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Descriptive Thesis: A model Structure Utilizing the Continuum of Mental Health Service to promote integration, build new partnerships and collaborative practices for Mental Health Service Delivery

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Purpose

The purpose of this thesis is to describe the process used in utilizing the Continuum of Mental Health Care/Service, to integrate the Mental Health Services of the Alberta Mental Health Board and the Calgary Health Region. The thesis will describe the shift in management thinking and practice required along with the challenges, obstacles, and pitfalls of what worked and what didn't work. Each element of the Continuum of Mental Health Care/Service will be described and how each element along the continuum links to an integrated service delivery system or network. The thesis will describe how the Continuum is used to develop new collaborative and/or partnerships, planning for future services and for the development of further integration within mental health, within health and across other jurisdictions providing related services to the population served by the Calgary Health Region.

Introduction

Context of Mental Health

Mental illness ranks first in terms of causing disability in the United States, Canada, and Western Europe, according to a study by the World Health Organization. This study found that mental illness including depression, bipolar disorder, and schizophrenia accounts for 25% of all disability across major industrialized countries. An economy's loss of productivity from mental illness is staggering, and in the United States alone amounts to $63 billion annually. The bottom line is that mental illness is wide spread and very disabling not to be dismissed as a character flaw or weakness.

Like physical illness, mental illness is treatable, especially when the treatment comes early[1].

Consider the future with respect to the demands for children's services alone. The nation is facing a public crisis in mental healthcare for infants, children and adolescents. Many children have mental health problems that interfere with normal development and functioning. In North America, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment[2]. Yet, in any given year, it is estimated that only one in five of such children receive specialty mental health services[2]. Unmet need for service remains high now, as high as it was 20 years ago. Furthermore, recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children.

These findings are one indication of an increase in demand for Mental Health services and because of such will require mental health service delivery systems to reform. The Mental Health Service delivery system is defined as a continuum of services and for the purposes of this study I am using the Canadian Council on Health Services Accreditation definition *"An integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined*

[1] World Health Organization 2001
[2] Burns, et al., 1995

populations. Elements of the continuum are: self-care, prevention and promotion, short-term care and service, continuing care and service, rehabilitation and support"[3].

The mental health service delivery system does not adequately serve all the people who need care and while many consumers do receive effective care, many others do not. The system has been fragmented and in disarray-not from lack of commitment and skill of those who deliver care, but from underlying structural, financial and organizational challenges contributes to its divisiveness. Many of the challenges are due to the historical "layering on" of multiple, well-intentioned programs without overall direction, coordination, or consistency across a service continuum. Current systems tend to compartmentalize the client and family often with no overall view of the person, within the context of a continuum of care. A central aspect of current mental health reform is service integration. Integration is best defined by the Canadian Council on Health Services Accreditation as: [4] *"Bringing together services, providers, and organizations from across the continuum to work together jointly so that their services are complementary to one another, are coordinated with each other, and are a seamless unified system, with continuity, for the client."*

To achieve the maximum impact on the health[5] of a group or population, health care delivery has to be provided in an integrated fashion. Notwithstanding the spectacular impact of the vertical approaches to health care, which aim to irradiate well-

[3] Canadian Council on Health Services Accreditation, Achieving Improved Measurement Standards, Second Edition, 2002
[4] Canadian Council on Health Services Accreditation, Achieving Improved Measurement Standards, Second Edition, 2002

[5] WHO defines health by use of the term "well-being"

defined disease entities, an integrated approach is required at many system levels of health care delivery when a range of different factors influence the state of health[6].

Background

The Traditional Mental Health System in Alberta

The Mental Health System that has existed in Alberta for decades has been comprised of two distinct systems. One system was a provincial system operated by the Alberta Mental Health Board and the other a regional system operated by the individual Regional Health Authorities. The provincial system lead by the Alberta Mental Health Board until April 2003, operated 75 community based Mental Health Clinics across the province and four Provincial Mental Health Hospitals, namely Alberta Hospital Edmonton, Alberta Hospital Ponoka, Claresholm Care Centre and Raymond Care Centre. The clinics operate on a service model whereby the patient, client or family can self refer with treatment and assessment provided by multidisciplinary staff with psychiatric consultation. The Provincial Mental Health Hospital system operated quite independently from the Community Mental Health System and patients enter the hospital system through referrals from general hospitals, general practice offices, and the community mental health clinics. The physicians are the gate keepers to the hospital system, be they general practitioners or psychiatrists.

The Mental Health system operated by the Regional Health Authorities is primarily focused in community or tertiary care hospitals that provide day hospital

[6] WHO 1996

programs, crisis response and ambulatory services both within the hospital and on an outreach basis. In this system the entry point is through a family physician referral, emergency room presentation and the psychiatrist is more or less the gate keeper to the service. Both the Alberta Mental Health Board system and the Regional Health Authority system operated autonomously from one another, even though both were funded by Alberta Health and Wellness. Integration, if indeed it happened, occurred on a voluntary basis.

The Calgary Health Region provides Mental Health Services on five hospital sites namely: Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, Alberta Children's Hospital and Colonel Belcher Veterans Care Centre. In the Calgary Health Region jurisdiction, the Alberta Mental Health Board provides Mental Health Services through 15 Community Mental Health Clinics; three within the city of Calgary and 12 in the rural communities of the region. In addition 14 contracts are in effect with external service providers and the Claresholm Care Centre a provincial rehabilitation centre.

A planning process was initiated in 1996 in Calgary for the Mental Health Services operated by the Calgary Health Region and the Alberta Mental Health Board to develop an integrated service plan. A joint Mental Health Program Design and Coordinating Committee were established with leadership representation from both organizations. This committee led an extensive community wide consultation process to gather input from key stakeholders and establish the needs and set priorities that both organizations would support. The recommendations from the planning process

were to "establish an Integrated Mental Health and Psychiatric Service that incorporates the services of the Calgary Health Region and the Alberta Mental Health Board"[7]. In order to facilitate the development of an integrated mental health and psychiatric service the leaders of Alberta Mental Health Board and the Calgary Health Region decided to pursue the hiring of a jointly appointed and funded Executive Director for Mental Health. This position would have equal authority in both organizations over the development and implementation of a fully integrated Mental Health and Psychiatric Service.

In 2000 the Alberta Mental Health Board and the Calgary Health Region jointly hired an Executive Director, Mental Health to lead the integration process that would integrate the Mental Health services provided by each organization. The Alberta Mental Health Board was a provincially run organization that was responsible for provincial Mental Health programs and the provincial Mental Health Hospitals. The Calgary Health Region is a large complex healthcare corporation, responsible for all health services including the tertiary, secondary and community hospital mental health.

The Report of the Premier's Advisory Council on Health, December 2001 known as the Mazankowski report concluded, [8]*"Mental Health is not well integrated with the health system".* The report went on to say that: [9]*"Currently, mental health services are primarily the responsibility of the Alberta Mental Health Board. Some arrangements are in place with regional health authorities but mental health services are not within their mandate. As a result, mental health services are not integrated with other health*

[7] Calgary Regional Health Authority and Provincial Mental Health Advisory Board, Integrated Mental Health and Psychiatric Services, Final Report of the Joint Mental Health Program Design and Coordinating Committee and the Regional Mental Health Advisory Committee, April 30, 1997. page vi
[8] Report of the Premier's Advisory Council on Health, A Framework for Reform, December 2001
[9] Report of the Premier's Advisory Council on Health, A Framework for Reform, December 2001

services available in regions. Many people suggest that this causes problems in the delivery of services in communities and that communities are under-served, and that communication between the Alberta Mental Health Board and the regions is problematic. Many suggest that it's time for mental health services to be transferred to regional health authorities so that integration can be improved, ideas like a single point of entry can be implemented, and regions can be more accountable for meeting mental health needs of people in their region".

April 1st, 2003 the services provided by the Alberta Mental Health Board in all Regional Health Authorities (RHA's) along with the provincial hospitals were transferred to the RHA's. Also on April 1, 2003 the Calgary Health Region's geographical boundaries for health were expanded to include the City of Calgary, the rural areas including Lake Louise to the West, Claresholm to the South, Didsbury to the North and Strathmore to the East. The Calgary Health Region grew to an organization serving 1.4 million people, with over 22,000 employees, creating one of the largest fully integrated health care organizations in North America. In the transfer of Alberta Mental Health Board services to the CHR there were the 15 community clinics, 14 external contracts and Claresholm Care Centre, a provincial hospital. A total of 551 staff was transferred.

In particular, this transfer has created a unique opportunity to address the most effective means of delivering optimal comprehensive community based mental health services. This study will describe a process of integration that utilizes the Continuum of Mental Health Services as a model for integration.

Interest in the design and impact of integrated service delivery models in mental health has increased markedly over the last three decades. The Table below indicates the number of published articles cited since 1978 (PubMed). This increase and interest is related largely to the increasing costs of delivering health care and mental health care in particular, which affect a significant proportion of the population.

Publication Year	Number of publications related to integration of mental health service
<1990	17
1990-95	59
1996-2000	235

Additionally, mental healthcare delivery systems have become an important focus of design with the goal of improving access and outcomes for those requiring mental health services. For example, service delivery models move to the forefront of consideration in that clinical variables and unmet needs, two foci of service delivery, account for a substantial amount of the variance (40%) in measures of the quality of life of people with mental illness (Anonymous. 1999a).

Research assessing the impact of mental health service reform as services proceed through the process of integration tends to be *ad-hoc* or *post-hoc*, or based on case study anecdotally reporting lessons learned[10] . Few studies of service integration

[10] (Bouchery & Harwood, 2003; Caron, Tempier, Mercier, & Leouffre, 1998; Fleury & Mercier, 2002; Fleury, Mercier, & Denis, 2002; Hoge & Howenstine, 1997; Wager, Heda, & Austin, 1997; Charns, 1997; Lee, 1997)

have attempted to employ a theoretical framework[11] or an *a priori* hypothesis to test the implementation of a planned system design. Some authors point to systems theory, activity theory and quality of life theory as formal frameworks to guide the study of mental health system integration[12]. There still remains however, a need to reconcile the gap between developing a theoretical approach to system integration and reform practice[13].

The theory that is required to guide practical application of integration models is likely to emerge in a step-wise fashion over time. What is called for and achievable at present, is a systematic approach to the study of regional planning, the development of organizationally based strategies to design, develop and implement integrated mental health services, which may help to inform a theoretical approach.

The importance of mental health services integration is self-evident in consideration of the central goal of current mental health reform, which is to increase access to and coordination of quality mental healthcare services. Integration across the service continuum is a cornerstone of creating a common language to describe mental health and emphasize adaptive functioning while taking into account the ecological, cultural, and familial context.

Integration of mental health services is currently viewed as a strategy that will help to prepare the whole mental health system's response to the current and the anticipated needs of the population. Furthermore, integration of mental health services

[11] (Byrnes, 1998; (Wolff, 2002); (Kessler, 2002); (Anonymous. 1999a); (Hiebert-White, 1996); (Hoge, Jacobs, Thakur, & Griffith, 1999)
[12] (Hamilton, 1998; Anonymous. 1999b)
[13] (Hoge et al., 1999)

across the service continuum holds the potential to provide a forum in which to resolve the often competing or conflicting goals that arise both within and between stakeholder groups. The consumers and providers of mental health care would benefit from having a common forum or network provided by integration. In this sense integration represents a substrate on which to identify, develop, and chart a shared path to achieve shared vision with its attendant goals and multiplicity of partners and stakeholders.

For the purpose of this thesis the definition of integration used is the one developed by the Canadian Council on Health Services Accreditation "bringing together services, providers, and organizations from across the continuum to work together jointly so that their services are complementary to one another, are coordinated with each other, and are a seamless unified system, with continuity, for the client".[14]

The Process used to develop the Continuum of Care

In 2001 the Mental Health Team wrestled with the question "whom do we serve?" We looked at what Mental Health prevalence data was available and came to the conclusion that there was no clear information available that would clearly focus our attention on "whom we should serve". This led us to look at population health and the key health determinants that drive the health status of the population we serve. When it comes to Mental Health it was felt there was considerable anecdotal evidence to support the notion that income, education and housing were significant factors affecting the health status of those with a Mental Health diagnosis.

[14] Canadian Council on Health Services Accreditation, Achieving Improved Measurement, Accreditation Program 1999

If we are serious about addressing the health of the population we need to take a systems approach, which led to developing the Continuum of Mental Health Service. We used as a starting point the definition of "continuum" developed by the Canadian Council on Health Services Accreditation "An integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations. Elements of the continuum are: self-care, prevention and promotion, short-term care and service, continuing care and service, rehabilitation and support"[15].

Based on these two definitions the Mental Health Executive defined the Calgary Health Region Continuum of Mental Health Care/Service as follows: Prevention & Promotion, Early Intervention, Crisis Intervention, Acute Inpatient, Basic Treatment (Focused Core Services), Specialized Treatment, Rehabilitation and Sustain and Support.

In conjunction with the Continuum of Care/Service the Mental Health Executive team brainstormed and developed a Vision and Mission for Mental Health in the Calgary Health Region that gives focus or lays the ground work for the integration process. The **Vision**: *A Mentally Healthy Population* and our **Mission***: To boldly build a comprehensive, responsive network of mental health services with innovative stakeholder partnerships*. These statements were in draft form until focus groups were held with frontline staff and our community partners to obtain their input and support.

[15] Canadian Council on Health Services Accreditation, Achieving Improved Measurement, Accreditation Program 1999

The Vision and Mission give the Mental Health Team the mandate to start moving the existing Mental Health System toward a more integrated service delivery system.

Specifically the elements comprising the continuum are described as follows:

Prevention and Promotion is activities designed to enhance health, human services and a sense of well-being. These activities are population focused and are aimed at children, youth, adults, seniors, families, and groups at risk or the general population. Examples of services addressed in this element are: suicide prevention, programs to build self esteem and self worth, parenting programs, consumer advocacy and support groups.

Early Intervention addresses activities aimed at identification and timely provision of appropriate services for individuals, families and groups with an identifiable but undetected mental dysfunction, disorder or disease. Examples of such services are primary care physician's services, student health initiatives, crisis and distress lines, and school counseling programs.

Crisis Intervention is a range of care and services focused on providing timely, coordinated responses for people experiencing a mental health crisis where immediate intervention is required. Examples of these services are emergency room mental health services, community response teams, primary care physician intervention, diversion teams, and secure treatment.

Acute Inpatient provides assessment and treatment services for unstable clients with acute mental illnesses. These services are comprised of inpatient hospital beds, outpatient day hospitals, short stay units and community mental health clinics.

Basic Treatment (Focused Core Services) addresses a range of community-based services that can be provided through community mental health services, primary care providers, assertive community treatment teams, consumer advocacy and support groups, in long term care facilities and home care for all age groups.

Specialized Treatment focuses on highly specialized services that are targeted to meet the special needs of clients with specific disorders or highly complex needs. Examples of these services are: forensic client's services, eating disorders, addictions, psycho geriatric and clients with severe and persistent disabilities such as schizophrenia.

Rehabilitation services are designed to optimize client's functional capacity and allow them to make a meaningful contribution in their community. Examples of rehabilitation are: assertive community treatment programs, rehabilitation services, vocational training, and employment. **Sustain and support** provides a range of collaborative activities and services to assist clients and their families to live a quality life as independently as possible in their community. Examples are income support programs, housing support programs, vocational training and employment, transportation, life skills and family supports.

Appendix A shows a visual of the Mental Health Continuum of Care/Service. This is a visual map of the services provided that are owned and operated by the Calgary Health Region as well as the services that are provided under contracts with external partners. For example the services operated by contract with the Calgary Health Region are noted with an (*). The Calgary Health Regions' Mental Health Services span the full continuum of care, as do the contracts with partners. The

external contracts which support the continuum are offered by the following agencies or partner organization: **Prevention & Promotion** – Canadian Mental Health Association and Schizophrenia Society, **Early Intervention** – Hull Child and Family Services, Interfaith, Woods Homes, Calgary Emergency Women's Shelter, Canadian Mental Health Association, and Okotoks Healthy Family Resource Centre, **Crisis Intervention** – Canadian Mental Health Association, Calgary Distress Centre, Woods Homes, Samaritans of Southern Alberta, Bow Valley Victims Services, Bow Valley Community Psychiatric Emergency Room Service and Foothills Regional Victims Services, **Acute Inpatient** – all two hundred and forty beds and outpatient programs are operated by the Calgary Health Region, **Basic Treatment** – Woods Homes, Foothills School Division #38, Palliser Vocational Rehabilitation Research Institute, School Division #26,and Claresholm FCSS, **Specialized Treatment** - VRRI & Persons with Developmental Disability, Rehabilitation – Calgary Association for Self Help, Canadian Mental Health Association and Clubhouse, **Sustain and Support** – Woods Homes, Hull Child and Family Services, Canadian Mental Health Association, LAMDA Society and Schizophrenia Society .

What has worked?

The continuum of Mental Health Service described above has brought more focus on the population we serve, that being the citizens of Alberta. The continuum of Mental Health Service has been utilized to map out the present services across this continuum and it has provided the Mental Health team with a clearer understanding of

the need for services to link, integrate, collaborate, plan and deliver a comprehensive continuum of care and or service in order to improve service delivery, client satisfaction and outcome. At this point in time we do not have any evidence that would demonstrate that this approach to service delivery does in fact improve client outcomes. Anecdotally we think it would but this remains work in progress.

The continuum of service map in Appendix A shows those services provided internally by the Calgary Health Region and those transferred from the Alberta Mental Health Board as well as those services provided by the 14 partners through various contracts in the community. The continuum of service map has become accepted as the vehicle to bring key stakeholders to the table to plan collaboratively and provide a framework and context for the service delivery.

Evaluation Methodology

The research methodology consisted of the development and administration of a questionnaire to standardize the interview process to elicit information and feedback from stakeholders internal to the Calgary Health Region and our external partners representing their contribution to the continuum of mental health care/service.

Interviews were conducted with focus groups representing mental health service providers within each element comprising the continuum. The focus group participants consisted of managers, frontline staff, consultants, and contracted services (external partners). The standardized questionnaire shown in Appendix C was used to gather the information. The interviews were conducted by the same three people, two facilitating

the groups and one recorder of information. There were a total of fifty three interview respondents in the six focus groups. By way of representation there were twelve contract service providers, five CHR Mental Health Managers and thirty-six CHR Mental Health Frontline Staff. The focus groups were as follows: Group one - Acute inpatient & Crisis intervention, Group two - Basic Treatment, Group three - Specialized Treatment, Group four - Managers, Group five - Prevention Promotion, Early Intervention, Rehabilitation, Sustain & Support, and Group six - Contracted Services. Each attendee completed their personal response to three questions: one, rating the mental health continuum of care in the Calgary Health Region on how well it is providing all of the elements necessary for good mental health care, two how easy it is for clients to move effortlessly from one service to another according to their needs and three comments they wished to make about the continuum of care. See Appendix C for the detailed questionnaire and table 1 below for the results of the individual response to these questions.

As can be seen in Table 1 the responses to question 1 – "On a scale of 1 to 7, with 1 = poor and 7 = excellent, please rate the mental health continuum of care in the Calgary Health Region on how well it is providing all of the elements necessary to good mental health care" the mean response was 3.5 on the scale of 1 to 7. The responses to question 2 "On a scale of 1 to 7, with 1 = poor and 7 = excellent, please rate the mental health continuum of care in the Calgary Health Region on how easy it is for clients to move effortlessly from one service to another, according to their needs" the mean response was 2.5 on a scale of 1 to 7.

Although this is a small sample of people providing mental health services one could conclude that this represents a baseline measure as work has just begun on integration and the continuum is a vehicle to identify further opportunities for integration. One could also say that the service providers see the continuum as a road map for identifying some of the barriers for clients whom are trying to access the service as well as for service providers who are trying to negotiate access for their clients in order to meet their needs in the most effective way possible.

Table 1 Response to Survey Questions for full detail see Appendix C

	QUESTION 1							QUESTION 2					
	1	**2**	**3**	**4**	**5**	**6**		**1**	**2**	**3**	**4**	**5**	**6**
Group 1 Acute Inpatient Crisis Intervention	1		4	3	1			1	1	5	2		
Group 2 Basic Treatment		2	4	2					5	2	1		
Group 3 Specialized Treatment	1		1	3	3	2			1	3	1	4	
Group 4 Managers			3	1	1					3	2		
Group 5 Prevention & Promotion Early Intervention Rehabilitation Sustain & Support	1	2	3	1	2			2	5	2			
Group 6 Contracted Services		1	2		1				2			1	
TOTAL	3	5	17	10	8	2		3	14	15	6	5	

What did we learn from the focus groups?

Summary of the Major Themes

There were significant numbers interviewed in the focus groups that had not actually seen or were aware that a Mental Health Services continuum but those who were aware had a good overall understanding of the continuum. The Child and Adolescent services representatives and Contracted Services group had the most awareness and the least awareness was in the Inpatient, Crisis Intervention focus group.

- Most had an awareness of their own service needs but lacked awareness about gaps and competing goals in other services. 100% of the respondents said no, the continuum did not help them resolve or understand competing goals.
- An overwhelming theme was that connections between services were a result of personal relationships between frontline staff and not a function of the continuum.
- There seems to be two conflicting philosophies on how the continuum could or should enhance service delivery:
  - One group believes that programs should identify clear mandates and push flow through.
  - The other group feels that the concept of flow through does not reflect the chronic nature of mental illness, that many clients need consistency and support lifelong particularly by those who suffer from long-term mental illness.

These are conflicting because there is no mechanism for known clients to re-enter the system other than being put on wait lists so long that they deteriorate and enter the system through the more expensive area of the continuum, inpatients.

There is no mechanism for known clients to get support once they have left the program's care. Staff understands this risk, so are reluctant to discharge and as a result the system gets backlogged. There is also a lack of options to access.

So while most believe the conceptual model makes sense on paper there is a lack of trust or demonstrated success of the continuum model working in practice. Therefore the continuum is more of a theoretical construct than a practical vehicle.

- Most respondents had difficulty connecting the continuum to the consumer. Seen as a model of service delivery rather than a conduit to service delivery. However child and adolescent staff had examples of consumer benefit due to the central point of entry associated with the Central Access and Intake System.
- Regarding the continuum's success at facilitating partnerships:
  - CHR programs have seen new partnerships develop especially between services within the CHR system where manager realignment has occurred.
  - In the community they believe the partnerships were already in place and are not seen as related to the continuum development.
  - Both groups agree there are not enough partnerships and the role of parties not clearly defined.
- The increased communication that has occurred between people in all elements of the continuum is viewed as what is working best with the model.
- The predominant themes of what is not working in the continuum were:
  - Flow through and access problems, related to lack of funding and general lack of service capacity (both in CHR and in Community services). Many commented that until these issues are addressed it is impossible to assess the continuum.
  - Lack of understanding of how decisions are made and how a decision in one area of the continuum will impact other areas. Respondents believe there is no communication of decisions related to funding, even in the manager focus group.

The following is a list of quotations from individual focus group members in reference to their perception of the continuum of care in relationship to integration.

- “The theory behind the Continuum of Service is excellent but there is a long way to go to put it into operation. Access to programs is still controlled by physicians and built on a medical model that is not always user friendly. I think we should continue to work with this and try to build the necessary bridges none the less”.
- “Despite the poor ratings given, I have been impressed by the interest, dedication, commitment, and willingness to work collaboratively of the front-line people and mental health managers”.
- “There is still some duplication of service. Need to remove barriers from entering programs”.
- “We could do more if we talked together more”.
- “I think that the model provides a potentially useful way of organizing and delivering services and that we are early in the process of creating some elements needed for the broad continuum”.
- “We need to allocate more resources to prevention and promotion, early intervention and sustain and support. We need to address the social determinants of health: education, housing, poverty, and support to clients in these areas. We can no longer say this is not our area or we do not do this”.
- “The continuum of care is a great idea. In our current state of health care system this will be able to address many issues. We need to continue questioning the meaning of being mentally healthy; realistic goals and how to address the “gaps”.

- “There seems to be in-roads being made i.e. increased communication and increased collaboration between services. The tough questions need to continue to be asked. We cannot be everything to everybody but we do need to meet population needs”.
- “Education for staff regarding the Continuum of Care would facilitate usefulness of the continuum and promote easier access for clients”.
- “I think the continuum is a new label or grouping of something that has been out there all along. The eight areas are linked by definition and need a lot of serious attention and change to become seamless”.
- “The idea is great, working it out and getting people through the continuum is difficult because of blockages in the system. There needs to be more community services to meet the needs of the individual we provide services to”.
- “Relationships and partnerships are most important; the continuum is a conceptual framework.”
- “There is a huge gap in affordable housing and services for severe and persistent mentally ill. The City of Calgary would benefit from more Assertive Community Treatment Teams”.
- Marion McGrath, Executive Director for the Association of Self Help, a contracted service said, “Until I saw the Association of Self Help plotted on the continuum of service template I was skeptical of the integration process. Now I believe our association is part of the continuum. We feel we are part of the Planning for the future in Calgary”.

Interpretation and Discussion of Information Collected from Focus Groups

In general the people who work in the Mental Health system be they internal stakeholders of the Calgary Health Region or external partners see the Continuum of Mental Heath Care/Service as a useful planning model. The fact that 100% of those surveyed stated the continuum did not help them resolve or understand competing goals would confirm that we have a system that is made up of competing interests and individual foci rather than a systems approach across the continuum.

The low ratings on the two questions providing individual feedback would suggest there is much work to be done on educating frontline staff about the continuum of Mental Health Service and how it relates to client or patient service and flow through a system of services that provide the client care and support.

The two conflicting philosophies regarding service delivery, one being programs with clear mandates push flow through and the other being the chronic nature of mental illness, clients need consistency and support life long, points to the need for further collaboration and understanding of the benefits of working across a continuum when dealing with persons with a Mental Health diagnosis. The stakeholders providing services on this continuum need to recognize they are not alone in the business of Mental Health, but by working together across this continuum can contribute to an understanding that each stakeholders contribution to the care/service continuum should prove to be better for the client and family. We cannot lose sight of why we are here to serve the patient or client.

The fact that the interviewees saw the continuum as a service delivery model rather than having any connection to the consumer speaks to the need of staying patient and client focused. This feedback would suggest that the endeavors to date have been seen largely as administratively driven rather than patient or client driven.

The focused interviews have confirmed that the continuum of care/service looks good on paper and is a visual for what an integrated Mental Health System should look like. However, in reality, there are multiple stovepipes across the continuum, which often serve as a barrier to integration. Some of these barriers are around professional jurisdiction, service philosophical differences, political competition, and service provider competition. Long wait times, hospital emergency rooms used as an access point to the continuum when service providers such as family practice physicians get frustrated only serves to frustrate the system even more.

For the most part, the new partnerships that have developed primarily internally to the Calgary Health Region among stakeholders on the continuum are positive. This would suggest that the focus on the continuum has provided a vehicle to connect with stakeholders together who are working with similar patient or client populations who in the past worked in isolation from one another. With this interpretation, over time we should see improved continuity of service to clients and hopefully improved client outcomes and a service delivery system that is responsive to the changing needs of clients and families.

The focus groups have pointed out that for integration to succeed in Mental Health a great deal depends on relationships that are established at a professional level

and at a service delivery level. This notion is supported by the literature. According to Leutz, full integration creates new programs or units in which resources (in the widest possible sense) from multiple systems are pooled to create new benefits and services. Integrated systems are also characterized by single, common information systems, rather than separate systems, which are shared or accessible by the different partners[16].

The literature would support that true integration will exist when several of the following characteristics are evident: joint goals, very close knit and highly connected networks, little concern about reciprocation, underpinned by a mutual and diffuse sense of long-term obligation, high degrees of mutual trust and respect, joint arrangements which are mainstream 'core business' rather than marginal, joint arrangements encompassing strategic and operational issues, shared or single management arrangements, joint commission at macro and micro levels[17].

The increased communication among stakeholders internally and externally to the Calgary Health Region is seen as what is working best with the model. This would foster hope in the future for a more desired and productive Mental Health Service delivery. It takes time to build relationships, trust and understanding. This is consistent with the literature "for staff members involved in the integration by far the largest group

[16] Leutz W. five laws for integrating medical and social services: lesson from the United States and the United Kingdon, Millbank Quarterly 1999

[17] Powell M, Exworthy M, Berney L, Playing the game of partnership, In Sykes R, Bochel C, EllisonN, editors, Social Policy Review 13, Bristol: The policy Press in association with Social Policy Association, 2001

of whom were mental health nurses, job satisfaction was related to team role clarity, team identification, emotional exhaustion and gender"[18].

The focus group feedback speaks to systems issues in that flow through is a problem in all services across the continuum whether they are CHR operated or community based. The opposing philosophies in approach to service delivery may contribute to this if stakeholders are holding on to clients because there is no known place to discharge to or provide support to the client. It takes time to build trust and possibly the continuum model is the vehicle that will start the dialogue to build that trust.

The focus group feed back speaks to how decisions are being made in the elements along the continuum with a lack of understanding of the impact of those decisions on other elements of the continuum. Particular reference is made to funding and decisions around funding allocation across the continuum. Clearer processes for decision making regarding funding allocation need to be in place to ensure stakeholder buy-in and commitment to further service integration. The interviewees see funding as an issue and when resources are tight it is difficult to expect stakeholders to risk putting all their cards on the table when they don't understand the processes for decision making.

[18] Gulliver P, Towell D, Peck E. 2003. Staff morale in the merger of mental health and social care organizations in England, Journal of Psychiatric & Mental Health Nursing

Benefits to the Continuum of Care/Service Model

Shift in Management thinking and Practice

A significant shift in the approach to service delivery has taken place. The Continuum of Mental Health Care/Service has caused managers and leaders to think systemically, to recognize they are not in Mental Health Service delivery alone that there are other elements along this continuum that provide care and service to clients. This is in the initial stages of implementation and it is too early to evaluate its impact.

In practice there has been a shift in management from one manager overseeing one service within an element of the continuum to leading several services across more than one element of the continuum that are interdependent and require integrating to improve service delivery. This however is only a beginning as there has been a shift in our approach to leadership from a management control perspective to one of leadership. To work collaboratively across the Continuum of Care/Service with multiple stakeholders managers are no longer the sole decision makers. The manager is no longer the sole owner of problems and issues; these are now part of a network of providers who are interdependent. The interdependency requires managers to work collaboratively with internal and external partners across the continuum. Managers in the Calgary Health Region Mental Health system are in a state of transition from a traditional management focus which is a more top down approach to decision making to one of providing leadership to a decision making process. Leadership in this sense embraces the principles of facilitator of a decision making process, mentoring, coaching, teaching, mediator and guide.

In a study done in England and Ireland where Social and Health Services were jointly administered, it was felt that such integration would promote collaborative working and interdisciplinary arrangements. The study showed that there was no evidence of the impact of integration on practice in areas such as: assessment, referral and medical screening[19].

Putting the Continuum of Care/Service Model into Practice

Alberta Provincial Mental Health Plan

In June 2003 the Minister of Health announced the kick-off to the nine health authorities the development of a Provincial Mental Health Plan, and that the plan was to be completed by March 31st, 2004. A number of the Calgary Health Region Mental Health Team members were part of this process. As a result the Continuum of Care/Service described earlier in this report is now imbedded in the Alberta Provincial Mental Health Plan. The anecdotal evidence would indicate that the Continuum of Care/Service has been utilized in this plan to address service gaps as well as give focus to a systematic approach to Mental Health care reform[20]. Other initiatives, which have used the continuum of care as a planning vehicle include:

[19] Reilly S, Challis D, Burns A, Hughes J. 2003. Does integration really make a difference? International Journal of Geriatric Psychiatry

[20] Albert Mental Health Plan pp 26

Eating Disorders Program

In collaboration with other health authorities in Southern Alberta the Continuum of Care/Service was utilized to map out a comprehensive service continuum plan that addresses the needs of the eating disorders population. The schematic of this plan is noted in Appendix D.

Housing

Housing for persons with a mental illness was identified as one of the top priorities of service gaps across the Continuum of Mental Health Service. The continuum has been utilized as a model to develop various models of supportive housing. This is a work in progress, but the work to date is noted in Appendix E.

Collaborative between Mental Health and Calgary Child and Family Services

This collaborative got underway to address children with complex needs. The Continuum of Care/Service was utilized to give focus to discussion around the work of the Mental Health Team and the Calgary Child and Family Services. Both organizations were funding the same partners to provide various segments of Mental Health Services. Each organization mapped out its Child and Adolescent services across the Continuum. It became very evident as to where the overlaps were and the opportunities this would provide in enhancing integration and hopefully providing a more efficient and cost effective service to children and families. This collaborative commenced in October 2003 with the hiring of a jointly funded and jointly accountable manager between Mental

Health and Child and Family Services. See Appendix F that demonstrates the use of the continuum to show the areas of overlap.

Southern Alberta Mental Health Network

This network is made up of Mental Health leaders from the Chinook Health Region, the Palliser Health Region and the Calgary Health Region. The network is a vehicle for joint planning of Mental Health Services across regional boundaries. This network utilizes the continuum of Mental Health Care/Service as a model for planning. The model has allowed the stakeholders from these regions to see the opportunity for enhancement and or access to appropriate service for the residents of Southern Alberta. For example, the specialized services on the continuum will be provided primarily by the Calgary Health Region with satellite service or telehealth service.

Recommendations

1. Education of consumers, families and public

We talk about being client and patient focused and the interview results would indicate that we only pay lip service to this.

- Educate the clients, families and public on the elements of the continuum of care/service in laymen's terms. The education should include how to access the various elements of the system, how the elements link to one another and how the elements provide the client with the service they require when they need it.

2. Education of service providers and professionals

Mental Health provider's feedback suggests they did not understand the elements of the Continuum of Mental Health as being linked.

- Educate both professional and support staff at a frontline level to the Calgary Health Region and the broader Community on the elements of the continuum of care/service and on how these services need to be complementary to increase service integration and decrease service fragmentation for the consumer. Provide educational opportunities for staff to learn how to work collaboratively and share responsibilities around competing demands for service.
- Work with the colleges and universities who are training future professionals to work in the system to utilize the continuum of care/service as a model for student practicum placements. Over time this would assist future workers in looking and thinking more systemically about their contribution along the continuum.
- Educate the Calgary Health Region providers on how community partners contribute to the continuum.
- As part of our education of staff and partners we need to find a way to ensure the client or patient remains the central most focal point of the work we do.

3. Funding

We have learned that by mapping the funding allocation across the continuum the disparity in how the continuum is resourced is blatantly obvious. Even after taking

into consideration the investment in twenty-four hour services in particular acute inpatient care, the diagram would state our focus on the acute hospital care from an investment point of view. See appendix C which shows the distribution of current funding in the light color and the dark color has quantified the service gap across the continuum requiring future resources.

- Recommend that in the future high priority be given to investing resources in Promotion and Prevention as well as Sustain and Support elements of the continuum and in particular housing and community services. Over time we would see a more equitable distribution across the continuum.
- Recommend that a funding model and process for resource allocation be developed that is transparent, coherent and equitably reflecting the needs of the population we serve.

4. Planning

The continuum has been used to identify the gaps in service but it also points out the barriers to integration, be they financial, philosophical or jurisdictional. In order for integration of Mental Health services to occur across this continuum and integrate with the rest of the health care system these issues still need to be addressed.

- Recommend that the continuum be utilized in future health service planning to ensure the right stakeholders are at the planning table, that the planning team stays focused on the population they serve and that appropriate future services are mapped across the continuum to develop a comprehensive, integrated health service system.

5. Communication

The survey identified that increased communication is essential between programs of the Calgary Health Region and the broader Community at a frontline staff level.

- Recommend that mechanisms be put in place to ensure there is a free flow of information and collaboration at the frontline worker level to ensure continuity of service to the client.

6. Electronic Health Record

The health information on clients in the mental health system is very sporadic. The type of information that is captured varies from service to service along the continuum within the Calgary Health Region as it does with the partners. There are issues around the sharing of information of a confidential nature. The continuum of mental health service is participating in the development of the electronic health record. The common data elements for client information collection have been identified and a plan is in place to roll out the implementation with in the next two years. The mental health portion of the electronic health record is part of the overall information management plan of the Calgary Health Region.

- Recommend that once the electronic health record is implemented that an evaluation be put in place to demonstrate the benefit of an integrated health record to the client.

7. Management Realignment

To facilitate further integration of mental health services the management structure was changed. Effective June 2003 the number of managers were reduced and those remaining took on a broader responsibility across more than one service on the continuum. The goal of this shift is to ensure further collaboration and integration of services that traditionally worked in isolation. An evaluation of this approach to management is underway and the indications to date would suggest that there are many opportunities to improve service to the client.

- Recommend that the evaluation be completed that would provide information from the frontline staff point of view, the client point of view and the partner point of view.

8. Performance Management

Accountability and performance management is an integral part of the development and implementation of the continuum that has been described in this thesis. All managers, directors and executives within mental health operate with an annual balanced score card. There are a number of performance measures that are developed and are being tested at the time of writing. These indicators are measuring improved access to the continuum of service through client satisfaction survey, stakeholder satisfaction survey, service provider satisfaction survey and Calgary Health Region staff satisfaction survey. The Regional Mental Health Advisory Committee made up of consumer and service provider representatives conducts focus groups

annually with clients and families on the elements on the continuum and this information is fed into the planning process.

- Recommend that there be continued development of performance indicators that measure the impact of the continuum on client outcome and health status and on integration within mental health and within health.

Conclusion

The thesis has attempted to demonstrate the importance of the Continuum of Mental Health Care/Service in providing a foundation for service integration from a systemic perspective. Those individuals involved in the interviews have been forthright about how they perceive the current state of the service delivery system but are also hopeful in that the continuum will be used to bring about client and patient focus.

In conclusion, this thesis has described the Continuum of Care/Service for Mental Health in the Calgary Health Region as a useful model for planning, developing and implementing service integration within Mental Health, across Health and with other jurisdictions such as Justice, Education and Family Services. The focus group interview information has confirmed that the work to date on integration is only in its infancy stage. The degree of integration seen across the continuum varies and is not sufficiently developed to have the impact upon the clinical outcomes for the patients/service users. The study did not attempt to evaluate the impact of service integration on client/family outcomes but this would be a useful area of further investigation.

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