GETTING OUR ACTS TOGETHER: INTERAGENCY COLLABORATIONS IN CHILD AND YOUTH MENTAL HEALTH

EXECUTIVE SUMMARY

GOAL
The goal of this project was to review literature to help us understand how child and youth mental health organizations can operate more seamlessly to provide services. In this report we paid specific attention to strategies and linkages between agencies (versus within agencies or between sectors).

Below you will find a summary of what we found. For more detail and a better understanding of our methodology, please refer to the full technical report (attached).

THE ONTARIO CONTEXT
Currently, we cannot be certain about how many Ontario children and youth have a mental disorder since there are no good up-to-date prevalence studies. What we do know, generally speaking, is that about one in ten youth has a serious emotional or behavioural problem that is severe enough to cause significant impairment in functioning at school, at home, or in the community (Friedman, Katz-Leavey, Manderscheid et al, 1996). Moreover, 75 percent of children with emotional and behavioural disorders do not receive mental health services (Ringel & Sturm, 2001; Stroul, Blau & Sondheimer, 2008), and those who do receive care often receive treatments and interventions that are not based on evidence of efficacy or effectiveness (Hoagwood & Olin, 2002). There is much work to be done, both in the Canadian context and abroad, to move toward the implementation of evidence-based practices in children's mental health service delivery.

Children, youth, and their families repeatedly describe the current service delivery system as disjointed and detached, reporting silos within and between service systems. These perceptions are echoed by advocates, service providers, administrators, researchers and policy makers. In the current system, there is a fairly wide range of services and supports, but this is coupled with increased fragmentation of service delivery. The combination of these factors creates barriers
for young people and their families in their attempts to access and negotiate services (Boydell, Pong, Volpe et al., 2006). Clearly, there is more to be done so that the children and youth of Ontario and their families have a seamless, coordinated experience with the mental health system.

**Setting the stage for seamless delivery – the Ontario policy context**

Opportunely, a framework for change already exists. In 2006, Children’s Mental Health Ontario (CMHO), in tandem with the Ministry of Children and Youth Services (MCYS), produced *A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health*. This policy document is the result of cross-sectoral collaboration and consultation and emphasizes the need for coordinated care – that families/caregivers, communities, service providers, government and all child- and youth-serving sectors are collectively responsible for the healthy development of Ontario’s children and youth. This framework provides strategic direction for ongoing improvements over the next several years. Key principles of the framework include a child-, youth- and family-centred system that is community driven, where supports and services are provided as close to home as possible. It is a system that is accessible, coordinated, collaborative, evidence-based and accountable. The policy report recognizes that a continuum of flexible, broad, needs-based services and supports are essential to success. The more recent MCYS document *Realizing Potential* outlines five key goals to enhance child and youth mental health:

1. Every child and youth has a voice
2. Every child and youth receives personalized services
3. Everyone involved in service delivery contributes to achieving common outcomes
4. Every child and youth is resilient
5. Every young person graduates from secondary school (MCYS, 2008).

These goals demand that Ontario strengthens partnerships and provides greater leadership in nurturing and supporting capacity building. The need to strengthen service interconnectivity features prominently in the plan.

**Ontario: “Integration ready”**

Encouragingly, the Ontario system is already well on its way in terms of the journey toward an integrated system. A policy document (described above) with a strong philosophical stance has already been established. The provincewide screening and measurement tools are now widely
accepted and used by service providers. Many children’s mental health organizations are establishing themselves as evidence-based organizations and changing their organizational cultures accordingly. But in order to move forward toward action, it is important to get a better understanding of what the research evidence tells us about integration and what we learn when those efforts are evaluated.

**Promising examples of integrated systems in Ontario**

Although the system of mental health services for children and youth in Ontario is often perceived as fragmented and confusing to the people who are trying to use it (as well as those working within it), there are some very good ‘home grown’ examples of attempts to more seamlessly provide services. This section provides a description of some of these programs, services and supports. When reading these examples, it is important to note that there is limited research information available as to their effectiveness and any positive outcomes on children, youth and their families. In the attached technical report, you can also find examples of integrated systems from other jurisdictions and from the adult mental health sector.

1. Contact Hamilton and Contact Brant represent an integrated children’s mental health screening, triaging, outcome measurement and service management system (Cunningham, Harrison, Knight et al, 2007). It is the central point of intake for all families seeking mental health and developmental services for their children. Peirson (2007) used qualitative case study to explore, understand and describe the implementation process of this initiative. She asked key questions pertaining to intent, expectations, implementation, and factors that influenced the process and found that the implementation process was dynamic and complex, unfolded over a number of years and involved many different agents, resources, decisions and activities. Key themes included: expanding the boundaries of implementation, the instrument of implementation and the human element, among others.

2. The Integrated Services for Northern Children (ISNC) program is a joint effort by the Ontario Ministries of Children and Youth Services, Health and Long-Term Care, Education, and Northern Development and Mines to meet the special needs of children in the region’s rural areas or small towns (Minore, Boone, Arthur et al. 2005). It is designed to provide an integrated network of mental health, special education and health services to children and their families who reside in the rural communities of the Thunder Bay District. The program’s service model depends on interdisciplinary teams of city-
based professionals – known as the resource group – who travel regularly to northern sites to provide assessment, consultation, and some treatment. Minore et al.’s study (2005) indicates that residents of outlying communities preferred the intervention worker model when it came to implementing care plans (on six measures of continuity), but they accepted the volunteer mediators who provided community-based treatment.

3. There are examples of multi-agency programming in Ontario, where resources from two or more agencies are combined to create new services. Creating a new service entity staffed by multiple agencies stimulates services integration. An example of this programming is the Whatever it Takes (WIT) program, a partnership between two child- and youth-serving agencies in the Greater Toronto Area - East Metro Youth Services and Griffin Centre. Together, they assist the service system in responding to the needs of children and youth who have complex clinical profiles and service needs. WIT is not a direct service program for clients. Rather, it helps the helpers, providing assistance to the entire service delivery system by finding and providing appropriate services for those in need. In addition, WIT communicates with the various ministries to make them aware of service needs and gaps. To date, there is no evaluative component to indicate how successful this model program is in terms of enhancing care for families and young people with complex needs.

4. Communities of practice (CoPs) have been used in the child and youth mental health system to bring together groups of stakeholders involved in utilizing the Child and Adolescent Functioning Assessment Scale (CAFAS), the common outcome measure for child and youth mental health. Barwick, Boydell & Basnett (2008) recently investigated nine regions in Ontario that regularly met to share their use of the CAFAS, their experiences and how the CAFAS may inform their practice. Practitioner trainees were assigned to either a community of practice group or a practice as usual group, and practice change and knowledge uptake were investigated. Findings support the potential of CoPs to bring about change in practice. They also reported that dedicated time on the job should be given to these types of activities in order to promote change readiness.

These examples clearly show that there are many exciting integration initiatives in child and youth mental health across the province, and early evaluation work is promising. There are also many more initiatives aimed at providing a seamless experience that lack any empirical evidence of their success and were not described here. However, these warrant attention and could be considered promising practices. As in the greater body of
research literature described below, much work remains in terms of exploring the relationship between actions and outcomes – they are often nonlinear and hard to predict.

WHAT THE LITERATURE TELLS US ABOUT INTEGRATION

A brief word on definitions and conceptual frameworks

We can conclude from the literature that there is no commonly accepted definition of integration (Durbin, Rogers, Macfarlane et al. 2001; England & Lester, 2005; Provan, Fish & Sydow, 2007; Wihlman, Lundborg, Axelsson et al. 2008). The term has many meanings and definitions (Kodner & Spreeuwenberg, 2002). Some of the terms associated with or used interchangeably with integration are: networking, cooperation, partnership, collaboration, continuity of care, joint venture, merger, alliance, amalgamation, coordination, alignment, and coalition. For the purposes of this document, we will use the Ontario Ministry of Health and Long-Term Care’s (MOHLTC) conceptual definition of integration:

Integration is defined broadly to encompass the process of effectively managing the alignment of multiple systems of independent (and interdependent) organizations with unique goals and objectives.

The scientific field is also grappling with understanding interagency collaboration and integration from a theoretical perspective, although this understanding is currently limited (Polivka, 1995). While this report is not intended to be a discussion of conceptual and theoretical models, it is important to note that they exist (for example, the Interagency Collaboration Model, Polivka, 1995; Polivka, Dresbach, Heimlich et al, 2001) and provide value in understanding the frameworks and processes underlying attempts at collaboration. A brief examination of three conceptual models can be found in the accompanying technical report.

What integration efforts have been shown to do

Our review of the literature indicates clearly that when you integrate services and agencies, you find that children, youth and their families experience enhanced access to services, increased community-based services, more timely assessment and referral and improved satisfaction with services (Bickman, 1996; 2000). Further, such efforts are shown to increase the involvement of families and young people in determining needed services that are individualized, flexible, culturally competent and strengths based (Burns, Schoenwald, Burchard et al. 2000). It is important to note, however, that integration does not necessarily save money, despite the fact that cost was one of the original reasons for integration. Research has found that it costs more
up front to do it, but there are some cost savings over the long term. Many authors are quick to point out that costs are offset by gains in quality of care and the experience of children, youth and their families.

**Lessons learned – Elements of success**

The integration literature has much to offer in terms of lessons learned that contribute to success (Johnson et al. 2003). The following features are identified in the Johnson et al review (2003):

- Commitment to the coordination effort is critical and is the foundation of successful interagency collaborations
- Shared goals and vision as well as a willingness to modify procedures
- Open lines of communication
- A proactive approach regarding partners should be taken wherein partners are up front about issues and address differences when they arise
- Frequent opportunities for communication should be created through regular meetings, e-mail and phone calls. It is critical that upper management be involved and provide direct assistance when problems arise
- Using a cultural view further encourages partners to seek solutions that are sensitive to the unique cultures of the agencies involved
- It is important to take the time to learn the mission, priorities and technical language of other agencies
- The provision of time and additional resources should be provided for those participating in collaboration, and rewards and incentives are also identified as facilitators of collaboration
- Finally, engaging in pre-planning is a feature of successful integration models, where steering committees are formed to develop the partnership and identify potential concerns and key issues, as well as similarities and differences between the agency cultures

As part of this project, all of the collected articles and reports were systematically reviewed with the specific intention of identifying common themes. We found nine central themes in the literature on integration in health and mental health care. These elements were shown to be critical factors in successful integration efforts, and can be considered as strategies and tools for achieving integration at the interagency level:
1. Produce a clear statement of philosophy enshrined in policy
2. Create standardized system-level screening and outcome assessment
3. Involve families and young people
4. Construct a learning organization
5. Support communities of practice (CoPs)
6. Attend to leadership issues
7. Consider an interagency council
8. Ensure formal contracts/agreements
9. The innovative role of the boundary spanner

**Barriers to integration**

Numerous barriers are identified in the integration of health care (Kodner & Spreeuwenberg, 2002). These barriers are important to understand so that we can plan and implement integration efforts in ways that will avoid as many of them as possible. One broad challenge that we know about is the limited effect integration efforts have on social problems that are shaped by national economic trends or public policy (Rowe, Hoge, and Fisk, 1998). At the agency level, staff/administrators may also resist what they feel is an intrusion on their right to make the decisions that they deem best for their agency and clients, leading to agencies which may counter strong attempts to emphasize system versus agency needs. There are also ‘opportunity costs’ – staff must devote time and resources to handling issues related to coordination that could be spent directly on client services. Thus, the costs of integration can be substantial.

Fundamental to any program’s success is the capacity to finance its efforts. However, as Zimmerman et al. (2001) demonstrate, existing financing structures are not set up to promote the integrated delivery of services and, in fact, often impede it. Johnson et al (2003) document a multitude of barriers to interagency collaboration in their review of the literature. These include a lack of understanding of other agency’s policies and cultures, lack of communication between policy makers and service providers, lack of time for collaborative efforts, unclear goals and objectives, and resistance to change. In the case of Ontario, barriers to integration have been identified that relate to the diversity of the people and the geography (Provincial Centre of Excellence for Child and Youth Mental Health at CHEO, 2006).

**Evaluating integration efforts**

The need for evaluation in this realm has been well established (Human Services Integration Network, 2007). In particular, there is increasing recognition of the need for individuals,
agencies and systems to create a culture of evidence (Stroul, Blau & Sondheimer, 2008). However, assessing networks and interagency linkages can be extremely challenging. There has been a plethora of literature examining the effectiveness of integration, and what has been consistent is the understanding that assessing networks is extremely complex (Provan & Milward, 2001, Briggs & Garner, 2008). A key theme that emerged from our review is that evaluation efforts are essential to determine the effectiveness and efficacy of integration; however, they currently lag behind integration efforts. Moreover, the process of integration is identified as being as important as the product, and this must be examined (Krueter, Lezin & Young, 2000). As Ontario moves toward a more seamless delivery of mental health services for children and youth, we must pay particular attention to evaluating these efforts to ensure the attempts are having the intended effects on the system.

TAKING ACTION AND BUILDING ON STRENGTHS: STRATEGIES AND TOOLS FOR ACHIEVING INTEGRATION AT THE INTERAGENCY LEVEL

Integration sets the stage for better mental health outcomes for children and youth with improved access, and more timely service (see for example, Burns & Goldman, 1999; Frideman, Reynolds, Quan et al. 2007). Effectiveness can be improved through services that are integrated. For example, service users do not have to repeat their health history for each provider encounter (Leatt, Pink & Guerriere, 2000). Achieving service integration has emerged as a key objective in most mental health systems in response to existing difficulties with fragmentation of care. In fact, it has been deemed “one of the most active fields of health care inquiry in Canada” (Leatt, 2002, p.i.). However, most integration efforts fail at the implementation stage as provider agencies zealously guard their organizational boundaries and struggle with one another for power and control (Hoge & Howenstine, 1997). Much of the literature on integration of health services has been framed within ‘continuity of care’ (Browne et al, 2002). In fact, Durbin and her colleagues (2006) have reported on the positive association between continuity of care (longitudinal and cross sectional) and system integration. In spite of the attention to systems integration, lack of clarity over roles and responsibilities and poor communication have led to an integration rhetoric/reality gap in practice (England & Lester, 2005).

It is important to remember that implementing integrated service delivery takes time and continuous adjustment (Leatt, 2002; Durbin et al, 2006). Achieving extensive organizational integration is not a quick process, given the contextual factors to be accounted for when
implementing change programs and the complexity of integration across the different dimensions (Robinson, Atkinson & Downing, 2008). Transformational change involves major shifts in organizational culture and practice, calling for strong leadership and extensive local embedding, so that some aspects of integration (for example, around capacity building, cultural transformation, local joint working tools and processes) may take root more slowly than others. The outcomes of reduced fragmentation and a more seamless service delivery system are well worth the challenges of integration. Ultimately, the focus of any model of service delivery for children and youth with mental health problems should be on ensuring that their needs are addressed in a coordinated, collaborative and seamless manner. As Health Canada’s Best Practices states, it is through synergy – a dedicated commitment from all partners – that the complex needs of this group of young people will be addressed both in the short term and into the future.