Vancouver Mental Health & Addictions System

Collective Impact Project

Phase 1 Work Summary

JANUARY 2017

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SPONSORS

Vancouver Coastal Health

VCH is a world-class innovator in medical care, research and teaching, delivering services to more than one million BC residents.

CITY OF VANCOUVER

The City of Vancouver is an active partner in ensuring healthy people, healthy communities, and healthy environments.

vancouver foundation

The Vancouver Foundation is Canada's largest community foundation, working throughout BC to build healthy, vibrant, livable communities.

PACIFIC BLUE CROSS

The PBC Community Connection Health Foundation provides support for organizations that help improve outcomes in the area of chronic disease and mental illness.

COORDINATORS

THE BLOOM GROUP
Community. Services. Together.

The Bloom Group is a community healthcare, housing, and social care agency based in Vancouver's Downtown Eastside.

CARMHA
Centre for Applied Research in Mental Health & Addiction

CARMHA at SFU is internationally recognized for innovative and interdisciplinary scientific research related to mental health and substance use.

This report is dedicated to the memory of Dr. Elliot Goldner

Purpose

This summary is presented by the project Strategic Advisory Group (SAG), a diverse group of organizational and individual stakeholders from across the broad mental health and addictions system in Vancouver (see page 5 for membership).

The summary is a preliminary report of the outcomes achieved in the 1st phase Collective Impact project, an initiative funded jointly by Vancouver Coastal Health, the City of Vancouver, The Vancouver Foundation, and the Pacific Blue Cross Foundation. The project's organizational coordinator was The Bloom Group, with project management undertaken by the Centre for Applied Research in Mental Health & Addiction at SFU.

This report along with a summary of the vision will be posted on-line for general view in (and feedback from) for the broader community.

Project Context

This project was initiated in 2015 as an experimental initiative flowing from the Mayor's *Task Force on Mental Health & Addiction*.

Its task was to explore the readiness for creating a common framework of success and action for the MH&A system across the system's diverse stakeholders.

It was not tasked with recommending any individual program or intervention, or with reviewing the individual mandates of any agency or body.

PRINCIPLES OF COLLECTIVE IMPACT

COMMON VISION

Defining specific scope and parameters of problem issue.

Ensuring common agreement on primary goals for initiative as whole.

SHARED MEASUREMENT

Agreement on common "dashboard" of metrics to assess initiative.

Focus on whole system, real-time feedback, and alignment.

COORDINATED PLANNING

Focus on coordination of differentiated activities.

Mutually reinforcing plan of action that recognizes individual mandates.

CONTINUOUS COMMUNICATION

Defined forums and communication approaches that connect stakeholders.

Focus on building trust and decision-making based on objective evidence.

"BACKBONE COORDINATION"

Neutral process support to coordinate initiative.

Dedicated resource invested, backed up by deliberate intent.

Theory of Change

What does the *Collective Impact* model offer in terms of a theory of social change?

1. CI responds to the common assessment of multi-stakeholder health, social, education and other community systems in developed countries like Canada that have struggled to find solutions to complex challenges whose roots cross traditional organizational and sector silos.

2. Higher levels of government, the public and service users, and even business leaders, are demanding better results. Yet resources are scarcer, and individual actors in the system increasingly feel that individual initiatives and projects, even those successful in their specific contexts, are not significantly changing the underlying context.

3. CI posits that these systems almost always lack a number of key foundational qualities, starting with a common vision for success, and a shared metrics system for measuring progress towards this success for the entire system. However, if these are developed and adopted core by all parties, and if supported by improved action planning models, better communication, and dedicated system coordination, the environment for innovation and change can radically improve.

Moreover, the shift to a broad "shared ownership" ethos of both challenges and successes can start to increase the output of whole systems beyond the sum of their individual parts.

This theory seemed to offer a new way of looking at Vancouver's MH&A system

where there is both a common acceptance of the need for change (not least on the part of service users and their families), and a strikingly diverse set of organizational stakeholders whose individual mandates both rely on, and are core to, the success of the broad system.

Community service providers and users alike have been calling for a more unified approach to action for some time,

even at a time when multiple new individual service and sub-system initiatives and responses are being developed and implemented. The goal of the project was to start work on a framework that can compliment (not contradict) these initiatives, providing a long-term framework for future work.

COLLECTIVE IMPACT RESOURCES:

CONCEPT OVERVIEW: article from ***The Stanford Social Innovation Review***

FIVE CONDITIONS OF COLLECTIVE IMPACT: illustrative video from **Greater Cincinnati Foundation**

SHARED MEASUREMENT DASHBOARD EXAMPLE: Seattle Roadmap Project

FURTHER COLLECTIVE IMPACT RESOURCES: The Collective Impact Forum

1st Phase Goals

Through its work, the Strategic Advisory Group agreed on the following goals for the 1st phase of work (adapting partially the goals set out in the original scope of work):

READINESS

Assessing the **readiness and capacity** of organizations and groups the broad MH&A system to adopt a *Collective Impact* approach to working.

COMMON VISION

Establishing agreement on the **system parameters and the common vision** for the MH&A system to be the focus of the initiative.

SHARED MEASUREMENT

Developing a prototype set of **objectives and metrics dashboard** for one section part of the overall system vision, assessing the possible indicator set against data already collected.

NEXT PHASE

Developing a set of goals and a project plan for a **2nd Phase** of the initiative, including a process for increased participation of individuals with lived experience, family members, and the broader community.

Contributors

At various points in the project, the SAG reached out to an extensive reference group of organizations and individuals working in and alongside, or receiving services from, the MH&A system.

Input from all stakeholder groups was not always sufficient, though it was large enough to provide confidence that this draft framework was ready for further distribution, feedback, and development (as reflected in the plan for the 2nd Phase).

STRATEGY ADVISORY COMMITTEE MEMBERS:

1. Dominic Flanagan **BC Housing**
2. Michelle Fortin **Watari Counselling & Support Services Society**
3. Natasha Golbeck **VCH**
4. Dr. Elliot Golder **CARMHA (project co-sponsor)**
5. Catherine Hume **Raincity Housing (and formerly MH Commission of Canada)**
6. Pam Liversidge **(formerly BC Ministry of Health)**
7. Anne Livingston **lived experience representative**
8. Sue MacDonald **VCH & lived experience representative**
9. Dr. Bill MacEwan **Providence Health Care**
10. Jonathan Oldman **The Bloom Group (project co-sponsor)**
11. Howard Tran **VPD**
12. Mary Clare Zak **City of Vancouver**
13. Rebecca Zappelli **CARMHA (Project Manager)**

Outcomes

1. "Readiness"

Through its various activities, the project briefed many system stakeholders, both institutional and individual[1], about the usefulness of the Collective Impact approach.

There was almost universal support for the concept, the system conditions it seeks to evolve, and its potential applicability within Vancouver's MH&A system.

The strongest feature of this support was for creating a shared system vision with sufficient detail and definition to drive future coordination forward. At the same time, many questions were raised about how the other key elements of Collective Impact can work in practice, including:

- How do you balance the strong desire within the system for a data dashboard with considerations of data validity and limitations of data availability? How to you select a "lead" indicator(s) to provide the initiative with a strong focus and easily describable overall target (e.g. "double the number of youth graduating from post-secondary education by 2020") when the MH&A system is so interconnected?
- What does "mutually reinforcing" action planning look like in the context of an ongoing Collective Impact initiative? How will it simplify and coordinate existing planning processes, rather than creating overlapping and additional architecture?
- How do you build support for the culture change the Collective Impact represents at all leadership and operational levels of participating organizations?
- How do you balance the need for really broad community inclusion in Collective Impact processes, especially the experience of individuals with lived experience and their families, with the need to present examples of potential frameworks for further development?

Perhaps none of these questions could be fully answered at this juncture. However, enough progress was made – and consensus achieved – to enable each of the SAG members to:

(a) support the outcomes and recommendations for further work contained in this paper, and

(b) seek (where necessary) the formal institutional support of their host organizations (processes for confirming this are in process).

1 Institutional participants at various parts of the process in addition to those represented in the SAG included: MCFD, Ministry of Social Development & Social Innovation, Ministry of Justice, First Nations Health Authority, BC Mental Health Review Board, and various not-for-profit service providers and advocacy groups.

2. "Common Vision"

The SAG developed – and gained broad consensus support from wider reference groups – for the following proposed project parameters and shared vision:

- **Geography:** The project will encompass the geographic City of Vancouver.
- **Target Population:** All individuals living in the City of Vancouver either at risk of an acute crisis or those experiencing recurrent crises associated with their mental disorder and/or substance use disorder.
- **System Definition:** The mental health and additions system is understood as both inter-sectoral and interdisciplinary. It encompasses a range of sectors that impact the lives of people living with a mental disorder and/or substance, both when they are in crisis and in supporting them to recover and stay well. This includes health and social sectors, justice, law enforcement, welfare and housing.

The SAG also developed a system framework that defines three contributory success to such a vision:

- **Access to support before crisis:** a person's first engagement with the MH&A service system for mental health and addictions issues is not during an acute crisis.
- **Access to crisis care:** responses to crises are effective, timely and coordinated.
- **Recovery from crisis and staying well:** Fewer people experience recurrent crises and receive the care and support they need to recover and stay well.

COMMON VISION

The Vancouver Mental Health & Addictions Collective Impact project is an initiative to establish a community and system-wide approach to support individuals living with mental disorders and/or substance use disorders.

Our shared goal is to reduce the level and frequency of crisis experienced by people living with mental disorders and/or substance use disorders, and to increase levels of stability, recovery and wellbeing.

3. "Shared Measurement"

Through a collaborative stakeholder workshop exercise, the project developed what it has called a "roadmap" for one of these three contributory success factors (effective response to crisis).

THE GOAL WAS TO ANSWER THE QUESTION:

*"What would success look like in the year 2020 if we were able to collectively coordinate a strategy for the **effective response to crisis** in Vancouver?"*

The group developed the following population definition and sub-vision for this success factor:

- **Population:** Individuals living with a mental health and addictions (MH&A) issue in Vancouver who have been brought to the attention of emergency crisis care services as a result of a crisis event associated with their mental health and/or substance use. The crisis event may have been precipitated by the episodic nature of their illness or a disruptive, traumatic or destabilizing change in their circumstances.[2]

- **Vision:** *"The mental health and addictions crisis response system is stabilizing and reduces the trauma associated with crisis for individuals and their families."*

From the detailed discussions that took place, the SAG has developed a proposed "Summary Framework for Effective Crisis Response" (see Appendix 1 of this report) that identified the objectives, outcomes, and potential indicators for achieving the vision.

In addition, the group brainstormed examples of potential mutually reinforcing activities that could be undertaken in the future.

Following this, the project's data group then compiled an overview of the current availability of data for the identified potential indicators (see Appendix 2 of this report).

7 KEY OBJECTIVES FOR EFFECTIVE RESPONSE TO CRISIS

1. An individual's first contact in a crisis is with an appropriate care provider;
2. 'Need to know' client information is shared during a crisis with providers of crisis services;
3. Individuals and families' experience of crisis care is positive and empowering;
4. Discharge from crisis care requires immediate supports and ongoing coordination of care;
5. Care provided is appropriate to age, gender, culture and trauma informed;
6. Access to specialized care is timely;
7. Responses to crisis are provided in a manner that most effectively resolves the crisis.

2 This could include: apprehension of a child, removal of housing, jail or remand, sudden changes in welfare, poor discharge planning, overdose etc.

4. "Next Steps"

The SAG has also developed a project plan for an 18 month 2nd Phase of the project: **"Organizing for Impact"** (see Appendix 3 of this report).

This phase is conceived as an intermediary step to further develop the work completed in the 1st Phase. If successful, it would lead to a longer term commitment and infrastructure to fully implement the initiative over a period of several years. The conceptual relationship between the 3 phases is set out in Appendix 3.

Specific milestones targeted for completion by the end of Phase 2 include: the live use of a first iteration metrics dashboard; the development of objectives and indicators for all 3 system success factors; the prototyping of an action planning process; and the implementation of a new community engagement plan.

The SAG approved the proposed Phase 2 Action Plan in the fall of 2016.

Closing Comments

This financial investment for this 1st Phase project was generously provided by 4 organizations:

Vancouver Coastal Health, the City of Vancouver, The Vancouver Foundation, and The Pacific Blue Cross Foundation. We thank them for their support.

As important, however, was the large investment of faith and time on the part of a range of individuals and organizations, including the members of the Strategic Advisory Group.

The Bloom Group and CARMHA would like to extend their sincerest thanks to team: they brought energy, vision, and the willingness to integrate their diverse perspectives – the true mark of a Collective Impact initiative.

APPENDIX 1: SUMMARY FRAMEWORK FOR EFFECTIVE CRISIS RESPONSE

TABLE 1: Summary Framework for Effective Crisis Response

Objectives	*Desired Outcomes*	*Potential Indicators*	*Potential Mutually Reinforcing Activities*
1. An individual's first contact in a crisis is with an appropriate care provider	• Reduced need to interact with emergency services for care when another provider may be more appropriate to the client's needs • All individuals are attached to a GP and/or a MH&A community care provider • Equal access to care • Increased coordination between medical/primary care system and community care and support providers	• Decreased # of MH&A adverse events during a crisis • Increased # of individuals with MH&A with a family doctor/primary care or community MH&A attachment • Decreased # of contacts with police in MH&A crisis • Decreased # of MH&A presentations at EDs • Decreased # of police MHA Section 28 apprehensions	• Explore the issues associated with 'appropriateness' of care to divert crisis contacts from more acute services for those that may be better served in primary care or with community providers
2. 'Need to know' client information is shared during a crisis with providers of crisis services	• Shared patient histories with essential care and support providers to support patient/client stability • Increased accountability within the MH&A system	• Increased % of ED presentations for MH&A crisis have information about prior care available during assessment • Decreased # of service providers reporting barriers to receiving information about patients	• Explore opportunities to scale up existing data sharing efforts that have proven to be effective • Pilot efforts to improve real-time data linkages between police, hospitals, primary care, housing and community, etc. • Mechanism to include family information created
3. Individuals and families' experience of crisis care is positive and empowering	• Individual's rights are respected • The system is strengths-based and ensures client and family empowerment through the provision of clear, timely information and connection to community supports • The system promotes and supports client self-direction by encouraging the development of crisis plans when people are well and incorporating these into decision-making	• Increase client/family/caregivers reporting that their experience of care is: - Timely - High quality - Empowering (including client/family involvement in case management planning)	• Ensure standards of involvement of clients and families in their crisis care and discharge planning are in place across the system • Ensure individuals are given access to an advocate of their choice to help during crisis service delivery • Scale up efforts that are proven to be effective in empowering clients and families in service design
4. Discharge from crisis care requires immediate supports and ongoing coordination of care	• Decreased chance of reoccurring crisis and destabilization • Better long term outcomes for patients • Increased participation in aftercare planning between patients and community care providers • Reduced reoccurrence of crises, apprehensions and admissions to ED	• Increased % of shared care plans in place on discharge • Decreased # of readmissions to ED • Decreased # of discharges into homelessness/vulnerable housing	• Strengthen strategies to ensure housing is secured for clients before discharge • Develop services and places that stabilize patients post discharge or can provide a bridge between services post discharge. • Shared training between and across acute, community and contracted services
5. Care provided is appropriate to age, gender, culture and trauma informed	• Improved client experience of the system • Improved care provider experience of the system	• Increase client/family/caregivers and care providers reporting that their experience of care is: - Culturally safe - Age appropriate - Gender appropriate - Trauma informed	• Introduce trauma informed care standards in place across the system • Ensure cultural and other training made available for all frontline staff • Ensure clients/families feedback incorporated into system design and delivery (peer service providers)
6. Access to specialized care is timely	• Improved user experience of the system	• Decreased wait times for specialized care services	• Strengthen access to community and peer run crisis response models to promote timely access and client stabilization • Improve linkages with addiction medicine and emerging practice in substance use with MH
7. Responses to crisis are provided in a manner that most effectively resolves the crisis	• Reduced severity of crisis presentations in the system • Reduced risk of self-harm or harm caused to others • Promotes client self-direction	• Decreased # of suicide and self-harm events • Decreased # of overdose events • Decreased # of harm or threat of harm to others events	• Improve linkages with addiction medicine and emerging practice in substance use

NOTE: Content collected from the group discussions that relate more closely to the contributing success factors of **'access to support before crisis'** and **'preventing recurrent crisis'** have been recorded at this time, and will be utilized during Phase 2.

APPENDIX 2: POTENTIAL INDICATORS SUMMARY & CURRENT STATUS

An overview of current availability of identified potential indicators.
All indicators still require baseline and target levels to be set, and may be analyzed by distinct age, gender, cultural or other population categories.

Level 1 = data currently collected and could be readily extracted
Level 2 = data currently collected but ***not*** easily extracted
Level 3 = data ***not*** currently collected

Potential Indicators	*Data Source*	*Current Status & Additional Notes*
1. Decreased # of contacts with police in MH&A crisis	VPD	**Level 1**: Police identify if a contact is coded as a MH&A crisis
2. Decreased # of MH&A presentations at EDs	Emergency Departments – VCH	**Level 1**
3. Decreased # of police MHA Section 28 apprehensions	VPD	**Level 1**
4. Decreased # of suicide and self-harm events	Suicide: Vital Statistics – MoH Self-harm: Emergency Departments – VCH	**Level 1**
5. Decreased # of overdose events	Emergency Departments – VCH	**Level 1**
6. Decreased # of harm or threat of harm to others events	VPD	**Level 1**: VPD as source defines indicator as only incidents that leads to police involvement
7. Decreased # of MH&A adverse events during a crisis	Emergency departments and acute services, community care teams	**Level 2**: Data would require consistent defined across system
8. Increased # of individuals with MH&A with a family doctor/primary care or community MH&A attachment	MoH	**Level 2**
9. Decreased # of readmissions to ED	Emergency Departments – VCH	**Level 2**: Requires matching across EDs as readmission may be at alternate ED
10. Decreased # of discharges into homelessness/vulnerable housing	Emergency Departments – VCH	**Level 2**: Discharge coding would be to 'no fixed address' or shelter locations.
11. Decreased wait times for specialized care services	Referral and admission data from selected specialized services	**Level 3**: Clarification required whether wait time data is currently collected for MH&A specialized care services
12. Increased % of ED presentations for MH&A crisis have information about prior care available during assessment	Emergency Departments	**Level 3**
13. Decreased # of service providers reporting barriers to receiving information about patients	Community service providers	**Level 3**
14. Increase client/family/caregivers reporting [positive] experience of care	Clients/families/caregivers	**Level 3**
15. Increased % of shared care plans in place on discharge	VCH	**Level 3**
16. Increase client/family/caregivers and care providers reporting that their experience of care is safe and appropriate	Clients/families/caregivers	**Level 3**

APPENDIX 3: RECOMMENDATIONS FOR PHASE 2

PROPOSED GOALS

- It is recommended that the overall goal **Phase 2** of the Collective Impact project be threefold:

    1. build on the work of Phase 1 to establish goals, metrics, and governance framework for ongoing action

    2. develop and prototype processes for action and impact; and

    3. broaden stakeholder engagement to included community members/people with lived experience.

    Together these goals would lead to a stakeholder business case and recommendations as to the sustainability and viability of establishing a 3-5 year initiative. The first step towards this work is to finalize the objectives for Contributing Success Factor #2 – *Effective Response to Crisis*, with the Reference Group engaged in Phase 1.

- A broader stakeholder consultation will follow to: 1) inform of them of the work undertaken in Phase 1; and 2) engage a broader set of stakeholders, service users, and families in the 'action and impact' activities proposed for Phase 2. The result will be the articulation of a process and framework for community consultation and engagement that can be scaled up in Phase 3.

- The following articulates the actions and process proposed for Phase 2 (a table version is also attached to summarize and distinguish between phases). These activities are suggested and their scale will be subject to available resources and the commitment of Phase 2 stakeholders.

- The following is provisionally conceived on an 18 month timeline, though this is subject further design and discussion amongst stakeholders.

A PLAN FOR ACTION & IMPACT:

1. **"Task Force" Process Development:** Prototype a "Task Force" (TF) process to create Mutually Reinforcing Action Plans (MRAPs) for 2-3 objectives within Contributing Success Factor #2 – *Access to Crisis Care*. Each TF would comprise of stakeholders that may have been engaged in the Phase 1 Reference Group and may also include new stakeholders engaged through the broader consultation described above. TFs will:

    a. Develop a MRAP to test strategies for improved system performance within the following categories:
        - Collaborative working practices/protocols;
        - Policy changes;
        - New service iterations (prototyping possible within current resource allocations)
        - New service investment (prototyping requiring new investment)

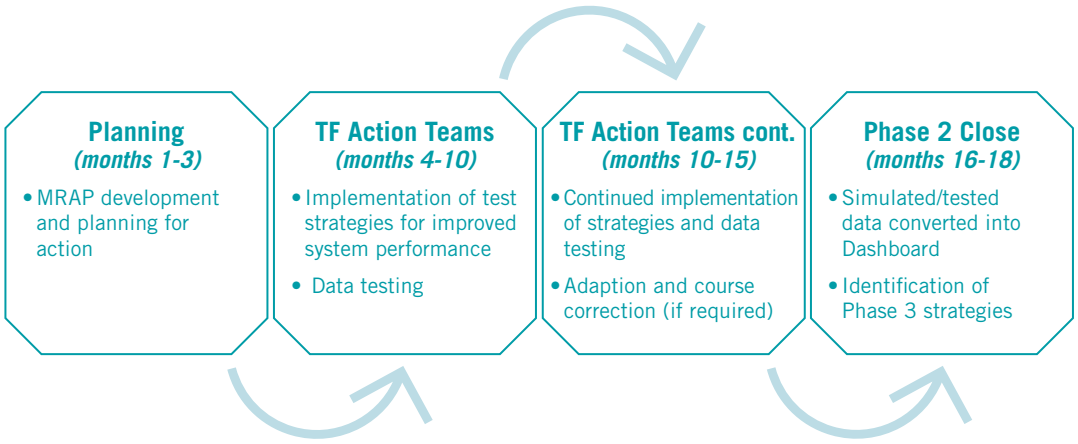
    b. Examine available data for each objective, working with an Expert Data Group (see below) to test the development of metrics, baselines, and (where necessary) explore new data collection opportunities.

2. **System Data Group:** Reconvene the Expert Data Group (formed in Phase 1) in order to support individual Task Forces (see above) in their work to develop and test MRAPs.

3. **Road-Mapping:** Repeat the Phase 1 Road-Mapping process undertaken in Phase 1 for the two other Contributing Success Factors (#1 – *Access to Support Before Crisis* and #3 – *Recovery from Crisis and Staying Well*). This process will aim to create a framework to articulate objectives, outcomes, strategies and indicators. These will contribute to the development of a Dashboard to indicate progress towards the projects larger Shared Vision 1.0 (developed in Phase 1).

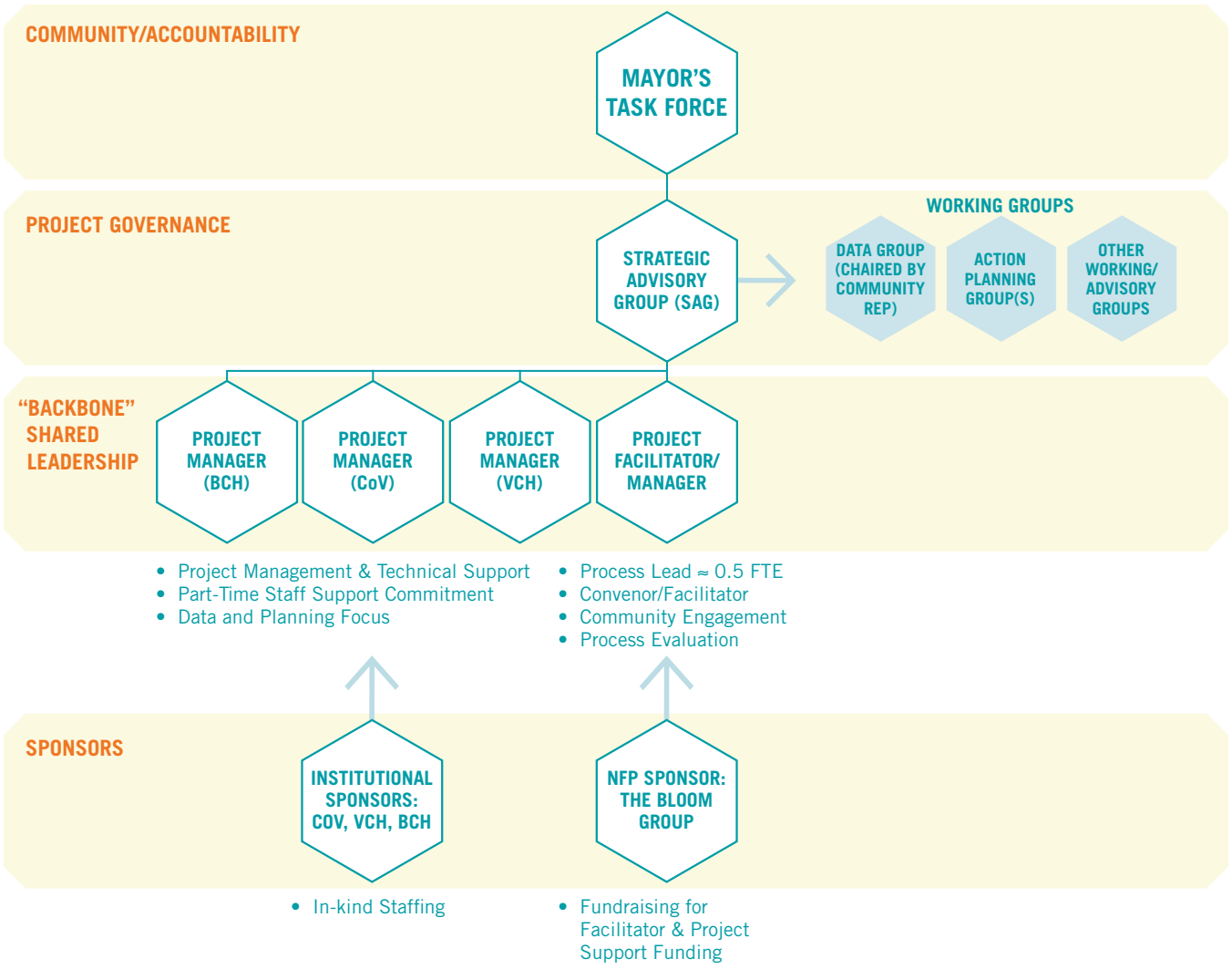
4. **Governance:** Continue to develop the project's governance capacity, developing plans for an ongoing "backbone" infrastructure, and for a project evaluation model, as part of building a business case to establish on ongoing 3-5 year MH&A Collective Impact initiative.

Fig. 1: Timeline and Process for MRAP Development



	Pre-Planning	Phase 1: Initiate Action (2015-2016)	Phase 2: Organize for Impact (≈18m)	Phase 3: Sustain Action & Impact (Duration tbc)
Governance & Infrastructure	• Interim infrastructure developed with institutional and sector stakeholders	• Established interim Backbone leadership • Established Strategy Advisory Group (SAG)	• **SAG provides project oversight (reporting to Mayor's Task Force)** • **Development of business case/plan for Phase 3**	• Ongoing "backbone" infrastructure in place • Ongoing oversight/ advisory bodies in place
Strategic & Action Planning	• Established urgency of issue and cross-sector willingness to participate	• Shared vision and 3 Key Success Factors (KSFs) identified • 1 of 3 KSFs "road-mapped"	• **Action planning (MRAP) process prototyped for "Effective Response to Crisis" KSF** • **Objectives and indicators for "Access to Support before Crisis" and "Preventing Reoccurring Crisis" KSFs defined**	• Complete Vision and Key Success Factors framework in place • MRAP groups actively planning in all KSF domains
Data & Evaluation	• Determined key metrics to define need for collective action	• Availability of current systems data reviewed • Potential metrics for KSFs identified	• **Ongoing community data group established** • **Metrics dashboard developed with "live" reports (for 1st then all 3 KSFs)**	• Ongoing development of metrics dashboard • Full project evaluation process in place
Community Engagement	• Partial engagement around concept through existing forums (e.g. Mayor's Task Force)	• A wider reference group established • Circle of project stakeholders and contacts expanded	• **Results from Phase 1 finalized through enhanced consultation** • **Community engagement plan developed and implemented**	• Ongoing stakeholder and community engagement process in place • Ongoing advocacy agenda identified

COLLECTIVE IMPACT – PHASE II PROPOSED GOVERNANCE/MANAGEMENT STRUCTURE



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