Mental health network governance and coordination: Comparative analysis across 10 Canadian regions

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MAIN MESSAGES:

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

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

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

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

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

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

- Issues of confidentiality could pose obstacles in coordinating services among organizations.

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

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

Our research describes and offers a comparative framework of the governance models and organizational mechanisms mental health networks use to coordinate services, by exploring the organizational processes adopted among them. The research was guided by organizational theory and used qualitative methods of focus groups and interviews with executives and front-line managers in 10 mental health networks across four provinces.

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

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

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

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

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

We found the networks that relied on voluntary mutual adjustment were unable to achieve a common vision and system coordination, even though some sub-network partnerships existed. When an alliance or corporate structure mediated coordination, shared understandings and service agreements were fostered. Catalysts of coordination included a network director of mental health services with jurisdiction across the continuum of care, and regional or network-wide committees with representation from hospital and community-based organizations that guided administrative and clinical arrangements among organizations.
Coordination was not as well supported when budget and planning decisions were made at different jurisdictional levels. We found that when budget decisions were made at the provincial level while services were planned at the local network level, the divided authority meant organizations that reported to the Ministry were not held accountable when their services were not aligned with the organizations in their network. Such misalignment was most evident when secondary and tertiary facilities reported to the Ministry, while networks planned local community services. Without a mandate or incentives for hospitals to align their care with community services, delays were experienced in achieving continuity of care; patients who had to navigate their own services were more likely to “fall through the cracks” and re-enter hospital.

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

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

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

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

Developing an ODS implies not only a range of services but the incentives and administrative structures inherent within it, as well as the processes and arrangements among organizations needed to ensure they function as a network to address a person’s needs on an ongoing basis.
the mental health system have access to the ancillary supports they need to sustain them in the community and to avoid their preventable re-entry into hospital. Local service networks offer a means to coordinate mental health care among hospital and community-based health and social service providers to create a system of care.³⁵, ³⁶

A network is a set of organizations and the specific relations among them that serve as channels through which communications, referrals and resources flow.³⁶-⁵⁷ The goal is to develop virtual ‘programs of care’ by coordinating the delivery of primary, secondary, tertiary health and social services, and to simplify clients’ access to them. Provincial health regions may include more than one network that operates among organizations with working relations. Governance is often shared between a regional authority and a local network through their respective management committees.

The coordination of mental health services, however, faces many challenges, including organizational survival, autonomy, and conflicting philosophical perspectives.⁹, ³⁸ Organizations in a network must translate their values into a common vision, negotiate who will provide which services, and determine how to alleviate potential gaps considering the strengths and resources of the organizations involved.³⁵-⁴¹ As an environment of consolidation can represent a threat to organizations seeking to ensure their respective roles in the system design, their activities can create an integration outcome different from the one intended.⁴²-⁴⁹

Models of regionalization range from deconcentration: the transfer of local administrative authority without political authority; to delegation: the transfer of managerial responsibilities to regional offices; to devolution: the creation of sub-provincial units with revenue and expenditure authority; and privatization: the transfer of functions to a nongovernmental organization.⁵⁰

Integration is also distinguished as voluntary, mediated and directed, given the role of the lead agency.⁴¹, ⁵³ In voluntary integration, the lead agency is a service provider; in mediated integration the lead agency’s mission is to coordinate the services provided by other agencies. Both voluntary and mediated integration can occur in an alliance structure. In directed integration, one organization has authority to mandate service coordination among agencies, as occurs in corporate structure.

Centralization refers to the degree to which management activities occur within centralized versus dispersed contexts, which has implications for decision making and accountability.⁵¹-⁵⁴ Centralization may be viewed from the perspective of decision making, planning and resource flows. Centralization from a resource flow side refers to the degree that resources emanate from, or flow through, a small subset of the network members. In a centralized network, the links between most of the organizations are indirect, mediated by the central organization. In a decentralized network, most of the members have direct ties to each other.⁶ Centralization refers to the degree that one organization has the authority to mandate the actions and policies of other organizations. The corporate structure is most centralized, while mutual adjustment is least centralized.

The governance model adopted thus influences the conditions that build intra-regional solidarity or fragmentation.⁵⁵-⁵⁹ An analysis of models of mental health system integration in the U.S. found that while tight central control over integration through a core agency can increase agencies’ efficiency in providing services, it may inhibit voluntary cooperation and spontaneity, which is more likely to occur in decentralized systems in which multiple providers work together informally.⁶⁰ Within decentralized structures, mediated systems had leadership advantages over voluntary systems.⁶¹ Our research compares mental health networks under regionalized and non-regionalized models, contributing insights in the Canadian context.

**APPROACH**

We conducted a comparative analysis of 10 Canadian local mental health networks from 2003 to 2006 to develop a descriptive framework of the governance mechanisms used to
develop systems of coordinated care, and to assess their strengths and weaknesses. To enhance
generalizability, the networks included a range of rural and urban geographic areas (with three
sizes of urban networks) and those with and without a psychiatric facility in four provinces.

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

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

To reduce bias, networks were purposively selected in Alberta, New Brunswick, Ontario and
Quebec to include a mix of rural and urban areas, and those with and without a psychiatric
facility. Of the 13 networks invited to participate, 10 agreed. Although the geographical
areas in which the 10 networks reside are anonymous (labeled A-J), they are categorized as
rural, or urban: large (> 1 million); midsize (>500,000 – 1 million); small (<500,000), and
with their province. From 2003 to 2006, 96 key informants participated in semi-structured
interviews and focus groups. The interviews were taped, transcribed and analysed using
qualitative methods to identify themes in key informants’ responses across networks on
common issues. Emergent themes were validated by the research team through triangulation
among key informants and convergence in their responses.

Our descriptive typology defines, categorizes and compares features of network governance
based on the following: regional framework, network management model adopted, degree
and process of coordination, inter-organizational arrangements (amalgamations, strategic
alliances, joint executive committees and contracts), mechanism of inter-sectoral collaboration,
and the use of financial incentives to achieve service coordination. Instead of offering detailed
descriptions of individual networks, we compare the governance models they used to achieve
coordination including decision-making processes, strategic planning, and service agreements
(resource sharing, program alignment, service delivery). A schematic depiction of the 10 networks
is also included (Appendix 1). The data clarify the means through which local, regional and
provincial mechanisms support coordination, resource allocation, and the potential for
innovation given the opportunties and constraints in regionalized and non-regionalized
contexts. The results are presented according to emergent themes.

The typology of models of local mental health networks is based on the following: regional
framework (regionalized/non-regionalized), network governance model (corporate, mutual
adjustment, alliance), rural or urban (small, mid-size, large), inter-organizational arrangements
(amalgamations, strategic alliances, joint executive committees and contracts), mechanism of
inter-sectoral collaboration, and use of financial incentives to achieve service coordination.
The presence of local decision-making processes, planning, service agreements (resource sharing,
program alignment, service delivery), and evaluation processes was noted. Organizations’
ability to adapt within a regional context and their links to primary care were also explored.
In Alberta and New Brunswick, authority for mental health services was transferred from a
provincial Mental Health Board to Regional Health Authorities (RHAs) in the year prior to
the commencement of the study. Key informants in the affected networks (B, C, J) included
their views on how the shift in governance affected service coordination.
In categorizing the range of governance models, we drew on key informants’ insights to assess the implications of how such approaches facilitated or inhibited organizational coordination. The results are presented according to provincial, regional, network, sub-network and organizational level themes. Structural features of the governance models inherent in the mental health networks studied are described, followed by an assessment of their implications for coordinated care.

RESULTS

MENTAL HEALTH GOVERNANCE

Jurisdictional governance for mental health services resided at different levels across the 10 networks studied, ranging from provincial (Ontario) to regional (Alberta, New Brunswick) and sub-regional authority (Quebec) (Table 1).

In Ontario, while the Ministry of Health and Long-Term Care (MOHLTC) was responsible for mental health policy, local administration was transferred to the seven regional offices of the Health Services Management Division, referred to as deconcentration. In Alberta and New Brunswick, authority for mental health planning and administration was devolved to RHAs in a phased manner: a central provincial Mental Health Board initially held authority, with authority then transferred to RHAs several years after they were established. In Quebec, the sub-regional “table de concertation” offered mental health organizations a forum to discuss service coordination, referred to as delegated authority. Although Quebec is regionalized, the boards of large hospitals remain, which has allowed psychiatric hospitals to exercise more autonomy than in other regionalized provinces.

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

ALIGNING BUDGET AUTHORITY WITH SERVICE PLANNING

Budget authority and service planning were divided to varying extents between provincial, regional and local bodies among the provinces studied. Aligning authority for the mental health service budget at the same level as service planning was found to best support service coordination (Network C, Key Informants 5 and 7). Conversely, when budget decisions were made at the provincial level, unlike services that were planned at the local level, local networks were found to lack a key lever to foster service coordination (Network A, Key Informants 3, 4 and 8; Network G, Key Informants 1, 2, 6 and 7). In Ontario, for example, hospital budgets were controlled by the province, while a regional context existed to plan community-based organizations’ services. The divided authority meant hospitals that reported to the Ministry were not held accountable when their services were not coordinated with community-based mental health services (e.g. Networks A, H, I). Such misalignment was most evident when mental health service planning occurred at the network level, while secondary and tertiary facilities reported to the province. Coordination did not always occur without formal processes or incentives in place to encourage hospitals to align their care with community-based services.

Similarly, we found coordination was less supported when organizational budgets were set at the provincial level, while networks were responsible for local mental health service planning. While the “table de concertation” in Quebec Networks D, E and G offered organizations a forum to discuss local plans and service needs, not all networks achieved consensus among their organizations. Even though the Ministry of Health and Social Services specified organizations were to coordinate their care, the organizations were not accountable to their networks. We found such ambiguous accountability could weaken the efforts of the “tables de concertation” to coordinate care which relies on local cooperation.
Conversely, we found coordination to be most effective when mental health governance and budget control resided at the regional or network level where local planning occurred, as reflected in Networks B, C, and J. Regional systems that allow integrated financial management were more likely to emphasize the goals of the system. In Networks C and J, for example, organizations’ shared goals fostered innovation and facilitated re-allocation of resources to needed areas. Network C implemented such innovations as an emergency department “Mental Health Team” by re-allocating hospital and Community Mental Health Centre (CMHC) budgets (including bed closures and staff re-allocations) to the Emergency Department. In contrast, we found provincial budget management was less likely to stimulate approaches that improve network function, due to lack of local insight that could make it difficult for them to foster a shared network vision. Provincial budget management instead tended to address the goals of individual operating units that were not necessarily congruent with a system vision. An exception to this was the Ontario “Community Investment Fund” through which organizations that sought funding to expand their programs were required to coordinate their services with those of other mental health organizations in their network – an incentive that led to coordinated initiatives across the province.68

MENTAL HEALTH NETWORKS
Several key informants emphasized the importance of coordinating access to care by clarifying the implications of failing to do so:

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

Local mental health networks adopted three different approaches to service coordination: corporate structure, mutual adjustment or alliance (Table 2).50 The corporate structure model involves regional devolution, where an RHA ensures coordinated care by overseeing institutional facilities and community mental health services. While coordination through an RHA could be considered directed,51,52 key informants in such networks indicated coordination was achieved through mediation. We found the two most coordinated networks (NB Network C and Alberta Network J) were in regionally governed models. However, Network C achieved most of its coordination prior to the transfer of mental health to its RHA. Conversely, comparatively less coordination was achieved under Network B’s regional governance model. Coordination advanced only after a director with jurisdiction for hospital and community services was appointed. The director formed committees with representation from hospital and community organizations to begin coordinated initiatives with the support of several sub-committees.

Ontario’s regional MOHLTC offices were transfer funding agencies that were not responsible for operations, and placed less emphasis on developing a system of coordinated supports than in regionalized provinces. Coordination in most Ontario networks studied occurred largely through voluntary exchange (e.g. client referral) without formal coordination mechanisms, referred to as mutual adjustment. Financial incentives through the former Community Investment Fund served as the main instrument: programs that sought to expand required a memorandum of understanding with other mental health organizations in their network to coordinate services (Table 3).61 In addition, the Ministry mediated coordination for such specific programs as ACT forensic teams, and the implementation of Community Treatment Orders (CTOs) (Networks H and I). RHA-governed Network J relied on mediated coordination; if organizations had not cooperated, negative incentives would have ensued.

In mid-sized urban Quebec Networks D and E, and Ontario Network F mental health organizations formed an alliance that mediated voluntary service coordination.51,52 The alliance in Quebec Networks D and E was initiated through their “table de concertation.” While
coordination was more formalized than in *mutual adjustment*, organizations retained their autonomy. The *alliance* in Ontario Network F evolved from the Addictions and Mental Health Executive Committee, whose leaders were committed to cooperating to coordinate services. Their *alliance’s* executive committee provided a forum for its leaders to *mediate* arrangements to coordinate services.

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

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

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

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

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

Accountability requires that organizations ensure a seamless transition across the continuum of care. RHAs incorporate the health system within their mission and accept accountability to ensure coordination among mental health services within their jurisdiction. A key component of New Brunswick Network C and Alberta Network J’s coordination was their central intake registry, which coordinated access to services.
LINKS TO ADDICTIONS, JUSTICE, EMPLOYMENT AND HOUSING PROGRAMS
As persons with SMI can suffer from a concurrent disorder, several networks aligned their addiction and mental health programs (A, C, F and I). Several networks also coordinated their justice and mental health systems by developing court diversion programs to guide persons with SMI to appropriate services (Networks C, E, I, J). Although forensic services are under provincial jurisdiction, local cooperation supported program implementation. Forensic programs rely on inter-ministerial, regional and local cooperation. While employment programs were available, they were unable to meet the demand in the networks studied.

In some networks, housing programs for persons with SMI are the key community provider, as they liaise with case managers and medical care as needed. However, hospitals are not necessarily informed of the importance of coordinating with providers of supportive housing services, which can create obstacles for persons in need of both types of service.

Another area of inter-sectoral planning involves coordinating access to drug benefits for persons with SMI who earn a low income, making them ineligible for publicly insured medication. A large proportion of persons with SMI require access to medications, without which their condition can deteriorate and lead to hospitalization. Their low income, however, may make medication inaccessible. New Brunswick ensures access to drug programs for employed low income persons with SMI. Other than New Brunswick and Quebec, no other provinces coordinate their mental health and drug benefit programs.

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

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

Ontario Network F developed a homeless initiative led by a sub-network and supported by the Ontario Community Investment Fund. A key informant in Network F noted, “We had leadership with vision that says, ‘I can help make this happen.’” Its hospitals and municipal government developed a protocol for referring patients to a regional emergency department. Staff from several hospital and community organizations also formed an outreach team that supported the homeless population’s access to mental health, social and housing services through a fluid connection to their home organization (Table 3).
SYSTEM WIDE OBJECTIVES
Several networks developed system-wide goals (Table 5). RHA- governed networks developed such goals through a central planning process with representation from executives of local mental health programs. In New Brunswick Network C, four working groups addressed issues that included network mandate, access, education, and partnering to support the development of system-wide goals. A communities of practice approach addressed administrative, structural, and clinical integration issues to support implementation.

Ontario networks developed goals through mental health implementation task forces (2002). Local Health Integration Networks (LHINs) have since articulated their goals through integrated health service plans. However, translating such goals into practice remains a challenge. Hospitals and community organizations may interpret and operationalize goals differently and may require a system-wide structure to support their implementation.

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

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

Once patient consent is attained, IS can enhance coordination and access to care. For example, in the emergency department the IS could be used to determine a person’s medications, date of last admission, and services that support them. Information systems are crucial to coordinate and enhance access to services. However, determining the type of system to adopt can be complex. In the absence of a common IS, organizations develop interfaces that allow coordination across different systems. New Brunswick Network C had the most comprehensive IS among the networks studied. These were designed to accommodate centralized service access, accessible to the general hospital psychiatric unit, to which addictions services were to be incorporated.

ADDRESSING RESOURCE CONSTRAINTS:
In networks with an alliance or corporate structure, the network executive committee assessed needs and achieved consensus on resource allocation. When a service gap was apparent, collective decisions were made as to how to reallocate existing resources to address identified needs. In Network C, the general hospital psychiatric unit closed several in-patient beds one summer when demand was low, and the Community Mental Health Centre (CMHC) reduced its staff to fund a network-mobile mental health urgent care team and a mental health emergency department team.

Network F developed two new programs: a network-wide emergency protocol, and a community-based homeless program to which hospital staff were re-allocated. Consensual decision-making was guided by leaders’ insights on how to alleviate clients’ “upstream” problems. In networks without an alliance or RHA, sub-networks in such areas as addictions, or court-diversion, fulfilled a similar role. An executive committee developed a solution that drew on organizational strengths and resources and fostered strategic alliances. Organizations in Networks C and F, in small and mid-size cities respectively, cooperated to resolve network issues. When a common understanding and consensus could not be reached within a network, a directed approach via regional authority was used to advance coordination, as occurred in Network B.
CENTRALIZED ACCESS
Centralized access supports coordinated care by removing the need for a person to seek access
to care or support services from numerous organizations. Such organizations may require the
submission of separate applications and may not have the capacity to accommodate clients’
needs or link them to related programs. While only some of the networks included in our study
had a centralized intake registry that offered access to a comprehensive set of mental health
services in their community (Networks B, C and J), others developed a system of triage to
coordinate the delivery of community services (Networks D and E) or centralized access to case
management (Network H). Network C coordinated mental health with addictions services in
the hospital and through their CMHC. Other networks had central intake processes that
incorporated primary health services (Networks D, E, G) or related community services
(Networks A, B and F). In Network H’s centralized access to case management and rehabilitative
services, one phone number and intake process directs a person to these services. Community
organizations’ ability to facilitate their clients’ access to see a psychiatrist was mixed in
many networks; in one case it relied on an organization’s relationship with a psychiatrist
(Network I, Key informant 6). Conversely, centralized access directs a person to such care
when their intake assessment demonstrates the need (Network C, Key Informant 1).

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

STRATEGIES TO ATTAIN COORDINATION:
THE CHALLENGE OF LEADERSHIP AND COLLABORATION
In networks that succeeded in coordinating services, the predominant governance model was
an executive committee with representation from its network organizations through which
consensus was attained and decisions were made (Networks B, C, E, F and J). Network C’s
Regional Management Team, for example, viewed its mandate as an opportunity to develop
more comprehensive and integrated services. Subcommittees ensured the decisions taken
were operationalized through coordinated action plans.

Limited coordination occurred in rural Network B until a joint director responsible for both
institutional and community-based mental health services was appointed, who formed
executive and integration steering committees and service teams. This coincided with the
establishment of a new in-patient psychiatric child and adolescent unit and a new mental
health centre, which created opportunities for referral relationships among organizations.
These steps preceded the transfer of jurisdiction for mental health to the RHA. Examples of
coordinated programs are shown in Table 2.

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

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

- Network J, Key Informant 5

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

In Network A, the absence of an executive forum to discuss coordination was an obstacle to continuity of care. Hospital discharge planning was ad hoc, making it a challenge for clients to access community services on discharge, which led to lapsed care. Conversely, executive forums make it possible to advance a shared understanding of system-wide goals, agree on the roles of service providers, and coordinate the necessary supports and performance measures (Table 4).

An RHA, however, is not the only mechanism through which coordination can occur. In New Brunswick Network C, the local mental health management team achieved coordinated care before jurisdiction for mental health was transferred to the RHA. Key informants noted that they expected coordination to advance further after the transfer of mental health services to the RHA, as the alignment of inter-sectoral services, including long-term care, home care, and housing, with mental health care would improve coordination further.

In the absence of a strong mandate and mechanisms to promote coordination, Ontario networks developed on an ad hoc basis. The Ministry mediated the coordination of key organizations to deliver specific programs. Coordination also arose through an alliance of local organizational leaders; examples included partnerships in Network I, where the CMHA partnered with housing agencies, a court support consortium coordinated hospitals, and several court services were available. The Ministry-mediated initiatives also included a forensic ACT team and an agreement to support Community Treatment Orders (CTOs) - urgent 72 hour inpatient assessment followed by case management in the community - among 11 hospitals and CMHA case management. The alliances in Quebec Networks D and E and Ontario Network F developed several joint programs (personality disorder clinic, justice program, homeless program, respectively).

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

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

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

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

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

GENERAL HOSPITALS’ EVOLVING LINKS TO COMMUNITY CARE

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

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

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

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

I think in-patient staff would tell you that they would absolutely love to be able
to discharge plan on every client. I think the difficulty is that many organizations
like ours have waiting lists… Which in turn has prompted organizations like ours
to try to support people while they’re waiting on the wait list, because we had
two very sad instances of two people committing suicide while on our wait list
two years ago, so that really made us look at what we could do differently…how
we could try to support people who were between those two – the in-patients and
the community services.
- Network H, Key Informant 4

Hospitals with a large catchment area must keep track of community service contacts in
several geographical areas, which can be a challenge. As care shifts to schedule 1 hospitals,
new staff may not be informed of whom to contact on patient discharge. For example,
because the schedule one and psychiatric hospitals to which Network A refers its clients are
outside its geographic network, communications regarding client discharge planning are
inconsistent. Primary care physicians receive a note on patient discharge, but community
services are often not informed, leading care to lapse for those with serious illness. While
family physicians in rural networks are often linked to community MH services, linking
hospitals with community services remains a challenge (Network A, Key Informant 2).
Recent health system restructuring has led to changes in personnel, which contributed to
inconsistent communication that affected discharge planning. In some networks, community
providers’ long-term relationships and knowledge of their clients were not always
acknowledged, which could compromise patient care on discharge.
Services in the hospitals have been resorted and restructured...When they change internally... internal communication is almost non-existent...we'll send a client in, and send follow-ups, we'll call, and we'll be informed that the client has been discharged and we haven't received a single word...discharge planning is extremely ad hoc...there isn't coordinated care with the community with the schedule ones.

- Network A, Key Informant 4

In other communities, general hospitals are becoming more responsive in coordinating their care. Key informants indicated the general hospitals seem to be reaching out to make the connection to the community, where their case management, inpatient, emergency services, and their mobile crisis team are “doing a great job.”

...emergency services is...making it possible for you to take your mental health clients to emergency and be seen by a psychiatrist first and not go through the medical stream and then wait for the consultation, because most of our folks... need crisis intervention.

- Network I, Key Informant 5

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

- Network J, Key Informant 4

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

**ACT TEAMS IN SYSTEMS OF COORDINATED CARE:**

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

Discussion: We found the three network governance models used in the 10 networks affected the degree to which organizations were able to unify their efforts to coordinate services among diverse providers. Several factors were found to be particularly supportive. While the *corporate* structure within an RHA could advance organizational cooperation most directly, some RHA-governed networks experienced challenges that were resolved only after they adopted certain strategies. These included assigning a joint director with jurisdiction for both institutional and community services, who then formed executive management, as well as implementing committees with representatives from both sectors.

Networks with an *alliance* governance model demonstrated the effectiveness of fostering of strategic connections by supporting network organizations to cooperate in defining their strengths and assigning services accordingly. Strategic alliances were viewed by several key informants as effective coordination mechanisms. When agreements are developed to coordinate programs, the cooperating partners review their strengths and decide which organizations are best suited to offer particular services. Cooperation through an alliance builds collaboration across organizations in the interest of the client base and fosters a
culture of interdependence. It also creates a forum that supports organizations to prioritize strategic investments in areas in which the evidence reveals the need for service capacity.\(^7\)

A community can create a culture of cooperation by mediating connections and cooperation across corresponding organizations, and by allocating investments in areas where evidence indicates the need for service capacity.\(^7\)

The alliances’ executive forum and its sub-networks were instrumental in developing a shared vision and in aligning organizations’ contributions (Networks D, E, F, H and I). They also instilled a sense of shared accountability toward both the population served and partner organizations. Implementation of CTOs in Networks H and I offers an example. Instead of merging community case management organizations with 11 hospitals, the same objective was achieved by coordinating case management through autonomous organizations. The key was assessing how people flow through the system, ensuring information technology was available to the providers, and building cooperation to link services among them. Another example in Network H entailed coordination of case management services across several organizations with an identified lead agency to which the Ministry transferred funds. The sub-network partnerships created among organizations, through the CTO implementation and Centralized Case Management in Networks H and I respectively, reflect a mediated model similar to an alliance.

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

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

We also found the presence of a psychiatric facility within a network could make coordination more complex (B, E, F, G and I). Shortell suggests that overly large organizations are not conducive to community building; their size, diverse programs, and services make it possible for them to disengage from community building exercises. A focus on individuality can also lead communal exercises to bring out protectionist tendencies and become a forum for organizations to advance their professional identity. Conversely, a sense of community emerges when organizations develop a capacity for vulnerability in which they recognize that fostering links to the community, where patients must re-build their lives, ensures their place in the system design by supporting continuity of care and the most efficient use of resources.\(^7\)

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

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

CONCLUSION

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

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

Across all communities, we found that networks that were mediated through an alliance had leadership advantages over voluntary mutual adjustment. Voluntary cooperation alone was unlikely to lead to a common system vision and introduce the supports needed to achieve coordinated care, even though isolated examples of partnership exist in such areas as justice and housing. We found coordination was invariably mediated through shared understandings and negotiated agreements among member organizations and supported through administrative, operational and clinical initiatives. In the networks studied, a committee of mental health program executives, often supported by a director responsible for mental health services across the continuum of care, launched a series of sub-committees to address coordination issues that were instrumental to its advancement.
We found that when accountability was assigned to the network or region (where the region and network communicated closely), their leadership cooperated in developing a system-wide vision and strategic plan, and reallocated resources to promote system innovation and to address service gaps. Conversely, when accountability remained at the provincial level or was ambiguously diffused across provincial/regional/network levels, planning tended to serve individual operating units rather than community needs. Communities in which performance appraisal was based on system-wide, as opposed to organizational goals, were also more likely to realize their objectives.

Cross-jurisdictional coordination of mental health services with addictions, justice, housing and employment required coordination across provincial, regional and municipal governments to ensure access to services controlled by other jurisdictions. A lack of resources to develop information systems and programs was a further obstacle to coordination; for example, discharge planning was made more difficult when case management services were unavailable due to lengthy wait lists. The burden of care however, was found to be reduced when service capacity was addressed in preventive areas such as early intervention and in community supports such as housing and case management. Organizations and providers could strengthen the continuum of care by linking patients to these community supports. Hospital staff was found to be pivotal to effective community-based care, and supported community programs in several networks. Mediated network governance models, which support a systems approach instrumental to resolving coordination issues, were found to offer the most potential to address coordination.
REFERENCES


Mental health network governance and coordination: Comparative analysis across 10 Canadian regions


