

*Mandated Collaboration: Command and Control or
Emergent Process*

Steve Lurie, CMHA Metro Toronto Branch

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Abstract: The management and support of forensic clients and people on community treatment orders is an area of interest to both clinicians and policy makers. Collaboration between hospital and community service providers is required and in some instances, mandated. This paper reviews some of the literature about mergers and alliances and examines selected experiences in the mental health field using a case study method. The case studies examine mandated collaboration comparing the development of the forensic MOU (memorandum of understanding) which involved CMHA Metro Toronto and three general hospital ACT teams with the community treatment order collaborative project, which involves our agency, the Centre for Addiction and Mental Health and 11 general hospitals.

The paper offers observations on the extent to which collaboration is an emergent process that is responsive to its particular environment and explores power dynamics and how trust and flexibility affect outcomes in a positive or negative sense.

Introduction

In 1999 the Ontario Ministry of Health published Making It Happen, a two volume planning and operational policy for mental health services in Ontario. One of the key themes was to streamline access to community services through a variety of mechanisms:

- Development of agreements between services
- Designation of lead agencies to coordinate services
- Development and use of common assessment tools.

Recently there has been considerable interest in the lead agency concept, which would create a network of services under a single governance structure. This model has been proposed for Northeastern Ontario and the model is under serious consideration by the Mental Health Implementation Task Forces, which have been set up to review and recommend the alignment of mental health services in each region of the province.

One of the forces driving the quest for single governance lead agencies is the urge to merge in both the private and public sectors, despite limited evidence that mergers actually succeed. On the other hand, there is evidence emerging that strategic alliances and partnerships can be more successful at less cost.

This paper reviews some of the literature about mergers and alliances and examines selected experiences in the mental health field using a case study method. I build on some of the work I did in the collaborative module by looking at mergers and alliances by examining mandated collaboration using two case studies comparing the development of the forensic MOU which involved CMHA and three general hospital ACT teams with the

community treatment order collaborative project, which involves our agency, the Centre for Addiction and Mental Health and 11 general hospitals.

In particular, I am interested in the extent to which collaboration is an emergent process that is responsive to its particular environment. I am also interested in power dynamics and how trust and flexibility affect outcome in a positive or negative sense. Based on the learnings that emerge from the literature review and case studies themselves, I will reflect on their application to leadership and management in the mental health sector.

On Methodology

Michael Quinn Patton notes “Professors have trouble getting graduate students to analyze less than the whole human experience in their dissertations” (Patton. 1997, 198). When considering the subject matter in this paper and the scope of the topic, this statement rings true. However, for the sake of brevity I have chosen an approach to methodology that begins with a review of the literature on collaboration. This is followed by a presentation of the two case studies.

My hypothesis (hunch) is that collaboration can be mandated but the form emerges through the interaction of the various stakeholders and is sensitive to dynamics in the domain environment. I will be attempting to “impose sense on past experience” (Mintzberg, Alstrand, Lampbel 1998, 195).

Patton suggests that this type of conceptual use of information can be used to stimulate thinking about what is going on or has occurred in the cases being reviewed (Patton. 1997, 82). While this use is directed at decision-makers, Patton also

acknowledges that the process of reflection on experience can be helpful to participants themselves. (Patton. 1997, 95)

Reflection may be helpful in helping explore the dynamics of interagency mandated collaboration. While the case studies are not evaluations, they are evaluative.

Barbara Gray has noted that collaboration is directly related to turbulence in the environment (Gray 1989, 1). Collaboration itself is a dynamic process that experiences turbulence. Evaluative reflection may assist leaders and decision-makers in understanding more about the process itself. Patton notes that “the degree of uncertainty facing an organization directly affects the degree to which goals and strategies for attaining goals can be made concrete and stable”. In a turbulent environment, evaluators are challenged to generate concrete and stable goals (Patton. 1997, 180).

Patton points out that evaluation can be focused in a number of ways. (Patton 1997, 192-4) The information/data I will be presenting will have a variety of foci:

- *Descriptive*- what has happened
- *Context*- what is the cultural and political environment
- *Knowledge*- what can be learned from these experiences to inform future collaborations
- *Theory of action*- what are the linkages and connections between inputs, activities and outcomes of the collaborations

The collaborations I am reporting on are in their formative stages. While patterns have emerged that lend themselves to analysis, it is too early, and the methodology is too limited to be more than speculative, unless framed in what Patton calls the connoisseurship approach, where the specialist or expert (me) applies their own criteria and judgment.

In essence, the case studies can be thought of as process evaluations, which focus on the external and internal dynamics of collaboration. Patton notes that these types of evaluations search for explanations. The evaluator tries to understand and document the day-to-day reality of the settings “ searching for the important nuances that give the program its character” (Patton 1997, 206).

This paper is informed by the literature review that I have completed on mergers and strategic alliances in the public and private sectors and data in the case studies will be interpreted using theory from the literature review. However, the interpretation is not purely deductive. Barbara Gray has noted that there is relatively little literature on mandated collaboration (personal communication). By writing down observations about the collaborations in the two case studies, I have been doing fieldwork to generate “theory grounded in real world practice” which is an inductive approach (Patton 1997, 224). At the same time, given the limitations of the case studies, it may only be possible to generate a theory of action.

Patton notes that theories of action are quite specific to “a particular program or organization, (while) deductive and inductive approaches make use of programs as manifestations of some larger phenomenon of interest” (Patton 1997, 221).

Notwithstanding the advantages and disadvantages of each approach, “ways of measuring complex phenomena involve simplifications that are inherently somewhat arbitrary (and) are always constrained by limited resources and time” (Patton 1997, 242). Collaboration is a complex phenomenon that requires a variety of analytic approaches to generate meaning, learning or understanding.

While the case studies are informed by the literature, they are themselves products of naturalistic inquiry derived from personal observation and “close contact with people in the setting(s) under study” (Patton 1997, 268). Patton suggests that observation can include being a program participant. This may involve trading off scholarly comportment and detached analysis for the understanding and sympathetic introspection that comes from being part of the process. (Patton 1997, 283).

Information in the two case studies is based on meetings and conversations I have participated in, journal notes and in some cases, correspondence and minutes. As such, the information is somewhat subjective. This approach is located in the qualitative research paradigm and as Patton notes “we are always dealing with perceptions not facts in some absolute sense... the qualitative/ naturalistic paradigm searches for perspective and understanding in a world of multiple realities, thus the inevitability of subjectivity” (Patton 1997, 281).

The theories and observations that emerge will come from two sources, the direct experience of collaboration and the literature. But they are not being imposed simply on the “basis of predetermined, deductively derived constructs” (Patton 1997, 279). Patton introduces us to Cronbach’s theory of extrapolation, which involves “logically and creatively thinking about what specific findings mean for other situations” (Patton 1997, 259). I am hopeful that the literature review, reporting, reflection and discussion of the case studies will be seen as contributing to knowledge about mandated collaboration and the process of collaboration in mental health services which can be refined as more information is collected on these and other collaborative ventures.

Literature Review

In 1999 the Ontario Ministry of Health published Making It Happen, a two volume planning and operational policy for mental health services in Ontario. One of the key themes was to streamline access to mental health services.

Making It Happen commits the MOHLTC to improving consumer choice and access to services while ensuring that services are linked and coordinated so that “consumers will move easily from one part of the system to another.” The policy framework notes that case managers can help coordinate services and that networks of services or strategic alliances among core mental health services can facilitate service integration (Ontario Ministry of Health 1999,4-7).

Recently there has been considerable interest in the lead agency concept, which would create a network of services under a single governance structure. This model has been proposed for Northeastern Ontario and the model is under consideration by Mental Health Implementation Task Forces, which have been set up to review and recommend the alignment of mental health services in each region of the province. However, there are other approaches to network creation that do not require single governance structures. The Central East Task Force has recently received a proposal from the Durham Mental Health Alliance, which proposes a cooperative model of system integration that builds on the relationships and cooperation that has developed among service providers. They propose co-locating services and developing integrated service delivery teams (Hume McKenna Associates 2001 24-33).

The London Mental Health Alliance represents a joining together of mental health and other community organizations to plan and coordinate mental health services.

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Membership includes the University of Western Ontario Dept. of Psychiatry, CMHA, Family Service London, other mental health agencies, Can Voice (a consumer organization and the Family Outreach Program. While not changing the governance structures of the member organizations, the Alliance proposes to alter the way mental health services are provided, through cooperation and joint activity.

One of the forces driving the quest for single governance lead agencies is the urge to merge in both the private and public sectors, despite limited evidence that mergers actually succeed. In fact private sector studies suggest that while mergers account for \$3.4 trillion of annual economic activity, only about 20% appear to succeed (Grubb and Lamb 2000, 9). At the same time there is evidence that strategic alliances and partnerships can be more successful at less cost (Grubb and Lamb 2000, 18).

Peggy Leatt and colleagues have noted that reengineering is often unsuccessful in achieving the goals of organization change and cautions that the “business of health care is too serious to be managed or changed on the basis of trends.” (Leatt, Baker, Halverson and Aird 9-10)

Mintzberg and Glouberman note that many countries are implementing administrative reforms in health care but there is very little effect on actual service delivery (Mintzberg and Glouberman 2001, 63). One of the forces driving reforms and consolidation is the myth of too many managers. The recent report of the Fyke Commission on Medicare in Saskatchewan frames the issue well.

“The Commission found no evidence to suggest that current expenditures on administering and managing the provincial health system were excessive... Moreover given the complexity of the system... a case may be made for more and not less administrative and managerial expertise (Fyke 2001, 102).

Mintzberg and Glouberman have a different perspective, arguing that traditional hierarchical, command and control methods of management will not work.

They suggest:

“The managers of the health system will have to distance themselves from a century of management thought as well as from the current kaleidoscope of trendy technique.... Clinical activities cannot be coordinated by managerial interventions- not by outside bosses or coordinators, not by administrative systems, not by discussions of “quality” disconnected from the delivery of it, not by all that constant reorganizing... *Management of clinical operations will have to be effected by the managed, not the managers* (Mintzberg and Glouberman 2001, 72-4).

They note that while differentiation is the essence of the health care system high degrees of integration are required. To them the central issue is how to bring health care providers together, into “collaborative working relationships” (Mintzberg and Glouberman 2001, 74).

Deliberations on organizational change to increase consumer choice and improve access to services in Ontario’s mental health system can be informed by a review of experience in mental health, health care, the corporate sector and the municipal sector. This review focuses on summarizing the findings of two recently published C.D. Howe Institute papers on municipal and health care restructuring, literature reviews commissioned for Health Canada on Health Human Resources and Organizational Models in Community- Based Health Care, a summary of the HSRC experience with health system reform as it pertains to organizational change, and selected literature on health service and corporate sector experience with mergers and strategic alliances.

C.D. Howe Institute Commentary on Local Government Amalgamations

The C.D. Howe Institute commissioned Dr. Robert Bish, Co-Director of the Local Government Institute at the University of Victoria to review 50 years of evidence about local government structure and performance. Key findings include:

“Given the diversity of communities and local services, no single organization can perform all the tasks demanded of local government. Metropolitan areas composed of a multiplicity of local governments and production arrangements are more responsive to residents’ needs and generally provide local government services at less cost than monolithic amalgamations. The superior performance of such a polycentric structure stems from rivalry among governments and from their use of a variety of production relationships with organizations of various scales, *including cooperation with one another.*” (Bish 2001,i)

Other findings include:

- When there is a multiplicity of small municipalities in metropolitan areas, the costs of governance are lower (Bish 2001, 1)
- No large monopolistic bureaucracy can achieve efficient production because different activities possess different scale characteristics and no single organization is the right size to do all things efficiently (Bish 2001, 4-5)
- With labor intensive activities, average costs increase with the size of organization producing the service (Bish 2001, 11)
- There is no evidence that per capita costs are lower in large municipalities, or that they provide better services (Bish 2001, 18).

While there were cost savings achieved when 11 municipalities were merged in Chatham- Kent, residents perceive the quality of services to have fallen (Bish 2001, 24).

The Halifax- Dartmouth amalgamation underestimated the cost of amalgamation by a factor of four; so far no savings seem likely, while taxes have increased (Bish 2001, 25).

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The study concludes:

“A system of local governments should be viewed as consisting of groups of citizens organized into cooperatives to provide the services they prefer through a variety of production arrangements on a geographic scale. *The focus thus changes from single organizations to the incentives and relationships that prevail among multiple organizations*” (Bish 2001, 27).

C.D. Howe Institute: Integrating Canada’s Dis-Integrated Health Care System

In this paper Cam Donaldson who holds the Svare Chair in Health Economics at the University of Calgary and colleagues Gillian Currie and Craig Mitton review the issue of integrating Canadian health services drawing on experiences in the UK, Sweden and New Zealand. They review the experiences of these countries with creating internal markets in health care systems through mechanisms such as health authority purchasing of services, general practitioner fund holding and creation of trusts. They find that despite public financing, health care is fragmented due to separate funding streams for hospitals, physicians, drugs and other services. They argue “true integration can never take place without financial integration” (Donaldson, Currie and Mitton 2001, 1). The creation of an integrated funding system, which includes physicians, is seen as critical to the creation of a seamless health care system (Donaldson, Currie and Mitton 2001, 21). Their assumption is that fiscal alignment will result in organizational alignment through purchasing contracts and competition among providers, which in return will result in optimal and more efficient care. This assumption is not born out in the studies they review on the various countries.

They caution against implementing reforms without evaluation. “Many of the reforms we have described were introduced wholesale, without any thought being given

to evaluation. This situation has contributed to the ambiguity of the evidence base.” They recommend a controlled pilot program and gradual introduction of reform (Donaldson, Currie and Mitton 2001, 21). Interestingly, they find that in both New Zealand and the UK, competition among providers has given way to cooperation, as the reforms have evolved (Donaldson, Currie and Mitton 2001, 8-15).

Health Canada Papers on Community Based Health Care

In 1995, the Federal Provincial/Territorial Conference of Deputy Ministers of Health received a three volume report which included comprehensive literature reviews on community based health human resources and organizational models. These reports surveyed the published literature to help inform policy about how to achieve high quality and cost effective services.

The report on Health Human Resources by researchers from the Healthcare Quality and Outcome Research Centre at the University of Alberta and the Northern Health Human Resources Unit notes that health care is a labour intensive industry with staffing costs accounting for more than 70% of spending. Special attention to human resource issues is imperative in developing a framework and policy for community based care (Pong, Sanders, Church, Wanke and Cappon 1995, iv). The study provides a useful perspective on shifting health human resources to a community based care orientation that should be kept in mind when developing organizational change strategies for mental health systems.

“The effectiveness of practitioners providing community-based health care and their quality of work life could be improved by various management and educational measures. Similarly, the ways providers are organized, deployed and remunerated could affect the quality and cost effectiveness of their services. *However there is neither a magic formula nor a one size fits all solution. As community based health care*

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encompasses a wide array of services, providers, agencies and organizational forms, it must experiment with different strategies, using experiences gained in other programs and jurisdictions...A trial and error approach and incremental improvements seem to be a prudent way to introduce appropriate educational models and management practices (Pong, Sanders, Church, Wanke and Cappon 1995, viii).

The review found that the multidisciplinary team approach was workable and effective for providing care in the community but “it is not clear from the literature what makes a team tick” (Pong, Sanders, Church, Wanke and Cappon 1995, 53). How community care is organized from a practitioner perspective is also important. Autonomy, flexibility, and freedom to manage contacts with clients were seen as important and rewarding aspects of the job (Pong, Sanders, Church, Wanke and Cappon 1995, 54). The study also found that management and service delivery approaches that demonstrated effectiveness in one particular program, agency or community could fail in other settings (Pong, Sanders, Church, Wanke and Cappon 1995, 56).

Church, Saunders, Wanke and Pong also completed a literature review on organizational models in community-based health care. Their task was to determine which organizational structures and modalities would improve the quality and cost effectiveness of community based services using pre-established criteria (Church, Saunders, Wanke and Pong 1995, iv). The review found that “integrated multidisciplinary models are less costly and more cost effective, than comparable services” provided by single services and institutions. Community based health services were shown to improve access to care and achieve better outcomes at lower cost than stand alone or institutional providers. Improved quality of life was shown in studies involving the elderly, mentally ill and terminally ill (Church, Saunders, Wanke and Pong

1995, v). They also found “significant barriers to system integration associated with existing power and resources.” There was no empirical evidence showing that integrated systems were less costly than non-systems, although these findings were based on studies of hospital systems (Church, Saunders, Wanke and Pong 1995, v).

An important issue, which they find is not addressed by the literature is the “optimum range and mix of service that constitute a continuum of care” or which services “function most efficiently or effectively when integrated or coordinated”(Church, Saunders, Wanke and Pong 1995, 36). Much of the research about integrated service delivery has been focused on cost reduction rather than “the extent to which multidisciplinary, multi service models lead to effective service delivery” (Church, Saunders, Wanke and Pong 1995, 37).

While the literature identifies advantages of unified administrative structures for community health services such as the ability to shift funds across service delivery sectors and the ability to plan on a systems basis, “moving from theory to practice is fraught with a variety of barriers”. A study the authors reviewed by Rondeau and Deber (1992) cites system complexity, competing visions, professional ideologies, lack of incentives and funding realities as barriers which could be reduced by “*the creation of a number of interrelated structures*” (Church, Saunders, Wanke and Pong 1995, 48). Clinical integration is seen as a prerequisite to vertical integration and achieving this requires the development of close relationships among service providers (Church, Saunders, Wanke and Pong 1995, 48).

While the symbolic and “rational” notion of coordination and integration can provide decision makers with legitimacy in pursuing system reform, there are drawbacks.

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The authors cite a study on mental health service coordination by White and Mercier (1991), which concluded:

“While service coordination is viewed often as the key to continuity of care, coordination also has negative effects. Coordination may lead to the *elimination of diversity of options for service delivery. In doing so the process may rob certain patients of the benefits offered by some organizations. Some patients may be marginalized or excluded through the standardization of services* (Church, Saunders, Wanke and Pong 1995, 48-51).

The review notes that integration is facilitated by the development of a new management culture, strong leadership, inclusion of physicians and the *development of integrated information systems*. Integration efforts fail because of resistance from major stakeholders and failure to fully understand the direction of the change (Church, Saunders, Wanke and Pong 1995, 52).

Health Services Restructuring Commission

In March 2000 the Health Services Restructuring Commission published a report reflecting on their mandate and attempts to restructure the hospital system in Ontario. While their focus was primarily on hospitals, their observations on “lessons learned” can be applied to organizational change with respect to mental health reform. As part of their work they established a vision for health care which “put more emphasis on the balance of resources needed along the entire continuum of care, (to) better integrate and coordinate care, and create a patient-centred (as opposed to hospital centred) system (HSRC 2000, 2). They held a series of roundtables on the vision, which identified a number of key priority issues:

- Leadership and communication regarding the vision of reform
- Elimination of silos and enhanced integration

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- Primary care reform as a foundation and “connector to the rest of the system”
- Investment in a shared information management system
- Alignment of incentives to improve accountability and stimulate “systems thinking and behavior” (HSRC 2000, 7).

Reactions to the HSRC vision surfaced concern about too much attention to structural issues and not enough emphasis on the impact that health system changes would have on health human resources and labour (HSRC2000, 30).

However, the HSRC’s final vision statement included a message concerning collaboration, stating “*while reflecting community and regional differences, the system’s health care providers (will) work together*” to achieve the vision” (HSRC 2000, 32).

As the HSRC mandate did result in the merging of hospitals and the transfer of programs, their final report provides useful insight on the challenges of changing governance structures. In terms of success factors, they observe that it is important to “develop evolutionary instead of revolutionary solutions” (HSRC 2000, 51).

The HSRC makes the following observations about organizational change and governance:

- There is no one best system/ model of governance, but “there is a need to find better ways to promote greater integration, efficiencies and effectiveness across the various components of the health system” (HSRC 2000, 44).
- New governance models should emerge which “allow individual organizations to use their strengths and talents” while preserving and enhancing organizational distinctiveness (HSRC 2000, 44).

Therefore they suggest a variety of organizational options including amalgamation, alliance agreement, contracts/ agreements, management administration contracts, support services contracts and clinical services contracts (HSRC 2000, 45-7).

Other Health System Reviews/Articles

A number of authors writing about health services have reviewed options for community-based collaboration. Moyer, Coristine, MacLean and Meyer observe that community collaborations go through stages. The first stage, identifying common ground facilitates the assessment for potential collaboration. Cooperative action can then be used as a “launching point for partnership(s).” This includes “cooperative actions such as workshops and the provision of services to a common client group” (Moyer, Coristine, MacLean and Meyer 1999, 208-9). A common project based on a partnership/ joint initiative provides opportunity for joint problem solving and the expansion of community networks. A multi agency/ multi-sectoral project provides “extensive links into community networks and (has) a greater potential to draw on community resources”. Although “agents represent their own organization, within the partnership they share responsibility for the project and so may have to expand their mandate to encompass common goals” (Moyer, Coristine, MacLean and Meyer 1999, 209).

The authors note that multi agency projects are more complex. While they require the strengths and resources of a number of organizations they have a greater potential for community involvement and can result in the emergence of leaders and joint ownership of community actions (Moyer, Coristine, MacLean and Meyer 1999, 210).

Gamm describes a continuum of collaboration.

➤ *Community action partnerships* address a specific problem or opportunity.

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- *Community organization partnerships* occur when organizations in a sector work together on mutual goals.
- *Community development partnerships* increase collaborative efforts on multiple fronts and contribute to community asset building (Gamm 1998, 51).

Gamm observes that community partnerships can range from services where cooperation enables each organization to pursue its own goals, to a “value added dimension of coordination wherein both parties contribute to the pursuit of a shared goal that neither organization could pursue as effectively on its own” (Gamm 1998, 56). He notes that effective approaches to partnerships avoid “outright control and domination by any single organization”. Community care networks call for “participating organizations to give up autonomy” through contractual arrangements. This allows organizations to work together “while preserving the integrity of competing values embraced by separate organizations. A merger, in contrast, might eclipse values held by one or the other.” Leadership is required to ensure that differences as well as shared interests are understood (Gamm 1998, 58).

Gamm refers to previously published articles by Boland and Wilson (1994) and Sofaer (1994), which note that leadership is distributed in partnerships. “Day to day relationships may be far more prevalent at the technical, line worker level than in middle or upper management” (Gamm 1998, 59).

The most sophisticated type of alliance or partnership “encourages coordination of health services across multiple populations through *effective planning, work coordination, and ongoing evaluation of system and component performance* (Gamm 1998, 62).

Gamm’s paper reviews three case studies of hospital community collaboration that “fell short of their goals and were ultimately fragmented by competition” (Gamm 1998, 64).

In March 2000, the Toronto District Health Council published a report, Integration in Action: Lessons Learned from Networks in Toronto. The report reviewed the experiences of seven service networks in Toronto. Three of the networks addressed a specific issue in the community while four had been developed with a broader mandate to improve health services through coordination and “streamlining of care delivery among service providers” (Toronto DHC 2000, i) The networks accomplished a number of things including:

- Reducing duplication of efforts among providers
- Improving communication and understanding of system–wide and community issues
- Preparation and submission of joint reports and grant proposals
- Coordination of service delivery resulting in improved access to services. (Toronto DHC 2000, ii)

The report also found a number of barriers to effective network operation including:

- Differences among services in terms of funding, operating styles and lack of a vision/direction for health care
- Lack of experience working together, lack of trust and resistance to loss of power and control
- Power differentials based on size
- Limitations on what networks can achieve without dedicated resources
- Lack of integrated information systems and data repositories

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- Challenges and costs related to human resource issues
- Absence of government support as well as legal constraints and complexities

(Toronto DHC 2000, 13-16)

The report sets out a series of lessons learned based on the case studies and discussions with various network participants. Key points include:

- Develop a common vision and shared purpose and a common meaning for “integration”
- Determine whether overlap in client populations actually exists and whether coordinated network action will work
- Membership should be voluntary and consumers should be included
- There is no “one set structure that meets every individual community’s needs or ability to coordinate...Don’t get lost in setting up formal governance/ board structures as this may slow down discussions/planning activities related to the overall purpose of the network.”
- Formal and informal communication is important including investing in “learning how to build consensus and resolve conflict”
- Work continually on building relationships and trust
- Each organization should have an equal voice regardless of size. (Toronto DHC 2000, 17-23)

The DHC report develops a number of recommendations to government, which include the endorsement of integration as a policy direction and the creation of an incentive fund to support the development of networks including dedicated resources and information systems (Toronto DHC 2000, 24-5).

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Zimmerman and Dooley examine the dynamics of hospital mergers and conclude that by promising economic efficiency they may actually maintain the status quo since “very few of the health care mergers in the US and Canada are designed to rethink the fundamentals of health care delivery or challenge the assumption of the hospital-centric health care model” (Zimmerman and Dooley 2001, 8-9). While there may be modest improvements in utilization, less duplication and some cost savings, the evidence about improvements to health care is equivocal. They cite Mark Sirower’s 1997 study of 300 hospital mergers that concluded the few consolidate more than administrative functions and cite a study by Arista Associates (2000) of 467 multi hospital systems, which reported an increase in operating losses from the previous year and increased fragmentation in the merged systems.

Zimmerman and Dooley suggest that there may now be a demerger movement in health care as “the stories about new mergers are increasingly being offset by stories of divorce, broken engagements and divestitures”. (Zimmerman and Dooley 2001, 10).

They cite a Canadian study by Denis, Lamothe and Langley, which suggests that hospital leadership is exerted by constellations of loosely coupled professional groups, which are fragile. Mergers can disconnect the leadership constellation from its organizational base and cause it to focus inward and lose connection to the external environment/community. (Zimmerman and Dooley 2001, 18). Zimmerman and Dooley suggest that hospital mergers, which are supposed to improve integration and knowledge creation, may in fact achieve the opposite effects (Zimmerman and Dooley 2001, 22-3).

Ontario Hospital Association

In 1997 the OHA commissioned researchers at the Ivey School of Business to review the experience of twelve Ontario hospitals that had been involved significant restructuring including mergers. The findings demonstrated that restructuring is challenging for hospitals and their stakeholders and may result in declines in services, high employee stress, as well as poorly planned and executed changes. The study noted that there was insufficient time to redesign service delivery or develop new organizational cultures. The report notes:

Most changes were “executed very professionally despite the challenges their environment presented them: no additional funds, poor data on costs and outcomes, very little assistance from District Health Councils, and numerous complications from different interest groups in their communities...*structural rearrangements are not sufficient by themselves to produce satisfactory outcomes and (that) any change takes considerable time*” (OHA, 1997, 5-9).

In 1998, the OHA asked KPMG to review the experience of seven hospitals that were developing health networks in their communities. The report is more positive about the potential for health networks to improve care and integration than the study on mergers. They found evidence of both clinical and non-clinical integration. However the authors note that they were unable to objectively measure improved performance related to patient satisfaction, increased efficiency, better operational performance or “a more coherent, accessible and user friendly system of care” (OHA and KPMG 1998, 40). The report confirms the concept found elsewhere in the literature that “*a single model for health integration would not realize the innovative potential for integration*” and notes that health care networks offer “probably the most promising avenue for the achievement

of long term health care integration, (by) *proceeding on a consensual basis and treating participants as equals*” (OHA and KPMG 1998, 4).

The bulk of the literature reviewed on organizational change in health care indicates that there is limited evidence of improvements to clinical care. The change process itself is complex and improving integration or changing organization cultures or relationships takes considerable time and resources.

Corporate Sector Literature

We now turn to a review of experiences with mergers and strategic alliances in the corporate sector.

In their book Capitalize on Merger Chaos, Thomas Grubb and Robert Lamb report that in 1999 world wide merger volume jumped 36% to \$3.4 trillion. Despite increasing activity related to mergers and acquisitions, only 20% actually succeed. “Most mergers typically erode shareholder wealth, create years of chaos, fear and turmoil for their employees...they are frequently the worst planned and executed business activities of all” (Grubb and Lamb 2000, 9-10). Grubb and Lamb argue that merger mania is dangerous because it hides true failure rates, promotes squandering of valuable corporate and human resources and causes organizations to focus inward. They find that there has been a continuing pattern of merger failure since the 1950’s (Grubb and Lamb 2000, 11-16). In addition, “many firm’s gross merger failures have driven them into a death spiral. The conglomerate graveyards of the 1970’s are littered with terminally failed mergers” (Grubb and Lamb 2000, 27).

Other studies suggest that the evidence against mergers is more equivocal, but tilted against success. In a review of the literature Alexandra Reed Lajoux found mixed

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results on post merger performance depending on the criteria used. A 1991 study of 31 acquisitions found that post merger performance depends more on post merger integration than strategy. A number of studies found that mergers were more successful if they were in overlapping businesses. A 1995 Mercer study found that only 17% of the deals increased shareholder returns. Another Mercer study compared firms that merged/acquired with those that didn't from 1990 –5 and found that that non-acquirers produced superior returns. “The 1995 Mercer/BW study blamed post merger failure on inadequate due diligence by buyer or seller, lack of compelling strategy, overly optimistic expectations of possible synergies, conflicting corporate cultures and slow post merger integration” (Reed Lajoux, 1998, 3).

Susan Cartwright and Cary Cooper have identified cultural compatibility as critical to successful organizational marriages. They find that most mergers focus on financial and strategic fit issues and tend to ignore or overlook the people issues.

“Lack of expertise and product knowledge on the acquirer or parent organization’s part may inhibit recognition of needed changes to current practices and culture of the acquired organization. Conversely, an organization with a proven record and successful organizational culture will not necessarily find that their culture is easily transferable, appropriate or acceptable to others. Integrating two previously separate and often very different workforces and organizational cultures presents a major managerial challenge to those involved. Mismanagement is likely to result in poor morale, employee stress, increased sickness absence, high labour turnover and lowered productivity” (Cartwright and Cooper, 1993, 2).

They note that culture incompatibility is widely reported as a cause of merger failure and that culture collisions resulting from poor integration have a significant effect on the performance of the acquired organization (Cartwright and Cooper, 1993, 3). They studied the relationship between combining organization cultures and post merger

performance. They used Roger Harrison's typology to identify corporate culture types. (Cartwright and Cooper 1993, 5)

- A *power culture* is autocratic; power is centralized
- A *role culture* is bureaucratic and hierarchical with an emphasis on rules and formal procedures
- A *task/achievement* culture emphasizes team commitment and zealous belief in mission. Worker autonomy is high and task requirements determine how work is done
- *Person/ Support* cultures focus on egalitarianism and are more frequently found in non-profit and community organizations.

Based on the typology they are able to predict which cultures will mesh. For example, bringing together role and power cultures can work, where the role culture is the dominant partner, or combining two organizations with role cultures. Combining a power culture, where the power culture is dominant with role, task or person /support cultures is likely to fail (Cartwright and Cooper 1993, 11).

They note “the attractiveness and acceptability of the culture of the acquirer or dominant merger partner is dependent on...whether the culture is perceived as increasing or decreasing employee participation and autonomy. Changes that are perceived to impose more control on employees will encounter more resistance than those perceived as likely to increase employee autonomy” (Cartwright and Cooper 1993, 11)

Cartwright and Cooper suggest that in order for mergers to succeed, a coherent and unitary culture must be created, based on the shared perception of the partners that aspects of the other culture are worth preserving. The greater the dissimilarity between cultures the longer the integration will take. Also the more dissimilar the cultures are,

“the greater degree of change each partner will have to accommodate to achieve the middle ground and create an optimum culture” (Cartwright and Cooper 1993, 12).

They propose three types of mergers that can take into account the cultural variables.

- *Extension mergers* take a “hands off” attitude and allow the acquired organization to operate as it has historically. The differences in culture are accepted.
- *Collaborative mergers* depend on the integration of operations. Differences in cultures are seen as adding value and success is dependent on the extent the two cultures integrate or create a new “best of both worlds” culture.
- *Redesign mergers* occur when the acquirer plans to introduce major change and displace the culture of the smaller partner. “Any differences in organizational culture are considered to be potentially counterproductive, irritating and obstructive” (Cartwright and Cooper 1993, 8). Redesign mergers occurred most frequently among the companies they studied and cultural tolerance was rare.

Dooley and Zimmerman suggest that where cultures are different, even simple conversations can become combat zones.

“ At certain crucial stages small differences can amplify such that they become a dominant shaping force. Connections, patterns of interaction, or conversations are like waves that can travel through a system very quickly. The overall shape of the organization can be quickly changed by the waves of conversation at these points in the merger” (Dooley and Zimmerman 2001, 25- 27).

The preceding articles point to the need to attend to cultural issues when combining organizations. Lee Marks suggests adding cultural fit to due diligence. He cites a British study of 40 acquisitions where none of the firms assessed talent or culture

in the firms being acquired. Yet British executives cited culture compatibility as being more important than price in effecting merger outcomes. In the US “a study of 100 failed acquisitions found differences in management styles and practices between the partners to be *the major problem in 85% of the cases*” (Marks 1999, 2).

Cartwright and Cooper suggest paying attention to the Japanese experience and considering mergers as a “*strategy of last resort, when all other alternatives are considered inappropriate*” (Cartwright and Cooper 1993, 12).

Grubb and Lamb suggest that alliances and joint ventures are among the alternatives that should be considered instead of “exposing your company to the 80% probability of merger failure”. They cite a prediction from Anderson Consulting that the value of alliances may reach \$40 trillion by 2005, and note that alliances are becoming the strategy of choice in the airline, pharmaceutical and high tech industries (Grubb and Lamb 2000, 64-6).

Alliances however, are not a magic bullet. While a considerable number do not work out Grubb and Lamb argue, “the financial and business benefits from strategic alliances far surpass those from mergers” (Grubb and Lamb 2000, 70).

Booz-Allen and Hamilton, a global management and technology-consulting firm, predict that cooperative business models will become dominant forces in the world economy. Since 1998 more than 20,000 alliances have been formed worldwide and 75% of senior executives surveyed by their firm noted that alliances were effective. The move toward alliances and away from command and control corporate structures suggests “we are moving toward a ‘Centreless Corporation’ where competitive strength will be based

more on harnessing capabilities, knowledge and power of people in ways previously unknown” (Harbison, Viscio, Pekar Jr. and Moloney 2000, 1-3).

There is now evidence that alliances outperform mergers in relation to value creation and various forms of alliance models and governance approaches are emerging (Harbison, Viscio, Pekar Jr. and Moloney 2001, 5-22).

Alliances are used to fill single and multiple gap deficiencies or create integrated products and services. The authors identify four models for alliances.

- The *franchise model* is used to fill a gap in the value chain that no one partner can fill. For example Nintendo uses this model to develop games for its consoles and closely controls the activities of its partners.
- The *portfolio model* occurs when a company creates partnerships with many companies to fill multiple gaps in the value chain. Time Warner uses this approach for content, applications, distribution and software. The various partners remain unrelated, with Time Warner managing the alliances as a portfolio.
- The *cooperative model* places the alliance at the centre rather than an individual company. No one company is in control. An example of this is the Tristar alliance among CBS, Columbia Pictures and HBO.
- The *constellation model* is composed of sets of equity-based joint ventures crossing industry boundaries and is emerging in the E-Procurement industry.

The authors suggest, “the successful company of tomorrow will develop coherence between the control model and the cooperative model of alliances... The cooperative model is a shared business model that needs its own leadership, but with few ‘owners’ they need to work through some cooperative governance structure. The challenge with these models is to establish a set of operating/ performance parameters”.

As more companies develop alliances, the challenge will shift from forming them to managing them. (Harbison, Viscio, Pekar Jr. and Moloney 2001, 12-19).

In mental health care cooperative alliance examples would include the Community Mental Health Evaluation Initiative, which is an alliance among the Centre For Addictions and Mental Health, The Ontario Mental Health Foundation and the Canadian Mental Health Association. With the funding of seven research projects, the alliance now includes them. Several examples of alliances have also developed in a number of regions in Ontario to create coordinated access to case management, ACT and crisis services.

Kanter provides another framework through which to view alliances. (Kanter, 1989, 185-6).

- *Service Alliances*: a group of organizations in the same industry pool resources and create a new entity to meet a need for all of them, like an industry based research consortium or purchasing group
- *Joint ventures*: companies join together to create a new entity that neither could develop alone, usually involving technology transfer nor market access
- *Stakeholder alliances*: are complementary coalitions of groups involved in different stages of the value chain. They can involve suppliers, customers, employee organizations in various combinations

Dee Hock and colleagues developed a set of principles for an alliance thirty years ago. (Hock 1995, 6,7) The principles were:

- *Equitable ownership* by all participants

- *Power and function distributed to the maximum degree* such that “no function should be performed by any part of the whole that could reasonably be done by any more peripheral part and no power vested in any part that might be reasonably exercised by any lesser part”
- *Distributive governance* with no individual, institution or combination able to dominate or control decision
- *Infinitely malleable yet durable*
- *Embrace diversity and change*

The alliance based on these principals is Visa whose products are created by 23,000 financial institutions around the world and whose 7.2 billion transactions exceed \$650 billion annually. Visa is a non-stock membership corporation. The alliance, which Hock calls a chaord “transformed a troubled product with a minority market share into a dominant market share and the single most profitable consumer service in the industry” (Hock 1995, 7).

There are other examples of successful corporate alliances. Jeffrey Dyer has analyzed the success achieved by Toyota and Chrysler in building extended enterprise supplier networks that made the two companies the best performing automakers during the 1980’s and 90’s. While his book Collaborative Advantage focuses on the two automakers, Dyer asserts that the auto industry today is a complex product industry and suggests that the findings would be relevant to other complex product industries or industries facing horizontal integration issues.

A complex product is knowledge intensive, “comprising a large number of interdependent components, functions and process steps... When tasks are not routine and interdependence and uncertainty is high, information processing shifts from impersonal rules to personal and idiosyncratic exchanges. Investments in dedicated assets and interorganizational knowledge sharing routines are often necessary to coordinate on non-routine tasks that are reciprocally interdependent. (Dyer 2000, 18-19)

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It could be argued that health services and mental health services fit Dyer's definition of a complex product industry. Therefore Dyer's analysis may be of assistance to us in developing or assessing mental health service networks.

Chrysler changed its adversarial supplier relationships into supplier partnerships. Toyota has developed a set of interorganizational processes that ensures the supplier network is highly productive and improving constantly; Toyota's performance as a firm is a function of the performance of the supplier network. Both Toyota and Chrysler have developed production networks that collaborate effectively and achieve virtual integration. In particular Toyota's suppliers "have created an identity for their production network so that suppliers feel they are part of a larger collective. *Consequently, individual suppliers in the production network behave as though they were members of the same company*" (Dyer 2000, 3-16).

Toyota has developed a comprehensive approach to knowledge transfer between itself and its suppliers. As a result "Toyota's suppliers actually collaborate with and help each other" (Dyer 2000,15). Toyota also uses strategies such a co-location and inter-firm staff transfers to create the mindset of one company among its suppliers. These strategies build relationships among the staff in various companies and lead to an integrated approach to product development.

Toyota's knowledge transfer strategies have been critical to their success. "Over the years it (Toyota) has invested heavily in networks of communication among its suppliers...the networks promote the spread of successful practices, involving both explicit and tacit knowledge" (Dyer 2000, 60). The strategies include:

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- Organization and ongoing support of a supplier association whose purpose is to develop relationships among suppliers and provide a forum for knowledge sharing on subject critical to all members
- Provision of free consulting services to suppliers
- Development of voluntary study groups on productivity and quality improvements
- Forming problem solving teams to work on emergent problems within the network
- Inter-firm employee transfers, job rotations occur across firm boundaries, throughout the network
- Providing regular performance feedback on production, costs, delivery, quality and management (Dyer 2000, 64-86)

Dyer asserts that Toyota's knowledge transfer strategies and the stability and predictability of their processes and routines have created a high degree of trust among the companies in the supplier network. He also demonstrates that the high degree of trust lowers transaction costs and that "trust is more effective than legal contracts" in minimizing transaction costs since trust may appreciate over time due to familiarity and personal interaction. He notes:

"Toyota and Chrysler spent only about 21% of their face to face interaction time negotiating contracts and prices and assigning blame for problems. By comparison, General Motors spent 47% of its face-to-face interaction time on non-productive, transaction-oriented activities. As a result GM and its suppliers need to invest in 50% more face-to-face contact time in order to get the same number of hours of productive work time (Dyer 2000, 92-4).

T.K. Das has explored the scholarly literature on mergers and alliances and found that it is "unclear and inconclusive about the relationship between trust and control".

Some authors see trust as a specific type of control mechanism while others see trust as a

substitute for hierarchical control (Das 1998, 5). He notes that control mechanisms vary depending on the type of alliance. Trust and control are parallel concepts and the “manifestation of trust among partners in strategic alliances is tied to the type of control they use”. Joint ventures develop elaborate control mechanisms such as frequent meetings between partners and written reports. Where trust is low and the need for control is high partners may use common norms as well as regulations rather than counting on goodwill and reliability. Contract rigidity will be used to cover contingencies and deter opportunism. However, when partners trust each other “they are in a better position to appreciate the benefits of contractual flexibility, which include faster response and more efficient environmental and inter-firm adaptation. (Das 1998, 9-10).

Das notes that confidence in partner cooperation affects the formation and management of alliances. He argues that trust should not be considered a control mechanism and that the deployment of control mechanisms may either enhance or undermine the level of trust (Das 1998, 19). Trust is built through communication that helps iron out kinks in operations and allows firms to “collect evidence about their partners’ credibility and trustworthiness”.

When extensive contractual safeguards are used suspicion rather than trust may dominate the relationship. When social control mechanisms are used through the development of shared goals, values and norms a long term orientation toward the relationship develops which can be nurtured through socialization, interaction and training.

Das notes that there is overlap between social control and trust building.

Moreover, cultural norms and systems are “only nurtured slowly” (Das 1998, 12-18).

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While goal setting may be critical in the development of alliances, consensus may have to develop gradually through participatory decision-making and partners may have to tolerate a “certain degree of goal ambiguity” (Das 1998, 17).

Das suggests that managing alliance cultures can be challenging, “because it is about blending and harmonizing two organization cultures” (Das 1998, 18). Both firms may be concerned about losing their own organizational identity. And as Kanter has noted, the boundary spanners in the alliance may be perceived as being disloyal to their own organization and its interests as the alliance develops its own way of working. (Moss Kanter 1989,184).

While there has been a fair degree of attention paid to the experience of firms with alliances in the US and UK scholarly literature, the Canadian experience on the ground, especially with respect to small and medium size enterprises has only recently been documented. Industry Canada has just published the results of the National Business Networks demonstration project. The project began in 1995 and provided information, training and network support to companies in the manufacturing, aerospace, aviation and information/ software industries in each region of the country. The findings were consistent with documented international experience.

“Internationally and domestically, networking has been proven to provide many benefits to business. Research by the Australian Bureau of Statistics found that businesses, regardless of size, that participate in networks consistently out perform non- network businesses in two key areas- employment and turnover” (Small Business Policy Branch, Industry Canada, 2000, 11).

The project findings confirmed, “by facilitating the sharing of resources and the creation of trust, a network can lower the cost of doing business, create new business opportunities and reduce the risk of doing business” (Small Business Policy Branch, Industry Canada, 2000, 3).

While the study was able to document the need for government support of networking activity, it noted that government support was only continuing in New Zealand and the Norwegian, UK and Australian government programs were being discontinued. (Small Business Policy Branch, Industry Canada, 2000, 12).

Besides the lack of government support, a number of other barriers were identified which included: costs, time, lack of common objectives, geography, perceived risk and lack of champions to bring firms together. (Small Business Policy Branch, Industry Canada, 2000, 11.) Success factors were found to related to targeting specific markets and how members related to each other in the networks (Small Business Policy Branch, Industry Canada, 2000, 19).

The project objective of establishing a systematic approach to achieve inter-firm collaboration was not met. *“There was no apparent consensus on the need for an integrated systematic approach managed by a single organization”* (Small Business Policy Branch, Industry Canada, 2000, 3-4).

The private sector management literature reinforces the diversity and complexity of organizational change issues that must be reviewed and planned for. It suggests, in similar fashion to the public sector literature, that there is no magic bullet, one size doesn't fit all and the effects and benefits of organizational change requires further study by scholars. Most importantly it demonstrates that most mergers do not succeed. Alternative strategies such as the development of alliances are highly complex, and require attention to cultural fit as well as issues of trust and control. Alliances are not in themselves guarantors of success.

Implications

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What are the implications for mental health system reform? As the review of the health services literature indicated, there is limited evidence that structural or organizational reform improves clinical outcomes. There is even less about the effects of mandated collaboration. The review of the performance of mental health authorities established in nine US cities under the Robert Wood Johnson Foundation Program by Morrissey and colleagues showed that while the authorities performed well, the gains in the performance of community support systems was much more limited. (Morrissey, Calloway, Bartko, Ridgely and Goldman 1992, 15). Shern and colleagues studied client outcomes in Denver, Colorado, one of the RWJ demonstration sites. When the newly established authority experienced a fiscal crisis, reorganized clinical services and reduced case management services, client satisfaction with services decreased.

Unmet need increased and the system reform had little impact on consumers' quality of life. (Shern, Wilson, Coen, Patrick, Foster, Bartch, and Demler 1992, 24-5).

The authors note potential negative effects of centralizing services:

“ To the degree to which power and budgetary authority are centralized in one entity, management errors or unanticipated changes in the environment that adversely effect the authority may result in *more negative consequences for a city than would have been the case with a single administrative entity and several independent mental health providers*... This highlights a general problem with the increasing homogeneity of service systems that may result from centralization. *Single points of authority may be associated with an increase in standardization of services and management practices and a related decrease in options for clients in choosing between services*. It may also result in decreased flexibility to anticipate or accommodate important environmental changes” (Shern, Wilson, Coen, Patrick, Foster, Bartch, and Demler 1992, 26).

In Canada the success of the New Brunswick Mental Health Commission appears to be the result of shifting resources from inpatient beds to community services and implementing community support and crisis services in a manner consistent with the

evidence that has been accumulated about psychosocial rehabilitation and recovery oriented services.

The recent merger of four separate organizations into the Centre for Addiction and Mental Health has yet to demonstrate significant improvements in clinical care, despite a well organized and executed merger process and a focus on increasing community partnerships. The merger, which occurred in 1998, has used savings from administrative consolidations to increase programming. Patient volumes have increased by 20%. Professional education has increased by 30% and the Centre has attracted additional funding for services and research. There have also been increased cost pressures, especially with regard to information systems and labour harmonization. However, it may be 8-10 years before the merger's impact on clinical care and community capacity is known. (Garfinkel, 2001,10).

The Case Studies

The Development of the Forensic MOU

In his chapter on the environmental school of strategy, Mintzberg quotes Isaac Bashevis Singer as saying “We have to believe in free will; we’ve got no choice” (Mintzberg, Alstrand, Lampbel 1998, 286). This case explores a similar paradox, how a multi party memorandum of understanding (MOU) voluntarily emerged in the context of a mandated collaboration.

Mintzberg suggests that strategy making can be a process of “bargaining and compromise among conflicting individuals, groups and coalitions. Introduce any form of ambiguity- environmental uncertainty, competing goals, varied perceptions, scarcity of resources- and politics arises” (Mintzberg, Alstrand, Lampbel 1998, 236). This analysis can be applied to collaboration. Barbara Gray notes “under turbulent conditions

organizations become highly interdependent with others in direct but consequential ways. Under these circumstances it is difficult for individual organizations to act unilaterally to solve problems without creating unwanted consequences for other parties and without encountering constraints imposed by others” (Gray 1989, 1).

In May 1999, the Ontario Ministry of Health announced funding for assertive community treatment teams in Toronto. Assertive community treatment (ACT) teams use a multidisciplinary approach to support people with serious and persistent mental illness in the community. One of the conditions of funding was that each team would have to accept referrals from the Centre for Addiction and Mental Health (CAMH), a newly merged organization that includes the Queen Street Mental Health Centre, formerly a provincial psychiatric hospital. In addition, five of the ACT teams would also have to accept referrals of forensic patients from the Centre’s Law and Mental Health Program. These patients are people who have been found not criminally responsible for their offences by virtue of their mental disorder. Offences can range from shoplifting to murder. Three of the ACT teams were sponsored by local general hospitals and two were sponsored by CMHA.

While the funding for the ACT teams was welcome, the domain environment met the conditions described by Mintzberg and Gray as being conducive to collaboration:

- hospital restructuring, which had destabilized general hospital psychiatric units
- distrust of CAMH by general hospitals and community agencies because of its size, power and limited experience with it as a partner
- pressures on existing psychiatric beds
- a shortage of community mental health programs
- reorganization of the Ministry of Health
- increased numbers of forensic patients

The Ministry of Health also released its mental health policy document Making It Happen, which called for the streamlining of services through lead agencies, service agreements and mergers (Ontario Ministry of Health 1999, 19). This is consistent with the growing trend on the part of government to mandate collaboration. Feeney argues that

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“Too often rules and practices which are imposed by external mandates may have no relationships to the local organization and its customary practices, or even its preferences for doing its work... Increasingly the funder community -particularly government contractors- has established requirements for collaborations or consolidations in order for nonprofits to be eligible to receive contracts to deliver” services to their communities.

(Feeney 2000, 5)

While all the organizations had had some experience with collaboration, they had never worked together on a project.

Following the funding announcement, a meeting was convened by the Centre (CAMH) to discuss forensic referrals to the five ACT teams. Staff from the Law and Mental Health program at the Centre described the forensic clients they intended to refer. They stated that once these clients were placed with the teams, the teams would be on their own to manage the clients and forensic risk, as the objective was to free up forensic beds. ACT team representatives expressed disagreement and frustration and the meeting was adjourned without resolution.

The outcome of the meeting was reported to the executive director of CMHA. He said the community placement of forensic patients was a risk management issue that needed to be reviewed, especially since the forensic patients were under the jurisdiction of the Ontario Review Board, which approves custody or community supervision of persons found not criminally responsible for offences under the Criminal Code. He decided to raise the issue at the next meeting of the ACT technical advisory panel, which was providing advice to the Ministry of Health on the implementation of ACT teams across Ontario.

The panel agreed that the issue of forensic referrals to ACT teams needed review and asked the executive director of CMHA to chair a working group of panel members to develop recommendations for the panel and the Ministry. He also invited the head of the Law and Mental Health program, a psychiatrist from one of the Toronto forensic ACT teams and the Ministry official responsible for forensic issues to join the working group.

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The working group had a series of meetings that identified issues and stakeholders. Key issues identified included:

- the selection of patients based on ACT clinical criteria
- risk management
- who was responsible for the patients in the community
- emergency hospital admissions
- the role of psychiatrists
- administrative costs

It was also agreed that there should be consultation with the Ontario Review Board (ORB) regarding its views about the placement of forensic patients with ACT teams, and discussions with provincial psychiatric hospital administrators and chiefs of psychiatry.

In December 1999 a half-day meeting was held with counsel from the ORB, a representative from the provincial psychiatric hospital administrators, members of the work group, and one of the chiefs of psychiatry who was also a member of the ORB. The ORB was not prepared, for a variety of reasons, to support direct placement of forensic patients with ACT teams. Therefore, it was agreed that referral and placement of forensic patients with ACT teams should be a matter of shared jurisdiction between designated hospitals (i.e. CAMH and other provincial psychiatric hospitals) and that patients referred must meet ACT clinical criteria. The working group was given a mandate to develop a template for agreements between ACT teams and designated hospitals.

Over the winter and spring of 2000 a draft MOU was developed. Drafts were reviewed by the technical advisory panel, in meetings of the Toronto forensic ACT teams and circulated to the psychiatric hospital administrators, chiefs of psychiatry and ORB counsel for comment. By April, a consensus draft emerged which embodied the principles agreed to at the December 1999 meeting, as well as guaranteed emergency admissions to the designated hospital subject to conditions of the disposition order or the Mental Health Act and an agreement that the designated hospital would accept the return of patients ACT teams were unable to manage in the community. The MOU also provided for the joint development of a forensic risk management plan by the designated

hospital and the ACT team, with training and consultation to be provided by the designated hospital forensic program as required.

When the consensus draft was presented to the technical advisory panel, a number of members expressed concern that acceptance of forensic patients would jeopardize the voluntary nature of ACT teams and that the teams could be swamped by increased referrals of forensic patients. The CMHA executive director reminded the panel that the MOU was a template/ tool for ACT teams across the province to use if they wished, but only required for Toronto where five teams had been given resources and responsibility to accept forensic referrals. He also pointed out that the Toronto teams were in general agreement with the MOU, subject to review by legal counsel. The panel agreed that implementation of the MOU should proceed and that they would request the CMHA executive director to keep them informed about developments.

The Toronto ACT teams agreed that counsel should review the MOU for CMHA and the Centre (CAMH was to be the designated hospital) as this would expedite sign off by senior management and counsel within each organization. In June 2000 the teams agreed to revisions suggested by CMHA counsel. At a meeting held on Sept. 18th, it appeared that the MOU was ready for implementation subject to a few housekeeping amendments suggested by the Centre's counsel. However, the MOU template was not finalized until April 2001. Other priorities kept the Centre's lawyer from communicating with the CMHA lawyer. At the January 2001 meeting the teams agreed ask both lawyers to work together develop one document. This was completed in February. Four out of five MOUs were signed by September 2001.

The group also agreed to meet regularly to monitor and resolve implementation issues and appointed a working group to develop a forensic risk management template that all teams could use. In April 2001 referrals began between the Law and Mental

Health Program and the ACT teams. Law and Mental Health staff are accessible "24/7"

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by pager to the teams, and this is perceived as both important and helpful. The regular meetings have been used to share information and problem solve. A task group has been formed to meet with the police to resolve apprehension and transportation issues that have emerged.

CTO Collaboration

In March 2000, the Ontario government announced its intention to pass legislation to amend the Mental Health Act to make it easier to hospitalize and treat people with serious mental disorders such as schizophrenia. Legislation was passed in May 2000 after a furtive consultation process and proclaimed in December. The amendments, which provided for community treatment orders (CTOs) as an alternative to hospitalization, or to shorten hospital stays, were controversial.

The research literature was equivocal about the effects of community treatment orders, and opinions among stakeholders were divided. Consumer survivor groups were opposed, seeing the measure as coercive, while the Ontario Schizophrenia Society, the largest family group in the province was supportive. While the OMA and the Ontario Psychiatric Association supported the bill, the Association of General Hospital Psychiatric Services was concerned about the effects the legislation would have on demand for hospital beds, which were full before the legislation was proclaimed. They advised the government that if it were to proceed, it would need to add inpatient and outpatient resources to their services, which were already strained.

Community agencies including the CMHA were opposed to the legislation, taking the position that more services in the community and more choice for consumers was a

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better alternative than coercive measures. The Centre for Addiction and Mental Health took a neutral stance, arguing that the research evidence was equivocal, more community resources were needed and that the effects of the legislation should be evaluated. Mental health lawyers signaled that the legislation itself was likely to be challenged under the Charter of Rights and Freedoms.

Faced with this turbulent environment, the Ministry of Health and Long Term Care approached CMHA and the Centre for Addiction and Mental Health (CAMH) and requested that they work together to implement community treatment orders in Toronto. They proposed to give CAMH funding to coordinate the issuing of CTOs and the education of physicians and offered to give CMHA funding to provide case management services to people on CTOs. Ministry staff acknowledged that they had considered dispersing the funding to various hospitals and community agencies, but favoured having CAMH and CMHA manage the project because the resources were limited, coordination was needed and they felt that both organizations were acknowledged leaders in their respective fields.

There was minimal direction given except that they expected 24-7 coverage for the general hospitals and the case management funding was to be used exclusively for people on CTOs. The final “spec” was that a project proposal had to be submitted within a week, as the Minister was going to make an announcement announcing that the resources required for the implementation of Bill 68 were in place.

Notwithstanding the Ministry’s vote of confidence in the two sponsoring organizations, neither organization had worked together on a major project and both organizations faced a potentially hostile reception to the project from stakeholders.

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General hospitals were likely to be concerned that they were not being given additional resources directly and community agencies that had waiting lists for their services were unlikely to be sanguine about CMHA getting funding for what they perceived to be an unnecessary and ill-advised service.

Following the meeting about the project with the Ministry staff, the executive director of CMHA and the chief operating officer from CAMH agreed that they would quickly work together to develop a proposal. The development of the proposal was delegated to the CMHA Executive Director and the Director of Clinical Operations at CAMH. It was agreed that both agencies would sign off on the proposal a few days later. Trust between the parties expedited the development of the proposal. The CMHA executive director and the CAMH COO had worked together for over 10 years. As well, the CMHA Executive director was a member of the CAMH Board of Trustees and chaired their Community Relations Committee. (The draft proposal was reviewed and signed off at a CAMH Board retreat a few days later). The Director of Clinical Operations was a skilled administrator who early on declared his relative inexperience with the issue and indicated that he was willing to defer to the CMHA executive director who had extensive experience with community treatment orders as a public policy issue.

Both CMHA and CAMH agreed that they could work within the specifications set out by the Ministry. The resources committed by the Ministry were seen to be reasonable. However, there was some concern on the part of CMHA that restricting case management services only to those who qualified for CTOs, might create problems for the general hospitals who were expecting increased demand for outpatient and community services as a result of changes to the Act. CMHA and CAMH agreed they would not push this

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issue with the Ministry immediately but wait until the project was under way. It was expected that other stakeholders would raise this issue as the project proceeded and that it would be prudent to get a handle on the demand for case management services rather than force the issue prematurely.

Both parties agreed that the success of the project would depend on their ability to engage the various stakeholders in a collaborative process. Community agencies would need to see the project as neutral or helpful, hospitals would need to see the project as helpful. Stakeholders concerned with rights protection (mental health lawyers, PPAO- Provincial Psychiatric Patient Advocate Program) would need to see that rights protection provisions in the legislation were being followed. The Ministry of Health would need to see that the project was achieving its purpose- adding resources to the mental health system for the implementation of Bill 68 in an organized way and successfully responding to the demand for CTOs. (MOH staff estimated that 40% of CTOs in the province would be issued in Toronto).

A number of strategies were used to create a climate of collaboration:

- Creation of a joint steering committee
- Meetings with hospitals and community groups
- Convening of an advisory committee involving key stakeholders
- Training and Education
- Making project staff accessible

These strategies will be reviewed in the context of fostering a collaborative process.

Joint Steering Committee: This committee is made up of key staff from both CMHA and CAMH. Membership includes: the Vice President of Community Relations from

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CAMH the Executive Director from CMHA, the CAMH Clinical Director, the CMHA East Metro Program Director, the CMHA West Metro Program Director, the CAMH CTO program manager, and the two CMHA CTO team leaders (East and West Metro). A regional consultant from the Ministry of Health is also a member. Membership has been selected based on who needs to be there to get the job done. While the structure is asymmetrical, i.e. more CMHA staff due to CMHA's decentralised structure, both organizations have equal voice and decisions are made by consensus. As well, other staff from both organizations have participated when their expertise was needed. The Assistant Executive Director from CMHA participated in the meetings when financial issues were being discussed and the legal counsel from CAMH attended the meeting when legal issues were being reviewed. The CAMH Vice President of Community Relations was invited to provide advice about an advisory committee process and ended up joining the steering committee because of her expertise in collaboration and her interest in the project. The CAMH physician in chief will be joining evaluation research group because of his interest in this particular area.

A representative of the Ministry of Health was asked to join the committee, so that there would be a link to the Ministry regional office. While there was a risk in asking the funder to join the committee, it was felt that exposing the Ministry directly to the project environment would make the Ministry part of the team and minimize the chance of arbitrary decision-making about the project on the Ministry's part. Both CMHA and CAMH agreed to offer membership to the Ministry when the project proposal was being developed. Neither organization expressed concerns about the potential of the Ministry rep being a witness to interagency disagreements during the life of the project.

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Meetings have occurred monthly focusing on information sharing about the progress of the project and decision-making about how to engage stakeholders in the project itself. Meeting locations have alternated between CAMH and CMHA and are chaired by the CAMH Clinical Director or the CMHA Executive Director.

As the project has evolved task groups have been formed, often involving outside stakeholders to deal with various issues. Workgroups were set up to decide on the roles of project staff, the use of sessional funding for physicians and evaluation. Membership and process has been fluid, drawing on parties the steering committee deems necessary to achieve the task at hand.

For example, the sessional working group meeting was convened at the Faculty Club, chaired by the CAMH physician in chief. The 11 general hospital chiefs of psychiatry, or their designates were invited and over dinner a funding and accountability framework emerged. The funding formula allowed each hospital to decide on the use of sessional funding as long as the use of funds was consistent with the CTO project. Each hospital agreed to submit reports to CAMH every six months. The arrangement allows the hospitals autonomy and positions the project as giving the hospitals reasonable access to additional resources. As a result, a number of creative proposals for the use of sessional funds have been developed including increased provision of crisis services, client support and clinical education. Hospitals have gained resources to help them respond to pressures created by the legislative changes and have been empowered to target the sessional funding to where it is perceived to be most helpful.

A key concern for the steering committee has been how to get hospitals and other stakeholders to buy in to the project. In particular the CAMH Vice President for

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Community Relations has been a forceful advocate of collaborative processes, challenging the steering committee and project staff to “walk the talk” of collaboration. She has supported outreach to consumer survivors and their inclusion on the Project Advisory Committee and various task groups. While one of the key consumer survivor groups declined to participate, CAMH was able to draw representation from its client council. Two of the downtown hospitals have been ambivalent about the project. The message to the project staff from the steering committee in response to this has been that the project has no mandate to force hospital participation, but that the staff should continue outreach efforts and offer resources.

The steering committee decided on a “less is more approach” to memoranda of understanding (MOU) with the hospitals. As the project will involve deployment of CAMH and CMHA staff at up to 18 general hospital sites, some framework describing the relationship was felt to be necessary. A MOU modeled on the forensic MOU developed between CAMH and the forensic ACT teams was proposed. It had considerable detail that was judged by the steering committee to lead to protracted negotiations with hospitals and referral to their legal counsel. The goal was to craft an MOU that could be signed of by each general hospital chief of psychiatry rather than involve hospital lawyers and CEOs in protracted negotiations.

A “scaled down” MOU is being used based on an MOU that has been developed between the project and one of the keener general hospitals. This MOU will be used as a template. The MOU incorporates the project job descriptions developed collaboratively with stakeholders, specifies that the hospital will provide space for project staff and deals

with insurance and indemnification issues. MOUs will be signed with each hospital as arrangements for project staff are negotiated.

It will remain to be seen how many hospitals sign the scaled down MOU, as some are known to favour MOUs of up to twenty pages. One hospital who recently signed a 20 page MOU with CMHA for non-CTO case management appears to be ready to sign the CTO project MOU with a few minor amendments and two others are in progress. The project is providing services while the MOUs are being negotiated, on the assumption that giving the hospitals assistance up front will facilitate the negotiation of the MOU. While there is some risk in this strategy, it is manageable and consistent with the project focus on relationship building based on trust, rather contractual controls.

The Steering Committee has functioned as a project facilitator, focusing on project vision, attending to nuances in the external environment, rather than trying to micromanage the staff process or the relationships with hospitals and community agencies. It has also encouraged the project staff to work as a team and sort out as many issues as possible without needing to refer back. This has led to a blurring of roles between CAMH and CMHA project staff as they work together on education and training and building relationships with individual hospitals.

Meetings with Hospitals and Community Groups: From the beginning both organizations realized there would have to be good communication with the various stakeholders if the project was to succeed. During the first two months of the project the focus was on engaging the hospitals, through individual meetings between CAMH, CMHA and the hospitals and a public meeting with all the hospitals, convened by the

Ministry of Health. The purpose of individual meetings with hospitals was to familiarize

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them with the project, assess their individual needs, and try to gauge reaction to the project in advance of the public meeting. CAMH and CMHA staff used their connections with personnel in various hospitals to set up the meetings. Most hospitals responded positively to the requests to meet and the meetings themselves and indicated their willingness to work with the project. The meetings also gave the project an opportunity to communicate timeframes for hiring and deployment of project staff and discuss options for 24/7 availability.

The public meeting with the hospitals provided the Ministry with an opportunity to publicly announce the project, assess reactions and officially “hand off” the project to the two organizations. It was well attended by psychiatrists and senior clinical staff of the various hospitals. CAMH and CMHA outlined the project and emphasized that the approach would be to work collaboratively to help hospitals and physicians administer CTOs and provide additional community services to people on community treatment orders.

Presentations were brief and allowed for questions and discussion. Through the interaction the project team and the Ministry were able to glean useful information to help with project planning. While the project outline received a positive response, it was clear that the hospitals themselves were divided on whether they would implement CTOs and use the resources offered to them through the project.

A few psychiatrists felt that CTOs would only be issued by the 13 assertive community treatment teams, which had been set up since 1999. They did not see the need for the project. Other psychiatrists and their clinical staffs were appreciative that the

Ministry was providing needed resources through CAMH and CMHA. One chief of

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psychiatry allowed that his clinical staff were split 50-50 on the question of CTOs and another chief said that 90% of psychiatrists didn't want to have anything to do with CTOs. Others said that the legal complexities of the legislation and the lack of legal services for psychiatrists presented barriers to implementation.

CMHA and CAMH invited the Provincial Patient Advocate Program (PPAO) to make a presentation at the meeting on how rights advice would be provided to people being considered for CTOs. Rights advice was a critical component of the legislation and the PPAO had a mandate to provide rights advice to anyone in the community who was being considered for a CTO. The executive director of CMHA had arranged for project staff to meet with the PPAO in advance of the meeting and it became clear that rights advice was going to be the third leg of the implementation stool, CTO coordination and case management, being the other two. The presentation on rights advice added to the complexity of the discussion at the public meeting and helped the project recognize that educating clinicians about the Mental Health Act itself and the mechanics of issuing CTOs would be critical to the project's success.

The meeting ended with an invitation to those present to participate in the various work groups being developed by the project and join an advisory committee along with other stakeholders that would meet quarterly to exchange information about the project's progress and provide advice on various issues including evaluation.

Hospital representatives said that the meeting had been useful and Ministry staff indicated that they were very pleased with the meeting. CAMH and CMHA debriefed on the meeting and agreed that it had gone well.

In addition to individual meetings with hospitals, community stakeholders were approached and invited to participate along with hospitals in the working group on roles. A meeting was held with the ACT team managers and psychiatrists to discuss the project. These meetings also allowed the project to canvass participants about participation on the advisory committee.

Project Advisory Committee: The advisory committee has developed slowly for a number of reasons. First, both CAMH and CMHA didn't want to encumber the project with a committee that functioned like a Board of Directors, or management committee. They wanted to allow relationships with hospitals to develop as project staff were deployed and they wanted to ensure that project staff were not micro managed in carrying out their functions. It was also clear from the meeting with the hospitals, that the hospitals didn't have the time or expectations to actively manage the project.

Most importantly, the Advisory Committee was seen as a way for the project to engage stakeholders besides the hospitals, including some consumer and community agency groups who were opposed to CTOs. The Steering Committee agreed that the advisory committee should function as a sounding board on issues affecting the project and provide advice on how the project should be evaluated.

The first advisory committee meeting was held in May 2001 and was well attended by community agencies, family groups and consumers from the CAMH client council. There was some representation from hospitals but they were in the minority. The agenda was similar to the agenda used for the meeting with the hospitals, except that it included reports from the advisory groups that had been established on roles, sessional

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fees and training. While the audience was different than the first meeting with hospitals, there was similar equivocation expressed about the usefulness of CTOs. Concerns were also expressed about the impact that the lack of housing might have on the project, and one agency reported that some CTOs had been issued improperly. The CAMH VP of Community Relations, who chaired the meeting welcomed the comment and encouraged people to bring issues and concerns to the project staff. One of the consumers asked whether CMHA would provide case management to clients who were unwilling to accept service. The executive director replied that services would be provided consistent with the legislation and CMHA values of empowerment and noted that one of the provisions of legislation stated that the person had to be able to comply with the CTO.

The non-defensive response to dissonant or discordant issues demonstrated that the project was welcoming to different voices and could tolerate differences of opinions and negative views.

Participants at the meeting reinforced the need for education of all stakeholders and volunteered to join workgroups on training and evaluation. It was also agreed that work groups would reach out to consumers and members of ethnoracial communities. It was agreed that the advisory committee would meet at least quarterly and provide a forum for the discussion of project issues and the telling of stories about project implementation so that members could contribute to and benefit from knowledge sharing.

At the second advisory committee meeting, held in October 2001, information was shared on the status of the project, the types of services being provided and the complexity of project evaluation. The meeting was chaired by the CMHA Executive

Director and attended by members of all stakeholder groups.

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It featured a spirited discussion about whether community treatment orders were leading to improvements in people's lives or whether it was the provision of services and relationship building with clients that were leading to improved outcomes. The discussion will inform future work on evaluation strategies and it was agreed that the next meeting would feature a discussion about possible evaluation questions and options for gathering information.

It would appear that the advisory committee process/meeting serves as a method of convening the divergent stakeholder groups and keeping the project in tune with its environment.

Training and Education: Information obtained in meetings and conversations with stakeholders have confirmed that education and training will be critical to the success of the project. Prior to the legislative changes, it was acknowledged that many clinicians, consumers and families did not understand the Mental Health Act. The amendments broadened the committal criteria and established specific criteria by which community treatment orders can be put in place. The Ministry recognized the need for stakeholder education and developed a web site with materials on CTOs and the Mental Health Act amendments and initiated some limited training of psychiatrists across the province prior to proclamation of the Act.

However it was clear to project staff and the steering committee that the provincial efforts were insufficient. They did not reach most psychiatrists and clinicians in the Toronto area. Feedback at meetings and requests for project staff to conduct general rounds on the project and changes to the Mental Health Act indicated that many psychiatrists would need education if they were to issue CTOs. As well comments made at the Advisory Committee meeting indicated that community agency personnel, consumers, family organizations and members of ethnoracial communities were anxious to be informed/educated about CTOs and the other legislative changes.

Project staff and steering committee members realized that providing training and education would meet expressed needs and help position the project as helpful to the field. As well, providing information about how to meet the legislative requirements would reduce the likelihood that CTOs would be issued improperly and over turned on appeal to the Consent and Capacity Review Board.

The first wave of training rolled out in June 2001. Both project staff and clinical staff were trained about the amendments to the Mental Health Act and how to issue CTOs. The training approach itself was collaborative, involving psychiatrists and legal experts who had had experience with the legislation as trainers. While the training was assessed by participants as helpful, a limited number of psychiatrists attended. The project will have to develop a variety of methods to ensure that physicians are exposed to training, including use of rounds and workshops at individual hospitals. These will be developed as relationships are built with the physicians and clinical staffs of hospitals.

There are competing agendas regarding training. Physicians need training to become comfortable with the mechanics of issuing CTOs and opportunities to discuss best practice issues. Clinical staff at the hospitals need to be educated in order to influence physicians to use CTOs. Community agencies and consumer groups want to be educated about the legislation in order to both understand how it works and prevent abuses and in some cases use of the legislation.

Competing agendas were evident in a recent report from the Training Work group to the Steering Committee. The group presented an ambitious work plan focusing on the education of community groups, consumer and family groups. There was limited representation from hospitals on the training work group, which may explain the lack of

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focus on physician and clinical staff training. Project staff were asked to bring back a work plan that balanced hospital training with community training. This is an example of the importance of tracking, balancing and responding to competing agendas in a broad based collaborative project.

Making Project Staff Accessible: Prior to the proclamation of Bill 68, the Executive Director of CMHA participated on committee to help the Ministry develop strategies to offset the pressures for increased services that the legislation would have on hospitals and community mental health services. The provincial strategy that was developed had two components:

- help hospitals and physicians issue CTOs and connect people to community mental health services by providing them with CTO coordinators
- provide community mental health agencies with additional case management staff to provide community based services to people with serious mental illness who were placed on CTOs and people at risk of psychiatric hospitalization who needed community supports to keep them out of hospital.

While Management Board and Cabinet approved the overall provincial strategy, each Ministry regional office was responsible for the deployment of these resources. The Toronto Regional office took the position that it was important to provide hospitals with coordinators to assist with CTOs, but wanted to ensure that case management resources were directed only to people who were on CTOs, due to an anticipated high demand in Toronto.

In October 2001 the Ministry agreed that case management resources could be used to continue services to people whose CTOs have expired, as well as provide services to high need clients who identified by hospitals as needing services, arising out of the

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changes to the Mental Health Act. While this arrangement is subject to review, the agreement was expedited by the Ministry consultant on the Steering Committee who helped the project with its advocacy to senior Ministry officials.

Early on, the Toronto project communicated that a key priority was making coordinators accessible to the hospitals. CAMH has experienced delays hiring coordinators, but has been able to place coordinators at a number of hospitals that have expressed interest in using CTOs or are emerging as volume sites for issuance of CTOs. Besides training, CTO coordinators and CMHA case management staff work as a team to assist physicians and clinical staff interested in developing CTOs for clients. This often is a step-by-step process, which includes arranging for the client, or his/ her substitute decision maker to have rights advice. Where coordinators are on site, the project is beginning to observe an increase in CTOs issued compared with time periods where no onsite assistance was available.

For example, at the most recent advisory committee meeting, a psychiatrist from North York General Hospital asserted that the high number of CTOs issued by the hospital was a direct result of having staff on site and easy access to case management services for clients.

One hospital manager reported that the psychiatrists in his hospital didn't know how to issue CTOs and wasn't issuing any. Project staff arranged a meeting with psychiatrists and other hospital staff to provide training on the use of CTOs and a coordinator will be on site at the hospital shortly. The availability of staff should result in this particular hospital making use of CTOs.

One of the challenges facing the project is keeping track of the number of CTOs actually issued. Information about circumstances of issuance, access to rights advice, and process and outcomes related to connecting clients to community based services is critical to ongoing evaluation of the project and ensuring quality. Where coordinators are directly involved in assisting physicians to issue CTOs it is relatively simple to capture relevant information. However there is no requirement that psychiatrists use coordinators to issue CTOs. ACT teams and psychiatrists operating outside of hospitals are not directly connected to the project. Project staff has met with Toronto ACT teams and provided training and will be working with them to develop an information sharing strategy. It has also been proposed that the CTO information forms being submitted to the Ministry of Health be shared with coordinators, who would then keep track of them and provide a service to psychiatrists by letting them know when CTOs were about to expire. This would enable the coordinators to build a relationship with any physicians issuing CTOs.

As well the project is looking at ways to disseminate information about Consent and Capacity Board decisions and best practice information to clinicians. Information transfer is being used as a relationship building strategy, which, it is, hoped will influence the provision of services as well as inform the project about conditions “on the ground”.

Discussion

Both case studies support Gray’s contention that “collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible” (Gray 1989, 5). As she notes, both cases required identification and coordination of a diverse set of stakeholders (Gray 1989, 9). The convening of the work groups, consultations with the ORB, hospital staffs, chiefs of psychiatry, community agencies, consumers and families can be seen as representing the first phase of the collaboration which “calls attention to the ways in which the stakeholders’ concerns are intertwined and the reasons why they need each other to solve the problem” (Gray 1989, 11).

The forensic MOU and the CTO project itself reflect Gray’s criteria of joint ownership of the issue. The various stakeholders were “directly responsible for reaching agreement” (Gray 1989, 13). By sharing responsibility for the community services to forensic clients and persons on CTOs, agreeing to mechanisms for monitoring , information exchange, problem solving and training, stakeholders in both projects have assumed “collective responsibility for the future direction of the domain” (Gray 1989, 14).

Power

Mintzberg and colleagues suggest that the issue of power in relation to strategy development invites us “to move away from the idea of strategy formation as the product of a single architect” (Mintzberg, Alstrand, Lampbel 1998, 239). An analysis of power dynamics requires “an understanding of the role of organized and unorganized interests in shaping or reshaping behaviors” (Mintzberg, Alstrand, Lampbel 1998, 239). The

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dynamic interaction of stakeholders in the workgroups and meetings shaped the development of the MOU and the CTO project. The process of collaborating enabled people to redefine their positions to ensure that their interests were protected. For example, in the CTO project consumers have raised questions about the effectiveness of CTOs and emphasized the need to attend to rights protection issues. However they also see the project as a source of education and information about CTOs.

Hardy and Phillips note the importance of examining stakeholders in the domain “and asking who has formal authority, who controls key resources and who is able to discursively manage legitimacy” (Hardy, Phillips 1998, 217). This analysis of power relationships helps us “to differentiate more clearly between strategies that are truly collaborative and strategies that are not” (Hardy, Phillips 1998, 217). The Ministry of Health, as government and funder had formal authority to require the ACT teams to accept forensic clients from CAMH as a condition of funding and legislative authority to provide for community treatment orders.

Formal authority was dispersed (Hardy, Phillips 1998, 219). The Ministry of Health set the conditions that caused the collaborations, but the collaborations were shaped by the interactions of the various stakeholders and in both cases project leaders had to respond to nuances in the project environment.

The ACT teams, and the CTO project had the “scarce or critical resources” (Hardy, Phillips 1998, 219) necessary to support forensic and CTO patients in the community while the Law and Mental Health Program other general hospitals didn’t. As Hardy and Phillips state, “when one organization or group relies on another for a critical resource...the dependent organization is at a power disadvantage” (Hardy, Phillips 1998, 219).

The ACT teams were able to influence the terms of the forensic MOU and obtain agreement on issues like guaranteed admissions because they possessed the means for CAMH to free up inpatient beds through community placement. CAMH and CMHA were able to get general hospitals to cooperate in the CTO project because they had case management, coordination and training resources to offer.

The CMHA executive director and the ACT technical advisory panel had discursive authority in relation to development of the forensic MOU. (Hardy, Phillips 1998, 219). In the CTO project the Ministry indicated it was looking to CMHA and CAMH for project leadership and that both organizations were recognized as speaking legitimately for issues and organizations in the domain (Hardy, Phillips 1998, 219).

In both cases the power dynamics shifted from contestation (Hardy, Phillips 1998, 226-7) to cooperation as the collaborative process took hold. As Hardy and Phillips suggest, this was possible because power was widely dispersed and shared among stakeholders in the collaborations. (Hardy, Phillips 1998, 227).

Another key factor in fostering collaboration was the willingness of project leaders to listen and respond constructively and creatively to issues raised in the MOU drafting process and the CTO implementation process.

Domain Transformation

Lawrence, Hardy and Phillips see collaboration as a “cooperative, interorganizational relationship that is negotiated in an ongoing communicative process that relies on neither market nor hierarchical mechanisms of control” (Lawrence, Hardy Philips, 5). While the relationship between the forensic ACT teams and CAMH have elements of a supply chain relationship (the teams will provide community services required by CAMH) there is no hierarchical relationship. The forensic MOU is a new, negotiated interorganizational relationship that was developed through an ongoing communicative process.

Similarly there is no hierarchical relationship between participating hospitals and the CTO project. Resources are made available based on discussions and agreements between the project and hospitals and information about the project is freely shared among all stakeholders through a variety of means.

While the process of developing the forensic MOU was a collaborative response to mandated funding conditions, implementation has just begun. As Gray points out, multi party agreements can founder if there is ambiguity about responsibility for implementation, or lack of attention to the implementation process (Gray 1995, 85). The fact that CAMH and the Toronto ACT teams have agreed to continue to meet and discuss

forensic MOU implementation issues holds promise in a domain that has been characterized by fragmentation and mistrust. (Ministry of Health, 1999, 12).

The CTO project has used a variety of means to keep people engaged, including individual meetings, the advisory committee and workgroups, training, consultation and the provision of coordination and case management services.

The forensic MOU is being used as a model to structure relationships between the Law and Mental Health and other internal CAMH programs, and was proposed as a model agreement to describe relationships between service providers and physicians with respect to the implementation of community treatment orders. It may be that the MOU plays a different role in the CTO project than it does in the forensic collaboration. The focus is on describing the services the project will provide to the hospitals and meeting minimum requirements regarding risk management. The development of the forensic MOU was a confidence and trust building exercise aimed at minimizing risk for the forensic ACT teams and sponsoring hospitals as they accepted clients from the Law and Mental health program. Its purpose was to describe the environment under which teams would accept clients they normally wouldn't serve and provide some "control" over an unpredictable situation.

While the CTO environment is unpredictable, the hospitals are receiving resources to help them respond and "control" the environment caused by changes to the Mental Health Act. Hence there is less need for the MOU to provide a control function. Both MOUs contribute to confidence and trust in the respective projects, but they operate at opposite ends of the continuum.

At any rate, the MOUs used in both projects have already demonstrated potential to codify relationships among a variety of institutional players in the domain. This is

consistent with Lawrence, Hardy and Phillip's hypothesis that there may be a link between collaboration and the "generation of new practices, technologies and rules" within a domain (Lawrence, Hardy Phillips, 5).

The two collaborations demonstrate high levels of involvement through the bilateral information flows and the partnership arrangements (Lawrence, Hardy, Phillips, 21). Both projects were characterized by multidirectional information flows to various stakeholders. This is one of the characteristics of embeddedness (Lawrence, Hardy, Phillips, 16). Organizational relationships are non hierarchical and an extended enterprise network orientation is developing.

Both projects have used the collaborative process itself to generate trust and have eschewed the development of extensive control mechanisms. Meetings, contract flexibility, nurturing and social control mechanisms have been used to foster collaboration. Each project has had to tolerate ambiguity as it developed.

At this juncture it is too early to say whether new institutional practices, technologies or rules for supporting forensic patients in the community will emerge or endure (Lawrence, Hardy, Phillips, 17). Both projects need to assess how the collaborative process affects client outcomes and use the learnings to adjust service delivery as the projects proceed.

Finally, both collaborative projects have demonstrated some changes in interorganizational relationships but it is too early say whether this will lead to significant network transformation or capacity building. (Lawrence, Hardy, Phillips, 19-20)

Mandated Collaboration

The collaborations grew out of government funding and legislative requirements. Using the framework developed by Mintzberg and colleagues, the Ministry requirement can be thought of as an umbrella strategy where the Ministry of Health was able to exert partial control of organizational actions and was able to define "strategic boundaries or targets" (Mintzberg, Alstrand, Lampbel 1998, 191) leading to collaboration.

Once the collaborations got underway there were elements of a process strategy (Mintzberg, Alstrand, Lampbel 1998, 191). The Ministry requirements mandated a

process, but the content emerged through interactions among stakeholders. Therefore, even though mandated collaboration can be a funding or policy requirement, these cases support Gray's contention that "collaboration is essentially an emergent process rather than a prescribed state of organization" (Gray, 1989, 11). In fact, the positions and interests of the various stakeholders emerged and shifted during the process.

The collaborations were also subject to power dynamics as described earlier and have the potential to transform the domain if they are sustained over time. Further investigation of these issues could contribute to our understanding of mandated collaboration.

Based on the evidence in both cases it would appear that mandated collaboration is an emergent process, dependent on power dynamics among stakeholders in the domain. Rather than micro manage collaboration, it seems prudent for government to set the process requirement and then get out of the way and let it happen.

Reflections

As we embark on mental health systems building activities to improve organizational connectivity in each region of the province, we should be mindful of what the public and private sector literature tells us about organizational and systems change.

1. *One size doesn't fit all*
2. *There is limited evidence of organizational/ structural change improving clinical process or outcomes*
3. *Use best practices and unified funding models to drive systems change*
4. *There is a need to attend to corporate culture and human resource issues if attempting structural change or alliance building*
5. *There is a need to deal with power, trust and control issues in alliances and mergers*

6. *Rome wasn't built in a day, the development of effective collaborative relationships take time*
7. *There is a need to experiment, evaluate and learn from experience*

The case studies confirm many of these themes as well.

Proposals for increased integration or collaboration mental health must be reviewed in relation to their proposed effects on improving choice and access to services for consumers and their families. Proposals should be reviewed and evaluated in terms of their proposed effects on the eight domains of health system performance outlined recently in Accountability and Performance Indicators For Mental Health Services and Supports: *acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency and safety*. (McEwan and Goldner, 2001, 36). Collaboration whether mandated or not needs to be seen as a means to an end (better services, more choice) rather than an end in itself.

Lessons learned in other systems of health care reflect a need to think beyond command and control to fostering collaborative relationships in networks. Witness the following excerpt from a brief by Cancer Care Ontario:

“The complexity of delivering truly integrated services defies simple governance structures because the success of the networks depends on the willing commitment of many independent parties. And the skill required to effectively manage the networks differ from those required by traditional command and control structures characteristic of simple governance models (Cancer Care Ontario 2001, 14).

The current environment challenges us to rethink the way we manage and lead our organizations and systems. Mintzberg and Glouberman suggest that health care managers need to practice a craft style of management that convinces rather than

controls, and encourages identification with collective need. They argue that a command and control approach to managing health care or anything else won't work because in management "nothing can really be standardized and barely anything of significance has been codified with reliability" (Mintzberg and Glouberman 2001, 80).

They warn against hierarchical organizational approaches because "health care and disease cure are complex nuanced services. Hierarchies do not solve so much as cap the problems of cost control and coordination". Instead they suggest using networks to foster better communication and solve mutual problems and propose that society should see collaboration as more important than competition and control. (Mintzberg and Glouberman 2001, 81-3).

Or as Don Tapscott suggests "relationship capital is the key asset in for the modern corporation...the bulk of an enterprise's assets will often be the ability in influence the behavior of others- in other words, a web of relationships" (Tapscott 2001, 19). This is consistent with Ken Gergen's observation about the need for postmodern leaders to encourage the sharing of realities inside and outside their organizations (Gergen 1991, 251). In other words, it's all about relationships. Promoting this approach to organizational alignment and "walking the walk" in organizational life is a critical ingredient of leadership.

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