Mental health network governance and coordination: 
Comparative analysis across ten Canadian regions

Mary E. Wiktorowicz,¹ Marie-Josée Fleury,² Carol E. Adair,³ Alain Lesage,⁴ Elliot Goldner,⁵ Paula Goering,⁶ Suzanne Peters⁷

Funded by: Canadian Health Services Research Foundation 
Co-sponsors: Ontario Ministry of Health and Long Term Care, Alberta Heritage Foundation for Medical Research, Canadian Mental Health Association

¹ Chair and Associate Professor, School of Health Policy and Management, York University
² Professeur adjoint, Département de psychiatrie, Université McGill
³ Adjunct Associate Professor, Department of Psychiatry and Department of Community Health Sciences, University of Calgary
⁴ Professor, Department of Psychiatry, Université de Montréal
⁵ Professor, Faculty of Health Sciences, Simon Fraser University
⁶ Professor, Department of Psychiatry, University of Toronto and Director of the health systems research and consulting unit at the Centre for Addiction and Mental Health, CHSRF/CIHR Chair in Generating and Disseminating Best Practices in Mental Health and Addictions
⁷ Doctoral candidate, Department of Sociology, York University
Main Messages:

• Shifting mental health care to the community implies developing a system of coordinated care. Local mental health networks that foster relationships among clinical, addictions, rehabilitation and housing services offer a means to facilitate such coordination.

• Implementing coordinated care is complex: it involves translating policy into client-related activities mediated by numerous organizations. We found the degree of coordination depended on the extent to which mental health organizations cooperated in a local network.

• A network executive committee was instrumental in developing a shared vision among its organizations; it also offered a forum for organizations to align their contributions and strategically focus resources in the areas evidence revealed the need for service capacity.

• An *alliance* governance model fostered cooperation in most small to mid-size urban and rural local networks: organizations defined their strengths and assigned services accordingly.

• Metropolitan networks were found to face the greatest challenges in developing an alliance, as achieving a common vision and dialogue among a multitude of organizations was complex. Metropolitan networks with an *alliance* model were found to require greater administrative support to assist organizations in developing a common vision and fostering coordination.

• Metropolitan networks with a psychiatric hospital experienced challenges in coordinating care, as hospitals offer a range of programs and have less need to connect to their network.

• Issues of confidentiality could pose obstacles to liaise services among organizations.

• Dividing budget and planning authority between the provincial government and network (or regional) governance respectively, could impede service coordination: hospitals that reported to the Ministry were not held accountable when their services were not aligned with the mental health organizations in their network. Such divided authority served individual operating units rather than network and community needs.
Executive Summary

As mental health care shifts to the community, each region and local area must address the challenge of determining how to develop mechanisms of service coordination among its organizations to ensure continuity of care. Operationally, this involves fostering relationships among mental health and primary health care, hospitals, rehabilitation, addiction, housing and related organizations through a local mental health network. Implementation can be complex as local policies must be translated into client-related activities mediated by numerous organizations to create a network of coordinated services. Developing an organized delivery system thus implies not only a range of services, but the processes, arrangements and incentives needed to ensure these organizations are optimally configured and coordinate their care.

Our research describes and offers a comparative framework of the governance models and organizational mechanisms mental health networks used to coordinate services, by exploring the organizational processes adopted among them. The research was guided by organizational theory and used qualitative methods of focus groups and interviews with executives and front-line managers in ten mental health networks across four provinces.

Mental health networks were found to adopt one of three governance models: corporate structure: an overarching formal authority fosters coordination through control of hospitals and community mental health centres as occurs through a Regional Health Authority (RHA); voluntary mutual adjustment: pairs of organizations engage in voluntary exchanges (e.g. client referral); and an alliance: autonomous organizations form a coalition whose relations are more formalized than in mutual adjustment, but in which organizations maintain their autonomy.

An alliance was the predominant model used to coordinate care in the small and midsize urban networks, whose size offers optimal conditions for coordination: developing working relationships is most manageable when a reasonable number of organizations are involved. The
ability of the key organizations to identify with each other and understand their collective role also tended to foster a sense of accountability to the network and local population.

Coordination in metropolitans is complex as developing a common vision and building mutual trust and cooperation among a multitude of organizations is more difficult. Inadequate means to share and protect the confidentiality of persons’ health records could further hamper service coordination. Small community-based organizations were also not as easily identifiable within metropolitans and found it difficult to establish working relationships with hospitals. Although three of the four large urban centres in our study relied on mutual adjustment to coordinate services, we found it was a weak model for coordinating care from a systems perspective. Metropolitan networks that sought to establish an alliance also experienced greater challenges and we found required additional support. Among the networks studied, those governed through a corporate model of a Regional Health Authority (RHA) with an integrated management structure offered most support to organizations in achieving unity of effort.

When a psychiatric hospital was present in a network, we found its cooperation was pivotal to achieving coordinated care. While the absence of a psychiatric hospital could limit access to beds, in some cases it could facilitate network planning. First, resources were not embedded in an institutional model which made it easier for programs to change course. Second, shifting services to the community was not affected by hospital union contracts.

Integration through a corporate governance model such as an RHA was not the only means to achieve coordination however. As the mid-size urban networks’ alliances demonstrated, a committee of program executives achieved consensus on how best to align their programs to address local needs. When service gaps were identified for example, alliance leaders developed innovative means to address them by cooperatively reallocating financial and human resources. In networks governed by mutual adjustment, an executive forum that could
address issues in a responsive manner generally did not exist. An *alliance* model was also found to be less effective in metropolitans that did not receive sufficient support.

We thus found the networks that relied on voluntary *mutual adjustment* were unable to achieve a common vision and system coordination, even though some sub-network partnerships existed. When an *alliance* or *corporate structure* mediated coordination, shared understandings and service agreements were fostered. Catalysts of coordination included a network director of mental health services with jurisdiction across the continuum of care, and regional or network-wide committees with representation from hospital and community-based organizations that guided administrative and clinical arrangements among organizations.

Coordination was not as well supported when budget and planning decisions were made at different jurisdictional levels. We found that when budget decisions were made at the provincial level, while services were planned at the local network level, the divided authority meant organizations that reported to the Ministry were not held accountable when their services were not aligned with the organizations in their network. Such misalignment was most evident when secondary and tertiary facilities reported to the Ministry, while networks planned local community services. Without a mandate or incentives for hospitals to align their care with community services, delays were experience in achieving continuity of care; patients who had to navigate their own services were more likely to “fall through the cracks” and re-enter hospital.

When a network was accountable for coordination, its executive committee aligned organizations to develop a vision, strategic and operational plans. Cooperative innovations were developed to address service gaps. Conversely, when accountability for coordination was at the provincial level or diffused ambiguously across provincial/regional/network levels, planning tended to serve individual operating units rather than community needs.
**Context:** As mental health care is re-conceptualized to extend beyond acute care to a system of coordinated health and social supports, the range of services extends to rehabilitation, case management, addiction, employment, housing, justice, transportation and income supports. Navigating such a diverse array of services would be a challenge for anyone; and, due to the nature of their illness, is additionally challenging for persons with serious mental illness (SMI). Developing effective coordination mechanisms among service organizations and providers is thus imperative. Such a system of care must also address clients’ changing needs by adjusting the nature of the supports as recovery ensues. The extent to which the community infrastructure has been developed to ensure a ‘systems’ approach for this higher needs sub-population is not well understood. Service coordination has been emphasized as a means to create a comprehensive recovery-oriented system of care.

Operationally, coordination involves fostering formal and informal inter-organizational relationships among mental health, medical, rehabilitation, housing and other agencies to create a comprehensive network of virtually integrated supports. The concept of a system of care thus implies not only a range of service types, but also the arrangements, incentives, structures and processes needed to ensure they function as a cohesive system. Advancing coordination is a complex task as it requires translating policy into client-related activities mediated by numerous organizations. Mental health care is thus facilitated or constrained or by the cooperative agreements, programs and referral patterns inherent within it. Shifting mental health care to the community therefore requires developing effective working relationships and coordination mechanisms among providers in local networks to ensure their optimal configuration. Interagency relationships are thus a core concept.

*Coordination* involves facilitating inter-organizational relationships to ensure the uninterrupted flow of information, services, staff and clients between independent organizations.
Service coordination has been defined as a process of combining or relating services across agencies and program lines. Alternatively, integration involves consolidating organizational administrations into a cohesive network through a single management structure that entails functional, clinical and physician integration, to reduce fragmentation and promote greater continuity of care. At the regional or sub-regional ‘network’ level, integration can involve centralizing, strengthening and rationalizing administrative authority.

Such an organized delivery system (ODS) can also be achieved through virtual integration, by developing strategic alliances and memoranda of understanding among organizations to achieve similar objectives through a flexible framework. The degree of centralization needed to achieve virtual integration depends on local organizational dynamics, including the ability of network partners to function as an ODS even as they remain distinct organizations. Although one role of case management, including Assertive Community Treatment (ACT), is to coordinate services for clients in the mental health sector, the range of services included in different models of case management varies, as does the degree to which case managers are able to coordinate with clinical care. Access to case management and ACT also differ across jurisdictions. Moreover, individuals with moderate mental illness generally do not have access to case management. As persons with SMI require supports that are seldom provided by a single organization, publicly commissioned reports have found links among organizations have not been sufficiently established to ensure continuity of care.

---

1 In functional integration, key support functions (strategic planning, information management) are coordinated across operating units. Clinical integration involves coordinating services across people, functions, activities and sites. Physician integration involves economically linking physicians to a system, and having them participate in its planning, management and governance.

2 ACT involves a multidisciplinary team of professionals which provides 24 hour case management in the community. Its range of services includes medication management, crisis care, life skills attainment, and access to community housing, employment and recreational support.
Implications: Developing an ODS implies not only a range of services but the incentives and administrative structures inherent within it, and the processes and arrangements among organizations needed to ensure they function as a network to address a person's needs on an ongoing basis.Coordination of such inter-sectoral services as housing, employment, legal aid, social assistance, education, transportation must also be incorporated to ensure persons in the mental health system have access to the ancillary supports they need to sustain them in the community and to avoid their preventable re-entry into hospital. Local service networks offer a means to coordinate mental health care among hospital and community-based health and social service providers to create a system of care.

A network is a set of organizations and the specific relations among them that serve as channels through which communications, referrals and resources flow. The goal is to develop virtual ‘programs of care’ by coordinating the delivery of primary, secondary, tertiary health and social services, to simplify clients’ access to them. Provincial health regions may include more than one network that operates among organizations with working relations. Governance is often shared between a regional authority and a local network through their respective management committees.

Coordination of mental health services however faces many challenges including organizational survival, autonomy, and conflicting philosophical perspectives. Organizations in a network must translate their values into a common vision, negotiate who will provide which services and how to alleviate potential gaps considering the strengths and resources of the organizations involved. As an environment of consolidation can represent a threat to organizations seeking to ensure their role in the system design, their activities can create an integration outcome different from the one intended.
Models of regionalization range from *deconcentration*: the transfer of local administrative authority without political authority, to *delegation*: the transfer of managerial responsibilities to regional offices, to *devolution*: the creation of sub-provincial units with revenue and expenditure authority, and *privatization*: the transfer of functions to a nongovernmental organization.\textsuperscript{50}

Integration is also distinguished as *voluntary, mediated* and *directed* given the role of the lead agency.\textsuperscript{41, 51} In *voluntary* integration, the lead agency is a service provider; in *mediated* integration the lead agency’s mission is to coordinate the services provided by other agencies; both *voluntary* and *mediated* integration can occur in an alliance structure. In *directed* integration, one organization has authority to mandate service coordination among agencies, as occurs in *corporate structure*.

*Centralization* refers to the degree to which management activities occur within centralized versus dispersed contexts which has implications for decision making and accountability.\textsuperscript{51-54} Centralization may be viewed from the perspective of decision making, planning and resource flows. Centralization from a resource flow side refers to the degree that resources emanate from or flow through a small subset of the network members. In a centralized network, the links between most of the organizations are indirect, mediated by the central organization. In a decentralized network, most of the members have direct ties to each other.\textsuperscript{36} Decision centralization refers to the degree that one organization has the authority to mandate the actions and policies of other organizations. The *corporate structure* is most centralized, while *mutual adjustment* is least centralized.

The governance model adopted thus influences the conditions that build intra-regional solidarity or fragmentation.\textsuperscript{53-55} An analysis of models of mental health system integration in the U.S. found that while tight central control over integration through a core agency can increase agencies’ efficiency in providing services, it may inhibit voluntary cooperation and spontaneity, which is more likely to occur in decentralized systems in which multiple providers work together informally.\textsuperscript{6, 56} Within decentralized structures, *mediated* systems had leadership advantages over *voluntary*
systems. Our research compares mental health networks under regionalized and non-regionalized models, contributing insights in the Canadian context.

**Approach:** We conducted a comparative analysis of ten Canadian local mental health networks from 2003 to 2006 to develop a descriptive framework of the governance mechanisms used to develop systems of coordinated care, and to assess their strengths and weaknesses. To enhance generalizability the networks included a range of rural and urban geographic areas (with three sizes of urban networks), and those with and without a psychiatric facility in four provinces.

Three units of analysis included: the provincial policy, the local mental health network, and the organization level. The provincial policy context was informed by a review of the grey and published literature, and 6-8 semi-structured interviews with senior provincial Ministry of Health or organization directors in each of the four provinces included in the study. Network level data was collected through a focus group with 6-8 senior mental health directors in each network. Organizational level data was collected through semi-structured interviews with 8 urban or 4 rural front-line service managers in each network.

The network level focus groups identified local coordination processes and their effect on service planning and coordination that included such areas as network leadership, strategic planning, inter-organizational arrangements (collaborative agreements, resource sharing, program alignment, service delivery), incentives for collaboration and innovation, resource allocation and evaluation. The organization level key informants addressed the processes organizations use to coordinate their services with other mental health and social service organizations. A secondary analysis of Fleury et. al.’s research informed our description and analysis of three networks in Quebec.

To reduce bias, networks were purposively selected in Alberta, New Brunswick, Ontario and Quebec to include a mix of rural and urban areas, and those with and without a psychiatric
facility. Of the thirteen networks invited to participate, ten agreed. Although the geographical area in which the ten networks reside are anonymous (labeled A-J), they are categorized as rural, or urban: large (>1 million); midsize (>500,000 – 1 million); small (<500,000) and their province. Ninety-six key informants participated in semi-structured interviews and focus groups from 2003 to 2006. The interviews were taped, transcribed and analysed using qualitative methods to identify themes in key informants' responses across networks on common issues. Emergent themes were validated by the research team through triangulation among key informants and convergence in their responses.

Our descriptive typology defines, categorizes and compares features of network governance based on the following: regional framework, network management model adopted, degree and process of coordination, inter-organizational arrangements (amalgamations, strategic alliances, joint executive committees and contracts), mechanism of inter-sectoral collaboration, and the use of financial incentives to achieve service coordination. Instead of offering detailed descriptions of individual networks, we compare the governance models they used to achieve coordination including decision-making processes, strategic planning, and service agreements (resource sharing, program alignment, service delivery). A schematic depiction of the ten networks is however included (Appendix 1). The data clarify the means through which local, regional and provincial mechanisms support coordination, resource allocation, and the potential for innovation given the opportunities and constraints in regionalized and non-regionalized contexts. The results are presented according to emergent themes.

The typology of models of local mental health networks is based on the following: regional framework (regionalized/non-regionalized), network governance model (corporate, mutual adjustment, alliance), rural or urban (small, mid-size, large), inter-organizational arrangements (amalgamations, strategic alliances, joint executive committees and contracts),
mechanism of inter-sectoral collaboration, and use of financial incentives to achieve service coordination. The presence of local decision-making processes, planning, service agreements (resource sharing, program alignment, service delivery), and evaluation processes was noted. Organizations' ability to adapt within a regional context and their links to primary care were also explored. In Alberta and New Brunswick, authority for mental health services was transferred from a provincial Mental Health Board to Regional Health Authorities (RHAs) in the year prior to the commencement of the study. Key informants in the affected networks (B,C,J) included their views on how the shift in governance affected service coordination.

In categorizing the range of governance models, we drew on key informants’ insights to assess the implications of how such approaches facilitated or inhibited organizational coordination.\(^{13,28}\) The results are presented according to provincial, regional, network, sub-network and organizational level themes. Structural features of the governance models inherent in the mental health networks studied are first described, followed by an assessment of their implications for coordinated care.

**Results**

**Mental health governance:** Jurisdictional for mental health services resided at different levels across the ten networks studied, ranging from provincial (Ontario), to regional (Alberta, New Brunswick) and sub-regional authority (Quebec) (Table 1).

In Ontario, while the Ministry of Health and Long Term Care (MOHLTC) was responsible for mental health policy, local administration was transferred to the seven regional offices of the Health Services Management Division, referred to as *deconcentration.*\(^3\) In Alberta and New Brunswick, authority for mental health planning and administration was *devolved* to RHAs in a phased manner: a central provincial Mental Health Board initially held authority,

\(^3\) *Deconcentration:* the transfer of local administrative authority to regions without political authority.
which was transferred to RHAs several years after they were established. In Quebec, the sub-regional “table de concertation” offered mental health organizations a forum to discuss service coordination, referred to as delegated authority.\(^49\) Although Quebec is regionalized, the boards of large hospitals remain, which has allowed psychiatric hospitals to exercise more autonomy than in other regionalized provinces.\(^54\)

Regions’ progress in coordinating mental health services was found to vary. In New Brunswick Network C, for example, most mental health services were coordinated and aligned prior to the transfer of mental health to the RHA. In other regions, coordinated care lagged several years after authority for mental health was transferred to the regions.

**Aligning Budget Authority with Service Planning:** Budget authority and service planning were divided between provincial, regional and local bodies to varying extents among the provinces studied. Aligning authority for the mental health service budget at the same level as service planning was found to best support service coordination (Network C, Key Informants 5 and 7). Conversely, when budget decisions were made at the provincial level, while services were planned at the local level, local networks were found to lack a key lever to foster service coordination (Network A, Key Informants 3, 4 and 8; Network G, Key Informants 1, 2, 6 and 7). In Ontario for example, hospital budgets were controlled by the province, while a regional context existed to plan community-based organizations’ services. The divided authority meant hospitals that reported to the Ministry were not held accountable when their services were not coordinated with community-based mental health services (e.g. Networks A, H, I). Such misalignment was most evident when mental health service planning occurred at the network level, while secondary and tertiary facilities reported to the province. Coordination did not always occur without formal processes or incentives in place to encourage hospitals to align their care with community-based services.
Similarly, we found coordination was less well supported when organizational budgets were set at the provincial level, while networks were responsible for local mental health service planning. While the “table de concertation” in Quebec Networks D, E and G offered organizations a forum to discuss local plans and service needs, not all networks achieved consensus among their organizations. Even though the Ministry of Health and Social Services specified organizations were to coordinate their care, the organizations were not accountable to their network. We found such ambiguous accountability could weaken the efforts of the “tables de concertation” to coordinate care which relies on local cooperation.

Conversely, we found coordination to be most effective when mental health governance and budget control resided at the regional or network level where local planning occurred, as reflected in Networks B, C, and J. Regional systems that allow integrated financial management were also more likely to emphasize the goals of the system. In Networks C and J for example, organizations’ shared goals fostered innovation and facilitated re-allocation of resources to needed areas. Network C implemented such innovations as an emergency department “Mental Health Team” by re-allocating hospital and Community Mental Health Centre (CMHC) budgets (including bed closures and staff re-allocations) to the Emergency Department. In contrast, we found provincial budget management was less likely to stimulate approaches that improve network function due to lack of local insight and an inability to foster a shared network vision. Provincial budget management instead tended to address the goals of individual operating units, that were not necessarily congruent with a system vision. An exception was the Ontario “Community Investment Fund:” organizations that sought funding to expand their programs were required to coordinate their services with those of other mental health organizations in their network, an incentive that led to coordinated initiatives across the province.68
**Mental Health Networks:** Several key informants emphasized the importance of coordinating access to care by clarifying the implications of failing to do so:

> If you are a consumer, or a family member, you have no way of knowing how to get access to case management or ACT services. There are...14 agencies that provide those services...14 phone numbers, 14 application forms, it’s a nightmare. Every planning document that has been developed in the last 20 years, has said coordinated access...our current initiative was born out of a network of mental health services. - Network H, Key Informant 4

Local mental health networks adopted three different organizational approaches to service coordination: *corporate structure, mutual adjustment or alliance* (Table 2). The *corporate structure* model involves regional devolution where an RHA ensures coordinated care by overseeing institutional facilities and community mental health services. While coordination through an RHA could be considered *directed*, key informants in such networks indicated coordination was achieved through *mediation*. We found the two most coordinated networks (NB Network C and Alberta Network J) were in regionally governed models. However, Network C achieved most of its coordination prior to the transfer of mental health to its RHA. Conversely, comparatively less coordination was achieved under Network B’s regional governance model. Coordination advanced only after a director with jurisdiction for hospital and community services was appointed, who formed committees with representation from hospital and community organizations to begin coordinated initiatives with the support of several sub-committees.

Ontario’s regional MOHLTC offices were transfer funding agencies that were not responsible for operations, and placed less emphasis on developing a system of coordinated supports than in regionalized provinces. Coordination in most Ontario networks studied occurred largely through *voluntary* exchange (e.g. client referral), without formal coordination mechanisms, referred to as *mutual adjustment*. Financial incentives through the former “Community Investment Fund” served as the main instrument: programs that sought to expand
required a memorandum of understanding with other mental health organizations in their network to coordinate services (Table 3). In addition, the Ministry mediated coordination for such specific programs as ACT forensic teams, and the implementation of Community Treatment Orders (CTOs) (Networks H and I). While RHA-governed Network J relied on mediated coordination, if organizations had not cooperated, negative incentives would have ensued.

In mid-sized urban Quebec Networks D and E, and Ontario Network F mental health organizations formed an alliance that mediated voluntary service coordination. The alliance in Quebec Networks D and E was initiated through their “tables de concertation.” While coordination was more formalized than in mutual adjustment, organizations retained their autonomy. The alliance in Ontario Network F evolved from the ‘Addictions and Mental Health Executive Committee,’ whose leaders were committed to cooperating to coordinate services. Their alliance’s executive committee provided a forum for its leaders to mediate arrangements to coordinate services.

An alliance was thus the predominant vehicle used to achieve service coordination in the small and midsize urban networks (Quebec D, E and Ontario F). The alliance in Network C also made significant progress prior to the devolution of mental health to the RHA. We found the small and mid-size urban networks appeared to offer the best conditions for alliances to function: developing working relationships was most feasible among a smaller number of organizations, which also fostered a stronger sense of accountability to the network.

Mutual adjustment was the predominant means of coordination in the large urban centres we studied, despite the range of governance models adopted across them (devolved, delegated and deconcentrated). Service coordination in metropolitans is more complex given the multitude of organizations that must attain a common vision and develop relationships of mutual trust and
cooperation. Coordinating institutional and community organizations can also be a challenge, as the key community service organizations may not be as easily identifiable or have prior working relationships with the hospitals and their satellite sites.

Among the largest urban networks, we found Alberta Network J to be most coordinated. Its *devolved* RHA governance and integrated management supported the greatest unity of effort, allowing *directed* coordination when necessary. And while Network J lacked a psychiatric facility that limited access to beds, it also facilitated planning. First, resources were not embedded in an institutional model which made it easier for programs to change course. For example, Network J developed centralized access to mental health care. Second, as psychiatric care was not concentrated in a hospital, it was more accessible to those seeking care in the community. In contrast, in other large urban networks with a psychiatric hospital, coordinating care between a regional psychiatric hospital and local community services was often difficult to achieve given providers’ constrained time, unless specific discharge planning supports and processes such as a liaison nurse (Network C) were in place to facilitate coordination.

We found that integrated governance through an RHA was not however the only means to achieve coordination. The mid-size urban networks’ *alliances* demonstrated coordination could be realized without integration. In these alliances, an executive forum and the commitment of organizational leaders was important to assess opportunities to align programs, guide coordination and re-allocate resources to serve community needs (Table 3).

Developing an effective *alliance* however requires the engagement of all organizations that provide mental health services in a network. When psychiatric hospitals were managed by provincial governments, psychiatric hospitals’ wide catchment area meant they did not always engage in local planning. In Ontario rural Network A for example, community providers found it difficult to coordinate care when their clients were admitted to a general or psychiatric hospital.
outside their network. Without a forum for community organizations to develop coordination mechanisms with the psychiatric hospital to which their patients were referred, it was difficult to establish agreements for coordinated care, which could lead to lapsed care when in-patients were discharged. Transferring jurisdiction for all mental health services to an RHA or local network would have facilitated coordinated planning by allowing community and institutional counterparts to develop a common vision and referral agreements aligned with that vision.62

Accountability requires that organizations ensure a seamless transition across the continuum of care. RHAs incorporate the health system within their mission and accept accountability to ensure coordination among mental health services within their jurisdiction. A key component of New Brunswick Network C and Alberta Network J’s coordination was their central intake registry which coordinated access to services.

Links to Addictions, Justice, Employment, Housing and Recreation Programs: As persons with SMI can suffer from a concurrent disorder, several networks align their addiction and mental health programs (A, C, F and I). Several networks also coordinated their justice and mental health systems by developing court diversion programs to guide persons with SMI to appropriate services (Networks C, E, I, J). Although forensic services are under provincial jurisdiction, local cooperation supported program implementation. Forensic programs thus rely on inter-ministerial, regional and local cooperation. While employment programs were available, they were unable to meet the demand in the networks studied.

In some networks, housing programs for persons with SMI are the key community provider, as they liaise with case managers and medical care as needed. However, hospitals are not necessarily informed of the importance of coordinating with providers of supportive housing services, which can create obstacles for persons in need of both types of service.
Another area of inter-sectoral planning involves coordinating access to drug benefits for persons with SMI who earn a low income, making them ineligible for publicly insured medication. A large proportion of persons with SMI require access to medications, without which their condition can deteriorate and lead to hospitalization. Their low income however may make medication inaccessible. New Brunswick ensures access to drug programs for employed low income persons with SMI. Other than New Brunswick and Quebec, no other provinces coordinate their mental health and drug benefit programs.

Joint Program Coordination through Sub-networks: Sub-networks connect service providers through shared understandings of service needs, allowing them to jointly deliver a single or coordinated program. While some sub-networks embody a shared understanding of their role, others are geared toward addressing an issue through a collective, time limited activity. In some, a committee meets regularly to address issues. Other sub-networks are based on an understanding of the flow of patients through the system: they include agreements for patient referral, or consultations on patient files. Most networks in our study had several sub-networks that addressed a particular program or sub-population, such as the homeless.

Enhancing Network Function through Leadership: We found the networks in our study evolved though organizational leaders’ vision and accountability to address service access on behalf of their client population. Leadership’s commitment to coordination was critical. Organizations’ staff also recognized the importance of coordination when resources were directed to it, which enhanced its visibility (Network F, Key Informant 2). We found leadership ‘buy-in’ was more likely to ensure a system was strategically aligned, and resources were reallocated to promote coordination. Who contributed to the strategic plan affected buy-in, hence the importance of involving all organizations’ leaders in developing a network’s strategic
plan. Collaboration was also most likely when it responded to a recognized need and was based on trust. “What was key…is how do you get people to learn how to trust each other? The process of ….negotiating a contract is the social heart of building trust.” (Network H, Key Informant 6) Senior executives in several networks emphasized the importance of trust. Some noted that as program directors build a network, it is important they maintain a flexible vision of how their organization will contribute and trust their counterparts will reciprocate to address population needs.

Ontario Network F developed a homeless initiative, led by a sub-network and supported by the Ontario “Community Investment Fund.” A key informant in Network F noted, “We had leadership with vision that says, ‘I can help make this happen.’” Its hospitals and municipal government developed a protocol for referring patients to a regional emergency department. Staff from several hospital and community organizations also formed an ‘Outreach Team’ supporting the homeless population’s access to mental health, social and housing services through a fluid connection to their home organization (Table 3).

**System wide objectives:** Several networks developed system wide goals (Table 5). RHA governed networks developed such goals through a central planning process with representation from executives of local mental health programs. In New Brunswick Network C, four working groups addressed such issues as: network mandate, access, education, and partnering to support the development of system wide goals. A ‘Communities of Practice’ approach addressed administrative, structural, and clinical integration issues to support implementation.

Ontario networks developed goals through Mental Health Implementation Task Forces (2002). Local Health Integration Networks have since articulated their goals through Integrated Health Service Plans. Translating such goals into practice nonetheless remains a challenge.
Hospitals and community organizations may interpret and operationalize the goals differently, and may require a system-wide structure to support their implementation.

While all organizations engaged in performance reviews, organization-specific rather than system-wide measures were often applied (Table 5). When organizations’ performance was evaluated on a unit specific basis, we found that unit over system goals tended to be promoted. Conversely, we found that networks that engaged in network or regional level strategic planning, and developed system-wide goals and performance measures were more likely to attain them, as Networks C and J demonstrated. System level performance evaluation was thus found to enhance system functioning, even though attribution problems could arise.

**Information Systems:** Health Information Systems (IS) were being developed across most networks, as they offer a means to track ‘pathways of care’ by facilitating providers’ access to client files. Information systems thus present an opportunity to understand clients’ care through the network, and optimize it according to evidence-based standards and service availability. The challenge is to develop an IS responsive to organizations’ and system needs. Given the high cost of implementing an IS, coverage varies, with many stand-alone systems across networks.

Once patient consent is attained, IS can enhance coordination and access to care. For example, in the emergency department the IS could be used to determine a person’s medications, date of last admission, and services that support them. Information Systems are crucial to coordinate and enhance access to services. Determining the type of IS to adopt can be complex however. In the absence of a common IS, organizations develop interfaces that allow coordination across different IS. New Brunswick Network C had the most comprehensive IS among the networks studied, designed to accommodate centralized service access, accessible to the general hospital psychiatric unit, to which addictions services were to be incorporated.
**Addressing resource constraints:** In networks with an *alliance* or *corporate structure*, the network executive committee assessed needs and achieved consensus on resource allocation. When a service gap was apparent, collective decisions were made as to how to reallocate existing resources to address identified needs. In Network C, the general hospital psychiatric unit closed several in-patient beds one summer when demand was low, and the Community Mental Health Centre (CMHC) reduced its staff to fund a network mobile mental health urgent care team and a mental health emergency department team.

Network F developed two new programs: a network-wide emergency protocol, and a community-based homeless program to which hospital staff were re-allocated. Consensual decision-making was guided by leaders’ insights on how to alleviate clients’ ‘upstream’ problems. In networks without an *alliance* or RHA, *sub-networks* in such areas as addictions, or court-diversion fulfilled a similar role. An executive committee developed a solution that drew on organizational strengths and resources, and fostered strategic alliances. Organizations in Networks C and F in small and midsize cities respectively, cooperated to resolve network issues. When a common understanding and consensus could not be reached within a network, a directed approach via regional authority was used to advance coordination, as occurred in Network B.

**Centralized Access:** Centralized access supports coordinated care by removing the need for a person to seek access to care or support services from numerous organizations - which may require the submission of separate applications – and which may not have the capacity to accommodate their needs or link them to related programs. While only some of the networks included in our study had a centralized intake registry that offered access to a comprehensive set of mental health services in their community (Networks B, C and J), others developed a system of triage to coordinate the delivery of community services (Networks D and E) or centralized access to case management (Network H). Network C coordinated mental health with addictions
services in the hospital and through their CMHC. Other networks had central intake processes that incorporated primary health services (Networks D, E, G) or related community services (Networks A, B and F). In Network H’s centralized access to case management and rehabilitative services, one phone number and intake process directs a person to these services. Community organizations’ ability to facilitate their clients’ access to see a psychiatrist was mixed in many networks; in one case it relied on an organization’s relationship with a psychiatrist (Network I, Key informant 6). Conversely, centralized access directs a person to such care when their intake assessment demonstrates the need (Network C, Key Informant 1).

In Ontario Network A, the CMHC offered a single point of entry to community mental health services in a geographically dispersed rural region.\(^4\) The CMHC coordinated with social services (children’s, police, justice, addictions, women’s shelters, housing and employment), but was unable to coordinate with the schedule 1 and psychiatric hospital to which patients in the network were referred. The approach is similar to the CMHC central registries in Networks C and J, with the omission of the hospital facilities. In Quebec, the CLSCs (centre local de services communautaires/local community service centre) in Network D and E offered centralized access to mental health programs and services.

**Strategies to attain coordination: The challenge of leadership and collaboration:** In networks that succeeded in coordinating services, the predominant governance model was an executive committee with representation from its network organizations through which consensus was attained and decisions were made (Networks B, C, E, F and J). Network C’s Regional Management Team for example viewed its mandate as an opportunity to develop more comprehensive and integrated services. Subcommittees ensured the decisions taken were operationalized through coordinated action plans.

\(^4\) Services included: ACT team, 3 regional mobile teams, case management, counseling, and crisis care.
Limited coordination occurred in rural Network B until a joint director responsible for both institutional and community-based mental health services was appointed, who formed executive, and integration steering committees and service teams. This coincided with a new in-patient psychiatric child and adolescent unit and a new mental health centre which created opportunities for referral relationships among organizations. These steps preceded the transfer of jurisdiction for mental health to the RHA. Examples of coordinated programs are shown in Table 2.

After jurisdiction for mental health services was transferred to the RHAs in Alberta, key informants in Networks B and J noted relationships among organizations were more fully developed, and coordination was more effective, replacing previous informal communication:

…the integration is much smoother – previously we were a number of silos doing our own thing and keeping our own population, and not communicating perhaps as well as we should have…managers coordinate conversations… we’re over a number of services now…a number of community agencies meet on a regular basis and identify gaps that we present to the region.
- Network J, Key Informant 5

In Network B, two clinics a few kilometers apart had sparse communication with each other, despite a common client base that frequented both sites. When their clients moved under one regional umbrella, resources were considered shared. Planning then occurred region-wide, as opposed to within separate communities.

In Network A, the absence of an executive forum to discuss coordination was an obstacle to continuity of care. Hospital discharge planning was ad hoc, making it a challenge for clients to access community services on discharge which led to lapsed care. Conversely, executive forums make it possible to advance a shared understanding of system wide goals, agree on the roles of service providers, to coordinate the necessary supports and performance measures (Table 4).
An RHA is however not the only mechanism through which coordination can occur. In New Brunswick Network C, the local mental health management team achieved coordinated care before jurisdiction for mental health was transferred to the RHA. Key informants noted they expected coordination to advance further after the transfer of mental health services to the RHA, as the alignment of inter-sectoral services (such as long-term care, home care, and housing) with mental health care would improve coordination further.

In the absence of a strong mandate and mechanisms to promote coordination, Ontario networks developed on an ad-hoc basis. The Ministry mediated the coordination of key organizations to deliver specific programs for example, or coordination arose through an alliance of local organizational leaders. Examples included partnerships in Network I, where the CMHA partnered with housing agencies; a court support consortium coordinated hospitals and several court services. The Ministry-mediated initiatives also included a forensic ACT team, and an agreement to support Community Treatment Orders (CTOs) - urgent 72 hour inpatient assessment followed by case management in the community - among eleven hospitals and CMHA case management. The alliances in Quebec Networks D and E and Ontario Network F developed several joint programs (Personality Disorder Clinic, Justice Program, Homeless Program, respectively).63

**Changing Role of Psychiatric Hospitals:** The strength of psychiatric hospitals is specialized care (for example for psychosis, treatment resistance, early intervention, forensic). While the psychiatric facilities in two mid-sized urban networks in our study connected well with their networks (Networks E and F), in other networks (rural and large urban) they were less effective. Such coordination mechanisms as telephone contact and referrals among network organizations’ staff did not occur consistently between hospitals and community organizations. Psychiatric hospitals experience difficulties coordinating their services with other organizations for a variety
of reasons. Orienting providers to connect with community programs could be a challenge. Communication between the psychiatric hospital and the community providers was also strained due to the technical medical terms used, which community providers do not always understand. The hospital staff interviewed indicated they were working to clarify terms to better support coordinated care. Patient confidentiality could also prevent hospitals from sharing files. “We need to link the services better between community and facility, and not have this disconnect, that we need to become a continuous service.” (Network B, Key Informant 2)

Psychiatric hospitals have been downsized as part of restructuring, and have different roles in some cases. In New Brunswick Network C for example, the psychiatric hospital was reduced from 320 to 50 beds in 1991, when its primary role shifted to that of long-term residence. With few discharges, beds are unavailable for new patients, whose needs must be met through alternate services including supportive residence.

The psychiatric hospital in Ontario Network F formed a fluid, outward looking relationship with the organizations and physicians in its community following restructuring, when psychiatric hospital staff were seconded to community organizations:

The vast majority of mental health programs had staff from the former psychiatric hospital working in them and many of them still do, so that really helped to bridge the gap between the tertiary hospital and the general hospital, tertiary hospital and community mental health program and there are a number of community mental health programs that probably wouldn’t have got off the ground or thrived without the ongoing support of the psychiatric hospital. So I think that is a really important part of the infrastructure of collaboration. - Network F, Key Informant 7

Network F also benefited from its medical school’s community and population-focused approached; the Department of Psychiatry adopted this philosophy, and developed collaborative projects with community agencies across the region (Network F, Key Informant 7). We found the commitment of psychiatric hospitals to coordination thus had a profound effect on
coordination and continuity of care in their network, and in other networks that referred patients to their facility.

**General Hospitals’ evolving links to community care:** As care has shifted to the community, general hospitals’ role in supporting patients with SMI has expanded. Hospital resources are stretched, constraining both the level of admissions and range of services. Departments such as Social Work and Psychology - whose responsibilities included discharge planning - have in some cases been curtailed. In Ontario Network I for example, it became incumbent on the program to which a person was connected (case management, supervised housing, or peer support) to follow their client in and out of hospital. Hospital staff are not always accustomed to communicating with community agencies (Network I, Focus Group Key Informants). Aside from limited communication, an attitudinal barrier can exist that focus group key informants suggested may take a generation to change:5

> I think there are some hospitals who would stand out in terms of their ability to connect, understand the power dynamics, but most of them, I don’t think are supportive.

> In terms of the connections, in terms of community planning I think the hospitals are there. But in terms of making discharge plans for the clients, I think…that’s still a problem.
> - Network H, Focus Group Key Informants

While the processes needed to ensure discharge planning are often not in place, community agencies can also have wait lists that create complications.

> I think in-patient staff would tell you that they would absolutely love to be able to discharge plan on every client. I think the difficulty is that many organizations like ours have waiting lists… Which in turn has prompted organizations like ours to try to support people while they’re waiting on the wait list, because we had two very sad instances of two people committing suicide while on our wait list two years ago, so that really made us look at what we could do differently…how we

5 An issue that was raised is the wage disparity between hospitals and community agencies. Hospital staff earn higher wages than their community counterparts, as their unions are able to negotiate higher wages. Community providers’ services may thus be under-recognized. In New Brunswick, where community providers earn a higher wage than hospital employees such attitudinal barriers were not evident.
could try to support people who were between those two – the in-patients and the community services. - Network H, Key Informant 4

Hospitals with a large catchment area must keep track of community service contacts in several geographical areas, which can be a challenge. As care shifts to schedule 1 hospitals, new staff may not be informed of whom to contact on patient discharge. For example, as the schedule one and psychiatric hospitals to which Network A refers its clients are outside its geographic network, communications regarding client discharge planning are inconsistent. Primary care physicians receive a note on patient discharge, but community services are often not informed, leading care to lapse for those with serious illness. While family physicians in rural networks are often linked to community MH services, liaising hospitals with community services remains a challenge (Network A, Key Informant 2). Recent health system restructuring has led to changes in personnel, which contributed to inconsistent communication that affected discharge planning. In some networks, community providers’ long-term relationships and knowledge of their clients were not always acknowledged, which could compromise patient care on discharge.

Services in the hospitals have been resorted and restructured …When they change internally… internal communication is almost non existent…we’ll send a client in, and send follow-ups, we’ll call, and we’ll be informed that the client has been discharged and we haven’t received a single word…discharge planning is extremely ad hoc…there isn’t coordinated care with the community with the schedule ones.
- Network A, Key Informant 4

In other communities, general hospitals are becoming more responsive in coordinating their care. Key informants indicated the general hospitals seem to be reaching out to make the connection to the community, where their case management, inpatient, emergency services, and their mobile crisis team are ‘doing a great job.’
…emergency services is…making it possible for you to take your mental health clients to emergency and be seen by a psychiatrist first and not go through the medical stream and then wait for the consultation, because most of our folks…need crisis intervention. - Network I, Key Informant 5

Three years ago there was minimal coordination between the psychiatric inpatient units and community care; in the last year and a half this has improved 25 to 35 percent. - Network J, Key Informant 4

Coordination of care between general hospitals and community organizations thus varies, and is improving as hospitals’ role in the system grows (Table 7). Community-based organizations serve an important role in re-integrating in-patients into the community. As general hospitals are at capacity, developing linkages with community programs that support their patients on discharge would reduce demand on beds.

**ACT Teams in Systems of Coordinated Care:** Although most communities offer some form of ACT, not all teams are integrated into their local network. Instead, many form a sub-network. As multi-disciplinary teams with connections to in-patient units, they have preferred access to supportive housing and accommodating employers, to which the population served would otherwise have limited access. Evaluations of ACT programs show they reduce the number of in-patient days and are considered cost effective.\(^6\) ACT programs have however been critiqued for being medically oriented, and not oriented toward the ‘recovery model’ that supports a person taking responsibility for him or herself.\(^6\) One key informant suggested placing more ACT teams in the community and requiring them to coordinate their intake with hospital inpatient units, rather than locating ACT teams in hospitals.

**Discussion:** We found the three network governance models used in the ten networks affected the degree to which organizations were able to unify their efforts to coordinate services among diverse providers.\(^{56, 57}\) Several factors were found to be particularly

\(^6\) In Ontario hospitals have been cutting ACT staff numbers per team in response to budget pressures.
supportive. While the corporate structure within an RHA could advance organizational cooperation most directly, some RHA governed networks experienced challenges that were resolved only after they adopted such strategies as assigning a joint director with jurisdiction for both institutional and community services, who formed executive management, and implementation committees with representatives from both sectors.

Networks with an alliance governance model demonstrated the effectiveness of fostering of strategic connections, by supporting network organizations to cooperate in defining their strengths and assigning services accordingly. Strategic alliances were viewed by several key informants as effective coordination mechanisms. When agreements are developed to coordinate programs, the cooperating partners review their strengths and resolve which organizations are best suited to offer particular services. Cooperation through an alliance builds collaboration across organizations in the interest of the client base, and fosters a culture of interdependence. It also creates a forum that supports organizations to prioritize strategic investments in areas the evidence reveals the need for service capacity. A community can create a culture of cooperation by mediating connections and cooperation across corresponding organizations, and allocating investments in areas where evidence indicates the need for service capacity.

The alliances' executive forum and its sub-networks were instrumental in developing a shared vision, and aligning organizations’ contributions (Networks D, E, F, H and I). They also instilled a sense of shared accountability toward both the population served and partner organizations. Implementation of CTOs in Networks H and I offers an example. Instead of merging community case management organizations with eleven hospitals, the same objective was achieved by coordinating case management through autonomous organizations. The key was assessing how people flow through the system, ensuring information technology was available to the providers, and building cooperation to link services among them. Another
example in Network H entailed coordination of case management services across several organizations with an identified lead agency, to which the Ministry transferred funds. The sub-network partnerships created among organizations through the CTO implementation and Centralized Case Management in Networks H and I respectively, reflect a mediated model similar to an alliance.

Leveraging information technology to facilitate shared information further supported these initiatives. Innovative strategic alliance initiatives include the Homeless Program and Emergency Protocol in Network F; the joint Personality Disorder clinic in Network D, and the joint Justice Service in Network E. Whether through an RHA, an alliance, or voluntary mutual adjustment, an executive forum allowed the organizations in a network to negotiate the terms of coordination and address emerging issues. Challenges occurred when organizations resisted cooperating without ensuing budgetary or other implications. Without recourse to financial incentives, a key lever to support coordination was missing.

Metropolitan networks however faced more complex challenges. First, maintaining dialogue among a multitude of organizations was more difficult. Although a ‘table de concertation’ existed in Network G for example, the number of organizations made it difficult to develop effective working relationships. As the ‘table de concertation’ was not sufficiently resourced to allow its members to engage in the process needed to develop a common vision – a complex exercise given the numerous stakeholders with diverse cultural and philosophical perspectives – divergent views remained. Although the Ministry requested a shift in care to the community and coordination was an implicit goal, some organizations were able to reinforce the status quo. In contrast, the “table de concertation” in mid-sized urban and suburban areas were more effective in coordinating care and re-deploying staff and resources to address population needs. While the size and level of resources within the large urban networks differed, the
findings were consistent across them: metropolitan networks that relied on voluntary mutual adjustment were unlikely to achieve coordinated care.

We also found the presence of a psychiatric facility within a network could make coordination more complex (B, E, F, G and I). Shortell suggests that overly large organizations are not conducive to community building: their size, diverse programs and services make it possible for them to disengage from community building exercises. A focus on individuality can also lead communal exercises to bring out protectionist tendencies, and become a forum for organizations to advance their professional identity. Conversely, a sense of community emerges when organizations develop a capacity for vulnerability in which they recognize that fostering links to the community - where patients must re-build their lives - ensures their place in the system design by supporting continuity of care and the most efficient use of resources.72

In the metropolitan networks with a psychiatric facility we studied, a commitment to coordination was often weak and not always reinforced through an executive forum. Under these conditions, no common vision existed and there were few incentives available to foster cooperation, or develop strategic or operational plans. Metropolitan networks thus experienced a dual challenge: the large number of organizations made efforts to coordinate care more challenging, especially when the inclination was often weak, and few resources were in place to coordinate care. To support such initiatives, incentives could be made available to organizations and professionals in community and hospital settings. Among the networks with a psychiatric facility our study, we found the mid-sized urban networks achieved most coordination. Since 2006, progress has been made in some of the metropolitans studied, with the psychiatric hospitals playing a greater role in coordination.

Conversely, Network C achieved considerable integration and coordination through its alliance which included such key factors as: 1) mental health executive team engaged in network
planning that facilitated creative, negotiated solutions; 2) network strategic vision and plan operationalized the process needed to achieve coordination (administrative, structural, and clinical integration); 3) network level control over an integrated funding envelope for mental health services: integrated financial management emphasized system goals which facilitated shifting resources to needed areas, as opposed to provincial budget management which emphasized the goals of individual operating units; and 4) community based liaison nurse coordinated access to community care for in-patients. We thus found a concerted effort comprised of management, financial, clinical and operational processes was needed to support coordination.

**Conclusion:** While mental health policy emphasizes a shift in care to the community, the regionalization and network building that communities have engaged in have sought to rationalize and coordinate care. In developing a framework to describe the governance and coordination mechanisms in local mental health networks, we assessed the extent to which three governance models (corporate structure, alliance, voluntary mutual adjustment) supported the shift to community care. While provincial policy guided such networks, the local context shaped their capacity for implementation. In small to medium-sized cities, we found an alliance could effectively coordinate services through a network model mediated by an executive committee and several support committees (C, D, E, F). We believe that introducing network accountability and information systems would further advance their coordination efforts.

Rural and metropolitan networks encountered different sets of challenges. In rural areas, coordination required aligning services across vast distances, which could make hospital discharge referrals to local community services a moving target, given staff and catchment area changes following restructuring. In metropolitans, the array of organizations combined with a weak mandate to coordinate hospitals’ and community providers’ programs, made it difficult to
develop cooperative, collaborative relationships. Despite the different challenges rural and urban areas face, we found the lessons were similar. The first step was for organizations and providers across the continuum of care to develop a common vision that supported individuals’ recovery and transition through the levels of care. While the organizational relationships needed to support a systems approach may not have been necessary in the past, as the community becomes the locus of care, they are pivotal to continuous care.

Across all communities, we found that networks that were mediated through an alliance had leadership advantages over voluntary mutual adjustment. Voluntary cooperation alone was unlikely to lead to a common system vision and introduce the supports needed to achieve coordinated care, even though isolated examples of partnership exist in such areas as justice and housing. We found coordination was invariably mediated through shared understandings and negotiated agreements among member organizations and supported through administrative, operational, and clinical initiatives. In the networks studied, a committee of mental health program executives, often supported by a director responsible for mental health services across the continuum of care, launched a series of sub-committees to address coordination issues that were instrumental to its advancement.

We found that when accountability was assigned to the network or region (where the region and network communicated closely), their leadership cooperated in developing a system-wide vision, strategic plan, and reallocated resources to promote system innovation and address service gaps. Conversely, when accountability remained at the provincial level, or was ambiguously diffused across provincial/regional/network levels, planning tended to serve individual operating units rather than community needs. Communities in which performance appraisal was based on system-wide as opposed to organizational goals were also more likely to realize their objectives.
Cross-jurisdictional coordination of mental health services with addictions, justice, housing and employment required coordination across provincial, regional and municipal governments to ensure access to services controlled by other jurisdictions. Insufficient resources to develop information systems and needed programs was a further obstacle to coordination. For example, discharge planning was made more difficult when case management services were unavailable due to lengthy wait lists. The burden of care was however found to be reduced when service capacity was addressed in such preventive areas as early intervention, and such community supports as housing and case management and that organizations and providers could strengthen the continuum of care by linking patients to these community supports. Hospital staff were found to be pivotal to effective community-based care, and supported community programs in several networks. *Mediated* network governance models, which support a ‘systems approach’ instrumental to resolving coordination issues, were thus found to offer most potential to address coordination.
References


Appendix 1

Network A
The Community Mental Health Centre in this rural Ontario network offers case management and related mental health services and coordinates with such social services as addictions and a women’s shelter in the local community. There is neither a general hospital nor a psychiatric facility in the local network.

Figure 1: Rural Network A


Index: CMHC: Community mental health centre; CO: Community organizations; inters: intersectoral; PMC: private medical clinics; GH: general hospital; MH: Mental Health; PSYH: psychiatric hospital
Network B

Mental health services in this rural Alberta community were transferred to the RHA about six months prior to data collection, a process which advanced service integration. Prior to the transfer, key informants expressed concern that psychiatric facility services were not coordinated with the broader community services. The network includes two primary health clinics, addictions services and the in- and out-patient programs of the psychiatric facility.

Figure 2: Rural Network B
Network C
The CMHC in this small urban centre in New Brunswick serves as a key network coordination mechanism, referring clients to services following initial assessment. Increasing organizational integration occurred among the network’s regional general hospital psychiatric unit, psychiatric mobile team, psychiatric emergency department services, and inpatient and outpatient addictions and rehabilitation services. While its psychiatric facility offers long term residential services, it has little interaction with the network as it has limited capacity for new admissions.

Figure 3: Small Urban Network C

Networks D and E
One of the CLSCs in this suburban Quebec community has a mental health team.

Figure 4: Mid-size Urban Networks D & E

Index: CMHC: Community mental health centre; CO: Community organizations; AD: administrative, clinical, physician integration; GH: general hospital; MH: Mental Health; PSYCH: psychiatric hospital; PMC: private medical clinics; Inters: intersectoral; PHA: personal health agencies; PHA: personal health agencies; CLSC: community mental health services centre; CO: community organizations; PMC: private medical clinics; GH: general hospital; MH: Mental Health; PSYCH: psychiatric hospital; Index: GH: general hospital; CLSC: local community services centre; PMC: private medical clinics; CO: community organizations; Inters: intersectoral; resources (housing, employment, justice, etc.)
Network F, Mid-size Urban Ontario

Figure 5: Mid-size Urban Network F

Points of entry: Local level

CMHC
GH
AD
PSYCH
PMC
CO
inters

Severe mental disorders

Strategic level:
- Addictions and MH Cnt
- Sub-network committees: outreach team, urgent care, network patient flow

Tactical level:
- CMHC client coordination / individual service plans
- Network MH Emerg Dept
- Mobile Team - Shared care

Operational level:
- Staff training

Range of services offered by GH, CMHC, CO

GH
- Emergency
- Day clinics
- Follow-up in the community

CMHC
- Individualized service plans

CO
- Community follow-up
- Peer assistance
- Hotline/crisis counselling
- Rehabilitation services
- Search for housing
- Recreation

Informal coordination / protocols / shared care

Index: AD: addictions services; CMHC: Community mental health centre; Cnt: Committee; CO: Community organizations; inters: intersectoral; PMC: private medical clinics; GH: general hospital; MH: Mental Health; PSYH: psychiatric hospital

Network G, Large Urban

Figure 6: Metropolitan Network G

Points of entry

PSYCH
GH
CLSC
CO
PMC
inters

Severe mental disorders

Sub-regional level

Strategic level: Delegation
Mental health coordination committee: elected coordinator

Tactical level: Sub-committees
- Housing - employment, treatment and community follow-up
- Working committee: mental health sub-sectors of intervention

Operational level: Training - teaching clinic

Regional level

(t-HSSB)
- General orientation
- Support to coordination committee and other sub-committees
- With the MHSS: budgeting for the initiatives, information system, regulation of staff, etc.

Development of integration strategies:
- Individualized service plans
- Inter-organizational internships and programs
- Clinical protocols, etc.

Index: GH: general hospital; CLSC: local community services center; PMC: private medical clinics; CO: community organizations; inters: intersectoral resources (housing, employment, justice, etc.); t-HSSB: regional health and social services board; PSYH: psychiatric hospital; MHSS: Ministry of Health and Social Services
Network H, Large Urban Ontario

**Figure 7: Metropolitan Network H**

- Strategic level:
  - Organization partnerships
  - Sub-networks: case management, CTO implementation

- Tactical level:
  - Coordinated case management

**Range of services offered by GH, CMHC, CO**

- GH
  - Emergency
  - Day clinics
  - Follow-up in the community

- CO
  - Care management
  - Peer assistance
  - Hotline/crisis counselling
  - Rehabilitation services
  - Search for housing
  - Recreation

Index: AD: addictions services; CO: Community organizations; inters: intersectoral; PMC: private medical clinics; GH: general hospital; MH: Mental Health

Network I, Large Urban

**Figure 8: Metropolitan Network I**

- Strategic level:
  - Organizational partnerships
  - Sub-networks: CTO implementation, psychiatry-justice

- MH service coordination:
  - Client referral

- Informal coordination

**Range of services offered by GH, CMHC, CO**

- GH
  - Emergency
  - Day clinics
  - Follow-up in the community

- CO
  - Care management
  - Peer assistance
  - Hotline/crisis counselling
  - Rehabilitation services
  - Search for housing
  - Recreation

Index: AD: addictions services; CO: Community organizations; inters: intersectoral; PMC: private medical clinics; GH: general hospital; MH: Mental Health, PSYH: psychiatric hospital
Figure 9: Metropolitan Network J

Regional level:
- Single point of entry:
  - GH
  - CMHC
  - PMC
  - CO
  - AD
  - inters

Integration among:
- Severe mental disorders
- Informal coordination / protocols / shared care

Strategic level:
- MH Management Team
- Sub-committees
- Administrative, clinical integration

Tactical level:
- Client service coordination
- Individualized service plans

Operational Level:
- Staff training

Provincial level:
- General orientation
- Support to MH Management Team
- Information system

Integration strategies:
- Single point of entry
- Mobile Team
- Shared care
- Protocols
- MOUs

Index: AD: addictions services; CMHC: Community mental health centre; CO: Community organizations; inters: intersectoral; PMC: private medical clinics; GH: general hospital; MH: Mental Health; PSYH: psychiatric hospital
Appendix 2

Definitions

**Assertive Community Treatment**: ACT involves a multidisciplinary team of professionals that provides 24 hour case management in the community. Its range of services includes medication management, crisis care, life skills attainment, and access to community housing, employment and recreational support.

**Case Management**: the brokering and co-ordination of multiple social, health, education, and employment services to promote self-sufficiency and strengthen family life.

**Clinical integration**: involves coordinating services across people, functions, activities and sites. See reference 63.

**Continuity of care**: a process involving the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system.

**Deconcentration**: the transfer of local administrative authority to regions without political authority.

**Delegation**: the transfer of managerial responsibilities to regional offices.

**Devolution**: the creation of sub-provincial units with revenue and expenditure authority.

**Functional integration**: involves having key support functions (strategic planning, information management) coordinated across operating units. See reference 63.

**Network**: A set of organizations and the specific relations among them, which serve as channels through which communications, referrals and resources flow. See references 39, 45.

**Physician integration**: involves economically linking physicians to a system, and having them participate in its planning, management and governance. See reference 63.
Appendix 3
Table 1: Governance models

<table>
<thead>
<tr>
<th>Network Type</th>
<th>Psych Hosp</th>
<th>Jurisdiction for MH</th>
<th>Single Board</th>
<th>Network Governance Model</th>
<th>Network Coordination Mechanism</th>
<th>Lead Agency (Formal)</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>No</td>
<td><strong>Provincial</strong></td>
<td>No</td>
<td>Mutual adjustment (V)</td>
<td>Exec Cmt²</td>
<td>Yes²</td>
<td>Provincial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*(Deconcentrated)*¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Yes</td>
<td><strong>Regional</strong></td>
<td>Yes</td>
<td>Corporate (D)</td>
<td>Exec Cmt¹</td>
<td>Yes</td>
<td>Regional</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Devolved)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td><strong>Regional</strong></td>
<td>Yes</td>
<td>Corporate (D)</td>
<td>Exec Cmt</td>
<td>Yes</td>
<td>MH Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Devolved)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>No</td>
<td><strong>Sub-regional</strong></td>
<td>No</td>
<td>Alliance (V)</td>
<td>Table de concertation</td>
<td>No</td>
<td>Regional</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Delegated from Region)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Yes</td>
<td><strong>Sub-regional</strong></td>
<td>No</td>
<td>Alliance (V)</td>
<td>Table de concertation</td>
<td>No</td>
<td>Regional</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Delegated from Region)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Yes</td>
<td><strong>Provincial:</strong></td>
<td>No</td>
<td>Alliance (V)</td>
<td>Exec Cmt</td>
<td>No</td>
<td>Provincial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*(Deconcentrated)*¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Yes</td>
<td><strong>Sub-regional:</strong></td>
<td>No</td>
<td>Mutual adjustment (V)</td>
<td>Table de concertation</td>
<td>No</td>
<td>Regional</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Delegated from Region)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>No</td>
<td><strong>Provincial:</strong></td>
<td>No</td>
<td>Mutual adjustment (V)</td>
<td>None</td>
<td>Yes²</td>
<td>Provincial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*(Deconcentrated)*¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Yes</td>
<td><strong>Provincial:</strong></td>
<td>No</td>
<td>Mutual adjustment (V)</td>
<td>None</td>
<td>No</td>
<td>Provincial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*(Deconcentrated)*¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>No</td>
<td><strong>Regional:</strong></td>
<td>Yes</td>
<td>Corporate (D/M)</td>
<td>Exec Cmt</td>
<td>Yes</td>
<td>Regional</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Devolved)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MH: Mental Health
Int/Coord: Integration/Coordination; Exec Cmt: Executive Committee
V: Voluntary; M: Mediated; D: Directed
¹ Deconcentrated from the Ministry of Health and Long Term Care regional office
² An executive committee functions at a sub-network level. Network A: Community services only; Network H: Centralized case management services only
³ Coordination mechanisms in additional to an Executive Committee included an Integration Steering Cmt, several Integrated Service Teams, and a Joint Director responsible for all mental health services, a position that was put in place prior to mental health services being transferred to the RHA.
Table 2: Strategies to integrate & coordinate mental health services

<table>
<thead>
<tr>
<th>MH Network Type &amp; Identifier</th>
<th>Approach</th>
<th>Integration strategies</th>
<th>Coordination strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Structural</td>
<td>Type of integration</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Mutual adjust (V)</td>
<td>++ Community services</td>
<td>++ + -</td>
</tr>
<tr>
<td>B</td>
<td>Corporate (D)</td>
<td>++ RHA - institutional &amp; community services</td>
<td>++ +</td>
</tr>
<tr>
<td>Small Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Corporate (D)</td>
<td>++ RHA - institutional &amp; community services</td>
<td>+ ++ MH &amp; Addictions</td>
</tr>
<tr>
<td>Mid-Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Alliance (V)</td>
<td>+ CLSC/hospital Personality Dis. Clinic</td>
<td>+ - +</td>
</tr>
<tr>
<td>E</td>
<td>Alliance (V)</td>
<td>+ Joint Justice Program</td>
<td>+ - +</td>
</tr>
<tr>
<td>F</td>
<td>Alliance (V)</td>
<td>+ Community services, General &amp; PH</td>
<td>++ ++</td>
</tr>
<tr>
<td>Large Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Mutual adjust (V)</td>
<td>+ PH and CLSC Mental health clinic</td>
<td>+ - + -</td>
</tr>
<tr>
<td>H</td>
<td>Mutual adjust (V)</td>
<td>+ Community services</td>
<td>+ - + -</td>
</tr>
<tr>
<td>I</td>
<td>Mutual adjust (V)</td>
<td>+ Addictions &amp; MH facility integrated</td>
<td>+ - + -</td>
</tr>
<tr>
<td>J Calgary</td>
<td>Corporate (D)</td>
<td>++ RHA - institutional &amp; many community components</td>
<td>++ ++</td>
</tr>
</tbody>
</table>

Legend: +: less than average; +: average; ++: above average
Voluntary (V) Directed (D)
Table 3: Financial Incentives & Negotiation Mechanisms to Achieve Coordination

<table>
<thead>
<tr>
<th>MH Network Type &amp; Identifier</th>
<th>Negotiation mechanisms when resources constrained</th>
<th>Negotiation mechanisms effective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>No formal mechanisms</td>
<td>+-</td>
</tr>
<tr>
<td>B</td>
<td>MH executive committee</td>
<td>+</td>
</tr>
<tr>
<td>Small Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Regional mental Health Mgmt Team</td>
<td>++</td>
</tr>
<tr>
<td>Midsize Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Régie regionale; Table de concertation</td>
<td>++</td>
</tr>
<tr>
<td>E</td>
<td>Régie regionale; Table de concertation</td>
<td>+ -</td>
</tr>
<tr>
<td>F</td>
<td>Network prioritizes overall needs</td>
<td>++</td>
</tr>
<tr>
<td>Large Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Régie regionale; Table de concertation</td>
<td>+ -</td>
</tr>
<tr>
<td>H</td>
<td>No formal mechanism; sub-network strategic alliances</td>
<td>+</td>
</tr>
<tr>
<td>I</td>
<td>No formal mechanism; sub-network strategic alliances</td>
<td>+</td>
</tr>
<tr>
<td>J</td>
<td>Council of mental health executives</td>
<td>++</td>
</tr>
</tbody>
</table>

Legend: +-: less than average; +: average; ++: above average
<table>
<thead>
<tr>
<th>MH Network Type &amp; Identifier</th>
<th>Organizations align program delivery</th>
<th>Decision-making type</th>
<th>Needs assessments</th>
<th>Strategic planning: MH Network</th>
<th>Integrated IS</th>
<th>Services with Access to IS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Level</td>
<td>Standardized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>+-</td>
<td>Provincial(^1)</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>B</td>
<td>+</td>
<td>RHA</td>
<td>organizational</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Small Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>++</td>
<td>RHA</td>
<td>network</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Midsize Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>+-</td>
<td>RHA, organizations</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>E</td>
<td>+-</td>
<td>RHA, organizations</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>F</td>
<td>++</td>
<td>Provincial(^1), network</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Large Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>+-</td>
<td>RHA, organizations</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>H</td>
<td>+</td>
<td>Provincial(^1)</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>I</td>
<td>+-</td>
<td>Provincial(^1)</td>
<td>organizational</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>J</td>
<td>++</td>
<td>RHA</td>
<td>network</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

Legend: +-: less than average; +: average; ++: above average  
MH: mental health  
IS: information system  
\(^1\) Ministry of Health and Long Term Care Regional Office  
\(^2\) As of November 28, 2005
Table 5: System Wide Goals and Performance Measures

<table>
<thead>
<tr>
<th>MH Network Type &amp; Identifier</th>
<th>System-wide goals</th>
<th>System-wide performance measures</th>
<th>Organizational performance measures</th>
<th>Goals translated into practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>+.</td>
<td>+.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td>B</td>
<td>+.</td>
<td>++.</td>
<td>++.</td>
<td>+.</td>
</tr>
<tr>
<td><strong>Small Urban</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>++.</td>
<td>++.</td>
<td>++.</td>
<td>++.</td>
</tr>
<tr>
<td><strong>Midsize Urban</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>+.</td>
<td>-.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td>E</td>
<td>++.</td>
<td>+.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td>F</td>
<td>++.</td>
<td>+.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td><strong>Large Urban</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>+.</td>
<td>-.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td>H</td>
<td>+.</td>
<td>-.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td>I</td>
<td>+.</td>
<td>-.</td>
<td>+.</td>
<td>+.</td>
</tr>
<tr>
<td>J</td>
<td>++.</td>
<td>++.</td>
<td>++.</td>
<td>++.</td>
</tr>
</tbody>
</table>

**Legend**: +.: less than average; +.: average; ++.: above average