Collaboration in progress

A perspective on the evolution of collaborative processes within 15 local service networks

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PARTICIPATING CSSS

Agenda

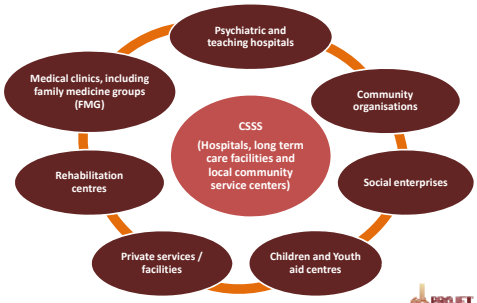
- Overview of Quebec's ministerial Mental Health Action Plan (MHAP)
- Overview of Dialogue Research Program
- A Model on Inter-Organizational Collaboration
- A closer look on two sites
- Conclusion

Quebec Mental Health Action Plan (2005)

Primary care is considered as the main component of mental health care delivery, using local networks to optimize services

- Implementation of mental health multidisciplinary teams in CSSS addressing all MH disorders (adult / youth) and supporting primary care providers
- Centralized access point to mental health services, located in primary care, for all mental health services
- Identification of clinical advisors to support primary care workforce

Local Services Network (LSN)



Dialogue Research Program

Overall goal

- To identify the contextual and organisational factors that influence the quality of mental health primary care services

Dialogue Research Program

- Contextual study
- Organisational study
- Clientele study

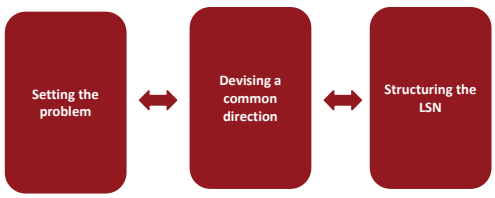
Contextual study
Methodological overview

Collaboration

2006 | 2007-2008 | 2009

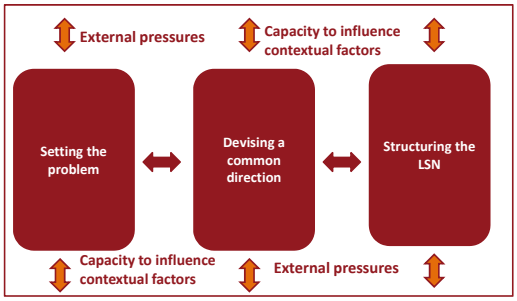
- **MULTIPLE CASE STUDY : n=15**
- **DATA COLLECTION**
  - **Focus groups with key informants (n>200)**
  - **Individual interviews**
    - **Local respondents**
    - **Regional respondents**
    - **Family physicians**
  - **Documentary sources**

Conceptual model on collaboration

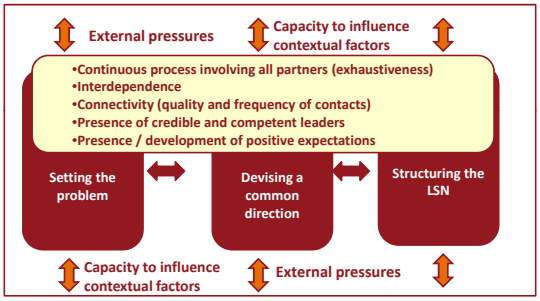


Adapted from Gray, 1985; Fleury & al., 2002, D'Amour & al., 2005; 2003)

Conceptual model on collaboration /2



Conceptual model on collaboration /3



PRESENTATION OF TWO LSN

- In the same region, under the same health authority
- Both served by the same teaching hospital
- Both without the capacity to hospitalize MH clients

An urban local service network
A few characteristics

An history of conflict between:

- Health organizations
- Psychiatrists and family physicians
- Various actors with the Health authority

CSSS → People with severe MI

Issues :

- Access to services
- Emergency services are under scrutiny
- Rapid development within CSSS (MH)

A rural local service network
A few characteristics

An history of close collaboration:

- Including family physicians
- Local organization of services (limited use of specialized care)

CSSS → people with common MI

Issues:

- Limited resources
- Small community
- MH remains marginal within CSSS

Collaborative Initiatives (Urban)

Regional Initiatives 2007-2008

- **Transfer of Clienteles** — CSSS + Teaching Hospital (TH)
- **Clinical Advisors (mentoring)** — CSSS+ Teaching Hospital (TH)
- **Training** — Health Authority (HA) + Teaching Hospital (TH) + CSSS

Local Initiatives 2007-2008

- **Length of Stay in Emergency Rooms** — TH +CSSS
- **Continuum of Care** — CSSS +TH
- **Liaison (from TH)** — CSSS+ TH
- **Clinical Supports (Navigating the system)** — LSN +Consumers
- **Access & Support of Residential Facilities** — CSSS+TH

Collaborative Initiatives (Rural)

Regional Initiatives 2007-2008

- **Clinical advisors (mentoring)** CSSS+ FP+TH
- **Transfer of clienteles** CSSS+TH
- **Tele Health +Training** HA+TH+CSSS

Local Initiatives 2007-2008

- **Service agreements** CSSS+ community organizations (across sectors)
- **Clinical project** CSSS, GP+ Local Partners
- **Suicide prevention** Community organisations (CO) + union+ CSSS

Collaborative Initiatives (Urban)

2009 -Regional initiatives

- **Clinical advisors (mentoring)** CSSS+FP+TH
- **Residential + Housing Needs** HA+TH+CSSS
- **Transfer of clienteles** CSSS+TH
- **Assessment tool for access points** TH+CSSS
- **Training** HA+TH+CSSS

2009 -Local initiatives

- **Liaison (from TH)** CSSS+ Addiction Rehab Centers +TH
- **Length of Stay in Emergency Rooms** TH +CSSS
- **Clinical Supports (Navigating the system)** LSN +Consumers
- **Continuum of care** CSSS+TH
- **Access & Support of residential facilities** CSSS+ TH

Collaborative Initiatives (Rural)

Regional Initiatives 2009

- **Residential +Housing Needs** HA+TH+CSSS
- **Assessment tool for access points** TH+CSSS
- **Clinical advisors (mentoring)** CSSS+FP+TH
- **Tele Health +Training** TH+CSSS
- **Transfer of clienteles** CSSS+TH

Local Initiatives 2009

- **Clinical project** CSSS, FP+ Local Partners
- **Service agreements** CSSS+ CO (across sectors)
- **Suicide prevention** CO+ union+ CSSS

Collaborating with family physicians (Urban)

Deploying Expertise – Clinical Advisors

2007- 2008 Planned deployment	2009 Implemented deployment	2009 Planned deployment

• **1 pharmacist**
• **1 GP**
• **3 Psychiatrists**
  • 2 for 3 Family medicine groups (FMG)
  • 1 for PC MH team
	• **1 Pharmacist**
	• **7 Psychiatrists**
	  • 3 in FMG
	  • 1 with PC MH team
	  • 1 Detention Center
	  • 1 Rehab Centre (dev.)
	  • 1 Nursing home
		• **Psychiatrists**
		  • 1 Rehab Center (Addictions)
		  • 3 for remaining FMG
		  • ? / Large medical clinics
		• **1 GP**

Collaborating with family physicians /2
Deploying expertise – Clinical Advisors (Urban)

As a result

- ↑ interest from psychiatrists for shared care
- ↑ connectivity with family physicians and participation in joint events on MH
- ↑ number of patients with mental health issues enrolled with a GP (2 for 1 deal)

Collaborating with family physicians - Rural

Changes Observed

2007-2008	2009
• Most GP were associated with CSSS (co-location) • A psychiatrist (private sector) offered mentoring sporadically through in-services • A family physician took an active role in supporting colleagues and MH services implementation	• Due to a medical reorganisation, GP have left the physical premises of the CSSS • A new psychiatrist assumed mentorship • Shadowing, community visits, consultations, trainings • ↓ connectivity with GP • ↓ involvement of family physician

Collaborating with family physicians - Rural

As a result

- ↑ interest from family physicians in shared care
- ↓ connectivity with family physicians
- Flexibility in response for patients of PC MH team

Integrating access (Urban)

Limited recognition of legitimacy of PC MH team in specialised care

Introduction of a PC MH nurse (liaison) working in specialised care

- Facilitate continuity of care with emergency services and psychiatric wards

Introduction of a addictions specialist in specialised care

- Pursuing same goals
- ↑ integration between specialised, PC MH services and Rehab Services

Leadership and change (Urban)

Both perceived as credible and competent within LSN

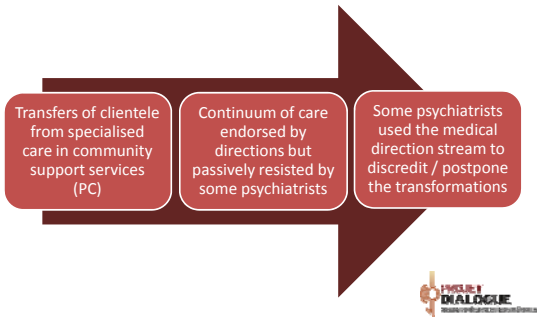
Managerial Leadership In CSSS MH Services

Medical and Managerial Leadership in Teaching Hospital MH Services

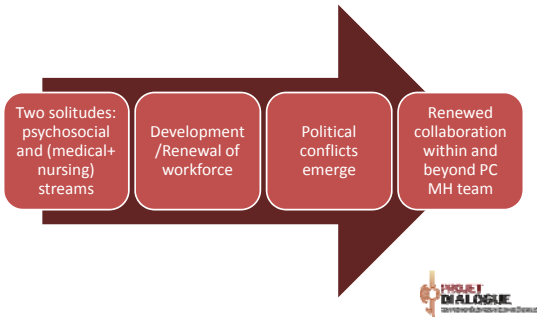
BUT

Managerial leadership was discredited by some psychiatrists in specialised care

Leadership and change (Urban) /2



Teamwork development (Rural)



A few lessons learned from the 15 sites

- The Quebec Mental Health Action Plan brought important changes in most LSN, including collaborative initiatives
- Parallel medical direction fosters challenges to services reorganisation
- Tensions between focused and diffuse attention to changes in systemic transformations
- Tensions between team development and team consolidation
- Complexity of needs drives collaborative practices
- Primary care MH services are the entry door of the MH system: they need to learn that they don't have to "do-it-all"

Conclusion

Local service networks are invited to:

- Favour co-location when possible
- Develop strategies to involve hesitant partners
- Work more collaboratively with family physicians
- Formalise collaborative initiatives

Questions or comments

Thank you!

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