Getting to Integration: Command and Control or Emergent Process

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Abstract

For more than 20 years there has been much discussion in health and mental health care circles about how to achieve improved organizational and service integration, on the assumption that changes in structure may improve clinical outcomes. This paper reviews some of the public and private sector literature about mergers and alliances and offers observations on the extent to which collaboration is an emergent process that is responsive to its particular environment and explores power dynamics and how trust and flexibility affect outcomes in a positive or negative sense.

Key Words: integration, collaboration, mergers, alliances

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Introduction

Over the past 20 years there has been considerable interest in how to achieve increased integration in mental health care and health care generally. One of the forces driving the quest for integration is the urge to merge in both the private and public sectors, despite limited evidence that mergers actually succeed. While there is evidence emerging that strategic alliances and partnerships can be more successful at less cost, Hughes and Weiss, writing recently in the Harvard Business Review noted that the failure rate is still over 60% (2007).

This paper reviews some of the literature about mergers and alliances and explores the extent to which collaboration is an emergent process that is responsive to its particular environment. Power dynamics and trust and flexibility may also affect outcomes in a positive or negative sense. Based on the learnings that emerge from the literature review, this review reflects on the applications to leadership and management in the mental health sector.

While collaboration can be mandated, the form emerges through the interaction of the various stakeholders and is sensitive to dynamics in the domain environment. Barbara Gray has noted that collaboration is directly related to turbulence in the environment (Gray 1989: 1). Collaboration itself is a dynamic process that experiences turbulence. Evaluative reflection may assist leaders and decision-makers in understanding more about the process itself. Patton notes that "the degree of uncertainty facing an organization directly affects the degree to which goals and strategies for attaining goals can be made concrete and stable." In a turbulent environment, evaluators are challenged to generate concrete and stable goals (Patton. 1997: 180). This may explain why there is relatively little outcome literature on the effects of integration efforts.

Barbara Gray has noted that there is relatively little literature on mandated collaboration (personal communication). Collaboration is a complex phenomenon that requires a variety of analytic approaches to generate meaning, learning or understanding.

Private sector studies suggest that while mergers account for $3.4 trillion of annual economic activity, only about 20% appear to succeed (Grubb and Lamb 2000: 9). At the same time there is evidence that strategic alliances and partnerships can be more successful at less cost (Grubb and Lamb 2000: 18).

Peggy Leatt and colleagues researching change in health care organizations have noted that reengineering is often unsuccessful in achieving the goals of organization change and cautions that the "business of health care is too serious to be managed or changed on the basis of trends" (Leatt, Baker, Halverson and Aird, 1997: 9-10) .

One of the forces driving reforms and consolidation is the myth of too many managers. The report of the Fyke Commission on Medicare in Saskatchewan frames the issue well.

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

Recently Fyke reviewed the process and outcomes of the establishment of regional health authorities in Canada which have combined hospital, long term care, public and mental health and addictions services under one management structure and found that these structures had limited effect on improving clinical health status. He found that there was an over concentration on structure and noted that the failure to include primary health care limited the effectiveness of the reforms (Fyke, 2007).

Mintzberg and Glouberman note that many countries are implementing administrative reforms in health care but there is very little effect on actual service delivery (Mintzberg and Glouberman, 2001: 63). They have a different perspective, arguing that traditional hierarchical, command and control methods of management will not work, noting:

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

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

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

C.D. Howe Institute Commentary on Local Government Amalgamations

The C.D. Howe Institute commissioned Dr. Robert Bish, Co-Director of the Local Government Institute at the University of Victoria to review 50 years of evidence about local government structure and performance. He found that municipal restructuring resulting in the creation of larger municipal governments did not improve service delivery. Key findings include:

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

Other findings include:

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

While there were cost savings achieved when 11 municipalities were merged in Chatham-Kent, residents perceive the quality of services to have fallen (Bish, 2001: 24). The Halifax-Dartmouth amalgamation underestimated the cost of amalgamation by a factor of four; so far no savings seem likely, while taxes have increased (Bish, 2001: 25). The study concludes:

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

The literature on health care restructuring, while calling for increased integration, is generally unable to provide evidence that large scale restructuring improves service delivery.

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

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

They caution against implementing reforms without evaluation. "Many of the reforms we have described were introduced wholesale, without any thought being given to evaluation. This situation has contributed to the ambiguity of the evidence base." They recommend a controlled pilot program and gradual introduction of reform (Donaldson, Currie and Mitton, 2001: 21). Interestingly, they find that in both New Zealand and the UK, competition among providers has given way to cooperation, as the reforms have evolved (Donaldson, Currie and Mitton, 2001: 8-15).

Health Canada Papers on Community Based Health Care

In 1995, the Federal Provincial/Territorial Conference of Deputy Ministers of Health received a three volume report which included comprehensive literature reviews on community based health human resources and organizational models. These reports surveyed the published literature to help inform policy about how to achieve high quality and cost effective services. Reviewing them in 2009, suggests that their findings have stood the test of time in terms of the complexity of achieving integration in healthcare.

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

> The effectiveness of practitioners providing community-based health care and their quality of work life could be improved by various management and educational measures. Similarly, the ways providers are organized, deployed and remunerated could affect the quality and cost effectiveness of their services.
>
> *However there is neither a magic formula nor a one size fits all solution. As community based health care encompasses a wide array of services, providers, agencies and organizational forms, it must experiment with different strategies, using experiences gained in other programs and jurisdictions…A trial and error approach and incremental improvements seem to be a prudent way to introduce appropriate educational models and management practices* (Pong, Sanders, Church, Wanke and Cappon, 1995: viii).

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

Church, Saunders, Wanke and Pong also completed a literature review on organizational models in community-based health care. Their task was to determine which organizational structures and modalities would improve the quality and cost effectiveness of community based services using pre-established criteria (Church, Saunders, Wanke and Pong, 1995: iv). The review found that "integrated multidisciplinary models are less costly and more cost effective, than comparable services" provided by single services and institutions. Community based health services were shown to improve access to care and achieve better outcomes at lower cost than stand alone or institutional providers. Improved quality of life was shown in studies involving the elderly, mentally ill and terminally ill (Church, Saunders, Wanke and Pong, 1995: v). They also found "significant barriers to system integration associated with existing power and resources." There was no empirical evidence showing that integrated systems were less costly than non-systems, although these findings were based on studies of hospital systems (Church, Saunders, Wanke and Pong, 1995: v).

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

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

While the symbolic and "rational" notion of coordination and integration can provide decision makers with legitimacy in pursuing system reform, there are drawbacks. The authors cite a study on mental health service coordination by White and Mercier (1991), which concluded:

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

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

In a paper being prepared on integration of mental health and addiction services in Canada, Rush and colleagues note that while there is program level evidence of integration leading to improved clinical outcomes, especially in relation to the treatment of concurrent disorders, there is limited evidence of clinical improvements from system level integration efforts (2008). The province of Ontario implemented a commission to close hospitals and consolidate programs in the late 1990's. Results have been mixed at best with limited evidence of improved clinical care due to restructuring.

Health Services Restructuring Commission

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

system"(HSRC, 2000: 2). They held a series of roundtables on the vision, which identified a number of key priority issues:

- Leadership and communication regarding the vision of reform
- Elimination of silos and enhanced integration
- Primary care reform as a foundation and "connector to the rest of the system"
- Investment in a shared information management system
- Alignment of incentives to improve accountability and stimulate "systems thinking and behavior" (HSRC, 2000: 7).

Reactions to the HSRC vision surfaced concern about too much attention to structural issues and not enough emphasis on the impact that health system changes would have on health human resources and labour (HSRC, 2000: 30).
However, the HSRC's final vision statement included a message concerning collaboration, stating *"while reflecting community and regional differences, the system's health care providers (will) work together" to achieve the vision* (HSRC, 2000: 32).

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

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

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

Other Health System Reviews/Articles

A number of authors writing about health services have reviewed options for community-based collaboration.

Gamm observes that community partnerships can range from services where cooperation enables each organization to pursue its own goals, to a" value added dimension of coordination wherein both parties contribute to the pursuit of a shared goal that neither organization could pursue as effectively on its own"(Gamm, 1998: 56). He notes that effective approaches to partnerships avoid "outright control and domination by any single organization". Community care networks call for "participating organizations

to give up autonomy" through contractual arrangements. This allows organizations to work together "while preserving the integrity of competing values embraced by separate organizations. A merger, in contrast, might eclipse values held by one or the other." Leadership is required to ensure that differences as well as shared interests are understood (Gamm, 1998: 58).

Gamm refers to previously published articles by Boland and Wilson (1994) and Sofaer (1994), which note that leadership is distributed in partnerships. "Day to day relationships may be far more prevalent at the technical, line worker level than in middle or upper management" (Gamm, 1998: 59). The most sophisticated type of alliance or partnership "encourages coordination of health services across multiple populations through *effective planning, work coordination, and ongoing evaluation of system and component performance"* (Gamm, 1998: 62). Gamm's paper reviews three case studies of hospital community collaboration that "fell short of their goals and were ultimately fragmented by competition" (Gamm, 1998:64).

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

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

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

- Differences among services in terms of funding, operating styles and lack of a vision/ direction for health care
- Lack of experience working together, lack of trust and resistance to loss of power and control
- Power differentials based on size
- Limitations on what networks can achieve without dedicated resources
- Lack of integrated information systems and data repositories
- Challenges and costs related to human resource issues
- Absence of government support as well as legal constraints and complexities (Toronto DHC, 2000: 13-16)

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

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

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

Zimmerman and Dooley examined the dynamics of hospital mergers and concluded that by promising economic efficiency they may actually maintain the status quo since "very few of the health care mergers in the US and Canada are designed to rethink the fundamentals of health care delivery or challenge the assumption of the hospital-centric health cure model" (Zimmerman and Dooley, 2001: 8-9). While there may be modest improvements in utilization, less duplication and some cost savings, the evidence about improvements to health care is equivocal. They cite Mark Sirower's 1997 study of 300 hospital mergers that concluded the few consolidate more than administrative functions and cite a study by Arista Associates (2000) of 467 multi hospital systems, which reported an increase in operating losses from the previous year and increased fragmentation in the merged systems. Zimmerman and Dooley suggest that there may now be a demerger movement in health care as "the stories about new mergers are increasingly being offset by stories of divorce, broken engagements and divestitures" (Zimmerman and Dooley, 2001: 10).

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

Ontario Hospital Association

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

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

In 1998, the OHA asked KPMG to review the experience of seven hospitals that were developing health networks in their communities. The report is more positive about the potential for health networks to improve care and integration than the study on mergers. They found evidence of both clinical and non-clinical integration. However the authors note that they were unable to objectively measure improved performance related to patient satisfaction, increased efficiency, better operational performance or "a more coherent, accessible and user friendly system of care" (OHA and KPMG, 1998: 40). The report confirms the concept found elsewhere in the literature that *"a single model for health integration would not realize the innovative potential for integration"* and notes that health care networks offer "probably the most promising avenue for the achievement of long te rm health care integration, (by) *proceeding on a consensual basis and treating participants as equals"* (OHA and KPMG, 1998: 4).

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

Corporate Sector Literature

We now turn to a review of experiences with mergers and strategic alliances in the corporate sector. While strategic alliances appear to out perform mergers, both strategies are prone to failure unless significant attention is given to the change process and people issues. In their book Capitalize on Merger Chaos, Thomas Grubb and Robert Lamb report that despite increasing activity related to mergers and acquisitions, only 20% actually succeed. "Most mergers typically erode shareholder wealth, create years of chaos, fear and turmoil for their employees… they are frequently the worst planned an executed business activities of all" (Grubb and Lamb, 2000: 9-10). Grubb and Lamb argue that merger mania is dangerous because it hides true failure rates, promotes

squandering of valuable corporate and human resources and causes organizations to focus inward. They find that there has been a continuing pattern of merger failure since the 1950's (Grubb and Lamb, 2000: 11-16). In addition, "many firm's gross merger failures have driven them into a death spiral. The conglomerate graveyards of the 1970's are littered with terminally failed mergers" (Grubb and Lamb, 2000: 27).

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

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

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

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

They note "the attractiveness and acceptability of the culture of the acquirer or dominant merger partner is dependent on…whether the culture is perceived as increasing or decreasing employee participation and autonomy. Changes that are perceived to impose more control on employees will encounter more resistance than those perceived as likely to increase employee autonomy" (Cartwright and Cooper, 1993: 11). Cartwright and Cooper suggest that in order for mergers to succeed, a coherent and unitary culture must be created, based on the shared perception of the partners that aspects of the other culture are worth preserving. The greater the dissimilarity between cultures the longer the integration will take. Also the more dissimilar the cultures are,

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

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

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

The preceding articles point to the need to attend to cultural issues when combining organizations. Lee Marks suggests adding cultural fit to due diligence. He cites a British study of 40 acquisitions where none of the firms assessed talent or culture in the firms being acquired. Yet British executives cited culture compatibility as being more important than price in effecting merger outcomes. In the US "a study of 100 failed acquisitions found differences in management styles and practices between the partners to be *the major problem in 85% of the cases*" (Marks, 1999: 2).

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

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

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

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

more on harnessing capabilities, knowledge and power of people in ways previously unknown"(Harbison, Viscio, Pekar Jr. and Moloney, 2000: 1-3). There is now evidence that alliances outperform mergers in relation to value creation and various forms of alliance models and governance approaches are emerging (Harbison, Viscio, Pekar Jr. and Moloney, 2001: 5-22). Alliances are used to fill single and multiple gap deficiencies or create integrated products and services. The authors identify four models for alliances.

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

The authors suggest, "the successful company of tomorrow will develop coherence between the control model and the cooperative model of alliances… The cooperative model is a shared business model that needs its own leadership, but with few 'owners' they need to work through some cooperative governance structure. The challenge with these models is to establish a set of operating/ performance parameters." As more companies develop alliances, the challenge will shift from forming them to managing them. (Harbison, Viscio, Pekar Jr. and Moloney, 2001: 12-19). Kanter provides another framework through which to view alliances (Kanter, 1989: 185-6).

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

Dee Hock and colleagues developed at set of principles for an alliance almost 40 years ago. (Hock ,1995: 6, 7) The principles were:

- *Equitable ownership* by all participants
- *Power and function distributed to the maximum degree* such that "no function should be performed by any part of the whole that could reasonably be done by any more peripheral part and no power vested in any part that might be reasonably exercised by any lesser part"

- *Distributive governance* with no individual, institution or combination able to dominate or control decision
- *Infinitely malleable yet durable*
- *Embrace diversity and change*

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

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

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

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

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

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

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

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

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

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

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

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

Das notes that there is overlap between social control and trust building. Moreover, cultural norms and systems are "only nurtured slowly" (Das, 1998: 12-18). While goal setting may be critical in the development of alliances, consensus may have to develop gradually through participatory decision-making and partners may have to tolerate a "certain degree of goal ambiguity" (Das, 1998: 17).

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

The private sector management literature reinforces the diversity and complexity of organizational change issues that must be reviewed and planned for. It suggests, in similar fashion to the public sector literature, that there is no magic bullet, one size doesn't fit all and the effects and benefits of organizational change requires further study by scholars. Most importantly it demonstrates that most mergers do not succeed. Alternative strategies such as the development of alliances are highly complex, and require attention to cultural fit as well as issues of trust and control. Alliances are not in themselves guarantors of success. Hughes and Weiss note that hundreds of failed alliances they have observed result from breakdowns in trust and communication and propose are series of principles and practices to overcome these problems. Key among them are: developing the right working relationships, embracing differences, and enabling collaborative behavior. (Hughes and Weiss, 2007:123)

Implications

What are the implications for mental health system reform? It could be argued that health services and mental health services fit Dyer's definition of a complex product industry. Therefore Dyer's analysis may be of assistance to us in developing or assessing mental health service networks and the advice of Das and Cartwright on the importance of culture and people issues is critical.

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

Unmet need increased and the system reform had little impact on consumers' quality of life. (Shern, Wilson, Coen, Patrick, Foster, Bartch, and Demler, 1992: 24-5). The authors note potential negative effects of centralizing services:

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

More recently, Goldman's review of the ACCESS project which looked at outcomes for homeless mentally ill individuals in 18 US communities, found that "Extensive and targeted efforts to promote systems integration do not produce desired social and clinical outcomes at the individual client level". Connecting access to housing with the provision of evidence based services did have a positive effect (Goldman, 2002). This suggests that focusing on service level strategies and taking action on the social determinants of health by improving access to housing will achieve far more than focusing on administrative structures and processes.

The 1998 merger of four separate organizations into the Centre for Addiction and Mental Health has yet to demonstrate significant improvements in clinical care, despite a well organized and executed merger process and a focus on increasing community partnerships. The merger used savings from administrative consolidations to increase programming. Patient volumes have increased, professional education has increased and the Centre has attracted additional funding for services and research and the Centre's budget grew by 60% between 1998 and 2006. There have also been increased cost pressures, especially with regard to information systems and labour harmonization. The

merger's impact on clinical care and community capacity has not been formally evaluated.

Gray's contention that "collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (Gray, 1989: 5). As she notes, successful collaboration requires identification and coordination of a diverse set of stakeholders (Gray, 1989: 9) and "calls attention to the ways in which the stakeholders' concerns are intertwined and the reasons why they need each other to solve the problem" (Gray, 1989: 11).

Gray's criteria of joint ownership of the collaborations is important. The various stakeholders must be "directly responsible for reaching agreement" (Gray, 1989: 13).

Power

Mintzberg and colleagues suggest that the issue of power in relation to strategy development invites us "to move away from the idea of strategy formation as the product of a single architect" (Mintzberg, Alstrand, Lampbel 1998, 239). An analysis of power dynamics requires "an understanding of the role of organized and unorganized interests in shaping or reshaping behaviors" (Mintzberg, Alstrand, and Lampbel 1998: 239). The process of collaborating enables people to redefine their positions to ensure that their interests are protected.

Hardy and Phillips note the importance of examining stakeholders in the domain "and asking who has formal authority, who controls key resources and who is able to discursively manage legitimacy" (Hardy and Phillips, 1998: 217). This analysis of power relationships helps us " to differentiate more clearly between strategies that are truly collaborative and strategies that are not" (Hardy and Phillips, 1998: 217). Funders may exert formal authority to require collaboration or integration. Formal authority can also be dispersed (Hardy and Phillips, 1998: 219). While governments or funders may set the conditions that cause the collaborations, the collaborations are shaped by the interactions of the various stakeholders. Project leaders will need to respond to nuances in the project environments.

Another key factor in fostering collaboration is the willingness of project leaders to listen and respond constructively and creatively to issues raised in the development of collaborations.

Domain Transformation

Lawrence, Hardy and Phillips see collaboration as a "cooperative, interorganizational relationship that is negotiated in an ongoing communicative process that relies on neither market nor hierarchical mechanisms of control" (Lawrence, Hardy and Philips: 5). While the relationships can have elements of a supply chain relationship i.e. there may be no hierarchical relationship. Resources are made available based on

discussions and agreements between partners and information about the project is freely shared among all stakeholders through a variety of means.

As Gray points out, multi party agreements can founder if there is ambiguity about responsibility for implementation, or lack of attention to the implementation process (Gray, 1995: 85). Hughes and Weiss suggest that it is critical to measure the process of collaboration and implement processes that will surface and resolve disagreements and problems in implementation quickly (Hughes and Weiss, 2007).

Mandated Collaboration

Collaborations can grow out of government funding and legislative requirements. Using the framework developed by Mintzberg and colleagues, these requirements can be thought of as an umbrella strategy where the government or funder is able to exert partial control of organizational actions and is able to define "strategic boundaries or targets," (Mintzberg, Alstrand and Lampbel, 1998: 191) leading to collaboration.

When collaborations get underway there are elements of a process strategy at play (Mintzberg, Alstrand and Lampbel, 1998: 191). Funder requirements can mandate a process, but the content emerges through interactions among stakeholders. Therefore, even though mandated collaboration can be a funding or policy requirement, experience on the ground may support Gray's contention that "collaboration is essentially an emergent process rather than a prescribed state of organization" (Gray, 1989: 11). In fact, the positions and interests of the various stakeholders are likely to emerge and shift during the process.

Collaborations will always be subject to power dynamics as described earlier, but do have the potential to transform the domain if they are sustained over time. Further investigation of these issues could contribute to our understanding of mandated collaboration.

Mandated collaboration is an emergent process, dependent on power dynamics among stakeholders in the domain. Rather than micro manage collaboration, it seems prudent for government or funders to set the process requirements and then get out of the way and let it happen.

Reflections

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

1. One size doesn't fit all
2. There is limited evidence of organizational/ structural change improving clinical process or outcomes

3. Use best practices and unified funding models to drive systems change
4. There is a need to attend to corporate culture and human resource issues if attempting structural change or alliance building
5. There is a need to deal with power, trust and control issues in alliances and mergers
6. Rome wasn't built in a day, the development of effective collaborative relationships take time
7. There is a need to experiment, evaluate and learn from experience.

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

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

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

The current environment challenges us to rethink the way we manage and lead our organizations and systems. Mintzberg and Glouberman suggest that health care managers need to practice a craft style of management that convinces rather than controls, and encourages identification with collective need. They argue that a command and control approach to managing health care or anything else won't work because in management "nothing can really be standardized and barely anything of significance has been codified with reliability" (Mintzberg and Glouberman, 2001: 80).
They warn against hierarchical organizational approaches because "health care and disease cure are complex nuanced services. Hierarchies do not solve so much as cap the problems of cost control and coordination". Instead they suggest using networks to foster better communication and solve mutual problems and propose that society should see collaboration as more important than competition and control. (Mintzberg and Glouberman, 2001: 81-3).

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

About the Author

Steve Lurie is the Executive Director of the Canadian Mental Health Association Toronto Branch, a post he has held since 1979. Steve has written and lectured extensively on mental health policy issues. He was a principal author of the Graham Report, *Building Community Support for People,* and conducted the 1992 snapshot of community mental health programs for the Ontario Ministry of Health and the Minimum Data Set Pilot Project (1998), which established a common data set for the reporting of client characteristics and outcomes in community and hospital based mental health services. He served as guest editor of the Canadian Journal of Community Mental Health special issue, *Innovation in Community Mental Health: International Perspectives*.

In 2005 he provided technical assistance to the Senate Committee Report O*ut of the Shadows At Last: Transforming Mental Health and Addiction Services in Canada.* In August 2007 he was appointed to chair the Service Systems Advisory Committee for the newly established Mental Health Commission of Canada. He was recently awarded the Canadian Mental Health Association's CM Hincks award for national leadership in mental health.

Steve has a Masters in Management (MM) from the McGill McConnell Voluntary Sector Leadership program (2002) and has a BA (1971) and MSW (1973) from the University of Toronto Faculty of Social Work where he is now an adjunct professor.

References

Bish, R. L. (2001). Local government amalgamations: Discredited nineteenth century ideals alive in the 21st. *CD Howe Institute Commentary No. 150*

Cancer Care Ontario. (2001). Integrated services for provincial cancer control. *Submission to the Cancer Services Implementation Committee*. www.cancercare.on.ca/about/postionpaper200901.pdf

Cartwright, S., & Cooper C. L. (1993) The role of culture compatibility in successful organizational marriage. *Academy of Management Executives*. 7(2) [cited 27 April 2001) www.stern.nyu.edu/~wstarbuc/mob/cartwright.html.

Church, J., Saunders D., Wanke M., & Pong, R.(1995). *Organizational models in community based health care: A review of the literature*. Health Promotion and Programs Branch, Health Canada

Das, T.K. (1998, July) Between trust and control: developing confidence in partner cooperation in alliances. *Academy of Management Review*.. [cited 02 May 2001] www.findarticles.com/cf_0/m4025/n3_v23/21060910/print.jhtml

Donaldson, C., Currie,G., & Mitton, C. (2001, April).Integrating Canada's dis-integrated health care systems: Lessons from abroad. *CD Howe Institute Commentary* No. 151

Dooley, K., & Zimmerman, B. (2003). Merger as marriage: Communication issues in post merger integration. *Health Care Management Review.* 28 (1): 55-67.

Dyer, J. (2000). *Collaborative advantage: Winning through extended enterprise supplier networks.* Oxford University Press. Oxford, New York.

Feeney, S. (2000). *Collaborations, mergers and alliances: Governance challenges for non-profit boards of directors.* Portland: Institute for Nonprofit Management, Mark O. Hatfield School of Government, Portland State University.

Fyke, K. J. (2001). *Caring for Medicare.* Saskatchewan Commission on Medicare

Fyke, K. (2008). *Regionalised health- care: A good idea badly done*. http://www.changefoundation.ca/docs/fyke.doc

Gamm, L. (1998). Advancing community health through community health partnerships. *Journal of Health Care Management* 43:1. 51-67.

Gergen, K, J. (1991). *The saturated self.* United Sates of America: Basic Books

Glouberman, S. & Mintzberg, H. (2001). Managing the care of health and the cure of disease: Parts 1 and 2. *Health Care Management Review*. 56-84.

Goldman, H., Morrisey, J., Rosenheck, R., Cocozza, J., Blasinsky, M., &Rudolph, F. (2002). Lessons Learned From the ACCESS Evaluation. *Psychiatric Services* 53: 967-9

Gray, B. (1989). Collaboration: The constructive management of differences. *Collaborating: Finding common ground for multiparty problems.* 1-25, San Francisco: Jossey- Bass.

Gray, B. (1995). Obstacles to success in educational collaborations. *School-Community Connections.* Rigsby, L., Reynolds, M. & Wang, M. eds. 71-96. San Francisco: Jossey- Bass.

Grubb, T. M. & Lamb, R. (2000). *Capitalize on merger chaos*. New York: The Free Press

Harbison, J. R., Viscio, A., Pekar Jr., P & Moloney, D. (2000). *The allianced enterprise: Breakout strategy for the new millennium*. Booz-Allen & Hamilton.

Hardy, C. & Phillips, N. (1998). Strategies of engagement. *Organizational Sciences*. March/ April 1998, 217-230.

Hock, D. (1995). The chaordic organization: Out of control and into order. *World Business Academy Perspectives* Vol. 9, No. 1. [cited 27 April 2001] www.chaordic.org/res_wba.html

Hughes, J., & Weiss, J. (2007, November) Simple rules for making alliances work *Harvard Business Review:* 122-130

Kanter, R. M. (1989). Becoming PALs: Pooling, allying and linking across companies. *The Academy of Management Executives*.

Lajoux, A. R. Do deals deliver on post merger performance? (1998, Sept- October) *Mergers and Acquisitions*. [cited 3 April 2001] www.findarticles.com/cf_0/m6401/n2_33/21160670/print.jhtml

Leatt, P., Baker, G. R., Halverson, P. K. & Aird, C. (1997). Downsizing, reengineering, and restructuring: Long- term implications for healthcare organizations. *Frontiers of Health Services Management* .13-4:3-35.

Lawrence, T. B., Hardy, C. & Phillips, N. *Collaboration and Institutional Entrepreneurship.* Unpublished.

Marks, M. L. (1999, Nov.- December) Adding cultural fit to your due diligence checklist. *Mergers and Acquisitions*. [cited 3 April 2001] www.findarticles.com/cf_0/m6402/3_34/58065174/print.jhtml

McEwan, K., &. Goldner, E. M. (2001). *Accountability and performance indicators for mental health services and supports: A resource kit.* Publications Health Canada. www.hc-sc.gc.ca/hppb/mentalhealth/service

Mitleton-Kelly, E. ed. (2003) *Complex systems and evolutionary perspectives on organizations*, Advanced Management Series. Elsevier Publishers

Mintzberg, H., Ahlstrand, B. & Lampel, J. (1998). *Strategy Safari*. New York: The Free Press

Morrisey, J.P., Calloway, M., Bartko, W. T., Ridgely , M. S. , Goldman, H. & . Paulson, R. (1994). Mental health authorities and service systems change: Evidence from the Robert Wood Johnston Foundation Program on Chronic Mental Illness. *The Milbank Quarterly*, Vol. 72, No. 1, *Providing Treatment to Persons with Mental Illness*. 49-80

Moyer A., Coristine, M., MacLean, L., & Meyer M. (1999). A model for building collective capacity in community based programs: The elderly in need project. *Public Health Nursing* Vol. 16 No. 3:205-214

Patton, M. (1997). *Utilization focused evaluation: The new century text* Edition 3. Thousand Oaks, London, New Delhi. Sage Publications

Pong, R., Sanders D., Church J., Wanke, M.& Cappon, P. (1995). *Health Human Resources In Community Based Health Care: A Review of the Literature*. Health Promotion and Programs Branch, Health Canada.

Ontario Hospital Association and KPMG. (1998). *Health Networks: Seven Case Studies: A Description and Preliminary Analysis.* Ontario Hospital Association Richard Ivey School of Business, University of Western Ontario. (1997). *Leading the management of change: A study of 12 Ontario hospitals.* Ontario Hospital Association

Rush, B., Fogg, B., Nadeau, L., & Furlong, A. (2008). *Integration of mental health and substance abuse system services.* Canadian Executive Council on Addictions

Shern, D. L., Wilson N. Z, Coen, A.S., Patrick D., Foster M.,. Bartch D. & Demler, J. (1992). Client Outcomes II: Longitudinal Client Data From the Colorado Treatment Outcome Study . *Milbank Quaterly* (1): 123-48.

Tapscott, D. (2001, September). Forget factories and equipment. Relationship capital is the key asset for the modern corporation. *R.O.B. Magazine, Globe and Mail.* vol. 18, #3, 19.

The Ontario Health Services Restructuring Commission. (2000). *A legacy report: Looking back, looking forward.* HSRC.

Toronto Distric t Health Council. (2000). *Integration in Action: Lessons Learned from Networks in Toronto.*

Zimmerman, B. & Dooley, K. (2001). Mergers versus emergers: Rethinking structural change in health care systems. *Emergence*, vol. 3 # 4, 65-82