

# Partnership at the Forefront of Change: Documenting the Transformation of Child and Youth Mental Health Services in Quebec

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## Abstract

**Objective:** The Quebec *Plan d'action en santé mentale* (PASM) (Mental Health Action Plan) reform, a major transformation of the province's mental health care system, has put primary care rather than hospital-based care at the forefront of mental health service delivery. This study documents perceptions of changes in child and youth mental health (CYMH) services following the reform, as well as facilitators and obstacles to collaboration and partnership in CYMH services, and the specific challenges related to collaboration and partnership when servicing multi-ethnic populations. **Methods:** This qualitative participatory research study collected data using semi-structured individual interviews, focus groups and participant observation in community-based health and social service institutions. Thematic analysis was performed. **Results:** The reform process encountered challenges in building a common culture of care within and between institutions, while collaboration and partnership evolved in a positive direction throughout the study. Study results highlighted the importance of fostering communication at all levels. Collaboration and partnership was facilitated by opportunities for clinical discussions, dialogue on models of care, harmonizing administrative and clinical priorities, and involving key actors and structures. The results revealed difficulties in implementing multidisciplinary work and in negotiating partners' responsibilities. Quality of partnership and collaboration appeared particularly crucial in providing optimal care to vulnerable families, including migrants. **Conclusion:** The PASM reform involved a major and challenging transformation in CYMH services. Continuous dialogue through time and leadership sharing appeared promising to foster this transformation.

**Key words:** *collaboration, partnership, youth mental health, child and adolescent psychiatry, family*

## Résumé

**Objectifs:** La réforme proposée au Québec par le Plan d'action en santé mentale (PASM) est une transformation majeure du système des soins de santé mentale qui a mis au premier plan les soins primaires dans l'offre de service, plutôt que les soins donnés en milieu hospitalier. Cette étude documente la perception des changements survenus dans les services de santé mentale pour enfants et adolescents, à la suite de l'application du PASM, de même que ce qui facilite ou freine la collaboration et le partenariat au sein des services. Elle présente de plus les défis spécifiques relatifs à la collaboration et au partenariat dans la prestation des services aux populations multiculturelles. **Méthodologie:** Cette recherche participative a recueilli des données qualitatives tirées d'entrevues individuelles semi-structurées, de groupes de discussion et d'observation participante, qui se sont déroulées dans des Centres de Services sociaux et de Santé. Les

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données ont fait l'objet d'une analyse thématique. **Résultats:** L'élaboration d'une culture commune de soins au sein des établissements et entre ces derniers a constitué un défi de l'implantation de la réforme. La collaboration et le partenariat ont évolué de manière positive tout au long de l'étude. Les résultats ont fait apparaître l'importance de la communication à tous les niveaux. La collaboration et le partenariat sont favorisés par les discussions cliniques, le dialogue sur les modèles de soins, l'harmonisation des priorités administratives et cliniques, et l'implication de structures et d'intervenants clés. Les résultats ont révélé des difficultés quant à l'implantation du travail multidisciplinaire et la négociation entre partenaires des responsabilités de chacun. La qualité du partenariat et de la collaboration était jugée essentielle lorsqu'il s'agissait de fournir les meilleurs soins possibles aux familles vulnérables, dont des familles de migrants. **Conclusion:** Le PASM implique une transformation majeure et présentant des défis, des services de santé mentale pour enfants et adolescents. La poursuite du dialogue et le partage du leadership sont des facteurs prometteurs du succès de cette transformation.

**Mots-clés:** *collaboration, partenariat, santé mentale des enfants et adolescents, psychiatrie de l'enfant et de l'adolescent, famille*

## Introduction

Health care systems rely on a diversity of professionals and institutions in order to provide accessible and adequate child and adolescent mental health care. Children and youth evolve in different environments, and professionals play complementary roles in prevention and intervention. Recent reports on a lack of multi-sectoral collaboration and a professional resistance to community-oriented care (Thornicroft et al., 2010) underline numerous obstacles which can interfere with the dynamics of collaboration between professionals and institutions in child and adolescent mental health service delivery. Globally, recent reforms have aimed at a better integration of mental health services into primary care (World Health Organization (WHO) & Wonca, 2008). On a national level, the Mental Health Commission of Canada, has outlined strategic directions to support child and youth mental health (CYMH) care, including enhancing the capacity of primary care services to deliver CYMH services (Kutcher & McLuckie, 2010). Quebec has instituted the most sweeping reform nationally, as it has reformed mental health services throughout the province.

This article documents the elements facilitating and hampering collaboration in the context of the ongoing mental health reform in Quebec. This reform is currently affecting a network of institutions and professionals whose formal and informal relationships constitute the crux of CYMH services delivery. The qualitative results of a mixed-method study exploring the dynamics of collaboration in CYMH services will be presented. The results illustrate these dynamics in the specific context of primary care institutions within an urban multi-ethnic setting.

## Background

In Quebec, while psychiatry departments were created in general hospitals in the 1960's and 70's, the Province reorganised health services in the 1970's and 80's by creating Local Community Services Centers (CLSCs) offering social and health services (Gaumer & Desrosiers, 2004).

They were also to offer primary care mental health services. Despite these efforts to facilitate access to care in the community, CYMH services in primary care remained underdeveloped and underutilized. The involvement of CLSCs in mental health care in Quebec contrasts with the organisation of services in other provinces, where primary care involves mostly family medicine.

A study of the profile of mental health service utilization in Montreal in 2004-2005 showed that children and youth were almost four times less likely than adults to have had a 'mental health contact'—general practitioners' consultation in a clinic, child-psychiatry consultation, emergency room visit, hospitalisation, or CLSC contact with a mental health profile—(Benigeri, Bluteau, Roberge, Provencher, & Nadeau, 2007), despite their similar rates of mental health disorder with adults (about 20%) (Brauner & Stephen, 2006). Two-thirds of these youth (64.4%) had a psychiatric hospital visit, while only 14.1% of them had a contact at a CLSC for mental health reasons. These results highlight two facts: a hindered access to CYMH care, and a profile of service utilisation focused on child psychiatry visits.

The 'Plan d'action en santé mentale 2005-2010' (PASM) (Mental Health Action Plan) is a governmental reform that designated CLSCs as the entry point to the mental health system, and aimed at strengthening primary care settings and to increase access to mental health care. It was inspired by the work of advisory groups and took into account comments from the Auditor General to draft a first Plan and then proceeded with extensive consultations following this first draft. It did not address specifically the availability of general practitioners. The PASM specified the organisation of mental health care between hospital psychiatry departments (including introducing the role of psychiatre-répondant -consulting psychiatrist- to primary care services) and the community based health and social service institutions (CSSSs) (Ministère de la Santé et des Services sociaux, 2005). The Plan mentioned the Child and Youth Protection Services ('Centres Jeunesse') whose mandate is to provide specialized help to children and youth experiencing severe

difficulties and to their families. This help is mostly provided by social workers, psychoeducators (professionals assessing children and youth adaptive capacities and difficulties and planning interventions in familial, social and school milieu to foster optimal functioning), psychologists and criminologists. However, the PASM did not specifically address the articulation of services with other partners (such as schools). Schools are nonetheless key partners within these networks, and CSSSs have social workers and nurses who visit the public schools within their territories.

Since the reform, the majority of children and youth have been progressively directed towards their neighbourhood CLSC to access mental health care. This has involved a major role modification for institutions, including hospitals and CLSCs. Whereas child psychiatrists traditionally worked in hospitals' specialised services, the role of consulting psychiatrist (entitled 'répondant') introduced a new role for psychiatrists to work with and within the CSSSs. A special position of mental health liaison person was created in the CLSCs Youth Mental Health (YMH) teams to function as a liaison between collaborators and partners. 'Youth' is here a translation of 'Jeunesse' and therefore includes 0 to 18 years old.

During the same period, the CLSCs were merged into 95 CSSSs within the province (Montreal has 12). This was combined with a standardized program management structure for child and youth care through specialized teams: the Healthy Schools; Youth and Family; Youth in Difficulty (YID); Youth Mental Health (YMH); and, Family Crisis Intervention teams.

The PASM implementation required negotiations between hospitals and CSSS's by requiring a transfer of budgets and/or professionals from hospitals to CSSSs, and imposing a triage intake system designating the CSSS as the unique entry point to request mental health services for a given geographical sector. These decisions involved major transformations of collaborative and partnership behaviours between child and adolescent psychiatry and CSSS services, the consequences of which have not yet been documented.

### **Goals of the study**

The study was undertaken as a research partnership between three CSSSs that had recently put in place their YMH teams, that had either a visiting (few hours per week) or on-site child psychiatrist and that were providing services in multi-ethnic neighbourhoods of Montreal, Quebec. Its objectives were to: (1) document the perceptions of key actors about the process of the reform; (2) identify facilitators and obstacles to collaboration and partnership in CYMH services; and, (3) identify specific challenges related to collaboration and partnership when servicing multi-ethnic populations.

## **Methods**

For this participatory research (Green et al., 2003), researchers and team leaders working in the CSSSs collaboratively defined the objectives of the study. Prospective qualitative data, particularly useful to explore complex systems (Bradley, Curry, & Devers, 2007), were collected using semi-structured individual interviews, focus groups and participant observation. The study received ethical approval from CSSSs research ethics boards.

Semi-structured interviews were conducted by a research assistant with 30 participants, ten from each of the three CSSSs. Six informants were managers (two from each CSSS), and 24 were primary care clinicians (social workers, psychologists, psycho-educators, art therapists and general practitioners) working mainly in the YMH or in the YID teams. Child psychiatrists were not interviewed. Purposeful sampling identified key informants in order to represent the different teams' diversity of training and experience. Interviews were carried out between November 2009 and August 2010. Themes explored included: collaboration and partnership before, during and after the reform; challenges and facilitators to collaboration and partnership; and, issues related to servicing an ethnically diverse population. Thematic analysis was first conducted separately by two members of the research team, then compared and finally validated with other research team members.

A focus group was organised with managers of the three CSSSs and with child-psychiatry managers at associated hospitals (seven participants) to discuss issues related to partnership between institutions. Throughout the year, the research findings were presented to the CSSS professionals in half-day meetings at each CSSS (about 20 participants each time). A joint meeting with workers from the three CSSSs (45 participants) allowed the participants to enrich the interpretation of the preliminary research findings. Participant observation was carried out by the research team in different clinical settings, including team meetings and inter-institutional meetings. These observations allowed the research team to contextualise the findings gathered in the interviews and from the focus group discussions.

## **Results**

The results are presented in three sections pertaining to: (1) intra-institutional collaboration; (2) inter-institutional partnership, focusing on partnership with hospitals, the main partnership transformed by the PASM; and, (3) aspects of collaboration and partnership when servicing multi-ethnic populations. In this paper, the term "collaboration" is used to designate intra-institutional interactions while "partnership" refers to inter-institutional relations and officialised collaboration between autonomous establishments.

The research findings particularly document the perspectives of professionals working in the CSSSs. The findings revealed that the three CSSSs had a similar vision about the obstacles and facilitators to collaboration within their respective institutions and to partnership building between institutions.

## **1. Collaboration within institutions**

### **Facilitating factors**

Frequent opportunities for individual and group communication emerged as a major factor facilitating collaboration within the CSSS. Regular exchanges between different child and youth CSSS teams were seen as crucial in resolving tensions, fostering cooperation between the teams and motivating clinicians. Formal and informal team communication was considered essential in order to clarify mandates and to provide a forum to help one another with challenging clinical situations. Formal mechanisms of communication, such as open communication with administrators, and clear procedures for referral and follow-up, were seen as necessary to ensure stability in the network, particularly in this sector where there is a lot of professional turnover. Nevertheless, informants believed that opportunities to communicate informally with other workers greatly influenced the quality of services offered.

Informants repeatedly expressed the desire to have more opportunities for clinical discussion, in the form of group clinical exchanges and supervision. Different avenues for clinical discussion were identified: with the consulting child psychiatrist; between colleagues of one team; with colleagues from other youth teams; and, with an external supervisor. Such opportunities were seen as fulfilling various functions: providing expertise and clinical support; building team relationships; providing alternate viewpoints which were helpful to increase the clinician's overall insight about cases and care; creating a forum to develop common professional values; and, co-constructing expertise.

Informants reported that the presence of child psychiatrists on the CSSS site facilitated collaboration and provided support and a training opportunity to increase clinical skills. Psychiatry consultations in all three CSSSs involved the active participation of primary care professionals (mostly psycho-educators, social workers, psychologists, creative art therapists, and much less frequently general practitioners). These clinical services were described as offering an opportunity to gather together the diverse partners involved with a child, as a means to help resolve impasses in treatment through in-consultation cooperation, and as a bridge to help reinforce the propositions for care formulated by primary care workers.

## **Challenges**

Clinicians and administrators jointly underlined a number of challenges, including balancing the administrative mandate of increasing access by minimising waiting lists and the clinical goal of offering good care, especially to vulnerable families with multiple needs. The pressure of the administrative mandate to increase the number of children and youth seen caused tension when combined with the need to develop trusting relationships with families experiencing a lot of psychosocial difficulties, a time consuming enterprise. Informants felt divided between their tasks of trying to provide sufficient help to vulnerable families while responding efficiently to all requests.

The tension between the administrative and clinical levels was also reflected within the care model. Multidisciplinary work was considered important in promoting effective collaboration by bringing together diverse perspectives, allowing for a better understanding of the therapeutic needs of children and youth and their families and the development of a shared treatment plan among professionals. Yet clinicians described a lack of resources (time, space), for establishing multidisciplinary interventions, particularly for vulnerable families with multiple needs, such as a combination of mental health difficulties in multiple family members and social precarity. Professionals reported feeling over-burdened.

Clinicians also named their discomfort with the statistical documentation of their case loads as required by government directives, as they felt the data requested did not reflect the reality of their work. They described how their work involved a diversity of activities, an intense involvement with children and youth and their families and multidisciplinary work, all of which were not reflected in the requested statistics. They expressed concern that the economic imperatives of lowering first-line costs and of assessing productivity in terms of number of clients seen could be a disincentive to collaboration and interfere with the delivery of quality services.

Albeit limited, the availability of a child psychiatrist for direct consultations was reported as a stimulus that helped to foster strategies of in-team consultation and mutual support around discussing challenging clinical situations. This in-team support developed further following the teams' gaining further experience of working together (2009-2010). The latest research meeting (2011) attested to the increased comfort of YMH team members in managing complex clinical situations.

### **Evolution of collaboration**

Collaboration evolved from the start of the study to the latest results, when the YMH teams became better established. With time there were more opportunities for communication

within the CSSSs and with external partners. Members of YMH teams invested in the increased role in CYMH care delivery for primary care professionals, and the overall discourse of informants focused more on building an innovative model of youth mental health care integrated in community-based services.

## **2. Inter-institutional partnership**

Hospitals are mandatory partners to the CSSSs in CYMH. Whereas primary care, or first-line, concerns the care provided by generalists and community teams, second- and third-line mental health care involve hospital-based professionals. The second-line care involves a specialist input, and the third-line involves ultra-specialized care, including hospitalization in psychiatry. Not surprisingly, the new partnership requirements that emerged from the reform induced a forced marriage between hospitals and CSSSs, and themes relating to this occupied an important part of the informants' discourse. Other important institutional partners, such as schools and Child and Youth protection services ('Centres Jeunesse'), were also mentioned as key partners by informants. Yet, the participants' pressing need to address the relations with hospitals took over most of the discussion time, leaving other partnerships largely unaddressed.

### **Facilitating factors**

Informants considered it crucial to enhance partnerships by providing opportunities for increased knowledge sharing among partners, to foster an agreement on common goals and to clarify each other's roles, rather than acting competitively.

The meetings that occurred as partners' round tables ('table de concertation') were clearly seen as fostering partnership with institutions, by facilitating: (1) continuity within the partnership; (2) opportunities to learn about one another and to cooperate around identifying population needs, respective mandates and resources; and, (3) trust-building among partners and the development of a consensus on objectives. Similarly, clinical meetings where transfer criteria between institutions and challenging clinical situations were discussed were identified as network-building.

Overall, informants perceived the triage intake system favourably as it helped to avoid duplication in the referral and assessment process, although professionals from both the CSSSs and the hospitals worried about how promptly children and youth would be attended to when referred to each other's institution. Informants acknowledged that the transformation of the health system would take a long time, yet both clinicians and managers identified inter-institutional meetings and the work of key actors (including child psychiatrists and liaisons) as instrumental in developing partnerships during this period.

## **Challenges**

The PASM reform introduced new tensions into the relationships between CSSSs and hospitals at the higher managerial level. The negotiation with the government about the transfer of resources from the hospitals to the CSSSs resulted in a decrease in partnership meetings which predated the reform. They were later slowly re-established once the negotiations were concluded. Negotiations also brought tensions around how to define primary, secondary, and tertiary lines of care where a consensus around definitions still remains to be clarified. Tensions also existed around who assumes responsibility for specific patients.

Lack of knowledge of the other institution and its resources was emphasized in partnership meetings. The inter-institutional tensions crystallized around the difficulty of referring patients between institutions. At first, successful collaborations between primary care and hospital partners were rarely mentioned by informants, and defensive attitudes regarding each other's institutions were frequent.

The different care models between hospitals and CSSSs fostered tensions, according to informants. Professionals described a tension between the hospital-based model where the psychiatrist acts as a leader of the treatment team, and the CSSS-based model where relationships between multi-disciplinary professionals are more horizontal. Informants felt the hospital-based model also permeated the training resources provided by hospitals, which were seen as being delivered with an expert-to-pupil tone, rather than providing a bilateral exchange of knowledge.

### **Evolution of partnership**

Informants noted that the knowledge translation activities provided through the research protocol allowed them to intensify the networking and brainstorming around strategies to enhance partnership. Comfort also developed around the triage intake process once it was established in the CSSSs. With time, some successes in inter-institutional transfers were acknowledged, and positive training experiences occurred.

## **3. Aspects related to collaboration and partnership when servicing multi-ethnic populations**

In general, the CSSS professionals identified the possibility of working with a multi-ethnic population and adapting their care as a positive aspect of their community-based work. They felt that all partners and internal collaborators needed to acknowledge this diversity and to reflect on how to adapt their interventions when needed. The transcultural aspect of many of the child psychiatry consultations was emphasized as instrumental in helping mediate perspectives about care between families and different partners. In addition to child

psychiatric consultations, consulting with CSSS colleagues was particularly appreciated in clinical situations in which psychopathology and family dysfunction interacted with migration and cultural issues. Informants felt that working with cultural diversity added complexity in situations where families were experiencing a lot of psychosocial adversity. Interpreters were also seen as important partners. The CSSS professionals were also concerned that the particularly long hours that it took them to provide multidisciplinary care to their multicultural clientele was not taken into account in resource allocation.

## Discussion

The PASM reform involved a major change that transformed collaborations and partnerships in CYMH services in Quebec. Health care organisations are recognized as complex entities dealing with significant pressures around accessibility and service delivery from both internal and external sources, which challenge their capacities to change.

A sweeping transformation such as the PASM could only emerge from a top-down leadership. Like other innovations, it came with controversy and growing pains. Our results highlight convergences between the perceptions of primary care professionals belonging to similar CSSS institutions. These convergences suggest that the transformations and associated tensions in partnerships have started to generate a common vision in the CSSSs in support of the PASM and solidarity among these institutions to enhance partnerships. Restructuring existing systems implies difficulties that can more easily be faced when actors are actively involved in the process and can create shared meaning (Edquist & Hommen, 1999). In such a situation, capacity for negotiation and compromise is crucial (Klein & Harrison, 2007).

Primary care professionals conveyed the importance of: (1) communication between clinicians and teams, administrative and clinical levels, and institutions; (2) opportunities for clinical discussion both within primary care institutions and between partners in the integrated network of CYMH services; and, (3) dialogue on models of care and harmonizing administrative and clinical priorities within the CSSSs. Thus, they emphasized the importance of building a common culture of care.

Opportunities for dialogue between professionals in the CSSSs and between CSSS professionals and hospital partners regarding services and clinical situations provided direct experiences of coordination. Our results suggest that these opportunities lead to an increase in comfort and foster collaboration and innovation. The need remains to develop further opportunities for dialogue with partners, most notably with hospitals.

The types of forums for clinical discussions and training requested by the CSSS professionals called for leadership sharing as opposed to a more classical hierarchical model. The medical model typically views physicians as the leaders and medical issues as predominant within the understanding of mental health issues. The notion of distributed leadership provides a model where the power of influence and decision-making is more collectively held (Chreim, Williams, Janz, & Dastmalchian, 2010). Collective leadership has been shown to positively influence change management (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007), and appears to be a critical requirement in a complex transformation such as the PASM reform.

This transformation implies redefining and (re)negotiating roles both within primary care institutions and between institutions. The expansion of primary care workers' roles in mental health likely explains the informants' wishes for more clinical discussions and training. This support increased their comfort, and likely their motivation to adapt to this transformation of their work.

These qualitative results converge with quantitative findings obtained within the same study. These latter findings indicated that four major factors significantly influenced interprofessional collaboration in CYMH: motivation; social support; organizational culture; and, group leadership (Nadeau et al., 2011). Interestingly, our results identify the same key aspects as a Norwegian study (Ødegård & Strype, 2009), which suggest that primary care-based CYMH services transformations may mobilise similar dynamics across regions and countries.

Finally, our study emphasizes that the quality of partnership and of collaboration appears especially crucial to provide optimal care to vulnerable families, including migrants. It also highlights how the capacity to increase accessibility is especially challenging when it comes to vulnerable families with multiple psychosocial needs.

The results predominantly represent the opinions of CSSSs primary care workers, especially those working frequently in mental health. The views of external partners to CSSSs including hospitals are thus underrepresented. Further research is needed to assess the perception of other crucial collaborators in youth mental health services, such as professionals working in hospitals, schools and Child and Youth protection services ('Centres Jeunesse').

## Conclusion

The successes and tensions around collaboration and partnership building within the CYMH field reveal the challenges associated with CYMH services transformation.

Implementing collaborative care requires shifts of power and a loss of privileges which upset partnership relations. It compels clinicians and managers to reflect on the blind spots that arise within a complex system, and to address them. It introduces new roles for professionals and also for their institutions. This study attests to some achievements, particularly in building intra-institutional collaboration and in investing in a model of care adapted to psychosocially vulnerable families in multi-ethnic neighbourhoods. The study also emphasizes that institutional transformation requires time and that dialogue between partners needs to continue. Other research will need to further explore this evolving partnership by including the views of CSSS partners, and also to document the relationship between the quality of partnership and patient outcomes. Finally, implications for training regarding collaboration and partnership within all disciplines involved in CYMH integrated networks will need to be carefully reviewed.

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