On Becoming New Best Friends

Integrating Front and Back Offices in Community Mental Health and Addictions

Final Report

David Reville & Associates
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Summary

We set out to “determine the potential for effective and efficient service delivery through the consolidation of community mental health and addiction agency office functions and agency services.” We gathered data primarily from interviews and a questionnaire.

We found the most activity in service integration. There’s less going on in terms of back office integration. There are just a few amalgamation discussions under way.

There is a lot of support for service integration, provided the integration is through partnerships and co-locations. However, many Executive Directors are skeptical about the benefits of back office integration. They said that in order to do any amount of back office integration, additional funding is needed. Amalgamations are not strongly supported and there is only a very small amount of support for forced amalgamations.

By far the strongest piece of advice we were given about consolidation was that the ministry needed to make it crystal clear that it wanted agencies to be working on it. The corollary was that the ministry should leave it to the sector to figure out how to do it and should provide support to the sector to help them do it. In short, the sector thinks the ministry should be clear and facilitative but not prescriptive.

In our recommendations, we suggest how the ministry could go about being clear and facilitative but not prescriptive.

We think that a policy statement about consolidation is the single most useful thing the ministry can do to encourage more activity in that area. Because we got the sense that the sector was feeling a bit tender, we’re suggesting that the ministry acknowledge the good work that has been and is being done in the consolidation area.

To get the most out of consolidation, we think that the ministry needs to make some strategic investments. We are suggesting some demonstration projects to learn what might be achieved. The modesty of our recommendations reflects our sense that, as things stand, there’s not much that can be done in terms of back office integration. We do think that agencies have back office needs that are not now being met and we think it would be appropriate to try to meet those needs with a shared services approach. We heard that even the largest agencies need expert advice in the human resources area and in employment law and that IT expertise was also in short supply.

Notwithstanding our belief that the back office is not where the sector should be putting its attention, there may be some efficiencies to be found. However, for that to happen, back office integration has to get on the agenda. That’s the rationale for supporting planning for back office (and service) integration at regional planning tables. Supporting agencies to amalgamate and supporting the evaluation of consolidation activities appear to us to be tangible ways for the ministry to show its support for consolidation work.

When talking with informants in Toronto, we heard a lot about the poor fit between LHIN boundaries and the existing service delivery patterns. There’s also a perception, both inside and outside Toronto, that mental health agencies in Toronto are disorganized. The way the sector developed in Toronto has resulted in a number of agencies that are relatively small and, although efficiency and effectiveness and size do not necessarily correlate, the sheer number of agencies may contribute to the sense of disorganization and “siloing.” These are matters that are best

addressed at local planning tables. Our recommendation is that the ministry assist the sector to develop planning tables that can deal with the special circumstances in Toronto.

Some CMHA branches are trying to get out in front of the curve and are studying the potential for back office integration. We think that the results should be shared.

Our informants frequently praised the community development skills of staff in the regional offices. We think they should be encouraged to continue in that role until the regional offices are phased out.

We were impressed by the partnerships that have been formed to deliver the service enhancements and homelessness funding. We think that they should become a feature of future investments.

Recommendation 9 reflects the concerns we heard about Consumer Survivor Initiatives (CSIs). We suspect that the leadership needs to be strengthened but we think a more thorough look is needed to really understand the needs of CSIs.

Finally, there are all sorts of reasons to share the report with the sector, not the least of which is that it will reinforce the fact that consolidation is on the ministry's agenda and that the sector needs to address it.

Recommendations

1. That the Ministry of Health and Long-Term Care issue a policy statement setting out its belief that more effective and more efficient service delivery can be achieved through the consolidation of community mental health and addiction agency office functions and agency services and that the ministry wants the sector to be actively engaged in consolidation activities. The policy statement should make it clear that the planning and implementation of consolidation should be done by the sector in each of the LHINs. The statement should recognize the valuable work that has already been done and is being done in the sector.
2. That the Ministry of Health and Long-Term Care inform community mental health and addiction agencies that any savings realized through the consolidation of office functions may be directed toward service provision.
3. (a) That the Ministry of Health and Long-Term Care invite proposals for demonstration projects that result in the sharing of back office expertise in human resources, legal services, information technology and information management.
   (b) That the Ministry of Health and Long-Term Care defray the costs of amalgamations, such costs to include fees for professional services and project management, communication and evaluation costs and layoff and severance costs.
   (c) That the Ministry of Health and Long-Term Care provide support for the planning for back office and service integration at regional networks or planning tables.
   (d) That the Ministry of Health and Long-Term Care provide support for the evaluation of back office partnerships and service integrations.
4. That the Ministry of Health and Long-Term Care invite proposals for the development and maintenance of a website that would feature best practices in back office integration, service coordination and amalgamation in the sector.
5. That the Ministry of Health and Long-Term Care provide assistance to community mental health and addiction agencies in Toronto in order to help them develop appropriate planning tables.
6. That the ministry request that the two groups of CMHA branches which are currently studying the potential for back office efficiencies make their results available to the sector. (CMHA Nipissing, CMHA Sudbury and CMHA Sault Ste. Marie; CMHA Windsor-Essex, CMHA Chatham Kent and CMHA Lambton.)
7. That the Ministry of Health and Long-Term Care make it a priority for staff in its regional offices to facilitate back office integration and agency service coordination.
8. That the Ministry of Health and Long-Term Care make working in partnership a condition of receiving funds from any new investments in the sector.
9. That the Ministry of Health and Long-Term Care invite proposals for a review of Consumer Survivor Initiatives with a view to understanding more about how to support a strong CSI presence in Ontario.
10. That the Ministry of Health and Long-Term Care make this report available to key informants and other interested parties in the sector.

Introduction

The idea of delivering mental health services to people in their communities is relatively new, new enough that the Windsor-Essex branch of the Canadian Mental Health Association, for example, didn't even exist before March 16, 1971. By the end of this year, however, that agency will be delivering about $10 million dollars worth of services and programs.

The Windsor-Essex branch, like similar organizations across the province, was established by concerned community leaders in response to the deinstitutionalization of the 60s and 70s.

Over roughly the same period, highly dedicated people, many with personal experiences with addiction, have been developing services and programs for people with addictions.

From virtually a standing start in the 70s, the community mental health and addictions sector has grown to almost 500 agencies with budgets totaling about $670 million.

Take the previous sentence apart and a different picture begins to emerge. For instance, it's misleading to talk of a community mental health *and* addictions sector. If you talk to the people who deliver addiction services, you hear things like this: "People in mental health complain they're the orphans of the health care system. That must make us the poor cousins of the orphans." Moreover, the enthusiasm for integrating mental health and addiction services is not only recent but also unevenly shared. There are those who insist that the users of addiction services are quite a different group of people from the users of mental health services, this in spite of evidence that concurrent disorders are common. Possibly misleading, too, is the "almost 500 agencies." Many of the 500 agencies are, in fact, hospitals that sponsor community mental health and addiction programs. Some agencies have more than one program number. Then there's the impression of rapid and exponential growth. The growth is, of course, relative, too; people in the sector complain that while their budgets have grown, their share of the health care budget has not.

Nor has the growth been steady. It has come in fits and starts. Over the last few years, there have been a number of significant investments in community mental health, among them "community investment," "homelessness money," "accord funding" and "service enhancements." However, community mental health providers complain that there were no base budget increases for more than a decade and that the investments that were made were not allocated evenly across the sector. Moreover, providers of addiction services have not benefited from the same level of investment that providers of community mental health services have enjoyed.

There's been a lot of scrutiny of the sector and a lot of reports have been presented to successive Ministers of Health. What is perhaps most remarkable is how similar the reports are. [The system is] "underfunded, unplanned, poorly coordinated, geographically uneven and heavily weighted toward the provincial hospitals and psychiatric units as opposed to community services." That was how Dr. Gil Heseltine saw it in the early 80s.[1] Those of us who remember that report can only sigh when along comes Senator Kirby in 2004 pronouncing that we (Canadians) still do not have "a real system in any recognizable sense of the term."[2]

The government of Ontario has embarked on implementation of a transformation agenda for health care. The government has a vision that relies on integration and on networks and on local planning and control. In this paper, we take a look at how well positioned community mental health and addictions providers are to fit into the transformation agenda and what measures the government could undertake to help the sector become better positioned.

[1] Towards a Blueprint for Change; A Mental Health Policy and Program Perspective" (1983). And see Reville, D. (2005) "Mental Health Reform: Tilting at Windmills" *Canadian Public Policy* Special Electronic Supplement, Queen's University.

[2] "Mental Health Reform for Canada in the 21st Century: Getting There From Here" (2005). *Canadian Public Policy* Special Electronic Supplement, Queen's University, p.S8.

Our Assignment

We – David Reville & Associates – were asked to "determine the potential for effective and efficient service delivery through the consolidation of community mental health agency office functions and agency services." We understood that as seeking answers to two large questions. One question was: Can agencies manage in a more collaborative way? The second question was: Can agencies deliver services in a more collaborative way?

Our Approach

We started by talking with our client. We drove out to Newmarket and Hamilton and Mississauga and St. Clair Avenue to talk to the ministry's regional people. We had teleconferences with those regional program managers and consultants who work in the north, the east and the southwest. We talked on the phone to other consultants who hadn't been able to meet in person or join a conference call. We were pleased that we were able to talk to at least two MOHLTC people in each region. They told us what was going on in their regions and they introduced us to the LHINs future. We asked them to help us develop a list of people to call. We said we were looking for visionaries, for Chief Executive Officers (CEOs) and Executive Directors (EDs) who were already engaging with the Transformation Agenda. We asked for lists of programs and budgets and names and phone numbers and e-mail addresses.

Then we made up our own list and began dialing and e-mailing. We set up interviews with 64 people and, over several weeks, we had long conversations, mostly on the phone, with them. Our phone bills are a tour of Ontario: Kenora in the northwest, Kapuskasing in the north, Cornwall in the east, Windsor in the southwest, St. Catharines in Niagara, big cities like Toronto, Ottawa, Hamilton and London, villages and towns like Seaforth and Cobourg. Most of the people we talked to manage multimillion dollar budgets. A few of the people we talked to run agencies with low six figure budgets.

We talked to providers in every part of Ontario but we were concerned that even though we'd talked to about 13% of the sector's leaders, our sample might be skewed. What if we were talking only to the converted? Our solution was to develop an e-mail questionnaire for the 200+ agencies that belong to the Ontario Federation of Community Mental Health and Addiction programs. The questionnaire provided us with data from 41 more agencies.[3]

At the end of this report there are eight appendices: three interview schedules, a questionnaire, a list of the ministry staff interviewed and two lists of the key informants in the field, those we interviewed and those who responded to our questionnaire. Appendix eight is a discussion of issues related to Consumer Survivor Initiatives.

[3] We are grateful to the staff at the Ontario Federation of Community Mental Health and Addiction programs for distributing the questionnaire to its members and for assembling the data from the returned questionnaires. The report ran to 73 legal-sized pages.

Our Findings

1.0 The Environment

1.1 Actually, we've got our hands full just now.

We wondered whether we'd come asking questions at a good time. What we found was that we were interrupting people who were very busy trying to put new programs in place. They said that they were absolutely delighted that there was new money, that there hadn't been any for so long. At the same time, though, they were struggling to meet the demand for other programs, the ones that hadn't received new money. One provider put it this way: "It's great that there's going to be new supportive housing on the justice side but that doesn't make the lineup shorter for everybody else."

While our contacts are busy with the past and the present, they are wondering about the future. They've been involved in pre-LHINs consultations and in public hearings on the legislation, but they don't yet know the effect that LHINs will have on them. They wondered whether it was a good time for us to be asking them about consolidation and integration and the other questions on our list. Maybe we could come back later?

1.2 We encountered a mild resistance to talk collaboration in the absence of more information about the impact on the sector LHINs would have.

- "We're waiting for the LHINs to kick in, so decisions aren't being made right now and there's a sense from people that 'I don't have to partner with anyone.' "
- "We're coping with LHIN restructuring – it may be logical to be discussing back office partnership at [our] planning table, but attention is focused on LHINs for now."
- "LHINs have put the brakes on integration."
- "It's a chaotic period. Nobody knows what's happening."

1.3 On the other hand, there are providers who are determined to get out ahead of the LHINs.

- "My attitude is that we should do it *before* the LHINs tell us to do it."
- "I think some of my colleagues have their heads in the sand. We need to get with the program."

1.4 Lack of information about how LHINs will function has created apprehension and speculation among agencies.

- "There is a sense of apprehension out there."
- "We need clear policy. We're all awaiting the LHIN legislation."
- "One of the fears around the LHINs is that a lot of agencies will disappear."

- "CCACs are collapsing into LHINs. Things are rolling into vertical integration."
- "I hear they're amalgamating everyone under $500,000."
- "It's hard to read the tea leaves to see what makes sense."
- "We are Davids in a world of Goliaths."

1.5 Some agencies view the LHIN boundaries with concern; these new boundaries cross their existing networks, threatening the coordination they have developed in their regions.

- "We must be careful not to destroy the networks that overlap the LHINs."
- "LHINs boundaries go right through our service; how are we going to handle that?"
- "We're in transformation right now. Who should we be in partnership with? What are the LHINs going to look like? Do we continue cross-LHIN?"
- "A lot of interlocking things have evolved. LHIN boundaries don't necessarily work for mental health."

1.6 Boundaries aren't the only concern about LHINs; there's concern about approach.

- Central East has said it will base the next round of planning on the Mental Health Implementation Task Force (MHITF) reports. There are problems with that: the reports are a bit stale and they aren't consistent. For instance, Toronto-Peel favoured a network-based focus; most of the other MHITFs recommended that there be one agency per district. That has the potential for some serious tension.

1.7 The picture isn't clearer now that we've seen the legislation.

- The LHINs legislation appears to be more proscriptive than we had been led to believe by the LHINs people.

1.8 In spite of the mild hesitation to discuss integration at this point, for the most part, agencies talked willingly enough about integration, saw integration as part of the agenda and were prepared to discuss working together (with the ministry, with LHINs, with one another) to develop – and continue to develop – models of cooperation.

Perhaps one of the strongest pieces of evidence that agencies are "with the program" came by courier early in December: an RFP from three agencies, already modeling collaboration, to develop a plan for integration. The agencies had signed off on a proposal that contained the following key messages:

- Transformation agenda in high gear
- Health services integration a priority for 2006
- LHINs will fundamentally change the dynamics of health sector governance
- Health services integration is in the "best interest" of the provider organizations

- A collaborative relationship between LHINs and provider organizations is essential to joint planning for (an) integrated system
- A collaborative relationship among providers is essential to meet LHIN expectations for health services integration
- Serious commitment, new relationships and new mechanisms are essential to collaboration at both levels

Despite LHINs-anxiety, the government's message about transformation has begun to penetrate, generating a willingness on the part of our sample of agencies to discuss back office and service delivery integration with us. A service provider put it this way: "LHINs mean partnership; LHINs mean 'don't go anywhere alone.' "

A visit by the Minister left a strong impression on one of our key informants: no more stand-alone agencies; nor more stand-offish agencies, either. We were told that the Minister said: "You will start to become new best friends whether you want to or not."

And, when you consider the extent to which back office and service delivery partnerships have been developing across the province, new best friends they have already started to become. This, in spite of the fact that providers do not always hear a unified message from the ministry. One provider pointed out that the government has changed four times since 1985; several pointed to a policy landscape littered with reports that have not been implemented.

1.9 The ministry has not delivered a clear message promoting integration. Although the Minister's message has gotten through to many key informants, Ministry decisions have not uniformly supported integration.

- "[There has been] no encouragement from the ministry to take on back office partnerships. All we hear are rumblings about mergers and other kinds of service partnerships."
- "Minister Smitherman's message has not been reinforced through the ministry as a whole; you get the same funds whether you partner or not. Some agencies are now saying, 'They haven't stopped funding me so why should I do anything differently?' "
- There are examples of agencies that have put forward co-location plans to the ministry for capital allocation but have not met with support. For instance, six agencies in Peterborough and Lindsay came together to co-locate but were unable to move forward due to lack of assets and no funding. In another instance, a proposal to centralize bookkeeping and MIS reporting two years ago was rejected by the Regional Office. Three years ago a group of agencies put forward a proposal to develop a coordinated access model by pooling surplus funds; the proposal was rejected by the ministry. "Funding decisions," one key informant mused, "don't always seem to reward integration."

1.10 This is an under-funded system.

Some providers told us that our efficiency questions were insulting and off the mark. Even with every drop of efficiency wrung out of the system, they said, it still doesn't have the resources to do the job. An informant pointed to a provincial study done for the Mental Health Implementation Task Forces (MHITFs) that showed that 50 per cent of all clients weren't getting the level of care they needed.[4]

[4] Contrast that with the 75 per cent of people needing care who get none at all. Dr. Paul Garfinkle, CEO of CAMH includes that statistic in almost all of his speeches.

- "The service integration conversation is happening everywhere – but how can people work together without an influx of funding?"

Providers complain that there's an assumption that the sector is adequately resourced and that if it could just get its act together, all would be well. Providers say that the assumption is erroneous and insulting.

1.11 Right now, there's a lot of growth in the sector. That growth has put a strain on administrative functions.

- One service provider suggests that organizations have been overwhelmed by the new money that has come into the system. This new money has gone to client service, not to administration, creating back office strain for some agencies.
- For instance, the Ottawa branch of the CMHA has added 32 new full-time equivalents (FTEs) in the last two years.
- The budget of an amalgamated CMHA Cochrane Timiskaming (formerly CMHA Kirkland Lake and CMHA Timmins) went from $300,000 to $3 million in six years.
- Supportive Housing in Peel (SHIP) grew by 200 per cent in eight months.
- York Support Services Network has grown by 50 per cent in two years, from 60 FTEs to 90.
- "Expectations increase as you become a larger organization; ignoring that organizations may break down because they can't handle the responsibilities."
- One service provider suggests that "core funding is not being shored up," and so while new programs are being added, they are "adding weight to a structure that is already crumbling."

1.12 Mental health and addiction services are delivered in very different environments.

When thinking about service models, it is important to remember that there are "four" Ontarios. There's urban Ontario, rural Ontario, there's the North, and then there's Toronto.

1.13 Key informants in rural Ontario urge rural-centred solutions.

- "It needs to be a rural model. Don't just look at a city model and think it will apply here in the sticks. Because it won't. We have no public transportation. We have no resident psychiatrists, we have no local Schedule 1 or tertiary care beds, we have limited employment opportunities for clients, we have huge housing waiting lists, we have various gaps in services, we have a doctor and all other medical service shortage, and we have a staff who have been around for many years who will be resistant to change…"
- "Geographic service area is a barrier. Understanding of rural and urban needs within the delivery model is a prerequisite."
- "As a rural agency, there may be some difficulty with distances between agencies."
- "The residential agencies are so spread out, it [back office integration] doesn't seem to make sense. Geography is a barrier."
- "[There is] difficulty seeing how we could work together: we're 45 minutes away from Peterborough; an hour away from Campbellford; 2 hours away from Haliburton."
- "It's difficult to talk about back office efficiency like in a large city. If you're in Windsor, you have public transportation. We have no public transportation in Eastern Ontario. We travel to see the client. Economies of scale go out the window."

1.14 Some key informants see geographical isolation as an impetus for developing partnerships.

- "Partnerships have facilitated the development of a broader range of services and improved access through the service connections. For example, outreach to clients in remote areas…"
- "Our isolation has contributed to our success at collaboration."

1.15 Notwithstanding a long list of examples of service coordination in Toronto, there is a strong perception among key informants both inside and outside the city that there are too many agencies and too little coordination. There is very little back office partnership or co-location among agencies in Toronto.

- "We [Toronto] have too many small agencies functioning on their own."
- "[Toronto has] a large number of agencies living side by each, and they haven't done a lot of coordinating."
- "The mental health system [in Toronto] is so big, the logistics of bringing it together are too difficult."
- "In Toronto in particular there's a hodge podge of services…"
- "Not a well coordinated sector [in Toronto]. Room for streamlining and coordination."
- "I was really shocked at how disorganized and disjointed Toronto is…I thought they would be much more coordinated."

2.0 Back Office Partnerships

2.1 There is a strong sense that the back office of community mental health and addiction agencies have been squeezed due to administrative under-funding over more than a decade.

Let's look initially at the overall reaction to the subject of back office integration among those agencies currently managing their own back office, either through their own infrastructure or by outsourcing back office functions.

- "We can do it," said one provider, "but it's not going to save any money. There's no fat in the system."
- Another executive director claimed, "Staff is doing double duty, working on the front lines, working in the back office. We don't really have a separate back end, there's nothing to extract."
- Another explained, "we lost so much ground in the 90s that our back offices are starving."

Again, the argument is that the real issue is the lack of resources.

- "We would need additional resources [to institute back office arrangements] – the back office function has been so stretched."
- "What's true in many agencies is that people have stretched their resources to deal with increased administrative requirements."
- "Without having a base funding increase in over ten years, our agency has already streamlined back office and other functions."
- "…the drive to reduce administration that has occurred over the past ten years has left agencies without the necessary administrative structure to effectively deliver service."

2.2 In larger agencies, back office functions are managed by small administrative and corporate teams.

Small agencies mainly outsource many of their back office functions to private sector companies or consultants in their communities, in particular, financial management and Information Technology (IT) functions. Often, the executive directors of small agencies perform many of the back office functions themselves, either with or without the support of an administrative staff person. Payroll and IT are routinely outsourced.

2.3 Many smaller agencies outsource payroll and IT; the Executive Director or a small administrative team (often of one FTE) does all the rest.

- One executive director described her back office as "chaotic" due to the fact that they've been doing this piecemeal for so long.
- "If your back office is an executive director, what are you going to do [to create efficiencies]?"
- When asked about the back office, an executive director responded, "You're looking at it."
- Take, for example, an agency that has one FTE for all of its back office functions. "We have one person doing data collection, accounts payable, accounts receivable and IT."

2.4 In some agencies, back office functions are provided by volunteers and volunteer board members.

- “We have a personnel committee composed of board and staff reps that do hiring and recruitment.”
- [We manage] Information Technology mostly with volunteer support or in-house expertise.
- “We have an experienced HR person on our board who chairs our HR committee and provides expert advice as required…We also have a volunteer who takes care of our website.”
- “All administration [is done] by a volunteer board of 10 people.”

2.5 Some back office functions are also provided by consumers.

- “[We have outsourced web services] to a consumer member.”
- “Payroll is done by consumers as part of their training experience.”

2.6 Back office integration is more common in the hospital sector.

- “Almost all of the back office support that I know about has been between hospitals.”
- “So many of the agencies are hospital-sponsored, so back office wouldn’t work [with community-based agencies].”
- “There are only three free-standing agencies in the neighbourhood…the others are hospital-sponsored…so there’s not much play in the back office area.”

2.7 Most providers clearly stated that in order for back office partnerships to work, further investment would be required.

- “We have a finance director, but one person can do only so much work. We would need another staff person before we could offer much in the way of help.”
- Another said, “We would help with MIS with smaller agencies but we need additional resources to do so.”
- “It costs money to set up back office partnerships.”
- “We could do it tomorrow but we would need a financial incentive.”
- “With supports and incentives, you can put agencies together left, right and centre.”
- “If new money were available, we could pull together a partnership.”
- “There are opportunities to do things more effectively but we’d need start-up funds.”
- “The ministry has to build in incentives of some kind to encourage back office.”
- “Other organizations may be struggling with hiring, finances, payroll and I’m open to working with those organizations, especially smaller organizations. The other parties would have to be willing to do it and some financial compensation would be necessary.”
- “What are the agencies going to get for this?”
- “Be clear about expectations. What do we each get?”
- “Everyone talks about partnerships but there’s no money to put them together…”
- “Our infrastructure is very lean. We do the books for the programs we sponsor. We could do it for other agencies but we’d need some more resources.”
- “Some ‘bigger organizations’ have indicated a potential to provide [back office] services for ‘smaller organizations’… However, funding is an issue.”
- “[We] could not take on work for outside agencies without additional resources.”

- "We could conceivably manage other organizations back office functions but would require additional resources."
- "[The] ministry…is encouraging these partnerships but lack of funding prevents it."
- "Partnerships require tremendous investment in resources to be effective and such resources are not available."
- "…none of the notions implied in this survey are shockingly new: the potential of benefits in economies of scale, back office integration, associative access to resources have been discussed for years – but the will and the money required to move them forward have been utterly lacking from MOHLTC."

2.8 In addition to the requirement for new investment, we found significant barriers to back office coordination, namely the absence of trust and the fear of loss of autonomy.

- "The unwillingness of smaller agencies to partner with larger agencies is due to the fear of amalgamation, the fear of being swallowed up by large organizations. The board fears loss of identity, the staff fear job loss."
- "Back office partnership is seen as the thin end of the wedge," the wedge being forced amalgamation.
- "Are we simply talking about sharing payroll, or is it a step to something else that isn't being tabled?"
- "Agencies have a vested interest in making sure they remain intact."
- "Agencies are used to being in competition with one another. That hasn't helped build trust."
- "We approached smaller agencies in a low-key way, offering to help them with their bookkeeping, to host their books on our software/hardware network; they declined because they were afraid that it would be perceived as a takeover."
- "In the lean times, agencies had their heads down. They were just trying to survive. That wasn't a good atmosphere in which to build trust."
- "Lack of trust is a barrier to back office partnership – agencies have to trust one another."
- Examples of two large community mental health agencies bear this out. Both offered back office services to smaller community agencies and were rebuffed, reportedly due to a lack of trust. One small agency offered to assist an even smaller one with its financial management; in spite of the fact that there were no strings attached, the offer was declined.

2.9 There's a difference of opinion about the importance of agencies having their own back office.

- "Organizational autonomy doesn't depend on having your own photocopier, for goodness' sake. That's a message that needs to get out there."
- "If we don't have a back office, will our capacity to develop internally be limited? Will back office sharing de-skill my staff?"
- "We might lose the on-site expertise we have developed to manage our needs."

2.10 Some key informants felt that back office integration would save little or no money; in fact, a few thought that back office integration might create new expenses.

- "There's not a lot to be harvested."
- "Coordination is OK," says one service provider, "but it won't free up a single body."
- "I'm not sure the work in coordinating back office functions would bring enough return on investment to make it worthwhile. Nickels and dimes… I'm not sure it's worth the energy."
- "I'm not sure that any efficiencies would be great enough to counterbalance the disruption."
- Several agencies looked at jointly hiring a bookkeeper but determined that it wouldn't have saved money.
- "I do not see likelihood of substantial savings. I do see the likelihood of a great deal more work, inefficiency and frustration, especially in the short term."
- "There would be limited advantages to partner for these services… We did explore a partnership in this area this past year but no savings were projected so the plan was cancelled."

2.11 Some barriers to back office partnerships are practical ones: different computer platforms and software, differing wage scales, union/non-union workforces and privacy.

- "Say both groups are unionized – different unions – what are you going to do, get rid of one of the unions?"
- "In theory, back office integration is great, but there's no consistency in the system – different salaries, benefits, hardware, software."
- "Despite the new legislation around privacy/confidentiality, there remain concerns about how to effectively and legally share client details."

2.12 The issues of responsiveness and over-centralization were also raised as potential downsides to the creation of back office partnerships.

- "Who gets served first in sharing back office?" one provider wondered.
- Another Executive Director foresees a reduction in efficiency: "I need my computer back up today. I can't wait for a shared IT person."
- "My managers would want to have the same ready access to advice, information and good return time on submissions to the back office."
- "You can be pretty much assured the person will be in the wrong spot some of the time."
- "[One] would have to assure the level of responsiveness and flexibility we require to maintain business processes."
- "With one person working for several agencies, we don't always have access to that person when we need them… "
- "Time-sensitive inquiries cannot always be answered as quickly as possible."

2.13 Many key informants saw little direct benefit for clients from back office integration. Providers emphasized the need for partnerships to benefit the client directly.

- The client "wouldn't know the difference," is a common refrain among key informants.
- "Meeting consumer needs is what all of this should be about."
- "I would expect little or no benefit to customers."
- "This should be driven by service to the client."
- "The only reason to do it is if there's a benefit to the front line (i.e., client service)."
- "Back office [efficiencies] might be invisible to clients."
- "Will it result in better service to the clients? Really? I doubt it."
- "Client, client, client has to come first."
- "…all the restructuring/transformation of agencies in the world is useless unless supported by sufficient front-line and administrative resources to deliver hands-on services to residents of our communities."
- One agency provider explained frankly why she does not pursue back office partnerships. "We have our hands full trying to provide service…there has to be a catalyst, an inefficiency in order to want to seek out change. There's no compelling reason to bother… I need five new staff tomorrow. Coordination isn't going to solve my problems."

2.14 Back office integration in respect of Information Technology (IT) was seen as useful by those who were skeptical of back office integration generally.

- As one agency put it, "Most agencies can't support an IT person. Sharing an IT person, Web designer and support through technology, we could coordinate services better."
- "I especially support the integration of the IT function: when health care organizations purchase their software independently, it costs so much more."
- "We should definitely be working better together on IT. We don't have dedicated IT positions; we could share an IT position."
- "We do a combination of contracting our IT out and relying on those in-house staff who have some facility, regardless of what else it is that they do. It's very challenging for us. We should be pooling funds among a number of organizations for trouble shooters or a system designer or a coordinator."
- "Community mental health agencies don't have salaried technical support. It's unlikely for the ministry to hire technical support for each. It would be very useful to have a shared IT support person, making it more efficient."
- "As far as IT goes, it would be great to be able to have a specialist that could be shared among agencies, as most agencies don't have a dedicated position for IT."

2.15 Sharing resources for Information Management was also seen as helpful, especially with the ministry's new MIS/CDS requirements.

- "It's rather daunting, even for larger agencies. I imagine that smaller agencies are really struggling."
- "The more technical the function, the more advantages there are [to sharing back office]. MIS is a good example."

- A number of larger organizations have offered to support smaller agencies with requirements for MIS/CDS.
- One regional consultant sees MIS as a first step toward greater integration: "MIS is driving coordination. Working together (on MIS) may be less threatening than working together clinically."
- "Help with MIS and tech support would be great for us."

2.16 Investment is needed to support partnerships in Information Technology and Information Management.

- "We would need one-time support to create standardized platforms."
- "We'd be glad to help smaller agencies with MIS but we can't do it without some more resources."
- "We would need to establish 'fee for service' to support additional staff resources to meet the demand. We have the facility and the technological resources."
- "It would be good to hear from the ministry, 'Here's some money for you to work together.' Maybe some additional resources for IT, some funds to hire consultants for IT and MIS."
- "A positive role would be to provide the incentives – e.g., 'OK, we will fund one FTE for an IT expert to share' or 'we'll give you start up funds to bring people together.' "

2.17 Sharing expertise means not having to build one's own administrative infrastructure.

- "It would be great if agencies like ours, which do not have the resources to hire senior HR and IT experts, could access a single shared resource for HR, IT, legal and labour relations advice."
- "Sharing the cost and having more skilled staff perform specific functions is the beginning of developing your own specialist staff."

2.18 A number of groups of agencies have come together, with Ministry support or resources, to share a consultant's expertise.

- The MOHTLC has funded a consultant to pilot an assessment tool and to create a shared intake and assessment process. (CMHA Durham and Durham Mental Health Services.)
- "What has been helpful to us are funds for consulting services to facilitate discussions and planning with other agencies…and to develop the tools and processes required to coordinate services. Funds for information tools and technology would also be helpful."
- HKPR Directors' Council commissioned "a roadmap to excellence" for back office partnerships and service integration.
- The CMHAs in Erie-St. Clair (LHIN 1) (Windsor Essex, Chatham Kent, Lambton) have put out an RFP for a consultant to assist them to work jointly on a plan to implement joint service and back office integration.
- Three CMHAs (CMHA Nipissing; CMHA Sudbury; CMHA Sault) have hired a consultant to assist them to look at back office efficiencies.
- In Peel, SHIP and CMHA Peel hired the same consultant to help them prepare to get MIS/CDS up and running.
- Adult Mental Health Services of Haldimand-Norfolk brought in an expert on dual diagnosis from Toronto for a day workshop and had 39 participants from other regional agencies.

2.19 Some CMHA branches across the Province are working together to find efficiencies.

- As part of a provincial network, CMHAs meet regionally, cross-pollinating ideas, helping each other with recruitment and talking to one another.
- CMHA Ontario provides access to legal and policy services for all of its branches, an efficient way to share services.
- CMHA Ontario has developed an evaluation template for the success of partnerships, which provides assistance in identifying possible challenges. One CMHA partner who used the template said "It is helpful to go through the process so that you are entering the partnership with an excellent picture of what the issues may be and are able to build the strongest partnership possible."
- A number of regional branches have also begun active processes with ministry-supported consultants to identify possible back office and other efficiencies with other CMHAs. (See above, section 2.18.)

2.20 There is a range of existing back office partnerships – from sharing a single function to total integration. Here are some examples of integrated back offices.

- CMHA Ottawa has an arrangement with Project Upstream, a housing and case management provider for the seriously mentally ill. Governed by a separate board, Project Upstream co-locates at the CMHA offices, where all of their back office functions are managed by the CMHA, including MIS/CDS, integrated client records, purchasing, bookkeeping and IT.
- In Toronto, St. Jude Community Homes and Madison Avenue Housing and Support Services have had a formal financial back office arrangement, since January 2005.
- Womankind, an addiction treatment facility, sponsored by St. Joseph's Health Care in Hamilton, has a formal relationship with New Choices, an addiction program for pregnant and parenting women and children under 6, run by the Salvation Army. Co-located with Womankind, New Choices shares the back office including supplies, parking, Internet; e-mail, photocopy, telephone; food, snow shoveling and cleaning. Apart from sharing the back office, these two organizations have also integrated some aspects of service delivery. The manager of Womankind sits on the advisory board for New Choices and together the organizations do joint programming, have joint staff, and have a common database for clients. "By co-locating with us," explains Debbie Bang, the manager of Womankind, "they have access to back office functions without having to build their own infrastructure."
  In addition, New Choices benefits from bulk purchasing with St. Joseph's Health Care, Womankind's hospital sponsor.
- CMHA Elgin assists two smaller agencies, Psychiatric Survivors Network of Elgin (a Consumer Survivor Initiative) and the Bereavement Resource Council of Elgin (a United Way agency), with some back office services. The CMHA has offered the Consumer Survivor Initiative help with MIS/CDS.
- With no administrative staff, only three FTEs and one coordination position spread over four communities, Sunset Country Psychiatric Survivors (a Consumer Survivor Initiative) has had its payroll and financial management supported by CMHA Fort Frances for the past six years. They are hoping to contract with CMHA Fort Frances for MIS/CDS as well. They have maintained their independence throughout.
- CAN-HELP, a consumer and family initiative, has no administrative staff; its back office functions are also performed by CMHA Fort Frances.

2.21 Here is a look, by function, of some highlights of current back office partnerships, along with some current thinking about back office.

Information Technology

- CMHA Durham is now exploring the provision of IT services and supports for Durham Mental Health Services, another community mental health program (DMHS). CMHA Durham has a server with a large capacity and it is investigating how to coordinate information systems.
- For its own part, Durham Mental Health Services has hired one FTE in IT. "We want to help smaller agencies. We're going to be offering support in the new year [2006]. We do it informally now, but we're going to formalize it."
- Toronto East Counselling and Support Service receives IT support from the South Riverdale Community Health Centre. See Section 3.7.

Information Management

- Durham Mental Health and CMHA Durham and some small agencies have bought a common database for MIS/CDS.
- CMHA Elgin is helping Psychiatric Survivors Network of Elgin with MIS/CDS.
- St. Joseph's Care Group in Thunder Bay provided training in MIS/CDS to small agencies in the area.
- Peel Addiction Assessment and Referral Centre (PAARC) "Our bookkeeper has already been trained in MIS by her home agency, so she will be an asset to us when we become compliant."

Financial Management

- CMHA Hamilton does the financial management for Mood Menders, a Consumer Survivor Initiative (CSI), as well as support for information management. Mood Menders maintains its own governance and autonomy.
- Several agencies informally share part-time bookkeepers.
- North Bay Community Housing Initiatives (NBCHI) has made its finance person available to the North Bay branch of CMHA which pays NBCHI for the time it uses.
- In Guelph, the Community Mental Health Clinic does payroll for some small agencies on a cost recovery basis.

Human Resources (HR)

- In the absence of HR support on staff, Executive Directors often manage the human resources duties.
- Sharing HR expertise would be a more effective way to meet needs than constantly hiring consultants.
- Some see merit in having an HR expert on employment laws and reference checking, for instance, making that their primary responsibility and sharing with other agencies.

Payroll

Many agencies outsource payroll to the private sector.

Insurance

A group of agencies presented themselves to an insurance carrier as an interrelated company, allowing one agency to provide benefits to its employees for the first time, and saving another agency $5,000 a year.

Recruitment

In an informal example, an Executive Director recently enlisted the support of managers from two local prisons to assist in hiring a discharge planner.

Audits

Some service providers suggested working with other agencies to leverage a better deal for annual audits. It is unclear whether or not this would produce efficiencies. More than one provider felt that their auditors were giving them a bargain.

Bulk Purchasing

Some agencies belong to purchasing consortia. For instance, in Thunder Bay, 12 different agencies have formed the Lakehead Purchasing Consortium through which they buy custodial paper, garbage bags, hydro and natural gas. Hospital-sponsored agencies benefit from membership in large bulk purchasing companies such as HealthPro. CMHA has a bulk purchasing agreement with Staples for its branches. Through Addictions Ontario, Alwood Residential Treatment Facility is a member of GAIN and saves money through bulk purchasing. Some agencies have abandoned bulk purchasing arrangements because they didn't work out. One Executive Director told us about a failed attempt to put together a group of five agencies to do bulk purchasing; apparently, an analysis did not demonstrate enough savings to make the effort worthwhile.

Marketing

All of the community mental health agencies in the southwest region came together to produce a common marketing brochure.

2.22 According to service providers, savings in the back office have got to be invested in service.

- "Any saving should be redirected to front line services."
- "Agencies should be allowed to retain the savings, at least for a couple of years."
- "There will be buy-in if the money goes back into the front line program."
- "One incentive would be keeping savings from efficiencies."
- "Put profits back into direct service."
- "Back office partnerships can generate resources that can be used for client services."

3.0 Sharing Facilities (or Co-location)

Many organizations are co-locating with other organizations both in their own sector and in the broader social services sector. Co-location has a positive impact on the client by creating "one-stop shopping" and a more "seamless" experience of services.

- "There is seamless service delivery when organizations are under one roof."
- "Clients shouldn't have to travel all over to get the services they need. In a client-centred world, we'd put the services in one place."
- "It would be easier for clients to access services if they were in the same building or area."
- As one service provider remarked, "If I can't serve a particular client, I can say 'let me take you down the hall and introduce you to John who does that.'"
- "[I]ncreased contacts among front-line staff tend to improve their understanding of service activities and functions that were more separate. Clients tend to have better access to 'one-stop shopping.'"

3.1 Here are a few examples of co-locations.

- North Cochrane Addiction Services (NCAS) in Cochrane, co-locates with social service agencies, health unit, doctors, mental health and justice diversion program in its two-year-old facility. Everyone shares the boardroom.
- Addiction Services of Eastern Ontario (ASEO) co-rents with CMHA in Alexandria. They also have co-location arrangements with the Montfort Hospital in Rockland and Winchester Hospital in Winchester.
- CMHA Ottawa co-locates with Project Upstream (and has a back office partnership).
- Addiction Centre (Hastings Prince Edward Counties) Inc. co-locates part-time with two community mental health agencies in Bancroft and Picton. Informally, they also share equipment such as overhead projectors, screens, and tables. Recently they shared human resources expertise when interviewing candidates for a concurrent disorders program.
- Womankind Addiction Services co-locates with New Choices (and shares back office and staff, including the manager).
- CMHA Elgin co-locates with Regional Mental Health Care which provides staff for consumers; CMHA is landlord, provides housing maintenance for nine bed residential program, policies and procedures.
- Sunset Country Psychiatric Survivors co-locates with CMHA Fort Frances in Kenora, and shares back office with CMHA Fort Frances.
- Muskoka Parry Sound Community Mental Health Service co-locates in two offices with Addiction Outreach.
- CMHA Durham plans to co-locate with an Integrated Community Health Team they have helped propose, creating joint access to primary health and community mental health care on the same site. They have made co-location arrangements with the Durham Region Employment Network (DREN) to use their eighth floor and for the Community Support Service (Peer Support Program) to use their fourth floor.
- CMHA Peel provides space for FAME (Families Mental Health Everywhere) and Peel Addiction Assessment Referral Centre (PAARC). It also provides meeting place for other community mental health agencies.

- Durham Mental Health Services co-leases with Pinewood addiction program. Pinewood offers a day program that they co-facilitate with CMHA.
- CMHA Peterborough co-locates with Schizophrenia Society of Ontario.
- Four County Crisis Program co-locates with Telecare.
- Addiction Services for York Region is planning a co-location with two other community mental health services, sharing human resources, financial management and IT. Currently ASYR co-locates satellite services with Pathways in Markham, with Family Services of York Region in Richmond Hill and with York Support Services Network in Sutton.
- Adult Mental Health Services of Haldimand-Norfolk shares space with an ACT Team run out of a local hospital. They have clients in common, and can very easily get together to discuss issues.
- There is a plan to co-locate most community mental health and addiction services in a single location in Belleville. The partners include the ACT Team, the crisis program from the general hospital, the addiction service, including the residential treatment program, the Consumer Support Service and Mental Health Services – Hastings Prince Edward. This plan was first submitted to the Ministry of Health Capital Branch in 2003.
- Mainstay Housing moved its head office into a church-owned facility which also houses two CSIs – Fresh Start Cleaning and Maintenance and the Raging Spoon Diner.
- Search Community Mental Health Services moved into a new facility in 2002 that was built specifically for their needs. They share the facility with an addiction agency; that sharing led to the development of a concurrent disorders group.
- The Salvation Army Ontario Central Division has a Scarborough Satellite program that is co-located after hours and at no charge on the site of the Scarborough Hospital Community Mental Health Program site. Their program runs Monday through Friday, 4 p.m. to 9:30 p.m.
- CMHA Huron Perth provides part-time clinic space for Alexandra Marine and General Hospital and for a psychiatrist one day a week.
- See section 4.10: CMHA Windsor-Essex and CHC.
- See section 4.6: Toronto East Counselling and Support is co-located with South Riverdale Community Health Centre
- See section 4.10: Mental Health Services – Hastings Prince Edward currently has an office in the Gateway CHC in Tweed.
- See section 4.10: Regeneration Housing in Toronto co-locates with a Community Health Centre.

3.2 Some agencies have space within their facilities that they share with other community agencies.

- In one case, these shared facilities create an employment opportunity for consumer/survivors, who provide catering for events taking place in the community space (CMHA Durham).
- The same agency is setting up a computer training room to train staff in the use of IT. The resource will soon be available to staff from other organizations at a small cost (CMHA Durham).
- Waterloo Regional Homes for Mental Health Inc. also has a shared board room that they are planning to make more available to other agencies once they move in March 2006.
- Toronto North Support Services shares its meeting space with other agencies. It has offered that space to a mental health agency with a multicultural focus, and finds that both agencies benefit, Toronto North Support Services from the multicultural expertise, and the other agency from the use of the space.

- There are also examples of agencies that work in service collaboration with other agencies and thereby second staff to work from the site of the other agency. One example is COSTI, which has a Portuguese worker out of the Toronto Western Hospital. In this example, co-location makes coordination of the program possible.
- PAARC (Peel Addiction Assessment Referral Centre) shares board room space with other agencies and uses facilities from a local mental health agency when they are closed on Saturdays. They also have met clients at another agency, when that has proven to be a more comfortable meeting place for the client.

4.0 Integration of Service Delivery

4.1 Some informants believe that, ahead of back office partnerships, the first priority should be to integrate service delivery.

- "There's money for expanding services and there's an emphasis on partnership; it's important to develop those partnerships and to get those new services out to our clients. Working on the back office should be secondary."
- "I'm less concerned about back office than I am about direct service functions."

4.2 As with Back Office Coordination, key informants identified some resistance to service delivery integration. (See section 2.8) The issue of trust is positioned front and centre as is the fear of the loss of autonomy.

- One agency manager compared integrating services with joining the European Union. "Is our culture going to be eroded if we join this big group? Will we get swallowed up?"

4.3 Some providers warned against integrating services just for the sake of integrating.

- "Integration should not be for the sake of integration, but to recognize a true value to clients and the system."
- "It makes little sense to form partnerships just for the sake of forming partnerships."
- "I currently see many agencies (especially smaller ones) rushing to engage into partnerships because it is expected of them (and because they fear for their existence if they don't) without appropriate planning and execution."
- "...the partnership needs to have value in itself – partnerships should not be set up just to satisfy a belief that partnerships, per se, are a good thing."

4.4 Philosophical differences are barriers to service delivery integration, according to key informants.

- "In Toronto, there are sharp philosophical differences between not just the three agencies that do mobile crisis intervention services but also between the three agencies and the police service. Those differences have to be overcome before an effective partnership can be built."
- "[Barriers to working together include] different philosophical points of views working with clients; even in addictions – what model do you use – harm reduction vs. abstinence models?"
- "Some people talk recovery. Some people do it. What if we see our agency as a Monday to Friday and you see your agency as a 24/7?"
- One community agency had a partnership with a hospital which was unsuccessful mainly due to their differences in philosophy, namely the community organization had a community-based (non-medical) model, as compared to the hospital's medical model.

4.5 When it comes to the integration of mental health and addiction programs, some providers of addiction services are concerned that their agencies will be overwhelmed by mental health programs.

- “People are fearful of… addictions being swallowed up by mental health and not being seen as a distinct service.”
- “CMHA approached an addiction agency to merge a few years ago, and then recently again – so far the response is ‘we’ll think about it’; they have $500K – we have $5 million; so it’s a matter of being swallowed up.”

4.6 However, some community mental health agencies have partnered with addiction agencies to provide programs for clients with concurrent disorders. Here are some examples:

- Amethyst Women’s Addiction Centre is in partnership with CMHA Ottawa in running groups for clients with concurrent disorders.
- Mental Health Services – Hastings Prince Edward is working with the Addictions Centre to develop a concurrent disorders program.
- PAARC (Peel Addiction Assessment Referral Centre) supports 20 to 25 clients with concurrent disorders and provides consultative services to Housing and Support Peel (HASP). HASP is an eight agency partnership which provides housing and support to those with mental health problems.
- CMHA Brant partners with an addiction service provider to offer a weekly concurrent disorders group.
- Toronto East Counselling and Support Service has an innovative partnership with South Riverdale Health Centre to provide primary health care, case management and other supports to individuals with concurrent disorders.
- TriCAS (TriCounty Addiction Services) has specific agreements in Lanark, Leeds and Grenville counties with Lanark County Mental Health and Leeds-Grenville Counselling and Rehabilitation to deliver concurrent disorder services.
- Eight addiction agencies and CMHA Ottawa provide 15 concurrent disorder treatment groups, co-facilitated by a CMHA mental health and addiction worker. There is an accompanying 5.5 day training program on concurrent disorders. The program is three years old.
- FourCAST and CMHA Peterborough run a concurrent disorder group.

4.7 Many agencies are engaged in a number of service delivery partnerships with other organizations in the sector.

- As one agency explains, “Service integration allows our agency to get access to a hospital doctor, to be connected to ODSP or Ontario Works, reducing the bureaucracy that can be a barrier to participants getting services that they should have.”
- Durham Mental Health Services partners with CMHA Durham to run a day program at the CMHA, with staff from both agencies.
- Waterloo Regional Homes is formalizing a partnership with CMHA Waterloo Wellington to provide a mobile crisis service.
- In Renfrew County, the three existing addiction agencies have become the Renfrew County Addiction Treatment System. They have Terms of Reference and a Work Plan. The executive committee meets monthly and they are currently developing a website and brochures.

- Mainstay Housing has created a formal "Support Service Agreement" to define mutual accountability for services between Mainstay and over 20 community and hospital-based mental health services which provide clinical support to their joint clients.
- COSTI has teamed up with the Centre for Addiction and Mental Health to provide a problem gambling prevention component for its multi-lingual treatment program. The program is delivered to twenty language communities by sixteen other agencies.
- COSTI sponsors its own awareness raising program for problem gambling with ten ethnocultural partnerships. It started as a pilot project and now receives annualized funding.
- In Toronto, COTA provides support services to tenants in partnership with Habitat services, which provides oversight and governance with private boarding houses.
- Community Mental Health Services of Renfrew is cooperating with the Phoenix Centre (mental health for children and youth) and Columbus House (a teen residential program) and Assessment Referral Service (addictions) to host SLAAMH (Students Learning About Addictions and Mental Health). They are hoping to get services into eight high schools in Renfrew.
- Adult Mental Health Services works closely with Addiction services: doing joint training, sharing the cost of a facilitator, getting concurrent service training, sharing an intake form, and assigning a specific contact with the organization as a liaison.
- CMHA Lambton provides training about mental illnesses to its local CCAC.
- Ottawa Salus and CMHA Ottawa collaborate to provide supportive housing. CMHA purchased the housing and Ottawa Salus does the property management.
- Street Outreach is a partnership of the Region of Peel with Peel Addiction Assessment Referral Centre (PAARC), Catholic Cross Cultural Services, St. Leonard's Society and CMHA Peel. They provide services to homeless people each night from a van.
- The "Dundas Osler" partnership involves COTA, Mainstay Housing, Community Resource Connections of Toronto (CRCT), and CAMH. Mainstay has two buildings, COTA works with CAMH to find suitable tenants; CRCT does individual case management and COTA provides group support to tenants in these buildings.
- Portuguese Mental Health and Addictions identifies COTA and CCAC workers with Portuguese language facility in order to create a Portuguese-speaking web throughout the system.
- CMHA Peterborough has a consumer employment partnership with the City of Peterborough for a client-run Coffee Plus on wheels. CMHA Peterborough has a similar partnership with Price Chopper to run a Coffee Plus.
- Durham CMHA operates the Hubbell Café in partnership with Hubbell Canada Inc., CMHA East Metro and Whitby Mental Health Centre.
- Human Beans is a coffee kiosk located at E.A. Lovall Adult Learning Centre, provided by Durham CMHA staff and clients in partnership with Durham Board of Education.
- Sistering co-facilitates an ongoing project for women in trauma with the Barbra Schlifer Commemorative Clinic.
- Addiction Services of York Region has a partnership with the York Catholic and Public School Board, called "Alternative to Long-Term Suspension." Students who have been suspended for alcohol/drug related offences for over 20 days receive counseling and education along with their families.
- Homeward has a partnership with Toronto (Don) Jail and Toronto West Detention Centre to deliver pre-release and post-release discharge planning for offenders with serious mental illness.

4.8 Agencies are working together to provide better access to primary care for their clients.

- A number of organizations have on-staff nurses, nurse practitioners, family physicans and psychiatrists, as well as other health professionals.
- A homelessness initiative in Peel, a partnership of Supportive Housing in Peel, CMHA, Peel Addiction Assessment Referral Centre (PAARC), Peace Ranch, India Rainbow, Trillium Health Centre and CAMH, provides clinical support (through a consulting psychiatrist) to all of the partners.

4.9 Some providers have excellent relationships with inpatient units at their local hospitals.

- Toronto North Support Services has a Memorandum of Understanding partnership with the North York General as do many other services in the hospital's catchment area.
- CMHA Peterborough has a partnership with Peterborough Regional Health Centre. Consumers have been hired to provide friendly visitation at the hospital and to help with discharge planning.
- Waterloo Regional Homes for Mental Health Inc. have two outreach staff who work in hospitals as case managers, doing discharge planning.
- CMHA Lambton County does all discharge planning for Bluewater Health (Hospital). Until recently, this service was provided by Bluewater itself.
- The CMHA in Windsor has two staff people on the ward at the Schedule 1 hospital where they do discharge planning.
- North Cochrane Addiction Services has good connections with the mental health inpatient unit at the Timmins hospital.
- Friends and Advocates Peel have an agreement with Trillium Health Centre to bring social recreation onto the inpatient ward.
- Brantford Vocational Training Association provides inreach to the psychiatric unit of the local hospital. "WE CARE" offers peer support, personal care items and information on community supports. BTVA is developing a proposal for individual visiting/peer support with patients.
- Search Community Mental Health Services partners with the Strathroy Hospital to provide an outpatient service.

4.10 There is a range of partnerships with Community Health Centres (CHCs) and Family Health Teams (FHTs), from informal client sharing to formalized partnerships in which the community mental health agency has intake staff at the CHC.

- As one executive director puts it, "I have access to primary health care, to clinical counseling services without having to own that expertise."
- Another executive director says, "CHCs are natural partners for services like ours."
- CMHA Lambton County has what it describes as an innovative relationship with a CHC in which the CMHA has fully integrated staff on site at the CHC and the two agencies work together.
- CMHA Ottawa has agreements with several CHCs in the area around case management services. The CHCs are entry points for mental health. In addition, concurrent disorder treatment groups are offered at CHCs.

- CMHA Durham recently created and submitted to the Ministry of Health and Long-Term Care (MOHLTC) a proposal for an Integrated Community Health Team (primary care and mental health services).
- Sistering has developed partnerships with four CHCs so that its clients will have access to primary health care.
- Toronto North Support Services has a partnership with French Language Health Centre (Centre Francophone) to provide case management in French.
- Toronto East Counselling and Support Service is co-located with South Riverdale Community Health Centre where they have an innovative partnership to provide primary health care services, case management and other supports to individuals with concurrent disorders.
- CMHA Windsor-Essex has a CHC as part of its organization, providing primary care to downtown Windsor with a specialization in mental health.
- A pilot project in Prince Edward County co-locates mental health and addiction services with Family Health Centres thereby improving access to primary health care for mental health and addictions clients.
- Across Boundaries, in Toronto, has partnerships with five CHCs in the community.
- Mental Health Services – Hastings Prince Edward currently has an office in the Gateway CHC in Tweed where it has a close working relationship with staff who work with their clients.
- Regeneration Housing in Toronto co-locates with a Community Health Centre, where they are able to provide complementary services and share some resources, e.g., a board room, equipment and educational sessions.
- Tri-County Addiction Services (TriCAS) in Smiths Falls is supporting a CHC in its proposal to develop a satellite in the TriCAS catchment area. The two organizations are discussing co-location.
- Options for Change in Kingston provides part-time staff to the methadone clinic at a CHC.
- Community Mental Health Clinic co-locates with a CHC in Guelph, creating many opportunities to collaborate. They share group rooms and training rooms, a post-partum depression group, an early intervention group for children and they share intake.
- CMHA Elgin has a formalized partnership agreement with a CHC, providing 1.5 FTE intensive care manager and 1 FTE social worker. CMHA provides clinical support, and the CHC provides primary health care and does intake for mental health clients.
  Integration of mental health services with the new CHC for North Durham is on the agenda of the North Durham Community Health Advisory Committee, the local network.
- CMHA Windsor-Essex County Branch, Leamington District Memorial Hospital, Hospice of Windsor and Teen Health Centre have developed a successful proposal for a Family Health Team.

4.11 Other providers are looking for ways to create better partnerships with primary care providers.

- Sistering, in Toronto, has identified a gap in communication with hospitals. It wants to be seen as a partner in case management and discharge planning to ensure that women are not being discharged into homelessness.
- “We need messaging from the ministry that is a strong recommendation to hospital administrators about the benefits of integrating; encouragement to form partnerships with community mental health and seriously marginalized people – so they can be seen as legitimate partners.”
- “How to get more doctors on the front line is a big issue for us. We often have clients going

a long way for their appointments or using televideo to connect with their doctors."

- "Better service coordination between addictions and primary care service providers would also be beneficial since the majority of our clients don't have a family physician and it is very difficult to find a family physician who is taking new clients."
- "Some clinical pathways, currently, are in need of better coordination. In particular, clients admitted to hospital and then discharged without the input or involvement of a case manager…"
- "I see value in service partnerships with professionals and agencies that provide primary care services."

4.12 Community mental health and addiction agencies have been developing formal relationships with police services.

- Durham Mental Health Services has a program with the police called the Advanced Mobile Team. A written agreement provides for the secondment of a police officer forty hours a week. Mental health workers and the officer provide follow up and education; advocacy; training in squad rooms with front line officers.
- York Support Services Network has a community crisis service which includes a 24/7 crisis line, a mobile response team composed of plainclothed police officers and mental health workers and 4 safe beds.
- Halton Peel has a mobile crisis service with police involvement.
- "We've partnered with the OPP for crisis intervention. We can call on them for assistance as needed and the OPP can get a fast response from us."
- The Chatham-Kent branch of the CMHA, the Chatham-Kent Health Alliance, ACT Team and Chatham-Kent Police Services have partnered in the development of the HELP Team, three police officers per platoon and some support staff partnered with mental health agencies. There's a protocol that provides for the interaction between the partners. The partners also provide much of the training for HELP Team members.
- Adult Mental Health Services work closely with the OPP on their crisis program. The OPP has designated a liaison officer.
- Womankind Addiction Services has a new partnership with the police, through the Hamilton Addictions System Coalition (HASC). Programming is emerging.

4.13 Duplication and coordination

When we asked about duplication in the sector, we provoked some strong reactions. One of the most common responses is that there is not enough capacity in the sector to meet the needs of clients. It is a question of having too little capacity, not one of having too many organizations.

- "Duplication is only duplication if the need is met or more than met. Here, the need is greater than the services being offered."
- "There are not enough services, so there is not a lot of duplication."
- "There isn't enough of any of these services, so duplication is not relevant."
- "It's so sparse in terms of mental health programs…you can only have efficiencies if you have too much service"
- "There are long waiting lists – so little in the way of mental health services, so it's difficult to have duplication."
- "There isn't duplication, there are gaps in service."

- "There aren't too many organizations; they're just too fragmented. They need to be puzzled together."
- "There's no shortage of work to be done, so it's a matter of coordination, not duplication."
- "The demand for service is so large that no matter what we do we just don't have the service volume to meet the needs."
- "We need many doors. That's one of our strengths. It sometimes looks like we have too many organizations. But they are niche service providers. The richness provides a lot of value to the system."
- "We do not see that roles played by partners are duplicative or excessive."
- "[With service integration, there is] no wrong door."
- "[Coordination means] fewer 'entry' points for clients to manoeuver."

4.14 Agencies are involved in a number of partnerships to better coordinate services.

- Mental Health Grey Bruce is a legal partnership comprised of three agencies that offer co-located services at five team sites, with four core services being delivered in an integrated fashion. Each Team has a Team Leader who is responsible for day-to-day operation of the Team. The Teams have standardized eligibility criteria and intake and assessment procedures. A joint clinical record is compiled for each Team client. At the point of intake each prospective client is informed about the model and required to sign a multi-agency consent form. Mental Health Grey Bruce also operates a shared website.
- With more than one agency doing case management in Ottawa, a partnership for co-ordination of eight organizations was struck in 1998. Known as Mental Health Community Support Services, it provides centralized intake – a coordinated access point into case management – for the district, with CMHA Ottawa as the lead agency. The common waiting list is a priority list based on acuity. "The door to case management is right where the people happen to be."
- A centralized intake project in Hastings and Prince Edward Counties is nearly ready to be implemented. There will be a single number to call. The prospective client will be screened, triaged and referred to the appropriate mental health and addiction services on the phone. Because there are long waiting lists, the client will be offered a peer support in the meantime.
- Four intensive case management agencies are avoiding duplication through centralized intake and a managed waiting list; all the information is kept at the Hamilton Program for Schizophrenia. The partners are CMHA Hamilton Wentworth; Wellington Psychiatric Outreach; Community Mental Health Promotion Program of City of Hamilton and St. Joseph's Health Centre.
- The London Mental Health Alliance has centralized and streamlined access to mental health services in London in order to reduce duplication and the number of times a client has to tell his or her story.
- A common client record (CCR) or electronic patient record is administered by CMHA London in collaboration with London Mental Health Crisis, WOTCH, Women's Mental Health Resources, Court Diversion, and justice-related crisis beds at St. Leonard's. (The hospitals do not yet share the CCR).
- Partners Community Mental Health Clinic, the CCAC and St. Joseph's Hospital provide a new specialized geriatric service using the same assessment and referral forms and additional staff.
- An Assessment Case Management Worker, working out of Serenity House, is a district position for all of the Champlain District. The worker goes out and conducts assessments and referrals for clients deemed to need residential treatment. An advisory group reviews the position.

- The Huron Perth Mental Health Network operates within a legal agreement to do common assessment, referral forms and process; a common website; common information sharing "release" protocol; education of staff and community; volunteer development; information and referral protocol and customer service. "At a front-line level, staff operate as a team, respecting the roles of each program entity."
- CMHA Durham is involved in a project to coordinate its intake and assessment process with Durham Mental Health Services (DMHS), another community mental health program. This project addresses the potential duplication of client data collection and differences in the way clients are assessed by each agency. They will also be working with the University of Waterloo to pilot the RAI-CMH Assessment tool and are now working with DMHS to create a shared intake and assessment process.
- The Toronto Housing and Support Services Directors, a network of all 31 supportive housing agencies has developed a "Coordinated Access to Supportive Housing" model, which includes: detailed inventory; clear agency description, a common application form and intake model to ensure good matches between consumer-survivor and housing. The ministry has recently provided funding to assist in implementing the model.

4.15 Agencies are working together on projects coming from new investment.

- The ministry encouraged the development of partnerships when it issued an RFP for the Phase 1 Homelessness Initiative. Regeneration House, for example, partnered with CAMH, Impact ACT Team, Women's Residence, Hostel Outreach Programs and Reconnect ACT Team.
- For the Mental Health and Justice funding, known as "service enhancements," the ministry also required agencies to form partnerships. In Toronto, five agencies have come together to provide housing supports, for instance. Four agencies are building a safe bed network. Several agencies are doing pre-charge, outreach and crisis prevention. A lead agency has been appointed for each of the services; the lead brings the other partners together to sort through operational issues.
- "[The Schizophrenia Society] received ministry funding to deliver early intervention services in the Toronto area in partnership with two other mental health agencies, the Mood Disorders Association of Ontario and the Family Outreach and Response program. This was the first time the ministry facilitated partnership development of any kind for us."
- The ministry basically said "if you want this money, you'll have to get together with other agencies and work it out together." (This is a reference to partnership requirements that the ministry linked to participation in recent investments.)
- "Early psychosis intervention and the court diversion program are collaborative efforts. Previously our mindset was more competitive. We were always looking out for how we could feather our own nests."

5.0 Mergers

Our questions about mergers caused a *frisson*. The first service provider we interviewed looked at our instrument and exclaimed: “I didn’t realize that mergers were back on the table.”

5.1 When it comes to mergers, there is a strong voice of opposition.

- As one key informant noted, “Agencies don’t need to merge, just to connect.”
- Another claimed, “When you put two agencies together, it causes a lot of stress, you don’t get buy in.”
- As one key informant put it, “It needs to be finessed, not forced. Don’t just clap them together. Clients will suffer if organizations are just whacked together.”
- One service provider agrees with the government’s direction, with a simple caveat, “People are working harder together. It doesn’t mean everyone needs to merge.”
- “There will be huge resistance to anything smacking of amalgamation.”
- A key informant says, “People will have a hard time with mergers. Don’t treat agencies like they’re disposable things.”
- “Clients prefer smaller agencies where they know everyone.”
- “Honest communication, values, principles and ethics… are essential to effective service delivery, not mergers or amalgamations.”
- “I’m all for partnerships and ongoing discussion with my community partners, but mergers don’t have to occur to achieve this… ”
- One provider referred to a recent amalgamation and remarked “There are not a lot of efficiencies coming out of integrated agencies.”
- One Executive Director has had the experience of merging two large organizations into an even larger one – which wound up affecting service negatively.

5.2 Agency representatives express concern about job loss when it comes to amalgamations.

- “People fear losing their job, and are afraid of takeovers.”
- Providers prefer to see mergers between agencies when one executive director is leaving naturally, as in the case for North Cochrane Addiction Services when one of the executive director positions was vacant at the time of merging.
- Addiction Centre Belleville partly attributes the success of their merger to the fact that one of the executive positions was vacant at the time of merger.
- “A solution and savings are possible if people can work in an environment that reduces personal risk and the fear of significant job loss.”

5.3 Some key informants argue that the creation of larger organizations doesn’t benefit clients.

- “I’m leery of merger by edict because I think what it sometimes produces is large organizations consuming smaller organizations. Oftentimes, the smaller organizations were serving marginalized communities and were created because larger mainstream organizations were not being responsive to those communities…”

- "We shouldn't be turning community resources into institutions."
- "Larger organizations tend to be more cumbersome and less able to respond to the community's changing needs."
- "In some sectors, bigger is better… Not in this sector."
- "Centralization isn't always an option – geography prevents it; right sizing might mean a loss of service so in some situations, it's best to keep a less efficient operation."
- "Do you want little organizations that are close to the hearts of people, or do you want larger organizations?"
- "Fewer service providers doesn't mean better outcomes."
- "Larger organizations are prone to be less flexible and responsive to their constituencies."
- "[A]malgamating agencies has the potential to create institutions, which come with their own set of problems and grow into hierarchies where administration becomes top heavy and procedures complex."

5.4 Some service providers believe that one of the results of mergers would be the reduction of access points for clients.

- "Centralization can be a problem, because then we're creating a barrier – narrowing the funnel – which could lead to clients being able to access service only through one particular organization; should not be making client get to the right place; rather it's about getting the service to the client."
- More than one interviewee warned of becoming too streamlined, and therefore "the only game in town."
- "It would be a crime to diminish access points for this sector."
- "If too centralized, access for smaller places is compromised."
- "Avoid streamlining access and communication to the point that one agency is the sole provider."
- "You need multiple and varied access points. Multiplicity of access points is good for patient care."
- "Reducing the number of sites could be a problem for access."

5.5 Underlying the resistance to mergers is a strong belief that choice for clients should be maintained.

- "I question the benefit of mid-size agencies merging. The risks are that you become more intimidating to the client, or more bureaucratic, risk losing communication and connections to volunteers, and the local board."
- "It's important to give clients choice; they don't get much in their lives."
- "Clients want choice. They may not want to deal with a mega-agency."
- "Offer choice to the client; don't lose that."
- "Consumers should have choice; mergers would reduce client choice."
- "We want to allow for client choice: not become a cookie cutter."
- "Smaller agencies are just right for some clients – different doors meet different needs."
- "Not sure bigger is better – with big huge structures, there's no choice for the client, smaller budgets get eaten up. Better to have more choice than big institutions.
- "Choice of services… equals empowerment of users of service!!!"
- "Would mergers/amalgamations limit consumer choice?"

- "The cornerstone of service reform, even reforms aimed at cost containment, should be the expectation that individuals and families will be better off, that their supports and choices will be improved."

5.6 Key informants provided a some examples of agencies that failed to merge.[5]

- One $5 million mental health agency spoke of having approached a $500,000 addiction agency about merging. "They have $500,000, we have $5 million, so it's a matter of being swallowed up. Another barrier is that we have different philosophical approaches."
- A housing provider in Toronto was approached by two agencies to talk about formal mergers, one a community mental health agency and the other an addiction service provider. The board did not think they were good matches philosophically so the merger did not proceed.
- The ministry requested that a small agency merge with a larger agency in London. When the small agency said they'd rather merge with a different agency, the ministry "backed off."
- A 17-bed residential addiction service was approached by two agencies to talk about formal mergers. The board did not think either agency was a good match. One was a mental health agency and the other was a twelve-step addiction service. The residential addiction service has a harm reduction philosophy.
- A housing initiative in North Bay approached the local CMHA to merge, but the CMHA declined.
- "The MOHTLC locally did encourage the board to consider a merger…(with a CSI in Windsor) at one point. A board advisor developed a review of the potential operating benefits and reviewed operating efficiencies in detail. Based upon that review, the board concluded there were minimal efficiencies to be realized from the proposed merger."
- "Before [an East York mental health agency] hired their recent executive director, [a supportive housing agency's] Board of Directors proposed to their board a strategic management direction that the two agencies merge. This overture was unsuccessful."
- "Several years ago, we were approached by another agency to amalgamate, and the two boards met for six months to discuss the proposal." Discussions ended when it became clear that one board did not share the other's commitment to issues such as diversity, harm reduction and outreach.
- "As a small agency we have actively pursued amalgamating with other agencies. The board of our agency has been clear that amalgamation should lead to an enhancement of service delivery. However, the cost analysis that was conducted indicated that service amalgamation would lead to a decrease in service in the east end of Toronto…"

5.7 A few service providers felt mergers were a good idea.

- One service provider thought that agencies with fewer than five FTEs were too small and that such agencies should be merged with larger ones. Our informant was quick to add that Consumer Survivor Initiatives, almost all of which have fewer than five FTEs, should be exempted from that rule.[6]
- A few service providers, mainly on a confidential basis, mentioned agencies that they felt should be merged or "unfunded."
- One key informant suggested that if agencies "are not involved in partnership, they don't deserve to survive."

[5] It is not our intention to identify specific agencies for possible merger, as we do not have adequate information on which to base such advice.
[6] See Appendix 8 for more on CSIs.

- "Mergers can make good sense if clients benefit and there are service efficiencies, but just to make a great large organization doesn't make sense."
- "There are too many agencies; some should merge."
- "I'm in favour of mergers. They should be done by a third party consultant – don't let the staff make all the decisions; it should be a combination of staff and the board and the ministry."
- "I would advocate merging only if local partners think it's beneficial."
- "While I agree with some amalgamation, I think we need to be very cautious and go about it slowly."

5.8 Some providers suggested that the addictions side is further ahead in terms of mergers because of the "rationalization" of the late 90s.

- "The addiction system has taken major steps toward [integration] and I believe the mental health system could benefit from the lessons learned in that sector."
- "Addictions is far ahead in terms of system integration."
- "[Addictions] is more coordinated than the mental health sector."
- "There was a lot of pushing on the addictions side (1995-96)."
- "The addiction field has made great strides in planning and developing protocols and tools to streamline and improve our system."

5.9 Some service providers spoke of mergers among addiction agencies that were seen to be successful.

- Addiction Centre (Hastings Prince Edward Counties) Inc. (Belleville): Five years ago, Addiction Centre (an outpatient agency) was asked (by the ministry) to assume the management of a residential facility. The success of the merger is attributed in part to geography (both agencies were in the same city) and to the fact that one of the managers left naturally.
- Womankind (addiction services): In 2004, Womankind took over the residential treatment and aftercare from Mary Ellis House when they realized the program would be lost due to financial difficulty. Board members from Mary Ellis House are still part of the Womankind board. They had to bring together non-union and union staff, devise a different working model, a new vision and a mission statement, as well as a new logo. Another merger, with a men's withdrawal management provider that is currently managed by Womankind is expected in 2006. A number of issues, in particular salary differential, and different unions, complicate the merger.
- Initiated by the Ontario Substance Abuse Bureau's Integrated Service Plan, FourCAST (an addiction agency) has successfully merged with two other small programs.
- In 1990, TriCAS (TriCounty Addiction Services) commenced discussion with two other small addiction agencies in the region to encourage merging their three operations. Two of them amalgamated by 1992 and the final combination of the three agencies was accomplished in 1996.

5.10 Those who have come through mergers talk about things that might have been done differently.

- For instance, in Grey Bruce, the home of a very successful legal partnership, there were two mergers, both of them forced. The ministry ordered an organizational review of Bruce Peninsula Health Services, a small housing and vocational rehabilitation program. The result of the review was a merger with Grey Bruce Community Health Corporation and that didn't

sit well with CMHA Grey Bruce. Another agency, Bruce Shoreline, decided not to join Mental Health Grey Bruce and was eventually dismantled by the ministry and its resources given to CMHA Grey Bruce. It is said the bitterness still exists, many years later.

- In 1999, all community mental health services in Renfrew County were amalgamated. Although the amalgamation was ultimately successful, it took many years of "disgruntlement" to realize that success. "We didn't spend enough time to engage the staff of the other services, we didn't do enough team building; we didn't do enough valuing of the history of the other services."
- The 2003 merger of CMHA York Region with Mental Health Services of York Region faced a number of challenges but has succeeded in bringing the two organizations under one Executive Director. The success is in part attributed to the ability to use surplus funds toward merger costs and to the fact that the former executive director of Mental Health Services became the Director of Clinical Services and therefore an executive job was not lost. (see section 5.2).
- In January 1999, the community mental health program at Pembroke Regional Hospital merged with the program out of the local public health unit and the Renfrew Victoria Hospital. The director of the Community Mental Health Services at Pembroke Regional says, "It's better if you don't force it. Our amalgamation benefited everyone in the long run. But it was very painful for a long, long time."
- "In 1997, when some programs were closed, we were asked to pick up services; [it would have been] much more healthy if [the merger had been] voluntary; clients were upset; people picketed programs; [mergers have] to be done in a collegial and consensus-building way."
- Mental Health Services – Hastings Prince Edward "was formed in late 2002 by dissolving two existing boards, forming a new corporation to accept the two groups of staff and finally adding more staff from a third agency. There was much time and money spent on the process… significant distractions created and sustained uncertainty for both consumer and staff over two to three years. This had a detrimental effect… I believe integration of services can be accomplished to achieve benefits without the trauma and expense of amalgamation."

5.11 Some agencies are either considering now or are open to amalgamating.

- Two CSIs in Sudbury – Peer Support of Sudbury and Northern Initiative for Social Action (NISA) – are discussing a merger.
- Mainstay Housing, the largest community based mental health housing and support agency in Ontario, says that it is open to discussing amalgamating with smaller organizations.
- Discussions about an amalgamation are underway between St. Jude Community Homes and Madison Avenue Housing and Support Services. "The process is underway. However, we must avoid threatening language at the onset – 'mergers,' 'amalgamations' – and let these relationships evolve naturally as we are confident they will. We believe in the 'courtship, engagement and marriage process.'"
- Serenity House [in Ottawa] indicates that "Yes, we are considering amalgamating the six charities that we now share all services with, but we can't until our gaming revenue is replaced by regular funding." They are able to run only one bingo if they amalgamate.
- An Ontario-wide association has "had discussions with a couple of different family organizations about amalgamation. However, these are very preliminary."
- One potential merger is on hold because one of the partners "has been hesitant to delve into the planning stages with us because they are uncertain of the new LHIN structure and how it will impact us."

6.0 Advice from the field: Conditions for successful integration

Our informants had lots of advice about how the ministry (or LHINs) could best support integration, both in the back office and in service delivery.

6.1 As seen in Sections 2, 3, 4 and 5, many service providers are already undertaking integration projects in various ways, both with and without ministry incentives. However, when it comes to back office partnerships and mergers, many service providers, reluctant to pursue these forms of integration, are requesting clearer leadership from the ministry.

- "Create opportunities to improve performances; give agencies the opportunities to meet expectations with transparent policy."
- "The ministry should be doing a lot more coordination…should be taking a stronger role to making this happen."
- "Have to clearly communicate what their policy is – not simply have the Minister giving the message – need much more clearly enunciated policy from the MOHTLC."
- "Need support from ministry to come together to figure out how to meet expectations."
- "Need to get very clear direction from the ministry re: requirements for new money."
- "The ministry has to take a stand – take some leadership in reorganization. Agencies won't volunteer to disappear."
- "The ministry will have to use a big stick; if it's left optional, nothing will happen."
- "If we have to do it, we'll do it."
- "Unless you direct amalgamations, it's not going to happen."
- "If they truly want organizations to merge, they have to be clear about that and be more directive."
- "You need a strong voice and mandate from the ministry (or the LHINs) to lead the agencies to partnerships and make it clear that it is a requirement of the funding."
- "We need the ministry to come up with a directive for coordination."
- "Make it a directive and we'll do it."
- "We need clear direction and decision-making. 'This is the way the government is going, so how do you people plan to get there?' We need a mandate from ministry."
- "Not having clear direction from the ministry is a barrier."
- "If the ministry had the guts to be more directive, the cost-savings could happen. They back away. The ministry should be more directive, not hesitant to impose integration and mergers."
- "If the ministry were more proscriptive, it would make it easier to work together…Be more specific about expectations."
- "We need clear direction from the ministry"
- "There needs to be clear direction regarding what is expected of the service provider. The vague policy frameworks and implementations plans that have come out of past m inistry initiatives have reinforced the status-quo."
- "The ministry is going to have to put its foot down and mandate the new way of operating (like they did with the Justice money)."

- "Don't leave it up to the organizations. The ministry has to set it up."
- "The ministry needs to tell people to do it [integrate]."
- "Why does the ministry sit back and let things happen the way it does? The ministry should be more active."
- "If it wants this kind of coordination, [the ministry] should provide more leadership."

6.2 It is important to note, however, that, although agencies are requesting clear direction, they are reluctant to pursue back office integration and amalgamation and do not wish to be forced to integrate.

- "Use authority to make agencies work together, not to police us; we need to develop agreements re: working together to streamline."
- "Don't have the iron fist saying this is what you ought to be doing."
- "[Integration should be] by agreement between agencies, compared to imposing which is less likely to work"
- "There are no disadvantages to service coordination if done through collaboration – just not forced and not one size fits all…"
- "Agencies have merged where there is conflict because they were forced…it won't work if you're forced."
- "[It's] hard when partnerships are forced; it's much healthier if voluntary; it has to be done in collegial and consensus-building way."
- "I would hope that there's no forced mergers; everything through collaboration."
- "We need a commitment at the agency level, not from the top down."
- "There's a difference between encouraging and foisting."
- "Why force things when you can work collaboratively?"
- "It's better if you don't force it. Our amalgamation benefited everyone in the long run. But it was very painful for a long, long time."
- "Some people just don't want to play ball together and you cannot make them. If you do, they might cause more problems…then the clients will suffer."
- "The notion of amalgamations/mergers has to be voluntary…the outcome and cost benefit analysis has to demonstrate that such a vehicle is worth the cost… "
- "[I am] apprehensive that [the ministry] might decide that [mergers] are the way to go and force it on us, even if we feel it be inappropriate."
- "[I would like to see the ministry] understand that amalgamations are not the first consideration and may lead to service disruption, not integration."
- "I don't think it would be wise to enforce amalgamations, as it is a complicated process that has numerous repercussions not always immediately transparent."
- "Integration, partnership, amalgamations, and mergers work best when all parties agree to what's happening."
- "In order for consolidation/amalgamations to work effectively, it must evolve as a result of working partnerships. If it is legislated and organizations are forced to comply, there is the risk that the outcome may be compromised."

6.3 If the ministry mandates back office integration and amalgamation, agencies look to the ministry for additional funding and guidance.

- "The ministry could provide resources for discussions and implementation. It should be encouraging creative partnerships – putting it on the table, asking people to look at it and providing money to do it."
- "It's unrealistic to expect organizations to completely reinvent themselves in the absence of a guiding hand; we have made some headway in service integration in the last 10 years; if we want a whole other level of integration, we need more direction from the ministry."
- "The ministry could give financial support to amalgamations and mergers. It's difficult for agencies to find that money themselves."
- "The ministry should be offering some carrots. They'd get lots of cooperation but they need to give us the ability to do it."
- "[The ministry should allow agencies] to keep year end surpluses, like hospitals, then we can use them strategically."

6.4 Key informants expressed the need for their input to be respected and for decisions to be made locally.

- "Consolidations have to be evaluated on a case by case basis and the ministry should be listening to input from organizations."
- "[Consolidations] should be voluntary and on best advice of community partners."
- "Ministry should respect community input."
- "The important thing is to look at situations on a local basis and decide what would work for that area."
- "Would rather create something than have it created for me."
- "The potential (to consolidate) is there but agencies have to be willing to explore. Could be agreements and understandings, not necessarily mergers and amalgamations."
- "The MOHLTC needs to recognize and reward sincere efforts at partnership and at system innovation that are in keeping with the goals of Mental Health Reform and the Health Transformation Agenda."
- "I don't think our creativity is rewarded; it's not even recognized. If we were being acknowledged, we'd get enough money to run our programs."
- "It would be nice if the ministry rewarded this kind of creativity."
- "[The ministry shouldn't] micromanage; let agencies be creative."
- "The ministry should be encouraging creative partnerships."
- "[The ministry should] recognize that a lot of work has been done."
- "There needs to be an acknowledgement that after years of doing more with less, there is no fat to cut."
- "Be supportive of opportunities and innovations."
- "Be clear about outcomes but let us figure out how to do it."
- "Tell the agencies the desired outcome and have them figure it out."
- "Ministry needs to tell the agencies what is expected, benchmarks, and then let them do it."
- "There's a readiness that the ministry is underestimating. Give us the tools and we'll finish the job."
- "[The ministry needs] to encourage and support but not create the rules.
- "The ministry should trust that those of us who are doing the work that, when given the opportunity, we come up with some pretty creative stuff."

- "[Agencies] work well together; we're creating best practices as we speak."
- "If the ministry doesn't get preachy and isn't stingy with resources, it will be very gratified with what the mental health and addictions sector can do."

6.5 Agencies are looking to the ministry to facilitate the implementation of integration, by demonstrating best practices.

- "Systems evolve. It won't succeed if you try to impose a dramatic shift; model change, instead, put in strategic funds to make the changes."
- "[The ministry should] bring leaders together, [and] speak to agencies in a non-threatening way."
- "If the ministry were a catalyst, a facilitator of the process, that would be a key thing."
- "The ministry could show agencies what is working (models) – getting it out to people."
- "[The ministry could provide] knowledge transfer around best practices help – how do we transfer good examples, learn from each other to make services better."
- "[The ministry could] provide resources for discussions and implementation."
- "The ministry could support our partnership; if they see two agencies that could work together, they could facilitate that."
- "The ministry could act as a clearinghouse for putting agencies together."
- "The ministry has a global picture of who it funds – so the ministry can broker conversations, not necessarily about mergers, but about service integration, where it knows there are commonalities. The ministry has the expertise to put community organizations together."
- "The ministry could bring people to the table. Fine line between imposing and supporting an idea. Put players together to see if there's a match, but not imposing."
- "The ministry (or LHINs) needs to facilitate and coordinate, bring people to the table, and rubberstamp the product at the end of the day."
- "The ministry could share some models that have been out there in the field and are working."
- "The ministry should play the role of bridge builder – put the right people together to share and compare and move it."
- "The ministry could bring forward examples of best practice in back office and service integration."
- "The ministry should facilitate the consolidation."
- "[The ministry] should fund a comprehensive analysis of the best model for mergers (if any), and then fund an implementation plan that evolves over time."
- "[The ministry should provide] further support to networks…"
- "[The ministry should provide] support to coordinating bodies…that could assist us in coordinating or consolidating services."
- "[The ministry could host a] forum to explore the possibilities."

6.6 Service providers saw a role for regional staff as animators and community developers to help implement change.

- "We need the regional staff through the transformation; they should play more of a community development role."
- "If regional offices had the mandate to consolidate the back office, agencies would implement it."

- "Need an open-minded, innovative approach from the ministry office; offer opportunities; permit people to get together to do things differently."
- "Regional staff are involved with agencies and networks as a community developer; They keep the agencies on track with government – identifying where there should be efficiencies that the agency wouldn't have known about."
- "They should be animators and should take a role in facilitating change."
- "Regional consultants should be animators – don't really have the authority to force change; why force things when you can work collaboratively?"

6.7 Service providers say that working for the good of the client is a condition of successful integration.

- "We agreed to work for the good of the client vs. the agency. This single focus for all clients made working together 'the right thing to do.'"
- "A willingness by both parties [is required] to attempt to improve services for clients."
- "[Our success was due to our] willingness on the part of myself and two former directors to think about the good of the system as a whole – and ultimately the good of the people that we serve – rather than the specific interests of our own agencies."
- "[We can] truly be seen as working together for the good of the client and not your own 'turf'…"
- "Whatever the need is that we are trying to fulfill, the most important issue is that it be done with the client in mind and not the central issue being your organization."
- "…we were able to develop policies and protocols that were client oriented."

6.8 Service providers say that as far as partnerships are concerned, putting it in writing is the best approach.

- "We use a written agreement with most partnerships and I ask the agreement be signed by the CEO."
- "(The agencies) came together (with a facilitator) and hammered out an agreement that essentially divided up the responsibilities over the two counties. They now have a legal network agreement that clearly outlines who does what."
- "For all partnerships, it becomes necessary to develop formal protocols."

6.9 Providers have found that both parties in an integration project must benefit if it is to be successful.

- "Successful partnerships are partnerships when there is some benefit to all parties…"
- "Each partnering agency has to benefit from the proposal/partnership."
- "For a partnership to be successful, both parties must gain some benefit."

6.10 Networks can play an important role in integrating service. They can foster both formal and informal partnerships; they are spaces where trust is built; they are places where providers can get a better sense of "who to call" when their clients need other services. And they are places where planning happens.

There are active regional and local networks across the province. Most of the regional networks have begun to reconfigure along LHIN lines. They are primarily concerned with service integration rather than back office integration. There are also places, specifically in downtown Toronto, where planning tables appear to be less active.

- "Being involved in networks builds trust between the representatives of different agencies. Often, the trust being built in networks allows agencies to move more easily to legal partnerships."
- The Human Services and Justice Coordinating Committees (HSJCCs) are an example of how a network can bring together providers of a wide range of services and make it possible for those participants to work together. Regional and local committees have representation from courts, crowns, probation, jails, police, mental health, developmental services, youth services, hospitals (Schedule 1 and tertiary), and family members.
- For instance, a partnership of the Durham Mental Health Service and CMHA Durham to reduce duplication in case management by coordinating intake, assessments and referrals originated as an idea at the Durham Mental Health Alliance, a monthly network of executive directors of community mental health, addictions and hospitals.
- The Champlain Mental Health Network is another example of a network that is promoting service integration. In place for under two years, the Champlain Mental Health Network is "becoming the go-to place for planning, coordinating, problem solving."
- "We have worked long hours together – writing proposals, position papers, meeting due dates, developing political approaches. We've worked weekends and evenings together. One of the results of working together is that we gain respect for one another; another is that we learn we can count on each other."
- "A new cohesion has emerged between addiction service agencies…this has a lot to do with new faces at the planning table…"
- "[Planning tables] are already forums for service integration in terms of better understanding of service entities, development of standards, collaboration and coordination.
- At the Addiction Centre in Belleville, knowing who to call means you can reach out for assistance to other organizations more effectively. Instead of hiring an unknown consultant for training, for instance, you can get on the phone to another agency and ask for what you need: "Can I have Trevor from Crisis Team?"

Conclusions

In theory, there is almost unanimous approval for the concept of agencies working together. Organizations are not only interested in working together to improve services for clients, in most regions, they are already working that way. These efficiencies and innovations are well underway and indeed, have been part of the way some agencies have been doing business for many years. The sector has some thoughtful advice about how to expand these models for partnership so that they will produce effective integration. However, the notion of merging, especially when forced, received very little support among our key informants. Back office partnerships received support under some very specific conditions.

In our efforts to learn about the capacity for the community mental health and addictions sector to incorporate efficiencies and effectiveness in their programs, we were struck by the deep commitment of key informants to the clients they serve. Service providers had clients in mind as they thoughtfully answered our questions. If a specific activity wasn't going to help them serve clients better, then it wasn't viewed as a worthwhile activity.

The Environment

Uncertainty about LHINs has created some anxiety and rumours about how the LHINs will change the community mental health and addictions sector, especially about how the new boundaries will affect existing networks. The Minister's message that agencies will become "new best friends" has penetrated, but there is a sense that the ministry itself has not uniformly supported integration.

According to key informants, the system is under-funded and that made our queries about efficiencies insulting to some providers. And while the mental health agencies acknowledge the new investments that have been made, they also point to the pressures that growth has put on the back office.

Geography is a key element in the environment, sometimes emerging as a barrier to integration. Solutions need to be sensitive to the urban-rural-northern splits in the province. There are inter-urban splits, too: large urban, urban and Toronto. There's a perception, both inside and outside Toronto, that mental health agencies in Toronto are disorganized. The way the sector developed in Toronto has resulted in a number of agencies that are relatively small and, although efficiency and effectiveness and size do not necessarily correlate, the sheer number of agencies may contribute to the sense of disorganization and "siloing."

Back Office Consolidation

The discussions that we've had with key informants lead us to doubt that there are real savings to be found in back office consolidation. On the contrary, back office consolidation would likely require additional funding. There is a willingness on the part of most agencies to share with other agencies, but sharing requires surplus capacity which agencies say they don't have. Even agencies having specific expertise to share with smaller agencies identified the need for financial incentives in order to pursue back office partnerships.

Agencies have used the limited administrative support that they have to make back offices as efficient as they can. Although some back office integration is taking place, and there is, as we

have said, considerable positive feedback regarding theoretical sharing in the back office, there is a strongly skeptical response among key informants that back office integration will result in savings.

In spite of general skepticism that back office efficiencies would result in cost savings, our informants thought that, were savings realized, they should be put into client service. Some providers went so far as to say that the only circumstance under which efforts to create back office efficiencies would be worthwhile was one in which savings went back into front-line service.

There is almost no question from the field that services need to be better coordinated, there is a question only of capacity, especially in this time of unparalleled growth. The growth in some of the larger agencies has been significant. The front office of some agencies has grown by 200 per cent while the back office has remained the same. That has put strain on agency administration.

Apart from the lack of resources, agencies resist back office integration because they fear losing their autonomy and identity. There's also an element of distrust. What if integrating the back office leads to a takeover? A smaller agency, contemplating partnering with a larger one, may fear that it will be "swallowed up." Thus, back office integration sparks a trust issue, suggesting that there has to be trust built before agencies will contemplate partnerships. Building trust requires relationships to be in place. In aid of building trust among agencies, networks or planning tables, like the Human Services and Justice Coordinating Committees (HSJCC), are invaluable vehicles for making contacts and getting people talking and planning together.

Another question for most key informants was the extent to which back office efficiencies would have any impact on clients. The tendency is to dismiss back office efficiencies as having very little direct effect on the lives of clients. Some key informants see the pursuit of back office partnerships as an unnecessary distraction from the work of delivering services to clients. A number of key informants wondered if, in the final analysis, back office integration was a meaningful exercise.

All that said, even the largest agencies say that they would benefit from additional resources in the back office, such as human resources and legal services, information technology and information management. By funding a resource that could be shared, the ministry has the opportunity to close a gap that currently exists in the back office of many agencies.

Co-location

Co-location among community mental health and addiction agencies and with other community agencies in general is a popular way for agencies to serve clients in a streamlined manner. It is also a way to share more than an address. Co-locating is also seen as a way to facilitate back office partnerships. It is an opportunity to share reception duties, some purchasing, and common rooms such as a board room, in addition to other back office functions.

Clusters of agencies are now co-locating in buildings they have purchased through capital allocations from the ministry and/or private fundraising. These co-locations create opportunities to coordinate direct services to clients. When community agencies co-locate under one roof it is seen as a way to create seamless service for the client, a kind of one-stop shopping that will help clients to find their way around. Staff in co-located facilities get to know one another, facilitating the work of the agencies and potentially expanding the projects they do together. Some agencies say that sharing space is a first step toward creating service delivery partnerships.

Service Delivery Coordination

Service delivery partnerships, when compared to back office partnerships, are seen to be more important for clients. The sector is already involved in a great number of service delivery partnerships.

Not unlike back office partnerships, the fear of loss of autonomy is a barrier to service delivery integration. Perhaps more so than in back office partnerships, philosophical differences can make service delivery partnering difficult. For instance, a split still exists between the medical model and the community-based non-medical model in community mental health, and between the abstinence and harm reduction models in addiction service.

As with back office partnerships, the goal of service partnerships should be better service to the client.

Many agencies are involved in alliances with primary care providers thereby creating a more "seamless" experience for their clients and helping to ensure that clients get the primary care they require. Integrating with Community Health Centres and Family Health Teams multiplies the organization's expertise and improves access to primary care for clients. Where partnerships do not yet exist, some providers are looking to partner with primary care providers to better serve clients.

Community mental health and addiction agencies have also been developing formal relationships with police services, thereby supporting an improved police response to people with mental illnesses and addictions.

There is some concern among those agencies that deliver addiction services that they will be overwhelmed by mental health programs. However, many community mental health agencies are working in partnership with addiction agencies to provide programming for concurrent disorders.

While some agencies suggest that there is no duplication in the sector, others argue for a more coordinated, streamlined system. Agencies have undertaken many projects, such as centralized intake, common databases and common client records, to reduce duplication and to better coordinate services in the sector.

The ministry has facilitated partnerships when it has made new investments, such as the Homelessness Initiatives, the Accord Funding and the Service Enhancements.

Mergers

On the whole, the field favours a model of integration that relies on collaboration and autonomy. There is a clear message coming back from the field that it favours integration; but integration à la a *Best Friends* model, with marriage almost entirely out of the question – at least so far as arranged ones go. Some providers are adamantly opposed to mergers, especially those mergers that are dictated or forced. Fear of job loss, generally and executive job loss in particular, is a primary concern when it comes to mergers. The natural leaving of an executive director is therefore an appropriate time to consider an amalgamation.

Mergers are seen to be potentially negative for the client, with the creation of larger and fewer organizations which reduce the number of access points and the amount of choice for clients. It is said that forced mergers can create bitterness that lasts a long time.

Advice from the field: Conditions for successful integration

Agencies are clear that the ministry needs to provide leadership and unambiguous direction in order to promote integration through back office partnerships and amalgamations. In order to help support a clear policy on integration, the ministry could take a proactive supporting role with agencies by bringing them together and "modeling change." Essentially, the data shows that if it wants agencies in the sector to integrate, the ministry is going to have to provide funding and guidance. To keep decision-making local, the ministry should allow planning and implementation of integration to be done by the sector in each of the LHINs.

In terms of conditions for successful integration, agencies shared how helpful regional offices had been as resources for the implementation of integrative practices. Additionally, integration has worked well when agencies have focused on the needs of clients, and when partners each had something to gain from the partnership. Formal, written agreements are key to successful integration projects, as are the relationships that are built through planning tables and networks.

Appendix 1

Interview Schedule – Ministry of Health and Long-Term Care Regional Office Program Managers

Mandate: "Determining the potential for effective and efficient service delivery through the consolidation of community mental health and addiction agency office functions and agency services."

1. Could you please list the LHINs in your region, as well as the former DHC areas?
2. Who should we be consulting? Can we consult with the regional consultants? Are there visionaries in the sector who we should consult? Contact information?
3. Can you point us to agencies that you think are especially effective?
4. Back office functions could include human resource management, information management, IT, leadership, shared resources/functions, etc. What's the potential for coordinating these and other back office functions among several agencies?
5. Can you help us identify agencies which could coordinate back office functions? Can you identify the single service agencies?
6. To what extent are agencies duplicating services in ways that would benefit from merging or other coordination of operations?
7. To what extent are your agencies already sharing resources and/or back office functions? Can you point to coordination projects that are already underway?
8. To what extent will efforts to consolidate back office function and/or services be perceived as a threat to local agencies?
9. Will there be a willingness to participate in this review on the part of agencies? How should we involve agencies? E-mail survey?
10. Are there particular opportunities to coordinate back office functions between mental health and addiction programs?
11. Do you perceive disadvantages to the kinds of coordination we are investigating?
12. What benefits can you see to the coordination of back office functions and service delivery? What is the carrot here?
13. Could back office function consolidation improve agency accountability to the ministry?
14. What impact will back office efficiencies and service coordination have on clients?

Appendix 2

Interview Schedule – Ministry of Health and Long-Term Care Regional Consultants

Mandate: "Determining the potential for effective and efficient service delivery through the consolidation of community mental health and addiction agency office functions and agency services."

1. Who should we be consulting? Are there visionaries in the sector who we should consult? Contact information?
2. Can you point us to agencies that you think are especially effective?
3. Back office functions could include human resource management, information management, IT, leadership, shared resources/functions, etc. What's the potential for coordinating these and other back office functions among several agencies?
4. Can you help us identify agencies which could coordinate back office functions? Can you identify the single service agencies?
5. To what extent are agencies duplicating services in ways that would benefit from merging or other coordination of operations?
6. To what extent are your agencies already sharing resources and/or back office functions? Can you point to coordination projects that are already underway?
7. To what extent will efforts to consolidate back office function and/or services be perceived as a threat to local agencies?
8. Will there be a willingness to participate in this review on the part of agencies? How should we involve agencies? E-mail survey?
9. Are there particular opportunities to coordinate back office functions between mental health and addiction programs?
10. Do you perceive disadvantages to the kinds of coordination we are investigating?
11. What benefits can you see to the coordination of back office functions and service delivery? What is the carrot here?
12. Could back office function consolidation improve agency accountability to the ministry?
13. What impact will back office efficiencies and service coordination have on clients?

Appendix 3

Interview Schedule – Key Informants

Mandate: "Determining the potential for effective and efficient service delivery through the consolidation of community mental health and addiction agency office functions and agency services."

The interview has three parts. The first part is a general inquiry into the potential for creating new partnerships. The second part is an investigation into the coordination of back office functions, currently and potentially. The final part investigates the potential for coordination of service delivery. The context here is efficiency and effectiveness, rather than cost savings per se.

By back office function, we are referring to the following types of functions: human resource management (including payroll), information management, information technology (IT), shared facilities, etc.

By coordination of programs, we are referring to coordination ranging from shared expertise and leadership to mergers to the integration of services.

Part I: General questions

What mental health and addiction services does your organization offer?

1. Are there community mental health and addictions information networks or planning tables in your region? Are these networks an appropriate forum to discuss back office partnerships/ service integration?
2. Are there examples of duplication in your region that should be addressed/are being addressed by back office partnerships and/or coordination of services?
3. Do you have any relationships with Community Health Centres in your region? Do you see any value in creating some, where none exist?

Part 2: Back Office Efficiencies

1. Theoretically, do you think it is a good idea to coordinate some back office functions with other agencies in order to use your administrative resources more efficiently?

   Human resources (payroll, etc.)

   Information Management (MIS/CDS):

   Financial Management (bookkeeping; audit)

   Information Technology (support and website)

   Co-location

      How much space do you currently rent?

      What is the monthly cost for renting your facilities?

      Are your space facilities adequate for the needs of your agency? Please elaborate.

      Do you have any space that you currently do not use?

Provided you had sufficient space to do so, do you see any advantages/disadvantages to hypothetically sharing space with another community mental health or addiction agency in order to maximize efficiency?

Have you considered purchasing real estate?

Other back office functions?

2. Are you involved in any back office partnerships? Do you know of any? Are there any written resources that outline lessons learned from existing partnerships? What role did the ministry play in encouraging these partnerships?
3. Do you see the potential for back office partnerships involving your agency? Involving other agencies?
4. What would you require in order to implement these efficiencies?
5. Are there any examples of back office partnerships that have been unsuccessful or thwarted in some way?
6. What are the barriers to back office partnerships?
7. What are the benefits of back office partnerships to your agency?
8. Are there other benefits of back office partnerships? What about for clients/consumers?
9. Are there particular opportunities to coordinate back office functions between mental health and addiction programs?
10. For larger agencies: Theoretically, would you be prepared to play the role of a coordinating agency – one that provides back office services to smaller agencies?

Part 3 – Coordination of service delivery

1. Theoretically, do you think it is a good idea to coordinate services with other agencies?
2. Can you report on successful service partnerships in your agency? In your region? Are there any written resources that outline lessons learned from existing partnerships? What role did the ministry play in encouraging these partnerships?

Conditions:

3. Do you see the potential for future service partnerships in your agency? In your region? What about mergers?
4. What would you need to assist you in coordinating or integrating services?
5. Are there any examples of coordination or integration that have been unsuccessful or thwarted in some way?
6. Are there particular opportunities to coordinate or integrate services between mental health and addiction programs?
7. What are the barriers to service integration?
8. What benefits are there to integrating services?
9. How will clients benefit from the integration of services?
10. Do you perceive any disadvantages to the coordination of services we are discussing?
11. What role do you think the ministry should be playing in encouraging these consolidations?
12. Do you have any other comments?

Appendix 4

Federation Questionnaire

We are writing to you to seek your advice for a project we have undertaken for the Ministry of Health and Long-Term Care. The purpose of the project is to determine the potential for effective and efficient service delivery through the consolidation of community mental health and addiction agency office functions and services. Please take a few minutes to answer and return the questionnaire so we can include the experience of your agency in the data we are collecting.

The interview has three parts. The first part seeks general information. The second part is an investigation into the coordination of back office functions, currently and potentially. The final part investigates the potential for coordination of service delivery. The objective here is efficiency and effectiveness, rather than cost savings per se.

Part I: General questions

1. What is your name, your title, the name and address of your organization? Please include your phone number, e-mail address and website if applicable.
2. What mental health and addiction services does your organization offer?
3. Do you sit at any information networks or planning tables for community mental health and addiction services? Are these networks an appropriate forum to discuss back office partnerships/service integration?
4. Do you have any relationships with Community Health Centres in your region? Do you see any value in creating some, where none exist?

Part II: Back Office Functions

By back office function, we are referring to the following types of functions: human resource management (including hiring, payroll, training and recruitment), information management, information technology (IT), shared facilities, co-location, etc.

1. As far as back office functions go, how are they currently managed in your office? For instance, do you outsource them to a private company, do you or your staff manage them, or do you have assistance from another (larger) community agency? Please specify for each.

   Human resources (payroll, hiring, recruitment, training)

   Information Management (MIS/CDS)

   Financial Management (bookkeeping; audit)

   Information Technology (support and web services)
2. Do you see advantages in partnering with another agency to manage your back office functions. Are there disadvantages?
3. Do you see advantages to re-locating so that you can “co-locate” with another community agency, including community mental health or addiction agencies? Are there any downsides?

Part III – Coordination of service delivery

By coordination of service delivery, we are referring to consolidation ranging from shared expertise and leadership to service partnerships, and finally, to amalgamation and mergers.

1. Please describe any partnerships you currently have with community mental health agencies and addiction agencies? Are there any written resources that outline lessons learned from existing partnerships?
2. What role did the ministry play in encouraging these partnerships?
3. What benefits are there to integrating services?
4. How will clients benefit from the integration of services?
5. Are you interested in pursuing further service partnerships with other agencies to enhance the work you are doing? Are you considering amalgamating with another agency?
6. What role would you like to see the ministry play in supporting service partnerships or amalgamations involving your agency?
7. What would you need to assist you in coordinating or consolidating services?
8. Are there any examples of coordination or integration that have been unsuccessful or thwarted in some way?
9. Are there particular opportunities to coordinate or integrate services between mental health and addiction programs?
10. What barriers exist to service integration?
11. Do you have any other comments?

Appendix 5

The Questionnaire and the Respondents

In December, the Ontario Federation of Community Mental Health and Addiction programs sent a questionnaire we'd developed to its members. In all, 55 responses were received. Eleven respondents said they'd been interviewed by David Reville & Associates and did not complete the questionnaire. Three agencies, marked with an asterisk below, returned completed questionnaires, notwithstanding that we had interviewed the executive director or CEO.
Net "new" agencies = 41.

AGENCIES
1. Across Boundaries
2. Alternatives: The East York Mental Health Counselling Services Agency
3. Amethyst Women's Addiction Centre
4. ARID Group Homes
5. A-Way Express Courier
6. Brantford Vocational Training Association
7. Canadian Mental Health Association Toronto Branch*
8. Canadian Mental Health Association, Brant County Branch
9. Canadian Mental Health Association, Windsor Essex Branch*
10. CMHA Nipissing Regional Branch
11. COPE Mental Health Program (COPE)
12. Dunara Wellington-Dufferin Homes for Psychiatric Rehabilitation
13. Eden Community Homes
14. ENSH Inc. Programs
15. Habitat Services
16. Homeward
17. House of Friendship
18. Houselink Community Homes
19. Lifestyle Enrichment for Senior Adults (LESA) Program, Ottawa
20. Loft Community Services, 301-205 Richmond St. West
21. Madison Avenue Housing and Support Services
22. Mainstay Housing
23. Mental Health and Addictions, North Bay General Hospital

AGENCIES
24. Mental Health Consumer/Survivor Employment Assoc. of Essex County
25. Mental Health Counselling and Treatment plus Assessment/Referral and Community Treatment
26. Mental Health Services – Hastings Prince Edward
27. North Shore Community Support Services, Inc.
28. Options for Change
29. Ottawa Salus Corporation*
30. Pathways Alcohol and Drug Treatment Services
31. Peel Addiction Assessment and Referral Centre
32. Peer Support of Sudbury Inc.
33. Psychiatric Survivors Network of Elgin
34. Regeneration Housing and Support Services
35. Schizophrenia Society of Ontario
36. Search Community Mental Health Services
37. Serenity House Inc.
38. St. Jude Community Homes
39. Syme-Woolner Neighbourhood and Family Centre
40. The Salvation Army Ontario Central Division
41. The Vitanova Foundation
42. Toronto East Counselling and Support Service (TECSS)
43. TriCounty Addiction Services
44. Wychwood Open Door

Appendix 6

Interview List

Central East

Rob Adams, Executive Director, Durham Mental Health Services

Linda Gallagher, Executive Director, CMHA Durham

Mark Graham, Executive Director, CMHA Peterborough

*Marie Lauzier, Executive Director, York Support Services

*Sandy McClymont, Director of Finance and IT, York Support Services

John O'Mara, Executive Director, Addiction Services for York Region

Donna Rogers, Executive Director, FourCAST (Four Counties Addiction Services)

Dr. Ilya Roumeliotis, Director, Community Mental Health, Northumberland Hills Hospital

Nancy Roxborough, Executive Director, CMHA Barrie-Simcoe

Sandra Rundle, Director of Corporate Services, CMHA Durham

Colleen Zakoor, Executive Director, CMHA York Region

North

Nancy Black, Manager, Addiction Services, St. Joseph's Care Group, Thunder Bay

Marielle Cousineau, Executive Director, North Cochrane Addiction Services Inc. and Cochrane District Detox Centre

Bill Davies, Executive Director, Muskoka-Parry Sound Community Mental Health Service

Mary Deciantis, Executive Director, Sunset Country Psychiatric Survivors

Shannon Desrosiers, Executive Director, North Bay Community Housing Initiatives

Patti Dryden-Holmstrom, Program Manager, Addiction Services Kenora, co-chair, Kenora /Rainy River Directors' Network

Marian Quigley, Executive Director, CMHA Sudbury

Judy Shanks, Executive Director, CMHA Timmins

Toronto

Paul Bruce, Manager, Community Support Services, COTA Health

*Lana Frado, Executive Director, Sound Times

Colleen Franklin, Executive Director, Transition House
(currently on secondment to the Ministry of Health and Long-Term Care)

*Anne Hertz, Director of Strategic Planning and Co-ordination, CAMH

Dennis Long, Executive Director, Breakaway and Past President, Addictions Ontario

Steve Lurie, Executive Director, CMHA Toronto

Susan Meikle, Executive Director, Toronto North Support Services

*Mario Nigro, Chair and President, St. Jude Community Homes and Chair and President, Madison Avenue Housing and Support Services

Vince Pietropaolo, General Manager, COSTI Family and Mental Health Services

Angela Robertson, Executive Director, Sistering

Dr. Jose Silveira, Director, Portuguese Community Mental Health

Central West

Wendy Czarny, Executive Director, Waterloo Regional Homes for Mental Health, Inc.

Diane Doherty, Executive Director, CMHA Halton Region Branch

John Jones, CEO, CMHA Waterloo-Wellington

Vern Lediett, Executive Director, Community Mental Health Clinic, Wellington-Dufferin

Sandy Milakovic, Executive Director, CMHA Peel

Laurie Ridler, Executive Director, Supportive Housing in Peel

Wendy Ross, Program Manager, William Osler Health Centre – Crisis Services

South West

Heather DeBruyn, Executive Director, CMHA Elgin

Pamela Hines, CEO, CMHA Windsor-Essex

Michael Petrenko, Executive Director, CMHA London

John Robertson, Executive Director, CMHA Huron Perth

Linda Sibley, Executive Director, Addiction Services of Thames Valley

Alan Stephenson, Executive Director, CMHA Lambton

Sandy Stockman, Executive Director, Grey Bruce Community Health Corporation

Caroline Tykoliz, Program Director, Mental Health Programs, Grey Bruce Health Services

Willy Van Klooster, Executive Director (A), Westover Treatment Centre

Central South

Debbie Bang, Manager, Womankind Addiction Service and Hamilton Men's Withdrawal Management Centre

George Kurzawa, Executive Director, CMHA Niagara

Marilyn Jewell, Executive Director, CMHA Hamilton

Brother Richard McPhee, Executive Director, Good Shepherd Non-Profit Homes,

Brent Woodford, Executive Director, Adult Mental Health Services, Haldimand-Norfolk

East

Glenn Barnes, Executive Director, Addiction Services of Eastern Ontario (ASEO)

Vicky Huehn, Executive Director, Frontenac Community Mental Health Services

Jai Mills, Executive Director, Mental Health Support Network – Hastings Prince Edward Corporation

Don Palmer, Co-Executive Director, Causeway Work Centre, Ottawa

Pauline Sawyer, Executive Director, Alwood Treatment Centre

Margaret Singleton, Executive Director, Ottawa Salus Corporation

Cate Sutherland, Executive Director, Addiction Centre, Hastings Prince Edward

Bernadette Wren, Director of Community Mental Health and Social Work Services, Pembroke Regional Hospital

Marion Wright, Executive Director, CMHA Ottawa

Additional Province-wide

David Kelly, Executive Director, Ontario Federation for Community Mental Health and Addiction Services

Shawn Lauzon, Executive Director, Ontario Peer Development Initiative (OPDI)

*Karen McGrath, CEO, CMHA Ontario

Other Providers

*Camille Orridge, Executive Director, Toronto CCAC

* – interviewed in person

Appendix 7

Interview List
Ministry of Health and Long-Term Care

Central East

*Robert Moore, Program Manager

Robert Bush, Regional Consultant

*Carol Lever, Regional Consultant

*Gail Waller, Regional Consultant

Toronto

*John Marshall, Program Manager (A)

*Gail Forsyth, Regional Consultant

*Robin Daly, Regional Consultant

North

Nancy Cornwell, Program Manager

Wendy DeMarco, Regional Consultant

Siobhan Farrell, Regional Consultant

Denis Lozier, Regional Consultant

Sandra Watson, Regional Consultant

Janis Yahn, Regional Consultant

Central West

*Ruth Flynn, Program Manager

*Peter Munns, Regional Consultant

South West

Brad Davey, Program Manager

Julia Elliot, Regional Consultant

Central South

*Lorne Langdon, Program Manager

*Ingrid Farag, Regional Consultant

*Miranda Borisenko, Regional Consultant

East

Katherine Barry, Regional Consultant

Rick McInnes, Regional Consultant

Corporate

Brian Davidson, Manager, Supportive Housing Unit, Mental Health and Addictions Branch

Other current and former MOHLTC interviewees

*Chris Higgins, Senior Program Analyst, Ministry of Health and Long-Term Care and Past Executive Director, Ontario Federation for Community Mental Health and Addiction Services

Terry Tilliczek, Hospital Consultant (A), North Region Branch, Acute Services Division, Ministry of Health and Long-Term Care; Former Executive Director of the Algoma, Cochrane, Manitoulin and Sudbury District Health Council

Eileen Mahood, President, EJ MAHOOD, INC. and formerly Regional Director, North Region, Ministry of Health and Long-Term Care

Appendix 8

Consumer Survivor Initiatives

Most of the Consumer Survivor Initiatives (CSIs) have very small budgets. Because of their unique role in the sector – they are self-help groups, not service providers – they should not be amalgamated with larger organizations. The new MIS/CDS requirements will be onerous for most CSIs, however. It is here that they could use back office help from larger organizations.

Following a recent organizational review of the Ontario Peer Development Initiative (OPDI), the ministry announced that it intended to reduce the mandate (and budget) of OPDI. One of the consequences of that change will be that CSIs will no longer have a provincial organization on which to call for technical support. Instead, the ministry will appoint a CSI in each LHIN to be a network lead. Perhaps those leads will assist the CSIs in their networks to make connections with agencies that can assist them with their reporting responsibilities.

Partnerships can be problematic for CSIs. Consumer control is very important to CSIs and partnering with larger organizations can be a threat to consumer control. Several respondents noted with concern that there were CSIs that had lost their autonomy and had been taken over by service providers. More than one key informant felt that the CSIs had been set up for failure from the outset because they had never been given sufficient resources. CSI employees and board members were not helped to get the skills they needed and insufficient attention had been paid to capacity building. Those CSIs that are involved in community-based business are particularly vulnerable when their managers go on sick leave and they are unable to find (and pay) replacements.

The leaders of some CSIs report that having the back office functions performed by a service provider has not undermined the independence of their organizations. CAN-HELP, for example, has no administrative staff and its back office functions are performed by CMHA Fort Frances. The members of CAN-HELP say they have maintained their autonomy.

CSIs are a best practice. It is our view that the MOHLTC should issue an RFP for a review of CSIs with a view to understanding more about how to support a strong CSI presence in Ontario.

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