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Canada's Hub Model: Calling for Perceptions and Feedback from those Clients at the Focus of Collaborative Risk-Driven Intervention

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In 2012, the province of Saskatchewan saw the human service professions of policing, mental health, addictions, education, and corrections, among others, begin a fundamental shift in the way they do business. As some strategists claim (SPSS Enterprise Group, 2011), there was a demonstrable need for human service professionals not only to collaborate in their efforts, but together, also focus on immediate mitigation of risks that lead to harm, thereby improving community safety and well-being in the long run. Responding to this need, human service professionals in Prince Albert, Saskatchewan, developed and mobilized what has since become known nationally as The Hub Model (McFee & Taylor, 2014).

The Hub Model

The Hub Model represents a gathering of human service professionals who typically meet once or twice a week to detect acute elevations in complex client risk, share limited information necessary to identify client needs, and plan rapid interventions designed to mitigate those risks before harm occurs (Nilson, 2014). The Hub Model was designed as an upstream, interventionist approach to community safety and well-being that would allow human service providers from multiple sectors to collaborate around the improvement of client outcomes.

The original architects of the Hub Model (Mcfee & Taylor, 2014) explain that observations of community collaboration efforts in Glasgow, Scotland were confirmation that human service professionals from multiple disciplines could work together. Furthermore, past evidence from Boston's Operation Ceasefire (Braga & Wesiburd, 2012) and other applications of the Pulling Levers Deterrence Strategy (Engel, 2013; McGarrell & Chermak, 2003; Papachristos, Meares & Fagon, 2007)—although quite different from Canada's Hub Model—demonstrated that multiple human service professionals can reduce harm by mobilizing supports around individuals showing elevations in risk. These assurances, combined with the shared desire to "do better", prompted community leaders in Prince Albert to launch the Hub Model in 2011 (McFee & Taylor, 2014).

In practice, the Hub Model facilitates the sharing of client information in a way that protects privacy. In fact, working within the confines of several privacy regulation frameworks, the Hub Model's Four Filter Process has allowed collaborators to mitigate risk while upholding several key principles of information sharing within the context of community safety and well-being (Russell & Taylor, 2014). This has allowed human service providers to step beyond their traditional government silos and collaboratively find innovative ways to help clients like never before (Brown & Newberry, 2015).

There are essentially three parts to the Hub Model. The first is an internal process of risk detection that human service agencies adopt in their day-to-day service delivery. Where single agencies cannot address composite risk alone, they approach the second part of the Hub Model—the discussion process. This highly disciplined process allows human service professionals to systematically share client information while complying with their respective privacy regulation frameworks. The third part of the Hub Model involves a multi-sector intervention that consists of a largely non-scripted, custom-made opportunity to offer clients support in a non-coercive fashion. Following this intervention, or "door knock", members of the intervention team report back to the larger table, and the group collectively determines if sufficient steps have been taken to close the discussion (Nilson, 2016a).

Existing Research on the Hub Model

Since the launch of the Hub Model in Prince Albert in 2011, dozens of communities across Canada have replicated these efforts through forms of collaborative risk-driven intervention (Kalinowski, 2016; Russell & Taylor, 2015). Following many of these replications has been the analysis of Hub data (Lamontagne, 2015; North Bay Parry Sound District Health Unit, 2015; Nilson, 2016b; Winterberger, 2015), along with a variety of evaluations (Babayan, Landry-Thompson & Stevens, 2015; Brown & Newberry, 2015; Lansdowne Consulting Group, 2016; Litchmore, 2014; Ng & Nerad, 2015; Nilson, 2014; Nilson 2016c; Nilson 2016d)—all of which have helped inform our understanding of the Hub Model, its process, outputs, and preliminary outcomes.

Early narratives on the model (McFee & Taylor, 2014; Nilson, 2014) helped to conceptualize and document the

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discipline and process of the Hub Model. Other contributions to the literature focused on early replications of the Hub Model in large urban areas (Ng & Nerad, 2015), as well as small rural communities (Nilson, 2016c). Previous examinations of the Hub Model have also reported on early outcomes, including: increased access to services (Nilson, 2014); quicker access to services (Litchmore, 2014); better understandings of client needs (Babayan et al., 2015); improved communication among agencies (Ng & Nerad, 2015); reduced barriers to support from human service agencies (Brown & Newberry, 2015); identified gaps in the human service delivery system (Brown & Newberry, 2015; Nilson 2015a); increased efficiencies in human service delivery (Lansdowne Consulting, 2016); and improved client-service provider relations (Nilson, 2016d). Beyond evaluation, ongoing analyses of Hub data have been highly informative on the risk factors affecting Hub subjects (Lamontagne, 2015; North Bay Parry Sound District Health Unit, 2015; Nilson, 2016b; Winterberger, 2015).

In much of the research and evaluation on this model, the perspectives and feedback gathered to develop data have largely come from human service providers and/or their management teams. In fact, only two evaluation efforts to date (Newberry & Brown, forthcoming; Nilson, 2016d) have successfully gathered data from actual clients involved in Hub discussions. Some of the reasons given for the lack of data from client subjects of Hub discussions include a lack of follow-up with clients in the Hub discussion process (Brown & Newberry, 2015), as well as limitations in data collection capacity at the local level (Babayan et al., 2015).

Despite these challenges in collecting data from clients, research and evaluation in other fields (Beinecke & Delman, 2008; Bloom, 2010; Clark, Scott & Krupa, 1993) has demonstrated that gathering data from clients of social interventions is a critical part of understanding the impact, strength, and weakness of that particular intervention. In fact, larger evaluation frameworks focused on community safety and well-being (Nilson, 2015b) have also called for methodologies to involve intervention clients as key data sources.

Gathering Data from the Subjects of Collaborative Risk-Driven Intervention

To fill this void, this commentary calls for researchers, evaluators, analysts, and human service professionals to work together in identifying opportunities for data to be gathered from the actual subjects of collaborative risk-driven intervention. Cooperation with human service professionals will be absolutely critical in gaining access to the preferred study cohort. Of course, the involvement of human service professionals in accessing clients does come with the risk of sample bias and even potential response bias among respondents. However, with proper sampling, survey and/or interview methodology, some of these limitations can be overcome.

In using discussion subjects as data sources, the research and evaluation community may wish to explore a variety of topics including client perception, satisfaction, change, impact, overall concerns, and suggestions for improvement. Being able to understand the impact of collaborative risk-driven intervention on clients and their families, from the perspective of Hub subjects themselves, will certainly validate (and/or challenge) the existing research to date. Additionally, gathering perspectives and feedback from clients at the focus of Hub discussions will enlighten our understanding of how well interventions are received, what makes them effective, the time duration and sustainability of their effects, and what can be done to improve collaborative risk-based client service delivery in general.

CONFLICT OF INTEREST DISCLOSURES

The author holds a business relationship with the Editor-in-Chief of this Journal.

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