An Evaluation of the *Connectivity* Situation Tables in Waterloo Region:

Addressing Risk Through System Collaboration

July 2015

PREPARED FOR

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About Taylor Newberry Consulting

Taylor Newberry Consulting (TNC) is community based research and evaluation organization located in Guelph, Ontario. We have extensive experience in program and system level evaluations, needs assessments, program and system design, organizational capacity building, and facilitation and training. Our projects range from small and local to large and national in scope. 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.

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Dr. Jaime Brown uses her high level of expertise in research and facilitation to help bring clarity to the work of non-profit organizations, utilizing research and evaluation evidence as tools for organizational learning, strategic planning and action. Jaime earned a Ph.D. in Applied Social Psychology from the University of Guelph, with a focus on health and social justice issues. She has over 10 years of experience working - both regionally and nationally - with not-for-profit organizations, government, grant-making organizations, and universities on issues related to health systems, health equity, disability rights and supports, public health and health promotion, food security, family relations, and child and youth development. Jaime's research has won awards from the Canadian Institutes of Health Research (2011) and the U.S. National Council on Family Relations (2014).

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Executive Summary

Connectivity is the name of the Waterloo Region "Situation Tables", which bring health and social service agencies together at a weekly meeting to collaboratively and proactively address situations of elevated risk. Connectivity is based on a Community Mobilization Hub Model originating in Prince Albert, Saskatchewan. The model is a multi-disciplinary, interagency approach to addressing situations of acutely elevated risk on a case-by-case basis. The approach enables organizations to be immediately responsive to acute needs in the community.

In January 2014, the Waterloo Regional Police Service (WRPS), in partnership with Langs, adapted and implemented the model in Cambridge. In partnership with Carizon Family and Community Services, a second Situation Table became operational in Kitchener in October 2014.

Waterloo Region received a Proceeds of Crime Grant from the Ministry of Community Safety and Correctional Services to design and implement an evaluation strategy for the Connectivity Tables in Waterloo Region. Taylor Newberry Consulting (TNC) was contracted to lead this evaluation work. In January 2015, a project launch session was attended by some key local organizational representatives involved with Connectivity. At this meeting we reviewed the current state of the Waterloo Region Connectivity Tables, our main information needs and areas of inquiry, and our proposed evaluation design. Informed by this consultation, the evaluation design focused on two major areas of inquiry:

1. **Evaluation of implementation** will focus on aspects of the development, evolution, and delivery of Connectivity's activities. *How is Connectivity being implemented in Waterloo Region? Who is being served by Connectivity?*
2. **Evaluation of outcomes** will focus on the ways in which Connectivity leads to benefits for individuals that become connected to the supports. The evaluation will also examine benefits at a service and system level. *What are the outcomes for the people being served by Connectivity? What outcomes or changes does Connectivity bring to bear on local services and systems?*

To answer these key evaluation questions, we collected data from three primary sources.

1. The Connectivity databases maintained for the Cambridge and Kitchener Situation Tables *NB: The data analyzed for this evaluation was drawn from all situations captured in the databases from the inception of the two Tables in 2014 through to the week ending March 14, 2015.*
2. Connectivity Member Focus Groups and Interviews
3. Other Key Stakeholder Interviews and Focus Groups

Across these data collection strategies, we engaged a total of 74 individuals. This included a total of 4 focus groups (68 participants), and individual interviews with 26 key informants. Some key informants participated in a focus group as well as an interview. All data collection took place between January and March 2015.

Although only recently implemented in Waterloo Region, the Situation Tables in both Cambridge and Kitchener have developed consistent and effective processes to address elevated community risk amongst people with complex challenges and there is a strong, integrated, cross-sectoral collective of organizations working together at both Tables. Multiple, confluent risk factors are being creatively addressed through the contributions of members representing health, mental health and addictions, police services, child and youth services, education, and a range of

social services. Members report enhancements and improvements in how they engage in collaborative work and new system relationships have developed to support table responses and local supports and services more generally. Although the longer-term impact of Connectivity on the people served is unclear at this time, there is evidence of short-term gains in creating new service connections and engagement, building trust and rapport, and mitigating elevated risk.

How is Connectivity being implemented in Waterloo Region?

Number of Referrals and Situations Discussed

- The Cambridge Connectivity Table has been operating since February 2014. In its first 13 months of operation, 122 situations were referred to the Table. Seventeen of those situations were rejected by the Table because they were not appropriate, resulting in a total of **105 situations discussed at the Cambridge Table.**

- The Kitchener Connectivity Table has been operating since October 2014. In its first 5 months of operation, 39 situations were referred to the Table. Four of those situations were rejected by the Table, resulting in a total of **35 situations discussed at the Kitchener Table.**

Who is Being Served by Connectivity? Risks Identified through Connectivity

- Situations of acutely elevated risk discussed at Connectivity tended to be characterized, not only by carrying significant risk with an urgent need to respond, but by carrying a multitude of distinct (although interrelated) risks. Connectivity Tables identified **an average of 6 risks involved in each situation** managed by the Tables.

- **Situations referred to Connectivity have often involved transitional aged youth (youth 16 -24 years)** (25% in Cambridge; 38% in Kitchener) **or adults aged 30-59 years** (30% in Cambridge; 33% in Kitchener). **School-aged children and youth (aged 6-15 years) have also been commonly involved in situations referred to Cambridge** (27%), but less so in Kitchener (18%). Older adults have only been involved in 5-10% of the situations referred to Connectivity in Cambridge and Kitchener (respectively).

- In both Cambridge and Kitchener, the most commonly identified risk factors were related to **mental health, criminal involvement, and substance use**. Housing was a prominent risk factor in both communities as well, but was cited slightly more frequently in situations presented at the Kitchener Connectivity Table.

Representation and Engagement of Local Services

- Both Situation Tables in Cambridge and Kitchener have a primary roster of approximately 25 members representing local services and organizations (with additional alternate members to stand-in when the primary representative is unable to attend). The Tables have been designed to include **cross-sectoral representation from education, police and justice services, primary health care, community health and hospital services, community mental health and addictions, child protection services, housing and homelessness support services, sexual assault and victim support services.** Efforts continue to grow the membership of the Tables in both communities to address important gaps in services. For example, recent connections have been made to developmental services and income support services.

- **A key factor in the successful implementation of Connectivity has been the strategic recruitment and engagement of members who are perceived as "leaders" and "decision-makers" in their home organizations.** This does not imply that members must be in a management role. Whether in a front-line or supervisor role, members should have the clout and endorsement in their organization to act swiftly with some degree of flexibility and autonomy in order to enact the kind of creative and rapid responses needed to mitigate acutely elevated risk.

- In both Cambridge and Kitchener, all of the referrals have originated from 10 services/programs. That means that **35-45% of the services represented at each Table have been responsible for bringing situations to Connectivity. Police services alone have referred almost three-quarters (73%) of the situations to the Cambridge Table, and over half (56%) of the situations to the Kitchener Table.**

- About 50% of the time, the service or agency that referred the situation became the lead agency in mobilizing a response to the situation. **Police services were the highest referral source in both Connectivity Tables, but were also frequently involved in leading or providing assistance in responding to risk. Police Services, CMHA-WWD and Family and Children's Services were the services most frequently engaged in responding (as a lead agency or assisting agency) to situations of elevated risk in both communities.** This is not surprising given that mental health and criminal involvement were the two highest types of risk identified at the Table and that at least one-third of situations referred to both Cambridge and Kitchener involved a child or youth (infant through 18 years). It is important to note that while a few organizations have been consistently involved in responding to most of the situations, nearly all members of Connectivity have been engaged as either a lead or supporting agency at some point.

What are the outcomes for people being served by Connectivity?

- Connectivity's core function is to connect individuals and families at acutely elevated risk to appropriate services and supports. The underlying assumption is that service connections will mitigate risk. **Connectivity has been successful in connecting individuals and families in situations of acutely elevated risk with services in over three-quarters (76%) of the situations they have addressed and closed**. Individuals refused to connect with recommended services and supports in only 13% of the situations. In other cases, individuals relocated, were unable to be found, or were informed of services but did not suggest they would be cooperative in follow-up.

- Success in connecting individuals to services is a product of the diligence, creativity, and time invested by Connectivity members to work closely with individuals at risk to facilitate cooperation and nurture trust in service providers. Case examples shared by the Connectivity Tables demonstrate that individuals served have experienced an **increased sense of trust in service providers and increased levels of stability and wellness** as a result of their involvement with the initiative.

- More appropriate use of emergency and crisis services is an important outcome of the Connectivity model. An underlying assumption of the model is that earlier intervention that results in connecting individuals to appropriate services and mitigation of elevated risk should lower the demand for expensive emergency and

crisis services. Evidence shared from the WRPS in Cambridge suggests that Connectivity may, indeed, be reducing the use of emergency and crisis services by connecting individuals to more appropriate services before crisis arises. The WRPS cross-referenced the number of calls for police service linked to an individual who was associated with a situation discussed at the Cambridge Connectivity Table in the 90 days prior to the situation being closed by the Table and in the 90 days following closure of the case. The aggregate findings demonstrate a **74% reduction in calls for police service associated with people presenting at the Cambridge Table during the 90 day period after the situation was closed**. Nearly 30% of the situations showed a 100% decrease in associated calls for service.

What outcomes or changes to local services and the service systems occur as a result of Connectivity?

- **Some services have reported that Connectivity has enabled them to reach vulnerable client populations they have had difficulty connecting with or finding through other community resources** (e.g., homeless or precariously housed individuals with mental health needs, victims of sexual assault or trauma). Services have connected with these clients through Connectivity referrals. Additionally, services have reported that participation in Connectivity has helped to raise their profile amongst other providers in the community, which is beginning to lead to increased referrals of appropriate client groups.

- The Connectivity Tables in both Cambridge and Kitchener have very quickly demonstrated a **positive impact on the way local service providers conduct their work. Service providers reported that the new relationships with other service providers developed through the work of the Table have enabled them to work more collaboratively, effectively, and efficiently** – even in their work outside of Connectivity.
    - Many reported consulting and collaborating with each other on non-Connectivity cases more frequently as a result of the sense of trust, accountability, and knowledge of each other's skills and expertise established through Connectivity.
    - Members also reported that Connectivity has helped to create streamlined pathways and processes, which enable agencies to serve clients more quickly and efficiently (e.g., subjects of Connectivity discussions have sometimes been "streamlined or fast-tracked" into services that would typically carry a waiting list).
    - Connectivity members reported "working differently" as a result of their participation in Connectivity. This has involved thinking more creatively in their work, and also working more proactively to identify and mitigate situations of elevated risk. For example, the WRPS in both Cambridge and Kitchener described mining their internal databases more frequently to detect trends and indicators of elevated risk to identify cases that may be appropriate for Connectivity. Connectivity has become a lever for organizations to work differently in order to better serve community members who may be at elevated risk.

- Although some members of the Connectivity Tables reported challenges in finding time to balance the work of Connectivity with work in their home organization, on the whole, **services and agencies involved in Connectivity are seeing great value in participating and, where possible, are creating capacity to sustain or enhance engagement in the Tables**. For e.g., the WRPS have designated a staff role in each community for work aligned with Connectivity. Some agencies (e.g., CMHA-WWD; WW-CCAC) have allocated resources

to allow additional staff members to participate in Connectivity, while other agencies have redistributed workloads internally to allow Connectivity representatives more time to attend meetings and participate in the rapid follow-up that Connectivity requires.

- Through their work, Connectivity is beginning to identify important service gaps in Waterloo Region. Both Tables have noted a need to expand **adult mental health services** (both community mental health services and psychiatric services).

Recommendations from the Evaluation

R1. Affirm that privacy protocols are acceptable to attending organizations and strategize on how to address an outstanding privacy concerns.

R2. Investigate the potential to allow each member onsite, remote access to their home organization's database to improve access to client information. This will facilitate participation among members who need this information to contribute to Table discussions and actions.

R3. Revisit the decision-making latitude of each member; when a member's decision-making authority on behalf of their organization is constrained, the Table leadership should consult with the organization to seek solutions.

R4. Consider petitioning organizations for additional members if the capacity of existing members to respond to Table decisions is stretched.

R5. It is recommended that a situation can be closed when there are "warm hand-offs" to services and confirmation of service engagement (e.g., a face to face meeting with a provider).

R6. Individuals refusing service should be flagged for periodic review and assessment if any new actions can be taken.

R7. Track specific service actions after situation closure after a specified time period.

R8. Develop the capacity at both Tables to strategically compile, analyze, and summarize data from the database for systems use.

R9. Create a governance committee (or committees) to provide oversight to the Tables, engage in systems level analysis, and strategically pursue system change and policy initiatives.

R10. Building off of the provincial logic model and evaluation framework, develop a tailored logic model for Connectivity specific to the local context, implementation, priority outcomes and impact pathways relevant to Waterloo Region.

R11. Drawing on the provincial evaluation framework, this report, and other sources, begin to build sets of indicators corresponding to the Situation Table risk categories and to common Table responses.

R12. Begin to build systems that will support the acquisition and use of secondary data that captures indicators of risk reduction for Connectivity users.

R13. Identify data, organized according to risk categories, that are useful to the deliberations and actions of the Table; and that can also double as outcome indicators.

R14. Pilot smaller outcome studies that are designed to answer specific questions of the Table and that gather narrative feedback from Connectivity users.

R15. Member and partner organizations involved with Connectivity begin to implement steps to become co-occurrence capable organizations and work towards building a Comprehensive, Continuous, Integrated System of Care in Waterloo Region.

Part 1 – Introduction and Background

"Connectivity" brings health and social service agencies together at a weekly meeting to collaboratively and proactively address situations of elevated risk associated with mental health and addictions, physical health challenges, homelessness, family dysfunction, and other risk factors. Connectivity was adapted from the Community Mobilization Model implemented in Prince Albert, Saskatchewan, which is characterized by a multi-disciplinary, interagency approach to addressing situations of acutely elevated risk in a community on a case-by-case basis. The approach enables organizations to be immediately and collaboratively responsive to acute needs in the community. In Ontario, these models are known as "Situation Tables".

In January 2014, the Waterloo Regional Police Service, in partnership with Langs, adapted and implemented the Connectivity Situation Table in Cambridge and North Dumfries. In partnership with Carizon Family and Community Services, a second Waterloo Region Connectivity Table became operational in Kitchener in October 2014.

There has much excitement among the agencies participating in Connectivity. It is believed that the Connectivity model is a more effective use of resources and a more responsive approach to the needs of the clients and the community, leading to improved outcomes for individuals and families. This is a unique multi-sector collaboration in Ontario and it is believed this partnership between police, and social and health services will evolve into a sustainable model for many provincial jurisdictions. A number of Situation Tables have recently been developed in Ontario and the list of communities showing interest in adopting the model continues to grow. As the initiative continues to develop and evolve, the need to develop and implement an evaluation strategy to better understand how the model has been implemented in Waterloo Region and its impacts on community members and local service systems has become increasingly important. The learnings about key successes and gaps associated with the implementation of the model in Waterloo Region are important for the continued refinement of the model to strengthen its impact locally. Importantly, as Connectivity is one of the early adopters of the Prince Albert Model, the findings from this work can also be used to inform evaluation design and planning strategies at a provincial level, as Situation Tables continue to emerge across Ontario.

1.1 Project Purpose and Key Questions

Waterloo Region received a Proceeds of Crime Grant from the Ministry of Community Safety and Correctional Services to design and implement an evaluation strategy for the Connectivity Tables in Waterloo Region. Taylor Newberry Consulting (TNC) was contracted to lead this evaluation work. In January 2015, a project launch session was attended by key local organizational representatives involved with Connectivity. At this meeting we reviewed the current state of the Waterloo Region Connectivity Tables, main information needs and areas of inquiry, and a proposed evaluation design. Informed by this consultation, the evaluation design was largely formative and focused on two major areas of inquiry:

2. **Evaluation of implementation** focused on aspects of the development, evolution, and implementation of Connectivity's activities. Key questions about implementation and development included the following:

    - *How is Connectivity being implemented in Waterloo Region?*
        - *What is the process to bring situations to the Tables?*
        - *What is the process to develop and mobilize required supports?*

- *What are the types of recommended actions for addressing the needs of individuals identified at the Connectivity Tables?*
- *How do members of the Connectivity Table and their home organizations experience the process?*
- *What are the strengths and challenges in regards to the above?*

- *Who is being served by Connectivity?*
  - *What is the range of presenting issues and the nature of risk for individual situations brought to the Table? What are the other characteristics and circumstances of the individuals in question?*
  - *What are the information gaps regarding important characteristics and circumstances of individuals in question that could be useful to Connectivity responses?*

3. **Evaluation of outcomes** focused on the ways in which Connectivity leads to benefits for individuals that become connected to the supports, to providers and organizations that participate, and to the system as a whole. Key questions included the following:

- *What are the outcomes for people being served by Connectivity?*
  - *To what extent do individuals engage with the supports and services developed and implemented by Connectivity?*
  - *What new services and supports do individuals access to meet their needs?*
  - *What are individuals' experiences with new supports and services?*
  - *What changes are observed in people's lives? How is risk mitigated or removed?*

- *What outcomes or changes to local services and the broader systems occur as a result of Connectivity?*
  - *What does the Connectivity partnership learn about providing supports to individuals exhibiting imminent risk?*
  - *What does the Connectivity partnership learn about how to manage privacy concerns?*
  - *What new partnerships, promising practices, and new capacities evolve out of this initiative? What new ways of collaborating across organizations and/or sectors result from Connectivity?*
  - *In what ways can Connectivity lead to greater integration or coordination of services in Waterloo Region?*

To answer these questions and to inform an evaluation strategy moving forward, we conducted a series of focus groups and key informant interviews to engage key stakeholders in the system, including members of the Connectivity Tables and providers responsible for carrying out the action plans of the Tables, and other important local community and system leaders.

This report provides summary background on key concepts of risk mitigation and system-level collaboration/ intervention, followed by the findings of our evaluation, organized according to issues of implementation, outcomes for service users, and outcomes on the system more broadly. We conclude with recommendations to improve the functioning of the Connectivity Tables and to pursue future evaluation.

1.2 Community Situation Tables for Collaborative Responses to Risk and Safety

Prince Albert Police Service (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 commonly referred to as the "Prince Albert Hub" – was established and has since been imported to a number of Ontario communities, including North Bay, Sudbury, Rexdale, Halton Hills, Cambridge and North Dumfries, Kitchener, and Guelph.

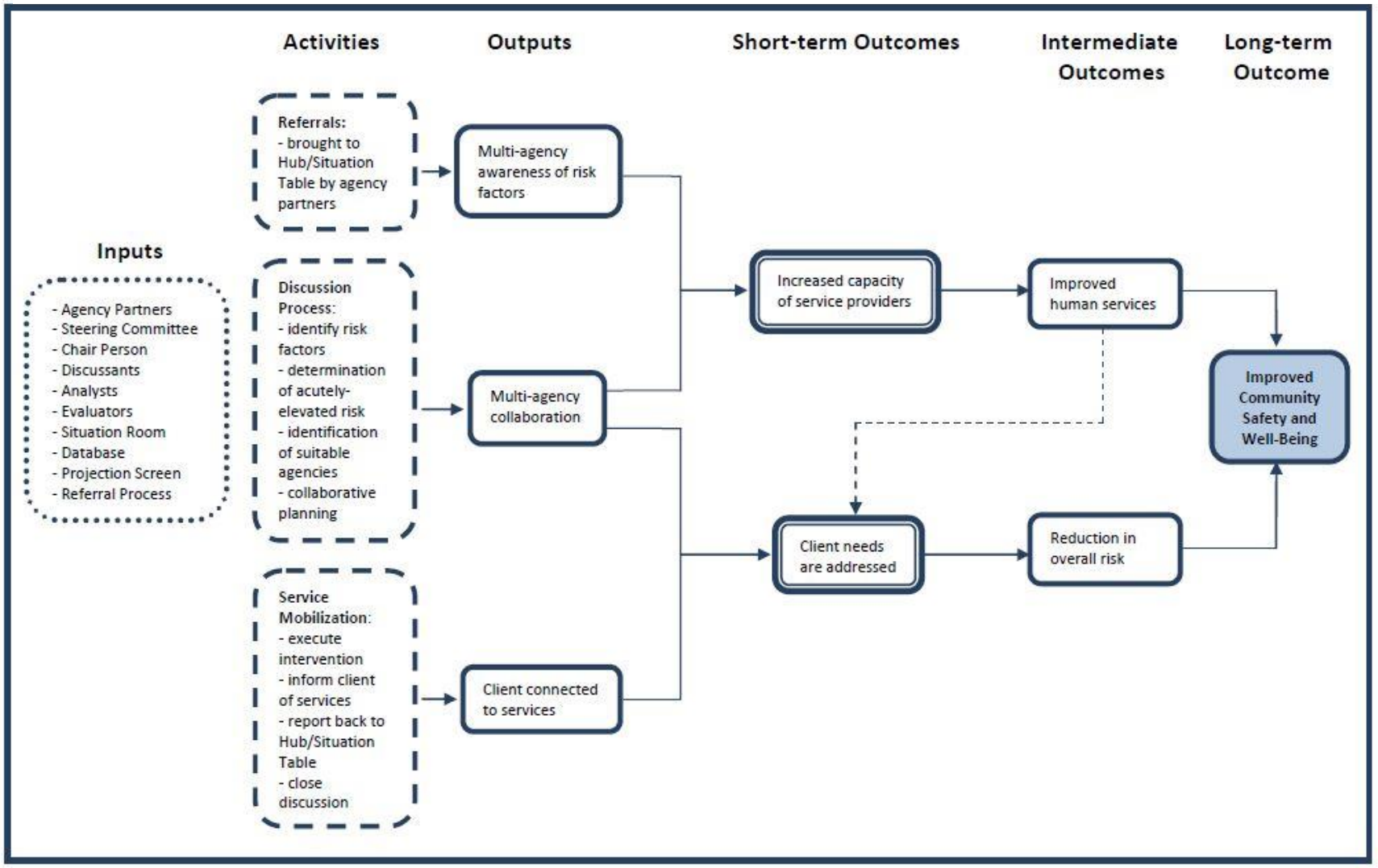
Situation Tables have a multi-organizational and multi-sectoral membership of police services, other justice services, mental health and addictions, children and youth services, school boards, hospitals, emergency shelters, housing, and others. Situation Tables are standing committees with consistent membership that meet weekly; representatives tend to be a mix of front-line workers and supervisors.

Situation Tables are concerned with the immediate alleviation of elevated risk. Committee members bring forth situations 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 the Table is to connect the individual to services that can help meet their immediate needs and mitigate presenting risks. Once this connection to services is confirmed and the group believes the priority presenting risks have been sufficiently mitigated, the situation is "closed" – it then becomes the responsibility of the relevant services to provide their supports. For a detailed description of the practices of Situations Tables and the evolution of the Prince Albert Model, see Nilson (2014).

In Figure 1, we share a sample logic model developed by Nilson (2015) as part of a comprehensive framework or guide for evaluating Situation Tables. The logic model demonstrates how the key processes involved in routine work of the Table (referral, collaborative determination of acutely elevated risk and response planning, and service mobilization) are connected to anticipated short, intermediate, and long-term outcomes. At this early stage in the development of many of the Situation Tables in Ontario, including Connectivity, the focus of evaluation is on short-term outcomes related to *increased capacity of service providers* and successfully addressing *client needs*.

In the following section, we highlight a Framework for Planning Community Safety and Well-being, developed by a working group comprised of leaders and partners of Ontario Situation Tables. This framework helps to position the model within a broader context of other initiatives aimed at promoting community safety and reducing harm. It also helps to illustrate the Situation Tables' contributions to the longer-term outcomes of community safety and wellbeing illustrated in the logic model.

Figure 1: Sample Logic Model for Situation/Hub Tables (Nilson, 2015)



1.3 The Ontario Working Group on Collaborative, Risk-Driven Community Safety

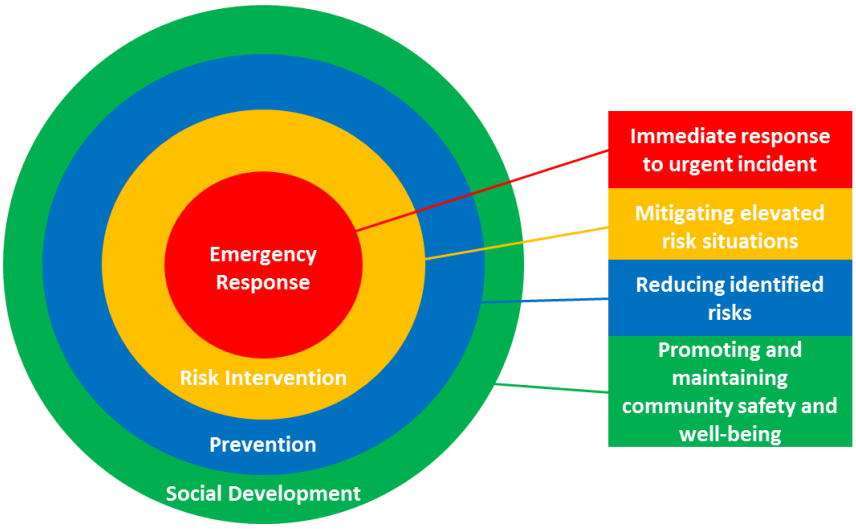
In Spring 2013, police services and community partners from four Ontario communities who had implemented a Situation Table in their own jurisdictions established a practice of meeting once monthly to share learnings and best practices related to their local implementation of the model. This network became referred to as the Ontario Working Group (OWG). With support from the Ontario Ministry of Community Safety and Correctional Services, this group expanded to include six police services and community partners and a shared mandate to direct research and development related to the Situation Tables within a broader framework of community safety planning (Russell & Taylor, 2014). The work of the OWG has centered on development of:

- A prototype framework for community safety planning
- Measures and indicators for community safety planning
- Guidelines for information sharing and protection of privacy
- Symposium to share this work with police and community partners
- Communications to support this project

The OWG's *Framework for Planning Community Safety and Well-being* (See Figure 2), promotes planning for community safety and well-being at four levels of community intervention: social development, prevention, risk intervention, and emergency response (Russell & Taylor, 2014).

The primary goal of the framework is to reduce harm and victimization within the community. Secondary to this, the aim of the model is to mitigate increasing demands for, and costs of, emergency services (located in the red zone in Figure 2). A thorough description of the framework and the interventions and considerations important at each level of the model is provided in Russell and Taylor (2014).

Figure 2: Ontario Working Group Framework for Planning Community Safety and Well-being (Russell & Taylor, 2014)



It is important to note that the "red zone" of emergency response is characterized by situations in which risk is very high and imminent and often in which harm has already occurred. At this inner circle, the focus of the intervention is on immediate emergency response of police, medical services, and/or crisis services in order to reduce the probability of further harm and victimization. The focus here is placed more so on threat management and harm minimization than risk mitigation or prevention.

The "amber zone" of risk intervention is characterized by strategies to reduce the incidence of harm by identifying situations of acutely elevated risk of harm and implementing a rapid response to mitigate those risks. It is at this level where the work of the Situation Tables is most relevant. By intervening to mitigate elevated risks before they become imminent, emergency, or crisis situations, communities are more likely to reduce demands for emergency response. Accumulating risk factors that are left unmitigated are likely to continue to drive the need for expensive emergency responses.

At the "blue zone" or prevention level of the framework, the focus of intervention shifts to mobilizing responses to known, existing, and identified risks. Intervention at this stage has been described by the Ministry of Community Safety and Correctional Services (2012) as involving a focus on injecting or strengthening designated protective factors for an identified vulnerable group subject to a known risk.

Planning and intervention in the "green zone," at the level of social development, is characterized by a focus on addressing root causes of the problems presenting at other levels in the model. Social development involves interventions that promote the maintenance of well-being and safety and eradicate conditions that lead to marginalization and victimization associated with elevated risk of harm. Russell and Taylor (2014) note that the addition of social development to the community safety planning framework is important because it reduces the demand for emergency response by substantially reducing the number of people at risk of harm.

The model is conceived as holistic in nature, in that failure to plan and implement intervention at any level will increase levels of harm and victimization, and demand for emergency response. This is a critical point for two reasons. The model is oriented around reducing the demand for emergency crisis services. This aim certainly aligns with priorities of human service systems provincially and locally in the Region. However, the model cautions against isolated interventions. To reap significant cumulative impacts on the demand for expensive emergency services, intervention is really required at all four levels. This aligns with a social determinant of health (SDOH) perspective, which recognizes that health outcomes are associated with the confluence of many different areas of life. Health is multi-determined by such things income security, education, employment, stable housing, food security, social support, and access to health and social services (World Health Organization, 2008).

What this suggests is that a Situation Table implemented in isolation of other preventative and social development strategies may not be sufficient to reduce high demands on our emergency response services. The Prince Albert partners recognized within their first year of operating that in attempting to work more collaboratively, flexibly, creatively, and swiftly to meet the urgent needs of individuals referred to the Table, that they encountered several systemic barriers in the service system. In response, they created a special team, referred to as the Centre of Responsibility (COR) whose role was, in part, to leverage the learnings of the Table in relation to key service gaps and system barriers in order to advocate for necessary policy and system-level changes. The addition of this systems-change function carried out by a group like the COR consequently helps to address the need for planning and intervention at the outermost levels (prevention and social development) of the Framework for Planning Community Safety and Wellbeing.

1.4 Mitigating Acutely Elevated Risk through Collaborative Community Intervention

Two concepts that are pivotal to the model are risk and collaboration (Russell & Taylor, 2014). It is useful to outline our understanding of these concepts in their relation to Connectivity as these concepts will frame the subsequent evaluation findings.

1.4.1 Understanding Risk

Connectivity is a 'risk-focused' model and is not intended to produce long-term care or case management plans, at least not directly. It is squarely focused on mitigating acutely elevated risk. What is meant by risk? The concept has been debated and contested in the psychological and justice disciplines for decades and there is a massive literature. In general, risk is broadly defined as the probability of behaviours that lead to adverse consequences to oneself or others, such as self-harm, violence, injury, sexual assault, or a range of criminal/dangerous outcomes (Ryan, 2000). Risk factors have been defined as "attributes, characteristics, or exposures" (World Health Organization, 2014) that "elevate an individual's probability of harm" (Nilson, 2014).

Historically there have been two conflicting approaches to the assessment of risk. Actuarial approaches predict risk based on static, personal characteristics and history (e.g., age, diagnosis, past criminal convictions) whereas clinical approaches predict risk based on dynamic, changeable factors (e.g., medication compliance, housing status, financial status) (Aegisdottir et al., 2006). Actuarial approaches – based on statistical probabilities – have been shown to be superior in predicting behavioural outcomes when compared to clinical assessments. There are some strong caveats to this claim however. Actuarial studies predict behaviours over longer periods of time, often in the order of years. Clinical approaches are much more concerned with predicting adverse consequences in the "here and now", given clinical presentation and other dynamic factors (e.g., recently losing housing, being discharged from hospital). In short, actuarial approaches claim better prediction because they wait long enough to observe the behaviours in question. In shorter periods, clinical approaches are superior (see Monahan, 2008; Westen & Weinberger, 2004). More recent approaches to risk assessment combine both approaches, such that static factors (e.g., past convictions) must be understood in relation to current context – and that the pile up dynamic risk factors is associated with elevated or imminent risk.

A crucial backdrop of this long-standing debate is the rather serious problem of locating risk "in the individual", which both actuarial and clinical approaches primarily do. In recent years, health and social service providers have begun to challenge this assumption by viewing risk as product of environmental stressors and instability. Service systems are now beginning to be seen as key contributors to risk in the sense that they are, very often, inappropriately and ineffectively organized to meet the needs of certain subpopulations of citizens. When the system speaks of people "falling through the cracks" the underlying assumption is that filling those cracks would mitigate risk – that a system's inability to meet needs puts certain people into a cycle of disadvantage.

Multiple service sectors and individual organizations have historically operated in silos with ineffective communication and referral practices. Service organizations often have ambiguous or "floating" eligibility criteria for service admission that serve to exclude certain individuals, especially those with the most complex needs. Information about an individual's circumstances may often be unavailable or unshared between different organizations. Different organizations make their own determinations of risk and eligibility using many approaches that range from comprehensive risk and care assessments to superficial judgements based on limited information (e.g., a criminal record). Organizations may also have widely different levels of "risk tolerance", leading to exclusions. Individuals are shuffled from place to place and are put in the unenviable position of having to go through numerous assessments

that require full disclosure of their lives. In this context, traditional, individualized risk assessments (formal and informal) begin to lose their utility because they too often function to exclude people from services, rather than drive coordinated care planning. Responsibility for the most vulnerable citizens becomes diffuse and uncoordinated and people begin to detach from the system of supports (Newberry, 2011).

1.4.2 System Integration and Complexity

Health and social service systems have been evolving towards greater service integration and cross-sectoral collaboration. While one of the goals is greater efficiency in the use of funding dollars, it is equally understood that well-coordinated, integrated supports are essential in order to provide responsive and effective supports and care. For example, service and system integration is a prominent concern in all provincial mental health and addictions policy discussions and initiatives. The Ministry of Health and Long-Term Care and Local Health Integration Networks (LHINs) have been calling for greater coordination and integration of services in order to promote a uniform, seamless, responsive, and person-centred experience of mental health and addictions programs and supports.

Recent advances in provincial mental health policy aim to strategically construct more integrated systems of supports. *Open Minds, Healthy Minds*, Ontario's mental health and addictions strategy (Government of Ontario, 2011) advances 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 promotes service integration and focuses on timely access to the "right mix of supports". The plan calls for integration of not just mental and addictions services, but with other sectors, including the justice system, housing, income support, and employment. Integration remains a priority within subsequent policy reports including Ontario's Action Plan for Health Care (Government of Ontario, 2012) and the "Drummond Report" (Commission on the Reform of Ontario's Public Services, 2012). This emphasis is echoed within the latest Integrated Health Service Plan of the Waterloo Wellington LHIN (2013), which specifies the priority goal of "creating a more seamless and coordinated healthcare experience."

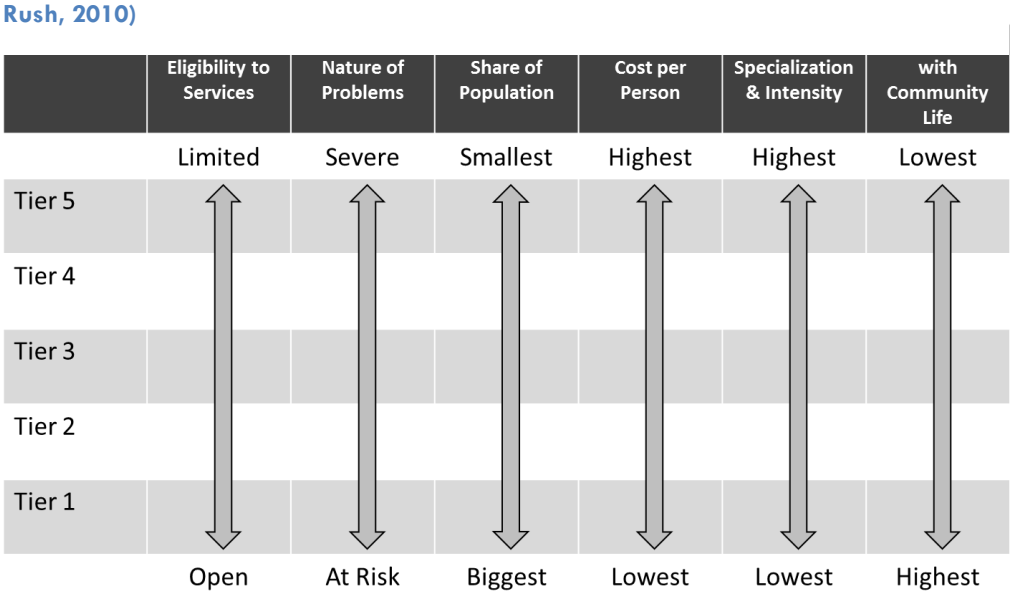
There has also been a strong focus, especially in our health systems, on meeting the needs of people with particularly complex challenges (e.g., the co-occurrence of mental health and addictions with developmental disability, and in the presence of housing instability). Complexity – which is very often tied to heightened risk – has been defined in a number of ways. For example, Reist and Brown (2008) articulate three interrelated dimensions of acuity, chronicity, and complexity. 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.

Rush (2010) describes tiered models of support in health systems that, at their highest levels, "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". Rush provides a set of dimensions that demonstrate how risk and

complexity intertwine with system capacity, shown in the figure below. These are people who are ineligible for many services, represent a high cost to the system, and require intensive, specialized supports.

People that experience the most complex challenges are persistent users of hospital in-patient and ALC services. Butterill et al. (2009) reported that long-stay hospital users with mental health and addictions issues accounted for

Figure 3: Criteria for Defining Tiered Substance Use Treatment Responses (adapted from Rush, 2010)



51% of the total of long-stay/ALC days in Ontario. They are also more likely to come in contact with police and other parts of the justice system.

It is clear within this conceptualization that individual health and social service organizations are often ill-equipped to meet the needs of this complex population. System integration is interested in mobilizing collaborative responses that are capable of addressing complex needs. Minkoff and Cline (2004) have described the need for agencies to develop as complex or "co-occurrence capable" organizations. Organizations should expect that individuals will present with such needs and must find collaborative solutions to meet them. This may include building new staff competencies, promoting a welcoming and recovery-oriented culture, and expanding specializations; but also requires collaborative service agreements with other organizations that can provide complementary services.

1.4.3. Collaborative Tables as System Integration

There are a number of different approaches to system integration. In Ontario, we are seeing examples of organizational mergers of health providers and the designation of particular lead agencies to provide particular core services (e.g., mental health case management being consolidated under a single organization in a local system) (Newberry, 2012). There are also advancements in the creation of multi-disciplinary care teams (e.g., Flexible ACT Teams) that provide wraparound care to targeted groups with high needs. Finally, we are seeing collaborative system response Tables, of which Connectivity is an example, as strategy to address complex needs (Newberry, 2015).

Case conferencing is a well-established front-line approach to tackling challenging care planning for individuals in need, and represents the gestation of collaborative systems Tables. Case conferencing is typically initiated by front line providers 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 at this front-line level. It is effective to the extent that the initiating worker is well-connected, dedicated, and persistent. However, case conferencing can be limited by systemic barriers that the process has little influence over.

Collaborative Tables move beyond case conferencing by formalizing the process. Tables meet consistently and are composed of service representatives with influence and leverage on behalf of their home organizations. The models are purposeful and strategic in attempting to meet the needs of defined population. "Service Resolution" is an example, appearing in wide variety of sectors (e.g., mental health and addictions, children's services, homelessness and housing) (Newberry, 2015). While service resolution models can be structured in a variety of ways, the common feature is a service resolution committee which is composed of high level managers representing a cross-section of organizations from multiple health and social service sectors: mental health, addictions, justice, developmental services, ABI, child and family services, 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 and create accountabilities to the care planning decisions.

Ontario's Situation Tables are highly similar to service resolution. Differences include the following: a) Situation Tables are primarily composed of front-line workers who bring forward situations and directly work with the users of the service; and b) the goal of Situation Tables is to create service connections that can mitigate elevated risk. Service resolution, in contrast, attempts to create more comprehensive, wraparound care plans over a longer period of time. Service resolution for mental health and addictions and developmental disabilities operate in Waterloo Region and the Connectivity Tables have linked individuals to this service.

What collaborative system Tables have in common is that they proceed on the premise that risk and complexity are exacerbated by, and inseparable from, system barriers. The Connectivity Tables do not conduct formal risk assessments to decide if an individual qualifies for service. Risk factors are subjectively recorded based on narrative descriptions made by Table members. The rationale is that many individuals are chronically disconnected from services and are exhibiting behaviours that are clearly harmful. In other words, risk is located in the relationship between the individual and the collection of services that have not helped, or been unable to help, with their difficulties thus far. It follows that the appropriate initial response is at a coordinated system level, with multiple organizations contributing resources and expertise. Although each situation is individually addressed, Connectivity is not an individualistic framework. Over successive situations, the manner in which services work together has the potential to grow and change. This reflects a meaningful form of system integration.

With Connectivity and its approach to addressing risk in mind, we now turn to the evaluation of the two Tables for Cambridge and North Dumfries and for Kitchener. We begin with a description of the evaluation methodology followed by detailed examination of the evaluation findings.

Part 2 – Project Design

2.1 Methodology

To answer our key evaluation questions, we collected data from three primary sources.

1. The Connectivity databases maintained for the Cambridge and Kitchener Situation Tables.
2. Connectivity Member Focus Groups and Interviews
3. Other Key Stakeholder Interviews and Focus Groups

Across these data collection strategies, we engaged a total of 74 individuals. This included a total of 4 focus groups (68 participants), and individual interviews with 26 key informants. Some key informants participated in a focus group as well as an interview. All data collection took place between January and March 2015.

2.1.1 The Connectivity Databases

Each Table maintains its own database including key, non-identifying details about each referred situation. The administrative assistant and/or coordinator for each Table manages data entry in real-time as each situation is discussed. The structure of the database (e.g., fields and associated drop-down response options) has been adopted from that used in Prince Albert, SK and since adapted by the ON Working Group. Key pieces of information tracked include: the initial discussion date, follow-up and concluding dates of discussion, the originating – or referral – agency for each situation, the risk factors identified through the referral, the status of the situation (i.e., open, rejected, concluded), and the lead and assisting agencies who have agreed to mobilize a response. See Appendix A for a complete listing of the database fields and response options.

We analyzed the databases maintained by both Cambridge and Kitchener Tables to understand how the situation Tables are functioning and have been implemented in these communities.

Timeframe for Analysis of Data Used in this Report: Our analysis included situations documented in the Connectivity databases **up to the week ending March 14, 2015.** For the Cambridge Table, the database included situations discussed over the course of 13 months - since its inaugural meeting on February 11, 2014 through March10, 2015. For the Kitchener Table, the database included situations discussed over the course of 5 months, since its inaugural meeting on October 2, 2014 through March12, 2015.

2.1.2 Connectivity Member Focus Groups and Interviews

We held two focus groups – one with each Connectivity Table. Both focus groups were scheduled to follow the regular weekly meeting, and included participation from Table members as well as the coordinator and administrative assistant. Nineteen of the primary roster of 25 representatives attended the session in Cambridge; 20 of the Table's 26 primary roster members attended the session in Kitchener.

The member focus groups were designed to answer evaluation questions about the implementation of the situation Tables, with some additional focus on outcomes related to service provision, collaboration and coordination. We also aimed to elicit suggestions for improving processes and procedures related to community risk feedback about capacity and directions for ongoing evaluation. See Appendix B for the semi-structured focus group guide.

Connectivity's lead partners nominated key stakeholders to participate in key informant interviews. These tended to be individuals whose organizations have been actively involved at one of the Tables or who were believed to have unique perspectives and insights to inform the evaluation. We completed a total of 14 individual interviews with members of each Table (7 for Cambridge and 7 for Kitchener). Additionally, we conducted interviews with 2 individuals who participate on both the Cambridge and Kitchener Tables.

These interviews were designed to gather the following types of information:

- How Connectivity membership is experienced by Table members – how participation impacts the daily work and capacity of the member and the member's organization.
- Feedback about how the Table functions, and concerns or challenges related to managing privacy and information sharing.
- Detailed case information about situations members have been involved in responding to and reflections on associated outcomes for community members served by the Table.

See Appendix C for the semi-structured guide used for interviews with Connectivity members.

2.2.3 Key Stakeholder Interviews and Focus Groups

In addition to our consultations with Connectivity members, we engaged the Connectivity leadership, other leaders associated with Connectivity, and individuals with specialized knowledge about Situation Tables in other communities. The aim was to gain insights as to how the Connectivity model fits with broader community priorities, visions, and directions for local system change, and any potential threats to the continued development of the model in Waterloo Region. We also sought feedback from these key stakeholders about the kinds of measurement information that would be most useful for local system/service planning in order to inform recommendations for an ongoing evaluation framework for Connectivity.

Based on recommendations from our project committee, we interviewed two research consultants who have been involved in the evaluation of other Situation Tables implemented in Ontario and Saskatchewan, and five leaders of policing, local health, and social service organizations and collaboratives in Waterloo Region.

We held two focus groups with local key stakeholders. The first included the Connectivity lead partners, coordinators, some members of the Tables viewed as key leaders and active participants in the initiative, and other stakeholders who have played an important role in helping to develop the initiative locally. This focus group was designed as a launch of the evaluation project and served to refine key evaluation questions and to gather some initial feedback about the role of Connectivity model in the region, emerging or potential impacts on community services/systems, and successes and challenges in implementing the model in both Cambridge and Kitchener.

A separate focus group was held with the Cambridge Health Links Steering Committee. The group was consulted because their membership represents a broad cross-section of key leaders from local health and mental health services. Our primary focus in engaging the Health Link Steering Committee was to gather feedback about the roles of Health Link and Connectivity in addressing local service coordination, collaboration, and system change. The Connectivity Table in Cambridge and the Health Link are both housed at Langs and have strongly aligned mandates of meeting the needs of people with complex challenges. The Health Link is viewed as highly useful destination for

individuals presenting at the Cambridge Table as it connects individuals to multidisciplinary care and supports and can lead to the development of a client-centred co-ordinated plan of care.

Interview and focus group questions varied slightly amongst key informants according to their particular expertise, role, and connection to/familiarity with Connectivity. See Appendix D for a general semi-structured interview guide used with local system leaders and consultants in other communities.

In addition to the collection and analysis of primary data from these sources, we observed two Connectivity discussions, one in each community. The observation was intended to gain deeper insight about the processes involved in Table deliberations and to inform subsequent data collection and analysis. To align with the privacy policy, no notes were taken during these observations.

Our original design also included interviews with individuals and families who had been served by Connectivity. However, we experienced challenges in identifying and recruiting service recipients to participate, partly as a result of project timelines, but also because of issues related to absence of protocol and information required for appropriate follow-up contact individuals engaged by Connectivity. These issues will be discussed later in this report with regard to limitations to the outcome evaluation and recommendations for ongoing measurement and evaluation.

In the remainder of this document we summarize the findings from our primary data sources as they relate to the guiding evaluation questions for this work. **Part 3** is concerned with the implementation, successes, and challenges of Connectivity in Waterloo Region, and who is being served by the two tables. **Part 4** reviews the outcomes for people being served by Connectivity. **Part 5** focuses on the potential benefits of Connectivity to the system as a whole and how it should group. **Part 6** concludes with a set of recommendations for improvement.

Part 3: Review of Findings - Evaluation of Connectivity Practices and Implementation

3.1 Connectivity Referral Processes and Service Responses

3.1.1 Process of Referral

A total of 161 situations have been referred to the Connectivity Tables since their inception in February 2014 through to early March 2014. A total of 122 situations were referred to the Cambridge Table in its first 13 months of operation; and a total of 39 situations were referred to the Kitchener Table in its first 5 months of operation.

As of the week of March 8th 2015, Cambridge had closed/concluded 82.8% (101) of those situations. Four situations remained open at the Table, and a total of 17 situations had been rejected by the Table. In Kitchener, 76.9% (30) of the referred situations had been concluded by the Table, 5 remained open, and 4 had been rejected.

Of the 4 situations rejected in Kitchener, the rationale was that the originator of the referral had not exhausted all options to address the issue, or that the Table believed the individual in question was already connected to appropriate services with potential to mitigate risk. Similarly, in Cambridge, the most common reasons for rejecting a referral were that the originator had not exhausted all options (9 situations), or that the individual in question was already connected to services or personal supports that Table members felt had the potential to mitigate risk (6 situations). In only 2 of the 17 rejected referrals did the Table determine that the situation was not one of acutely elevated risk, and therefore not appropriate for Connectivity.

Number of Referrals and Situations Addressed

The Cambridge Connectivity table has been operating since February 2014.

- 122 situations were referred to the table in its first 13 months of operation.
- 17 situations were rejected by the table because they were not appropriate.
- 105 situations have been discussed at the Cambridge table.

The Kitchener Connectivity table has been operating since October 2014.

- 39 situations were referred to the table in its first 5 months of operation.
- 4 situations were rejected by the table because they were not appropriate.
- 35 situations have been discussed at the Kitchener table.

3.1.2 Referral Sources – Originating Agencies

In Cambridge, 73% (89) of the situations referred originated from the Waterloo Regional Police Service. Police Services were also the most common referral source in Kitchener, responsible for 56% (22) of the situations.

After police services, Langs was responsible for the largest number of referrals to the Cambridge Table – nearly 10% of referrals extended from Langs Medical (5 referrals), Social Work (5 referrals) and Outreach (2 referrals) teams. Youth Justice Services referred nearly 6% (7) of the situations to the Table, while 4% (5) of the referrals originated from Family and Children's Services, and 3% (4 referrals) extended from the Waterloo Region District School Board (WRDSB). The remainder of referrals were scattered across 5 other member agencies. In sum, a total of 10 member agencies have been responsible for referring situations to Cambridge Connectivity for discussion.

Likewise, in Kitchener, all referrals to Connectivity thus far have originated from 10 of the member agencies. OneROOF followed police services as the main contributor of referrals, bringing forward 20.5% (8) of the situations discussed at the Table. The remainder of referrals originated from 8 of the other member agencies, who brought 1 or 2 situations each to the Table for discussion.

Referral Sources

Connectivity referrals have originated from 10 services/agencies. That means that 35-45% of the services represented at each table have been responsible for bringing situations to Connectivity.

Police services alone have referred almost 3/4 of the situations to the Cambridge table, and over half of the situations to the Kitchener table.

Table members in both Cambridge and Kitchener have questioned whether agencies who have not served as a referral source are not bringing referrals to the Table because of privacy concerns. In the early days of Connectivity, management in some agencies expressed enthusiasm about their staff joining in the work of the Table, but reported concerns about legal and ethical ramifications of referring their own clients to the Table.

> *We're all allowed to get involved, but some of us still aren't allowed to present because of the privacy, right? So that's why it seems like sometimes the police are doing most of the presentations or one other specific agency. There's a lot of agencies that sit there, but I'm wondering--and maybe they do have the approval now and they're just not doing it. – Cambridge Connectivity Member*

Through our consultations with Connectivity members, no agency was specifically described as having prevented their representative from referring situations to the Table as a result of privacy concerns or internal policies. Members often cited organizational policies that permit their right to share information, under the condition that the purpose is to promote client safety. These members expressed confidence in the Table's practices to protect privacy. That said, some agency representatives expressed a preference within their organization to establish consent before referring a situation to the Table to mitigate the privacy risks. Two members describe this below.

> *My lived experience at my workplace is… we might get a case that comes up that we feel the risk is so high, we should just bring it to the Table, and some people feel like we need that client to consent first. That can create a really interesting time delay when we feel clinically that the risk factors are so high…. So I wonder if some of the privacy issues are driven more from the representative at the Table's relationship with the agency, versus what we do at the Table, because I feel like the Table has actually adopted quite a great stance on privacy. – Kitchener Connectivity Member*

> *We have [asked for consent to share information at Connectivity] in certain circumstances … we've made it aware to some parents that we would be bringing it to the Table just to request outside services… It's something that I think is important. If you don't have the opportunity to and the risk is that imminent that you need to bring it there, which that is most cases, then…we have the right to speak about it in a case management perspective to build a better plan for that youth. - Cambridge Connectivity Member*

It should be noted that the Connectivity WR lead partners have worked hard to communicate with management in the member services and agencies to work through privacy concerns. The Privacy Commission was invited to observe Connectivity sessions in Winter 2015 and is working with the lead partners to address outstanding concerns of stakeholders. One organization we interviewed who is not currently a member but is closely connected to agencies involved noted that they see great value in the Connectivity model but is delaying participation until there is clear endorsement from the Privacy Commission that the work of the Table is not in violation of privacy policy.

Existing member organizations we consulted through this evaluation noted that privacy concerns have largely been addressed. Privacy is an ongoing consideration and discussions at the Table have become more nuanced as the members strive to continually improve their information sharing practices.

It is during the referral process that members felt privacy concerns are most salient. There has been ongoing discussion at the Connectivity Tables about the presentation of risk factors and how much information is appropriate, and whether historical information about the situation is relevant. Members have described these conversations as an indicator of the maturation of the Tables. All of the members we consulted expressed a great deal of confidence in the management of information sharing. Concerns related to the referral process were described more as part of a process of further refining their processes. As the groups have become more experienced and familiar in utilizing the four-filter model adopted from Prince Albert (see Nilson, 2014 for a description of the four-filter process), and as external groups have observed their process and provided feedback, the Tables are reflecting more deeply and critically about how they are implementing the model and where there is room for improvement. These concerns are described below by a member of the Cambridge Table, where these discussions about privacy at the referral stage have been more prominent.

> *There was a big discussion about this, and it was like how much information do you share, what not to share and what do you need to share, what information is relevant…What we do with the risk factors-- so when a case is presented they say a little blurb about the story, and then they say the risk factors - you know, 'homelessness, criminal involvement,' whatever. So somebody would say, well, how recent was his criminal involvement? And they would say, oh, he got charged six months ago with uttering threats. Okay, well that's six months ago, should we be using that as a risk factor today? Is it fair to use somebody's historical information as concurrent risk? …Three-quarters of the Table was like, yeah, that's relevant information, that shows that this has happened before, which ups the risk. Other people at the Table were saying, it's not fair to disclose that information when that's not the information that's affecting the individual today…. But those kinds of conversations are creeping up now. – Cambridge Connectivity Member*

While privacy concerns may contribute to a lower rate of referrals from some agencies, members reported that it was more likely the nature of their work that correlated with fewer referrals being brought forward. Some organizations represent key resources to address certain situations, but that does not mean the organization routinely operates in a context where elevated risk is directly observed. Furthermore, some organizations have the capacity to address elevated risk directly without having to bring a situation to the Table. This explains why Police Services are a majority referral source, as they are unable to address the presenting needs directly.

As the profile of Connectivity continues to grow in Waterloo Region, members noted that they expect referrals may increase. However, at present, many are comfortable with the present rate of referrals and recognize the police service as a natural and appropriate referral source as a consequence of the nature of their role as a point of first contact in the community.

3.1.3 Mobilizing a Response

A key consideration in understanding how Connectivity is implemented revolves around how collaborative responses are mobilized by the Tables once they have decided to accept a referral and 'open' the situation. In particular, we were interested in exploring what types of organizations and services are involved, how they become involved, the roles organizations play, current service gaps, and if the resources available to the Table appropriately address the needs of presenting situations in a timely manner.

The presentation of risks and characteristics associated with a situation during the referral process (i.e., Filter 2 discussions) is a critical tool and driver in identifying the lead agency and team of assisting agencies who will assume responsibility for mobilizing a response. Matching the major presenting needs (e.g., mental health, substance use, criminal involvement) and characteristics (e.g., age) of a situation with Table member expertise and resources is often the primary determinant of who will respond. For example, child and youth-focused agencies would often take a lead role in situations centred on a child at risk. Given that many of the situations referred to the Table include multiple risk factors at varying levels of intensity/stability, it is the risks that are most salient, elevated, or associated with problematic behaviours or degenerative outcomes that tend to dictate team composition.

> *We look at the biggest need. So for an elderly person who is not being cared for, I'm not going to be the first to go necessarily. It might be someone who's got the geriatric medical background… So I think we look at the number one thing that's happening, that's the highest imminent factor, and decide who should be the person… Who's the most important person that needs to be there? – Cambridge Connectivity Member*

In Kitchener, a member referred to a match between agency mandate and presenting needs as a key factor in determining who will respond to a given situation.

> *Mandate for sure. That automatically compels certain agencies. If there are clear mental health issues, then CMHA is going to give support, and F&CS is often called on as well if the person being brought forward has kids or is a Crown Ward – Kitchener Connectivity Member*

This focus on the match between an agency's mandate and the highest priority risk factors is consistent with the response mobilization process utilized in the Prince Albert Model (Nilson, 2014). Interestingly, when asked what processes and factors were involved in assembling a response team in Cambridge, members attributed their success to a commitment to flexibility and collaborative intervention, rather than becoming hamstrung by organizational mandates regarding service boundaries, eligibility, and so on. This viewpoint was shared by many members, and was described as a unique and critical element of their approach. These views are described by Cambridge Table members in the quotations below.

> *One of the things that I think that makes the Table work is people come from their organizations, but when that case gets put forward, that's who we look at first. We look at those risk factors and we're not looking at do they fit my criteria, would they fit into our agency--you know? …We decide who can be of best help, not whether or not it's my job… Those silos drop, and it's like we work for one agency, but we're bringing our expertise and our resources… And that's the way it really should be, because if one agency could handle them, they wouldn't be coming here. These people are coming with all kinds of dynamics that cross all these different agencies and stuff. We need to step up. We can't allow the clients to fall between the cracks. – Cambridge Connectivity Member*

> *[It] is the relationship building within the Table… If you're willing to be that hard worker and say, listen, this has nothing to do with me, but I know you need to feel supported in what you're doing with this individual, so I'll support you to a certain extent. It's beyond my mandate, right, and realistically that's what a lot of the Table is about. It's about going beyond your mandate… If we weren't doing it, we'd be dumping. – Cambridge Connectivity Member*

This character of the Tables is particularly crucial and addresses the recognition that much of what we understand as risk is located in the system, and not the individual. If agencies reproduced exclusionary policies that are often applied by individual organizations (e.g., the organization lacks the skills and expertise to meet this complex need,

this person does not fit our service criteria), the Table would be inert and ineffective. A collaborative and creative approach goes beyond what single organizations are willing and able to do.

Another key driver in assembling a response team is the identification of other agencies who are already involved with the client, which is often uncovered when basic identifying information about the individual/family in question is shared (i.e., Filter 3 discussions). It is at this stage, where lead and assisting agencies are delegated to the situation.

Cambridge Table members noted that an existing connection between a provider and the client in question does not necessarily mean that they are the most appropriate lead. The decision is still based on the match between the highest priority presenting needs and the expertise, and contextual or relational fit of the agencies at the Table. The focus is on who will have the greatest probability of success in connecting with this individual. This is described by a Cambridge Table focus group participant below.

> *Sometimes I think we look at if the person has a connection already----then we can go, well, you know what? I've gone, it didn't go so well… Maybe you should try your luck. So sometimes we've used that tactic as well… But where that should land is even if we're doing that - and we've done this, I think, for the most part - even if it's somebody who has a connection, the lead should still be the primary need. And I think we've done a good job of that. - Cambridge Connectivity Member*

Although the assembly of the response team is a collaborative process, facilitated by the Table coordinator, our observations and consultations with Table members suggested that agency representatives tend to self-select or volunteer their participation on a response team. Some concerns were raised – particularly in relation to the initial operating months of the Tables – that some agency representatives were not well-positioned to "step up" to lead or assist in an intervention. In the few cases where this has been an issue, it was attributed to the limited capacity of the most appropriate lead agency or to gaps in services represented at the Table. These concerns were more prominent in Kitchener, and described often as a consequence of its relatively early stage of development. Without an obvious match between priority needs and agency mandates, Table members with either the closest mandate, or greatest propensity to flex their mandate, struggled to take on situations that challenged their capacity.

> *Frankly, I would say the only few times we've floundered, it comes down to people's capacity. They don't have the time …to get something done in a week, even if they are the primary person that should be there. Or if we've identified a gap, if there isn't someone at the Table who should be when the most sort of salient need comes forward, then it's sort of like, I'll take the lead for now, but if we can engage someone from addictions services that isn't here, or something like that. We've experienced that in Kitchener. - Cambridge Connectivity Member*

Members commended the ongoing efforts of the coordinator to build relationships with key service providers, which has resulted in successfully filling most of these gaps, which have been primarily related to adult mental health services. The addition of support from Grand River Hospital and expansion of represented services through CMHA and Here247 has assisted in this.

3.1.4 Member Engagement – Referring, Lead, and Assisting Services and Agencies

It is useful to understand the various roles agencies play in referring and responding to situations. A sensitive issue at the Tables, particularly from the perspective of police services who refer the majority of situations to the Table, is the perception that referring organizations are "dumping" work onto partner agencies without sharing responsibility for the required intervention and follow-up. Our analysis of the Connectivity databases demonstrates that this concern is unfounded. Table 1 displays the number of situations in which member agencies played a referring, lead, or assisting role in Cambridge and Kitchener.

Agency/Service Engagement

About 50% of the time, the service or agency that referred the situation became the lead agency in mobilizing a response to the situation.

Police services, CMHA-WWD and Family and Children's Services were the agencies most frequently engaged in responding to situations of elevated risk in both communities.

Table 1 – Referring, Leading, and Assisting Roles of Member Services and Agencies

Community	Member Service or Agency	# Situations Served as Referring Service or Agency	# Situations Served as Lead Service or Agency	# Situations Served as Assisting Service or Agency	Total # Situations Served on Response Team
Cambridge & North Dumfries	Waterloo Regional Police Service	89	32	40	72 (68.6%)
	Canadian Mental Health Association – Waterloo-Wellington-Dufferin	1	8	36	44 (41.9%)
	Family and Children's Services of the Waterloo Region	5	17	27	44 (41.9%)
	Lutherwood	1	5	35	40 (38.1%)
	Langs (Medical, Outreach, Social Work)	12	10	29	39 (37.1%)
	Cambridge Memorial Hospital (ED , Mental Health & Geriatric Emergency Management Network)	1	2	33	35 (33.3%)
	Waterloo Region District School Board	4	5	23	28 (26.7%)
	Canadian Mental Health Association – Waterloo-Wellington-Dufferin and Stonehenge: *Specialized Outreach Services Program*	-	7	13	20 (19.0%)
	Youth Justice Services	7	7	12	19 (18.1%)
	Ray of Hope	1	2	12	14 (13.3%)

Community	Member Service or Agency	# Situations Served as Referring Service or Agency	# Situations Served as Lead Service or Agency	# Situations Served as Assisting Service or Agency	Total # Situations Served on Response Team
	Waterloo Region Catholic District School Board	-	1	12	13 (12.4%)
	Stonehenge	-	1	11	12 (11.4%)
	St. Mary's Counselling Services	-	1	9	10 (9.5%)
	Sexual Assault Support Centre Waterloo Region	1	2	7	9 (8.6%)
	Waterloo Wellington Community Care Access Centre	-	1	6	7 (6.7%)
	Cambridge Self Help Food Bank	-	1	5	6 (5.75%)
	Cambridge Shelter Corporation	-	-	2	2 (1.9%)
	Supportive Housing of Waterloo	-	1	-	1 (<1%)
	Total	122	105	312	
Kitchener	Waterloo Regional Police Service	22	5	21	26 (74.3%)
	Canadian Mental Health Association – Waterloo-Wellington-Dufferin	-	5	12	17 (48.6%)
	Family and Children's Services of the Waterloo Region	-	1	14	15 (42.9%)
	Grand River Hospital	-	3	9	12 (34.3%)
	oneROOF	8	9	3	12 (34.3%)
	Front Door Program, Lutherwood	-	2	8	10 (28.6%)
	Ray of Hope	-	-	10	10 (28.6%)
	Waterloo Region District School Board	2	1	9	10 (28.6%)
	Kitchener-Waterloo, Wilmot, Woolwich and Wellesley (KW4) Community Ward / Health Link	-	2	6	8 (22.9%)

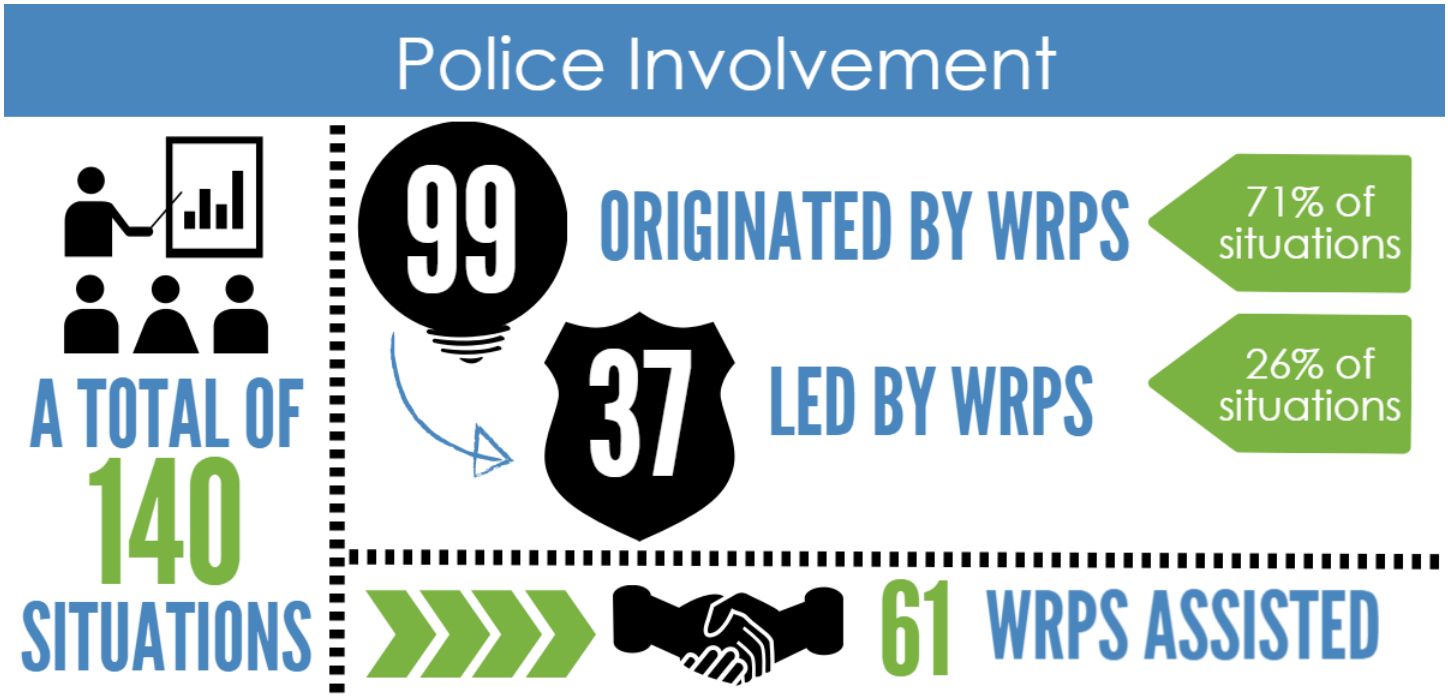
Community	Member Service or Agency	# Situations Served as Referring Service or Agency	# Situations Served as Lead Service or Agency	# Situations Served as Assisting Service or Agency	Total # Situations Served on Response Team
	Sexual Assault Support Centre Waterloo Region	-	-	6	6 (17.1%)
	St. Johns Kitchen/ The Working Centre	1	-	6	6 (17.1%)
	Ministry of Children and Youth Services	1	1	4	5 (14.3%)
	Ministry of Community Safety and Correctional Services	1	1	4	5 (14.3%)
	Lutherwood	1	2	2	4 (11.4%)
	Wilmot Family Resource Centre	1	1	3	4 (11.4%)
	Promise of Partnership	1	-	3	3 (8.6%)
	Waterloo Region Catholic District School Board	-	-	3	3 (8.6%)
	Waterloo Wellington Community Care Access Centre	-	-	2	2 (5.7%)
	Interfaith Community Counselling Centre/ Elder Abuse Response Team	1	-	2	2 (5.7%)
	Region of Waterloo - Social Services, Employment, and Income Support	-	-	2	2 (5.7%)
	Elizabeth Fry Society	-	-	1	1 (2.3%)
	Total	39	35	130	

In 52% (73) of the 140 situations that were opened at the Connectivity Tables, the referring or originating agency, became the lead organization in mobilizing a response. In Cambridge, 53% (56) of the 105 situations opened by the Table were taken on by the referring organization for that case; In Kitchener, the corresponding rate was 49% (17 of 35 situations).

As mentioned previously, Police Services was the highest referral source in both Connectivity Tables. However, Police Services was also the most frequent member organization to respond to the situations. They served as the lead or an assisting agency in 69% of the situations in Cambridge, and in 74% of the situations in Kitchener. It should be noted that in Kitchener, Police Services acted as lead agency in only 14% of the situations; they have predominantly served an assisting role (60% of situations). In Cambridge, Police lead 31% and assisted with 38% of Connectivity situations.

In both communities, the agencies most frequently engaged in intervention were Police Services, CMHA-WWD, and Family and Children's Services. This is not surprising, given that mental health and criminal involvement were the two highest risk categories in both communities, and situations involving children and youth accounted for one-third or more of the situations presented in both Kitchener and Cambridge.

Figure 4 – Summary of Police Involvement in Connectivity Waterloo Region



At times, the Connectivity Tables have recruited the assistance from non-member organizations. Cambridge has done this 3 times, recruiting the support of ODSP workers. Kitchener Connectivity has utilized the support of non-member organizations 4 times, recruiting the assistance of Ontario Works, the YWCA, the local Elder Abuse Response Team (a collaborative partnership between Police Services and the Waterloo Wellington CCAC) , and St. Mary's Counselling – who are members of the Cambridge Connectivity Table.

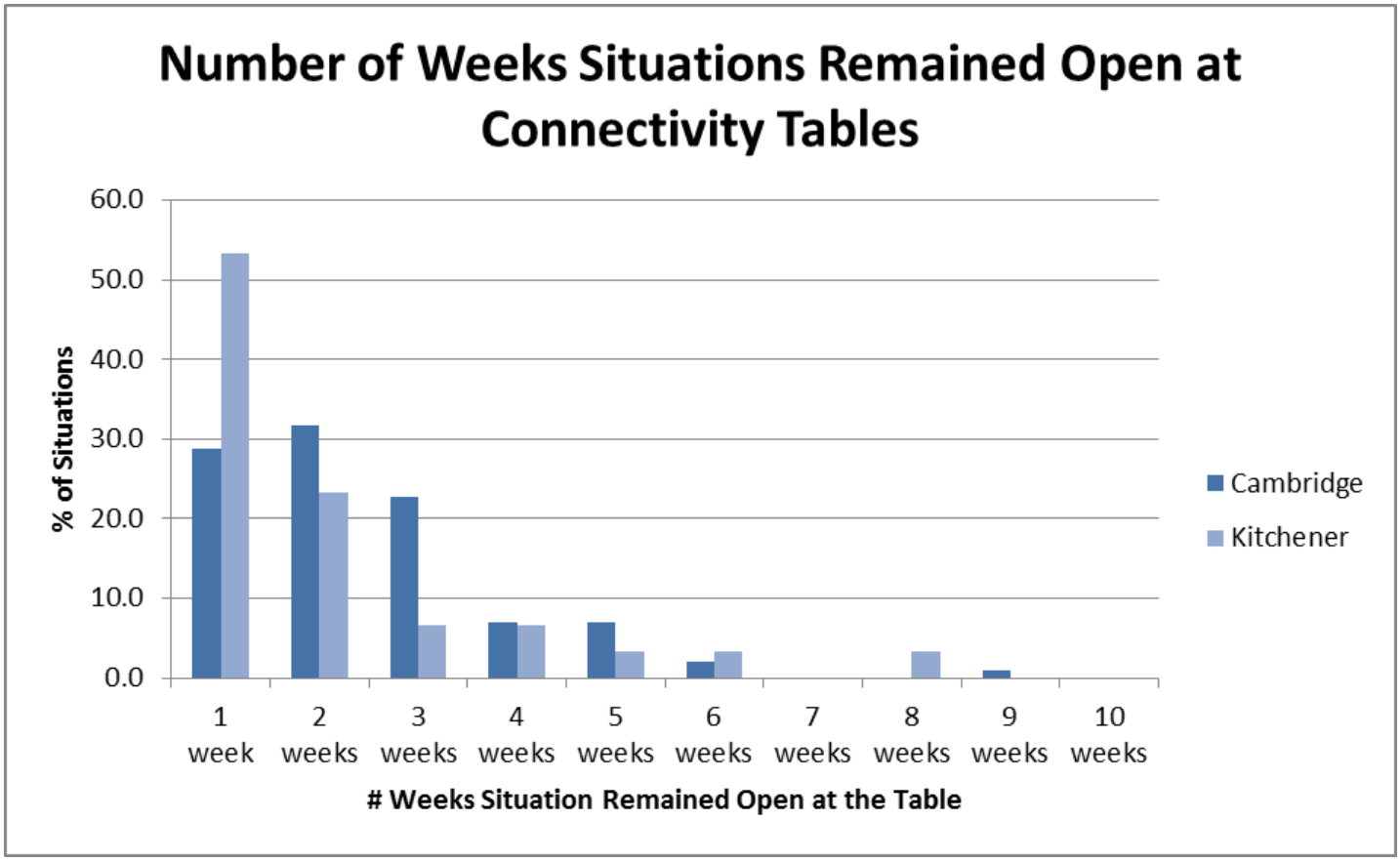
3.1.5 Timelines of Intervention: Duration of Situations at the Connectivity Tables

The Connectivity Tables have aimed to intervene within 24 to 48 hours from the date the situation was opened at the Table. Following the approach employed by the Prince Albert Model (Nilson, 2014), the main intervention typically involves a "door knock" or meeting with the individual or family in order to offer immediate support and initiate a connection with other appropriate supports and services. Although responses are mobilized within 48 hours of the meeting, the "open" or "closed" status for situations is documented only on a weekly basis during the weekly Connectivity meetings. The Tables track how long situations remain "open" or active at the table. This serves as a proxy to understand the relative complexity of situations referred to the table and accessibility of resources required to effectively mitigate the presenting risk. The Tables aim to resolve and close situations as quickly as possible.

Figure 5 displays the duration of weeks that situations remained open at the Cambridge and Kitchener Tables. Connectivity situations remained open for an average of 17 days in Cambridge and 13.6 days in Kitchener. In

Kitchener, over half (53%) of the situations were closed within 1week of opening – by the next Connectivity meeting. In Cambridge, 29% of situations were concluded within 1 week. The majority of situations in both communities have been resolved within 2 weeks. These findings suggest that, on average, the Tables are mitigating elevated risk in a timely manner. The maximum time a situation remained active at the Table was 9 weeks in Cambridge, and 8 weeks in Kitchener.

Figure 5: Duration of Situations at Connectivity Tables



The lack of a rapid conclusion does not imply lack of a swift response. Connectivity members have expressed satisfaction with the ability of the Table to coordinate and implement responses in a timely manner and have noted that they hold each other accountable for this.

> *We're accountable to make something happen this week. Because it's every week, you know--I think many of us feel accountable. I don't want to come back to this Table and not have done my piece. I'm accountable to this group professionally and for that family.. There are lots of* [other] *meetings you go to, and walk away from, and then there's no accountability in place. But this table has that. - Cambridge Connectivity Member*

The ability to close a situation quickly and effectively is influenced by a number of factors outside the control of the Table. Examples included challenges in locating the individuals in question, challenges in gaining individuals' consent or willingness to connect with supports, and challenges in accessing the services and resources locally that are required

to mitigate the prominent risks in the situation (e.g., access to psychiatry has been a consistent barrier in Waterloo Region).

Other factors influencing response time are related to the capacity (e.g., time, workload) of the Table's response team. For example, a lead or assisting agency may be involved in responding to up to 6 new situations on a given week. At both Tables, the mean number of newly referred situations on a given day was 2. In Cambridge, the number of new situations referred to the Table on a given day ranged from 1 to 6; in Kitchener, the number of new referrals per meeting ranged from 1 to 4. Below, this challenge is described by an active member of the Kitchener Table.

> *There has to be a handful of us - and I think it's probably police, school board, Family and Children's Services and probably children's mental health services - that are involved in lots of different situations, so sometimes it's like, okay, I've got five little breakout meetings and who can all talk right now, kind of thing. So it sort of gets a little bit odd that way… you've got five places to be and can't possibly… let's talk about what we can do this week. – Kitchener Connectivity Member*

3.2 Assessing Risk

The model adapted from Prince Albert is centred on identification and mitigation of situations of acutely elevated risk (Nilson, 2014). The Prince Albert Model defines situations of acutely elevated risk as being comprised of four conditions:

- Significant interest at stake
- Probability of harm occurring
- Severe intensity of harm
- Multi-disciplinary nature of elevated risk.

If one or more of these conditions is not present, the Table will reject the situation and refer it back to the originating agency or other community services for action.

We examined the Connectivity's approach to risk assessment and its function in decisions to accept a referral and open the situation to the Table, or to reject the situation and refer back to the originating agency. Some important findings emerged. Connectivity members certainly agreed that their Table's role is centered on identifying and mitigating *acutely elevated risk*. It is important to note that in our discussions, Table members distinguished *acutely elevated risk* from *imminent risk*. Situations of imminent risk require *immediate* response rather than the rapid, but not necessarily instantaneous, response facilitated through Connectivity, and as such, may not be appropriate for the Table. Situations of imminent risk – or emergency – are those that members address through their home organizations (and often the mobilization of emergency services) because they cannot sustain a waiting period of up to one week to present the situation to the Table and coordinate a collaborative response.

Situations of acutely elevated risk were described as containing an element of urgency, but relative to the operating time frame of the Table (i.e., weekly meetings with a rapid-response implemented typically within 24-48 hours). The guiding assumption is that intervention is warranted in situations where failing to coordinate an immediate response would likely result in further accumulation and escalation of significant risk. This is described below by a Kitchener Table member.

> *I think the language is important…If we're talking imminent risk, we're getting emergency services involved to deal with that and mitigate that. If we're talking acutely elevated, it's if we don't do something in the next week, this could really deteriorate… That's how we sort of filter it in our own organization about what we bring forward. – Kitchener Connectivity Member*

This is an important distinction because it highlights the unique role of the model as preventing crisis, emergency response, and all the attendant consequences. If functioning properly, the actions of the Table should prevent incidence of *imminent risk* requiring immediate response. Nilson (2014) specified that the role of the Table is to "intervene in these situations of acutely elevated risk, both swiftly and carefully, to prevent such risk from being elevated to the point of crisis" (p. 45).

The assessment of acutely elevated risk at the Connectivity Tables was not described as a linear or rigid consideration of sufficient and necessary criteria, but rather as the result of a collaborative, consensus-based conversation, guided by consideration of a number of factors – including discussion of urgency, as noted above, as well as the criteria defined by Prince Albert.

Probability of harm occurring – and particularly harm of a severe nature – is a primary consideration in assessments of risk. Although the presence of multiple, concomitant risk factors is common in situations of acutely elevated risk (and is in fact the norm more than the exception), Connectivity members did not describe this as a prerequisite for accepting a referral. Rather, elevated risk of severe harm – either extending from many risk factors or one significant risk factor – was described as the key consideration in assessment decisions.

> *Certainly there's not a tick box in terms of--it's interesting, it's not like "oh, we have to meet four criteria or four risk elements." It's so contextual, right, and each circumstance is so different. One person might only have two or three risk factors but they could be extremely significant, so it's really hard to quantify it because there's some qualitative information in there that's hard to capture. – Kitchener Connectivity Member*

The mean number risk factors identified per situation was indeed lower for situations that were rejected from the Tables (M=4.90, N=21), than for referrals that were accepted and opened by the Tables (M=6.44, N=140). However, some situations were accepted to Connectivity with as few as 2 risk factors identified (range=2-8), and situations were rejected with as many as 8 presenting risk factors (range=1-8).

Perhaps the most prominent consideration in assessing appropriate levels of risk for referral to Connectivity has been community members' lack of connection to, or engagement with, appropriate services and supports. Connection to services was frequently implicated as the primary proxy indicator of the presence of acutely elevated risk in decisions to accept a referral, and in decisions to close situations after a response has been mobilized.

> *We've closed everybody. Everybody, as soon as they're connected, it's like okay, connected to services - close. – Cambridge Connectivity Member*

> *I think that the mandate of Connectivity is obviously to connect people, so when they get connected and we feel like some of the risks have been mitigated, we close it. I think we've closed some cases even though some of the risk factors are unmet, but enough of them are met that we feel that we can close it. – Kitchener Connectivity Member*

However, recent discussions about how the Tables should be defining acutely elevated risk and how to assess if risk has been mitigated have begun to shift conversations at the Table away from equating 'connection' to services as a

proxy indicator of risk mitigation, and towards a deeper consideration of how the work of the Tables has changed the level of risk in the situation. This is described in the quotation below from one of the Table members.

> *That came up … do we want to close this situation? And it was one of mine, and I said I'm not sure. I've contacted the individual, he has spoken to me and we have another meeting set for Wednesday afternoon, and we've involved a service resolution coordinator…Some people were like, well, we could close, and yeah, no problem - he's connected; and other people then piped up and said, but is the risk mitigated? And I was like, no, the risk is still exactly the same as it was when we brought him here, I've only spoken to him. Is he connected? Yeah. Is he going to stay connected? I don't know - I've only met him twice. There is no change in his risk level, so then there became a discussion about, well, do we close it because he's connected or do we keep it open because he's connected but nothing has changed with the risk? So we ended up keeping him open. It just became clear…we need to have a bigger conversation around this at some point. – Cambridge Connectivity Member*

3.3 Characteristics and Risk Profiles of Situations Presenting at Connectivity

3.3.1 Targets of Service, Gender, and Age Groups

Across the population of situations presenting at both Connectivity Tables (161 situations), 70% of situations were described as involving an individual (112 situations), while 28% (45 situations) oriented around a family. (NB: 4 situations were not classified).

In Cambridge, 60% (73) of situations targeted an individual, and 37% targeted a family. In Kitchener, all situations were classified as focusing on an individual.

Even in situations involving a family, rather than one individual, the Table identified a primary individual as the target of service and identified the gender and age group of that primary target. Across both Tables, 58% (93) of situations focused on a male and 42% (68) focused on a female. The gender split was more pronounced in Cambridge, with 61% (74) of situations focusing on males, and 39% (48) focusing on females. In Kitchener, situations were more evenly split across gender, with 49% (19) of situations targeting males and 51% (20) targeting females.

The age groups served by the two Tables presented in Table 2.

Age Groups Referred to Connectivity

Situations referred to Connectivity have often involved

- transitional aged youth (youth 16 -24 years) (25% in Cambridge; 38% in Kitchener) or
- adults aged 30-59 years (30% in Cambridge; 33% in Kitchener).

School-aged children and youth (aged 6-15 years) have also been commonly involved in situations referred to Cambridge (27%), but less so in Kitchener (18%).

Older adults have only been involved in 5-10% of the situations referred to Connectivity in Cambridge and Kitchener (respectively).

Table 2 – Age Breakdown of Connectivity Situations

Age Group	# Situations in Cambridge	# Situations in Kitchener	Total # Situations in Waterloo Region
Infant 0-5	1	-	1
Child 6-11	15	-	15
Youth 12-15	19	7	26
Youth 16-17	13	6	19
Adult 18-24	17	9	26
Adult 25-29	8	2	10
Adult 30-39	18	5	23
Adult 40-59	18	8	26
Older Adult 60+	13	2	15
Total	122	39	161

The most frequently served cohorts were: Youth 12-15 years (26, 16%), Adult 18-24 years (26, 16%), and Adult 40-59 years (26, 16%). To date, only one situation focused on an infant (0-5 years) at elevated risk, and this was in Cambridge. Cambridge has also discussed 15 situations involving a child aged 6-11 yrs., whereas Kitchener has only been involved with individuals aged 12-15 years and older. The 25-29 year old cohort has been the age group least frequently involved in Connectivity. Transitional aged youth (aged 16-24) have been one of the cohorts most frequently referred to Connectivity. This is notable as the need to address service barriers for transitional aged youth has been identified as a priority by the provincial government in *Ontario's Policy Framework for Child and Youth Mental Health* (Ministry of Children and Youth Services). Locally, service providers have also reported gaps in services targeted to transitional aged youth. As youth are shifted from child/youth supports to adult community-based supports, they are sometimes lost in the transition as a result of not fitting specific eligibility criteria for services or because services that are accessible are not an appropriate match for the unique needs of this age group.

The results of this analysis suggest that Connectivity WR has been successful in catching those transitional-aged youth who are at elevated risk but disconnected or unable to access appropriate services. Longer-term follow-up is required to determine the success of these service connections for transitional youth made through Connectivity and whether the navigation and concerted support provided by the Table to these youth is enough to address the existing gaps and barriers to access.

3.3.2 Presenting Risk Factors

The mean number of risks identified per situation across Connectivity Waterloo Region was 6.2 (min= 1, max = 8). In Cambridge, the mean number of risks per situation was 6.3 (min= 1, max = 8), and in Kitchener, it was 6.1 (min= 1, max = 8). As noted previously, the mean number of risks per situation was slightly lower for referrals that were rejected from the Table.

The most prominent categories of presenting risk factors across in both Cambridge and Kitchener were mental health (146 situations) criminal involvement (134 situations), and substance use (involved in 92 situations). As depicted in Figure 6, the profile of risk factors begins to diverge for the two communities after this. Housing is a prominent risk factor in both communities, but is slightly more visible in Kitchener; whereas in Cambridge, physical violence ranks higher than housing as a common risk factor, but has been nearly non-existent in situations presented in Kitchener.

Identified Risk Factors

Situations of acutely elevated risk discussed at Connectivity tended to be characterized by carrying a multitude of distinct (although inter-related) risks.

Connectivity tables identified an average of **6 risks** involved in each situation managed by the tables.

In both Cambridge and Kitchener, the most commonly identified risk factors were related to:

- **mental health**
- **criminal involvement**
- **drugs**

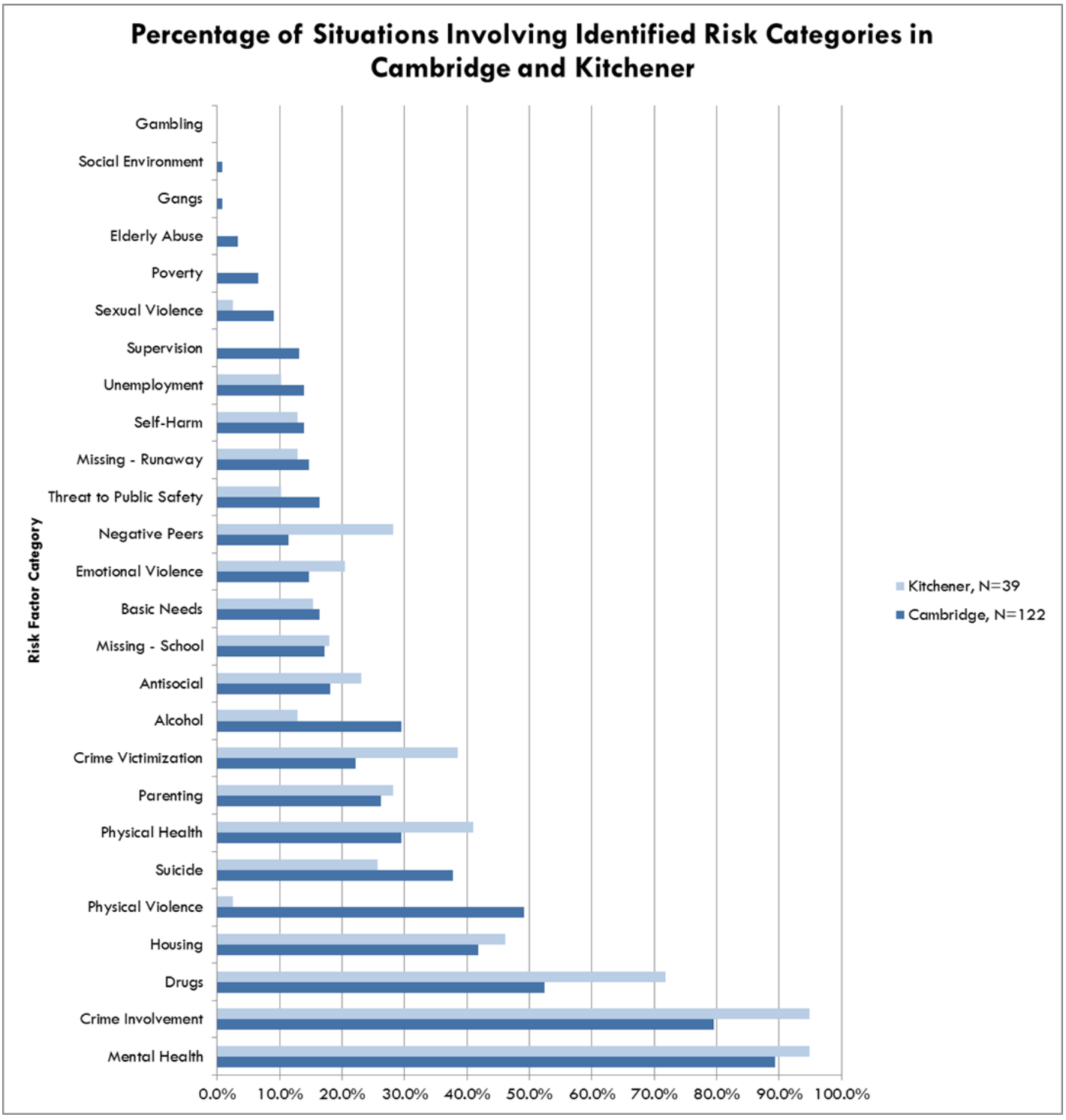
The risk categories, which collapse across more specific risk factors, are useful in generating a profile of the general types of vulnerabilities and concerns presented at the Connectivity Tables in Waterloo Region. However, examination of specific risk factors presented for each situation reveals a more nuanced understanding of the unique risks present in Cambridge and Kitchener.

A *diagnosed* mental health problem was the most frequently identified risk factor, present in over one-third (59) of all situations referred to both situation Tables. This was closely followed by a *suspected* mental health problem and lack of access to appropriate housing, which were present in a total of 57 situations each.

Examining the specific presentation of risks in Cambridge and Kitchener, there are interesting differences. In Cambridge, a *diagnosed* mental health problem was the most frequently cited risk factor (54 situations; 44% of situations), with perpetration of physical violence as the second most frequently observed risk factor (42 situations) and lack of access to appropriate housing as the third most commonly identified risk (41 situations). In Kitchener, a slightly different picture is revealed with the top 3 risk factors being: drug use by the target recipient (20 situations), a *suspected* mental health problem (present in 19 situations), and lack of appropriate housing (16 situations).

These points of divergence between the two cities may be instructive for continued strategic efforts to grow and refine the membership of the Tables, and may also help to identify unmet needs and important service gaps in the community. For example, although the Kitchener Table is still early in its development, the prominence of drug use and undiagnosed mental health issues highlights a potential need for increased engagement of addictions and mental health services at the Connectivity Table. The need to bolster the capacity of existing resources/services to address mental health needs in Kitchener was corroborated by concerns raised by key informants in our interviews.

Figure 6 – Frequency of Risk Categories of the Cambridge and Kitchener Connectivity Tables



Continued monitoring of risk factors and evaluation of the Connectivity's activities may be useful in advocating for system changes and resources to grow the capacity to address the most significant and prominent risk factors in

Waterloo Region. It is important, however, to couch our interpretation of the risk factors identified through this analysis in the understanding that the risks identified at each Table are influenced by a number of factors – for example, the presentation style of the referring Table member (e.g., narrative approach versus a listing of risks), and the particular perspectives of the service providers who participate at each Table, which may make certain risks stand out as more salient than others. Comparisons between risks presenting at the Kitchener versus the Cambridge Table must also be qualified by the fact that Connectivity Kitchener has been operating for a much shorter time than Cambridge. As additional data on presenting risks is gathered and monitored over time, Connectivity WR will have a more robust and reliable dataset upon which to base community planning and policy decisions.

3.4 Challenges and Benefits to Organizational Capacity of Member Services and Agencies

Successful implementation and sustainability of Connectivity is dependent upon the engagement of its member agencies and their capacity to effectively balance their responsibilities at the Table with those at their home organization. Therefore, key questions in our evaluation focused on understanding:

- *How do members of the Connectivity Table and their home organizations experience the process?*
- *What outcomes or changes to local services and the broader systems occur as a result of Connectivity?*
- *What the strengths and challenges?*

The answers to these questions were nuanced; staff representatives and leaders of member agencies identified a number of ways by which participation in Connectivity both benefited and challenged capacity within their organizations. The stakeholders we consulted with highly valued the work of the situation Tables and were enthusiastic about the benefits of participation, to their organization and to the broader community.

Organizational Capacity

Although some members of the Connectivity Tables reported challenges in finding time to balance the work of Connectivity with work in their home organization, on the whole, services and agencies involved in Connectivity are seeing great value in participating and, where possible, are creating capacity to sustain or enhance engagement in the tables. For example,

- The WRPS have designated a staff role in each community for work aligned with Connectivity
- Some agencies (e.g., CMHA-WWD; WW-CCAC) have allocated resources to allow additional staff members to participate in Connectivity
- Other agencies have redistributed workloads internally to allow Connectivity representatives more time to attend meetings and participate in the rapid follow-up that Connectivity requires.

3.4.1 Organizational Challenges

The primary capacity challenge experienced by member agencies is time. Active participation requires a commitment of approximately 2 hours a week to attend regular meetings (NB: this is doubled for the three agency representatives who participate in both Cambridge and Kitchener), and varying additional hours depending on the level of involvement in active situations. Stakeholders in Cambridge informed us that the Cambridge Table has lost one member of their Table in its first year of operation due to limitations in time to participate.

Capacity to balance the work in one's home organization and that of Connectivity was flagged as an ongoing concern, particularly for those working in smaller organizations, and thus may limit the level of engagement of some Table members.

> *If I start getting involved in a filter four case, that obviously increases the workload… that's where a lot of the real work happens and that can be challenging for a small agency. There is nobody I can delegate to; it's just me… and I still have to carry my full case load because I'm still responsible to our funders. – Kitchener Connectivity Member*

Inversely, the challenges to capacity are less salient in larger organizations, where managers participate at the Tables and can, in some circumstances, delegate some of the work resulting from the Connectivity discussions to the staff they supervise in their home organizations.

> *I mean, for* [some of the Connectivity members]*, we have big organizations. We have 8,000 employees. That's a big organization. We supervise staff, so we come from this Table and then we direct the work that needs to take place as a result of that, so that's why it works. But that's because we're in a big organization. - Cambridge Connectivity Member*

Some of the larger organizations involved in Connectivity have been able to create internal capacity for staff to participate in Connectivity as they see fit. For example, larger member organizations have:

- Created a designated staff role for Connectivity work, as the Waterloo Regional Police Service have done in both Cambridge and Kitchener.
- Shifted case load duties to other staff to free time for involvement in Connectivity interventions on the day of the weekly Connectivity meeting, as Family and Children's Services has done in Kitchener.
- Allocated resources for additional staff members to participate in Connectivity in order to share the workload resulting from Table participation, as CMHA-WWD has done in Cambridge.

It is important to note that while some Table members have been successful in lobbying their organizations for expanded capacity to participate, this has been more of an exception than the norm. This is not a reflection of management's lack of endorsement of the initiative, but rather, challenges in resourcing.

> *The police have been fortunate in their ability to create a role designated for this. I don't know that there are many organizations at the Table that have done that. We certainly have not. I was keen to add it to my portfolio because this is the work that motivates me, but it certainly is in addition to my full portfolio, and I think that's typical of most agencies that are participating. There's no added capacity in terms of hours or funds to do the work, right, so it's busy, there's no doubt about it… if a time comes when it becomes too much, then I need to be very clear about that because I can't let original portfolios flounder because of this work… But really, it would be lovely to have more capacity to do the work. – Connectivity Member*

3.4.2 Organizational Benefits

In terms of the benefits of involvement in Connectivity, agency representatives reported that membership has helped to bolster their organizational profile, broadening their exposure to other service agencies in Waterloo Region, which has helped them to connect with clients who are most appropriate for their services. It has also helped fulfill organizational mandates to access people most in need.

> *Some of the pros, I think, for us is exposure to the community. Because we are so small, it's difficult to get good exposure in the community. I think we provide really good quality services for the size that we are, so to increase our ability to serve more people who might not otherwise get connected with us, I think is a pro – Kitchener Connectivity Member*

> *We're inundated with referrals, but sometimes there are people that escape us because they're so afraid to use the shelter system and they're squatting on people's couches or whatever. They're precariously housed, and we don't even know that they exist… So, the hub is a really great place for us to get really appropriate referrals, because we are a specialized team looking for the sickest of the sick. That's what our role is - we're looking for the people that are on the street, mentally ill, drug-dependent, completely homeless. For me, it is really a great source of referrals for us, and we do get a lot of them but I would prefer to be extremely busy and get stuff done, than I would to be twiddling my thumbs…So I personally don't find it too overwhelming yet. - Cambridge Connectivity Member*

A final note in regard to capacity is that some members noted that the group's current practice of meeting once per week works well and advised against either increasing or decreasing the frequency of meetings. Members advised that a monthly meeting would not be sufficient to address urgent risks and that meeting twice per week would likely overwhelm the capacity of the current membership.

3.4.3 Managing Information Sharing and Privacy

As discussed previously in this report, in the earlier stages in the development of Connectivity, some members' home agencies had concerns about protocols and practices of Connectivity to protect the privacy of clients whose situations were discussed at the Table. Members have noted that these concerns were not rooted in particular criticisms of the four-filter approach to managing privacy (see Nilson, 2014 for a description of the four-filter process), but more generally centered around ensuring internal organizational polices could be reconciled with Connectivity's practices. Throughout our consultations with member organizations, we learned that agencies have, for the most part, reconciled these privacy concerns.

> *At my agency we have kind of reconciled it in our confidentiality policy that we hand out to clients. We say when areas are outside our expertise or our scope, or there are risks to yourself or to other people, we are required to contact the appropriate authority. … and I think we've negotiated in our agencies that the proper authority now is sometimes Connectivity. – Kitchener Connectivity Member*

Members in both communities expressed a general sense of comfort, competence, and professionalism in their adherence to the four-filter process, which prohibits the sharing of basic identifiable information about a client until the group collectively agrees the situation is one of acutely elevated risk, at which point, it is necessary to identify which agencies are already involved or should be involved with the client.

Comfort in applying this filter process was described as evolving over time, as Table members gained familiarity and experience in learning how much and what type of information is sufficient to demonstrate acutely elevated risk in a de-identified manner.

> *I think we're just much more efficient when we go through the process each week now, from week to week… We've really tightened up our procedures around that… We've gotten a lot better about trying to only use de-identifying information and only share what is absolutely necessary… But that's just come with experience and with time. I think* [the coordinator] *really leads the Table well that way and we have a better idea of what we can and can't do because we've tried different strategies. - Kitchener Connectivity Member*

As noted by a Kitchener Table member above, the role of the Table coordinator in holding presenters accountable for adherence to the filter process has been a critical element of success. Skillful implementation of the filter process has continued to improve over time in both Kitchener and Cambridge, as reported by members. However, Cambridge Table members have also noted that as their Table has matured and members become more comfortable and trusting

of each other, they have begun to reflect more critically on particular stages in the process where confidentiality and efficiency in information sharing could be tightened even further. For example, in discussing Connectivity's referral process earlier in this report, we highlighted some recent debate concerning the relevance and confidentiality risks associated with presentation of clients' history of risk in Filter 2 and 3 discussions. Table members have also raised concerns around identifying information shared through narratives presented when reporting back to the Table after interventions have been implemented. While maturation of the relationships between Table members may lead to more comfort in story-telling and sharing information that is not essential, it is that same level of trust that enables Table members and their coordinator to feel safe in holding each other accountable to privacy protocols.

> *We had some visitors that were there the week before, and some of the feedback was that perhaps we talked too much in the third filter and perhaps--and I think part of this is the nature of the work we do, we're about storytelling right? That's just the work, but we have to be really diligent around how brief we keep our narratives, so we've decided to tighten that up by reinforcing the accountability from the chair to cut us off and respect that, and also from one another. We came up with a few new strategies that would help to endorse that shortened filter three stage, and give each other permission to be told to stop sharing information and then respect that, because sometimes you do it without even realizing it. So I think it's just a reminder and a little bit of accountability, and we have the relationship to be able to do that. – Connectivity Member*

Members are committed to continued improvement and refinement of their approach to addressing elevated risk and are enthusiastic about continuing internal discussions and critical reflection to guide their continued development. While the Tables are eagerly receptive to external feedback, some members have cautioned that critical reflection and quality improvement must be tempered so as not to act as a barrier to continuing the good work of the Table. These debates and discussions about how to better manage information sharing have not been fully resolved and will continue as the Tables evolve.

3.5 Key Factors Related to Successful Implementation in Waterloo Region

Our consultations with members and leaders within represented organizations helped to unveil some of the key factors that have contributed to successful implementation of Connectivity. Some of these key success factors have been discussed in previous sections and relate to the processes and tools developed by and adopted from the Prince Albert model (specifically the four filter process); the critical role of a trusted and engaging coordinator to build the Table's network; the importance of effective facilitation; and mutual accountability of members to these processes. We now turn to additional success factors identified in the evaluation.

Key Success Factors

A number of factors were identified as important to the successful operation of Connectivity. These included:

- **The Connectivity database**, which is critical for monitoring the key features of situations referred to the Tables and decisions about those situations
- **Remote access to agencies' client databases** during Connectivity meetings
- A practice that has evolved at the Tables of **identifying assets and protective factors** associated with referred situations in addition to risk factors
- **Endorsement and support from leadership of member organizations**.

3.5.1 The Connectivity Database

It is an essential component of ongoing monitoring, evaluation, and improvement of Connectivity is the database. The database enables the Table to identify patterns and trends in the types of situations and responses mobilized

by the Table, which is informative for continual development of the membership and resources required to sustain the work. The role of a dedicated administrative coordinator responsible for effective data management associated with the Table's work is crucial. The database can also be used in the future to identify trends in root causes of elevated risk and gaps in the local service system. Armed with this information, the partnership is better positioned to advocate for and direct important policy and system changes necessary to mitigate risk on a broader community scale, and promote increased health and wellbeing of community members. In the Prince Albert model, this function is carried out by the Centre of Responsibility (COR), an assembly of leaders focused on leveraging the learnings of the daily operations of the Tables to inform systems change efforts. Although a COR group has not yet been established in Waterloo Region, there have been discussions amongst the partnership about developing such a cross-Table group in the near future. Continued effective management of the database will be an important tool for this committee.

3.5.2 Access to Home Organization Databases

One key tool that was cited as helpful at both Tables was members' access to their home organization's client management databases. Real time access to home databases become important in Filter 3, when agencies attempt to identify whether they have existing involvement with the individual or family at the centre of the situation under discussion. In our focus groups and during our observations, we recognized the significant role this access to information plays in expediting the process of assigning agencies to the situation and mobilizing a response. When agency representatives do not have access to this information, they must consult their organizational files in their home office outside of the meeting. This can delay planning as Filter 4 discussions typically occur immediately after the conclusion of the meeting where a situation was opened. It is in these Filter 4 discussions where the lead and assisting agencies quickly design a rapid response to be immediately implemented.

Agency representatives who have not had any – or even consistent – access to their client database have reported feeling "unhelpful" in mobilizing a response. Lack of access to information limits their capacity to fully engage in the Table's processes.

Some members have noted that organizational privacy policies have prohibited their ability to use their client database in the meeting. Others have noted that their agency does not have a database that is amenable to mobile or off-site use. Where Table members have had access to their client database and other communication technologies (e.g., intra-office direct messaging systems) that enable rapid access to relevant information during the course of a Connectivity meeting, capacity to respond in a swift, informed and confident manner is enhanced.

> *We have an internet messaging system, so then I can be at the Table, and let's say you have an open file that's being talked about, and I can go on this system and just message you back at the office and say, "hey, this file is being talked about, what happened yesterday"; or, "did you know that so-and-so is in the hospital", or that kind of thing. I think there was a situation or two where I was able to have quick sort of messaging with another worker and I was able to determine [facts about who was involved in the situation]… It kind of helps shape the understanding of what the risk would be. – Kitchener Connectivity Member*

As the Tables continue to evolve, the lead partners and membership may be advised to educate and advocate for increased access to organizational client databases for use during sessions.

3.5.3 Identifying Strengths and Assets

Another regular, though more informal practice employed by the Connectivity Table in Cambridge has been to incorporate discussion of assets and protective factors alongside risk factors in helping to plan an appropriate intervention.

> *We're trying to look for those strengths... protective factors... as well. We do it in the questions that we ask after the situation is presented, so sometimes you'll hear people say, "what's the source of income, are their parents involved", and we're looking for those strengths. We're trying to figure who we can tap into, are there other connections, who are other people that have been the positives. ... [It is important in designing a response], because someone will say, "oh yes, I should have told you, her mom does live really close by and often babysits the kids for her", and then we can go off with that. – Cambridge Connectivity Member*

The presentation of protective factors is not presently incorporated in the situation profiles documented in the database currently in use. However, the Ontario Working Group, with support from the Ministry of Community Safety and Correctional Services, has recently re-designed the database used by Situation Tables across Ontario and has included the capture of protective factors in these changes. Connectivity WR has agreed to pilot this system for the Ontario Working Group once the amendments are complete later in 2015.

3.5.4 Organizational Endorsement and Support of the Connectivity Model

Member organizations' endorsement at the management and leadership level was identified as a critical ingredient to successful implementation. Organizations who not only endorse, but champion the work of the Tables, find creative ways to create capacity for their staff to participate meaningfully in the Table's activities. For example, organizations have flexed their internal policies and mandates to allow staff to contribute their expertise and share sensitive information about complex situations. Organizations have also flexed work schedules, reallocated internal caseloads, or reallocated/created new resources to support the work of the Tables. The onus has typically been on frontline staff members to advocate to their management for increased support and capacity to participate on the Tables. In some cases, this has been successful – mostly in larger organizations with some flexibility with regard to resource allocation.

Key Success Factors

A key factor in the successful implementation of Connectivity has been the **strategic recruitment and engagement of members who are perceived as "leaders" and "decision-makers"** in their home organizations.

Whether in a front-line or supervisor role, **members should have the clout and endorsement in their organization to act swiftly with some degree of flexibility and autonomy** in order to enact the kind of creative and rapid responses needed to mitigate acutely elevated risk.

Table members noted that more of the organizations need to find creative ways to develop capacity for their staff to participate in the work of the Table and noted that this will be critical to the ongoing success and sustainability of the model. The following call for continued advocacy for increased capacity comes from a Cambridge Table member whose organization has reallocated resources to facilitate dedicated involvement in Connectivity.

> *[We need] to say to the higher decision makers, you need to start giving time to your employees to follow through on the background that comes out of this... if you don't do that, you are going to lose the sustainability of this. And when I say the sustainability, I don't mean that this would ever collapse. What I mean is we won't*

> *do our job as well as we could. We won't do this as well as we're doing it now if you just keep getting more and more and more on your caseload… So, how do we make this better? You need to start funding people in this room to be able to do what I'm doing, because if that doesn't happen, this isn't going to last. – Cambridge Connectivity Member*

Frequently, our stakeholders noted that the most helpful form of support organizational leaders can provide to their Table representatives is decision-making autonomy – the "latitude" and endorsement to "think outside of the box, " and participate in and lead creative collaborative solutions that may fall outside of their normal roles and responsibilities. This was asserted in comments made by a manager of an organization represented at the Cambridge Table:

> *I'm not here just to hear about something and then say, okay, that sounds interesting, not sure if we can do anything. I'm here to find a way to get the resources for the individual, and that means making sure that frontline staff are supported, they have time and they have the resources… But I think that we need to make sure that we're empowering people to take action… You know, you have to give a little bit of a "blank cheque" latitude. – Cambridge Connectivity Member*

One of the most frequently cited contributing factors to the successful implementation of Connectivity relates to the personalities of the agency representatives themselves. A number of stakeholders noted that for the Table to function as intended, you need to have the right agencies around the Table, but it is equally important that you have the right kind of people at the Table. What individuals are the best fit for the Connectivity Table? Cambridge Table members oriented around the notion of "doers" versus "observers."

> *Observers and doers, right, and I think at this Table you've got doers. They go out and do the work, and it doesn't matter if you're a management level person or a frontline worker, or directly working with the clients or not. There's just this understanding that we'll be doers and we'll get the work done. We need to make things happen fairly quickly, and if they aren't able to do that, then there needs to be consideration for who is there representing those agencies. – Cambridge Connectivity Member*

Effective members or "doers" were also described as "decision-makers" and "leaders" in organizations, which does not necessarily imply that members should be in a management role, but that they have the clout and endorsement in their organization to make decisions and act creatively with some degree of flexibility and autonomy. Effective members were described as having a keen interest in and commitment to exercising creativity and flexibility in working quickly and collaboratively in untraditional roles with sometimes atypical partners in order to address the complex, multi-faceted needs of the individuals and families the Tables serve. Connectivity members asserted that success in the Connectivity can be attributed, to a large extent, to the intentional and strategic recruitment of "doers" to the Table.

> *When the folks out in Cambridge were recruiting for this initiative, they invited us out for information sessions and they were really clear about you have to have people at that Table who will, do the work and take part in it, but also who have a bit of clout, even if they're not a in a leadership position, to go back and make things happen. We don't want you to send someone to the Table who can't get things done, so pay close attention to who you're bringing and who you're going to put forward. - Cambridge Connectivity Member*

The product of this strategic recruitment is a strong sense of trust, shared accountability, and commitment to collaboration and team work, which Table members described as foundational and essential for the successful implementation of Connectivity.

3.6 Key Factors for Successful Leadership of the Situation Tables

As part of our consultations with key stakeholders, we interviewed the three partners responsible for directing Connectivity in Waterloo Region to capture their insights and feedback on the strengths and challenges experienced in the leadership, design, and implementation of the Situation Tables in Cambridge and Kitchener.

Connectivity Waterloo Region Lead Partners

- Bill Davidson, Executive Director of Langs (Cambridge Connectivity)
- Sue Gillespie, Chief Executive Officer of Carizon Family and Community Services (Kitchener Connectivity)
- Barry Zehr, Superintendent, Waterloo Regional Police Services (Connectivity Waterloo Region).

3.6.1 Factors Associated with Successful Leadership

Waterloo Regional Police Services was instrumental in facilitating the development of the Situation Tables in Waterloo Region, but from the very beginning, positioned Police Services as a partner, rather than a driver, of the initiative. From inception, Connectivity WR was intended to be a community-based and community-owned initiative, led by community organizations with deep roots and broad networks across multiple service sectors. Leadership of Situation Tables implemented in other jurisdictions in Saskatchewan and Ontario have been primarily police-focused, at least in earlier stages. Informed by a social determinants of health perspective, the intention of the Connectivity leadership was to steer the direction of the Tables in WR away from enforcement and towards enhanced integration of social and health services.

This approach has been described by the lead partners as a critical element to the success of the Tables so far in relation to strengthening the local service system and is viewed as a key contributor to the sustainability of the Tables moving forward. By nurturing shared ownership and responsibility for the work across key organizations and multiple sectors, the initiative will develop a broad network of roots and will have a better chance of feeding off the strengths, assets, and resources across those different sectors in the community.

Key Factors Associated with Successful Leadership

- Community-based leadership; leadership is shared across community organizations rather than driven by one organization
- Long-standing and strong relationships amongst all three lead partners
- Lead partners are well-respected in the community as conveners, each with a rich history of leadership in multi-service collaboration
- Lead community organizations already positioned as leaders of physical service hubs
- Lead partners share a service provision philosophy informed by a social determinants of health perspective; experience in integration of social and health services in community interventions

The selection of Langs as a lead partner in Cambridge and North Dumfries was natural for the WRPS for a variety of reasons. The WRPS had a long-standing positive working relationship with Langs and shared vision for how to work collaboratively to better serve the needs of vulnerable people and families at risk. Also, as a successful Community Health Centre, Langs has extensive experience as a leader in integrating health, social and community services, has a strong network of partnerships with local service providers from multiple sectors, and serves as a physical multi-service hub where community members and service providers have a history of coming together. At this time, Langs has also been identified as a lead for the development of a local Health Link. The leadership viewed this connection to the Health

Link and possible alignment between the work of the Health Link and Connectivity as an enabler to deepen the impact of these initiatives on local service systems and comprehensive service access.

The subsequent addition of Carizon Family and Community Services as the lead partner for the Kitchener Connectivity Table was inspired by the same rationale. Carizon Family and Community Services has been a long-standing host for a prominent and very successful Family Violence Project in Waterloo Region. Through that initiative and their other work, Carizon Family and Community Services has built a strong network of multi-sector partnerships across the local service system. The organization also serves as a physical community hub wherein multiple service providers share office space – including Waterloo Regional Police Services. Langs and Carizon Family and Social Services also have a history of strong community partnership outside of the Connectivity initiative. Carizon Family and Social Services offers services onsite at Langs in Cambridge.

The strength of the existing connections between the three lead organizations has been a strong foundation to build upon in this initiative. The trust amongst the partners has allowed them to act quickly in their transition from design to implementation and to leverage each other's existing partnerships to help strengthen networks in both communities. Comfort in communicating clearly and honestly about needs, capacity, and roles has helped the partners determine "who leads when" in order to capitalize on each other's strengths and capacity to better serve the initiative as a whole.

All three lead partners identified the following as some of the most important contributors to the success of the initiative so far.

- Community-based leadership; leadership shared across community organizations rather than driven by one organization.
- Long-standing and strong relationships amongst all three lead partners.
- Lead partners well-respected in the community as conveners, each with a rich history of leadership in multi-service collaboration.
- Lead community organizations are already positioned as leaders of physical and networked service hubs.
- Lead partners share a service provision philosophy informed by a social determinants of health perspective and have experience in the integration of social and health services.

The focus on a social determinants of health perspective in this work has influenced two characteristics of Connectivity WR that the lead partners view as distinct from Situation Tables in other municipalities:

- The engagement of health providers (e.g., community health, primary care, hospitals), and health system leaders (i.e., connections to the LHIN and local Health Link).
- A focus on protective factors as well as risk factors associated with situations of acutely elevated risk, with movement toward an assets-based approach to community intervention. The Ministry of Community Safety and Correctional Services has recently updated the shared database used by Situation Tables across the province and has included protective factors in these updates for pilot. Connectivity WR will serve as a pilot site for this work.

The participation of the Connectivity WR lead partners in the Ontario Working Group has been another important element in Connectivity's story of success thus far. Involvement at this level has helped the leaders better understand the provincial government's vision for plans and policies related to Situation Tables and community safety and well-

being planning more broadly. This participation has also helped to shape government planning as government officials participate on the OWG and often look to Connectivity as a best practice.

3.6.2 Challenges in Implementation

When asked to describe challenges faced in implementing and operating Connectivity, the partners agreed that the primary challenge they have faced was the reservation of some local organizations and groups to participate because of privacy legislation concerns. Although this has not been a large hurdle, the partners were particularly surprised that some organizations in Kitchener were slower to engage even when their affiliate agencies or branches had already been participating for some time in Cambridge.

In response, the Connectivity partnership has been increasingly transparent about how information is shared at the Table, has engaged the Privacy Commissioner in their operations and has explored future training options to alleviate the concerns of organizations with reservations.

This challenge also led the partnership to recognize how differently some organizations operate across the two communities, has highlighted the importance of community context that is unique to both Tables (even within the same region), and challenged assumptions about the ease of transferring an existing model to another community. Different communities have different needs, different players, different ways of working, and thus, although the Connectivity model is the same in both Cambridge and Kitchener, different conversations were required to recruit appropriate partners to engage.

3.6.1 Supports and Resources for Continued Development and Sustainability

The lead partners identified supports and resources that will be important for the continued development and sustainability of the initiative. Most importantly, the partners asserted Connectivity needs to maintain shared community leadership. The initiative must continue to maintain the commitment and continuity of its partners and member organizations. It is critical that ownership is shared and that member organizations continue to commit resources to their involvement. The lead partners noted that they have clearly framed Connectivity not as a "project" but as a "different (and better) way of doing our work." The lead partners agreed that opportunities for additional funding for the work of the table are unlikely to arise and thus the work requires investment and reallocation of existing resources shared across community partners. Continuing to build a strong sense of shared ownership and commitment to the model can be supported by evidence of successful implementation and impact. Continued evaluation, monitoring, and knowledge sharing (locally, as well as leveraging learnings of other municipalities) to demonstrate the value of the initiative will be important to sustain engagement and buy-in.

Where the lead partners noted additional resources may be most needed to sustain this work is in relation to the coordination required to operate Connectivity. Connectivity relies upon strong relationships and community engagement – assets that require much time and effort to build and sustain, are rarely funded, but are essential to this work. Lastly, the partners identified continued support of the Privacy Commissioner as critical to the sustainability of Connectivity and Situation Tables in other jurisdictions. Sustainability of this work could be powerfully influenced by the Privacy Commissioner's endorsement of the model and continued investment in providing updated training resources and working with Situation Tables to ensure practices align with legislation.

Part 4: Review of Findings - Outcomes for Individuals Served through Connectivity

A consistent gap in the evaluation of community Situation Tables (but a frequently recommended practice), is the gathering information from service users in order to better understand the impact on their lives. A range of outcomes are expected but rarely tracked beyond the confirmation that they have been connected to services. A connection made to services is often considered a proxy of risk mitigation, but observed reductions in *actual* risk are not included in evaluations. Subsequent outcomes, such as continued engagement with services and an improvement to health and wellness are inferred but not systematically investigated.

The present evaluation suffers from the similar gap in outcome data. Due to compressed timelines, the evaluation was limited to examining immediate/short-term outcomes. We were unable to connect directly with recent users of Connectivity as part of the present research, and our analysis is therefore focused on the case examples reported by Table members. The following questions were relevant:

- To what extent do individuals engage with the supports and services developed and implemented by Connectivity?
- What changes are observed in people's lives? How is risk mitigated or removed? To what extent to individuals experience increased awareness and trust of local services or increased trust in local? To what extent is stability and wellness promoted?

In addition, we were also able to access service call data collected by Waterloo Regional Police Service in relation to the Cambridge Table. This allowed for inferences regarding changes to the frequency of crisis situations requiring the involvement of police, a key outcome suggestive of reduced risk mitigation over time.

4.1 Connection to Services

Many members describe Connectivity's core function as connecting individuals and families at acutely elevated risk to appropriate services and supports. The underlying assumption is that service connections will mitigate risk. Although 'connection to services' has been frequently employed as a proxy indicator of mitigated risk, and subsequently invoked as the primary rationale for closing a situation, the Tables have recently developed a more nuanced understanding of risk mitigation. Efforts have been made efforts to clarify and confirm when individuals have meaningfully engaged with services as opposed to merely being referred.

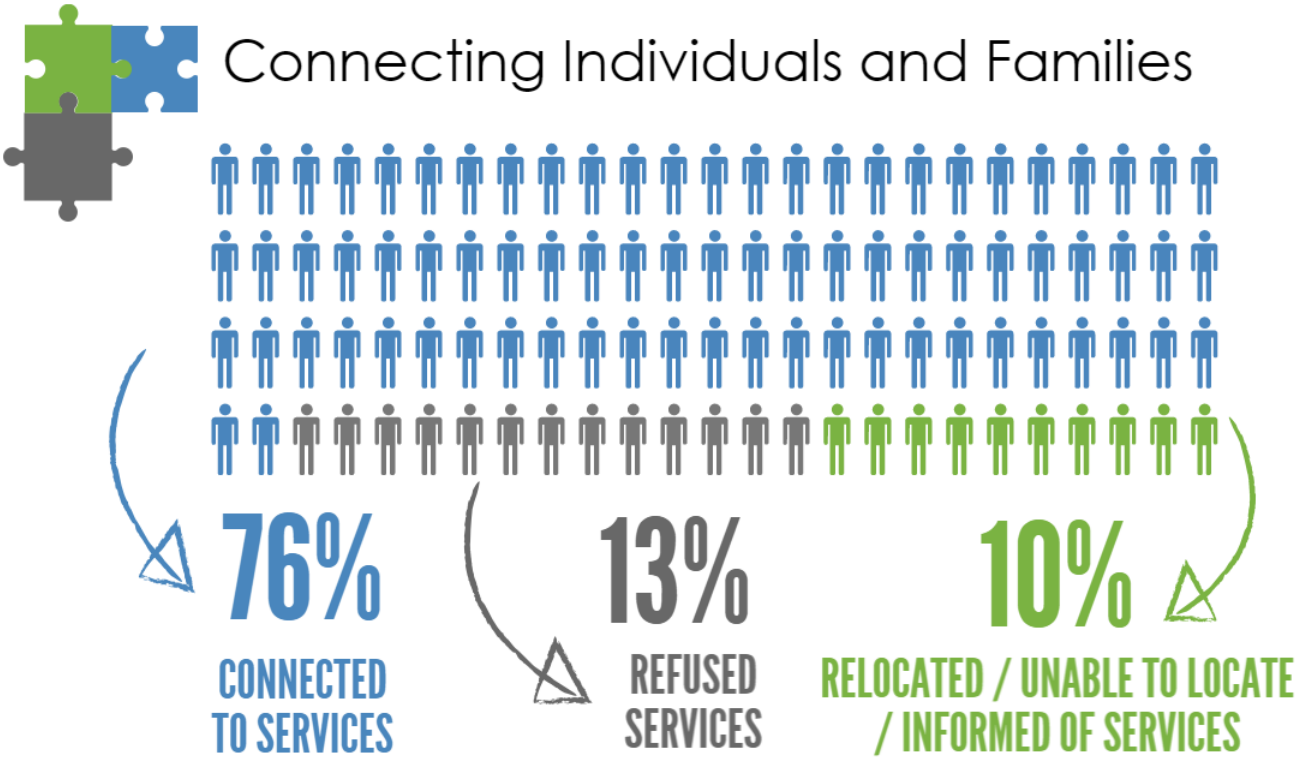
Connecting People to Services

Connectivity has been successful in connecting individuals and families in situations of acutely elevated risk to connect with services in over three-quarters (76%) of the situations they have addressed and closed.

Individuals refused to connect with recommended services and supports in only 13% of the situations. In other cases, individuals relocated, were unable to be found, or were informed of services but did not suggest they would be cooperative in follow-up.

Figure 7 displays the distribution of results of the efforts of both Tables to connect clients to services. Tables have been successful in achieving the cooperation of individuals and families to connect with services offered. In 76% of closed situations, the Tables have been able to confirm that individuals were at least initially cooperative and amenable to connecting with recommended services. Individuals refused services in only 13% of situations.

Figure 7 – Results of Service Connection Efforts



This reflects the diligence, creativity, and time spent by members in working with individuals to facilitate cooperation and a sense of trust in engaging with service providers. This success may also be linked to the additional time that situations remained open at the Tables while members ensured individuals' willingness to engage, rather than closing situations after simply informing individuals about available services.

An example of this "vigilance" of members was communicated in our interviews. A young woman with a developmental delay and risks associated with poor family support was experiencing abuse from her partner, and was referred through Connectivity to counseling. There were also existing connections with the police. In this case, the young woman did not refuse service, but was reluctant to engage and had attempted to cancel counselling appointments set up for her. Because the staff at the agency were aware of her association with Connectivity and elevated level of risk, they suggested that she refer back to the police for advice before canceling. The police advised that she attend at least once before deciding to disengage. Because of the diligence and perseverance of the police and the counselling staff in encouraging connection to services, the young woman agreed to attend one session. By the end of that first session, the woman agreed to sign consents and expressed interest in returning for subsequent sessions. The member who shared this example attributed this success to the perseverance and trust-building of the Connectivity response team that wrapped around this individual.

> *So you think about the interactions that happened that wouldn't have happened, because of Connectivity. So you have the receptionist who is really aware that this is a high-risk client, you have police who said, you have to go to counseling once. You have the young woman who heard the police--when she called, the police said*

yeah, you have to go once. You have our counselor who is really vigilant because it's high risk, having connected with the other partners and really doing everything to engage. Without Connectivity, someone calls and cancels an appointment, if we had reason to worry, the counselor might follow up, but if the person just said, oh, things are fine, I don't need to come in, we're not going to follow up, right? So you see how differently that went because of Connectivity.- Kitchener Connectivity Member

4.2 Increased Trust in Services

As was reflected in the previous example, outcomes for service recipients, beyond connection to services, have included in increased sense of trust in service providers. For many of the vulnerable individuals that are referred to the Table, trust in formal services has been eroded, often as a result of systemic barriers that have made it difficult for people with co-occurring complex needs to access appropriate services. Lack of trust in formal services is a key reason why many of the individuals referred to Table have remained disconnected from support, and why many refuse services or evade connection when it is offered. Re-building trust in services is a slow and labour-intensive process, but it is a foundational stepping stone towards meaningful engagement with necessary supports. An example of the Kitchener Table's success in establishing rapport and building a vulnerable individual's trust in services is described below.

I can give you an example of a really challenging case that was brought to the Table because she was calling 911 every day and causing some disturbance in her apartment building to her neighbours and things like that…. previously had been refusing any services, and now she's--it's again a slow rapport, this didn't happen in a week, but we were able to get in and sort of get her trust and get into the apartment, talk to her, and eventually over many, many, many visits - she's going to accept personal support for some help with personal care. She's getting some care, she's not calling 911, she's not harassing the neighbours, so that was definitely a success. – Kitchener Connectivity Member

4.3 Increased Stability and Wellness

There have been examples where connections to services made through the work of the Connectivity Tables has resulted in increased stability and wellness for individuals in situations of acutely elevated risk. In some cases, relatively simple interventions were all that was required to help an individual access the supports needed to stabilize. For many of the situations in Waterloo Region which involve unmet mental health needs, a psychiatric referral can have a significant impact on stability and wellness. However, because psychiatry services are so limited in the region, securing even a simple referral can take a significant amount of time and labour.

Being involved in a lot of the mental health cases, a lot of times it's being able to get them the psychiatric referral or appointment, or being able to get them admitted to hospital to get the care that they need. Sometimes it's just that stabilization in terms of the medications or things like that to just make. So it's just a very small tweak, but it can make a huge difference in their functional mental health. – Kitchener Connectivity Member

In one example described by a member of the Cambridge Table, advocacy and support provided by the designated team to facilitate access to stable, appropriate treatment in hospital for a homeless woman with untreated mental health and addictions issues resulted in significant increases in stabilization and quality of life. These benefits have been sustained since her involvement with Connectivity about a year ago.

We have another person brought forward who was homeless with a drug addiction, who has been resistant to service for many years and had caused many, many problems. I think in the year that she was brought

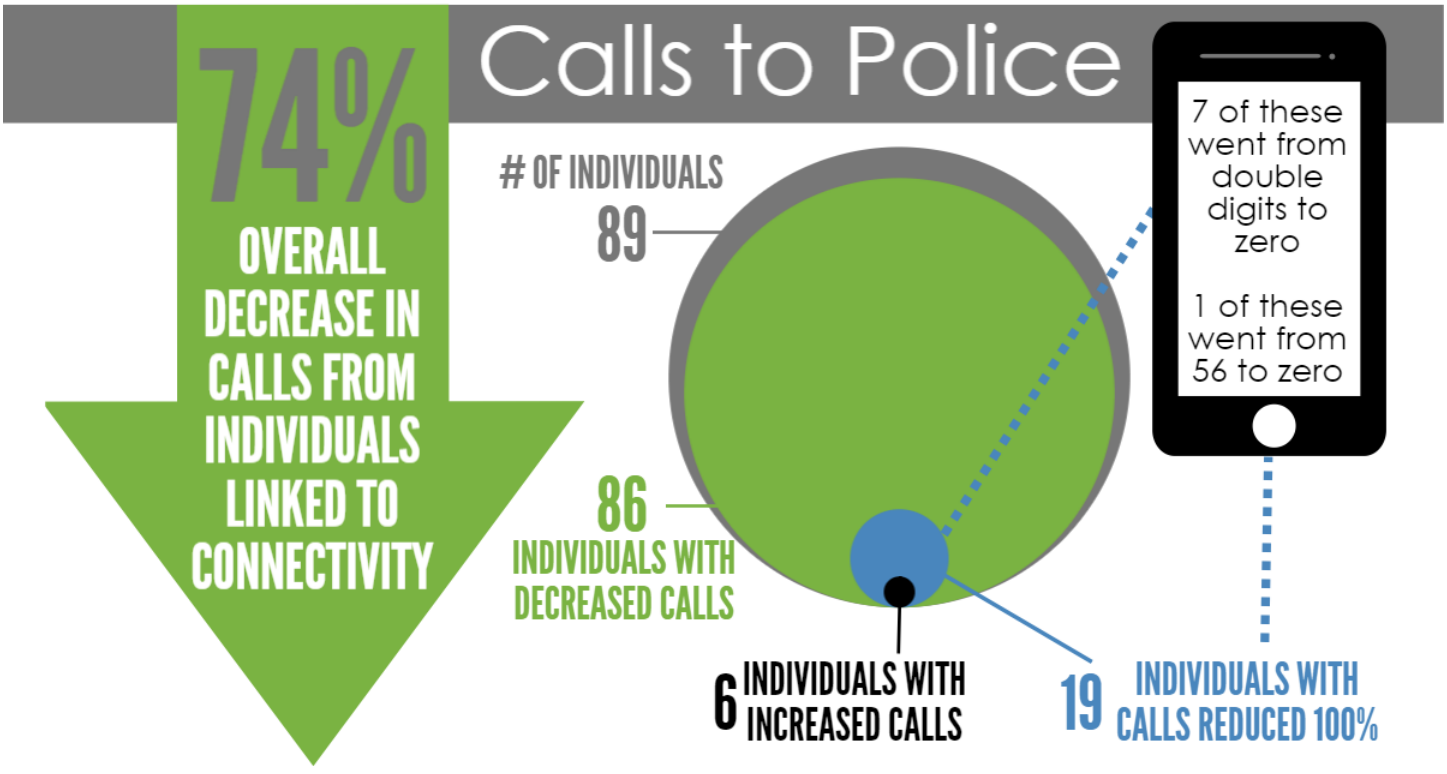
forward, they had had 250 calls about her, the police had, in a year, so they were really concerned about her well-being. So we did go and find her, speak to her, and she did end up getting apprehended by us. We made a plan to apprehend her because she was too psychotic at that time to try to talk to. The hospital had been seeing her regularly but had been discharging her back onto the street. ….So when we got involved, we got the hospital involved, we got police involved, and we got her in the hospital. As soon as she kind of sobered up and settled down and got on appropriate medication for her psychosis, she engaged with us. …She had been estranged from her family because of her addiction and her untreated schizophrenia. Now she has been residing with her mother here and I see her all the time, and she is lovely. She is totally sober and sane, and she is housed, she is working towards some things, taking care of her elderly mother. – Cambridge Connectivity Member

4.4 More Appropriate Use of Services: Evidence of Decreased Calls for Police Services

The Waterloo Regional Police Service in Cambridge recently polled their internal database (Niche RMS) to examine the potential impacts of Connectivity interventions on police calls. A reduction in calls for service after a Connectivity intervention is a decent proxy indicator of successful risk mitigation as result of service engagement.

The police cross-referenced Connectivity situations to identify calls for service in their database that were associated with individuals who they brought forward to the Cambridge Connectivity Table (n=89). Situations presented at the Table that were rejected by the Table were not included in the analysis. No consideration was given to whether or not the individuals accepted or refused service, so this is a conservative analysis (i.e., if individuals who refused services were excluded, total police calls would presumably be lower). The analysis examined all calls for service in a 90 day time period prior to, and a 90 day time period following, the date that the situation was closed by the Table.

Figure 8 – Evidence of Decreased Calls for Police Services



The resulting sample included a total of 66 situations. Of these cases, a total of 684 calls for service were made in the 90 days prior to closure of the situation at the Table. Within the 90 days following the closure of a situation, a total of 179 calls for service were logged in relation to the subject of the Connectivity situation. The aggregate findings demonstrate a 74% reduction in calls for service associated with people presenting at the Cambridge Table, during a 90 day period after the situation was closed. An increase in calls for service was noted in only 6 of the situations included in the analysis. A total of 19 of the situations (30%) showed a 100% decrease in associated calls for service. Seven of these 19 situations declined from "double digit" calls to 0 calls, post-Connectivity.

While we cannot control for extraneous factors that may have influenced these trends, it is highly suggestive of the beneficial impact of Connectivity. What is encouraging is that risk mitigation (at least pertaining the level of risk that leads to police intervention) has some durability, demonstrating maintenance over a 3-month period. This allays some concerns that connection to services as a proxy indicator is superficial and may not be associated with risk mitigation.

4.5 Risk 'Relapse' – Returning Referrals to the Table

The Kitchener Table has not had any situations re-opened at the Table to date. Cambridge has had seven situations referred back once to the Table, and has had two situations referred back twice to the Table. In one of these instances, the situation was rejected because it was discovered that the individual was already connected to appropriate services. In the remaining instances, the situations were reopened at the Table. Two of these situations, which were reopened in March 2015, remain open at this time. Six of these returning situations were concluded and the individuals in question were cooperative in connecting to services. In one instance, the individual was informed of services, but the lead agency was not confident in their willingness to connect, and in one other instance, the individual in question refused services. The duration of time required to conclude these reopened situations varied from 7 to 35 days, with the majority of situations remaining open for 2 or 3 weeks. This extended duration of time that reopened situations require at the Table may be an indicator of inherent complexity and challenges in linking the individuals at the centre of the situations to appropriate supports.

It is important to note that it is not necessarily an indicator of intervention failure when individuals with multiple, co-occurring complex needs are referred back to the Connectivity Table. The rapid interventions mobilized by the Table are designed to mitigate the most urgent or highest priority presenting risks within a given situation. While we would not expect to see high rates of return to the Table, it is reasonable to expect that situations involving multiple significant risks will re-present as problematic and require attention. Additionally, risks that were previously mitigated may relapse or re-escalate if there are personal or systemic barriers to engaging with appropriate services. To address the cyclical nature of some of the highly complex, multi-layered risk situations presenting at the Situation Tables, the Cambridge Connectivity Table is currently considering the promise of developing an ongoing plan of care for some Connectivity Table clients through their close association with the developing local Health Link.

4.6 Barriers and Limitations to Mitigating Risk

One particular example from the Cambridge Table helps to illustrate how complex and co-occurring needs paired with service/system barriers can pose challenges to the Table's capacity to mitigate risk – or result in risk relapse. A situation that was once concluded, but recently reopened at the Table centred on problematic hoarding was opened at the Table. The situation focused on a man who was living with his elderly mother. The hoarding and the man's suspected mental health issues were associated with surmounting negative health consequences for the elderly mother. The Table intervened and were able to remove the mother from the unhealthy environment and connect her to

appropriate health care. The physical environment was cleaned of the hoarding and the male who was at the centre of the situation was connected with a family doctor and support for associated financial issues as well. The situation was reopened recently because the service providers that were connected raised concerns that the risks in the situation had become elevated again – hoarding was becoming problematic again, and there were ongoing health concerns for the individuals involved. In this case, the apparent pivotal issue – or missing link – has been the inability to connect the man to psychiatric services to be assessed and diagnosed, which are necessary criteria to access longer-term or follow-up support for the man. Below, an agency representative involved in the situation described the impact of these systemic/service barriers on the ability to effectively mitigate the risks in this situation.

> *We can get him long-term support, but it's voluntary - he has to be open to it. But he needs a diagnosis first, and we need a psychiatrist... He needed a family doctor to do the referral, and he didn't have a family doctor, so we got him connected with a family doctor. That family doctor did the referral through Here 24/7, and then he went on the wait list. Then he's got to wait a year for the psychiatrist. So everything will fall apart long before those things happen, so we end up sort of just hanging at the critical point, right? There were so many people involved going into the home, but it's at a standstill because we can't get that appropriate mental health diagnosis. – Cambridge Connectivity Member*

Another commonly reported barrier relates to the voluntary nature of the work and some individuals' refusal of support. Certainly this limitation is not unique to the Connectivity model and is challenge of community and health services in general. However, in a model that is designed to respond rapidly and intervene early to prevent continued escalation of significant risk, refusal of services poses a significant challenge to the ability of the Table to fulfill its mandate.

> *Sometimes they refuse service, right, so that's often the challenging issue.... I would say in two cases I can think of particularly, and again it's around some psychosis and delusional thinking, so they don't necessarily have great capacity to make those decisions. Like really, they're just under that threshold of being able to be formed. So those ones that you can't necessarily help or intervene yet... and you almost have to wait for the crash, and that's really the hard part, because you'd like to put the brakes on but sometimes you can't.– Cambridge Connectivity Member*

4.7 Issues Related to Measurement of Longer-term Outcomes for Service Recipients

Discussion of potential longer-term outcomes of Connectivity for service recipients with Table members were characterized by a sense of interest, but tempered by cautions that it may be too soon still to see potential impacts. Members felt that the focus of the Table – and what they have more direct control over – is the mitigation of immediate presenting risks in complex situations. Connecting the work of the Table to longer-term outcomes like improved global health and well-being is not only challenging to evaluate, but may also represent an unreasonable expectation of the intervention. In short, many things have to happen in people's lives to move from acute and complex difficulties – associated social determinants of health like poverty, homelessness, isolation, and past trauma – to long-term changes to health and wellness.

Connectivity members were careful in our consultations to specify that, because the Table serves individuals with multiple, concomitant and complex needs, there is not an expectation that risks will be eradicated through their work. The goal is to mitigate, or reduce to some extent, the highest priority and urgent risks that, if left unaddressed would likely lead to significant harm for the individual or others. Some members characterized the work of Connectivity as "early intervention" and "harm reduction," acknowledging that the individuals they serve will likely require ongoing

support from community and health services over the longer-term in order to truly impact quality of life and wellbeing.

> *These are going to be our clients now or later, right, so it just brings them to our attention if they aren't already on our radar. It brings them to our attention a little bit sooner, which lets us intervene a little bit sooner and get going on the work and sort of manage or bring that crisis down perhaps a level or two. These families, if they've reached the Connectivity Table, they are likely going to be experiencing long-term crisis that sort of ebbs and flows, and I think some of us are more comfortable accepting that that's where they're at than others. We aren't expecting our outcomes to be that these families go from imminent risk and crisis to very well managing and nothing is happening at all. –Connectivity Member*

Many Table members and organizational leads expressed interest in following up with individuals to better understand their trajectory, actual level of engagement with services, and well-being, but noted that it was beyond the scope of the Table itself to manage such follow-up. Such endeavors may also be considered outside of Connectivity's mandate. It is not the role of Connectivity to hold individual agencies accountable, such as through evaluation, to long-term impacts of the services they deliver. Such questions fall to the organizations themselves. This does not preclude the possibility of longer-term impact studies, however. Some members oriented to the possibility of shifting responsibility for longer-term measurement and follow-up to individual organizations, provided there was agreement on scope, purpose, and available capacity. There were, in general, concerns about the capacity of organizations to manage such projects.

> *I mean, I think once we have people in service, we do keep a handle on what's happening in the community with people. But in terms of keeping actual statistical information about the outcome, I think for us the outcome changes. You might be engaged and be good for five months and then have an episode of psychosis, and they we are back out. But it doesn't mean that you've disengaged from service; it just means we're having an episode and we're trying to get it under control and whatever is happening. So it's hard to keep track of that actual statistical information. – Cambridge Connectivity Member*

Part 5: Review of Findings - Outcomes for the Local Service System

In this evaluation, we were also interested in understanding the potential outcomes or benefits to the functioning and integration of the local service system. In particular, we were interested in answering the following questions:

- What new partnerships, promising practices, and new capacities evolve out of this initiative?
- What new ways of collaborating across organizations and/or sectors result from Connectivity?
- In what ways can Connectivity lead to greater integration or coordination of services in Waterloo Region?

We found that the two Tables in Waterloo Region have very quickly demonstrated a significant positive impact on the way local service providers conduct their work. In fact, the members, who are chiefly responsible for the successful implementation of Connectivity, have also been the initiative's main beneficiaries in the short time that it has been operating.

Benefits for Local Service Providers

The Connectivity Tables in both Cambridge and Kitchener have very quickly demonstrated a positive impact on the way local service providers conduct their work.

- Service providers reported that the new relationships developed through the work of the table have **enabled them to work more collaboratively, effectively, and efficiently** – even in their work outside of Connectivity.
- Some services have reported that Connectivity has **enabled them to reach vulnerable client populations** they have had difficulty connecting with or finding through other community resources (e.g., homeless or precariously housed individuals with mental health needs, victims of sexual assault or trauma). Services have connected with these clients through Connectivity referrals.
- Additionally, services have reported that participation in Connectivity has **helped to raise their agency's profile amongst other providers in the community, which is beginning to lead to increased referrals of appropriate client groups**.

5.1 Working Differently

Participation in Connectivity has empowered service providers to work differently – more creatively and flexibly. For example, members have appreciated the license to bend their organizational mandates and to work in community settings rather than their traditional clinical settings in order to better serve the kinds of complex clients who are referred to Connectivity. Working within the Connectivity model has inspired some members to both think and work "outside of the box" in their home organizations in order to better serve challenging clients in their daily work.

One example of "working differently" to better address community needs can be found in the evolving practices of the Waterloo Region Police Officers. Officers reported utilizing existing internal data more frequently – e.g., digging through logs of calls for service – in order to detect trends and indicators of acutely elevated risk that may be appropriate to bring to the Table. Connectivity, in this sense, has become a lever for working differently in order to better serve community members who may be at elevated risk. This practice was described by a member of the Waterloo Regional Police Service in one of our focus groups.

> *I'm always digging through our system to look for patterns. I'll run addresses - oh wait, we've got the same address keeps coming up, what's going on? Oh, it's a bunch of noise complaints, okay. Move on to the next thing - wait, hold on, there's something else going on, they're hearing something that's not really happening, and then I dig further and find out, oh, they don't have a doctor, whatever else might be going on that maybe*

seems appropriate for here. I probably weed out 10 before I bring the one here, so it's just checking into these things and finding out--you know, I'm on the phone, I'm doing door knocks, I'm finding they are connected, they're just struggling today, or whatever the problem may be. - Kitchener Connectivity Member

5.2 Streamlined Processes and Pathways

A number of members noted that although their workloads have increased as a result of participation in Connectivity, that Connectivity has also made their work easier in a number of important ways. Many noted that involvement in the Table has helped to create streamlined pathways and processes, which enable agencies to serve clients more efficiently. For example, working with clients who have been subjects of the Connectivity discussions has sometimes led to a more "streamlined" or "fast tracked" pathway into services that would typically carry a waiting list. The streamlined pathways into service have been facilitated informally by the relationships and networks developed at the Table, but also through formal organizational policies that prioritize access to services for Connectivity clients.

Perhaps the most common outcomes to the service system are those related to members' expanded knowledge of the local service system, new and enhanced partnerships and opportunities for inter-agency collaboration, and a bolstered sense of support from a network of providers.

5.3 New System Knowledge

One of the more immediate benefits of involvement with the Table has been learning about the vast array of existing local community health and social services and programs. Participation in Table meetings has helped to expand participants' knowledge of not only what services are available in the community, but key contacts within the organizations, and a deeper understanding of their mandates, who they serve, where their strengths are, and how they function. This knowledge is gained as a function of witnessing how agencies engage with the Table – what types of situations they refer to the Table, what kinds of resources and supports they offer in mobilizing a response, as well as in personal interaction and conversation that occurs around the meetings.

Well, for me I feel like it really is invaluable... I wasn't even necessarily aware of all the agencies in the community and what their role was in the system, so it's been really valuable in that sense. I have an idea of where to refer my patients now and you know, instead of just having a name, having a face to the name as opposed to just approaching them more formally, not necessarily the people who are represented at the Table but just know that there are resources and you can make those informal connections. – Kitchener Connectivity Member

In addition to new knowledge about the system landscape of existing agencies and programs, members have found the informal networking that occurs around the Table as valuable and educational. In these conversations, quick consultations across agencies and even sectors have been described as informative to service planning outside of Connectivity.

5.4 New or Expanded Relationships and Partnerships and Opportunities for Collaboration

One of the outcomes of the Connectivity initiative that has been most frequently reported by stakeholders is the strong relationships that have formed around the Tables. The bonds of trust that are established through working closely together on a weekly basis - and on such complex situations - have reaped benefits for the members beyond the work of the Table. Members in both communities have reported consulting and collaborating with each other on non-

The Connectivity Table in Cambridge and North Dumfries during a weekly meeting (2015).

Table situations more frequently than they did before they joined Connectivity because they have established a sense of trust, accountability, and an appreciation for each other's strengths and expertise.

I think there is a misconception that we all got together and created Connectivity, It's the inverse. The truth is this Table created the connections between us, because I didn't know who all these people were. It was a sign on a wall on a building somewhere… A name on an email, and so the Table created that, not the other way around. - Cambridge Connectivity Member

An important secondary outcome of the trusting relationships that have developed across agencies as a result of Connectivity is that collaboration between agencies has resulted in addressing risks in the community before they reach the level of acute elevation that would warrant their referral to the Table. Because agencies are now working more collaboratively more frequently as a result of Connectivity, they are able to circumvent escalation of risk and prevent situations from reaching the Connectivity Table.

> *At the Table, Waterloo Regional Police sits there every week so they often see me, and they might not bring a patient right to the Connectivity Table but they'll bring it right to me and say, this person is not acutely elevated risk but we think that they could really benefit from some extra supports from this and that, just trying to preemptively put a plan in place before it does become a crisis, so we've done that on multiple occasions and that's been really effective. Again, that early intervention is to the person's benefit. – Kitchener Connectivity Member*

Multi-agency collaboration offers benefits in terms of additional skills, resources, and expertise that will translate to more effective services and improved outcomes for clients. But it also offers providers a sense of comfort and confidence in that they are working within a team and that they alone are not shouldering the responsibility for the care of clients with such complex needs. This increased sense of professional support is an important outcome for providers, with corresponding benefits to clients.

> *One of the benefits to the clients is that his primary therapist feels more confident and supported, which means that the client is going to feel that, feel more connected and feel more taken care of. We were in a situation where we were running out of options and he was obviously facing risks, which is why he was going to the Table, and the counselor was at a complete loss - what do we do now? So we brought this to the Table, got some ideas through the fourth filter group, brought those back to the therapist who is working with him, and she's feeling very confident….When your therapist feels confident that we can get some results, the clients feel that, like okay, somebody wants to help me, people are trying to take care of me. So he's highly motivated to come back, highly motivated to participate, and he's given some options around his own treatment plan… He's feeling more empowered. – Kitchener Connectivity Member*

5.5 Contribution to Local System Change

5.5.1 Perspectives of Local System Leaders

Leaders of important community services in Waterloo Region have witnessed the early impacts Connectivity is already making on the local service system. Connectivity is changing the way service providers work across health, mental health, justice, and social services. Work within and across service sectors is becoming more collaborative and less siloed. Agencies are exercising more creativity and flexibility in order to be more responsive and more closely attuned to priority needs within the communities they serve.

Building off of these early successes, Connectivity is being viewed by local leaders as a lever for systems change across Waterloo Region. A local system leader consulted through this research positioned Connectivity as an integral model or driver for broader systems change across the region in effort to utilize resources more efficiently and provide human services more effectively.

> *I think from an executive level, it's not about more resources. It's about how do you manage those resources more effectively, and one of those things for me is really around systems change. The Connectivity Table is integral to that because although I believe that we've had a long history of working in partnership with all of our stakeholders, quite often it was in isolation and individual approaches. I think what Connectivity does is it's really about delivering human services more effectively, more efficiently, which in the end gives the client a better service but then it also reduces the long-term workload demand on organizations. But I think it will hopefully in five to 10 years from now, we'll start to see some of the benefits of the work that we're doing. I view this as an investment strategy, but I think it's essential. This isn't a program, this isn't a fad, this is an actual strategy do business differently. – Local System Leader*

Connectivity is also seen as a driving force in the movement towards building a more "complex capable" human service system. Leaders in the health and mental health systems have acknowledged a push from the Waterloo-Wellington LHIN towards and increased expectation that service organizations should be capable of effectively serving individuals with multiple, co-occurring complex needs. As a cross-sectoral approach, Connectivity may push local providers to enhance their capacity to serve more complex populations by providing a model for how to do this. It grows cross-sectoral networks of providers who are gaining experience in working in this way.

Impact on the Local Service System

Through the work of the Tables, Connectivity is beginning to identify important service gaps in Waterloo Region. Both tables have noted a **need to expand adult mental health services** (both community mental health services and psychiatric services).

A key priority moving forward is to identify/develop a systems-level advocacy group to leverage the learnings of Connectivity to inform policy and systems planning.

An intended and important future systems-level outcome of Connectivity is to identify key system barriers and service gaps that may be contributing to the incidence of acutely elevated risk in Waterloo Region. By continuing to document and analyze trends in highly problematic and commonly presenting risks and needs, and noting where efforts to connect individuals to services to prevent and mitigate these risks are falling short, Connectivity can act as a lever for change and system improvement. The Tables have already begun to identify important local service gaps related to adult mental health services and housing supports, as is described below.

> *One of the things that I want this Table to be able to do, is we need to be able to mobilize those decision makers who are deciding where the money needs to go… We have just nothing for people with mental health,*

> *hardly anything for anybody with addictions. Housing is deplorable. We get this every week, every week, every week, and no more money is going into it, right? We need to triple the amount of mental health workers on the ground helping people. – Local System Leader*

> *I think once we know what we're dealing with, maybe that drives the long-term public policy piece, right, and that changes the long-term budgeting piece and all those other perspectives. The success rates and all those other things are important, and return rates and recidivism, and all those things are important, but I want to know what's driving all the different issues. I think the Table should drive some form of public policy or public agenda around change, and that would include allocating dollars. – Local System Leader*

The critical piece that needs to be put in place for Connectivity to influence systems change is the development of a governance or systems-level advocacy group with the skills, clout, and connections to drive meaningful change in relation to policies and resource allocation.

> *I'm not necessarily sure that the people who are the practitioners at that Table will drive that change, but the work that they're doing is driving it. So for me right now, where there's a disconnect, is who's responsible on the policy change front. So we need to find a way to align all the fantastic work that is happening, and then create this other sort of regional approach to the way we do business, and that includes provincially and federally. I think we're on the cusp of starting some good systems change, but we need to leverage that, so that's where I see there's a disconnect in the short term, but at some point there needs to be some form of governance around Connectivity Tables that takes it to the next level. – Local System Leader*

In developing the emerging systems change mandate of Connectivity as a broader, regional approach, there will be a need to carefully align plans with existing groups and initiatives with similar mandates. In fact, when we asked key informants we identified as local system leaders to cite potential risks in continuing to develop Connectivity in Waterloo Region, the only caution referred to the need to carefully manage alignment with existing initiatives and to maintain an inclusive, shared community approach to governance, guarding against potential concerns over 'ownership' and 'protectionism' if one particular group or agency were to be viewed as driving systems change. For Connectivity to continue to grow and succeed in achieving important systems and policy changes, the version of a non-siloed, cross-sectoral team-based approach with a shared commitment towards serving the best interests of the community will need to scale up to a systems-advocacy agenda.

5.5.2 Perspectives of Connectivity's Lead Partners

The partners view Connectivity as an important catalyst to address important barriers and service gaps in the local service system that may be associated with the presentation of acutely elevated risk in Waterloo Region. To date, the focus of the Leadership has been primarily on the daily operations of the Tables. A top priority moving forward will centre on developing a mechanism to leverage the learnings of the Connectivity Tables to inform local community safety plans and policies. This may involve assembling a new committee of local system leaders to perform this function or aligning with/capitalizing an existing local committee with a similar function and systems-change mandate. In Cambridge, the Health Link Steering Committee has been identified as a potential body that could perform this function. An appropriate existing committee in Kitchener has not yet been identified. The partnership will continue to assess the merits of developing a new committee versus utilizing and existing committee, but agree the function of this group is a priority for Connectivity.

The lead partners of Connectivity were cautious in how they view Connectivity with respect to the broader service system. They noted that it will be important to remember that Connectivity is but one of many potential catalysts for

change. It is part of a solution but it is not "the solution" to address local system barriers and gaps for vulnerable community members. It will be important to position Connectivity appropriately amongst the network of other local initiatives in order to prevent mission drift or scope creep. One of the lead partners asserted that Connectivity is "a starting point" within a continuum of care – it is about reaching people where their immediate needs are. When those individuals are connected and require further follow-up and care planning, that work becomes the domain of another initiative further along the continuum, like a Health Link team. There is some concern that losing sight of the specific mandate of Connectivity, and it's important, but specific position amongst the broader system of care, may lead to an inappropriate broadening of scope for the initiative, and thus diminish its potential to positively impact levels of risk in the community as well as broader system improvements.

Partners reported the greatest potential for Connectivity to impact the local service system will likely be through

- Influencing policy directions of the Privacy Commission related to collaborative, multi-service responses to acutely elevated risk
- Helping to identify local priorities and needs to inform planning and resource allocation of local agencies, services, and funders
- Informing and strengthening the practices (operations and measurement) of other Situation Tables across the province through continued engagement and knowledge sharing with the Ontario Working Group
- Influencing formal practices of front-line providers and policies of local agencies and services to foster greater collaboration, coordination and responsible information sharing

One of the lead partners noted that perhaps the most significant impact Connectivity may have on the local service system is on how organizations work together. By shifting the way front-line providers work together now through Connectivity – building trust and understanding of roles and capacity, learning to collaborate and to share information safely and effectively – a ripple effect may be created in terms of how these front-line workers, who will be system leaders in 10 years, manage their organizations – resulting in a community service culture in which collaboration and coordination are normative practice, while apprehension, silos, and politics related to ownership are diminished.

Part 6 – Conclusions, Recommendations, and Future Evaluation Practices

Although only recently developed, the Connectivity Tables in Cambridge and Kitchener have developed consistent and effective processes to address elevated community risk among people with complex challenges. There is a strong, integrated, cross-sectoral collective of organizations working together at both Tables. Multiple, confluent risk factors are being creatively addressed through the contributions of multiple members representing health, justice, and social services. Members report enhancements and improvements in how they engage in collaborative work and new system relationships have developed to support Table responses and local supports and services more generally. Although the longer-term impact of Connectivity on the people served is unclear, there is evidence of short-term gains in creating new service connections and engagement, building trust and rapport, and mitigating elevated risk.

To close this report, we discuss a number of recommendations. Some recommendations are focused on straightforward issues of implementation. Others have been developed in relation to future evaluation options for Connectivity and issues of evaluation design. The newly released provincial framework on evaluation of Situation Tables (Nilson, 2015) informs these discussions. Finally, we provide recommendations regarding strategic data use, system governance, and system change.

6.1 Capacity and Participation at the Table

Our findings demonstrated that certain organizations (such as Waterloo Regional Police Service and CMHA-WWD) bring forward and lead the majority of situations. Other organizations bring forward and lead relatively few situations. There are a number of acceptable reasons why this is so, such as police being the first point of contact and the predominance of mental health issues as a risk factor. Within this context, the Tables should review with each member the circumstances that may be preventing greater participation. There are several recommendations:

R1. Affirm that privacy protocols are acceptable to attending organizations and strategize on how to address any outstanding privacy concerns.

R2. Investigate the potential to allow each member onsite, remote access to their home organization's database to improve access to client information. This will facilitate participate among members who need this information to contribute to Table discussions and actions.

R3. Revisit the decision-making latitude of each member; when a member's decision-making authority on behalf of their organization is constrained, the Table leadership should consult with the organization to seek solutions.

R4. Consider petitioning organizations for additional members if the capacity of existing members to respond to Table decisions is stretched.

This last recommendation is potentially delicate. Organizations may already feel stretched in contributing staff to the Table as it is, and adding members may necessarily detract for existing caseloads. This is where the system advocacy role of the Table is particularly important – if resource needs can be strategically demonstrated by the Table as a

collective that "speaks with one voice", there may be opportunities for new resource allocations from funders. We will review this point shortly.

6.2 Closing Situations

There were minor disagreements on when to close a situation, tied to ambiguity as to what constituted a "connection to services". Members agreed that a mere referral to services was inadequate to close a situation. A challenge is determining if a *meaningful* linkage to service has been made and what evidence of service engagement is necessary to close.

R5. It is recommended that a situation can be closed when there are "warm hand-offs" to services and confirmation of service engagement (e.g., a face to face meeting with a provider).

Individuals refusing services are flagged in the database and closed. The presumption is that elevated risk is likely to persist. It might be beneficial to revisit this subset of individuals periodically to assess new information and possible avenues for connecting. File review of this type must be made consistent with privacy protocols and will fall to originating member to initiate.

R6. Individuals refusing service should be flagged for periodic review and assessment if any new actions can be taken.

Currently the database tracks the circumstances under which a situation is closed ("conclusion variables"). The tracking options do not go beyond "Connected to Services" (as in R1, above). While there may be capacity challenges, it could prove useful to capture more detail about service actions. We do not view this as long-term follow up activity, but a fairly immediate accounting of the more specific responses that providers make, perhaps a month after the situation is closed. The database could provide date-based alerts for the lead agency to provide some detail on actions taken (e.g., entered counselling, received medication, accessed psychiatry, acquired a family doctor, etc.). If the answer is "unknown", this is itself instructive. This information can inform system responses, capacities, and gaps and represents a more robust proxy of mitigated risk beyond "connected to services".

R7. Track specific service actions after situation closure after a specified time period.

6.3 Systems Analysis and Strategic Data Use

This evaluation has confirmed the consistency and effectiveness of the Connectivity model in practice, which was a formative goal of the evaluation. It is not practical (nor recommended) to continually implement intensive evaluations of the Table. This evaluation has provided confidence that the model is robust and working as intended. While we have developed recommendations for further outcome evaluation that may be considered (to be discussed), it is otherwise reasonable to move forward with basic monitoring of the Tables' activities.

Because Connectivity embeds case level data into its day to day operations, there is an excellent opportunity to compile summary data that speaks to important systems issues. For example, our analysis of the database demonstrated the ubiquity of mental health issues, criminal involvement, and housing as risk factors in both communities. The database also has the potential to demonstrate how the system can respond to such issues, and where there are gaps. This constellation of needs, gaps, and strategies can be routinely mined and summarized by

the Tables for systems analysis. The collection and availability of this type of data in health and social systems is rare and should be taken advantage of. The remaining questions are "by whom?" and "for whom?"

The latter question – "for whom" – demonstrates a need for a systems level committee composed of high level managers/directors of member organizations and other key organizations. Such a committee would provide governance to the Tables and would receive summarized information for the purposes of analysis and consideration of systems change. Analysis could also inform targeted funding requests enhancements, expansion, etc. In Cambridge, a natural body for this purpose in Cambridge may be the Health Link Steering Committee, as it is comprised of system-level leaders. The growing connection and integration between the Cambridge Table and the Health Link service reinforces this idea. An outstanding issue is the extent to which this choice precludes a cross-Table governance committee. In other words, it may make strategic sense for both Tables to be united by an overarching governance committee that speaks to the systems issues of Waterloo Region, rather than having two separate committees devoted to Cambridge and Kitchener, respectively. In any case, the functions of governing committee remain important.

The question "by whom?" refers to the need to build the analytic capacity of the Table to continually work with the database to answer questions about needs, trends, gaps, and so on. This function is crucial and needs to be properly resourced so the collected data can serve the dual purpose of guiding Table decisions for individuals while also reflecting on systems issues.

R8. Develop the capacity at both Tables to strategically compile, analyze, and summarize data from the database for systems use.

R9. Create a governance committee (or committees) to provide oversight to the Tables, engage in systems level analysis, and strategically pursue system change and policy initiatives.

6.4 Aligning with Provincial Evaluation Framework

The newly released provincial framework to support evaluation of Situation Tables provides a detailed set of options for future evaluation (Nilson, 2015). This document is not a standardized or prescriptive framework that specifically directs local Tables on a preferred evaluation design. Rather, it provides a very useful menu of options regarding evaluation questions (organized by developmental, formative, and summative questions), potential indicators, and the range of data collection opportunities that Tables may have available. Our own evaluation mirrors many of these evaluation and design measurement considerations and options. For example, the menu of suggested quantitative and qualitative indicators match much of the data we collected in the areas of collaboration, risk, and service mobilization (see Nilson, 2015, pp. 17-18). The provincial evaluation framework will prove to be a key resource for Connectivity for the purposes of designing evaluations.

Our recommendations for future evaluation focus primarily on assessing the outcomes of users. The present evaluation was formative in design and need not be repeated, aside from basic monitoring of implementation, or unless the model itself appears to have significantly drifted from its intended implementation over time. User outcomes, however, represent a gap in Situation Table evaluations. As mentioned, past evaluations have been limited to "service connections" as proxy for risk mitigation – the central outcome of the model. As Nilson (2015) points out, "Having a client perspective will deepen and enrich our understanding of the impact that collaborative risk-driven community safety and well-being may have on clients, their risk factors, satisfaction, and perspectives on multi-sector

teams offering supports through an intervention process" (p. 20). In addition to direct client experiences, there are other data sources that can contribute to an assessment of risk reduction. The framework makes a key distinction between different types of data:

- **Primary data** – direct reports by service users; and direct assessments of services users collected by providers.
- **Secondary data** – targeted or general population data from external community sources (e.g., a database of all emergency department users).
- **Hybrid data** – data collected as part of the regular processes of a program or intervention, which can also be harnessed for evaluative purposes.

Primary data, with good tools, tends to be the most reliable and interpretively clear evaluation data. It should also be noted that a common form of primary data is "reports of others" about the individuals in question. Self-reports of providers reflecting on the outcomes of service users is common in health and social service fields. The interpretation of such information is limited to the extent that it is anecdotal in nature. However, when many reports are collected over time and in a consistent matter, the evaluation has moves beyond anecdotes to a systematic qualitative inquiry that can be highly informative.

Secondary data is useful to understand community needs, but less useful to determine the impact of an intervention, unless the intervention is universally applied to the population to which the data speaks. If it does not, case-level data linking is required, which is intensive work. For example, Waterloo Regional Police Services pulled call data on every person using Connectivity in Cambridge, one person at a time, to build the dataset on call frequencies. The big benefit of secondary data sources is that they have already been collected – the drawback is that it can be logistically difficult to parse the data and match to situations in order to meet particular evaluative needs. Secondary data also might not represent the "best" indicators of interest as the evaluator is obviously restricted to what has been collected. There are also often privacy concerns and ethical considerations when attempting to access data from other sources.

Hybrid data is often quite useful because there is often alignment of the information programs need to do their work with the information sought in a corresponding evaluation. A recurring problem is that program data is often not in the best form conducive to evaluation design and analysis. For example, clinical case notes may be comprehensive and full of depth, but they are very hard to extract into a group summary form. At Connectivity, risk factors are identified by the Table, a process which dovetails with a range of formative evaluation questions, such as who is using Connectivity or how well-matched Table members are to needs. However, the Table's risk identification is not risk assessment in any formal and reliable sense – these are global and dichotomous (i.e., "yes" or "no") determinations based on the narrative observations of Table members. Such data are insufficient to measure risk reduction and additional indicators are needed.

The provincial evaluation framework provides some potential outcome indicators that revolve around risk mitigation, and appear below[1].

Table 3 – Potential Indicators to Assess Risk Reduction (adapted from Nilson, 2015)

- Access to services, by service types
- Police calls, # and type (e.g., mental health calls, public disturbance, domestic violence, public intoxication)
- Criminal charges, # and types
- Probation, # of breaches
- Probation, length of compliance
- Emergency room visits, # and reasons
- Hospital admissions, # and reasons
- # of uses of mobile crisis services
- # of detox admissions
- Addictions treatment completions
- Frequency of substance use
- New or renewed access to income assistance
- Child protection, # of diversions and apprehensions
- # of school truancy incidents
- Grade completion
- School graduation
- Employment status
- Housing status
- Physical health status (e.g., incidents of injury, sickness)
- # of incidents of victimization
- Self-reports of individuals regarding risk reduction outcomes (e.g., reflection on the above indicators and other issues)
- Client reports of satisfaction with services

The provincial evaluation framework rightly observes that evaluating risk reduction via direct risk assessment is difficult. One suggestion is to develop a "multi-sector risk assessment tool that is administered to situation Table subjects before and after a mobilization of services and supports." Risk assessment tools are well established and there are many that could be used; yet each has significant drawbacks. As mentioned in the introduction, many tools have been designed to "manage risk" – i.e., protect against the likelihood of unsafe behaviours and their consequences. Most tools conceive of risk in relation to violence committed by the individual, rather than viewing risk as heightening the threat of victimization. Many risk assessment tools rely on static historical factors which by definition cannot be changed, and so are unsuitable for assessing risk reduction. Some tools, such as the HRC-20, includes some clinical judgement of dynamic factors (which are open to change), but again this tool is focused on assessing for probability of aggression (Monahan, 2008).

Assuming an appropriate risk assessment tool could be adopted, implementation would be challenging. Obtaining the "pre-test" data would be intrusive to rapport and trust-building and would be logistically difficult given the context of first contact. Training on all the frontline members who bring situations forward on how to use the tool would also require significant training and capacity.

We would caution against developing a new standardized global risk assessment tool for the purposes of Situation Table evaluations, given the challenges already described. We do believe, however, that developing a menu of risk-associated indicators that could be customized for each individual situation could be fruitful. Core indicators, such as those listed in Table 3, could be assembled in relation to identified risk areas that have already been established by the Situation Tables – these are essentially a set of proxies for risk reduction that are more refined than simple "service connection". Indicators can be selected based on the *primary* risk factors that are operating around an individual, as judged by the originating agency and the Table members. Indicator selection should also be driven by

[1] Several non-empirically worded indicators (e.g., "reduced victimization") were omitted; others were modified or replaced to support objective measurement (e.g., "addictions recovery" can be better indicated by "treatment completion" and "frequency of substance use").

the nature of the service plans that are recommended. For example, if an individual has presented with multiple crisis events and hospital admissions and the Table response is to connect them to mental health services for supports and medication, then the indicators of interest should likely include "medication compliance", "use of mobile crisis services", and "emergency department visits". This approach is more refined than generic risk measures and does not require collecting indicators that the intervention is not expected to change.

6.4.1 Collecting Indicator Data for Connectivity Outcomes

The biggest challenge in moving forward with evaluation of outcomes is identifying the actual data to be collected, who is responsible for collecting it, and resourcing/managing the overall design. Ideally a process should be instituted that is streamlined and consistent – multiple data collection strategies that are different for different indicators should be avoided. To guide the identification of relevant indicators (and data collection strategies), it will be important to first build off of the provincial logic model and theory of change (Nilson, 2015) to develop a tailored logic model specific to Connectivity WR that provides a sharper reflection of the unique local context and implementation of the model, locally relevant outputs and priority outcomes, and impact pathways. This will help to clarify measurement priorities and streamline data collection to conserve evaluation resources.

Two key points are worth remembering with regard to collecting indicator data:

1. All indicators could be sourced as primary, secondary, or hybrid data. For example, an evaluation could ask individuals directly how many times they were hospitalized in the last 3 months (**this is primary data**); hospitalization data could be acquired from hospital databases and Connectivity users admission rates could be pulled out for analysis (**this is secondary data**). Finally, the Connectivity Table could decide that acquiring admission rates of individuals will be a useful practice in the determination of risk (this is **hybrid data**, because it is collected for programmatic reasons, but could be used to answer evaluation questions). Each data type has its strengths and weaknesses depending on the indicator.

2. For almost all indicators, observing change requires collecting data before and after an intervention point. While the time period in question will depend on the theory of the intervention (e.g., the impact of counselling can take many months whereas the impact of medication might be fairly immediate), comparing data at two time points greatly aids interpretation. Exceptions can include retrospective self-reports, such as narratives of users regarding the impact of supports on their lives.

We recommend the following:

R10. Building off of the provincial logic model and evaluation framework, develop a tailored logic model for Connectivity specific to the local context, implementation, priority outcomes and impact pathways relevant to Waterloo Region.

R11. Drawing on the provincial evaluation framework, this report, and other sources, begin to build sets of indicators corresponding to the Situation Table risk categories and to common Table responses.

R12. Begin to build systems that will support the acquisition and use of secondary data that captures indicators of risk reduction for Connectivity users.

Police call data and other justice focused indicators are already captured by existing systems. The same is true for indicators associated with hospital services and perhaps schools. Acquisition of this data and subsequent identification of particular individuals will tend to contravene privacy policies of the organizations hosting the database. This could be addressed by de-identifying the data but will also tend to limit how the data can be subsequently used and interpreted.

There are also indicators that are not collected by any secondary data sources. For example, employment status, housing status, and use of income supports would need to be collected directly from individuals, typically by providers. This seems straightforward at first glance, but in the context of Connectivity it can get challenging. At the front end, it is a fairly easy process, because contact has been made with the individual and basic information can be gathered. At follow up, however, things can get tricky as the individual in question may no longer be in contact with the services of the lead agency. There are ethical concerns in following up with an individual for these purposes. This problem will tend to bias data towards people that have remained connected. These limitations aside, indicators gathered from individuals will be necessary for certain outcome evaluations.

R13. Identify data, organized according to risk categories, that are useful to the deliberations and actions of the Table; and that can also double as outcome indicators.

In other words, fairly simple data can be collected that lies behind and informs the selection of risk factors. In fact, the risk database already does a lot of this work. For example, the housing risk factor could be supported by a little more detail about the context and risk of a person's housing status. This recommendation is provided with the acknowledgement that the database is already large and complex and the time resources required to systematically populate it with more data points is potentially prohibitive. It may be helpful for Tables to identify information that is continually asked for, in relation to specific factors, when formulating a response. Such information may be better collected proactively and, if appropriate, used as indicators of risk reduction.

It is also worthwhile to consider outcome evaluations that gather primary data from service users, alongside complementary information from frontline workers. Information from individuals should be in the form of interviews that can yield personal narratives of their experiences with services and how things have (or have not) changed in their lives as a result. Ideally, interviews should be conducted by researchers rather than direct service providers, to mitigate bias that may result from the provider-client relationship. That said, for some individuals the trust and rapport that has been established by providers is a necessary ingredient to gaining participation; in these cases providers should conduct the interviews.

Another question is who should participate? An initial inclination is to stratify across service groups and then randomly select individuals to get a balanced cross-section of service users. This may be a preferred approach if the general question is "how are Connectivity users doing, and has the Table reduced their risk?" Alternatively, there may be targeted questions that suggest more purposeful sampling. Ideally these questions should be driven by other data. For example (and hypothetically), perhaps secondary data demonstrates an overall decline in emergency department visits for people with mental health challenges, but no observable decline for people with addictions. A purposeful sampling of these two groups may help to understand the reasons how and why Connectivity has been successful and when it has not. In short, sampling should be strategically tied to evaluation questions to be answered.

It should be noted, however, that a certain level of positive bias in a voluntary interview sample is unavoidable – among people living in complex and challenging circumstances, those consenting to participate in an evaluation will tend to be doing better than those who decline.

R14. Pilot smaller outcome studies that are designed to answer specific questions of the Table and that gather narrative feedback from Connectivity users.

We should acknowledge again that some Table members felt that outcome evaluations following Connectivity participation lie outside the mandate of the initiative. The Table does not direct services of the member organizations and those services are accountable to their own organization and not the collective at the Table. In short, there appears to be some organizational risk in consenting to evaluation of outcomes of people with highly complex needs, when those outcomes may be assessed in relation to the performance of particular services. This requires further discussion of the represented organizations; ultimately a governance committee will need to drive consensus on the focus and purpose of outcome evaluations. With these thoughts in mind, we believe collecting outcomes, especially from the voices of the people served, will be beneficial to continued improvement of Connectivity. We do not suggest large scale, complex qualitative research projects. Instead we believe smaller, focused outcome studies (in which interview narratives are gathered) combined with targeted indicators – ideally secondary data that can be readily accessed – can answer many of the formative and summative questions of the Tables.

6.5 Connectivity in the Larger Sphere of System Change

In section 6.3, we emphasized that a higher level governance committee of Connectivity, which uses data emerging from the Tables(s) for strategic decision-making purposes, was a necessary component to promote system level analysis and actions. Given the broad representation of organizations on the Table, this governance committee could have significant influence over policy associated with health, mental health and addictions, justice, and other sectors. A number of key informants felt Connectivity represented an important driver of systems change because it models collaboration and system integration, it can assess community needs over time, and it represents a strong cross-sectoral network.

This positions the Connectivity leadership to look beyond the immediate frontline mandate of its work – the mitigation of elevated risk – to the "outer circles" of prevention and social development found in Russell and Taylor's (2014) Framework for Planning Community Safety and Well-Being (see Figure 2, p. 11). This requires information sharing, system advocacy, and partnerships with other planning groups and committees in the Region that are responsible for the many sectors that Connectivity works in. Connectivity needs to ensure it is not cast as merely a "near crisis" response that is only concerned with immediate risk – that in fact the model is part of an integrated, holistic system of health and well-being that requires prevention and health-promotion oriented actions. In Cambridge, Langs' leadership role in Connectivity and the local Health Link has been instrumental in beginning to build a bridge between the two initiatives in effort to better coordinate risk planning, care response, and system planning.

A key barrier to meeting the complex needs of some of our community members is inherent in the way organizations have been structured to provide services – in silos, with a focus on specific issues or diagnoses. Initiatives, like Connectivity, which are aimed at improving collaboration and coordination of services across individual health and social service organizations, enable the system to respond in ways that are capable of addressing the multiple complex needs of our most vulnerable community members. This impact could be further bolstered if individual

organizations continued to grow their capacity, internally, to become complex or "co-occurrence capable." We noted earlier in this report that this may involve development of collaborative service agreements with other organizations that can provide complementary services, but also includes building new staff competencies, promoting a welcoming and recovery-oriented culture, and expanding specializations. Minkoff and Cline (2006) have outlined available tools, definitions, and common steps taken by programs and agencies towards becoming co-occurrence or "dual diagnosis capable." While these steps are primarily targeted to psychiatric and addictions service providers, the concept of developing organizational capabilities to manage co-occurring complex needs of clients is relevant across the social and health service sectors. Minkoff and Cline situate co-occurrence capable organizations as a necessary component of their Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders. The model is designed "to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies" (p. 5). Given the prevalence of mental health and addictions issues in situations presented at the Connectivity Tables, the CCISC model may be a promising fit for health and social service organizations in Waterloo Region as a means of enhancing the system's capacity to address co-occurring needs associated with situations of acutely elevated risk. Minkoff and Cline caution that for the model to work, attention to co-occurring disorders must be a priority in all system activities and in the utilization of all resources across the system. Complexity and co-occurrence of needs must be considered an expectation rather than an exception. As such, the model demands that all programs within the service system must develop as "dual diagnosis programs" by meeting minimal standards of "dual diagnosis capability" (p. 12). Minkoff and Cline outline 12 steps for implementing the CCISC model. A summary of these steps is provided below in Table 4 (for more details see Minkoff & Cline, 2004). Minkoff and Cline also offer consultation services to systems interested in implementing the CCISC model and organizations aiming to develop dual diagnosis or co-occurrence capabilities.

Table 4 – 12 Steps for Implementing the CCISC Model (adapted from Minkoff & Cline, 2004)

1. Integrated system planning process: Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system
2. Formal consensus on CCISC model: The system must develop a clear mechanism for articulating the CCISC model
3. Formal consensus on funding the CCISC model: CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream
4. Identification of priority populations, and locus of responsibility for each within the service system for welcoming access, assessment, stabilization, and integrated continuing care.
5. Development and implementation of program standards: A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability. Note: Program competency assessment tools (e.g., COMPASS™ Zialogic, Albuquerque, NM) can be helpful in both development and implementation of DDC standards.
6. Structures for intersystem and inter-program care coordination: CCISC implementation involves creating routine structures and mechanisms for programs and providers to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries.

7. Development and implementation of practice guidelines: CCISC implementation requires system wide transformation of clinical practice in accordance with the guiding principles of the model.
8. Facilitation of identification, welcoming, and accessibility
9. Implementation of continuous integrated treatment
10. Development of basic dual diagnosis capable competencies for all clinicians: Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Competency assessment tools (e.g., CODECAT™ Zialogic, Albuquerque, NM) can be utilized to facilitate this process.
11. Implementation of a system wide training plan: In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance.
12. Development of a plan for a comprehensive program array: The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps.

Connectivity is well positioned to act as an advocate and lever for moving the service system toward becoming a Comprehensive, Continuous, Integrated System of Care and for partner organizations to develop as co-occurrence capable organizations. We recommend:

R15. Member and partner organizations involved with Connectivity begin to implement steps to become co-occurrence capable organizations and work towards building a Comprehensive, Continuous, Integrated System of Care in Waterloo Region.

Finally, Connectivity needs to continue its contribution to provincial level discussions, planning, and initiatives of the Ontario Working Group (OWG). This umbrella network of Ontario-wide Situation Tables will continue to help build the capacity, knowledge base, and evidence based practices of local Tables. Reciprocally, the practices and experiences of Connectivity, including those documented within this evaluation, can contribute to and reinforce the work of the OWG.

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Appendix A - Connectivity Waterloo Region Database Structure

Situation ID#:	Open response
Initial Review Date:	Open response
Situation Rejected Due To:	• Originator has not exhausted all options to address issue • Already connected to services and risk was mitigated • Already connected to personal supports and risk was mitigated • Already connected to appropriate services with potential to mitigate risk • Already connected to appropriate personal supports with potential to mitigate Risk • Situation not deemed to be one of acutely elevated risk • Single agency can address risk further
Lead Agency:	**Cambridge and North Dumfries:** • Cambridge Shelter Corporation • Waterloo Wellington Community Care Access Centre • Cambridge Memorial Hospital -Crisis Intervention • Cambridge Memorial Hospital –Emergency Department • Cambridge Memorial Hospital -Mental Health • Cambridge Memorial Hospital -Geriatric Emergency Management Network • Canadian Mental Health Association – Waterloo-Wellington-Dufferin • Canadian Mental Health Association – Waterloo-Wellington-Dufferin and Stonehenge: Specialized Outreach Services Program • Developmental Services Ontario • District Housing Corporation • District Health • Family and Children's Services of the Waterloo Region • Langs--Medical • Langs--Outreach • Langs--Social Work • Lutherwood • Ontario Disability Support Program • Ontario Works • Ray of Hope • oneROOF

	• Sexual Assault Support Centre Waterloo Region • St. Mary's Counselling • Waterloo Region Catholic District School Board • Waterloo Region District School Board • Waterloo Region Housing • Waterloo Region Police Service • Youth Justice Services **Kitchener:** • Canadian Mental Health Association – Waterloo-Wellington-Dufferin • Carizon Family and Community Services : Promise of Partnership • Community Care Access Centre / Elder Abuse Response Team • Family and Children Services of Waterloo Region • Family Violence Project of Waterloo Region • Front Door Program (Lutherwood) • Grand River Hospital • Interfaith Community Counselling Centre • Kitchener-Waterloo, Wilmot, Woolwich and Wellesley (KW4) Community Ward / Health Link • Lutherwood • Ministry of Children and Youth Services • Ministry of Community Safety and Correctional Services • oneROOF • Ray of Hope • Region of Waterloo Social Services, Employment, and Income Support • Sexual Assault Support Centre • St. John's Kitchen / The Working Centre • Victim Services of Waterloo Region • Waterloo Catholic District School Board • Waterloo Region District School Board • Waterloo Regional Police Services • Wilmot Family Resource Centre
Next Discussion Date:	Open response
Date Concluded:	Open response
Status:	• Open • Concluded • Rejected

Conclusion:	• Connected to services/cooperative • Connected to Services in other jurisdiction • Deceased • Informed about services • Refused services/uncooperative • Relocated • Unable to locate
Old ID #: (if situation returning to Situation Table)	Open response
Originating Agency:	(See list of Lead Agencies)
Type:	• Dwelling • Environmental • Family • Neighbourhood • Person
Gender:	• Female • Male • NA • Unknown
Age Group:	• Infant 0-5 • Child 6-11 • Youth 12-15 • Youth 16-17 • Adult 18-24 • Adult 25-29 • Adult 30-39 • Adult 40-59 • Older Adult 60+ • Unknown • NA
Risk Factors: (Space for up to 8 Risk Factors)	• Alcohol - alcohol abuse in home • Alcohol - alcohol use by person • Alcohol - harm caused by alcohol abuse in home • Alcohol - history of alcohol abuse in home • Alcohol - alcohol use by person • Antisocial/Negative Behaviour - antisocial/negative behaviour within home

	• Antisocial/Negative Behaviour - person exhibiting antisocial/negative behaviour • Basic Needs - person being neglected by others • Basic Needs - person neglecting others' basic needs • Basic Needs - person unable to meet own basic needs • Basic Needs - person unwilling to have basic needs met • Crime Victimization - arson • Crime Victimization - assault • Crime Victimization - break and enter • Crime Victimization - damage to property • Crime Victimization - other • Crime Victimization - robbery • Crime Victimization - sexual assault • Crime Victimization - theft • Crime Victimization - threat • Crime Victimization - theft • Criminal Involvement - animal cruelty • Criminal Involvement - arson • Criminal Involvement - assault • Criminal Involvement - break and enter • Criminal Involvement - damage to property • Criminal Involvement - homicide • Criminal Involvement - other • Criminal Involvement - robbery • Criminal Involvement - sexual assault • Criminal Involvement - theft • Criminal Involvement - threat • Criminal Involvement-Drug Trafficking • Criminal Involvement-Possession of Weapons • Criminal Involvement - human trafficking • Criminal Involvement - trespass • Drugs - drug abuse by person • Drugs - drug abuse in home • Drugs - drug use by person • Drugs - harm caused by drug abuse in home • Drugs - history of drug abuse in home • Elderly Abuse - person perpetrator of elderly abuse • Elderly Abuse - person victim of elderly abuse • Emotional Violence - emotional violence in the home • Emotional Violence - person affected by emotional violence

	• Emotional Violence - person perpetrator of emotional violence • Emotional Violence - person victim of emotional violence • Gambling - Chronic gambling by person • Gambling - Chronic gambling causes harm to self • Gambling - Chronic gambling causes harm to others • Gambling - Person affected by the gambling of others • Gangs - gang association • Gangs - gang member • Gangs - threatened by gang • Gangs- victimized by gang • Housing - person doesn't have access to appropriate housing • Housing- person transient, but has access to appropriate housing • Mental Health - diagnosed mental health problem • Mental Health - grief • Mental Health - mental health problem in home • Mental Health - not following prescribed treatment • Mental Health - self-reported mental health problem • Mental Health - suspected mental health problem • Mental Health - witnessed traumatic event • Missing-Runaway - person has history of being reported to police as missing • Missing-Runaway - person reported to police as missing • Missing-Runaway - with parents knowledge • Missing-Runaway - without parents knowledge • Missing School- Chronic absenteeism • Missing School- Truancy • Negative Peers - person associating with negative peers • Negative Peers - person serving as a negative peer to others • Parenting - parent-child conflict • Parenting - person not providing proper parenting • Parenting - person not receiving proper parenting • Physical health - chronic disease • Physical health - general health issue • Physical health - physical disability • Physical health - pregnant • Physical health - terminal illness • Physical Health- Not following prescribed treatment • Physical Health- Nutritional deficit • Physical Violence - person affected by physical violence • Physical Violence - person perpetrator of physical violence

	• Physical Violence - person victim of physical violence • Physical Violence - physical violence in the home • Poverty - person living in less than adequate financial situation • Self-Harm - person has engaged in self-harm • Self-Harm - person threatens self-harm • Sexual Violence - person affected by sexual violence • Sexual Violence - person perpetrator of sexual violence • Sexual Violence - person victim of sexual violence • Sexual Violence - sexual violence in the home • Social Environment - frequents negative locations • Social Environment - negative neighbourhood • Suicide - affected by suicide • Suicide - person current suicide risk • Suicide - person previous suicide risk • Supervision - person not properly supervised • Supervision - person not providing proper supervision • Threat to Public Health and Safety - person's behaviour is a threat to public health and safety • Unemployment - caregivers chronically unemployed • Unemployment - caregivers temporarily unemployed • Unemployment - person chronically unemployed • Unemployment - person temporarily unemployed
Assisting Agency: (Space for up to 6 Agencies)	
Other Non-Member Assisting Agencies:	Open response
# Helped:	Open response

Appendix B - Semi-Structured Focus Group Guide: Connectivity Members

1. **What is the process by which situations are brought to the Connectivity Tables? Do you have anything to share about how this functions or recommendations to improve the process?**
   - Does the type of information and risk factors tracked in the database provide what you need for the Table to respond effectively? What are the gaps, if any?

2. **What are the key factors that determine whether a situation is accepted or rejected? How do you determine elevated vs. imminent risk? How do these types of risk differ and what are the implications for how the Table responds?**

3. **What is the process through which Connectivity develops and mobilizes required supports for situations brought to the Table?**
   - What are the types of recommended actions? Are the right actors at the Table? Does the Table have the resources necessary to act in a timely manner?
   - How are these actions sustained over time? What happens after a situation is closed at the Table? What would you like to see happen?
   - How do you know when to close?

4. **How have processes/practices of the Table evolved over time and what are the impacts of those changes? What is the Table learning about providing supports to people exhibiting imminent risk?**

5. **How do members of the Connectivity Table and their home organizations experience the program? How does it help your work? What new challenges does it create?**

6. **Sharing information between organizations about individuals is essential for Connectivity to be effective. Do you have any concerns or cautions about privacy and how information is used? Please explain.**

7. **What outcomes or changes does Connectivity bring to bear on local services and systems? What new partnerships, promising practices, and new capacities have evolved out of Connectivity?**

8. **Have you seen any evidence that Connectivity is leading to greater engagement of individuals served with services over time? For example,**
   - Re-engagement in community services that serve to promote wellbeing
   - More appropriate use of community and emergency/crisis services
   - Decreased number of calls for emergency/crisis services?

   What do you think needs to happen in order to see these types of impacts?

Appendix C - Semi-Structured Interview Guide: Connectivity Members

1. **How do you, as members of the Table, and your organization, experience the program? How does it help your work? What new challenges does it create? In what ways does it impact your capacity? Specific examples?**

2. **If you or your organization is involved in Connectivity in both Cambridge and Kitchener, does the level and nature of engagement differ between the two communities? If so, what are some of the factors and impacts associated with this?**

3. **Sharing information between organizations about individuals is essential for Connectivity to be effective. Do you (or your organization) have any concerns or cautions about privacy and how information is shared/used through Connectivity? Please explain.**

4. **Do you have any further feedback on the Table's processes or suggestions for improvement?**
   a) Re: How you (or others) determine if a situation is appropriate for the Table; how you prepare/what information is presented in the referral to the Table?
   b) How is risk assessed? Risk factors and risk levels are not the same thing. What defines a case – for you/for the Table in practice – as being one of elevated risk?
   c) Re: How the Table develops a response for a situation; What are some of the challenges you confront? Are the right people (and sufficient resources) at the Table to develop an appropriate and timely response? Are there promising practices in how to do this?

5. **What changes are observed in people's lives? How is risk mitigated? Do you have some specific examples of situations you were involved in responding to that you can describe? Is there any data that you have on a case basis that could indicate that people demonstrate these changes people are experiencing? (e.g.,** Increased knowledge/awareness of local services and support? Increased trust in local providers? Improved stability and wellness?)

6. **What do you believe to be the Table's role in relation to longer-term supports and health promotion?**

7. **What types of information about individual client outcomes do you think is important to collect? Thinking about the kind of service and outcome data your organization already collects, do you think there would be a way to track a few key pieces of client level outcome data for cases involved with Connectivity?**

8. **What new partnerships, promising practices, and new capacities have evolved out of Connectivity? (e.g., What new ways of collaborating across organizations and/or sectors result from Connectivity?) Can you provide some specific examples of these new relationships, new resources/capacities, or new ways of working?**

9. **To what extent are the connections to/support from the multi-service team sustained for the primary/lead provider after they take on the lead care for the case?**

10. **What is the Table learning about providing supports to people exhibiting imminent risk? How have processes/practices of the Tables evolved over time?**

11. **There has been some debate as to whether Connectivity is cost efficient? What is your take on this? What would you look at to answer this question?**

Appendix D - Semi-Structured Interview Guide: System Leaders

1. **How does Connectivity align with the priorities of your organization? How do you feel Connectivity is contributing (or can contribute) to these priorities?**
   How does it help your work? What new challenges does it create? In what ways does it impact your capacity? Specific examples?

2. **What do you believe to be the Table's role in relation to longer-term supports and health promotion?** i.e., some see the Situation Tables as squarely focused on mitigating elevated risk. What could/should the Table's role be in relation to follow-up, wrap-around supports, etc.? For a Situation Table to track the details of situations across all the implicated agencies is enormous. But to not check at all?

3. **How do you see Connectivity informing practices and policies across the community service sectors in Waterloo (justice, social and health services)?** *How do you see Connectivity leading to greater integration or coordination of services in Waterloo Region? Can you provide some specific examples of new relationships, new resources/capacities, or new ways of working?*

4. **Considering your organization as a key audience of the Connectivity evaluation, what information would you be looking for and how would you use it?**
   Do you have data about community risks and/or assets that could inform the work/planning activities of the Connectivity Tables?

5. **From your perspective are there any areas of concern or risk in continuing to develop the Connectivity model in Waterloo Region?**
   Risks may extend beyond privacy concerns, certainly. However, sharing information between organizations about individuals is essential for Connectivity to be effective. However, concerns or cautions about privacy and how information is used could be a barrier for some. What is your perspective on this?

6. **There has been some debate as to whether Connectivity is cost efficient? What is your take on this? What would you look at to answer this question?**