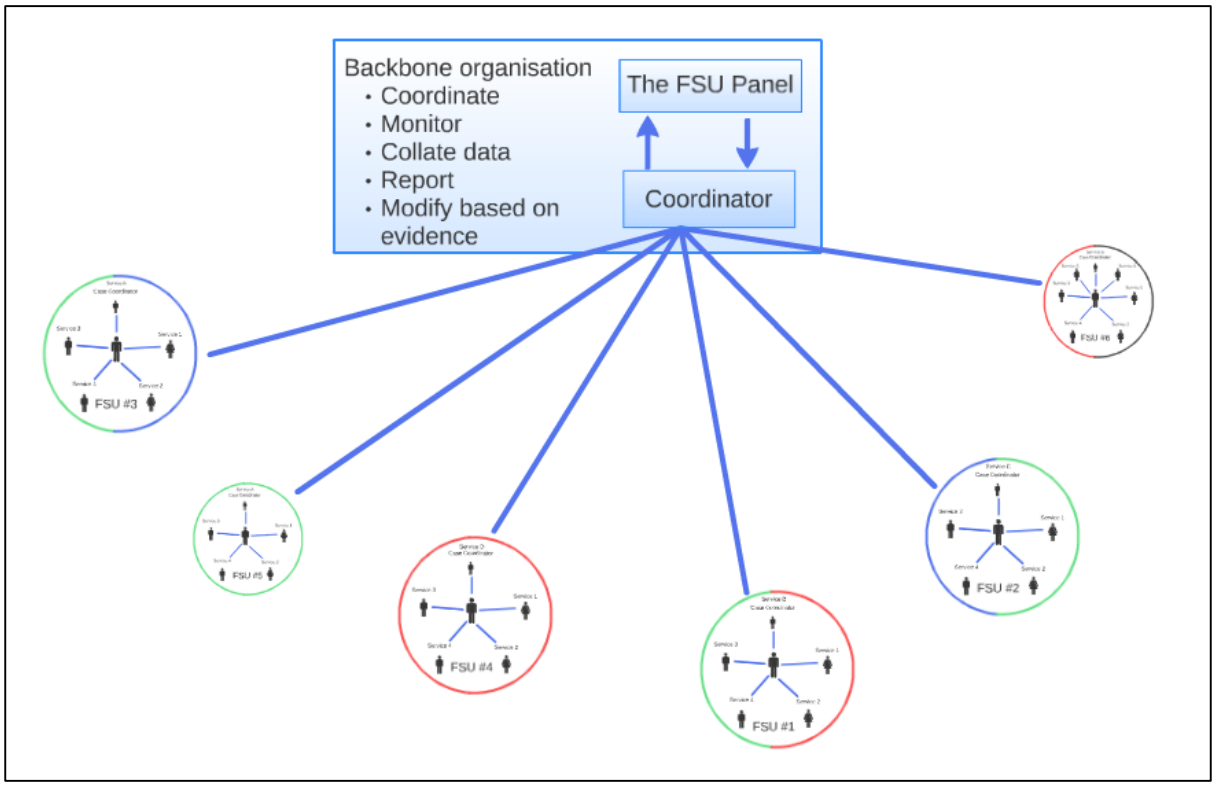
5. Backbone organisation

A backbone organisation(s) with staff and specific set of skills to serve the entire initiative and coordinate participating organisations and agencies.

The minimal resources needed to run the model are:

- A common data system
- A person to coordinate activities between teams and the panel with skills in data analysis, coordination and report writing
- A panel of advisors
- Sufficient networked IT resources and a physical location ideally centrally situated

Figure 1: A visual representation of the model with 6 FSU's



Model 2: Fully funded dedicated service response

Underpinning commitment to collaboration

Agreement is reached among the CEO's of agencies representing the following sectors to tackle frequent service users who fit the agreed criteria (see notes from that part of Making Links forum #3 on the agreed criteria).

The sectors (initially) are:

- Homelessness
- Mental Health: Clinical and Community
- Alcohol and other Drugs
- Primary Health: Hospitals, RDNS and Community Health
- Housing: Community and Public

The Model

A service response made up of staff, coordinators, and physical resources to enable teams to be co-located in one of the sector agencies.

Model elements

- Examples: HOMHS (OHMS) and MS2H
- Focus on agreed target groups
- Multi-disciplinary teams with a specific focus on the target groups
- Teams co-located at multiple sites across a region
- Teams supported by FSU Panel
- FSU panel supported by a Coordinator
- High level strategic steering committee

The work of the teams could take a number of forms:

- Direct work and case (care) coordination
- Case (or care) coordination
- Secondary consultation to the sector in support of capacity building

Support to each team provided by:

- The **collaborative environment** provided by the agreement that each agency has entered;
- The **FSU panel** which is made up of senior management and clinicians, whose role is operational and to provide regular review, advice, consultation and service access, as well as to assist in the creation of a shared narrative and ongoing monitoring of each FSU;
- An **FSU coordinator** whose role is to act as a liaison between each team and the FSU panel and to provide support to both. This will include:
    - Arranging clinical group supervision to the each FSU team when requested;
    - Arranging access to specialist secondary consultations for each FSU team when requested, ideally through contacts on the panel;
    - Supporting the creation and updating of client summaries from teams and for the panel;
    - Monitoring data quality;

- Monitoring and reporting on outcomes;
- Supporting the maintenance of a shared client narrative;
- Ensuring that client monitoring post-housing (long-term, safe and sustainable) continues and is part of regular outcomes reporting;
- Supporting sector capacity building by working with the Networkers across the various sectors to develop regular coordinated training and support events;
- Creating annual review reports, quality improvement plans and structures for celebrating success for the project.

The model also has a **high level strategic (executive level) steering committee** made up of either CEO's or GM's of participating agencies. Their role is to oversee strategic collaborative relationships across the model.

These include providing input to the work of the FSU Coordinator to ensure that the following capacity building work occurs annually:

- The provision of regular training and support events to ensure a culture of cooperation and open learning is fostered across the related sectors;
- The development of rules and resources which support creation of long-term structures of cooperation between the sectors who participate in the model ensuring the continuous transfer of learnings to the wider sectors;
- Partnerships with academia for the purpose of evaluation and model development.

Key questions

- How many of these do you need across the region the service x number of FSU's?
- Is there one panel and one FSU Coordinator per region?
- Are there as many panels and coordinators as there are teams?
- Is there only one high level steering committee for the state or are there multiple?
- What is the cost of each of these?
- Do you start with a pilot in one region?
- Which data system will be used and how will duplication be avoided?