FIRST STRATEGY
Fast Intervention Risk Specific Teams

CHATHAM-KENT'S FAST INTERVENTION RISK SPECIFIC TEAMS
FINAL EVALUATION REPORT

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To the human service professionals leading
collaborative risk-driven intervention in Chatham-Kent,
thank you for all that you contributed to this evaluation process.

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EXECUTIVE SUMMARY

ABOUT FIRST	Launched in February of 2016, Chatham-Kent's *Fast Intervention Risk Specific Teams* (FIRST) *Strategy* provides an opportunity for human service providers to mitigate risk before harm occurs. On an ad hoc basis, members of FIRST detect risk, share limited information, plan rapid interventions, and mobilize appropriate services around individuals/families in situations of acutely-elevated risk. FIRST represents Canada's first ad hoc adaptation of the conventional Hub Model of collaborative risk-driven intervention.
EVALUATION PURPOSE	The purpose of this evaluation is to provide some preliminary understanding of the strengths, weaknesses, challenges, benefits, appropriateness, satisfaction, and potential improvements for Chatham-Kent's FIRST Strategy.
METHODOLOGY	A mixed-methods approach was used to gather data between May and November 2016. This included analysis of quantitative data from the *FIRST Discussion Database* and the *Services Mobilized Toolkit*; as well as interviews with 1 client, 18 team members, and 6 Steering Committee members.
QUANTITATIVE RESULTS	Since launching in February, 2016, FIRST received 13 referrals and accepted 12 of those referrals. Most clients were under 25 years of age, 8 were male, 5 were female. The main risk factors affecting clients were mental health, criminal victimization, drugs, emotional violence, basic needs, alcohol and criminal involvement. Most clients had a fairly high complexity of risk, with most presenting more than 10 risk factors. The most common sectors mobilized to support clients included mental health, victim support, housing, and income assistance. The most common reason services were not mobilized was *refusal of services*.
QUALITATIVE RESULTS	According to interview respondents, FIRST opens up new opportunities for service access; enhances the already strong collaborative network in Chatham-Kent; bridges longstanding communication divides between agencies; allows human service providers to become more preventative; motivates partner agencies to increase their capacity; covers service gaps; and reveals hidden systemic issues affecting client access to services.
STRENGTHS	There is shared ownership among the partners; the members see it as bringing added value to their day to day work; there is strong discipline and guidelines that protect privacy; the ad hoc approach provides opportunities to mobilize team members more rapidly than a fixed-meeting approach; and the ad hoc approach saves time for agencies not involved in the discussion. Part of FIRST's success so far can be attributed to having a hired coordinator; members with the authority to make decisions; and instant access to information.
REMAINING CHALLENGES	FIRST has no mechanism for members to report back on intervention outcomes; there is limited collaboration in the actual deployment of interventions; the ad hoc model limits opportunities for team members to build relationships and knowledge of one another; the situations brought so far have been generally chronic high risk as opposed to newly elevated risk; their remains uncertainty on the role of consent; the training did not prepare team members adequately for immersion in the ad hoc model; the ad hoc approach may limit the team's collaborative risk detection capabilities; and periodic on-demand meetings do cause members to abandon what they are currently working on at their home agency.
IMPROVEMENT	Develop mechanism for report-back; involve more members in closure stage; educate home agency staff on purpose and process; improve early risk detection; provide opportunities for team members to build relationships and awareness of one another; ensure all appropriate sectors are represented on FIRST; deploy multi-sector not single-sector interventions; identify collective capacity to sustain the costs of FIRST; develop a process for team members to communicate systemic issues to upper management in their organizations.

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1.0 INTRODUCTION

To improve community safety and well-being in Chatham-Kent, ON, various human service agencies collaborated around the development and implementation of the community's FIRST (*Fast Intervention Risk Specific Teams*) Strategy. At its core, FIRST is a multi-sector group of frontline human service professionals, who through a disciplined process of risk detection and information-sharing, rapidly mobilize an intervention around individuals and families before crisis occurs. Each partner agency has the opportunity to detect risk and request deployment of the team. A central coordinator of FIRST helps streamline communication and facilitate the processes of risk detection, information sharing and collaborative intervention. The immediate goal of FIRST is risk reduction through service mobilization.

As major partners to FIRST, Chatham-Kent Police Service secured funding to develop, implement and evaluate FIRST. With Family Service Kent serving as the accountable partner and equal stakeholder in FIRST, both Chatham-Kent Police Service and Family Service Kent reached out to the *Global Network for Community Safety* to conduct an evaluation of Chatham-Kent's FIRST Strategy. Although the FIRST partners realized that their initiative was still quite new (and in development) when the evaluation process started, they wanted to use the evaluation as an opportunity to identify weaknesses and improve their application of the model sooner, rather than later. This report serves as the final deliverable in a preliminary evaluation of FIRST conducted between March and November, 2016.

The next section in this report provides some background context on FIRST, as well as on the Hub Model of collaborative risk-driven intervention that FIRST is based on. Following this, is a review of existing evaluation literature on collaborative risk-driven intervention. The fourth section of this report summarizes the consultation process initiated to involve community stakeholders in the design of this evaluation. Driving the methodology (sixth section) of this evaluation are some main evaluation questions presented in section five. The seventh section of the report presents the different evaluation activities that occurred leading up to this report. Next, the results and discussion of findings present what has been learned through this evaluation process. Following the conclusion and limitations of this report, is a proposal of recommendations for FIRST partners to consider moving forward.

The intent of this report is not to be conclusive, nor summative. Rather, it largely represents an exercise in process evaluation designed to generate formative observations that will be helpful for FIRST partners moving into the future. Although several outcomes of FIRST are discussed in this evaluation, additional evidence is required to confirm actual impact of the initiative. Very apparent in this evaluation are two main themes: the strengths and weaknesses of the ad hoc approach, and how FIRST's ad hoc approach compares to conventional applications of the Hub Model (e.g. regularly-scheduled meetings).

2.0 BACKGROUND

Chatham-Kent's FIRST Strategy originated out of a cross-sector meeting among community safety and well-being stakeholders in February of 2015. During that meeting, participants discussed the high potential for collaborative risk-driven intervention to be an effective tool for reducing risk and averting harm in Chatham-Kent (FIRST, 2016). Preliminary evaluations of the Hub Model (Nilson, 2014), along with efforts to help Ontario communities adopt collaborative risk-driven intervention initiatives (Russell & Taylor, 2014a), increased the already growing appetite for such collaborative measures in Chatham-Kent.

The Hub Model

At the time of the meeting, the leading application of collaborative risk-driven intervention in Canada was the Hub Model. Designed and first implemented in Prince Albert, Saskatchewan, the Hub Model is "an evidence-based collaborative problem-solving approach that draws upon the combined expertise of relevant community agencies to address complex human and social problems before they become policing problems" (McFee & Taylor, 2014:2).

As the first evaluation of the Hub model in Canada describes:

> *The Hub is structured as a venue for human service professionals from a variety of human service disciplines, to meet and collaborate on interventionist opportunities of addressing situations of acutely-elevated risk. The Hub itself is inherently risk-driven, and lends itself to both secondary and tertiary efforts of prevention. The Hub meets Tuesday and Thursday mornings for up to 90 minutes each day. The focus of these meetings is to identify complex risks of individuals or families that cannot be addressed by a single agency alone. When situations are brought to the table by one of the partner agencies, the appropriate human service professionals become engaged in a discussion, which results in a collaborative intervention to connect services and offer supports where they were not in place before. The goal of the Hub is to connect individuals-in-need to services within 24 to 48 hours.*
>
> (Nilson, 2014:9)

Since the launch of the original Hub Model in 2011, dozens of communities across Canada have replicated these efforts (Kalinowski, 2016). Known generically as *Situation Tables* in Ontario, at least 30 communities have either launched or are preparing to launch a collaborative risk-driven initiative of their own in the province (Russell & Taylor, 2015).

While discussing application of the conventional Hub Model in Chatham-Kent, several service providers reflected on what they had learned of the model through other adopter communities in Ontario. Stakeholders in Chatham-Kent felt that, for a number of reasons, an ad hoc approach to collaborative risk-driven intervention would better suit their community's needs than would a conventional pre-scheduled Hub/Situation Table, which typically meets once or twice a week[1].

[1] One reason justifying an ad hoc approach to the Hub Model was the lower level of aggregate risk in Chatham-Kent. Another reason is because Chatham-Kent has an active police and mental health intervention unit which responds to a lot of high risk situations. A third reason is because of the small size of Chatham-Kent, combined with Chatham-Kent being a single-tier service delivery system, collaboration has been a long-standing practice among the human services (e.g. case management, VTRA).

In formalizing the operational process of an ad hoc approach in Chatham-Kent, the FIRST partners stuck to the main principles of the Hub Model. These principles include *the protection of privacy*, *multi-agency commitment of resources to the process*, *collaboration in risk detection and intervention*, and being an *action-based* initiative (Nilson, 2016a). Within their Terms of Reference, partners to the FIRST Strategy also committed to adopting two critical components of the Hub Model: The *Four Filter Process* and *acutely-elevated risk* (FIRST, 2016).

With respect to the former, the Four Filter Process is described in recent evaluative work on a Hub Table in Alberta (Nilson, 2016b:20):

> *The first filter involves the originating agency exhausting all options currently available within their own agency, to meet the needs of the client. The second filter is the actual consideration of the four elements of acutely-elevated risk. Once acutely-elevated risk is determined, the table moves to filter three. This is where basic identifiable information is shared about the individual or family for the purposes of triggering any additional agency involvement. Finally, the fourth filter is a separate discussion among those agencies suggested by the table to participate in the intervention. During this discussion, participants share additional information about the situation and plan their intervention.*

Regarding the latter, acutely-elevated risk is "deliberately distinct from other operating thresholds that might trigger a much more limited range of unilateral response and enforcement options by one or more of the agencies involved, often characterized by common terms such as crisis, imminent danger, violent threat, or criminal activity in progress" (Russell & Taylor, 2014b:19). In practice, there are four elements of acutely-elevated risk. These include a *significant interest at stake*, *probability of harm occurring*, *severe intensity of harm*, and *multi-disciplinary nature of elevated risk* (Nilson, 2014).

Fast Intervention Risk-Specific Teams (FIRST)

Chatham-Kent's adaptation of the conventional Hub Model does away with regularly-scheduled meetings among team members. Instead, when a situation of acutely-elevated risk is detected by one of the partner agencies, that agency's FIRST representative will review de-identified details with the FIRST coordinator. Following this, the coordinator will invite team members to engage in a Filter Two conference call discussion. Following that, most of the regular practices in the Hub Model of collaborative risk-driven intervention come into play.

To help guide their members in this ad hoc approach, some key steps have been designed to makes sure that communication, planning and deployment of a multi-sector intervention can occur (FIRST, 2016). These include:

1) Human service providers that detect elevated risk in a client complete an *Internal Referral Form* that captures basic information about the client, their situation, risk factors, consent status, and whether they feel this situation meets the threshold of acutely-elevated risk. This constitutes Filter One.

2) The originating agency provides a de-identified summary of the situation and risk factors to the FIRST Coordinator, who then completes a brief review of the situation. If the situation appears that it might not meet the threshold of acutely-elevated risk, or more work could have been done at the home agency, the originating agency is encouraged to revisit the situation

internally. If the coordinator identifies a potential for acutely-elevated risk, she and the originating agency submit a *Situation Description* form to the FIRST partner agencies. This form provides de-identified information on the situation, risk factors and what agencies should be involved in the discussion.

3) In reviewing the Situation Description, agencies that had not been suggested for the intervention team, have an opportunity to suggest their agency's involvement in the situation. At this time, the responding agencies also identify whether they will join the meeting in person or by teleconference.

4) Within 24 to 48 hours, the *Risk Specific Team* (involving only "relevant" agencies) meets to review the situation and risk factors. This constitutes Filter Two. If the team unanimously decides that the situation meets the four elements of acutely-elevated risk, then they move to Filter Three—where limited information about the client, including their identity is shared.

5) Once the Risk-Specific Team becomes more familiar with the client's needs, they identify the lead and assisting agencies that will participate in the intervention. At this time, the remaining agencies not relevant to the discussion, leave the meeting. Following this, those agencies identified to be involved in the intervention, move to Filter Four.

6) At Filter Four, the relevant agencies discuss client needs further. They then plan the logistics of their intervention and deploy the intervention.

7) After the intervention, the lead agency reports back to the coordinator on the status of the situation, including the intervention team's latest view of the situation. If within 7 days the coordinator does not hear from the lead agency, she will contact the lead agency and request a de-identified update.

8) Situations are closed when risk is lowered, where services are put into place, or where the client has refused services or is unreachable.

During this process, it is the responsibility of agencies to keep their own notes on the intervention. Agencies not involved in the situation are asked not to take notes. The only data gathered by the coordinator during this process are de-identified data on client risk factors, age cohort, gender and which agencies are involved in the intervention.

Although FIRST is an ad hoc application of collaborative risk-driven intervention, members of FIRST had planned to meet regularly to discuss process, challenges, opportunities and strategy. During the first few months, these meetings were instrumental in building partner awareness of the process, familiarity with one another's services, and collegiality among team members. Additional collaboration and interaction also occurs at monthly meetings of the FIRST Implementation Committee, and quarterly meetings of the FIRST Strategy Steering Committee (FIRST, 2016). To illustrate the diversity of agency members of Chatham-Kent's FIRST Strategy, Table 1 identifies each agency by their role in FIRST.

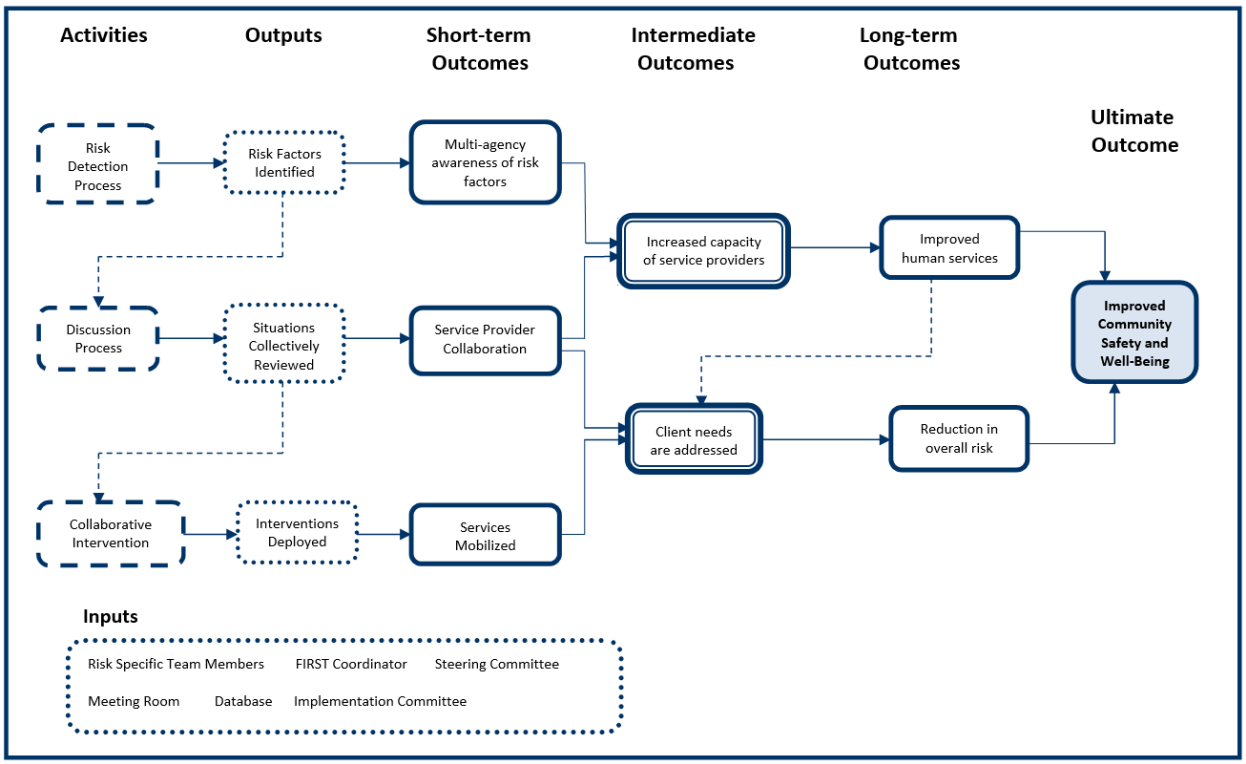
Table 1. **FIRST Strategy Partners by Agency and Role**

MEMBER AGENCY	RISK SPECIFIC TEAMS	IMPLEMENTATION COMMITTEE	STEERING COMMITTEE
Adult Language and Learning	●	●	
Alzheimer's Society	●	●	
Canadian Mental Health Association	●	●	
Chatham-Kent Building and Enforcement	●	●	
Chatham-Kent Children's Services	●	●	
Chatham-Kent Community Health Centre	●	●	
Chatham-Kent Employment and Social Services	●	●	●
Chatham-Kent Fire and Emergency Services	●	●	●
Chatham-Kent Health and Family Services	●	●	●
Chatham-Kent Housing Services	●	●	
Chatham-Kent Not for Profit Network	●	●	●
Chatham-Kent Police Service	●	●	●
Chatham-Kent Police Service's Board		●	
Chatham-Kent Victim Services	●	●	
Chatham-Kent Women's Centre	●	●	
Erie St. Clair LHIN*	●	●	●
Family Service Kent	●	●	
Lambton-Kent School Board	●	●	
Medavie EMS	●	●	
Municipality of Chatham-Kent	●	●	
Salvation Army	●	●	●
St. Clair Catholic School Board	●	●	●
Union Gas			●
United Way of Chatham-Kent	●	●	●

* FIRST is in the process of inviting agency to Steering Committee.

To summarize the design and intended impact of Chatham-Kent's FIRST Strategy, a logic model has been developed (see Figure 1). The intent of a logic model is to illustrate the required inputs of an initiative, followed by the expected activities, outputs and outcomes of that initiative. In the case of FIRST, with improved community safety and well-being as the ultimate outcome, the key long-term outcomes are risk reduction and human service improvements. These are generated by two intermediate outcomes: increased capacity of human service providers and client needs being addressed. Within the evaluation period, the more measurable outcomes are services mobilized, service provider collaboration and awareness of risk.

Figure 1. **FIRST Logic Model**



3.0 REVIEW OF EVALUATION LITERATURE

Since the launch of the original Hub Model in 2011, several evaluations on collaborative risk-driven intervention initiatives have been conducted. Lessons learned through these inquiries, help to inform future measurement and monitoring of the Hub Model of collaborative risk-driven intervention. They also contribute to our collective understanding of the model's capacity to improve community safety and well-being.

The first evaluation of the Hub Model (Nilson, 2014) took a rather wide-sweeping approach, from multiple perspectives, to fully examine this new innovation in collaborative risk-driven intervention. Extensive interviews, passive-observation, and data collected at the Hub Table, were all used to generate some early understandings of the model's key principles, design, function, key ingredients, strengths, challenges and opportunities for improvement. Following this evaluation of the Hub in Prince Albert, SK, other evaluations of collaborative risk-driven intervention were conducted in several Ontario communities, including Toronto (Ng & Nerad, 2015), Brantford (Babayan et al., 2015), Kitchener (Brown & Newberry, 2015), Guelph (Litchmore, 2014), Ottawa (Lansdowne Consulting, 2016), Cambridge, (Brown & Newberry, 2015) and Barrie (Nilson, 2016c).

Within nearly all of these evaluations, mixed-methods approaches were implemented to gather data and deliver key findings. Examples of these methods include interviews (Nilson, 2016b; Brown & Newberry, 2015), focus groups (Babayan et al., 2015; Ng & Nerad, 2015), surveys (Brown & Newberry, 2015; Lansdowne Consulting, 2016), observations (Ng & Nerad, 2015; Nilson, 2014), and case studies (Ng & Nerad, 2015, Nilson 2014). While most data sources for these evaluations are either human service providers or data captured at the Hub/Situation Table, a few evaluations (Brown & Newberry, forthcoming; Nilson, 2016d) have attempted to gather data directly from clients who are the focus of collaborative risk-driven intervention. Unfortunately, gathering data from clients has not been easy (Babayan, et al., 2015; Newberry & Brown, 2015; Nilson, 2016d). However, as others point out (Nilson, 2016e), there is a real need for data from clients to be included in the ongoing measurement and monitoring of collaborative risk-driven intervention.

One consistent data source used not only in the above-referenced evaluations, but in other analytical reports on Hub/Situation tables (Gray, 2016; Lamontagne, 2015; North Bay Parry Sound District Health Unit, 2015; Nilson, 2015a; Winterberger, 2014), has been the *Hub Database*[2]. Originally created by Nilson, Winterberger & Young (2015) for the Prince Albert Hub, the Hub Database is now used Canada-wide to track de-identified information on risk factors, demographics, agency involvement, intervention actions, and systemic issues. Many evaluations (Babayan, Landry-Thompson & Stevens, 2015; Brown & Newberry, 2015; Lansdowne Consulting Group, 2016; Litchmore, 2014; Ng & Nerad, 2015; Nilson, 2014; Nilson 2016c; Nilson 2016d) use data from this database to describe the achieved target group of the initiative they are evaluating.

Overall, the evaluation and analytical literature on the Hub Model of collaborative risk-driven intervention has been quite positive (Nilson, 2016e). Some early outcomes reported in the evaluation literature include increased service access (Nilson, 2014); clearer determination of client needs (Babayan et al., 2015); improved communication among agencies (Ng & Nerad, 2015); reduced barriers to support

[2] In adopting the original "Hub Database" from Saskatchewan, the Ontario Ministry of Community Safety and Corrections uses the term "Risk-Driven Tracking Database" for its collection of data from Situation Tables.

(Brown & Newberry, 2015); improved client-service provider relations (Nilson, 2016d); and increased efficiencies in human service delivery (Lansdowne Consulting, 2016). In addition to these findings, other evaluations show promise for the model's application in large urban areas (Ng & Nerad, 2015), small urban areas (Babayan et al., 2015), and rural communities (Nilson, 2016b). As existing measurement frameworks on collaborative risk-driven intervention suggest (Nilson, 2015b), future evaluations may soon inform us on service engagement, mobilization, collaboration, and a multitude of community safety and well-being outcomes.

Although the evaluation literature on collaborative risk-driven intervention is still growing, there is a lot that can be learned from past experiences in measuring and monitoring Hub/Situation tables. Unique to this evaluation, is that Chatham-Kent's FIRST Strategy is a one-of-a-kind, first-in-Canada ad hoc adaptation of the conventional Hub Model. Therefore, this evaluation itself, may very well contribute something new to our overall understanding of collaborative risk-driven intervention.

4.0 STAKEHOLDER CONSULTATIONS

To build interest, ownership and engagement for the evaluation process, FIRST stakeholders were approached to participate in an evaluation consultation process held in March of 2016. During the consultations, members of FIRST, FIRST Strategy Steering Committee and FIRST Implementation Committee, met with the evaluator to discuss their interests, questions, and hopes for the evaluation process. These consultations also provided an opportunity to discuss data availability, data collection capacity, and the general scope and parameters of the evaluation.

The result of the consultation process was an informed understanding of what FIRST stakeholders would like to learn through the evaluation process. As Table 2 highlights, FIRST stakeholders had a number of questions and interests around activities, process and outcomes.

Table 2. **Evaluation Topics of Interest Mentioned by FIRST Stakeholders**

EVALUATION TOPICS	
Client access to services	Barriers affecting service access
Service response leveraged through collaboration	Proper membership in FIRST
Agency satisfaction with FIRST process	Impacts of collaboration
Expected outcomes of FIRST	Agency risk detection
Benefits of FIRST to agencies	Changes in service practices
Benefits of FIRST to professionals	Agency understanding of risk
Benefits of FIRST to clients	Efficiencies of FIRST
Risk trends in the community	Changes in service demand
Rapid response of team	Agency understandings of one other

5.0 EVALUATION QUESTIONS

Based upon the consultation process with FIRST stakeholders, common practices in evaluating collaborative risk-driven intervention (Brown & Newberry, 2015; Lansdowne Consulting, 2016; Nilson, 2014; Ng & Nerad, 2015), and the scope and parameters of the current evaluation, the following questions were drafted for the evaluation of Chatham-Kent's *Fast Intervention Risk Specific Teams*:

- How has FIRST fostered collaboration among human service providers?
- What service mobilizations are attributable to the FIRST collaboration process?
- How efficient is FIRST between initial risk detection and actual intervention deployment?
- What is the impact of FIRST on agency-to-agency relationships?
- Is there a genuine sense of shared ownership among FIRST partners?
- Are clients satisfied with their experience with FIRST?
- Are human service providers satisfied with their experience in FIRST?
- What are the advantages of implementing an ad hoc model of collaborative risk-driven intervention?
- What are the disadvantages of implementing an ad hoc model of collaborative risk-driven intervention?
- What have been the challenges in implementing FIRST?
- What are some opportunities to improve FIRST in Chatham-Kent?

6.0 METHODOLOGY

To answer the questions driving this evaluation, a mixed-methods approach was required. Mixed-methods approaches have been common in evaluating collaborative risk-driven intervention initiatives in Ontario (Babayan et al., 2015; Brown & Newberry, 2015; Ng & Nerad, 2015; Nilson, 2016d), Saskatchewan (Nilson, 2014), and Alberta (Nilson, 2016b).

Part of the methodology involved interviews with members of FIRST, the Implementation Committee and the Steering Committee[3]. Respondents were interviewed individually and/or in groups after providing informed, voluntary consent. In total, 18 individual interviews were conducted in-person and 2 were conducted over the telephone. In addition, a group interview was conducted with 6 members of the Steering Committee. In total, 24 individuals were interviewed for this evaluation[4]. Responses to interviews provided qualitative data on satisfaction, process, impact, benefits, challenges, and opportunities for growth.

Another part of the evaluation involved analysing the ongoing reporting data captured by FIRST during and after the discussion process. Like many other collaborative risk-driven initiatives in Ontario, Alberta, British Columbia and Prince Edward Island, FIRST adopted the original *Hub Database* developed in Saskatchewan. This database captures data on risk factors, gender, age, agency involvement and reasons for discussion closure (Nilson, Winterberger & Young, 2015). The Hub Database is a performance monitoring tool used to help collaborative risk-driven intervention tables maintain consistency and discipline, while also gathering important operational and evaluation data (Nilson, 2015b). Analyses of these data were used to explain FIRST's achieved target group during the evaluation period.

A third part of the evaluation involved the implementation of a *Services Mobilized Tracking Tool*. Created by Global Network for Community Safety, this tool gathers de-identified data from lead agencies on the extent to which clients have been informed, connected or engaged in services, during or shortly after an intervention. The collaborative context in which these services were mobilized is also a key feature of the tracking tool.

Finally, one voluntary, anonymous interview was conducted with a past intervention subject to offer a glimpse into the experience of a collaborative risk-driven intervention from the perspective of the client. Topics covered with that client included satisfaction, perception, impact and service engagement.

To illustrate the different components of this methodology, Table 3 offers an evaluation matrix that identifies the indicator, collection method and data source for each variable in this evaluation. The implementation of this evaluation methodology was largely dependent upon the participation, cooperation and support of FIRST members, Implementation Committee members and Steering Committee members.

[3] Hereafter, both committees are referred to as the Steering Committee.

[4] Two members of the Steering Committee were interviewed individually as well as in the full group setting.

Table 3. **Evaluation Matrix for Chatham-Kent FIRST Strategy**

VARIABLE	INDICATOR	COLLECTION METHOD	DATA SOURCE
Risk Awareness	risk factors detected	FIRST Discussion Database	FIRST Coordinator
Agency Collaboration	improved communication	interviews	team members, Implementation Committee members, Steering Committee members
	completed interventions	FIRST Discussion Database	FIRST Coordinator
		Services Mobilized Toolkit	lead agencies
	activities external to FIRST process	interviews	team members, Implementation Committee members
Service Mobilization	types of services mobilized	Services Mobilized Toolkit	lead agencies
	extent of service mobilization		
	nature of service mobilization		
Efficiency	team member feedback on service access	interviews	team members
	team member feedback on partner communication		
	Implementation Committee member feedback on service access	interviews	Implementation Committee members
	Implementation Committee member feedback on partner communication		
Agency to Agency Relations	team member feedback on agency relationships	interviews	team members
	Implementation Committee feedback on agency relationships	interviews	Implementation Committee members
Ownership	team member perception of ownership	interviews	team members
	Implementation Committee perception of ownership	interviews	Implementation Committee members
	Steering Committee perception of ownership		Steering Committee members
Satisfaction	client satisfaction	surveys	clients
	team member satisfaction	interviews	team members
	Implementation Committee satisfaction	interviews	Implementation Committee members
	Steering Committee satisfaction		Steering Committee members
Challenges	client perception of challenges	survey	clients
	team member perception of challenges	interviews	team members
	Implementation Committee perception of challenges		Implementation Committee members
	Steering Committee perception of challenges		Steering Committee members

	evaluator observations of challenges	observation	evaluator
Improvements	client suggestions for improvements	interview	clients
	team member suggestions for improvements	interviews	team members
	Implementation Committee suggestions for improvements		Implementation Committee members
	Steering Committee suggestions for improvements		Steering Committee members
	evaluator observations of improvements	observation	evaluator

7.0 EVALUATION ACTIVITIES

Throughout the course of this evaluation, a number of activities were undertaken during the implementation of the methodology, analysis of data, and preparation of results. The following items summarize the efforts put into this evaluation of Chatham-Kent's FIRST Strategy:

- Creation of evaluation matrix, logic model and evaluation plan.
- Development of data collection instruments to capture services mobilized data.
- Development of interview guides for clients.
- Development of interview guides for FIRST members.
- Development of interview guides for Steering Committee members.
- Support to local data collectors on the Hub Database (FIRST Discussion Database).
- Collection of original data through an interview with 1 client.
- Collection of original data through interviews with 6 Steering Committee Members.
- Collection of original data through interviews with 18 FIRST members.
- Analysis of services mobilized data from tracking sheets.
- Analysis of risk and agency data from the discussion process.
- Submission of interim report.
- Analysis of interview data from interviews with a client, FIRST members and Steering Committee members.
- Preparation of final report.

8.0 RESULTS

The results of this evaluation are presented in their respective method of data collection. To begin, quantitative data from the FIRST Discussion Database provides an overview of the target group achieved, included client demographics and risk factors. This initial section also identifies the agencies involved in each intervention. Next, results of the Global Network's *Services Mobilized Toolkit* are presented to show the types of services mobilized during the intervention process. Moving into the qualitative results of this evaluation, interview dialogue from 1 client, 18 FIRST members and 6 Steering Committee members are summarized in their individual subsections.

8.1 FIRST DISCUSSION DATABASE

Since the launch of FIRST in February of 2016, data have been captured on 13 different referrals. Using the FIRST Discussion Database, the coordinator captures de-identified information during and after discussions of acutely-elevated risk. Reported in this evaluation are data on demographics, risk factors, agency involvement, reasons for closure, and the number of clients supported.

Demographics

During the discussion process, the exact age of discussion subjects is not provided. Rather, age cohorts are used to generalize the age of individuals that the team is planning to support. Analysis of FIRST data reveal that most subjects discussed at the table are under the age of 25 (see Table 4). Another demographic captured during the discussion process is gender. Analysis of FIRST data show that of all 13 situations, 8 involved interventions to male subjects and 5 involved interventions to female subjects (see Table 4). Finally, where it is realized that criminal charges are pending, professionals from the criminal justice system must declare that the situation is entering a conference under the Youth Criminal Justice Act. During the first 10 months of FIRST, no situations involved declaration of a YCJA conference.

Table 4. **Demographics of FIRST Situation Subjects *(N = 13)***

VARIABLE	VARIANT	*N*	%
Age	16 – 17 years	4	30.8
	18 – 24 years	4	30.8
	25 – 29 years	0	-
	30 – 39 years	1	7.7
	40 -59 years	3	23.1
	60+ years	1	7.7
Gender	Male	8	61.5
	Female	5	38.5
YCJA Conference	Yes	0	-
	No	13	100.0

Risk

One of the most significant roles of the database is to capture data on risk. As information is shared during the discussion process, data are captured on 103 individual risk factor variables. These risk factors can be grouped into 26 different risk categories. Overall, 145 individual risk factors were

identified in the 12 FIRST discussions[5]. When all 145 risk factors are grouped into their respective risk categories, the most common risk category observed was mental health (*N = 18*, 12.4%), followed by crime victimization (*N = 16*, 11.0%), criminal involvement (*N = 10*, 6.9%), drugs (*N = 32*, 6.9%), and emotional violence (*N* = 10, 6.9%), respectively. As Table 5 illustrates, there is some variation in the proportion of risk categories across FIRST's initially detected 145 risk factors.

Table 5. **Number and Percent of Risk Identifications by Risk Category** (*N* = 145)

RISK CATEGORY	*N* of Risk Factors Identified	% of all Risk Factors Identified
Mental Health	18	12.4
Crime Victimization	16	11.0
Criminal Involvement	10	6.9
Drugs	10	6.9
Emotional Violence	10	6.9
Basic Needs	8	5.5
Housing	7	4.8
Alcohol	7	4.8
Physical Violence	7	4.8
Parenting	6	4.1
Sexual Violence	6	4.1
Supervision	6	4.1
Anti-Social Behaviour	5	3.4
Negative Peers	5	3.4
Suicide	5	3.4
Poverty	5	3.4
Social Environment	4	2.8
Self-Harm	3	2.1
Threat to Public Safety	3	2.1
Unemployment	1	0.7
Physical Health	1	0.7
Missing School	1	0.7
Missing/Runaway	1	0.7
Elderly Abuse	0	-
Gangs	0	-
Gambling	0	-

Table 5 above shows the raw number of risk factors identified in each category of risk. In some situations, however, there can be several risk factors appearing under the same category. To gain a better understanding of the independent categories of risk represented in FIRST situations, Table 6 presents the total collapsed number and percent of risk categories (*N = 111*). This helps provide a more realistic sense of the types of risk categories presented in situations discussed by FIRST.

[5] Of the 13 situations presented, 1 situation was rejected, therefore the database only has risk on 12 situations.

Table 6. **Number and Percent of Risk Categories Represented in Situations (*N* = 111)**

RISK CATEGORY	*N* of Risk Category Entrees	Overall % of Risk Categories
Mental Health	11	9.9
Drugs	9	8.1
Basic Needs	8	7.2
Alcohol	7	6.3
Crime Victimization	7	6.3
Housing	7	6.3
Emotional Violence	6	5.4
Physical Violence	6	5.4
Anti-Social Behaviour	5	4.5
Criminal Involvement	5	4.5
Sexual Violence	5	4.5
Supervision	5	4.5
Negative Peers	4	3.6
Parenting	4	3.6
Poverty	4	3.6
Social Environment	4	3.6
Suicide	4	3.6
Self-Harm	3	2.7
Threat to Public Safety	3	2.7
Missing School	1	0.9
Missing/Runaway	1	0.9
Physical Health	1	0.9
Unemployment	1	0.9
Elderly Abuse	0	-
Gambling	0	-
Gangs	0	-

Overall, FIRST was designed to address multiple risks that have a cumulative effect on the individual and their family. Neither in practice nor research is it appropriate to assume that more risk factors equate to higher elevated risk—for the intensity of risk itself is not reflected in the current database for FIRST. However, one way to interpret higher numbers of risk factors per situation is in overall complexity. As Table 7 shows, the average number of risk factors in each situation is 11.3. Most situations involved at least 10 to 15 risk factors. This, from a preliminary standpoint, suggests that most situations discussed by FIRST involved a high degree of risk complexity.

Table 7. **Number of Risk Factors in FIRST Situations (*N = 12)***

Number of Risk Factors	*N*	%
1 to 4	0	-
5 to 9	4	33.3
10 to 15	8	66.7
Average = 11.3		

Agency Involvement

When it comes to agency involvement in discussions at FIRST, there are three main roles: originating agency, lead agency and assisting agency. Regarding the former of the three, the *originating agency* is the agency which initiates the discussion by presenting a new situation to FIRST. Within the analysis period, Chatham-Kent Police Service and Chatham-Kent Children's Service brought the most (*N = 3)* new situations. Once a discussion is accepted and the risk factors are identified, FIRST members select a lead agency to spearhead the intervention. To date, several agencies have played a lead agency role in the interventions planned by FIRST (e.g., Canadian Mental Health Association). Similarly, agencies can also play an assisting role in the interventions. Much of this is determined by the risk factors of a situation and the relevance of each agency's services to those risk factors. In some cases, however, an existing relationship with the client can also determine whether an agency plays a lead or assisting role in the intervention. As Table 8 illustrates, the extent to which agencies play an originating/lead/assisting role in interventions varies.

Table 8. **Number of Situations for Originating/Lead/Assisting Agency by Agency**

	AGENCY INVOLVEMENT TYPE		
AGENCY	**Originating***	**Lead^**	**Assisting^**
Adult Language and Learning	0	0	0
Alzheimer Society	1	1	0
Canadian Mental Health Association	0	4	7
Chatham-Kent Building and Enforcement Services	0	0	0
Chatham-Kent Children's Service	3	2	1
Chatham-Kent Community Health Centre	0	0	0
Chatham-Kent Employment and Social Services	1	0	7
Chatham-Kent Fire and Emergency Services	1	1	1
Chatham-Kent Health Authority/Health Links	0	0	2
Chatham-Kent Housing Services	0	0	0
Chatham-Kent Police Service	3	1	5
Chatham-Kent Victim Services	0	0	6
Chatham-Kent Women's Shelter	0	0	1
Family Service Kent	1	1	4
Lambton Kent School Board	0	0	1
Medavie Emergency Medical Services	2	0	1
Salvation Army	0	2	5
St. Clair Catholic District School Board	0	0	0
United Way	1	0	0

** N = 13 ^ N = 12*

Discussion Closure

Once FIRST members deem that a discussion should be closed, there is a collective determination among intervention team members of why it should be closed. Data from FIRST indicate that discussions are closed for a variety of reasons. As Table 9 illustrates, these include situations where risk is considered to be lowered, as well as, where risk is considered to still be elevated.

Table 9. **Number and Percent of Reasons for Closure *(N = 12)**

REASONS FOR DISCUSSION CLOSURE	*N*
Overall risk lowered - connected to services	1
Overall risk lowered - connected to personal supports	2
Overall risk lowered - connected to services in other jurisdiction	-
Overall risk lowered - through no action of situation table	1
Rejected - originator has not exhausted all options	1
New information reveals AER did not exist to begin with	1
Still AER - connected to services with potential to lower risk	-
Still AER - informed about services but not connected	3
Still AER - refusal of services	-
Still AER - relocated	-
Still AER - systemic issue	1
Still AER - unable to locate	2
Deceased	-

* At the time of this analysis, 1 situation remains open.

People Supported

As FIRST closes a discussion, the number of individuals supported through an intervention is also captured in the database. This helps to account for the overall reach of the intervention process. Data from FIRST indicate that in total, 12 individuals received some form of support through the intervention process. Two of the 13 discussions delivered support to at least five people, while two discussions delivered support to one person.

8.2 SERVICES MOBILIZED TOOLKIT

The final source of quantitative data in this evaluation is the Global Network's *Services Mobilized Toolkit*. Following the closure of each intervention, the FIRST coordinator requests the lead agency of each discussion to populate a table using de-identified information. Based upon each risk factor identified in the discussion, the toolkit tracks *services that were mobilized*, *services that were appropriate but not mobilized*, and *reasons why services were not mobilized.* At the time of this report, data were available on 9 of the 12 situations discussed by FIRST.

Generally, each situation involved 3 to 6 service mobilizations. One particular situation involved 9 total service mobilizations. In contrast, most discussions involved 1 or 2 services *not* being mobilized. As Table 10 shows, the most common services mobilized included mental health, victim support, police, housing, and income assistance. In contrast, the most common service that was appropriate, but not mobilized, was addiction services[6].

[6] A cross reference for why addiction services was not mobilized revealed a mix of reasons (e.g. refusal of services, personal barriers, systemic barriers).

Table 10. **Number of Services Mobilized/Not Mobilized in Interventions (*N* = 9)**

SERVICE SECTORS	SERVICES MOBILIZED	SERVICES APPROPRIATE BUT NOT MOBILIZED
addiction services	1	5
advocacy/navigation	2	1
child protection	1	-
cognitive support	-	-
corrections	1	-
counselling	2	2
courts	-	-
cultural support	-	-
education	1	-
employment services	-	-
fire and emergency services	1	1
food support	-	-
harm reduction	-	-
home care	-	-
housing	3	2
income assistance	3	1
legal-justice support	-	-
life skills	-	-
medical health	1	1
mental health	6	2
mentorship	2	-
outreach	2	-
paramedic/ambulatory	-	-
parenting support	-	-
parole	-	-
perpetrator support	-	-
police	5	1
probation	1	-
public health	-	-
recreation	-	-
safe shelter	2	-
sexual health	-	-
spiritual support	-	-
transportation	-	-
victim support	4	1
other	3	-

Once it was identified that appropriate services were not mobilized in an intervention, FIRST leads were asked to identify the reasons why these services were not mobilized. As indicated in Table 11, the most common reason includes *refusal of services.*

Table 11. **Number of Reasons Appropriate Services Were Not Mobilized**

	REASON SERVICES NOT MOBILIZED	*N*
General	refusal of services	10
	unable to locate	-
	deceased	-
	risk lowered – through no action of FIRST	1
	new information revealed risk did not exist to begin with	4
Barriers	personal barriers (e.g. fear, distrust, anxiety)	2
	situational barriers (e.g. travel, language, affordability)	-
	systemic barriers – no appropriate services	2
	systemic barriers – difficult threshold for service access	1
	systemic barriers – long wait list	-
	systemic barriers – *other*	1
	societal barriers – stigma based	-
	societal barriers – cultural based	-
	societal barriers – *other*	-

8.3 CLIENT INTERVIEW

As described in the methodology, the evaluator was able to sit down with one of the 12 clients that FIRST had mobilized services around during the evaluation period. The client provided informed oral consent to participant anonymously in the interview. The client was also assured that his/her comments or lack of comments would in no way affect the support he/she receives from the different human service organizations that support him/her. Following the interview, the client was provided with a gift card in show of appreciation for his/her time spent with the evaluator.

During the interview, the client described that his/her initial involvement with FIRST came about when his/her social worker realized the many different needs he/she was affected by. When the social worker identified the diverse set of needs, accompanied by a downward spiral (elevated risk), FIRST was mobilized to address school attendance, tutoring, lack of finances, barriers to attending appointments, housing needs, and counselling support. When asked to describe his/her reaction to a diverse group of human service providers all reaching out together, the client replied: “Holy crap, all of these people want to help me after all the bad things I’ve done? I felt a lot less stressed, less angry, because people were willing to help me.”

Through sharing his/her experience with FIRST, the client explained that, prior to getting multi-sector interventionist support, he/she used to cancel a lot of meetings, have little trust for human service providers, and never really know where to go for help. Since the intervention, he/she has made an increased effort (confirmed by social worker) to show up at scheduled appointments, has created positive relationships with human service providers that were previously strained, and is beginning to reach out for help before things get out of control.

In describing the impact of the intervention, the client shared that: “It made me feel happy that people cared—even if I messed up. I don’t feel as stressed out, I don’t get in as much trouble at school, and I now look forward to graduating and having fun in life.” When asked to describe his/her overall satisfaction with this experience, the client identified that he/she was very satisfied because “all of the people care and I didn’t realize they cared”.

One of the topics discussed during the interview was the client's observation of difference or change in this recent interaction with human service providers compared to previous interactions. The client responded by saying:

> *It was a different experience because it showed me that they all cared together and made a commitment to get things done for me. I actually felt included—they made me part of the actual plan. When they worked together as a team, I actually saw a change in their roles in my life to be supportive and helpful—as opposed to strict and disciplinary.*

The final question asked to the client inquired about a message that he/she would share with other individuals who found themselves in a similar situation. More particularly, what would they share about the multi-sector collaborative experience with others. The client expressed that: "It's a lot better to have 3 or 4 people in the room who can help you with a bunch of different things at once than trying to see them all separately."

8.4 FIRST MEMBER INTERVIEWS

The interviews with FIRST members helped to provide a first person understanding of the structure, function, benefits, successes and remaining challenges with Chatham-Kent's ad hoc approach to the conventional Hub model of collaborative risk-driven intervention. During the interview process, respondents were motivated by their experience, inspired to find ways of improving FIRST, and committed to seeing how this initiative could further reduce risk in Chatham-Kent. At the time of these interviews, only 8 situations had been addressed by FIRST. As such, all of the respondents were admittedly modest, and limited in their conclusions about FIRST and its impact on acutely-elevated risk.

The interviews with each FIRST member began with an overview of their perspective on the model. In many ways, the FIRST members praised the opportunity that this approach to community safety and well-being brings to Chatham-Kent. Several commented on how the collaborative aspects of the model create new opportunities to help clients in ways that human service providers have not been able to succeed in previously. Within this dialogue, respondents pointed to the fact that collaboration breeds innovation in their collective efforts to help clients. Additional feedback indicated that the collaborative approach of FIRST has actually mitigated a long-standing failure of human service providers to work together around the needs of a single client. As one member remarked:

> *This model is long overdue. Too many clients fall through the cracks in our human service delivery system long before we recognize that they are at-risk. A lot of that had to do with a failure to communicate.*

Following this initial discussion, the interviews were guided by a number of questions in specific topic areas. These include, efficiency, service access, benefits, success, challenges, and barriers, to name a few. The following sub-sections present results of interviews with FIRST members in each of these key topic areas.

Efficiency

In discussing efficiency of the FIRST process, respondents were very impressed with the model's ability to deliver detection of risk, quick mobilization of services, and real-time information sharing on urgent client needs. Several of the respondents observed that FIRST pulls human service providers together

much faster than any other collaborative initiative they are aware of. Others felt that the model's efficiency comes not only from quickly mobilizing the right organizations, but immediately moving towards action—as opposed to talking about it, then going separate ways. One of the threats to efficiency, as pointed out by at least 3 respondents, is when not all relevant information on a client is shared. In their application of the Hub Model, FIRST members who do not feel relevant to the proposed situation, leave the meeting before the name is disclosed. On some occasions, the agencies who left, took with them valuable information that could have been used to plan an intervention. As one respondent explained: "We don't know what we don't know—and when agencies leave the meeting, the rest of us have to spend time hunting around for information that was otherwise right there in the room."

Client Access to Services

A major interest to stakeholders of this evaluation is the extent to which clients are gaining access to services. Within the evaluation period, while only 8 situations had been discussed, FIRST members were able to offer some preliminary observations on this topic. According to one respondent: "FIRST has really expedited our ability to access all services available to that client; traditionally, we would not have known of those other services." Similarly, another respondent explained that FIRST has helped clients gain access to services that the client him/herself was not aware of. In addition to introducing new services, respondents also pointed out that FIRST has been helpful in streamlining and fast-tracking the engagement of services so that the clients' needs are more quickly responded to.

Multisector Collaboration

One of the major themes of this evaluation is collaboration among different sectors in the human service delivery system. During the interview process, FIRST members were asked to describe whether their initiative was improving collaboration among human service sectors in Chatham-Kent. By and large, most respondents pointed out that their community already had a well-established collaborative environment before FIRST. As a few highlighted, because Chatham-Kent is a smaller community, agencies have historically had to work together to serve client needs. However, all of the respondents felt that despite this tradition of collaboration in Chatham-Kent, FIRST has actually increased the intensity and consistency of that collaboration.

Some of the reasons why FIRST has enhanced collaboration in Chatham-Kent are that it actually gives agencies an avenue to work together, provides an opportunity for agencies to better communicate with one another, and as one respondent shares, "ignites us to learn more about other agencies, and about the diverse needs of clients…It gives us an understanding of how we can better help clients together". An added value of this enhanced collaboration, according to one respondent, is that "FIRST presents a collective pressure among partner agencies to get things done."

Although most respondents felt that FIRST was a great enhancer of the collaboration that already existed in Chatham-Kent, a few felt that it helped to form new relationships between agencies in the community that had not existed before. One respondent explained that although his agency was aware of some of the other agencies in the community, his agency never actually worked with some of them others before FIRST. Another respondent observation suggests that FIRST actually helped to repair and strengthen multisector collaboration, while also producing a new collective way to address social issues in the community:

One of our challenges in the beginning was that everyone was holding one another accountable for failing to meet the needs of chronic high risk clients. However, by working collaboratively, we soon realized that this was an opportunity to work differently and we began to create new perspectives on addressing the problems.

Benefits

An easy topic for the FIRST members to discuss during the interview process was the benefits of FIRST for human service delivery in Chatham-Kent. Some of the benefits mentioned involve shared workload among agencies, raised profile of agencies, and an opportunity to more effectively help clients with complicated needs. Others included:

- It is a proactive approach to getting people the support they need.
- Multiple brains and sectors around the table helps agencies better serve clients.
- We all share the benefit of each other's strengths.
- Gets people access to help without running them through the justice system.
- Reduces silos and minimizes the guarding of information and turf.
- Helps to reinforce our partnerships, not only making them stronger, but action-oriented.
- This has helped us identify systemic barriers in the community, that without a multi-sector lens, we may not have realized.

Attributes to Successful Mobilization of FIRST

Although the FIRST members acknowledged that their collaborative risk-driven intervention initiative was still in an early phase, they were able to point out a number of attributes to the successful mobilization of partners within the FIRST initiative. Some suggestions included a commitment of human service providers to think innovatively; a willingness and eagerness to help; and both an investment and prioritization of the FIRST process. Additional attributes for the successful mobilization of FIRST include a willingness to break down pillars, team openness, a changed mindset to be more upstream thinking, and being able to develop trust for one another in addressing client needs.

During this discussion on what has led to a successful mobilization of FIRST, at least three attributes were mentioned by more than one respondent. The first and most commonly-mentioned attribute was the actual coordinator position for the team. Several highlighted that the team would not have been mobilized, nor would have been able to come together so quickly, if it were not for the effective mobilization efforts of the FIRST coordinator. The second attribute mentioned by a number of respondents was that members on the team are prepared and able to make decisions. This really helped the partners in being able to immediately move forward with an intervention plan—without having to check back at the home office. Finally, the third common attribute was the instant access to information sharing and understanding of what services FIRST members can connect their clients to. Several respondents pointed out that exchanging client knowledge and being aware of service options has been instrumental in keeping the team mobilized and ready to address new situations of acutely-elevated risk.

Strengths of the FIRST Model

In discussing their experience and observations of FIRST, members of the team were able to identify a number of strengths that they felt will lead them down a path of success. The first was that the ad hoc nature of the model allows the team to mobilize around situations of acutely-elevated risk without having regularly-scheduled meeting dates. Since there is a lot of collaboration in the community already, proponents of the ad hoc approach felt that meeting only when required would free up time to meet client needs. In describing this strength, one respondent shared that: "When a meeting is called, everyone knows that it is time to act quickly, as opposed to fulfilling a regular weekly meeting commitment where they might not be so quick to act."

The second strength identified by respondents was that there is a shared ownership of FIRST among all of the agencies involved. As one respondent explained: "Although the key drivers are the police and Family Service Kent, the fact that it is a shared initiative brings a lot of commitment to the team." Another respondent pointed out: "Because everyone sees FIRST as a genuinely shared initiative, it becomes a priority for the partner agencies—resulting in everyone moving much quicker." A third respondent commented that "the shared ownership approach to FIRST helps the partner organizations be more accountable to the process and hold onto their commitments."

The third main strength of the FIRST model is the way in which it protects privacy. Several respondents felt that being able to share information and collectively meet client needs has only been made possible because the model satisfies privacy and information sharing regulations. According to respondents, "the Four Filter process from the original Prince Albert Hub Model has allowed FIRST to share client information while working within our requirements to protect privacy". Another respondent shared: "Our agencies were comfortable putting us on this team to share information because of the solid filter process that protects privacy". Overall, there was a general sentiment among the respondents that a strength of the FIRST model is its ability to facilitate necessary information to mitigate risk and prevent harm, without infringing one someone's right to privacy.

Weaknesses of the FIRST Model

Just as FIRST members were able to point out strengths of their model, they also were able to highlight some of the key weaknesses. Some of these weaknesses focus on the *process* team members use while fulfilling the goals of FIRST. Other weaknesses focus on the *design* of FIRST and the limitations it presents the team in their effort to implement collaborative risk-driven intervention. Finally, some weaknesses concern actual *application* of partner agencies in the collaborative risk-driven intervention process. Table 12 summarizes the main weaknesses observed by interview respondents.

Table 12. **FIRST Member Suggested Weaknesses of the FIRST Model**

TYPE	WEAKNESS
Process	• There is no report-back verifying reduction in risk or service mobilization; which leaves the rest of the team to presume something was done—but we're never sure. • Too often, the resulting intervention team simply makes a plan, then goes their separate ways. • There is no real consensus around closure. Everyone disperses and we never hear why a situation was closed. That is not only concerning, but doesn't do much for group motivation. • We do not always do a door knock as a team. Instead we reach out to the human service provider who has the most familiarity with the client. Not sending the whole team on the door knock has resulted in the interventions being driven by a single agency. This is counter to the principles of collaborative risk-driven intervention.
Design	• In our ad hoc approach, we do not get the familiarity and team synergy that a full table does. • There is no mechanism to ensure agencies follow through on intervention plans. • We do not hear the name until the so-called "irrelevant" agencies leave the meeting. This is troubling in that we do not know what we do not know. That client could have been involved in the agency that just left the meeting. • We get the deidentified basics of a situation on email before we come together as a team. However, this is not enough information to bring the right person to the meeting.
Application	• Currently, this is more of a venue for referrals than an actual intervention team. We need to be more involved collectively in approaching clients with the offer of support, and closing a situation when our involvement is not needed anymore. • Some service sectors still wait for clients to come to them when they want help. There is such a small window of opportunity to connect with them. • It becomes difficult when some partners are not quick to come through with services. • There is not sufficient access to information from agency partners when we need it. • We're bringing too many chronic high risk situations to FIRST. Instead, we should be bringing the upstream situations that are recently elevated—where the client has not had service access yet.

Sector Involvement

In any new collaborative initiative, it is always difficult to make sure all of the appropriate sectors are involved from the start. In the case of FIRST, as the team began taking on new discussions and planning interventions, they soon realized that a few different sectors were not adequately represented on the team. During the interview process, these were identified as community living, cognitive disabilities, elderly care, education, probation, mental health, and acute health care.

Appropriateness of the Ad Hoc Approach

One of the key questions driving this evaluation is the appropriateness of the ad hoc approach to collaborative risk-driven intervention. In comparing their own ad hoc approach with the conventional scheduled approach to collaborative risk-driven intervention, respondents were able to point out both advantages and disadvantages of their own approach. Table 13 summarizes some of the key observations shared by FIRST members.

Table 13. **FIRST Member Reported Advantages and Disadvantages to the Ad Hoc Approach**

	OBSERVATIONS
Advantage	• This approach has allowed us to actually assemble when help is needed, as opposed to waiting until the next Tuesday or Thursday like the conventional Hub Model. • This is a good approach for Chatham-Kent because we already have a lot of collaboration in the community. • The approach is very convenient, so long as we can incorporate a few improvements (e.g., report back). • We are a small community, with limited resources, so we need to be very efficient in what we do. This approach allows us to mobilize when necessary, without tying up resources. • The ad hoc approach is conducive to our needs, because thankfully, we do not have a lot of problems in our community that our existing agencies cannot deal with.
Disadvantage	• Our Ad hoc approach is challenging in that it is hard to build consistency, discipline and a real understanding of proper roles among agency representatives. • It certainly saves us time by not having regular meetings. However, it sacrifices opportunities for partnership building, understanding one another, and actively detecting risk each week. • The ad hoc model is a challenge in that we cannot plan for when the team gets together, so we have to drop other commitments on short notice. This is fine for crisis, but not early risk detection. • The conventional model provides a chance for building collegiality and updates. The challenge with the ad hoc approach is that we are often scrambling to find a way to meet and plan an intervention. • The problem with the ad hoc approach is that there is too much individual work, and not enough collaboration in risk detection, planning, deployment and debriefing. • A concern with our ad hoc approach is that we end up by default, using the team for response to chronic high risk, rather than early risk detection and mitigation. Nobody wants to interrupt each other's work schedule for a meeting unless it's really serious. So, although we are functioning as we had hoped, I fear it's for the wrong purposes. • Since it is ad hoc, people may not use the model very often, and will fall out of practice on the discipline and process.

Training

In implementing a new initiative, the success of community partners to reach their goals is, in some parts, attributable to the preparation put into the initiative before a launch date. In responding to questions about preparation leading up to the launch of FIRST, nearly all respondents ended up commenting on the training they received[7].

Several of the respondents felt that the training they received was a nice introduction to collaboration, information sharing and privacy and information-sharing frameworks. They felt that examples from other Hub/Situation tables in Ontario were quite useful. Many of the respondents felt that the explanation of the original Hub Model's Four Filter Process prepared them for sharing information within a team setting.

Although respondents were able to highlight a few benefits of the training they received, they were also quick to point out some challenges with the training they received. These include:

[7] Free training was provided to FIRST through a partnership between Wilfred Laurier University and the Ontario Provincial Police.

- I was very frustrated that the training did not explain the difference between our ad hoc approach and conventional Hub/Situation Table approach.
- The trainers did not provide a lot of context around the model or how it works operationally.
- The training left a lot of confusion on process and involvement in agencies.
- Training needs to be more hands-on, involve mock scenarios, and videos.
- The training is focused on the conventional Hub Model—yet we are ad hoc, so that made it difficult.
- It would have been nice to have a basic understanding of the Hub Model before we got right into the actual training workshop.
- We were provided with a large manual and a brief overview of the filter process, but nothing of substance around collaboration, risk detection or intervention.
- There was nothing to help us roll the Hub Model out in an ad hoc approach.
- I found that the training was too focused on privacy interpretations rather than actual techniques in collaborating, planning interventions, or reaching out to clients.
- The training seemed more like a presentation on Situation Tables as opposed to an opportunity that trained us to do something.

Challenges

One of the goals of this evaluation was to uncover remaining challenges, so that the partners of FIRST could work to overcome those challenges moving forward. In their response to a question on remaining challenges, the FIRST team respondents raised concerns on understanding, client interest, process, capacity and practice. Table 14 summarizes these responses.

Table 14. **FIRST Member Identified Challenges**

TYPE	CHALLENGES
Understanding	• It has been hard to get agencies to understand that we are only looking at risk…and that we bring people together based upon risk—not crisis. • We all still have different views on consent and its role in this process. • Some agencies are still unclear on their ability to share information without consent, which undermines the efforts of the team to plan an effective service intervention. • It is still unclear who needs to be at the table and who in our agencies should be trained. • There is still a lot of siloed behavior around the team; which is largely perpetuated by different rules around consent and information sharing.
Client Interest	• Some clients still do not show up for intervention meetings because of the composite risk factors they experience. • Clients refuse services without knowing the benefits of a full team approach.
Process	• We hear of the plan being made, but never know what the outcome is. • There is no actual mechanism for us to hear how and why a situation is closed.
Capacity	• Some people on FIRST do not have the right role within their own agency to effectively contribute to the process. • It is still difficult to pull everyone together in such short notice—we end up having to move/cancel things to accommodate FIRST. • We have still had trouble finding funding for our coordinator position.
Practice	• Following the intervention, it becomes a real challenge when people do not follow through with their plans made with the client. This makes the client feel hopeless. • Sometimes what agencies say they are going to do, and do, are two different things. • We have had too many situations that are chronic high risk, instead of lower level situations of elevated risk. • When not all of the information is shared, it becomes a disservice both for the other agencies and the client. • Too many agencies come if a meeting is called, but do not bother actually presenting new situations. There is no ongoing risk detection—we're simply responding to crises.

Improvements

Following their identification of remaining challenges with FIRST, respondents were asked to identify opportunities for improving the model. In this discussion, the responses provided by FIRST members suggested improvements in three areas: practice, design and understanding.

Concerning practice, one suggestion given by several respondents was that FIRST has to start focusing on situations of risk instead of chronic crisis. As one respondent observed: "We need to be thinking more preventative and focus on new at-risk situations instead of the chronic high risk clients everybody is already involved with." Another felt that, in fact, it was the actual ad hoc approach of FIRST that made people reluctant to bring lower, more preventable risk situations. A second suggested practice improvement concerned the need for agencies to do more homework at Filter One. As one respondent shared: "Some of us need to do a bit more work trying to meet the client's needs in our own agency, rather than just bring the complicated ones here for everyone else to deal with." The final suggestion for improving practice concerned the number of human service providers involved in the actual intervention. According to one respondent, more agencies should be involved at the beginning:

If clients are already engaged in an agency, then a single agency door knock might be ok. However, if it is newly at-risk, and there are multiple risks presenting, we should really be doing a full intervention on that client. That's the whole point, isn't it?

The next set of suggested improvements focused on the design of FIRST. Generally speaking, most of the respondents suggested the addition of a report-back on interventions that FIRST had mobilized. This would keep other agencies informed of progress, and provide some verification around the tasks undertaken in the intervention. Another suggestion in this area called for a full-team involvement on closure. Currently, only the intervention team is involved in closure. This not only leaves other agencies wondering what happened, but it does not allow for the collective team to make sure that enough was done for the client. One respondent felt that "if we can get together and decide to work with a client, then we should also collaborate in the decision to walk away from that client". Similarly, another respondent suggested: "Seeing the end result of an intervention would give us all the incentive to bring more situations…Even if it was de-identified, at least we would know what happened". A final suggestion on design was the opportunity for more regularly-scheduled team meetings to improve interagency awareness and build the types of relationships FIRST needs to be effective.

The final area of suggested improvement focused on actual understanding of FIRST among the human service agencies involved in the initiative. Some respondents felt that the staff of agencies involved in FIRST needed more education on how they can become involved in the initiative. Some felt that, in particular, there could be more education and advocacy around actual risk detection, the referral process, and collaboration in a team environment. Another suggested improvement in this area called for improved understanding of agency roles within the model, as well as services provided in the community. Finally, one respondent suggested that the team needs to understand success differently—not from their own agency's perspective, but from a collective perspective.

Sustainability

The final question posed to FIRST members asked what they felt was required in order for FIRST to be a sustainable approach to collaborative risk-driven intervention. As summarized below, some of the requirements involved engaged leadership, having a permanent coordinator, public awareness, ongoing measurement of outcomes, and opportunities to continuously strengthen the model.

- In lieu of inconsistent meeting times, the ad hoc approach requires a funded position to make things happen.
- There needs to be ongoing coordinated governance and active leadership of the model.
- Agencies must feel that they are contributing something to the model.
- We need to keep all agencies interested and engaged, even the fringe agencies—so that when we need them, they can be mobilized.
- At the very least, we need to inform team members and their agencies of the generic outcomes.
- We must bring the whole team together more often, so they feel like a team and are committed to working together.
- We need consistency in the team so that they can work efficiently, and build strong working relationships with others on the team.
- There needs to be public awareness of FIRST—so that they can see the benefits of this approach and how it leads to a better community.

- We need to continuously review challenges, gaps, benefits and opportunities to strengthen the model.

8.5 STEERING COMMITTEE INTERVIEWS

Interviews with members of the Steering Committee covered many of the same topics brought up in interviews with the actual FIRST members. A few additional topics surrounded observations of the impact FIRST may be having on the staff members representing their agency at FIRST. The following subsections present the interview results with Steering Committee members of Chatham-Kent's FIRST model.

Involvement

To begin, members of the Steering Committee were asked to explain why their agency chose to become involved. Respondents shared that FIRST was an opportunity to better support at-risk clients in the community—in a more efficient and effective fashion. Some explained that FIRST was an opportunity to build upon the excellent collaboration between police and mental health in Chatham-Kent—where clients were actually connected to appropriate services. Steering Committee members also pointed to the growing body of evidence supporting the Hub Model, and were driven to meet or exceed the outcomes of other communities applying similar models of collaborative risk-driven intervention. Finally, a major reason for most agencies to become involved in FIRST was because of the opportunity it provided for collaboration with other agencies.

Ownership

Similar to the interviews with members of Chatham-Kent's FIRST, members of the Steering Committee were also asked to identify where ownership of the initiative actually fell. Feedback from respondents suggested that ownership was genuinely multi-sector in nature. While it was no secret that the Chatham-Kent Police Service spearheaded the effort, FIRST was considered a shared initiative among all partner agencies. During this discussion, one Steering Committee member recalled that, even though community leaders from the policing sector introduced the model to everyone else, the initial step they made was to hire a civilian coordinator from Family Service Kent to run the initiative. This was seen as a major step toward making sure FIRST was never owned by a single sector or agency.

Collaboration

In discussing collaboration among human service agencies in the community, members of the Steering Committee felt that FIRST had truly enhanced the already strong collaborative relationships being enjoyed in Chatham-Kent. As one respondent shared: "From my level, I see that there is more collaboration…agencies are stepping up and working together to get things done." Another respondent commented: "FIRST has allowed us to further enhance our partnerships. We are working together and even beginning to align our service agendas." Additional observations of how FIRST has affected collaboration included fostering an openness for agencies to work together; making agencies feel included; new relationships where none existed previously; and increased cooperation on different social issues in the community.

Benefits

In identifying benefits to the FIRST Model, members of the Steering Committee discussed benefits in the areas of capacity, effectiveness, collaboration, service access, and approach. Concerning capacity, respondents explained that the multi-sector lens that FIRST provides has actually encouraged agencies to grow their internal capacity and effectiveness in addressing diverse client needs. In addition, Steering Committee members felt that FIRST provided agencies with a broad set of tools to better meet client needs; delivered a disciplined, structured process for information sharing; and has highlighted gaps and barriers in service that would have otherwise gone unnoticed without the type of collaboration that FIRST provides.

With respect to effectiveness, members of the Steering Committee felt that FIRST has actually put some friendly pressure on agencies to "up their game" in working with others, problem solving, and meeting client needs. This has increased cooperation among agencies and helped all agencies better respond to client needs. In fact, as one respondent reported: "It has actually shown that vulnerable clients in our community are not getting all of the services they need—which has triggered FIRST partners to step up and deliver those services."

One of the clear benefits for most Steering Committee members was the fact that FIRST fostered collaboration among the human service agencies involved. According to one respondent, "FIRST has helped human service agencies move from community mobilization to community engagement to community collaboration." With such collaboration, agencies are provided with an opportunity to approach community problems differently. As one Steering Committee member shared: The model has helped us collectively address social issues that we have traditionally been doing in our separate silos."

Another common response from Steering Committee members concerning the benefits of FIRST was the extent to which it improved service access for clients. Several respondents pointed out that FIRST has expedited service access for the few clients that have already been through the model. As one committee member shared: "[FIRST] helps clients gain quicker access to services…If they would have tried to go through conventional channels, they would have regressed past the point of restoration before they actually got any help."

Finally, concerning agency approach, some members of the Steering Committee observed that FIRST has helped a few agencies shift from being traditionally reactive, to more proactive. In particular, a few respondents felt that FIRST allowed the policing and fire sectors to make a shift toward problem-solving and connecting vulnerable people to the services they need. In explaining why some agencies have made a shift in their overall approach, one Steering Committee member shared: "It challenges all the agencies to be part of the solution, change the way we do things internally, and generate better outcomes for our clients—even if that means changing our approach to the problem."

Strengths

When asked to discuss the strengths of the FIRST approach to collaborative risk-driven intervention, respondents from the Steering Committee focused on several different strong-points. The main themes of these strengths include the coordinator position, structure and discipline, and agency commitment.

The first was the fact that FIRST has a single coordinator to help ease some of the communication and time restraints placed on the partner agencies. Some of the Steering Committee members shared that

the coordinator has been instrumental in bringing members together and facilitating the type information sharing and collaboration required of FIRST.

Another strength of the FIRST model is that, according to respondents, it adds accountability, structure, and procedure; and helps organizations be respective of the limitations in information sharing that are present. This clear structure and discipline was suggested to have brought a lot of confidence to the Steering Committee. In addition to this, confidence of the Steering Committee in this model was also increased because of the tight time parameters that pull the team together more quickly than conventional collaborative initiatives.

A third area of strength mentioned by respondents from the Steering Committee involved commitment among the partners to this initiative. Some of the feedback from respondents reveal that there is a willingness among agencies to commit to the process; all partners have placed resources into the process; there is a sense of shared pride and ownership; and agencies have made this a top priority. In explaining why agencies have made such a commitment to FIRST, one respondent shared two reasons. The first was because of the great potential that agencies have to more effectively reduce risk and prevent harm. The second is that there is a bit of self-induced pressure to get this right, as Chatham-Kent is the first adaptation to the Hub Model of its kind (ad hoc).

Challenges

From the level of the Steering Committee, a number of remaining challenges are still visible. The feedback from respondents has been broken down into four types of challenges: threats, client-based, process, and design (see Table 15).

Table 15. **Remaining Challenges to FIRST as Identified by Steering Committee**

TYPE	CHALLENGES
Threats	• When the right agencies are not present, it affects progress and undermines the team's ability to mitigate acutely-elevated risk in a timely fashion. • There are a lot service gaps in Chatham, which means our staff are already stretching their mandates. It has not yet become immediately clear for everyone that this is a solution to that problem. I worry of pull-back if we cannot demonstrate its worth quickly. • There is a risk that our infrequency of meetings may result in lost interest and people placing this initiative on the backburner. • As turnover begins within FIRST, the stability of the model may be threatened if there is no consistency in leadership, training and ongoing support.
Client-based	• Some clients have burnt bridges with some of our partner agencies, which makes intervention difficult. • Some clients have been blacklisted by services in this community that they really need. This makes planning a truly multi-sector intervention a real challenge.
Process	• We know the model mobilizes an intervention, but the collaboration seems to stop after that point. Clients need ongoing support to make that happen. The team needs to dig a little deeper to get at the root causes, or it will slip back into acutely-elevated risk. • A challenge is that we identify services that are relevant, but then when it comes to intervention, we realize that the client has already been engaged with most of the agencies. This is a symptom of getting clients too late in the process—when risk is chronically high. • I feel that in our application of this model, we are still responding to crisis. We need to move upstream and focus on risk detection—that is what the team is for. We're so used to crisis mode—not risk. We have a lot to learn on 'detecting risk' as opposed to crisis. • There are still too many loose ends after the intervention—our staff never know what happened and are unsure if the client got the support they needed. This is behaving like a referral table instead a risk mitigation table.
Design	• The model pre-defines what agencies should be at the intervention, however, this limits the breadth of tools we can bring to a client, based on what we assume an agency can contribute. • The design of this model does not ensure ongoing coordination of services to offer continuous support to those clients. • The trouble with the ad hoc approach is that it does not give us a sense of successes, challenges, barriers or lessons learned in other situations.

Appropriateness of the Ad Hoc Approach

During the interview process, members of the Steering Committee were asked to describe their observations of the appropriateness of the ad hoc approach for Chatham-Kent. Similar to feedback from FIRST members, respondents from the Steering Committee were able to point out both advantages and disadvantages of the ad hoc approach (see Table 16).

Table 16. **Steering Committee Reported Advantages and Disadvantages to the Ad Hoc Approach**

	OBSERVATIONS
Advantage	• It was much easier for agencies to buy-in to an ad hoc model than a full-time commitment. • Agencies that provide services across jurisdictional borders are not tied up in regular meetings with several tables at once. • With Chatham-Kent being single-tier and having low human service provider turnover, the existing collaborative work here negates the need for a full-time table. • Ad hoc approach through conference call has a benefit for regional entities located in different communities. • The ad hoc approach respects privacy better because only appropriate agencies are involved when the client's name is shared. • Convening ad hoc by phone saves a lot of time driving and meeting in person.
Disadvantage	• Our ad hoc approach does not allow for the weekly relationship-building that comes with actual scheduled meetings. • Our team members lack the ongoing learning opportunities that regular Hub table members receive by observing each other coordinate referrals, interventions and closures. • Without regular meetings, there is no consistent reminder to detect low—yet elevating levels of risk. As a result, they end up just bringing chronic high risk situations to the FIRST. • The ad hoc approach requires a coordinator who is asked to take an initial view of referrals and determine their appropriateness before pulling the team together—this is not collaborative.

Improvements

Following their identification of remaining challenges, respondents from the Steering Committee were asked to suggest some improvements that they felt would strengthen the FIRST model. In providing suggestions, respondents focused on two types of improvements. The first includes improvements to things that FIRST is already doing, but should be doing better. Suggestions of this nature included getting better at detecting newly at-risk situations (as opposed to chronic high risk); developing a better understanding of the thresholds of acutely-elevated risk; and not having the coordinator or originating agency suggest who should be on the intervention team, but rather, let agencies decide without prompting or suggestion, whether they should be on the intervention team.

The second type of improvement offered by Steering Committee members included implementations or additions of something new to the FIRST Model. These suggestions for improvement include:

- All-inclusive closure mechanism.
- Collaboration to continue after the situation closes with FIRST.
- Start tracking client outcomes following an intervention.
- For chronic high risk clients, there needs to be a continuous intervention and support plan outside of FIRST.
- We need to take what we learn at FIRST, and begin systematically identifying gaps and barriers of services, so that we can plan and find solutions to fill them.
- We as a Steering Committee need to be more actively engaged in steering this initiative, including trouble shooting, breaking down barriers for our staff on the team, and encouraging the other staff in our organizations to also participate in risk detection and referrals to FIRST.
- The partner agencies need to find a way to combine data for the purposes of better identifying acutely-elevated risk.

- Expand the team to involve more agencies, particularly for the purpose of detecting risk and making referrals to the process

Sustainability

The final topic discussed with members of the Steering Committee was sustainability, and what they felt the key ingredients were to keeping FIRST operational in years to come. In their responses, Steering Committee members identified: new sources of funding for the coordinator position; opportunities for local agencies to contribute dollars; multi-year commitments of individual team members and agencies; ongoing buy-in from the community and leadership as a whole; and ongoing awareness among human service agencies in Chatham-Kent. Some more specific suggestions for achieving sustainability called for continued interest in the initiative—which would require agencies becoming aware of intervention outcomes, learning of successes, and continued opportunities to provide feedback and generate improvements. One final suggestion from Steering Committee members was for FIRST to start identifying systemic issues and present them to the Steering Committee where they can be further examined (and possibly resolved).

9.0 DISCUSSION OF FINDINGS

The results of this evaluation process reveal that Chatham-Kent has been able to successfully implement an adaptation of the conventional Hub Model of collaborative risk-driven intervention. Although we are still quite some time away from verifying successful impacts of FIRST, the initial few months of the FIRST Strategy have shown some great promise.

Within the evaluation period, FIRST was able to engage human service providers in 13 separate situations—12 of which were accepted and acted upon. During the resulting interventions, FIRST members engaged a target group of vulnerable individuals mostly under 25 years of age. The more common risk factors impacting this slightly male-dominated cohort included: mental health, crime victimization, drugs, basic needs, alcohol, emotional violence and criminal involvement. A striking feature of the achieved target group, according to risk-tracking data, is that most of the clients supported through FIRST have rather high complexities of risk. This is corroborated by interview data, which suggests that a majority of FIRST situations involve individuals of high chronic risk—as opposed to newer situations of acutely-elevated risk.

Once risk has been detected, a variety of different agencies have become involved in a fast intervention risk-specific team. The more active agencies involved in the process to date have been Canadian Mental Health Association, Chatham-Kent Employment and Social Services, Chatham-Kent Police Service, Chatham-Kent Victim Services, Family Service Kent, Chatham-Kent Children's Services, and Salvation Army. During these rapid interventions, FIRST members have been able to mobilize multiple services around the needs of clients. The most common services mobilized to date include mental health care, victim support, housing support, and income assistance. When appropriate services are not mobilized, this is largely because of a client refusal of services or because new information has revealed that certain suspected risks did not exist to begin with.

From one client's perspective, the concept of a multi-sector collaborative intervention is pleasantly surprising. Having an opportunity to work with multiple human service providers at once, and around the needs and interests of the client, was described as being quite favourable. Suggesting future client buy-in the most, was the observation that the collaborative setting FIRST provides help to improve and support the roles and dynamics between human service providers and the clients they serve.

Data from interviews with both human service professionals and their managers involved in the FIRST Strategy revealed a lot of optimism for this model. Themes in the qualitative data suggest that FIRST provides new opportunities to help clients collaboratively that were never realized previously. Consequently, this has bridged many longstanding divides in communication, information sharing and inter-agency cooperation. During the mobilization process, members of FIRST were able to engage in real-time detection of risk, limited information sharing, and deployment of an intervention to mitigate the potential for harm. Preliminary reports indicate that this has not only expedited service access, but has introduced both human service providers and clients to services that neither had heard of before.

Outside of mitigating acutely-elevated risk, FIRST produces a number of secondary benefits for the partner agencies involved. One includes the recognizable enhancement to the already strong collaborative working environment in Chatham-Kent. Others include the opportunity for a shared workload, raised community profile, increased internal capacity, and an opportunity to help clients with complex needs. Results of this evaluation also suggest that FIRST helps to close service gaps, bring

additional tools to participating agencies, and inspire human service providers to *up their game* in finding pragmatic social solutions to improving community safety and well-being in Chatham-Kent.

While still only a very young collaborative initiative in Chatham-Kent, key stakeholders have already been able to identify some key attributes for its successful implementation. These include having a central coordinator to maintain momentum and facilitate communication; involving human service providers with sufficient experience and authority to make decisions; and securing instant access to information sharing. Contributing to this success are a number of important strengths: the ad hoc nature of FIRST, shared ownership, protection of privacy, strong discipline, and the speed of service delivery.

Despite rather broad optimism among FIRST Strategy's key stakeholders, a number of critical shortfalls remain. These include: no mechanism for FIRST members to report back on their intervention outcomes; limited multi-sector collaboration in the actual deployment of an intervention; lack of ongoing and consistent early risk detection; minimizing agency relevance before the client is identified; no means to ensure agency follow-through on their commitments; and a pattern of referring chronic high risk clients as opposed to those who may be newly at-risk.

These shortfalls are compounded by a number of challenges, including: respondent reports that not all of the appropriate agencies are involved in FIRST yet; some agencies are slow to access and share information; the training did not prepare team members adequately; there is still uncertainty surrounding the role of consent—which perpetuates siloed thinking; dropping current work commitments for a FIRST intervention causes complications; and not hearing how situations closed undermines both human service provider and agency excitement and motivation for the collaborative risk-driven intervention process.

Although this evaluation is aimed at exploring multiple aspects of the FIRST Strategy, one area of particular interest for many is the design—and in particular, the ad hoc nature of FIRST. Findings of this evaluation suggest great potential for an ad hoc adaptation of the conventional Hub Model. Some respondents claim that the ad hoc approach allows for quicker mobilizations of service than fixed-schedule initiatives—which typically wait for a pre-determined meeting date to present situations. Other positive outcomes for participants of the ad hoc approach include the saving of time, reduction in travel barriers and costs, knowledge of risk (and ability to prepare) before the meeting, and easier cross-jurisdictional communication and responsiveness. Combined, these and other positive qualities of the ad hoc approach contribute to much easier buy-in from community leaders to join and sustain their involvement in FIRST.

In contrast to these positives, the results of this evaluation also highlight a number of challenges. In simple point form, these include:

- The ad hoc approach makes if difficult to build consistency, discipline and role understanding.
- The process for FIRST sees relevant agencies leave the meeting before they can determine previous or current client involvement.
- There is no regular or anticipated interaction among FIRST members concerning process, practice, challenges or solutions.
- Periodic, on-demand meetings undermine continuous detection of elevated risk in favour of an emphasis on easily-visible chronic high risk.

- The ad hoc approach does not naturally foster collaboration beyond the discussion process (e.g. deploying an intervention).
- There is a risk for the team members that if they do not partake in periodic intervention discussions, they will fall out of practice.
- The ad hoc approach requires a coordinator position, which is beyond any human resource or financial requirements of conventional Hub/Situation tables.

Overall, the findings of this evaluation represent one community's very early experiences with an ad hoc approach to collaborative risk-driven intervention. Results on the strengths, challenges, benefits, appropriateness, and perceived impact of FIRST, will hopefully set a new solid foundation for future research and evaluation on Chatham-Kent's *Fast Intervention Risk Specific Teams Strategy*.

10.0 CONCLUSION

Chatham-Kent's adaptation of the Hub Model of collaborative risk-driven intervention using an ad hoc approach is a first of its kind in Canada. In pursuing this approach, the *Fast Intervention Risk Specific Teams Strategy* has experienced both successes and challenges. The findings of this evaluation process have increased our understanding of FIRST—including its origin, design, function, benefits, strengths, weaknesses, and perceived impact. The findings reported herein also help us understand the benefits that human service professionals and managers see in the model.

Moving forward, this evaluation has identified a number of recommendations and suggested improvements to Chatham-Kent's approach to collaborative risk-driven intervention. There is great potential for key stakeholders and members of FIRST to build upon these ideas and maximize the effectiveness, efficiency and overall outcomes of FIRST. In doing so, it is important for all partner agencies to be involved in the planning, development and improvement process. It is this common principle of collaboration, that has helped FIRST transform from an idea to reality.

In close, there is still much to be discovered about the impact of the Hub Model of collaborative risk-driven intervention. In Chatham-Kent, we've seen just the beginning of one small interconnected community's efforts to apply leading practice principles in a manner that best meets their own needs. Only time, and additional risk-specific interventions, will allow us to fully realize the impact of this model on community safety and well-being in Chatham-Kent, ON.

LIMITATIONS

Although evaluators make their best effort to develop sound methodology, gather sufficient quality data, and objectively analyse the results of an evaluation, there are always limitations to the true potential of their evaluation project. In the case of this evaluation, there are a few limitations to disclose to the reading audience. The evaluator has made a concerted effort to reduce the impact of these limitations on the validity and reliability of this evaluation process. However, in the interest of fair and ethical science, they are certainly still worth sharing:

- At the time of this evaluation, there were very few (*N*= 12) discussions completed by FIRST. Therefore, the findings of this evaluation, and the experience of stakeholders upon which these results are based, should not be generalized to a broader ad hoc application of collaborative risk-driven intervention.

- Relatedly, the small *N* of discussions completed within the evaluation period have produced very limited amounts of quantitative data on demographics, risk, and service mobilization. As such, there is very little we can interpret from these results outside of the actual population studied.

- As in any collection of qualitative data from those individuals involved in an initiative, there is a risk of respondent bias. All of the respondents interviewed for this evaluation had at least some type of investment (e.g. time, staff) into FIRST. Furthermore, most of the respondents were aware that FIRST is a one-of-a-kind ad hoc adaptation of the conventional Hub Model that other communities may be curious to learn about. As such, between their own investments in FIRST, and pressure to *look good* for others, there may be an unconfirmed risk of bias in some of the responses.

- Similar to the previous limitation, the evaluator, although fully committed to objectivity, has past experience evaluating collaborative risk-driven intervention initiatives. Although these previous experiences may help to inform questions, data sources, methods and analysis in the FIRST evaluation, there is always a risk that pre-conceived notions of collaborative risk-driven intervention may have influenced the evaluator's assessment of the results.

RECOMMENDATIONS

The findings of this evaluation revealed a number of opportunities to improve, strengthen, expand and sustain Chatham-Kent's *Fast Intervention Risk Specific Teams Strategy*. In September of 2016, the evaluator offered some preliminary recommendations to FIRST in an interim report (Nilson, 2016f). Since then, a number of these recommendations have been acted upon. Where some actions have been taken by FIRST members to implement these early recommendations, a brief update is provided. All remaining recommendations provided herein, are offered for FIRST Strategy partners to consider implementing as they continue to move their collaborative model forward.

1. **REGULAR RELATIONSHIP-BUILDING MEETINGS:** Due to the ad hoc nature of the FIRST Strategy, there is little opportunity for the team members to get to know one another, develop synergy as a team, and build working rapport. Therefore, regular monthly meetings should be held to discuss process, opportunities, questions, practices and the services that each agency provides in the community. {**Update**: *FIRST has initiated a bi-monthly meeting schedule supported by increased email communication*}

2. **REPORT-BACK FEATURE:** Due to the ad hoc nature of the FIRST strategy, there is no opportunity for team members to receive information after the intervention. A simple report-back email or conference call with basic information outlining the action and result of the intervention would validate the process for all team members and their agencies. {**Update:** *FIRST has initiated a secured web-access opportunity for providing de-identified information that updates team members on the result of an intervention*}

3. **DETECT RISK EARLIER ON:** Similar to other collaborative risk-driven intervention initiatives in Canada (e.g. Hub tables), the first few situations brought to FIRST involved chronic high risk individuals. Although this process should be used to address all elevations in risk (e.g., med to high, low to med), it is particularly well-suited for clients who are newly at-risk. Therefore, in identifying referrals to FIRST, team members should be detecting elevations in risk that are further upstream, where rapid intervention has the opportunity to be more effective. {**Update:** *Some partner agencies have begun trying to identify internally, how they can better detect risk at Filter One*}

4. **MOVE TO A HYBRID AD HOC/SCHEDULED APPROACH:** Related to recommendation #3, there is strong evidence in this evaluation that would suggest one of the reasons FIRST has had only 12 discussions in 9 months is because of its ad hoc approach to collaborative risk-driven intervention. Evidence outside of this report shows that similarly-sized communities have had considerably more discussions within this same time frame[8]. Feedback from FIRST respondents suggests that of the 12 situations brought forward, many involved chronic high risk, as opposed to newly at-risk. According to interview data, this is largely because team members felt it hard to justify mobilizing a meeting with lower levels of risk. The spirit of collaborative risk-driven intervention is to work upstream and prevent situations from becoming chronic high risk. Therefore, it is recommended that FIRST explore opportunities to combine their ad hoc approach with regularly-scheduled meetings (e.g. biweekly) to increase their consistency,

[8] Brantford = 144 in 6 months (Babayan et al., 2015); North Bay = 97 in 6 months (North Bay Parry Sound District Health Unit, 2015); Barrie = 66 in 6 months (Nilson, 2015a); Cambridge = 122 in 12 months (Brown & Newberry, 2015); Lanark County = 57 in 12 months (Gray, 2016).

capability and commitment to early risk detection; while also preserving the benefits of an ad hoc approach.

5. **EXPAND PERCEPTION OF "RELEVANT" AGENCIES:** In its design, the FIRST Strategy excuses "non-relevant" agencies from the discussion process at Filter Two, prior to the client's name being shared. Feedback gathered in this evaluation process has identified that even within the small number (N = 12) of situations FIRST has discussed, those leaving the discussion at Filter Two happened to have valuable information that the intervention team required. Although FIRST has adopted this practice in response to interpretations of privacy and information sharing guidelines, the narrowness of what is considered "relevant" appears to be limiting the team's ability to confront the de facto principle of *you don't know what you don't know*. The composite and diverse nature of risks presented at FIRST, combined with the sheer volume of different risk factors (average = 11.3) would suggest that there are many more relevant human sectors that should be sticking around for Filter Three than there are currently. Therefore, it is recommended that while still remaining diligent in their efforts to protect individual privacy, FIRST broaden its understanding of "relevant agencies" so that more agencies can contribute to limited information sharing at Filter Three, and ultimately, risk mitigation at (and after) Filter Four.

6. **ENGAGE SECTORS THAT ARE MISSING:** In a multi-sector approach to risk mitigation, it is critical that as many sectors are accessible as possible. Therefore, it is important for FIRST to engage additional sectors not currently represented on the team (e.g. cognitive disabilities, senior care). Similarly, while some sectors may be part of the team, ensuring that all sectors are actively detecting risk and contributing to interventions (when appropriate) is also critical. Therefore, FIRST should consider a brief campaign to engage new sectors and reenergize existing sectors that participate in the process. {**Update:** *The FIRST coordinator has booked presentations with other community agencies who are not yet involved in FIRST*}

7. **DEPLOY MULTI-AGENCY INTERVENTIONS:** Some of the interview feedback and quantitative reporting data suggested that a number of the interventions are being deployed by a single agency, as opposed to a collaborative team effort. Although each intervention plan is (and should be) uniquely individual, the merits of collaborative intervention considerably outweigh those of single sector intervention. Therefore, when appropriate and as much as possible, FIRST members should engage clients in a collaborative approach[9].

8. **INVOLVE ALL AGENCIES IN DISCUSSION CLOSURE:** One difference between the ad hoc approach and the conventional approach to collaborative risk-driven intervention is that the former has no report-back. The other is that there is no opportunity to involve the full team, as a collective, in a brief discussion around closure. Therefore, just as previous recommendations suggest providing the partner agencies with a de-identified report-back, this recommendation suggests that FIRST involve all partner agencies in a de-identified discussion around closure. Involving the full team in a discussion around the reasons for closure will create an environment of discipline and accountability that ensures the very best opportunity was presented to the client before his/her discussion is closed.

[9] It may very well be that single agency interventions have occurred through FIRST because the majority of the 12 interventions to date involved chronic high risk individuals—who may already have a pre-existing relationship with a human service provider. In these cases, it may not be optimal to deploy an initial intervention with more than one team member.

9. **PROVIDE HOME AGENCY STAFF WITH AN ORIENTATION ON FIRST:** With reports of uncertainty among staff of partner agencies on the purpose, design, and process of FIRST, it may be appropriate for the FIRST coordinator, in cooperation with each agency's representative to FIRST, to give a general orientation session to all staff in each partner agency. This has the potential to not only improve awareness of FIRST, but improve detection of risk and cooperation during intervention planning and deployment.

10. **EXPLORE SUSTAINABLE FUNDING OPTIONS FOR COORDINATOR POSITION:** Since the results of this evaluation highlight the critical importance of the coordinator position to the ad hoc approach, the partner agencies should begin looking both internally and externally to see how they can sustain this position as a collective. Although Chatham-Kent Police Service and Chatham-Kent Employment and Social Services have contributed generous amounts to FIRST, those funds are not endless. For FIRST to be truly sustainable, each partner agency may wish to consider how much it can build into its annual budget to help cost-share the coordinator position (and other related expenses).

11. **IDENTIFY AND COMMUNICATE SYSTEMIC ISSUES TO AGENCY LEADERS:** Thinking toward the future, as FIRST continues to rapidly mobilize services around individuals in situations of acutely-elevated risk, the members will be confronted with a variety of systemic barriers. Gone unaddressed, these barriers will undermine the efforts of human service providers to improve client outcomes. Therefore, it is important that FIRST members work with their Implementation Committee and Steering Committee to implement a process through which systemic issues identified by FIRST can be communicated upward—for management to try and address.

12. **CONTINUE ONGOING EVALUATION OF THE FIRST STRATEGY:** As a first step in exploring progress to date, this evaluation has provided an opportunity to examine early successes, challenges, lessons learned, and opportunities for improvement. Ongoing analysis of FIRST discussion data, in conjunction with continued evaluation of the ad hoc approach, will help FIRST establish better understandings of its impact on service access, risk reduction, and ultimately, community safety and well-being in Chatham-Kent.

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APPENDICES

FIRST Evaluation

CLIENT INTERVIEW GUIDE

1) How did you initially become involved with this diverse team of professionals from different agencies and sectors?

2) What was your initial reaction when this group of different professionals approached you to offer help and support?

3) Have you behaved or acted differently since they mobilized an intervention around you?

4) What was the impact of their intervention on you?

5) Did you notice a change in this interaction with human service providers compared to your previous interactions with them?

6) If you were to share a message with other people who this team might mobilize around, what would that message be?

FIRST Evaluation

TEAM MEMBER INTERVIEW GUIDE

1) What is your overall perspective on FIRST?

2) How efficient is the team from the point of risk detection to service mobilization?

3) Has the team been effective at getting clients access to services?

4) How has FIRST enhanced collaboration among the agencies involved?

5) What have been the benefits of FIRST to your agency?

6) Within the context of FIRST, what attributes to successful mobilization of services?

7) What are the strengths of this model?

8) What are the weaknesses of this model?

9) Are all the necessary human service sectors involved in FIRST?

10) Is the ad hoc approach to collaborative risk-driven intervention appropriate for Chatham-Kent?

11) What preparations were taken to help you and your colleagues become ready for FIRST?

12) What challenges have you observed to exist with FIRST?

13) What suggestions do you have for improving FIRST?

14) What is required to secure the sustainability of FIRST?

FIRST Evaluation

STEERING COMMITTEE INTERVIEW GUIDE

1) Why did your organization become involved in FIRST?

2) In your perspective, where does the ownership of FIRST lie?

3) How has FIRST affected collaboration among the partner agencies?

4) What have been the benefits of FIRST?

5) What do you see as the strengths of the model?

6) What do you see as being the challenges faced so far?

7) Do you feel that the ad hoc approach is appropriate for the needs of Chatham-Kent?

8) What suggestions do you have for improving FIRST?

9) What do you feel is required for FIRST to become sustainable?

ABOUT THE AUTHOR

Dr. Chad Nilson is vice president of research and evaluation at the Global Network for Community Safety, where he provides research, evaluation, advising and planning services to various community-based organizations and government agencies in municipal, provincial, federal, and Aboriginal jurisdictions. Chad is also the inaugural research fellow at the Centre for Forensic Behavioural Science and Justice Studies – University of Saskatchewan. Chad has developed a strong research agenda in community safety, has helped communities build strategies for violence reduction, and as lead investigator with the Living Skies Centre for Social Inquiry, has conducted numerous evaluations of crime prevention and health promotion programs.

Since releasing his 2014 preliminary impact assessment on the Hub Model in Prince Albert, Chad has been invited to lead and support conversations and planning of collaborative risk-driven intervention practices, data collection and evaluation across the country. As a technical advisor to the Ontario Working Group on Collaborative Risk-Driven Community Safety, Chad developed a supportive guide to lead evaluation of community safety and well-being in Ontario. On behalf of Public Safety Canada, Chad gathered lessons learned from the Samson Cree Nation Hub in Alberta. Chad also serves as an evaluation advisor to several Hub/Situation Tables in Ontario, Saskatchewan, Alberta, Manitoba, British Columbia, and Prince Edward Island. Finally, Chad continues to support various communities with his expertise as the lead developer of the Hub (Risk Tracking) Database now being used across Canada.

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