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

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Acknowledgements

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)

- Psychiatric and teaching hospitals
- Community organisations
- Social enterprises
- Rehabilitation centres
- Private services / facilities
- Children and youth aid centres
- CSSS (Hospitals, long term care facilities and local community service centres)

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

Setting the problem

Devising a common direction

Structuring the LSNI

Adapted from Gray, 1985; Fleury et al., 2002, D'Amour et al., 2005; 2003)
Conceptual model on collaboration /2

Setting the problem
- Capacity to influence contextual factors

Devising a common direction
- External pressures
- Capacity to influence contextual factors

Structuring the LSN
- External pressures
- Capacity to influence contextual factors

Conceptual model on collaboration /3

Setting the problem
- Continuous process involving all partners (exhaustiveness)
- Interdependence
- Connectivity (quality and frequency of contacts)
- Presence of credible and competent leaders
- Presence / development of positive expectations

Devising a common direction
- External pressures
- Capacity to influence contextual factors

Structuring the LSN
- External pressures
- Capacity to influence contextual factors

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 Clients
  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)
  LS + Consumers
- Access & Support of Residential Facilities
  CSSS + TH
Collaborating with family physicians (Urban)

Deploying Expertise – Clinical Advisors

2007-2008 Planned deployment
- 1 Pharmacist
- 1 GP
- 3 Psychiatrists
  - 1 for 3 family medicine groups (FMG)
  - 1 for PC MH team

2009 Implemented deployment
- 1 Pharmacist
- 7 Psychiatrists
  - 3 in FMG
  - 1 with PC MH team
  - 1 Detention Center
  - 1 Rehab Centre (dev.)
  - 1 Nursing home

2009 Planned deployment
- Psychiatrists
  - 1 Rehab Center (Addictions)
  - 3 for remaining FMG
  - 7 / 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
- 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

2009
- 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

- Transfers of clientele from specialized care in community support services (CSC)
- Continuum of care endorsed by directions but passively resisted by some psychiatrists
- Some psychiatrists used the medical direction stream to discredit/postpone the transformations

Teamwork development (Rural)

- Two solitudes: psychosocial (medical+nursing) streams
- Development/Renewal of workforce
- Political conflicts emerge
- Renewed collaboration within and beyond PC MH team

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:

• Favor 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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