



Getting our acts together:
Interagency collaborations in child and youth mental health

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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 & Guerrierre, 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.





GOAL

To produce a pragmatic literature review pertaining to interorganizational linkages and strategies to assess and understand how child- and youth-serving mental health organizations can operate more seamlessly to provide services. (See Appendix A - project terms of reference)

BACKGROUND

CHILD AND YOUTH MENTAL HEALTH: THE CURRENT CONTEXT IN ONTARIO

In a recent review of current evidence regarding incidence and prevalence of mental health disorders among children and youth, it was found that the commonly reported figure of 'one in five' is misleading (Offord, 1989; CMHO, 2008) and that the actual prevalence may be higher or lower than 20 percent (Schachter, Girardi, Gelinias et al, 2008). The review found that it was not possible to pinpoint the extent of mental disorder in children and youth using current empirical literature, as the studies were inconsistent vis-a-vis the methods used, types of difficulties or disorders assessed, and the populations investigated. In the international studies reviewed, reported overall rates ranged from 0.6 percent to 43.2 percent. The most rigorous study identified in the review came from the United Kingdom, where a current prevalence of 9.5 percent was estimated, but did not consider children and youth whose suffering did not qualify for a clinical diagnosis. Schachter et al (2008) concluded that a coordinated and prospective effort to accurately measure the current mental health difficulties and disorders among children and youth is urgently required to support the planning of services and supports in Ontario.

It has been reported that one in 10 youth has a serious emotional or behavioural disorder 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). This context creates a pressing agenda for the implementation of evidence-based practices in children's mental health service delivery.





A disjointed and detached service delivery system characterized by silos within and between service systems has been repeatedly confirmed and reinforced by children and youth, families, advocates, service providers, administrators, researchers and policy makers. The multiplicity of services and supports, coupled with increased fragmentation of service delivery systems, pose barriers to young people and their families in their attempts to access and negotiate services (Boydell, Pong, Volpe et al., 2006). Thus, the need for integration in the child and youth mental health system has been firmly established.

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 central and pressing 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).

THE PROBLEM OF DEFINITION

The literature suggests 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). Integration-related terminology includes networking, cooperation, partnership, collaboration, continuity of care, joint venture, merger, alliance,





amalgamation, coordination, alignment and coalition. The conditions needed for an integrated approach to mental health include ways of working that recognize the significance of creating a seamless pathway for service users as they make their way through diverse parts of the mental health system (England & Lester, 2005). In health care, systems integration refers to attempts to improve the service system for a defined population as a whole, on a continuum varying from basic information sharing and communication to full integration (Cocozza, Steadman, Dennis et al., 2000). The Ontario Ministry of Health and Long-Term Care (MOHLTC) provide a 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.

Systems integration refers to attempts to improve the service system for a defined population as a whole rather than for individual clients and can vary in the level of the system addressed (i.e. service delivery level, program level or policy level) (England & Lester, 2005). For example, Boutillier and her colleagues (2008) present types of interagency integration on an intensity continuum ranging from communication (interagency information sharing) to cooperation (shared policies or protocols for dealing with service users) to collaboration (sharing resources, staff decision-making) to integration (integrated programs, planning, funding). The goals of these methods and models are to enhance quality of care, quality of life, consumer satisfaction and system efficiency across multiple services, providers and settings. The Ministry of Children and Youth Services (MCYS) policy document *A Shared Responsibility* (2006) identifies five domains of service integration in increasing degree of connectivity: awareness, communication, cooperation, collaboration and fusion.

TYPES OF INTEGRATION

Different types of integration are described in the literature (Ardal, Butler & Edwards, 2007; Devers, Shortell, Gillies et al, 1994; Durbin et al, 2001). Key among these is the distinction between vertical and horizontal integration (Fooks, 2007). **Vertical integration** refers to the coming together of different organizations, who establish processes to facilitate transitions along the continuum of care. It involves the bringing together of different levels in one hierarchy, under





one governance and management structure. **Horizontal integration** refers to cooperation/collaboration between providers at the same level, forming of linkages and sharing resources between organizations delivering similar services. It is the bringing together of professionals, services, and organizations that operate at similar levels in the care hierarchy (England & Lester, 2005).

The best-practice literature provides strong evidence for creating a collaborative framework involving all partners (community, regional, and national) in order to develop a seamless system of care that enables clients to move freely between the entire range of human services they need (Pires, 2008). One of the challenges of creating an integrated service delivery system for children and youth is that their needs are varied and multiple. A wide variety of services are required to meet the needs of young people with mental health problems (e.g. mental health, health, education, substance abuse, social welfare, juvenile justice) that need coordination across different systems of care. Different levels of integration occur, including within an organization or agency, between child and youth mental health agencies, across agencies (child welfare, youth justice) and cross sectoral (education, health, juvenile justice). The main elements of service integration include system governance, system administration and system development and change. The first two elements apply to the structure of the system and it is assumed for purposes of this report that these are in place in local communities. In this paper, we focus on strategies for development and change in order to help communities realize integration at the interorganizational level. Specifically, this project focuses primarily on horizontal integration at the community or sectoral level, although literature regarding the interface between different systems of care was reviewed in order to understand broad approaches to system integration in mental health care.

Opportunely, a framework for change already exists. In 2006, Children's Mental Health Ontario (CMHO), in tandem with the 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 applies to all Ontario children and youth up to the age of 18 years, and 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, wherein supports and services are provided as close to home as possible. It is a system that is characterized as 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.





METHODS

LITERATURE REVIEW STRATEGY

Finding and analyzing literature is particularly difficult where integrated care is concerned. To address the breadth of research and debate – across different service sectors, professional and agency boundaries and academic disciplines – makes the searching process more complex, given that the review needs to locate material across diverse professional, academic and organizational bodies of knowledge. In the case of this literature review, material reflecting different forms of interorganizational relationships and integration, including between service sectors (i.e. health and mental health care), between professions (i.e. nurses, social workers, doctors and physiotherapists), between settings (i.e. institutions and community, primary and secondary care) and between organization types (statutory, private and voluntary sector) were searched.

The review, therefore, was initially broad in its scope and range. Keywords were selected to reflect the different terms used in different disciplines. Identifying and locating material was dependent on both expertise in retrieving and locating material through ‘insider knowledge’ (HSRCU and Boydell research teams), and expertise in using data searching tools and processes (SickKids librarian). The literature search focused on accessing both published material and grey literature that related to the topics and issues identified by the lead consulting group, the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO and the MCYS.

Retrieval and acquisition of material

Material was retrieved from both electronic databases and from the grey literature. A wide range of electronic databases were searched to reflect the wide scope of interagency coordination and integrated care. The search was limited to English-language articles in the health and social care context.

A different search process was needed for ‘grey literature’ – material which has not gone through a peer-reviewed publication process, including in-house reports and reviews, informal





evaluations and progress reports and items in practice journals. Traditional (non-electronic) methods were used, including looking in the reference lists of articles and books to see what information sources the authors used and asking experts in the topic for their recommendations of grey literature. The websites of key organizations in the field of health service management were also checked for relevant literature. The grey literature also underwent this second stage selection process.

Analysis of the literature

A process of thematic content analysis was used, i.e. recording particular aspects of interorganizational/interagency integration of care. Articles were read, annotated, and entered into EndNote using a standard data extraction form according to a number of characteristics, including:

- The form of integration that was addressed (e.g. between service sectors)
- The dimension of integration that was addressed (e.g. the interface between agencies/services/care sectors)
- The substantive topic area (e.g. youth, adults with mental illness, chronic care, children and youth)
- The type of publication (e.g. research journal or newsletter)
- Details about method, design, subjects/participant, the country of origin
- Key issues or outcomes that were addressed
- Key phrases that were identified in the item

Central themes in the literature

- Problems of definition and the need to clarify the concept of integration (types of, influences on, and integration-related terminology)
- Conceptual and theoretical frameworks
- Strategies
- Approaches
- Barriers and facilitators
- Youth and family involvement
- Factors linked to success
- Common elements and key features
- Evaluation





THE VALUE OF CONCEPTUAL AND THEORETICAL MODELS

Theoretical understanding of interagency collaboration and integration is rather limited (Polivka, 1995). It is important to understand theory because meaningful efforts at interagency coordination are grounded in underlying beliefs and assumptions of the service stakeholders. The most extensive body of literature on interorganizational relationships and networks has been in organization theory (Isett & Provan, 2005). Several conceptual frameworks have been developed for interagency collaboration. For example, Polivka's model – the Interagency Collaboration Model – shows that collaboration is a function of environmental conditions, organizational situations, and task characteristics (Polivka, 1995; Polivka, Dresbach, Heimlich et al, 2001). Theories of change approaches to interagency planning in child mental health have also been used (for example, Hernandez & Hodges, 2006).

D'Amour and her colleagues (2005) describe collaboration as commonly defined through five underlying concepts: sharing, partnership, power, interdependency and process. The most complete models of collaboration appear to be those based on a strong theoretical background, either in organizational theory or organizational sociology and on empirical data. D'Amour et al (2005) found a significant drawback in current models of collaboration. Specifically, the literature fails to determine integration of service users into the health care team (even though they are the ultimate reason for collaboration). The role of the patient/client/family in the collaborative process is poorly conceptualized. Two key elements of collaboration are identified: i) construction of a collective action that addresses the complexity of client needs and ii) the construction of a team life that integrates perspectives of each professional and in which team members respect and trust one another.

Huxham (2003) arrived at a theory of the nature of collaborative working, based on 15 years of action research. It is a practice-oriented theory that tries to understand the management issues involved in working jointly across organizations (Huxham & Vangen, 2004). Two contrasting concepts are central to this theory: 1. Collaborative advantage, which is concerned with the potential for synergy from working collaboratively and 2. Collaborative inertia, which relates to the often disappointing output in reality. The theory is structured as a set of overlapping themes, which are key issues that practitioners see as causing pain and reward in collaborative





situations. Five example themes are discussed: common aims, power, trust, membership structures and leadership. Huxham argues that the theory captures the complexity that underlies collaborative situations and conveys it in a way that seems real to those involved. It aims to empower those involved because it acknowledges the frustration they may experience and provides conceptual strategies to help address the practical issues involved.

The intent of the Huxham theory was to empower those involved in two ways, providing a dual basis for thoughtful action. The first basis is through legitimizing the pain and addressing the isolation that people often feel when trapped in 'collaborative inertia'. Many practitioners find that simply understanding that the problems that they are experiencing are inevitable is empowering. In this respect, the theory is intended partly to increase self-confidence and partly to highlight the need to address the problems of collaboration more determinedly and sometimes more aggressively. The notion of 'collaborative thuggery' can be particularly helpful in legitimizing a degree of manipulation and politicking. The second, and perhaps more significant way in which the theory provides a basis for action, is through the conceptual handles that the theory underlying each of the five theme areas provides. The theory is intended to alert managers to aspects of collaborative situations that will need active attention and nurturing if problems of collaborative inertia are to be minimized. Each theme provides a particular perspective on this, and can be used in isolation to stimulate thinking about that aspect of a collaborative situation. However, the issues raised by each theme overlap with those raised in others, so the combination of themes always needs to be in the background even if the focus at a particular time is on one of them. The theory is therefore designed to be used in a reflective practice mode in which the actual action to be taken is a matter for practitioner judgment.





INTEGRATED SYSTEMS OF CARE: CURRENT EXAMPLES

ADULT MENTAL HEALTH SYSTEM

The Access to Community Care and Effectiveness Services (ACCESS) involved a five-year longitudinal evaluation to assess implementation of integration strategies on a wide range of outcomes¹ in 18 sites in nine cities for those homeless and mentally ill (Cocozza, Steadman, Blasinsky et al, 2000). In each city, an ACCESS grantee agency at both sites received funds to enhance outreach and assertive community treatment and one was randomly selected to receive system integration funding. Service integration was expected to improve in the experimental sites across mental health, substance abuse, housing, primary care and social welfare sectors. Results indicated that an integrated service system is a complex undertaking that requires significant time, resources, a well-functioning infrastructure and ongoing technical assistance (Randolph, Blasinsky, Leginski et al, 1997). Some integration strategies had a higher probability of successful implementation, including the establishment of a local interagency coordinating body, a systems integration coordinator position, and interagency agreements. Special targeted funding for systems integration activities was extremely important. Cocozza and his colleagues (2000) concluded that, when supported, communities can develop and implement a variety of strategies for integrating services.

In a three-year study, two integrated service agency demonstration programs that combined structural and program reforms were examined to determine whether they produced improved outcomes for a cross-section of clients with severe and persistent mental illness (Chandler, Meisel, Hu et al, 1996). Clients at an urban site and a rural site were randomly assigned to an integrated service agency program or to a comparison group that received services as usual. Clients served by the integrated service agencies had less hospital care, greater workforce participation, fewer group and institutional housing arrangements, greater social support, more leisure activity, less family burden, and greater client and family satisfaction. Clients in the urban demonstration program, but not those in the rural program, did better than the comparison group on measures of financial stability, personal well-being, and friendship. The costs for

¹ Outcomes included client functioning, quality of life, and housing outcomes.





demonstration clients were much higher than the costs for services used by comparison clients. Three-year outcomes for a cross-section of clients with severe mental illness in the integrated service agencies were broadly favorable, but costs of services for those clients were high relative to costs for clients receiving the current standard of care.

For a more comprehensive report on system integration in the adult arena, see Durbin and her colleagues' recent comprehensive review of five initiatives considered exemplary in terms of systems integration research (Durbin, Goering, Streiner et al, 2006). Their review revealed a consistent and positive association between systems integration and continuity of care. With respect to systems integration and clinical outcomes, results generally found no association.

CHILD AND YOUTH MENTAL HEALTH SYSTEM

In the United States, the field of child and youth mental health focuses on building systems of care in the community (Friedman, 2005; Stroul & Blau, 2008). A number of factors led to this development, including an inadequate range of services and supports, failure to individualize services, system fragmentation, lack of clear values/principles for the system, lack of clarity about the population of concern, inadequate accountability and lack of adequate responsiveness to cultural differences. A system of care is a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children, youth and families facing severe emotional disturbances. The concept of a system of care connotes not only a range of particular service elements, but also the mechanisms, arrangements, incentives, structures and processes needed to ensure that these individual elements interconnect as a coordinated and cohesive whole. So envisioned, a system of care is the converse of a fragmented system (Johnsen, Morrissey & Calloway, 1996). England and Cole (1992) report on basic system features of the Robert Wood Johnson Foundation's Services Program for Youth grants to develop systems of care for mentally ill children and youth. Two essential features of systems development identified were interagency steering committees and long-term intensive case management. Each of the demonstration sites in the study created an interagency steering committee comprised of staff close to the front line so that issues of interagency cooperation and access to services could be quickly resolved. These steering committees tended to operate under the rubric of a higher state or community level that created and sanctioned formal agreements of





affiliation. Long-term intensive case management, wherein the staff group provides intensive care for the child over the long term, was critical for an effective interagency system. Results of a qualitative, multi-site case study of the impact of managed care on federally funded Center for Mental Health Services (CMHS) system of care communities indicates that communities that are more successful in integrating system-of-care values into the managed care system (a) had pre-existing system-of-care philosophies and (b) utilized a comprehensive planning process involving individuals with expertise in children's mental health services (Stroul, Pires, Armstrong et al, 2002). When these conditions were met, communities were more successful in integrating several systems-of-care features: a broad array of home- and community-based services, access to services in the least restrictive setting, individualized and flexible care, service coordination, family involvement, and cultural competence.

The Fort Bragg study (Bickman, Summerfelt & Noser, 1997) on children's mental health services represents a large-scale initiative in the United States, wherein service delivery was integrated through a number of strategies including centralized access through a single point of entry, timely assessment and referral, a continuum of high-quality services ranging from least to most restrictive levels of care, and case managers and treatment teams assigned to complex cases. The system-of-care studies by Bickman (1996, 2000) show that system coordination alone enhances access to services for children and families, leads to improved satisfaction with services and reduces hospitalization and other restrictive forms of care. However, these studies also demonstrate that clinical outcomes – for example, alleviation of symptoms, functioning, or reduction of impairments – for children are not impacted by service integration. These remained the same whether children were receiving coordinated services through systems of care or were receiving services as usual.

The wraparound model of service delivery (Burns, Schoenwald, Burchard, Faw, & Santos, 2000) is the most promising for cross-agency service integration, and wraparound principles are well supported by theory and research (Walker, Bruns & Penn, 2008). Wraparound is a care-management process that has progressed over the past two decades through efforts to help children with the most challenging concerns function more effectively at home, school, and in the community. As wraparound has become a more widely implemented option for coordinating care for youth with serious and complex mental health issues, programs, communities and states have been increasingly interested in measuring implementation fidelity (Sather, Burns &





Hyde, 2008). Further, wraparound has proven particularly useful for youth already served by multiple agencies or at risk of residential placement (Burns & Goldman, 1999). The wraparound model evolved from the mental health system-of-care concept, pioneered in the Child and Adolescent Service System Program (Stroul & Friedman, 1986). Situated within an "unconditional care" commitment (a no-eject, no-reject policy), wraparound reflects the ideal principles of service planning and delivery. These include parent and child involvement in determining needed services, integration of services and delivery systems, flexibility in the funding and providing of services and individualized, strengths-based, family- and community-centered, culturally competent services (Burns et al, 2000).

Wraparound Milwaukee and the Dawn Project in Indianapolis, Indiana, are identified as excellent examples of proven-effective wraparound service delivery models that integrate juvenile justice, mental health, child welfare and other systems in addressing the needs of youth and their families (Burns & Goldman, 1999; Friedman, 2005). In Milwaukee, wraparound reduced the use of residential treatment centres from 375 to 50 youth, and is using the same monies to serve more children in home- and community-based services with better outcomes. (Pires, Stroul Armstrong et al, 2008). Florida and New York are other examples of integrated service delivery. In Florida's unique Community-Based Care initiative, a local provider network and county-based community alliances provide services for children and their families and ensure an orderly transition of child welfare services from the public to the private sector. New York State's Office of Children and Family Services provides a continuum of services, including early intervention, home-based response, out-of-home placement, post-placement reintegration and community support. This continuum serves as a single frame of reference for child welfare and juvenile justice system staff and supports cross-system programs.

The Alberta Children and Youth Initiative (ACYI), a collaborative partnership of government ministries working together on issues affecting children and youth, produced an Information Sharing Guideline (the Guideline) to ensure that integrated planning and services for children, youth and their families is supported by appropriate cross-sector information sharing (2003). The Guideline is intended to represent a foundation for the sharing of information among government ministries and agencies in the best interests of children and youth. The Guideline identifies the processes by which information can be shared between service providers (and





others) who are providing services and supports to the same child, youth and/or family. The guiding principles support this overall vision. The purposes of the Guideline are to:

- Enable the sharing of necessary information about children and youth among service providers
- Minimize barriers, perceived or real
- Support an integrated approach to service delivery by strengthening the ability to share required information about children and youth, based on consent
- Enable effective coordination of supports and services by service providers, including the ability to collectively plan short- and long-term interventions

Performance indicators are used to measure readiness to learn, success in school and healthy behaviours over time.

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. A resource coordinator administers the Brief Child and Family Phone Interview (BCFPI) as one component of a comprehensive intake interview and its results are utilized to inform recommendations for triaging to the most appropriate services. Service priorities are established and interim service options are suggested to family caregivers to consider while they are waiting. Peirson (2007) used qualitative case study to explore, understand and describe the implementation process of this initiative. The key questions were: What was the stated intent of the policy and the local implementation plan? What were the expectations regarding the implementation of two critical system features (single point of access and common tool for intake) articulated in the Ministry document *Making Services Work for People* and the local implementation plan? How did the implementation process unfold in the case community? What crucial dynamics and elements influenced the process in general and specifically the process of implementing the two system features of interest? Data were gathered from 21 individual semi-structured interviews and from documents regarding the policy and implementation process. An analytic framework incorporating constructs and models presented in past implementation research, elements of systems theory, principles of social ecology and a general theory of organized action was used to extract, refine and relate themes





and constitutive patterns from the data. The analytic and interpretive narrative described the implementation process as a dynamic and complex process that unfolded over a number of years and involved many different agents, resources, decisions and activities. Salient themes permeating the process of implementation (expanding the boundaries of implementation, the instrument of implementation and the human element) and other themes revealed through the application of the study's conceptual framework were highlighted.

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. Referrals by parents are processed locally by case managers as they are the only single point of access to the ISNC program. 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. Case managers, who reside in the communities, act as the single point of entry and co-ordinate these services. As originally conceived, the continuity of care provided depended upon volunteer "mediators" (such as parents or teachers) implementing the intervention plans developed for clients by the resource group professionals. However, in response to concerns of parents and schools about the consistency of care and the program's ability to ensure compliance by unpaid mediators, the District of Thunder Bay Integrated Services for Northern Children program began to employ its own discipline-specific paraprofessionals: occupational therapy/physiotherapy intervention workers, behavioural intervention workers and speech-language intervention workers. This was partly supported by modest supplementary program grants awarded on a year-by-year basis, but primarily paid for through accumulated budget surpluses. Minore et al's study (2005) indicates that while residents of outlying communities prefer the intervention worker model when it came to implementing care plans (on six measures of continuity), they accepted the volunteer mediators as they provided community-based treatment.

Examples of multi-agency programming exist in Ontario, wherein resources are combined from two or more agencies 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 from 0 to 18 years of age who have complex clinical profiles and service needs. WIT is not a direct service program for clients, rather, it helps the helpers by 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.

Communities of practice (CoPs) have been used in the child and youth mental health system to bring together groups of stakeholders using the Child and Adolescent Functioning Assessment Scale (CAFAS), the common outcome measure for child and youth mental health. CoPs are groups of people who share a concern, set of problems or enthusiasm about a topic, and who deepen their knowledge and expertise about a topic by interacting on an ongoing basis (Wenger, McDermott & Snyder, 2002). They are part of a wider tradition of collaborative small group learning environments related to reflective practice, continuing medical education, education and adult learning theory. In a project funded by the Canadian Institutes of Health Research (Barwick, Boydell & Basnett, 2008), nine regions in Ontario regularly met to share their use of the CAFAS, their experiences and how the CAFAS may inform their practice. The context for this study was Ontario's children's mental health sector where 120 organizations comprising over 4,100 practitioners were mandated since 2000 to use a standardized outcome measurement tool to monitor client response to treatment and service outcomes (CAFAS). Using a new group of practitioner trainees randomly assigned to either a community of practice (CoP) group or a practice as usual (PaU) group, practice change and knowledge uptake were investigated. Findings support the potential of collaborative methods and reflective practice to bring about change in practice. Dedicated time on the job should be given to reflective practice in order to promote readiness to change. The CoP practitioners have opted to continue with the CoP experience even though funding has ended. This is an important finding, given that all practitioners in this group had to travel between one to three hours to attend a full-day meeting.





CoPs were considered a particular approach to facilitate collaborative interagency working in the United Kingdom (Lathlean & leMay, 2002). Lathlean and le May (2002) reported that CoPs may also be useful ways in which insights can be gained into the practices of other agencies. Therefore, they have the potential to break down both interagency and interprofessional barriers and boundaries. They acknowledged that when consumers were involved in the CoP, this provided additional opportunities for understanding the breadth of perspectives required to tailor services more accurately to meet needs.

As indicated in this review, although many integration initiatives in child and youth mental health are promising as indicated by early evaluative work, there are a plethora of exciting programs that lack empirical evidence of their success. Much work remains in terms of exploring the relationship between actions and outcomes – they are often nonlinear and hard to predict.





BARRIERS TO INTERAGENCY COLLABORATION

Numerous barriers are identified in the integration of health care (Kodner & Spreeuwenberg, 2002). Competing agency mandates and unwritten policies may undermine planners' efforts, social service institutions may resist change, positive symbolic value of coordination may overshadow the political work of negotiation and compromise that is necessary to integrate service systems and there is limited effect on social problems that are shaped by national economic trends or public policy (Rowe, Hoge, and Fisk, 1998). Provan (1997) further shows that problems of service integration also include the potential loss of decision autonomy (whenever an agency is asked to coordinate its activities with another, some autonomy is sacrificed), and when multiple agencies are involved (for truly integrated delivery systems), agency decisions regarding resource allocation and treatment must be constrained by the needs and decisions of the other agencies that collectively comprise the service delivery network. In addition, the more tightly coupled the providers are, the more the decisions of any one provider agency will have an impact on the decisions of the other (Provan, 1997). Agency 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 resist strong attempts to emphasize system versus agency needs. Because of these difficulties, systems are often coordinated by a lead agency that provides multiple services, but draws on members of the network for other services (Provan, 1997). The benefits must therefore be obvious; otherwise, agency staff may become only peripherally involved in integration efforts, making the service delivery system weak in some areas. 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. Another barrier to consider is that agency staff may view clients as "difficult" and pass them on too readily to other agencies in the system. Subsequently conflict may arise between the goals and needs of staff professionals and administrators (Provan, 1997). Therefore, there is a strong need for agency and staff trust in order to secure the broader commitment of agencies.

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. Their study highlights the critical nature of seed money in funding the complex and time-consuming process of launching and





sustaining integration efforts, which the study sites typically obtained in the form of grants. At the practice level, reimbursement structures hinder the ability of providers to consult and engage in joint planning with their patients' other individual (e.g., mental health counsellor) and institutional (e.g., school) providers.

Johnson et al (2003) document a multitude of barriers to interagency collaboration in their review of the literature. They include a lack of understanding of other agencies' policies, lack of communication between policy makers and service providers, lack of time for collaborative efforts, unclear goals and objectives and resistance to change. Their own qualitative study involves in-depth interviews with statewide policy makers and practitioners about the factors that contributed to success as well as those that jeopardized success. Their findings mirror those of the literature described, but also identify the lack of understanding of collaborating agencies' cultures.

Wihlman and her colleagues (2008) analyze key intertwined barriers in four organizations in Sweden. They identify three key barriers: *uncertainty*, which was comprised of unclear goals, leadership and roles; *prioritizing one's own organization*, which encompassed territoriality, formal and financial focus, distrust and different perspectives; and *lack of communication*, which included lack of dialogue, lack of participation, and lack of learning. They conclude that one way to address these barriers is to take the needs of service users as a point of departure in the development of joint services and to also involve them in the development of inter-organizational integration. 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).





ELEMENTS OF SUCCESSFUL INTERAGENCY COLLABORATION

From Johnson et al. (2003)

<p>Commitment</p>	<ul style="list-style-type: none"> ▪ Sharing of goals and vision ▪ Critical factor and the foundation of successful interagency collaborations ▪ Willingness to modify procedures
<p>Communication</p>	<ul style="list-style-type: none"> ▪ Open lines of communication a critical component of successful collaboration ▪ Proactive approach to communication with partners ▪ Upfront about issues, differences addressed ▪ Created frequent opportunities for communication through regular meetings, e-mail, phone calls ▪ Develop personal, informal connections
<p>Strong leadership</p>	<ul style="list-style-type: none"> ▪ Critical that upper management be involved and committed to the collaboration ▪ Need to have enough authority to make decisions ▪ Able to provide direct assistance when problems arise ▪ Can authorize use of agency resources for collaboration
<p>Understanding the culture of collaborating agencies</p>	<ul style="list-style-type: none"> ▪ Using a cultural view encourages partners to seek solutions sensitive to unique cultures of agencies involved ▪ Taking time to learn the other agencies' mission, priorities, and technical language
<p>Providing adequate resources for collaboration</p>	<ul style="list-style-type: none"> ▪ Time and additional resources should be provided for those participating in collaboration ▪ Provide rewards and incentives
<p>Engaging in serious preplanning</p>	<ul style="list-style-type: none"> ▪ Form a steering committee to develop partnership and identify potential problems, key issues, and similarities and differences between the culture of participating agencies





TAKING ACTION AND BUILDING ON STRENGTHS: TOOLS AND STRATEGIES FOR ACHIEVING INTERORGANIZATIONAL INTEGRATION

The literature informs us that although no one element of integrated models of care is effective in and of itself, all successful programs possess key common features, regardless of the context (McAdam, 2008; Centre of Excellence for Child and Youth Mental Health at CHEO, 2007). The tools and strategies in this section are suggested for consideration in order to move forward with *A Shared Responsibility* – an integrated interagency system of care in child and youth mental health. They are strategies identified in the extant literature as essential ingredients in an integrated system of care and should be considered when seeking to establish the best evidence-based integration model available for Ontario's children and youth. It is important to note that the Ontario system is already well on its way in terms of the journey toward an integrated system. A policy document 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.

PRODUCE A CLEAR STATEMENT OF PHILOSOPHY ENSHRINED IN POLICY

Spalding and her colleagues' (2002) study of continuity of care suggests that to build a true system, it is essential that an overall policy framework for children exists. A shared vision is critical to successful integration efforts (Hollander & Prince, 2008). Core foundational processes identified in the United States child and youth systems-of-care approach include a clear statement of values and principles developed in a participatory way with all stakeholders, a logic model conceptualized as a beginning effort to assist communities in identifying where they are going and what they want to accomplish and a performance measurement system aligned with the principles and goals. In established systems of integrated care, values and beliefs drive outcomes (Friedman, Hodges & Blasé, 2008). Further, a policy framework might function to provide one ministry or department the mandate, authority and funding to oversee children's services in an integrated fashion. Child and youth mental health stakeholders indicated that





although overarching directions, clear principles and broad outcomes for service integration activities should be provided by government, local modifications that make the best use of existing resources should be encouraged (Sparrow Lake Alliance, 2007).

An agreed-on vision or goal is critical to successful collaborative mechanisms (Kreuter, Lezin & Young, 2000; Sparrow Lake Alliance, 2007). *A Shared Responsibility* outlines the transformation agenda created through consultation with hundreds of key stakeholders throughout the province. It represents a multi-year blueprint and is an enabler of change. A clear vision, principles and strategic goals are identified in the policy document. The more recent Ontario MCYS strategic framework *Realizing Potential* (2008) specifically outlines five key goals to enhance child and youth mental health and strengthen partnerships and service interconnectivity.

CREATE STANDARDIZED SYSTEM-LEVEL SCREENING AND OUTCOME ASSESSMENT

How can organizations maintain strong relationships when there are budget and other organizational pressures that work to undermine them? One very useful strategy is to make sure that outcomes important to each participating agency are measured. Measuring outcomes is identified as a particularly important strategy for programs that seek to integrate services across agencies (Zimmerman, Schwalberg, Botsko et al, 2001). Standardized assessments are viewed as critical as they prevent service users from having to complete new assessments each time they enter a different service. They also allow for a common base of information which can be shared across service providers. Common classification systems which can be used to determine care needs, irrespective of the site of care, tend to be non-existent or in their infancy. However, a common classification system and a common assessment tool are essential elements for planning and management in regard to complex systems of care (Hollander & Prince, 2002; 2008).

The MCYS already has a common measurement system in place for systematic screening (BCFPI) and outcome management (CAFAS) across the province. This Ontario initiative began in 1999 as part of a four-point plan for child and youth mental health that also saw the development of intensive child and family services, mobile crisis services and telepsychiatry (Boydell, Barwick, Ferguson et al, 2005; Barwick, 2007). Service providers in the child and





youth mental health sector have shifted from skepticism to acceptance to commitment as they move toward integration of these measures into their day-to-day clinical practice (Barwick, 2007). This initiative provides all working in the area with tools that are viewed as an important element of each client's assessment and treatment plan.

To date, the lessons learned from the measurement initiative suggest there is a need to build individual and organizational readiness for change, improve the state of technological literacy and infrastructure across the sector and improve the exchange of knowledge among stakeholders regarding the clinical benefits of the tools and the data they will produce with respect to children receiving mental health service in Ontario. Recent reports suggest appreciation for what the tools contribute clinically is growing with practitioner experience (Barwick, 2007). Consequently, the child and youth mental health sector in Ontario has experienced organizational and practice change and now represents a culture that is more inclined to welcome evidence-based practice and service delivery innovations.

CommuniCAFAS Wiki is a more recent project within the measurement initiative designed to reduce e-mail overload and enable sharing of a collaborative workspace so content is not duplicated, best practices are shared and travel is reduced. It represents a collaborative space that focuses on best practice knowledge for CAFAS and BCFPI use across Ontario. This space includes reference tools, general information about the measures, best practice procedures, meeting agendas and minutes, subscale rules, protocols, discussion platforms, FAQs, clinical guidelines, workspace for collaborative projects, training and support.

INVOLVE FAMILIES AND YOUNG PEOPLE

Family involvement has been found to improve integration efforts (Zimmerman et al, 2001). The results of a study by Briggs et al (2006) provided empirical evidence of the hard work and contributions made by family members in the science of enhanced collaboration between families and professionals, and improved service systems overall. Also highlighted were implications for future study on how the contributions of family members can effect changes in key areas of children's mental health through participation in statewide family networks.





Unfortunately, there remains little evidence of far-reaching service user involvement in integrated service development. Within service redesign, it is not yet accepted culture in practice to involve children and families, and individual services have arrangements for user involvement which do not fit together (Robinson, Atkinson & Downing, 2008). Robinson and colleagues (2008) further indicate that the common features of enablers associated with the models of extent of integration include, in particular, the need to encompass strong involvement of children, families and communities in service design, without which it was suggested that integrated services are likely to be ineffective. Thus, the role of service users in integration efforts is critical and cannot be ignored (Pautler & Gagne, 2005).

Family involvement is found to improve integration efforts (Zimmerman et al, 2001). A growing number of collaborative mental health projects highlight the role of the consumer through specific allotment of time and resources. For example, this includes the provision of educational materials, sessions or information centres available to consumers, their families and caregivers about conditions and diseases so that they can make knowledgeable choices about treatment and self care. Involving consumers, their families and caregivers in the development of collaborative mental health care initiatives (e.g., participation in focus groups, advisory committees) and program evaluations (e.g., designing instruments, taking roles as peer researchers and respondents) is also important (Matarese, Carpenter, Huffine et al, 2008). Coupled with this is the need to adapt health promotion and treatment interventions to reflect the unique needs and cultural experience of each consumer.

CONSTRUCT A LEARNING ORGANIZATION

Although individuals possess the capacity to learn, the structures and systems within which they function do not often allow for reflection and engagement (Senge, 2006). Senge asserts that in times of rapid change, only those organizations that are flexible, adaptive and productive will excel. In order for this to take place, organizations are required to tap into people's commitment and capacity to learn. As Senge (2006) notes, simple frameworks are often applied to complex systems in which the parts rather than the whole are focused upon. Individuals need to shift their thinking toward viewing the organization as a dynamic process and seeing wholes rather than parts. They should avoid seeing individuals as helpless reactors and instead see them as active participants, engaged in shaping their reality and creating their future.





SUPPORT COMMUNITIES OF PRACTICE (CoPs)

The acquisition of knowledge is a social process wherein individuals can participate in communal learning. A great deal of clinician knowledge is gained through the process of interaction with colleagues, clients/patients and systems. The CoP provides an opportunity for the exchange of tacit knowledge and for reflection and solutions to real world problems to emerge. Frequently, there is little time for reflection and critical analysis in everyday practice because too many things may be occurring simultaneously to create space for focusing on the reasons why things are not working well (Lockyer, Gondocz & Thivierge, 2004). CoPs are based on collegiality rather than reporting relationships, and membership depends on participation rather than institutional affiliation.

Hoge & Howenstine (1997) identify the success of such modes of informal communication that prompt staff to cross agency boundaries and interact with other providers, thus stimulating the development of relationships and connections. These informal relationships and communication patterns, in addition to formal structures, produce the desired goals of referral and cooperation across agency boundaries and also facilitate the development of relationships. Inattention to this level of organizational development may account for the repeated failures to achieve service integration and positive outcomes among clients served.

ATTEND TO LEADERSHIP ISSUES

Leadership from government as well as leadership through participation and support from provider organizations is critical to overcoming resistance to integration (Durbin et al, 2001; Johnson, Zorn, Tam et al, 2003). Essential to the development and sustenance of these interagency relationships is the involvement of a dedicated leader who can attract support and resources, motivate people, and solve problems. The development of opportunities for and encouragement of staff, as well as leader involvement in alliances have been identified as important parts of the attempt to create a more integrated social service delivery system (Foster-Fishman et al, 2001). Partnership synergy has been identified as being most closely associated with the effectiveness of partnership leadership and with partnership efficiency (Weiss, Miller Anderson & Lasker, 2002). Leadership styles that are open to risk and change have also been advocated (Sparrow Lake Alliance, 2007). In a learning organization, leaders





are designers and teachers; they are responsible for building organizations where individuals continually expand their capabilities to understand complexity and clarify vision.

It is equally important, however, that a project not become dependent on the commitment of a particular person. If a project is to be sustainable and replicable, it cannot be premised on the leadership of someone who is perceived to be superhuman. While it may be a difficult job, it must be one that an ordinary person can do (Zimmerman et al, 2001). There has also been a need recognized to have different partners take a leadership position on different issues (Boutillier, O'Connor, Zizys et al, 2008). While many efforts to strengthen workforce capacity have focused on issues of recruitment, retention and training of individuals, it is now clearly recognized that leaders and leadership development is a critical component not only to support a quality workforce, but also to sustain and transform systems of care in states and communities (Hoge, Morris, Daniels et al. 2007).

Issues relating to trust are also commonly raised in the service integration literature (Huxham & Vengal, 2004). The common wisdom seems to be that trust is a precondition for successful collaboration. However, while the existence of trusting relationships between partners probably would be an ideal situation, the common practice appears to be that suspicion, rather than trust, is the starting point. Hence, it is important to focus any attempts at building collaborative relationships on trust-building.

CONSIDER AN INTERAGENCY COUNCIL

The effectiveness of interagency councils, as measured by sharing of resources and joint problem solving, has been demonstrated (Howell, Kelly, Palmer et al, 2004). Five key components of an interagency infrastructure include information exchange, cross-agency client referrals, networking protocols, interagency councils and integrated services. "As agencies interact more through interagency forums they tend to become more aware of other services that are available to meet their clients' needs and, thus, to make more referrals" (Rivard et al., 1999, p. 77). Supported by information exchange and effective cross-agency client referrals, participation in interagency councils has been shown to lead to resource sharing and joint action to solve service issues and problems. A regional coordinating council and interagency service delivery teams create structures and processes intended to facilitate interorganizational





exchanges. The development of opportunities for and encouragement of staff and leader involvement in these alliances may be critical to the attempt to create a more integrated social service delivery system (Foster-Fishman, Salem, Allen et al, 2001).

ENSURE FORMAL CONTRACTS/AGREEMENTS

Isett and Provan (2005) contributed to the body of organization theory by demonstrating that formal contracts are necessary in a public sector context, due to the regulatory requirements of funding agencies. Contracts provide an essential framework for carrying out basic network functions in public and nonprofit sectors. Isett and Provan (2005) also found the need for formal contracts remains constant among publicly funded organizations and, moreover, that trust is not negatively affected by the presence of such contracts. Networking protocols refer to negotiated agreements between agencies that outline information exchange and cross-agency client referral conditions and procedures (Morrissey, Johnsen, & Galloway, 1997). Such agreements have been shown to stimulate growth in communication and increased client sharing.

THE INNOVATIVE ROLE OF THE BOUNDARY SPANNER

Cross-sectoral collaboration experiences problems arising from differing disciplinary languages, research approaches and cultures. Understanding across sector and discipline boundaries can be improved if people are trained to communicate across those boundaries – the ‘boundary spanners’. The role of the boundary spanner includes: creating internal and external networks, issue identification, translating the knowledge back into the organizational culture, influencing and educating internal and external stakeholders, creating buy-in and support and identifying internal senior-level champions.

Boundary spanners connect informal networks with external groups, for example other agencies, sectors or regions (Kerr, 2002). Through their relationships with the outside, boundary spanners provide a quick and efficient conduit of relevant information. They are especially important when agencies need to frequently tap into specialized skills, such as technical expertise or research knowledge. Sometimes long-term consultants can play this role in an organization. Organizations need to ensure that their boundary spanners are connecting to the right people inside the organization, so that relevant external information flows quickly to the





network. For example, boundary spanners should connect to central connectors rather than people on the periphery of the network.

A number of unique positions defined in terms of function rather than discipline have emerged in the delivery of collaborative care. In some jurisdictions, like Great Britain, these positions have been prescribed in primary care and mental health reform policy. Often they are formulated to liaise between primary and mental health care. People trained in a variety of disciplines fill these roles because the emphasis is on their combined personal characteristics, attitudes and skill sets, rather than on their specific training (CCMHI, 2005).





EVALUATION AND MEASUREMENT OF INTEGRATION EFFORTS

Evaluation is an important tool, not only in enhancing what is already known, but also in furthering the knowledge base to produce optimal results. The sustainability of service integration programs depends on the projects' ability to demonstrate the success of their efforts (Zimmerman et al, 2001). The need for evaluation in this realm has been well established (Human Services Integration Network, 2007), particularly the increasing recognition of the need for individuals, agencies and systems to create a culture of evidence (Stroul, Blau & Sondheimer, 2008). However, assessing networks and interorganizational 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). One study documented five important and interlocking domains in addressing barriers and bottlenecks, which include: funding, administrative, organizational (tools), service delivery and clinical (Kodner and Spreeuwenberg, 2002). Additional evaluation strategies include reviewing aspects such as knowledge transfer and outcomes, the ebb and flow of agencies to and from the network and the range of actual services provided by the network, rather than simply the number of agencies involved (Provan & Milward, 2001). Provan and Milward (2001) argue that network or integrated human services must be evaluated from three perspectives – the network itself, the client perspective, and the community. Manteuffel and her colleagues (2008) suggest the need for meta-analyses to review what is already known and identify gaps in understanding systems integration and its impact on outcomes.

It is essential to assess the multiplicity and strength of the network as well as the number of linkages between agencies. In addition, determining the strength of the relationships between and among network members is critical, especially across the full network, as it reflects on the commitments among network agencies (Provan & Milward, 2001). The importance of network involvement for individual agencies can be evaluated using four primary criteria: client outcomes, legitimacy, resource acquisition and cost (Provan & Milward, 2001). A measure that can determine the extent, scope, depth and outcome of integration is needed (Browne et al, 2002). Consequently, Browne and her colleagues made one of the first attempts to use a theoretical framework to measure and quantify the extent, scope, and depth of integration within





a community program (Browne, Roberts, Gafni, Byrne, Kertyzia & Loney, 2004; Butt, Markle-Reid and Browne, 2008).

Cashman et al. (2004) investigated an intervention to enhance the functioning of an interdisciplinary health care team in a primary care setting. They used the System for the Multiple Level Observation of Groups (SYMLOG) tool to highlight the changes in team functioning over the course of the study and compared the team's values to those of an optimally effective team. The authors provide useful information about institutional-, organizational-, and team-related supports and barriers that affect the development of collaborative integrated teams. Other measures and tools used to examine the impact of interagency collaboration include the Partnership Assessment Tool by the Center for Advancement of Collaborative Strategies in Health (Weiss et al, 2002), the Interagency Collaboration Tool (Polivka, Dresback, Heimlich et al, 2001), and the Alberta Continuity of Services Scale for Mental Health (Anthony, 2004).

Very few studies have used provider satisfaction as a measure of success of integrated models of care (Farrar, Kates, Crustola et al, 2001; Kodner & Spreeuwenberg, 2002; Fooks, 2007). Providers play a key role in the success and acceptance of new health care delivery models, and satisfaction can predict acceptability of the model. Farrar et al (2001) found that providers felt integrated approaches to health care make services more accessible and satisfying to patients, improve communication among specialties, and create teams that deliver enhanced mental health care. Briggs and Garner (2008) stressed that user views are important to measure as they will influence the uptake of integration strategies and their effectiveness. Approaches and challenges to measuring interagency collaboration in a service delivery system and communicating social network analysis findings to stakeholders remain to be examined (Friedman, Reynolds, Quan et al, 2007). Useful strategies for addressing the complexity of the issue and the context in which integration occurs include case studies, ethnography and narrative analysis (Friedman, 2005; Huxham & Vengal, 2004).

In summary, research and evaluation needs to be embedded in all integration efforts, despite the fact that the challenges of doing so can be overwhelming (Kreuter, Lezin & Young, 2000).





IMPLICATIONS FOR POLICY AND PRACTICE

A provincial framework must be adaptable to the particular strengths and capacities of individual communities. This flexibility will ensure that any framework or model is equally applicable to a major urban centre or a relatively isolated rural community. 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 and local joint working tools and processes) may take root more slowly than others.

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.

Systems thinking ... says that there is plenty to do, of a different sort of "doing." The future can't be predicted, but it can be envisioned and brought lovingly into being. Systems can't be controlled, but they can be designed and redesigned. We can't surge forward with certainty into a world of no surprises, but we can expect surprises and learn from them and even profit from them. We can't impose our will upon a system. We can listen to what the system tells us, and discover how its properties and our values can work together to bring forth something much better than could ever be produced by our will alone.

Meadows, 2002





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APPENDIX A: TERMS OF REFERENCE AND SCOPE OF STUDY

In 2006, the Ministry of Children and Youth Services (MCYS) developed a policy framework for child and youth mental health in Ontario titled *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health* (November 2006). A key strategic goal and priority area for action that ensued called for government and community stakeholders to work together for “a child and youth mental health sector that is coordinated, collaborative and integrated at all community and government levels, creating a culture of shared responsibility” (p.11). Concurrent with this development was the work of a subcommittee struck by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (the Centre), whose goal was to understand integration and the ways in which fragmentation in the child and youth mental health system could be reduced. Currently, MCYS (along with other relevant Ministries) is involved in a mapping project in order to document mental health services for children and youth along the continuum of care at the agency and program level. The mapping process does not address interorganizational relationships.

Given this combined interest and activities from both government and the Centre in this area, the Health Systems Research and Consulting Group at the Centre for Addiction and Mental Health was contacted to produce a literature review (published and ‘grey’ literature) pertaining to interorganizational linkages and strategies to assess and understand the ways in which organizations can operate more seamlessly to provide services. It was clearly specified that MCYS did not want a product that included recommendations or advice, rather, the focus was to be on evidence pertaining to seamless delivery of service.

