

**COMMUNITY NETWORKS OF
SPECIALIZED CARE**

Regional Solutions Report

And Addendum (April 12, 2006)

**Prepared for the
Hamilton/Niagara and South West Regions
Ministry of Community and Social Service**

*Please note: Hamilton/Niagara and South West Regional
Offices' comments have been inserted and highlighted in bolded
italics throughout this document.*

Prepared by

Rice and Associates

December 9, 2005

Executive Summary

The purpose of this report is to summarize the findings from the Hamilton/Niagara and South West Regions (MCSS) Environmental Scan; describe how networks can be used to address the issues identified in the Scan; and propose a design for the Community Network of Specialized Care in Hamilton/Niagara and South West regions.

Highlights from the Environmental Scan

It is estimated that there are approximately 24,000 people with dual diagnosis in Hamilton/Niagara and South West regions. Approximately 60% of these people live at home with family or in their own accommodation in the community. The findings from the environmental scan indicate that services for people with dual diagnosis are fragmented. The availability of services depends upon where a person lives, whether there are resources in the community, how well the person is known to the service providers, how vocal the caregivers are and the length of time the person has spent on waiting lists.

Although thoroughly described in the background of the full report, it should be noted in the executive summary that the term ‘dual diagnosis’ is a common one that refers to individuals with a developmental disability and co-existing mental health issue and/or behavioural challenge.

The following headlines represent the most important gaps and barriers within the system:

1. Adults with a dual diagnosis have complex needs which are difficult to serve.
2. The need for community based support for adults with a dual diagnosis is increasing.
3. There is no unified service system for people with dual diagnosis.
4. Access to services is variable across the two Regions.
5. There is a gap between the services provided to children and those provided to adults.
6. Developmental services experience many challenges in meeting increasing demands.
7. When a crisis event happens there are few local resources to provide support.
8. The service system does not have an overall strategy for encouraging people into the field.

The Joint Implementation Team acknowledges Dr. Rice’s headlines and recognizes that they form the foundation of the network model being proposed.

In order to respond to these challenges MCSS is creating regional Community Networks of Specialized Care. The main functions of the Networks are to improve access to a coordinated and comprehensive system of specialized clinical services, supports and resources; expand recruitment and retention of qualified health and allied health staff through professional development, education and training opportunities; identify research needs and priorities; promote the use of evidence-based practices; provide

clinical services, consultation and coordinated access to designated specialized accommodations; and ensure case management for complex cases.

Developing a network to meet this wide array of functions is a difficult task. Networks are relationships and structures that involve two or more independent and autonomously managed organizations working together to achieve a common objective. Networks' ability to achieve their objectives varies. They are very good at information exchange, creating relationships, serving as a forum for debate and discussion, developing a common purpose, fostering planning and policy development and providing a venue for system analysis. However, they are much less effective at service delivery because in a voluntary horizontal structure it is difficult to hold network members accountable and almost impossible to voluntarily pool resources over a sustained period of time.

Networks that provide direct service require high levels of contact and trust in order to create the conditions in which the organizations can count on each other to do their share of the work.

The Network Design

Meeting the needs of people with a dual diagnosis is a joint effort between caregivers (families and agencies) and specialized service providers. The CNSC needs to attend to both the provision of services for people with dual diagnosis and the planning and coordinating of specialized services. At the same time the design of CNSC must take into account the strengths and weaknesses of 'networks' as a vehicle for achieving the MCSS goals. A two tier CNSC is recommended to ensure a systematic approach to the resolution of systems problems. The model builds on the capacity of existing services and structures in supporting people with dual diagnosis. As well, it places responsibility for providing, managing and developing support and services at appropriate levels.

The first CNSC tier is responsible for creating stable conditions for people with dual diagnosis, managing crises when they happen and creating the conditions necessary for delivering specialized services effectively.

The second CNSC tier is responsible for planning and coordinating the delivery of these services.

First Tier: Service Delivery Network

We recommend that a Service Delivery Network be developed at the local level. This approach builds on local capacity that continues to support people with developmental disabilities and co-existing mental health and/or behavioural issues. The Service Delivery Network brings together local agencies and caregivers so that they may continually review the needs of people with dual diagnosis and develop coordinated ways of addressing emerging issues. In addition to providing services to people with high needs the Network should also be responsible for:

- Creating connections between people with dual diagnosis and local resources
- Identifying people with dual diagnosis and ensuring adequate assessment
- Developing community based service plans for people with high needs
- Developing a local crisis response for people with high needs

- Identifying local training needs regarding issues related to people with dual diagnosis.
- Identifying emerging gaps and barriers to services
- Communicating with the Planning and Coordinating Network

The JIT suggests that it is necessary to define 'local level'. It is our understanding that local levels refer to the local communities within each Region.

Membership on this network also needs to be defined more thoroughly in the upcoming Business and Implementation Plans.

Suggested membership is noted on the diagram on page 12.

Second Tier: Planning and Coordinating Network

A Planning and Coordinating Network should be developed within each region. The Network should be responsible for ensuring that the Service Delivery Networks have access to the specialized services they need to achieve their goals. The Planning and Coordinating Network would also be responsible for:

- Identifying changing needs across the communities.
- Identifying cross community gaps and barriers to service
- Identifying the need for specialized services that span more than one region
- Ensuring the capacity of the specialized service providers to meet the service plans for individuals with dual diagnosis
- Avoiding duplication of services
- Coordinating the delivery of specialized services across the Service Delivery Networks
- Collaborating with community colleges and universities to develop student placements and educational opportunities
- Developing training programs and professional development opportunities to enhance the ability of developmental services workers to support people with dual diagnosis
- Developing community information programs to increase the general understanding of professionals, other community agencies and the public regarding the needs of people with a dual diagnosis

Membership of this body will be defined as part of the upcoming Business and Implementation Plans.

Suggested membership is noted on the diagram on page 12.

The JIT recommends that collaboration occur through cross representation between the two partnered networks, i.e. Hamilton/Niagara and South West. At face value, this recommendation suggests that there will be two networks. This is not the case. The two regions are committed to working collaboratively at every opportunity. The regions will develop one business plan and one implementation plan; will work with one Network Coordinator and have a centralized budget for the CNSC.

Resolving Systemic Issues

There are a number of systemic issues that must be dealt with by MCSS at the provincial level for the Community Network of Specialized Care to be effective at the regional and local levels. These include the following issues:

Through survey responses and participation at various forums, Dr. Rice has identified a number of issues as reflected in the feedback received from the local service communities.

- Providing increased resources to relieve pressures within the system.
- Providing additional wage support to the system in order to attract and hold workers.
- Negotiating intergovernmental agreements regarding cross sector service provisions particularly between MCSS and MOHLTC.
- Developing plans and processes for attracting new employees into the field by encouraging professional bodies to develop a specialty in the field of developmental disabilities.
- Ensuring research on new practices by creating a funding mechanism to encourage research in the field and developing a centre of excellence to promote best practices.
- Developing effective educational programs that meet the needs of new professionals in the field by encouraging universities to develop specialized education programs related to developmental disabilities (as well as co-existing mental health and/or behavioural problems).
- Creating a rights based agenda for people with developmental disabilities (and dual diagnosis) by introducing legislation that defines program and service rights of people with developmental disabilities and mental health or behavioural problems.
- Establishing population based service targets in order to ensure fair and equal access to programs and services across the province.

In the last year the government has identified a plan to transform developmental services and strengthen specialized care for individuals with a developmental disability and a coexisting mental health or behavioural issue. They have committed resources to providing better access to services for adults with developmental disabilities by strengthening community-based services for individuals who require specialized care. They are developing plans for recruiting and retaining more professionals, strengthening clinical services and creating new places where individuals with very high care needs can live and get the intensive support they require.

In addition to the development of the Community Networks of Specialized Care, the ministry is taking action to substantially reduce current wait lists, expand services and improve client care across the developmental services sector. A number of initiatives have been announced that will invest in better, stronger community services for all people with a developmental disability and include:

September, 2004

- **Facilities Initiative**

November, 2005

- **launch of the Ontario Developmental Services Career Connections Grant**

July, 2005

- **Passport, a new initiative to help young adults make a successful transition from school to a wide range of community participation activities and/or work**
- **Additional funding for the Special Services at Home program as well as policy changes which will result in reduced waitlists, better service for families, increased utilization of SSAH funding and greater flexibility in managing their funds**
- **funding for community agencies to address operating expenses and to make safety and security improvements**
- **agency funding to support at risk clients assessed to be in need of immediate care**
- **Regulatory changes to the Developmental Services Act to allow bedrooms in basements and above the second floor in group homes for adults who have a developmental disability**

May, 2005

- **Ministry strategy to strengthen specialized care for adults with a developmental disability by:**
 - **establishing four Community Networks of Specialized Care**
 - **creating 390 spaces through the Home of Your Own initiative, including 90 spaces for individuals who have very high needs and mental health issues and/or challenging behaviours**

The recommendations and suggestions contained within this Regional Solutions Report build upon these strengths.

Table of Contents

Executive Summary	.....	i
Background	.....	1
System Pressures	.....	1
MCSS Transformation Agenda	.....	4
Building a Network to Respond to the Need for Specialized Services	.....	6
Role and Function	.....	6
Stakeholder Participation	.....	7
Effectiveness	.....	7
Challenges	.....	8
Enablers	.....	9
Benefits	.....	10
The Network Design	.....	11
Values and Principles	.....	11
Diagram of the proposed Network	.....	12
First Tier: Service Delivery Network	.....	13
Functions and Activities	.....	13
Resources	.....	14
Membership	.....	15
Lead Agency	.....	15
Second Tier: Planning and Coordinating Network	.....	15
Functions and Activities	.....	16
Resources	.....	16
Membership	.....	17
Lead Agency	.....	17
Planning and Coordinating Networks		
Working Together	.....	17
Provincial Enablers for the Community Network of Specialized Care	.....	18
Summary	.....	19
Bibliography	.....	21

Regional Solutions Report

Background

The Ministry of Community and Social Services (MCSS) is committed to transforming services and supports for adults with a developmental disability and co-existing mental health and/or behavioural challenges, commonly called a dual diagnosis. This transformation will improve accessibility, fairness and sustainability in the developmental services system and will support the inclusion of people with a developmental disability in all areas of society. A key element in this process is the creation of four regional Community Networks of Specialized Care to address current gaps in the availability of community-based resources.

As part of this strategy, the Hamilton/Niagara and South West Regions of MCSS contracted with Rice and Associates to carry out an Environmental Scan and prepare a Regional Solutions Report. The Environmental Scan is designed to identify where in the two regions people who have a dual diagnosis and their families may go for services and support. The objectives of the Regional Solution Report are to make recommendations and identify strategies that address the issues and resource/service gaps identified in the Environmental Scan.

This report summarizes the outcomes of the Environmental Scan, describes how Networks can be used as effective change agents for improving services to people with developmental disabilities and mental health or behavioural issues, and proposes a design for the Community Network of Specialized Care in Hamilton/Niagara and South West regions.

System Pressures

The findings from the environmental scan indicate that services for people with dual diagnosis are fragmented. When families and DS agencies were asked whether they can obtain the services they need for people with dual diagnosis they report that “it depends”. It depends on where a person lives and whether there are resources in the community; whether the person is known to the providers; whether they are already part of the system; whether there is a functional relationship between the DS sector and the mental health sector; whether the family or agency is able to advocate on the part of the person and how long the waiting list is for services. Stakeholders indicate that there is not a strong, responsive, continuum of care for adults with a dual diagnosis. Families, developmental service providers, specialized service providers and other key informants all confirm multiple challenges facing the system.

It is estimated that there are approximately 24,000 people with a dual diagnosis in Hamilton/Niagara and South West regions¹. Approximately 60% of these live at home with their family or in their own home in the community. Services and supports are not equitably available to clients living at home or in other residential settings, and across the regions, e.g. meaningful activity, respite to clients and families, and crisis support.

¹ This calculation is based on a population estimate of 2,700,000 for Hamilton/Niagara and the South West with a prevalence rate of 2.5% for developmental disabilities and 35% for prevalence of dual diagnosis.

Families supporting their adult child at home often have great difficulty being an advocate for services and supports in an environment characterized by scarce resources, changing client symptoms, and family capacity that diminishes over time.

Developmental service agencies have adapted in an environment where demand for service outstrips supply. Many participate at local round tables, cooperating with and coordinating local response to emerging issues. **[Generally, they cope with fractured policy and program initiatives that do not provide a continuum of care for clients. These include housing options, responsive and timely mental health services, and education and training options.]** Developmental services also face internal problems. Frontline workers enter the field, receive training and move on to less stressful or better paying jobs. Agencies do not have the staff or material resources to respond to episodes of crisis in people with dual diagnosis. And some agencies report having difficulty obtaining the support they need from specialized service providers.

[The ministry is taking action to substantially reduce current wait lists, expand services and improve client care across the developmental services sector. A number of initiatives have been announced that will invest in better, stronger community services for all people with a developmental disability and include:]

Facilities Initiative

- ***September, 2004***

November, 2005

- ***launch of the Ontario Developmental Services Career Connections Grant***

July, 2005

- ***Passport, a new initiative to help young adults make a successful transition from school to a wide range of community participation activities and/or work***
- ***additional funding for the Special Services at Home program***
- ***additional funding for community agencies to address operating expenses and to make safety and security improvements***
- ***agency funding to support at risk clients assessed to be in need of immediate care***
- ***Regulatory changes to the Developmental Services Act to allow bedrooms in basements and above the second floor in group homes for adults who have a developmental disability***

May, 2005

- ***Ministry strategy to strengthen specialized care for adults with a developmental disability by:***

- **establishing four Community Networks of Specialized Care**
- **creating 390 spaces through the Home of Your Own initiative, including 90 spaces for individuals who have very high needs and mental health issues and/or challenging behaviours**

The following summarize the key findings from the Environmental Scan.

1. Adults with a dual diagnosis have complex needs.

The needs of adults with a dual diagnosis manifest themselves as ongoing low-level demands, episodic crisis events, and long-term disruptive events. Mental health problems merge with behavioural issues and are difficult to diagnose and provide effective intervention for. Small changes in a person's life and daily routine can have dramatic effects on their ability to function that make their behaviour and situation unpredictable. All of these issues make it difficult to provide coordinated services.

2. The need for community based support for adults with a dual diagnosis is increasing.

Aging parents have diminishing physical, emotional and sometimes financial resources to continue to provide around the clock care and support for their adult children. They are also concerned about what will happen to their child when they die. In addition, the Ontario government plans to close the three remaining institutions in the province; the closing of Southwestern Regional Centre in Chatham-Kent will effect the demand for services primarily in that area but also in the South West Region (**Community spaces are being created as a result of the closure of SWRC, HRC and RRC.**)

3. There is no unified service system for people with dual diagnosis.

The continuum of care and support for adults with a dual diagnosis and their families/caregivers comes from diverse policy and program sectors and funding sources. This makes the provision of an effective and responsive continuum of services more complex. The diverse sectors include:

- multiple public sector partners e.g. Ontario Ministries of Community and Social Services (MCSS), Health (MOHLTC), Education, Justice as well as their transfer payment agencies
- non profit sector services e.g. YWCA residential and recreational programs
- private sector services and supports e.g. psychiatrists, training programs
- other community supports, some supported by community fundraising.

The lack of integration between MCSS developmental services and MOHLTC mental health appears to be the result of misperceptions about each sector's capacity and responsibility. The consequences include disconnected service provision at the local level; the lack of a long-term shared agenda for sustained, effective care and support; and the lack of a long-term plan for dealing with increased needs.

The JIT recognizes that we need to take this opportunity to forge a linkage with the Local Health Information Networks in both Hamilton/Niagara and South West.

4. Access to services is variable across the two Regions.

Meeting the needs of people with dual diagnosis depends upon where they live, the ability of their family to advocate on their behalf, the availability of resources in the community and the relationship between the developmental services sector, the health sector and other resources sectors.

5. There is a gap between the services provided to children and those provided to adults.

A gap in services is created when a person with a developmental disability moves from having rights to an education as a child, to having no rights to services as an adult in the adult system.

6. Developmental services experience many challenges.

Developmental services are functioning at capacity. There is a waiting list for most of the services. At the same time, agencies' ability to deliver effective, timely, and responsive client and family services is at risk. **[Workers in the field are "tired" of stretching resources, and participating in the development of community service plans, multi year plans and capacity assessments with little follow-up implementation activity for improved client outcomes.]**

[The Hamilton/Niagara Region is currently in the process of providing comments and feedback to both the Transformation Community Plans submitted in October 2005 and Community Service Plans annual report.]

7. When a crisis occurs there are few local resources to provide support.

The lack of available continuous, consistent and quality support for many adults can provoke unstable client behaviours and crises. Families and providers lament the lack of a "safe space" to diffuse crises episodes for staff, family and client. Emergency psychiatric response is overwhelmed generally, and under trained specifically to respond to the presenting situation and the underlying conditions.

8. The service system does not have an overall strategy for encouraging people into the field.

There is insufficient focus on developmental disability issues in the training and education of professionals. There is no specialty in medicine, nursing, social work or other highly trained disciplines that addresses the needs of people with dual diagnosis.

Effective recruitment and retention of trained frontline workers is difficult in a environment characterized by declining interest in underpaid and stressful work, lack of cross sector training, diminished access to specialized supports for staff training and mentoring, and client intervention e.g. psychiatry.

MCSS Transformation Agenda

In order to respond to these challenges MCSS is transforming developmental services. More specifically, they plan to enhance specialized resources to create a fairer, more accessible and sustainable system of community-based supports.

Four regional Community Networks of Specialized Care are being created in Ontario to address gaps in services for adults with a dual diagnosis. The main functions of the Networks are to increase and improve service, facilitate education and training, and generate and disseminate research on best practices in the field. The Network activities will be supported by collaborative partnerships with community developmental services and generic service providers, universities, colleges, research institutes and other stakeholder groups. Anticipated outcomes include a regional system of specialized resources, sustained retention of qualified health and allied health professionals, integrated evidence-based practice, and 90 specialized accommodation spaces in the community. In addition, Networks will increase the communities' capacity to receive and support people leaving institutionalized care.

As noted earlier, the JIT wishes to clarify that there are other initiatives that will contribute to the overall transformation of developmental services in Ontario.

MCSS ascribes Network goals as:

- Improve access to a coordinated and comprehensive system of specialized clinical services, supports and resources by building on existing specialized resources, fostering relationships and coordinating resources among health, corrections, justice and other service providers.
- Expand recruitment and retention of qualified health and allied health staff through professional development, education and training opportunities in evidence-based practice methods of specialized care, clinical interventions, case management and service coordination.
- Coordinate with other Community Networks of Specialized Care to identify research needs and priorities, collaborate on research activities and disseminate results and/or demonstrate applications related to specialized care, support, clinical interventions, case management and service coordination etc.
- Increase awareness among generic service providers of the needs of individuals who have a developmental disability and co-existing mental health issue(s) and/or challenging behaviour.
- Promote the use of evidence-based practices through community outreach activities that educate and train family members, support workers and generic community professionals.

- Provide clinical services, consultation and coordinated access to designated specialized accommodations where clients can easily access multi-disciplinary teams for clinical/consultation.
- Ensure case management for complex cases that cannot be managed through other means/services.

Building a Network to Respond to the Need for Specialized Services

The proposed design for an effective Community Network of Specialized Care in Hamilton/Niagara and South West regions addresses the challenges and issues identified in the system, the requirements of MCSS in their transformation agenda, and the experience of networks as change agents. This section describes elements of network role, structure, function and effectiveness, and how the literature can inform the design of a community network of specialized care.

Networks are relationships and structures that involve two or more independent and autonomously managed organizations working together to achieve a common objective (O'Toole 1997). They are increasingly useful mechanisms to promote information sharing, innovation, and coordination. Networks draw on diverse expertise, resources and organizations by means of a common agenda for shared goals. Successful networks rely on: the explicit willingness and ability of members to work toward a common goal; the level of organization and contribution from members; and the use of influence, persuasion, consensus building and information sharing for sustained functionality. Networks are a means to achieve the goals that individual organizations cannot manage on their own.

Role and Function

In the human services sector, networks are increasingly forums for sector wide planning and problem solving. The network encompasses a set of organizations - called a service cluster - that frequently work together to serve distinct needs, often defined by a population or catchment/referral area. Networks themselves are not generally direct providers of service and do not represent integrated services under unified management and funding. Rather, network participants, acting together, facilitate the coordination of services to enhance linkages, maximize new sector/program developments (e.g. policy shifts, funding) and, identify and promote best practice. As a collaborative table for problem solving, networks focus on the needs of a defined client group, their caregivers and their providers and, improve service linkages for an effective continuum of care and support.

Networks perform many functions. Gilchrist (1995:4) has drawn these together into five categories: information exchange; developing relationships of support and solidarity; developing a sense of common purpose on the basis of shared values and identity; providing a forum for debate and discussion; and negotiating and articulating a collective view on issues which are relevant to participating members. Networks can be an effective means for planning social services delivery methods and training (Agranoff and McGuire, 2001); and disseminating information, fostering innovation, promoting organizational flexibility and enhancing co-operation (Raab and Milward, 2003). Networks too, can have a role in service delivery whereby network partners may

contribute funding or in-kind resources such as staff, equipment, office space and supplies intended to meet the goals of the network (Mays et al 1998).

Stakeholder Participation

Participation or membership in a network is generally voluntary and guided by shared goals and a common agenda. The voluntary, horizontal ties of networks are strengthened by trust, mutual obligations and reciprocity. The connectivity, or institutional glue that holds networks together may include interpersonal relationships between network partners; informal agreements about service delivery; formal contracts defining who will do what, with whom, and when; and contractual relationships enforced by third party organizations such as government (O'Toole 1997). The form the connections take depends upon how stable the partners need the relationship to be.

Organizations play different roles in a network. Highly influential organizations connect with many other organizations and transmit high levels of commodities – resources, intelligence, insights - through their interactions. They often play an important role in maintaining and facilitating the network. These organizations have the most to gain or lose from the success of the network. At the periphery of a network there are other organizations that interact with few other organizations and transmit little through their interactions. Bardach (1998) claims the more balanced the roles, the more functional the network.

Effectiveness

The effectiveness of networks is variable. Networks appear to be good at information exchange, creating relationships, serving as a forum for debate and discussion, developing a common purpose, fostering planning and policy development and providing a venue for system analysis. O'Toole and Meier (1999), make the point that networks of interdependent organizations that consciously collaborate and cooperate should be more effective at providing complex services than the same organizations working alone. However, service delivery is very difficult for partners who are joined in a voluntary horizontal structure (Sue Gross 2001) and it is difficult to hold network members accountable and almost impossible to voluntarily pool resources over a long period of time (Provan and Milward, 1995, 2001).

The design of a network must deal with two different types of functions. The first function is where two or more organizations work together to provide one service or program (joint production). These relationships require high levels of contact and trust in order to create conditions in which the organizations can count on each other to do their share of the work. A joint production network is difficult to develop and maintain because of the high transaction costs in terms of time and energy. Provan and Milward (2001: 416) also claim that "joint production of services may satisfy clients with multiple needs, but it may also raise substantial problems regarding resource sharing, political turf battles, regulatory differences, and the like." In order for a joint production network to overcome these obstacles, the members must be prepared to put the time and energy into getting to know and trust one another.

The second function is where organizations agree to coordinate services they normally offer in a way that meets the needs of a network plan (joint provision). Each organization is responsible for providing its programs and services in a way that meets

the expectations of the network but do not jointly produce these programs or services. This second function requires planning and coordination but does not require the same level of engagement as the first.

Given the transaction costs, the first type of function is more effectively performed by small, densely connected networks that develop the trust needed to provide joint production activities. The second type of function does not require the same level of connection, so it can be provided by a much larger network of organizations. Both types of networks benefit from the process of working together.

In one of the few studies that directly address network effectiveness, Provan and Milward (1995) determine that the most effective networks are the least likely to have voluntary and horizontal relationships. Their evidence suggests that to be effective in delivering services, networks should centralize control of resources. It also suggests that, to be successful at producing or delivering services, networks need both sufficient resources *and* a means for holding members accountable (Provan and Milward 1995).

The relationship between the longevity of the network role and function, and its success, is also important. Networks can be episodic and short term, or ongoing and longer term.

- Episodic networks are fluid; relevant stakeholders work together as required to solve particular problems. Each successive interaction contributes to enhanced problem solving, a pattern of interactions and incremental trust building. These short-lived networks are intimately connected to the problem needing resolution and serve to strengthen community capacity.
- Longer lasting networks develop deeper connections and trust, and can deal with more complex problems. The focus of these networks has been, as Raab and Milward (2003) describe, to develop connections that allow networks to think through and plan processes for non-routine, non-standardized, or even ill structured problems. The more challenging the problem the more useful long lasting networks are in trying to think it through.

Challenges

Creating and maintaining a network is very difficult. Bardach (1998) points out that “working cooperatively is often much more complicated than it sounds” (p. 306). A major barrier is the problem of scarce resources. Agencies find it difficult to give up control over resources lest their own traditional missions be compromised. Managers will resist putting scarce agency resources into network building because careers are tied up in agencies and hence in the protection of agency autonomy. The larger and more diverse the network the more challenges it faces in ensuring accountability, responsibility and service delivery.

Networks themselves can complicate ways of work. Romzek and Johnston (2005) point out that conditions of instability can seriously complicate the work of contemporary public managers – especially those overseeing services delivered through extensive networks of service providers. Network members/partners have different needs. They may share a common value or vision but have different objectives. Partners from organizations responsible for service delivery, for example, need a network to focus on problem solving, to help them determine the conditions of eligibility, intervention, service maintenance, and working conditions. Those representing organizations that deliver

specialized services need a network to focus on: developing service mechanisms that meet the needs of particular agencies; developing specialized services that meet the needs of clients with complex needs; recruiting and maintaining experts; training; and information sharing outside of the delivery system. And finally those from organizations concerned with the structure and function of the system need to focus on cross sector relationships; the education of people coming into the field; research initiatives; and the identification and support of best practice.

Finally, risk tolerance for relationship building is variable, especially between competing entities. Members of cross sector networks (e.g. from Ministries of Community and Social Services and Health) have to reveal information about their strengths and weaknesses in a way that make them vulnerable. Organizations in this position are often reluctant to be fully open. They believe that by fully sharing information they risk being taken advantage of. Bardach (1998) claims that questions of whether individuals (and agencies) are really working hard in the common enterprise or are faking it, and the question of whether they will take pains to protect another's interest when they might conceivably exploit them, affect the ability of cross sector networks to function successfully (p. 309).

Enablers

Local and regional experience with networks suggests that the things that make a small service-delivering network successful include: strong focused leadership; a shared vision; innovative approaches; shared accountability; and inclusive participation. Stakeholder consultations for community networks of specialized care reveal that small networks are able to problem-solve on critical issues close to home, share resources on the basis of mutual obligations and hold one another accountable because they are intimately aware of what the partners are doing and how much they are contributing to the process.

A sustained commitment to system planning and problem solving requires deep connectivity. The literature on the experience of health networks describes the factors that facilitate the development of Dementia Networks in Ontario. To keep a large network viable over a long period of time, seven factors are needed:

- Inclusive: include relevant stakeholders
- Important: hold a significant mandate
- Investment: members both receive and lend value to the network
- Interdependence: problem resolution is complex and pluralistic
- Integrated: services/outputs combine to create a continuum of services
- Informed: network makes evidence based decisions
- Institutionalized: the network is binding

The success of the Hamilton Hospice and Palliative Care Network confirm the need for infrastructure and tools to support the intent of a Network². Things that make networks successful include having senior leadership at the table to make decisions; MOHLTC participation as a funder at the Steering Committee table; having terms of reference and a work plan with deliverables and timelines; having dedicated resources for a Director to

² Communication with Janet Noble, Director, Hospice and Palliative Care Network, Hamilton. Nov. 21/05

provide leadership; and a sincere willingness on the part of the key stakeholders to make progress on palliative initiatives.

Benefits

The benefits of networks are becoming clear with experience. People who need services benefit from improved access, timely and appropriate information and a wider array of supports. Families and caregivers have better access to information and support. Agencies are more effective and more able to do their jobs, with an understanding of their role and function within a service cluster. Expertise is shared and resources are deployed more effectively. Further, networks can provide access to broad stakeholder groups, and provide a platform for integration.

Networks have their strengths and weaknesses. Generally, networks are very good at:

- Allowing people to get to know each other and sharing information
- Conceptualizing problems holistically
- Identifying problems, planning, and setting priorities
- Presenting ideas and solutions, designing services and programs
- Developing standards, designing evaluation frameworks
- Identifying resources

At the same time, networks, especially larger networks, are not very good at:

- Governing and holding members accountable
- Being accountable to an authority outside of the network
- Sharing responsibility
- Producing and/or delivering services or programs

The design features of the Community Network of Specialized Care for Niagara/Hamilton and South West regions must respond to the strengths and weakness of networks themselves. Bardach (1998) suggests that it is possible to achieve an optimal balance of production/service provision, and systems planning and coordination, by combining sub-unit specialization with larger unit co-operation (p.10). He claims “the optimal combination of specialization and integration must be achieved by some blend of intelligent structural differentiation among sub-units, formal hierarchical coordination and informal working relationships (p. 10).”

The evidence suggests that smaller (less than four or five members), more centrally controlled networks have the greatest likelihood of delivering effective services. Larger, more autonomous networks have greater success in sharing information, developing plans and providing collective analysis. These findings are important for the design of the Community Network of Specialized Care for Hamilton/Niagara and South West regions.

The Network Design

Values and Principles

The creation of a Community Network of Specialized Care (CNSC) is an important regional response to the challenges that exist within the system. The Network is shaped by values and principles, and builds on existing strengths in the system of supports for people with a dual diagnosis. Central to the role and function of the Network are five tenets:

- a) People with a dual diagnosis are citizens and are entitled to safe and supportive accommodation and meaningful activity.
- b) Family caregivers and local DS agencies provide the primary care and support to these people.

The vast majority of this care focuses on the social, emotional and physical care of the person. A stable living environment reduces the occurrence of highly dysfunctional behaviour.

- c) People with a dual diagnosis need to be cared for in their local community.

This limits the disruption to the individual, maintains social networks, strengthens connections to the local service community, and develops local capacity.

- d) The Community Network for Specialized Care (CNSC) builds local capacity.

The CNSC respects existing strengths and builds on existing capacity in the regions. Where ever possible existing systems, structures, collaborations, committees and networks are maintained and become part of the new networks.

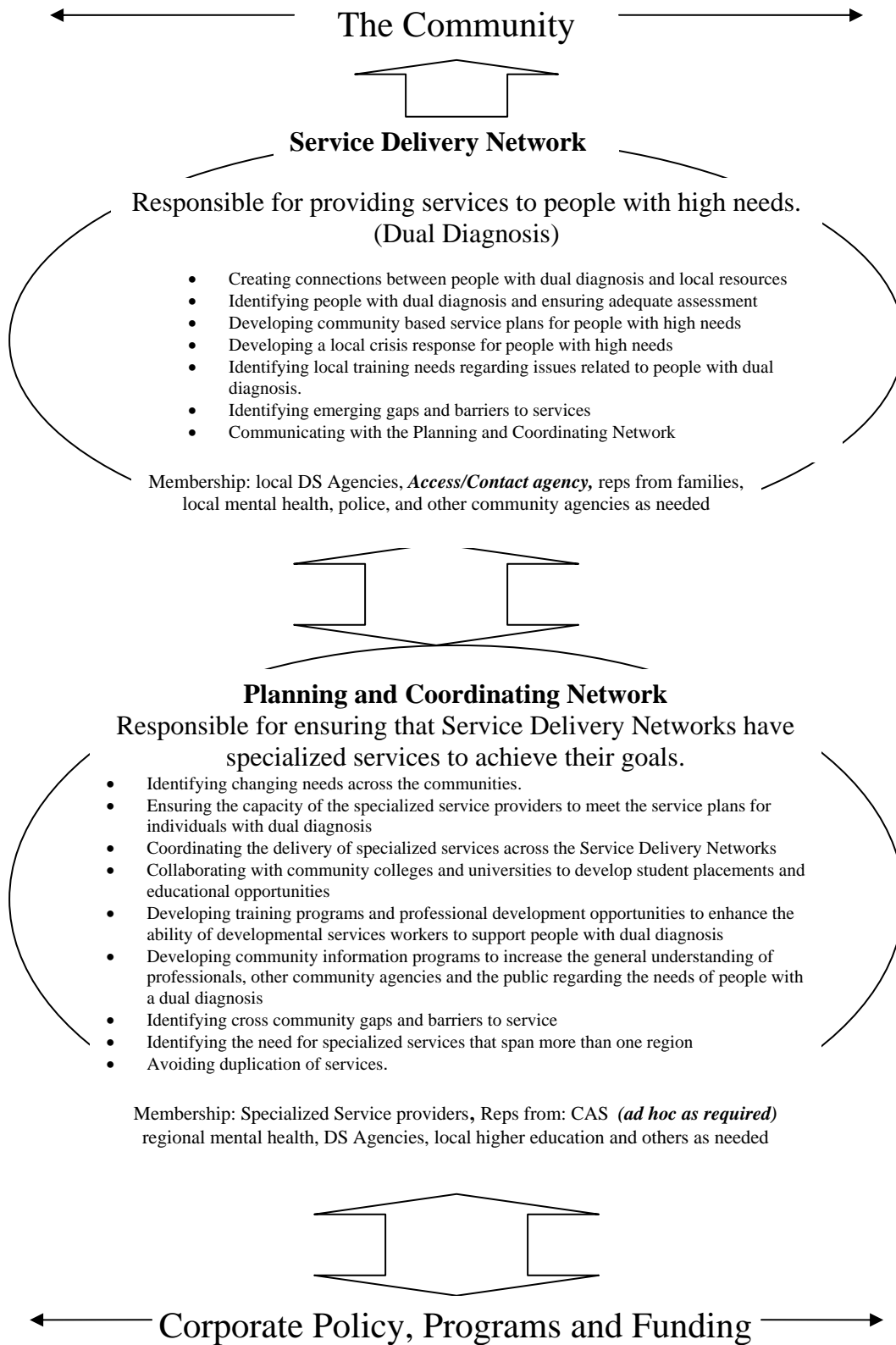
- e) The CNSC is accountable to clients and their families, and funders.

Meeting the needs of people with a dual diagnosis is a joint effort between caregivers (families and agencies) and specialized service providers. The CNSC needs to attend to both the provision of services for these clients and the planning and coordinating of specialized services. At the same time the design of CNSC must take into account the strengths and weaknesses of 'networks' as a vehicle for achieving the MCSS goals. A two tier CNSC is recommended to ensure a systematic approach to the resolution of systems problems. The model builds on the capacity of existing services and structures that support people with a dual diagnosis. As well, it places responsibility for providing, managing, and developing support and services where they are appropriate.

The first CNSC tier is responsible for creating stable conditions for people with dual diagnosis, managing crisis and creating the conditions necessary for delivering specialized services effectively.

The second CNSC tier is responsible for planning and coordinating the delivery of these services. Diagram 1 presents the structure of the two tiers.

Community Networks of Specialized Care



The CNSC needs to attend to both the services required at the local level and the planning and coordinating needs of specialized services. While there are unique functions ascribed to each of the two CNSC tiers, there are members who have a role at both. For instance, the existing case resolution process involves people from the local community, specialized service providers and others as needed. This process should continue involving participation from both levels. In addition, the implementation of short and long term specialised accommodations will require an organization like Bethesda to plan at both the regional and local level to ensure that some services are provided reasonably close to home. Bethesda will need to develop working relationships with local Service Delivery Networks.

First Tier: Service Delivery Network

In the Hamilton/Niagara Region, this tier appears to be a modified case resolution mechanism. In keeping with the values and principles described above, this first tier could be developed with existing structures and resources.

We recommend that a Service Delivery Network be developed at the local level in each community. This approach builds on local capacity that continues to support people with developmental disabilities and coexisting mental health and behavioural issues. The Service Delivery Network brings together local agencies and caregivers so that they may continually review the needs of people with dual diagnosis and develop coordinated ways of addressing emerging issues. In addition to providing services to people with high needs the Network should also be responsible for:

- Creating connections between people with dual diagnosis and local resources
- Identifying people with dual diagnosis and ensuring adequate assessment
- Developing community based service plans for people with high needs
- Developing a local crisis response for people with high needs
- Identifying local training needs regarding issues related to people with dual diagnosis.
- Identifying emerging gaps and barriers to services
- Communicating with the Planning and Coordinating Network

Many communities in the two regions already have mechanisms for dealing with these issues. The intent of this recommendation is not to replace these mechanisms but rather to build upon this strength by providing resources and identifying outcomes so that the networks function more effectively in meeting the needs of the target population. Where such mechanisms do not exist we recommend that they be developed.

Experience with networks suggests that in order to function successfully as ‘service producers and providers’ networks must be tightly integrated. Members of the network should know each other well and develop high levels of trust so that there can be mutual accountability. It may be necessary in larger communities to develop more than one Service Delivery Network. These local networks would need to find ways of communicating; sharing ideas and best practices; and when necessary, sharing resources with other Service Delivery Networks in the community.

Functions and Activities

The Service Delivery Network will be responsible for creating and managing a flexible local safe space designed to support adults in crisis or whose needs exceed current caregiver capacity. The safe space must provide sufficient structure and supervision to ensure a secure environment with as little restriction as possible. This safe environment may be in the person’s home, in a local agency, in specialized temporary

accommodation, or in a local mental health facility depending upon what is appropriate in the local community.

The Service Delivery Network must develop a crisis response team drawn from local staff that can support the individual while they are in the safe space. This team must be trained to cope with aggressive and disruptive behaviour. The team must also have access to specialized services that include stabilization, assessment, specialized clinical intervention, and individualized planning. The model would be similar to the one the RSA has developed with agencies in the South West. The Network would be responsible for providing a safe environment and crisis response and the specialized service providers would provide expert assessment, consultation and clinical interventions.

The Service Delivery Network must also have access to specialized services to meet the longer-term needs of people with dual diagnosis. The specialized services should include treatment interventions and clinical supports to help individuals address their mental health issue(s) and/or challenging behaviour. The interventions should encourage the person to participate in meaningful activities, particularly those that enhance relationship building and social, community living and personal management skills. The Network will work with specialized service providers to determine when the client is able to move back to their family or to permanent community accommodations.

The Service Delivery Network must have access to mental health services for situations that are so urgent and severe that immediate hospitalization is necessary. This requires the development and implementation of local protocols among the Service Delivery Network, emergency mental health response and hospital inpatient services (similar to the one developed in the South West). Shared responsibility for the care and support of the client in crisis may require the trained response team to provide support services within the hospital. Part of the admissions process to the hospital must be a transition plan to move the client back into the community.

The structure of the Networks should be flexible and respond to the service need of the individual and community. The development of local Service Delivery Networks overall will increase fairness and equity in the system. The model offers a process for reaching out to clients and their caregivers so that they can receive services that will allow them to remain in their communities.

Resources

Resources will be needed to ensure the Network meets its goals. Resources include funding for developing safe environments, training and supporting a support team and hiring a Network animator.

Flexible funding is required for the Service Delivery Network to provide a 'safe environment' when a person with a dual diagnosis is in crisis. DS agencies report that 80 to 90% of the care of people with dual diagnosis involves the regular provision of social, emotional and residential needs. By providing for the regular needs, either the family or the agency can limit the severity of disturbing problems. If the problems persist after these needs have been attended to it is an appropriate time to ask for specialized service. When a person experiences episodic crisis, the provision of a safe, secure environment helps to contain injurious behaviour and marks the path for stabilization.

The safe environment will require a team of two specially trained people to provide short-term support to this individual. They would provide this support wherever the person was placed in the 'safe environment'. It is expected that this level of care would only be

needed for 24 to 48 hours. During this period a specialized service provider would be contacted and an intervention strategy developed if one did not exist already.

The Service Delivery Network would also require the part-time services of an Animator to facilitate the development of the Network and relationships among network members. Employed by the lead agency, the Animator would be responsible for supporting the network, developing network capacities, and ensuring the network goals are being met.

Membership

Each local Service Delivery Network would include a small number of members and membership would depend upon existing relationships. Membership could include local DS agencies, representatives from the mental health sector, and possibly police or other service agencies as needed. Similar to the wraparound process, the Network should place the person at the center of their concerns, and include as participants the caregiver and/or family members. Where possible the Network could include either a family physician, or a psychiatrist (or other specialized resources) to help in providing effective interventions.

Lead Agency

Please note that the process will need to be more closely reviewed before implementation. The Facilitator will review when developing the business plan.

The role of the network 'Animators' needs to be clearly defined in the business plan and will be developed within existing available resources, roles, protocols and processes.

A local DS agency will be responsible for facilitating the development of the network. The network would decide who can best play the leading role. The lead agency will fulfill its responsibilities for three years.

The lead Agency will be required to prepare an annual plan that describes how the Service Delivery Network will function, the resources required to achieve their goals and how it will ensure ongoing sustainability.

The lead agencies will have the responsibility of organizing and managing the network, being accountable for the funds it receives from MCSS, administering these funds to meet the goals of the network, and coordinating the efforts of network members. The lead Agency will hire a staff member who will be the part-time network animator and who will be responsible for developing relationships among network partners.

Second Tier: Planning and Coordinating Network

A Planning and Coordinating Network should be developed. The Network should be responsible for ensuring that the Service Delivery Networks have access to the specialized services they need to achieve their goals. The Planning and Coordinating Network would also be responsible for:

- Identifying changing needs across the communities.
- Identifying cross community gaps and barriers to service
- Identifying the need for specialized services that span more than one region
- Ensuring the capacity of the specialized service providers to meet the service plans for individuals with dual diagnosis
- Avoiding duplication of services

- Coordinating the delivery of specialized services across the Service Delivery Networks
- Collaborating with community colleges and universities to develop student placements and educational opportunities
- Developing training programs and professional development opportunities to enhance the ability of developmental services workers to support people with a dual diagnosis
- Developing community information programs to increase the general understanding of professionals, other community agencies and the public about the needs of people with a dual diagnosis

Functions and Activities

The primary function of the Planning and Coordinating Network is to enhance the system's capacity to care for people with a dual diagnosis by collaborating to deliver specialized services.

The Network will develop strategies for the regional coordination of assessment, consultation, clinical and behavioural services, and access to designated specialized accommodations.

The Network will ensure the development of a full range of specialized services. It will work with the local Service Delivery networks to identify emerging needs and gaps and create services and training programs to meet these needs.

The Network will coordinate teaching, education, and training. The network will work with local colleges and universities to provide practicum and placement opportunities for students interested in working with people with developmental disabilities.

The Network will provide information and training to local health and social service practitioners regarding the needs of people with dual diagnosis.

The Network will set priorities for the Network Coordinator and review annual work plans.

Resources

The Planning and Coordinating Networks will require the services of a Network Coordinator. This person would advise and support the functions of the Network; provide orientation and ongoing information to network members; develop and maintain the network's business plan; prepare an annual report for the network members; organize and support an annual (joint regions) planning and coordinating network conference; work with the Service Delivery Network animators to create linkages with these networks; and disseminate information about the network.

The Network Coordinator will receive directions from the Network but be employed by and accountable to the lead organization.

The JIT suggests that one Administrative Network Coordinator share the role for both regions. This can be further defined during the business case phase of this initiative.

The Planning and Coordinating Network will also require financial resources to support network functions, including planning for future client needs, and performance monitoring.

Membership

The Planning and Coordinating Networks in Hamilton/Niagara and the South West Regions will build on the capacity and membership of existing regional initiatives. In the Hamilton/Niagara Region, the Network will build upon the Clinical Coordination Network membership. In the South West the Network will be built upon the South West Region Dual Diagnosis Advisory Committee. The intent is to avoid duplicating existing networks.

The feasibility of building upon the CCN in Hamilton/Niagara and the DDAC in South West Region needs to be determined as part of the business case/implementation plan.

Membership should include:

- Developmental Service Agencies (small number of representatives)
- Specialized DS services
- Community based clinical services
- Mental Health services (related to dual diagnosis)
- Regional Treatment Programs
- College and/or University representative (with programs related to developmental disabilities)

Lead Agency – CNSC Lead

The recommended CNSC lead in each Region should be a Developmental Service provider from the membership of CCN and DDAC.

JIT members agree that the CCN and DDAC are the appropriate existing forums to assume CNSC co-lead responsibilities. The Hamilton/Niagara Regional Office and the CCN will jointly recommend the service provider agency that will function as the CNSC co-lead. The South West Regional Office and the DDAC will jointly recommend the service provider agency that will function as the CNSC co-lead.

The lead agency can be identified in either of two ways. The group from among which the lead agency is selected can agree among themselves on the choice, or, the Implementation Advisory Committee can invite expressions of interest from among the eligible leads and appoint the lead agency.

The lead agencies will have the responsibility of: organizing and managing the network; being accountable for the funds it receives from MCSS; administering these funds to meet the goals of the network; and coordinating the efforts of network members. This lead organization must be able to take responsibility for hiring and supervising the Network Coordinator.

Planning and Coordinating Networks Working Together

Collaboration between the two regional networks is critical to promote equity and fairness across the Hamilton/Niagara and South West Regions. We recommend four initiatives:

The feasibility of these recommendations must be tested in the development of the business plan.

In addition, an evaluation phase must be included in the implementation plan.

First, there should be an annual meeting between the two regional Networks. This meeting should provide an opportunity for network members to share information, best practices, challenges and opportunities for future development.

Second, the two Networks could meet to develop a coordinated plan they share with other Community Networks of Specialized Care to: identify research needs and priorities; collaborate on research activities; and present research results related to specialized care, clinical interventions, case management and service coordination etc.

Third, the Lead agencies from both regions should meet regularly, share information, and work together to develop annual business plans. These meetings could provide an opportunity to examine how the Networks could develop joint research projects or share research findings.

Finally the Network coordinators should meet regularly to discuss the best ways of strengthening the planning and coordinating functions for the best outcomes.

JIT members believe that it is imperative that the co-leads work collaboratively at every opportunity. Network co-leads must work on common objectives to achieve the outcomes of a cross-regional implementation plan. In keeping with the intent of the CNSC initiative there must be an opportunity to build the necessary relationships between the regions in order to achieve the goal of a single cross-region Community Network of Specialized Care.

Provincial Enablers for the Community Network of Specialized Care

There are a number of systemic issues that must be dealt with by MCSS at the provincial level to allow the Community Network of Specialized Care to be effective at the regional and local levels. These include the following issues:

- Providing increased resources to relieve pressures within the system.
The system needs to develop additional residential spaces in order to reduce the waiting lists. This in turn would allow for more appropriate placements resulting in less disruptive behavioural issues. It also needs to develop more day programs. People with mental health and behavioural problems need safe and secure places to spend their time.
- Providing additional wage support to the system in order to attract and hold workers.
This would result in less staff turn over and burn out and would ensure that there are enough trained workers to manage the challenges of people with mental health and behavioural problems
- Negotiating intergovernmental agreements regarding cross sector service provisions particularly between MCSS and MOHLTC.
This would lead to a more functional relationship between these two service providers and others providing services to people with dual diagnosis.
- Developing plans and processes for attracting new employees into the field by encouraging professional bodies to develop a specialty in the field of developmental disabilities.

- Ensuring research on new practices by creating a funding mechanism to encourage research in the field and developing a centre of excellence to promote best practices.
- Developing effective educational programs that meet the needs of new professional in the field by encouraging universities to develop specialized education programs related to dual diagnosis.
- Creating a rights based agenda by introducing legislation that defines program and service rights of people with developmental disabilities and mental health or behavioural problems.
- Establishing service targets based on the number of people with dual diagnosis to ensure fair and equal access to programs and services across the province.

The resolution of these issues will have a dramatic effect on the ability of the system to deal with the challenges related to people with dual diagnosis. Resolving any of these issues would make the system more effective and less stressful. It is important however not to wait for these issues to be dealt with before attending to local problems and challenges.

Summary

The developmental services sector has a long history of fighting for the rights of people with developmental disabilities and providing programs and supports for people with dual diagnosis. Since the commitment to create community based services in the 1960s, the developmental service system has found ways to integrate people with developmental disabilities and dual diagnosis into the mainstream community. Local development service agencies along with their boards and family supporters have advocated for the social integration of people with developmental disabilities so they may participate fully in the social and economic life of the community. Since 1974 MCSS has provided support and resources to the development of this sector.

Families continue to be the primary care givers to people with developmental disabilities and coexisting mental health and behavioural problems. When conditions become unmanageable they call for assistance from DS agencies or specialized providers and when these are not available they turn to the police or hospital emergency rooms for help. Families are an important resource in meeting the needs of people with a dual diagnosis.

At the same time DS agencies have developed considerable experience in dealing with and managing the problems of people with a dual diagnosis. They have created residential and social supports that allow the vast majority of these people to live in the community. They achieve this by ensuring that their staff have adequate training to meet the challenges of people with high needs. They are however unable to do this alone. They draw upon the skills and expertise of a number of organizations who have developed either out of the institutional sector or in the local communities to provide specialized services to people with mental health and behavioural issues. These organizations respond to requests from families or local DS agencies by developing an array of programs and services meant to meet the complex needs of people with dual diagnosis. They have developed multidisciplinary teams of professionals including behaviour therapists, social workers, nurses, psychologists and others who work together to provide effective services.

The developmental sector has matured into a highly integrated system of services. Agencies participate in networks to deal with the complex needs of people with dual

diagnosis; these include Dual Diagnosis Committees, Case Resolution teams, specialized training programs, annual conferences and the development of cross sector networks with mental health, justice and educational organizations. The result has been a significant increase in the capacity of the developmental service sector's ability to deal with the problems and challenges of meeting the needs of people with developmental disabilities.

In the last year the government has identified a plan to transform developmental services and strengthen specialized care for individuals with a developmental disability and a coexisting mental health or behavioural issue. They have committed resources to providing better access to services for adults with developmental disabilities by strengthening community-based services for those who require specialized care. They are also developing plans for recruiting and retaining more professionals, strengthening clinical services and creating new places where individuals with very high care needs can live and get the intensive support they require.

The recommendations and suggestions contained within this Regional Solutions Report build upon these strengths.

Bibliography

- Agranoff, Robert & McGuire, Michael. 2001. Big Questions in Public Network Management Research. *Journal of Public Administration Research and Theory*, 11(3) July: 295-326.
- Bardach, Eugene, 1998. *Getting Agencies to Work Together: The Practice and Theory of Managerial Craftsmanship*, Washington: Brookings Institution Press.
- Gilchrist, Alison, 1995. *Community Development and Networking*. Great Britain: Community Development Foundation.
- Hill, Carey. 2002. *Network Literature Review: Conceptualizing and Evaluating Networks*. Southern Alberta Child and Youth Health Network.
- Lunsky, Y., & Bradley, E. (2001). Developmental disability training in Canadian psychiatry residency programs. *Canadian Journal of Psychiatry*, 46(2), 138-143.
- Mays, G. P., P. K. Halverson and A. D. Kaluzny. 1998. "Collaboration to improve community health: trends and alternative models" *Joint Commission on Quality Improvement* 24(10) October, pages 518-540.
- O'Toole, Laurence J., Jr. 1997. Treating Networks Seriously: Practical and Research-Based Agendas in Public Administration. *Public Administration Review*, 57(1) January/February: 45-52.
- O'Toole, Laurence J., Jr. and Kenneth J. Meier. 1999. Modeling the impact of public management: Implications of structural context. *Journal of Public Administration Research and Theory*. 9 (4) 505-526.
- Provan, Keith G., and H. Brinton Milward. 1995. A preliminary theory of interorganizational network effectiveness: A comparative study of four mental health systems. *Administrative Science Quarterly* 40: 1-33.
- Provan, Keith G., and H. Brinton Milward. 2001. Do networks really work? A framework for evaluating public-sector organizational networks. *Public Administration Review* July/August Vol. 61, No. 4.
- Raab, Jorg and H. Brinton Milward, 2003. Dark networks as problems, *Journal of Public Administration Research and Theory*, Vol. 13, no. 4, pp. 413-439.
- Romzek, Barbara and Jocelyn M. Johnston, 2005. Networks, Stability, Management, and Performance: Learning from Social Welfare Contracts. Prepared for the 2005 Conference of the Public Management Research Association, September 29-October 1 University of Southern California, Los Angeles, CA

Addendum

April 12, 2006

The following decisions have been made:

There will be one Planning and Coordinating Network across the two regions

Regional Support Associates (RSA) and Bethesda Community Services will act as the lead organizations for the development and management of the Network. They will act jointly and separately in providing leadership and services in meeting the goals of the Network.

The Advisory Committee has met and received the Regional Solutions Report.

The South West Dual Diagnosis Advisory Committee and the Hamilton Niagara Clinical Coordinating Network has met and received the Regional Solutions Report