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What factors contribute to the effectiveness of public service delivery networks? : the case of community networks of specialized care in Ontario

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WHAT FACTORS CONTRIBUTE TO THE EFFECTIVENESS OF PUBLIC SERVICE DELIVERY NETWORKS?
THE CASE OF COMMUNITY NETWORKS OF SPECIALIZED CARE IN ONTARIO

by

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What Factors Contribute to the Effectiveness of Public Service Delivery Networks?
The Case of Community Networks of Specialized Care in Ontario

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Master of Arts, Public Policy and Administration, Ryerson University 2010

Abstract

The public administration literature in support of network governance has grown in the past two decades. Some empirical evidence suggests that if a range of public services are integrated through a network of service providers, a more coordinated seamless service system will be created, reducing fragmentation, gaps, and replication of services, and increasing capacity to plan for and address complex problems with improved client outcomes. There is limited empirical evidence about the factors that contribute to the effectiveness of public service delivery networks. The Ontario Ministry of Community and Social Services moved to a network model of service delivery in 2005 to address the needs of citizens with developmental disabilities and mental health/behaviour problems. Using secondary sources and key informant interviews, this research analyzes the factors that contribute to the effectiveness of social service delivery networks by examining Community Networks of Specialized Care in Ontario four years after implementation.

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I did not understand the meaning of a champion until I met the participants in this study. My deepest gratitude for the time and energy you spent teaching me about the Community Networks of Specialized Care. I hope I have done justice to your tremendous accomplishments!

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To my daughters, Michelle and Laura, your generous spirits and strong character are inspiring.

This work is in memory of my parents, the only people in my life, who truly impressed me, until I met the champions of the Community Networks of Specialized Care, who demonstrate the same, passion and common sense, in their drive to remedy what can be a disabling system of care.

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CHAPTER 1

Introduction

The World Health Organization (WHO) estimates that the overall prevalence of mental retardation (developmental disability) is between one and three percent of the total population (Fact Sheet N 265, December 2001). According to Balogh (2010), the range in prevalence can be explained by different methods of measurement. Governments use "administrative prevalence" which counts only those cases that are known to them, while others use "true prevalence" which reflects "the total number of persons in a population regardless of whether or not they required or receive services" (Balogh 2010, 3).

In 2005 there was an estimated 12,392,721 (Carver, 2005, 9) people residing in Ontario. Based on this figure 123,927 to 371,781 individuals could have a moderate or severe developmental disability. According to the National Coalition on Dual Diagnosis, "a conservative estimate of the percentage of people with a developmental disability, who also have a mental health problem is 38%"(National Coalition on Dual Diagnosis 2009, 6). The Public Policy Committee of the Canadian Mental Health Association (CMHA), Ontario Division, reports that mental illness in persons with developmental disability, referred to as a dual diagnosis, is "often unrecognized, undiagnosed and untreated" (SPC 2005, 2).

"The Ministry of Community and Social Services (MCSS) is a department of the Provincial Government of Ontario that provides the broad policy framework and majority of funding to support a comprehensive service system for adults who have a developmental disability (DD) and their families" (N.A.D.D. Presentation: November 12-14 2008, 5). The responsibility for the care and support of individuals with a developmental disability and mental health problems and/or challenging behaviours such as, aggression, self injury, destruction, disruption and non-compliance (National Coalition on Dual Diagnosis, 2009) has been diffused amongst various levels of government and community agencies resulting in a "network of services that is highly complex, fragmented, duplicative and uncoordinated" (SPC 2005, 3). The funding for the treatment of mental illness is provided by the Ministry of Health and Long Term Care (MOHLTC), while the MCSS funds all other services. This division between the MCSS and the MOHLTC has set up a "dual track system that has made it very difficult for individuals to access care and treatment if they are dually diagnosed" (National Coalition on Dual Diagnosis, 2009). The National Coalition on Dual Diagnosis reports that these individuals also have unmet needs in the area of primary medical care, income support, employment, education, housing, nutrition, safety and social inclusion, all which are important social determinants of health (National Coalition on Dual Diagnosis, 2009). They

add that, “our systems are not well designed to provide accessible, adequate or appropriate supports and services for those with complex needs” (National Coalition on Dual Diagnosis 2009, 6).

The Network approach is offered as a solution to the inter-ministerial challenges rooted historically and culturally and which impact service delivery. The potential benefit of this new form of governance is that it will enhance the communication and collaboration between these sectors so that each accepts responsibility for this complex and vulnerable group of individuals.

History of Developmental Services Policy and Service Delivery in Ontario

In 1839 the Ontario government passed “An Act to Authorize the Erection of an Asylum for the Reception of Insane and/or Lunatic Persons” (Kyle et al, 2008). The first government owned and operated institution was built in 1876. Between, 1900-1970 the system of care was predicated on a Medical or Custodial Model (JLS Management Consulting Inc. June 5, 2007). The Ministry of Health had responsibility to protect society from individuals with mental illness and development disabilities whose behaviour could put them and/or members of society at risk (Jongbloed, 2003). By the mid 1970’s there were 10,000 people with developmental disabilities (Kyle et al, 2008) living in nineteen institutions directly operated by the government (Schedule 1 facilities) (MCSS, May 2006).

In the 1970’s and 1980’s, families of institutionalized individuals and patient advocacy coalitions, challenged the law, claiming the human rights of individuals living in these institutions, were being violated. “The politicization of disability during this period resulted in the creation of the sociopolitical model of disability, which held that disability resulted from a failure in the social environment rather than from individual functional limitations” (Jongbloed 2003, 206). A report commissioned by the Ministry of Health in 1971, concluded that the institutions were “isolated from mainstream health, education, social and family services and could not adequately establish and administer services that responded to community needs” (Kyle et al., 2008). The Provincial Secretary for Social Development, wrote a document, “Community Living for the Mentally Retarded in Ontario: A New Policy Focus” (Kyle et al., 2008). He recommended that; individuals residing in institutions be returned to the community, reallocating resources to community-based residential care; policies supporting the employment of individuals with developmental disabilities in mainstreamed society be developed, coordinated access mechanisms to a broad range of services be established locally and provincially, and individuals with developmental disabilities residing in the community have access to “guardianship and protective services” (Kyle et al., 2008). The intent of the changes was to afford individuals with developmental disabilities the same opportunities as the general population.

The Developmental Services Act (1974), incorporating these recommendations, was passed into law, and responsibility for developmental services was transferred from the Ministry of Health to the Ministry of Community and Social Services because of the change in focus from a medical to a community model of care.

The first of two, five-year plans was designed following a Developmental or Program Model" (JLS 2007, 10) and implemented in 1977. One institution was closed and the number of individuals residing in the others was reduced (Kyle et al., 2008). Between 1982- 1987, the MCSS implemented its second, five-year plan, closing eight provincially operated institutions and reducing the number of individuals residing in others. Additional supports and services were made available to individuals living at home with their families. Between, 1975-1987, the Ontario government increased spending on community-based services from $10 million to $181 million, supporting an additional 20, 400 individuals living in the community (Kyle et al., 2008).

The MCSS, "Challenges and Opportunities, Community Living for People with Developmental Handicaps", document outlined a strategy for the years between 1987-1997, that included closing six institutions, establishing a comprehensive system of community-based services and establishing a long term plan to phase out the remaining provincially run institutions. Between, 1997-2003, an additional three institutions were closed and the MCSS reformed the developmental service sector policy framework with the introduction of the *Making Services Work for People (MSWFP)*, initiative (April 1997). The goal was to improve supports and services to individuals with developmental disabilities, by "making the most of available resources in each local community and to allocate resources to those most in need" (MCSS May 2006, 7). Single points of access to services were established across the province, and local community planning groups, comprised of community-based agencies, were created to establish a coordinated local access process to residential supports (MCSS, May 2006). The Ontario Disability Support Program Act, 1997 was passed which provides "a separate income and employment support program for eligible persons with disabilities" (Kyle et al., 2008).

According to Hughes (2003) a new form of governance was required because the traditional model of public administration would not work in community-based programs. A "flexible, market-based form of public management" (Hughes 2003, 3) was introduced, which altered the government's role in society and with the bureaucracy and citizens (Hughes, 2003).

By the late 1980's there was an emerging debate, whether the paradigm shift in the 90's to the "Citizenship or Community Membership Model" (JLS 2007, 10) was implemented to be more responsive to individual needs or is a guise for neo liberal policies to curtail spending and more broadly part of New Public Management (NPM). The acceleration of community-based services for individuals with developmental disabilities under the Harris government (1995-2002), appears to be part of the neo-liberal framework to reduce government involvement and spending. According to Owen Hughes, "the move from an administered to a managed bureaucracy and from a system of public administration to one of new public management" (Hughes 2003, 2) reflects a "major cultural shift, from the old management paradigm, which is largely process- and rules- driven to a new paradigm which attempts to combine modern management practices with the logic of economics, while retaining the core public service values" (Hughes 2003, 5).

In 2004, the McGuinty government released a draft plan for transforming community-based development services in the province, called *Building the Foundation for the Future: Transforming Developmental Services.* The goal of the transformation is "to create a more fair, accessible and sustainable system of community-based supports" (MCSS May 2006, 3). The intent is to provide a range of services and supports that will allow people with DD to live as independently as possible. Support is defined as "resources and strategies that promote the interests and welfare of individuals and that result in enhanced personal independence and productivity, greater participation in an interdependent society, increased community integration and or/improved quality of life"(Thompson 2004, 7). Policy work for this initiative focused on "researching, consulting, developing and testing key system features to help the province improve, transform and modernize service delivery" (N.A.D.D. Nov 12-14 2008, 6).

As part of the transformation process, the MCSS conducted consultations with individuals, families and service providers, who identified serious gaps in the provision of specialized/clinical services and supports to adults with a developmental disability and mental health and/ or challenging behaviour (dual diagnosis). In response to the identified need, in May 2005 the MCSS announced a plan to establish four regional Community Networks of Specialized Care (CNSC). They are a critical component of the province's transformation of developmental services, representing a 41 million dollar investment ($3 million dollars shared annually across the four regional networks) (MCSS September 30 2008, 1). The mandate of the four CNSC is to work at the local systems level with community-based transfer payment agencies in the developmental and mental health service system to; "develop strategies to improve navigation, coordination and service delivery between local mental health and developmental services

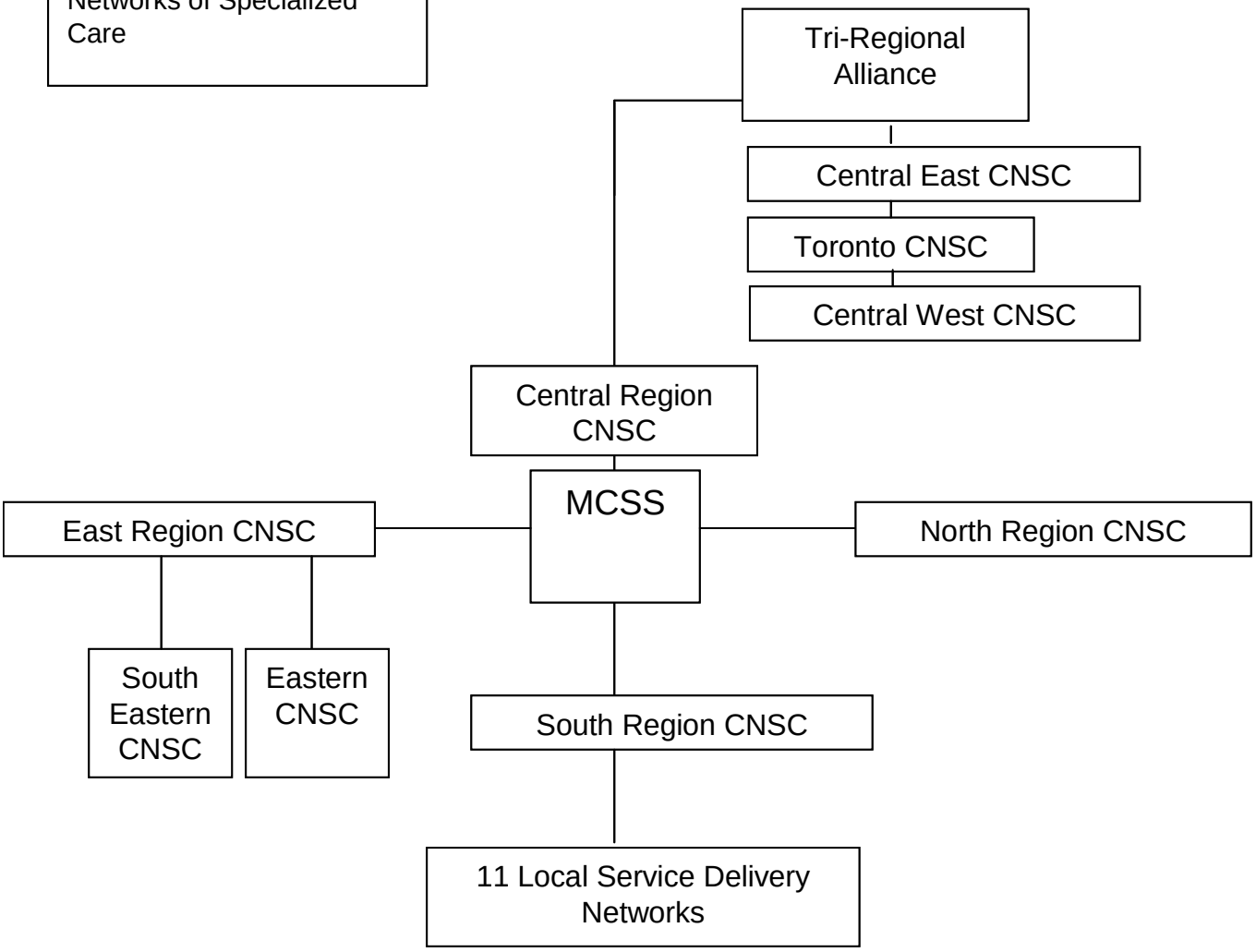
agencies; to increase the range and availability of specialized supports and; to build expertise and community capacity through joint research and training initiatives" (N.A.D.D. Nov 12-14 2008, 12).

In support of this transformation the government passed the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* (Bill 77) on October 8, 2008 (N.A.D.D. Nov 12-14 2008, 7). It will be proclaimed when the regulations are approved and will repeal legislation that is 34 years old and designed to meet the needs of people with a DD living in provincially owned and operated institutions (MCSS Backgrounder May 15 2008, 1). Several issues that have delayed the final regulations are, a year long debate on the eligibility criteria for developmental services, the design and implementation of an individualized and standardized application package and an allocation model that matches an individualizes needs with resources.

The intent of the MCSS was for a regional Community Network of Specialized Care (CNSC) to operate in each of the four quadrants of the province that are represented by two or more MCSS Regional offices, but it was left to the discretion of the four regions, Central Ontario, East, North, and South, to design the Network structure that was best suited to the existing service delivery system in their region. The Central Region Community Network of Specialized Care (CNSC) is comprised of three geographic sub-regions, Central East, Toronto and Central West and home to fifty percent of the provinces population. This regional CNSC elected to create three sub- regional Community Networks of Specialized Care because of its size, the; Central East CNSC, Toronto CNSC and Central West CNSC and an umbrella organization, the Tri-Regional Alliance of Specialized Networks.

The East Region Community Network of Specialized Care (CNSC) is comprised of the Eastern and South Eastern geographic sub-regions. This regional CNSC created two sub- regional CNSC; the Eastern CNSC and the South Eastern CNSC, to address the needs of the large Francophone population in the Eastern sub-region. The North Region Community Network of Specialized Care (CNSC) is comprised of the Northern and North East geographic sub-regions. They created one CNSC, the North Community Network of Specialized Care. The South Region Community Network of Specialized Care (SNSC) is comprised of the South West and Hamilton- Niagara regions. This regional CNSC created, eleven Local Service Delivery Networks, recommended by the consultant that completed an environmental scan of the region. Figure 1.1 depicts the seven regional Community Networks of Specialized Care.

Figure 1
The Ontario Community Networks of Specialized Care



Following the announcement that regional CNSC were being established, the MCSS formed Joint Implementation Teams (JIT) in each of the four regions to oversee their development. Membership was comprised of regional MCSS managers and key representatives from the developmental and mental health service sectors with knowledge and expertise in the needs of individuals with a DD and mental health and/or challenging behaviour. Each JIT retained a consultant(s) to conduct an environmental scan for their region. In the fall of 2005 the consultants held focus groups with agencies and health care professionals that deliver specialized services to, identify the existing core and specialized clinical services for the target population, strengths and deficits in the coordination and delivery of services, and resources for education and training. They also reviewed best practices in other jurisdictions and in the literature regarding the delivery of specialized clinical services. The consultant(s) prepared Regional Solutions Report recommending a network design for each of the CNSC (Central Region CNSC September 7, 2006).

In March 2006 agencies interested in leading the CNSC submitted proposals to the MCSS. The transfer payment agencies chosen to head the CNSC were selected by service providers in the sector through a community-based process and demonstrated a capacity to manage a collaborative regional Network of specialized clinical services. Network Implementation Advisory Committees (NIAC), accountable to the JIT, were established in each of the CNSC to; develop a structure for the CNSC; provide strategic advice and expert opinion on the roles, functions, services and membership of the Networks; ensure that the Networks reflect the needs of individuals, families and communities they serve. Network Advisory Committees replaced the NIAC once the organizational structure of the Networks, were selected. Their role it is to, "develop, deliver, monitor, evaluate and coordinate the specialized resources at the regional level with facilitated support from the Network Coordinators" (Central Region CNSC April 1, 2009-March 31, 2012, 15). The Community Networks of Specialized Care became fully operational in early to mid 2007(Central Region CNSC September 7, 2006).

Provincial Governance and Accountability Structures

CNSC are governed following the, "lead organization governance model" (Provan and Kenis 2005, 235) with a memorandum of understanding-based partnership. In this model, "all major network-level activities and key decisions are coordinated through and by, a single participating member, acting as a lead organization" (Provan and Kenis 2005, 235). The CNSC are cooperative, inter-organizational entities that collaborate at three levels, the broad community, specialized service providers and individual organizations, to accomplish the mandate and key functions delineated by the MCSS (Reed, 2009). Governance of the Community Network of Specialized Care is through the Board of Governors of each of

the lead agencies (Carver, 2005). The formal accountability relationship between the MCSS and the lead agencies is delineated in the annual funding contract and service description schedule, which hold the lead agencies accountable for the leadership, development, operation, attainment of outcomes and fiscal management of their individual CNSC. They are obligated to comply with the Ministry's annual Transfer Payment Business Cycle, and monitoring and reporting requirements by preparing a Multi-year Business Plan and annual Work Plan, that describes what services will be available to individuals in the target population, how they will access the services and how the Network will coordinate the process. The Lead Agencies are required to provide the ministry with data on outcomes that could involve formal evaluations. (Central Region CNSC, September 7, 2006).

The lead agencies are accountable to the Network members and their Steering/Advisory/Network Committees for administrative and leadership roles and responsibilities as defined in the Memorandum of Understanding (MOU) and the Terms of Reference for the CNSC. The Network/Video Conferencing/Education/Research, Coordinator (s) report to their Network Lead for job performance accountability and to the Steering/Advisory/Network Committee for network functioning and assigned coordination roles/tasks (Central Region CNSC, September 7, 2006).

The Network partners are formally accountable to their funding ministry/ministries (regional Ministry of Community and Social Services (MCSS) and/or Ministry of Health and Long Term Care (MOHLTC)/ Local Health Integration Networks (LHIN) through their service contract which "stipulate what services they are funded for and what their targets are for each service type, including the elements of specialized clinical services offered through the network" (Central Region CNSC September 7 2006, 23). "Compliance with the respective ministry is also regulated through directives, reviews, audits, inspection and regular meetings" (MCSS May 2006, 6). The Network partners are also accountable to, the Lead Agency, the Steering/ Advisory/ Network Committee and the other partners, through Memoranda of Understanding (MOU) which, delineate the roles, responsibilities, required communication, shared processes and agreed-upon protocols between all three groups as it relates to service delivery, coordination and training (Central Region CNSC September 7, 2006).

The CNSC are mandated to implement the *Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis*, revised in December 2008, with the LHINs, the new management structures of the MOHLTC, accountable for planning and funding of all health services, including mental health, primary care, and specialized clinical services, to individuals with a dual diagnosis (Central Region CNSC, September 7, 2006). Although these guidelines have

existed since 1997, “the roles, responsibilities and actions of those serving these individuals has not been clearly defined, understood or accepted (Rice 2005, 52).

Resources

The fiscal budget for each of the four regional CNSC in the province has been $977,000 annually since 2006. This includes salaries for the Network Coordinator, and the Administrative Assistant, a budget for Purchase of Services, which includes regional specialized service priority allocations, professional clinical services, and flexible funds, a budget for training/research, evaluation, and other operating expenses (Central Region CNSC, September 7, 2006).

The MCSS consultation document, *Opportunities and Actions*, released in the fall of 2006, announced the following additional financial resources for the CNSC; funding for ninety specialized community-based accommodation spaces, divided among the four regional CNSC, that include treatment beds for individuals in crisis and “permanent accommodation for individuals with persistent high-risk behaviour, who need ongoing specialized supports”(MCSS 2006, 27); capital and operating funding for Video-Conferencing technology; an education and training Grant for the recruitment and retention of professionals to work with the target population (MCSS, 2006). Under the MCSS Facilities Initiative (September, 2004), resources have been allocated for residential and day supports for individuals reintegrating into the community from the remaining provincially operated institutions. Under the service enhancements initiative the MOHLTC provides funds to the MCSS, for twelve dual diagnosis justice case managers (three full time equivalent positions in each of the four regional CNSC) that offer intensive court support case management to people with or suspected of having a dual diagnosis. The case managers support individuals who are at risk of becoming involved in the justice system, or are already involved, by linking them to appropriate community-based developmental and specialized clinical services (Bricker May 25, 2009, 12).

These networks provide an interesting set of cases to examine effectiveness of public service delivery networks, ranging from local networks that address the needs of individuals residing in small communities, to networks that cover a population spread over a vast geography. The success of this policy initiative is contingent upon the cooperation and collaboration within and across ministries and non-profit sector organizations in the developmental and health service system, as well as the justice and academic sector

Theoretical Perspective

The dominant theoretical perspective in public administration is that service delivery networks are not only the emerging reality in the partnership world of public administration but that they have specific benefits and advantages over classical Weberian state-centered models of service delivery in terms of democratic legitimacy and service delivery outcomes. O'Toole defines networks as "structures of interdependence involving multiple organizations or parts thereof where one unit is not merely the formal subordinate of the others in some larger hierarchical arrangement" (O'Toole 1997, 46). According to Adam and Kriesi the "concept of policy networks is strongly influenced by inter-organizational theory which stresses that actors are dependent on each other because they need each other's resources to achieve their goals"(Sabatier 2007,129). According to Provan and Milward (1995) networks have been examined in the organization theory literature from primarily two theoretical perspectives, "resource dependence and related exchange perspectives, and transaction cost economics" (Provan, Milward 1995, 1). Resource dependence theory suggests that organizations choose to cooperate in an exchange of resources because the potential gain exceeds costs in terms of autonomy and control. Transaction cost economics suggests that organizations participate in networks because they are an efficient way to deliver services, thereby reducing costs. This study examines the case of the CNSC from a resource dependence perspective.

The CNSC are an example of an "inter-organizational" or "whole network", defined by Provan et al., (2007) as a group of three or more legally autonomous organizations, formally established, and governed to achieve a common goal (Provan et al., 2007). Relationships are primarily non-hierarchical and participants often have substantial operating autonomy. They are linked by many types of connections, such as information, materials, financial resources, services and social support (Provan et al., 2007). The prevailing view is that "interdependent groups of two or more organizations that consciously collaborate and cooperate with one another are more effective at providing a complex array of community-based services than the same organizations are able to do individually" (Provan and Milward 2001, 415). In keeping with network theory, it is assumed that by "integrating an array of services through a network of provider agencies", a more coordinated seamless service system will be created, reducing fragmentation, gaps, and replication of services, and increasing capacity to plan for and address complex problems with improved client outcomes (Provan and Milward 1995, 2). Provan and Milward (1995) claim that, it is increasingly common for "the not-for-profit and public sector to form cooperative alliances as a way of enhancing competition and effectiveness, that would not be possible through the traditional governance mechanisms of market or hierarchy" (Provan, Milward 1995, 1).

There is a growing interest in and empirical research about the effectiveness of network-level activities and structure or identifying which elements of networks produce meaningful outcomes (Provan, Milward 1995). Provan et al. argue that "only by examining the whole network can we understand how networks evolve, how they are governed, and ultimately, how collective outcomes might be generated"(Provan et al. 2007, 3). Agranoff and McGuire (2001) suggest that "network management is in need of a knowledge base, equivalent to the hierarchical organizational authority paradigm of bureaucratic management" (Agranoff and McGuire 2001, 297), in order to understand the factors that contribute to effectiveness.

This thesis uses a network level of analysis to identify the factors that contribute to the effectiveness of social service delivery networks using information from secondary literature, government documents and key informant interviews. The aim of this thesis is to contribute to a knowledge base of network management by acquiring information about the role network structure, network governance and network participants have on network effectiveness using existing theory and empirical observations for this case in Ontario. The findings from this research will contribute to the public administration literature on public service delivery networks, and may help guide policy planners in developing effective health and social service delivery systems for individuals with a dual diagnosis.

It is important to review the theories related to network effectiveness, in order to understand the factors that could contribute to their effectiveness. One of the most prominent determinants of network effectiveness discussed in public policy and administration literature is collaboration. Gray (1989) describes collaboration as, "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). Gray and Wood (1991) make a distinction between collaboration that they deem, a process and a collaborative alliance, which they define as "an inter-organizational effort to address problems too complex or protracted to be resolved by unilateral organizational action" (Gray and Wood 1991, 4). Gray and Wood (1991) reviewed case research in search of a theory to help explain collaboration and collaborative alliances, identifying six theoretical perspectives that could "be used to examine and explain collaborative behaviour" (Gray and Wood 1991, 3). They are; "resource dependence theory; corporate social performance/institutional economics theory; strategic management/social ecology theory; microeconomics theory; institutional/negotiated order theory; and political theory" (Gray and Wood 1991, 3). However, Gray and Wood (1991) did not find that any of these, "provides an adequate foundation for a general theory of collaboration" (Gray and Wood 1991, 3).

Wood and Gray (1991) expanded on this theoretical work by creating a comprehensive definition of collaboration, which they regard as critical to theory building. Collaboration occurs when "a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain" (Wood and Gray 1991, 146). Stakeholders are understood to be organizations that share varying degrees of interest in some aspect of the problem domain. Autonomy is included in the definition because while members of the collaborative alliance "agree to abide by shared rules" (Wood and Gray 1991, 146) it is understood that "they retain their independent decision making powers" (Wood and Gray 1991, 146). The interactive process denotes that stakeholders are engaging in a "change-oriented relationship" through a structure (Wood and Gray 1991, 146) that involves rules, norms and agreed upon goals and outcomes. Wood and Gray (1991) consider these elements as necessary preconditions for collaboration (Wood and Gray, 1991).

They also discuss the merit of a "convener to facilitate the formation of an alliance" (Wood and Gray 1991, 149). There is no theory that delineates how a convener influences the stakeholders to collaborate and establish a common vision with shared values and norms. Gray (1989) suggests that the convener's role is to select stakeholders for their relevance to the problem domain and to accomplish this, the convener must be recognized as a legitimate unbiased authority who conveys to the stakeholders the potential and value of the collaborative process in achieving mutually agreed upon goals (Gray, 1989). The operating mode of a convener will be contingent on their formal and informal authority (Gray, 1989).

Provan and Milward (1995) outline the basic elements of a theory of network effectiveness based on the results of their study of four comparable sized mental health delivery systems. They conclude that, "networks can lead to improved system level outcomes when network integration is centralized with legitimate external control that is direct and nonfragmented, the system is stable and resources adequate" (Provan and Milward 1995, 26).

The existing literature on partnerships also informs Network effectiveness. Roussos and Fawcett (2000) reviewed literature on collaborative partnerships for community health improvement and identified "seven interconnected and modifiable factors and conditions that may determine their effectiveness" (Roussos and Fawcett 2000, 369); participation from members in establishing a clear vision and mission for the collaboration; a concrete action plan for community and system change, regularly reviewed and revised if required; developing, supporting and transferring leadership as required, including core competencies related to effective leadership; documentation and ongoing feedback on progress; technical assistance and support for the capacity building of the leadership; securing adequate financial resources to

fulfill the established mandates; setting and sustaining outcomes of value to the key constituents and funding body. These authors also identified several broader outcomes of collaboration that may contribute to effectiveness; the context in which the partnership occurs; the social capital that is both invested and results from the partnership and the ability of partners to provide input into the process (Roussos and Fawcett, 2000).

According to Mitchell and Shortell (2000), partnerships experience unique governance and management issues, not encountered by traditional forms of alliances or partnerships because of the voluntary nature of the collaboration. They conducted a multidisciplinary literature review to understand "which dimensions of governance and management contribute to the effectiveness of community health partnerships (CHP)" (Mitchell and Shortell 2000, 243). They identify the following five governance tasks; "setting priorities for strategic goals that are aligned with those of the members in the partnership and the external community; selecting the composition of the membership to align with the purpose and mission of the partnership; ascertaining and securing sufficient internal and external resources to attain the projected outcomes; selecting a governance structure that fits with the formal and informal coordination required for the integration of the partnership; identifying how the partnership will measure and report on outcomes to establish accountability" (Mitchell and Shortell 2000, 243). The following are the management tasks they identify; "creating a shared vision/mission with the members and maintaining their interest and engagement; implementing coordinating mechanisms to ensure the members participate in an exchange relationship; managing communication in the partnership to address conflict; devising a system to monitor progress, evaluate and report on outcomes" (Mitchell and Shortell 2000, 244).

Findings from their literature review are summarized in six intersecting lessons for effective partnerships. The first and of utmost importance for those governing and managing partnerships is understanding and considering the context in which the partnership is occurring, including who the internal and external stakeholders are, the community's current capacity, resources and challenges, and the history of previous collaboration among the stakeholders (Mitchell and Shortell, 2000). These factors should inform the selection of the structure and operating processes of the partnership so that the "internal operations and strategic direction" (Mitchell and Shortell 2000, 261) is aligned with the "characteristics and demands of the external environment" (Mitchell and Shortell 2000, 261). The second is to select a form for the partnership that denotes the purpose of the partnership, from the perspective of all stakeholders. The nature of the problem being addressed by the partnership should parallel the heterogeneity of the members selected, which is the third lesson. The more complex the problem, the greater the need there will be for diverse representation. The fourth lesson for effective governance and management is to

establish a “diversified resource base” with contributions from a wide membership so the focus remains on the goals of the partnership, not its financial sustainability. Implementing coordinating mechanisms that are aligned with the nature of the problem being addressed and the partners involved, is the fifth lesson and the final is creating appropriate outcome tools to measure the effectiveness of the partnership.

Provan and Milward (2001) propose a framework for network evaluation that focuses on three different levels of analysis: the community, network and organizational participant level and suggest that, network effectiveness is likely based on interactions across all three (Provan and Milward, 2001). They offer the following criteria for evaluating effectiveness at a network level of analysis; growth in network membership, increase in the range of services provided; an absence of service duplication; an increase in the number and strength of connections between members; the creation and maintenance of an organization to manage the network; the integration and coordination of services; resources to maintain the network; and the commitment of the members to the goals of the network (Provan and Milward, 2001).

Agranoff and McGuire (2001) explore the answers to “seven meta questions that address the nature of network management tasks; group process in collaboration; flexibility of networks; self responsibility and public agency accountability; the cohesive factor; power and its effect on group; problem resolution; results of network management to contribute to an empirically derived knowledge base of network management” (Agranoff and McGuire 2001, 295). Activation, Framing, Mobilizing and Synthesizing are four management behaviours that Agranoff and McGuire claim could prove useful in creating effective networks (Agranoff and McGuire 2001, 298). Activation refers to selecting network participants based on the knowledge, skills and resources they can contribute to the venture. It is critical to frame the purpose and function of the network in a manner that elicits agreement from participants and mobilizes the membership to agree “on the role and scope of the network” (Agranoff and McGuire 2001, 300). To merge the varying goals, values and perception of partners (synthesize), the managers must facilitate communication and cooperation for mutual gain. Agranoff and McGuire (2001) refer to this process as “groupware” which requires the social capital that is produced when resources are shared with other organizations. Another important requirement of groupware is negotiation and collaboration because of the potential outcome for learning, which generates support for the network. In the absence of legal authority the authors suggest that “networks will be effective if they are based on trust, share a common purpose, are mutually dependent, resources are available they have “catalytic’ actors and, the managers have the required skills” (Agranoff and McGuire 2001, 312).

More recent theory and research has focused on the significance of network formation as a determinant of effectiveness measured in terms of collaboration. Bryson, Crosby and Stone (2006) "define cross-sector collaboration as the linking or sharing of information, resources, activities, and capabilities by organizations in two or more sectors to achieve jointly an outcome that could not be achieved by organizations in one sector separately" (Bryson et al. 2006, 44). "Cross sector collaboration is increasingly assumed to be both necessary and desirable as a strategy for addressing many of society's most difficult public challenges" (Bryson et al. 2006, 44). They offer twenty one propositions to consider when developing and implementing cross-sector collaborative partnerships, based on an extensive literature review on the topic.

The first three propositions address conditions that could impact the formation of a cross-sector collaboration. First, the type of inter-organizational structure selected by the collaborators should support its intended function, that is to "reduce resource dependencies in the environment or to decrease transaction costs" (Bryson et al. 2006, 45). Second, cross sector collaborations are selected by policy makers as an alternative to individual organizations addressing the issue based on evidence that they have failed or will likely fail if entrusted with the task (Bryson et al., 2006). Third, the authors suggest that individuals with a positive history of interaction will be more likely to engage in a coordinated effort based on established trust and legitimacy. In the absence of previous collaboration Bryson, Crosby and Stone suggest that a partnership may take longer to evolve, engaging in initiatives that present less risk, until a foundation of trust is established.

Bryson, Crosby and Stone (2006) identify six process factors that may positively impact the outcome of collaborative work. The first is securing a formalized agreement on the purpose of the collaboration, the structure of the partnership, such as roles and responsibilities, and decision making authority. The second is the presence of committed sponsors and effective champions who provider formal and informal leadership. The third factor that can impact success is the ability of the collaborative partnership to gain internal and external legitimacy. This is critical for obtaining support and resources and building trust among the partners which is the fourth factor. Bryson, Crosby and Stone (2006) claim that, "trusting relationships are often depicted as the essence of collaboration" (Bryson et al. 2006, 48). The fifth factor for success is to effectively manage conflict by addressing resource and power issues and the sixth and final factor is to utilize the skills of network partners in the planning and operation of the collaboration.

Bryson et al (2006) also discuss structural and governance components that can lead to a successful collaboration. Factors that influence structure are the context in which the collaboration occurs that is the

availability of resources, the stability of the system, and the purpose of the partnership. They suggest that the governance of a partnership involves an established entity providing coordinating and monitoring activities and the governance structure selected can influence effectiveness (Bryson et al, 2006).

Kenis and Provan (2009) identify three deficiencies in the measurement of network effectiveness that present a challenge to the assessment of network performance. The first is the tendency to focus on the characteristics of networks and or outcomes at the organization level as evidence of effectiveness. Kenis and Provan argue that "in order to better understand why some networks perform well and others do not, we need studies where network performance is the dependent variable" (Kenis and Provan 2009, 441). The second deficiency is the failure to specify what constitutes effectiveness, focusing instead on the "conditions or success factors that contribute to effectiveness" (Kenis and Provan 2009, 442). This makes it difficult to establish and predict the relationship between the "conditions and success factors", (Kenis and Provan 2009, 442) and outcomes. The third deficiency is "equating scores on measurement instruments with effective performance, without understanding the meaning of the scores" (Kenis and Provan 2009, 442). Kenis and Provan (2009) recommend that after defining performance, appropriate, reasonable and factual criteria for its measurement be established, based on three exogenous factors they imply impacts the ability of the network to meet the criteria; "the governance form of the network; whether it is mandated or voluntary; and the developmental stage of the network" (Kenis and Provan, 446). It is their opinion, that "only when the network has the theoretical capacity to actually influence the score on a criterion is it appropriate or reasonable to assess the functioning of the network on that criterion" (Kenis and Provan, 445). Further the exogenous factors "might explain why some networks perform better and should be considered in assessing network performance" (Kenis and Provan, 445).

Wood and Gray (1991) established the foundation of a theory of network effectiveness, by identifying the preconditions of collaboration. Roussos and Fawcett (2000) and Mitchell and Shortell (2000) elaborate on components beyond a shared vision, mission, rules, norms, and structures required to achieve a common goal (Wood and Gray, 1991). They suggest that to be effective, partnerships need a designated leader with governing and management skills, to develop a concrete action plan that is aligned with the needs of internal members and the community at large. Dedicated resources that are used efficiently and effectively are required to achieve the agreed upon outcomes, that are tracked, measured and reported to the stakeholders. Partners with a history of prior collaboration may have an advantage at establishing an effective network.

Provan and Milward (2001) offer a number of measurable outcomes that if attained could contribute to network effectiveness. Agranoff and McGuire (2001) contribute to the theory, by targeting the managerial tools that Mitchell and Shortell (2000) identify as potential contributors to network effectiveness.
Bryson, Crosby and Stone (2006) reiterate the factors previously introduced with a focus on cross-sector collaboration, which is considered the panacea for "many of society's most difficult public challenges" (Bryson et al. 2006, 44).
Effectiveness in this study is defined as the coordination of the specialized service system, which is one of the three broad mandates of the CNSC established by the MCSS.

Effectiveness is measured by the presence of;

- Partners who share accountability and responsibility for the individuals and the system that exists within the Network
- Active Network lead
- Clearly defined goals
- Post-network programs that address barriers and gaps in specialized service system, at multiple levels
- Reduction in resource gaps

Independent Variables

This study focuses on five factors that may contribute to the effectiveness of the CNSC.

1) The first is the influence of prior collaborative relationships between Network partners, on critical elements such as "trust, legitimacy, coordination and cooperation" (Bryson et al. 2006, 46, Roussos and Fawcett 2000, 389). According to Bryson, Crosby and Stone (2006) and Roussos and Fawcett (2000), network members previously engaged in mutually dependent relationships that involved "sharing risks, resources and responsibility in pursuit of a common purpose" (Roussos 2000, 389), may find it easier to cooperate in a coordinated effort, because of the trust and legitimacy that exists. Information from the key informant interviews and secondary sources is used to examine the presence and influence of previous relationships on the collaborative activity in the CNSC.

2) Among the studies reviewed by Roussos and Fawcett (2000), "leadership was the most often reported internal (or organizational) factor for a partnerships effectiveness, in creating community and systems change"(Roussos and Fawcett 2000, 385). The second factor examines the governance and management

tools utilized by the Network lead, to recruit; a broad spectrum of local consumers, agencies, and families that are included in developing and maintaining a Network that is responsive to their needs; and a strong, empowered core group of partners willing to work as cross-sector, cross-disciplinary teams, to accomplish the goals of the Network. Information from the key informant interviews and secondary sources is used to examine the composition and diversity of the network members, their type and degree of involvement in network activities, their degree of connectedness and the influence and impact of this on goal attainment.

3) The third factor is ensuring that the, mission, purpose, and goals of the CNSC are agreed to by the individual network partners and the community at large. Referred to as internal and external alignment, the literature attributes its presence, to an increase in membership support and contribution of resources, higher levels of active participation over time and community consensus and acceptance (Mitchell and Shortell, 2000). Mitchell and Shortell (2000) and Roussos and Fawcett (2000) suggest that in the absence of this element a partnership risks "conflict, opposition or dissolution" (Roussos and Fawcett 2000, 384). Information from the key informant interviews and secondary sources is used to determine the internal and external alignment in the CNSC based on the presence of a defined and supported structure that streamlines access to specialized resources.

4) Due to the voluntary nature of participation in community partnerships, there is a reliance on the informal integration of network partners, through social control mechanisms, such as "norms of trust, cooperation and reciprocity" (Mitchell and Shortell 2000, 268) to achieve goals. The presence of an informal coordinating mechanism in the CNSC is the fourth factor that may contribute to their effectiveness. Information from the key informant interviews and secondary sources is used to examine the relationship between social control mechanisms and the programs that have been created by cross-sector partners to address to address barriers and gaps in service at multiple levels.

5) The fifth factor related to network effectiveness is the availability of dedicated funds, human resources, shared and in-kind resources, information/knowledge, and technical assistance to achieve the goals and outcomes of the Network. According to Provan et al. (2007), while the availability of resources influences the legitimacy and development of the network, managing and distributing the resources to benefit the whole is as important for establishing trust and mutual dependency. Information from the key informant interviews and secondary sources is used to examine the relationship between the reported reduction in resource gaps, and the management of resources.

Hypotheses

Hypothesis 1:

The CNSC will be effective if some of the Network partners engaged in previous mutually dependent relationships that involved sharing risks, resources and responsibilities, to achieve a common goal.

Hypothesis 2:

The CNSC will be effective if the Network lead, uses communication, facilitation, negotiation, and networking skills to recruit a strongly connected stable core group of partners willing to work as, cross-sector, cross-disciplinary teams, to achieve the goals of the Network and a broad spectrum of informal partners, who agree with and support the goals of the Network and are moderately to mildly connected.

Hypothesis 3:

The CNSC will be effective if there is a defined and supported structure that streamlines access to specialized and non-specialized resources.

Hypothesis 4:

The CNSC will be effective if cross-sector network partners have jointly created programs that address barriers and gaps in service at multiple levels.

Hypothesis 5:

The CNSC will be effective if there is a reduction in resource gaps, commensurate with the dedicated funds and human and in-kind resources secured and managed by the Network.

Methodology

A case study approach was followed using secondary literature, government documents and key informant interviews, following a semi-structured interview questionnaire (Appendix C: Interview Questionnaire). The research questions gathered information about the development and evolution of the Network, the organizational structure and goal attainment.

Academic Literature and Secondary Sources

Public administration and community development literature was reviewed for information about the development and management of networks and collaborative relationships. Health and developmental

disability literature was reviewed for, examples of collaborative efforts to provide services to persons with complex needs, in other jurisdictions.

Policy Documents

To gain an understanding of service delivery history and reform, and to develop questions for the primary research, several government documents were reviewed. The following were particularly important:
Developmental Services Act R.S.O. 1990, c. D.11 (DSA);

The Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008;

Joint Policy Guidelines for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis, December 2008

Publicly accessible documents that contain information pertinent to the development, organization and management of the CNSC were requested and provided by the study participants.

Study participants were located on the Community Networks of Specialized Care (CNSC) website and the Ministry of Community and Social Services, Organization Chart, and the Ontario Government Employee Directory, available through the MCSS website. An Information and Interview request letter (Appendix A) was sent to a sample selection of individuals, describing the research study and requesting their participation. Interviews were set up with 25 subjects. The consent form was signed at the time of the interview, or prior and sent by fax. The sample included;
Directors of the Lead Organizations (Network Leads) for the four CNSC (seven cases), Network Coordinators, (including Facilitators and a Video Conferencing Coordinator), Advisory Committee Members, and Program Supervisors for the MCSS.

To allow the study participants to prepare for the interview, the questions were forwarded in advance. Eleven study participants chose to be interviewed in person, seven chose video conferencing and seven chose teleconferences. The in-person interviews and teleconferences were audio recorded and transcribed by the researcher. The video conferencing files were saved as audio files for transcription purposes. All study participants are anonymous. Names appear on a face sheet and on the consent form, with their unique study identification number but there is no direct or indirect attribution in the written thesis. The identity of the key informants is protected when the case can be identified, by grouping information provided by informants. Anonymous quotes are included in chapter 6, where information is presented across cases and anonymity can be maintained.

Study documents are stored in a locked filing cabinet in the thesis supervisors secure office at Ryerson University. The audio tapes were transcribed by the researcher and will be destroyed, after the thesis is defended. The questionnaire and interview transcripts are coded with the study identification number and are stored in a locked filing cabinet at the researcher's home for the duration of data analysis and than in the thesis supervisors secure office at Ryerson University.

Key Informant Interviews

The questions for the key informant interviews were developed after reviewing public administration, community development, health and developmental disability literature, the draft Business Plan and data collection template created by the MCSS.

This explanatory case study uses content analysis to examine the factors that are determinants or help to explain the effectiveness of public service delivery networks. The unit of analysis is the CNSC and the key informants are the units of observation. Using the framework approach created by Pope (2000) key ideas, concepts and recurrent themes in the data were placed in analytical categories based on the questions and hypotheses generated for the study. After the information was indexed, charts were created by placing summaries of the key informants views and experiences into subject areas. The interview data was synthesized with the information gathered from related documents submitted by the key informants, policy documents and secondary literature. The charts were used to "define concepts, map the range and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings" (Pope 2000, 116). This process considered the original research objectives as well as the themes identified in the data.

Rating scale for Level of Connectedness

The key informants were asked to rate the level of connectedness of Network partners on a scale of 1-5, ranging from Strongly Connected at 5, to Not at all Connected at 1. They were prompted to define their choices by describing the type and degree of involvement and the number of of links between partners. This information was placed in analytical categories and indexed following the framework approach. A definition of connectedness was established based on the perceived strength of the partner's participation in network activities and the number of links between partners. When there was more than one key informant for a CNSC or Local Service Delivery Network the ratings of the Network Coordinator or Facilitator were used, as often the other key informants did not have sufficient information to answer the question for all of the Network members. Of note, all ratings were documented and compared and there

was little variance between informants rating the same structure, with the exception of missing information.

Definition of Connectedness

Strongly Connected

90% of the time: attend committee, subcommittee task/ad hoc/working group meetings that they agreed to participate in; volunteer to do the work required by the committee(s)/groups; agree with and promote the values, mission, goals of the CNSC; provide in-kind resources (financial, or human, or specialized services and supports); minimum of 3 links to partners.

Moderately Connected

70% of the time: attend committee, subcommittee task/ad hoc/working group meetings that they agreed to participate in; volunteer to do the work required by the committee(s)/groups; agree with and promote the values, mission, goals of the CNSC; provide in-kind resources (financial, human, specialized services and supports); minimum of 2 links to partners.

Somewhat Connected

50% of the time: attend committee, subcommittee task/ad hoc/working group meetings that they agreed to participate in; volunteer to do the work required by the committee(s)/groups; agree with and promote the values, mission, goals of the CNSC; provide in-kind resources (financial, human, specialized services and supports); minimum of 1 link to partners.

Mildly Connected

30% of the time: attend committee, subcommittee task/ad hoc/working group meetings that they agreed to participate in; volunteer to do the work required by the committee(s)/groups; agree with and promote the values, mission, goals of the CNSC; provide in-kind resources (financial, human, specialized services and supports) minimum of 1 link to partners.

Not at all Connected

Not actively involved in network activities and no links to partners

According to the key informants, the four regional CNSC, develop an annual Work Plan that includes goals, activities and outcome measures to address the mandate and functions they are responsible for. Although the CNSC were announced in May 2005, they did not become operational until May 2006. The

key informants indicated that for the first year of operation, the focus of the Networks was on planning and development. Thus the outcome data available for this thesis is from May 2007 until May 2009. Each CNSC followed their own system of documenting outcomes and goal attainment, in this two year period, because a template for data collection was not developed by the MCSS until April 2009.

The MCSS require all of the CNSC to fulfill the following mandate and key functions.

Mandate and Key Functions

1. Coordinate specialized service system
   a) streamline access to specialized services
   b) breakdown barriers between the Developmental Services (DS) specialized and mental health service systems
   c) expand partnerships
   d) strengthen linkages and formalize relationships with DS and specialized mental health providers such as MOHLTC Assertive Community Treatment Teams to better manage scarce resources and improve the case resolution process for the most challenging clients
   e) Network leads will also develop intra/interregional access protocols and intake/prioritization mechanisms for specialized services linked to non-specialized service system

2. Enhance Service Delivery
   a) improve capacity of Network members to develop a broader range and increase the volume of services that both specialized and DS service providers can offer (e.g. by providing consultation, specialized assessment, clinical services to and supports to Francophne, Aboriginal, remote and rural communities, where applicable)

3. Train and Build capacity in the community
   a) develop relationships with the academic and research community
   b) improve access to research/best practices
   c) increase expertise in specialized services through professional development and practicum opportunities, train general health and social service practitioners, develop plans to recruit and retain more specialized providers
   d) Networks are mandated to work together to develop province-wide strategies and initiatives that promote partnerships, collaboration, and coordination of activities across the four regional CNSC, including access to provincial resources, videoconferencing, targeted research and training; coordination of the MOHLTC service enhancements initiative to keep individuals with a mental illness out of the criminal justice system
   (MCSS May 8, 2008, 1).

This study examines the outcomes of the first mandate, to coordinate the specialized service system, as a measure of the Networks effectiveness. The outcomes for this mandate are identified in the logic model and/or annual Business Plans, developed by the four regional CNSC and are used in the analysis to determine the effectiveness of the CNSC. The criteria were selected from a list generated by Reed (2009) for the evaluation of the Central Region CNSC and from secondary literature.

The outcome measures are as follows;

- Shared Accountability and responsibility for individuals and the system exists within the Network
- Specialized service options are clearly defined and communicated
- Agency Collaboration occurs at multiple levels
- Gaps in services are identified and plans are developed (Reed 2009, 74)

The criteria used to measure the attainment of outcomes, are as follows;

- Composition and diversity of leadership
- Size and heterogeneity of the Network, partner participation (time, attention, in-kind resources)
- Presence of inter-sectoral , cross-sectoral partners
- Partners share a common understanding of the goals of the network
- Goals related to integration, short and long-term goals
- Degree to which the network is based on shared responsibility for achieving goals
- Number of new linkages as a result of the network, formal (contractual/written) and informal
- Evidence of working together on programs
- Integration and Coordination of services (formal and informal accountability)
- Absence of service duplication
- Strategic resources are obtained and constraints to achieving network integration addressed (Reed 2009, 74)

There are several limitations to the study methodology. The Networks have been fully operational for only two years, which is a short duration for a study of effectiveness. It is also hard to generalize the findings given that only seven cases are studied. It was overly ambitious to expect to thoroughly address all of the questions in the 1.5 hour limit, set for the interview. The informants found it especially challenging to answer the questions on network structure such as the indirect and direct connections between Network partners, fragmentation, cliques and structural holes, due to the large number of partners, in their network and because they have been operating for only two years. While this limited the

analysis and discussion of, fragmentation, structural holes, and cliques as factors in network effectiveness, it may not have been an appropriate question because the CNSC fall somewhere between a newly forming and a mature network. This study methodology requires the use of direct quotes to support the analysis. This presents a challenge when the anonymity of the key informants is guaranteed and there are a small number of cases and key informants, which could reveal identity.

The Central Region CNSC is treated as three cases in the analysis. Although the Central East, Toronto and Central West CNSC, that comprise the Central Region CNSC, share an administrative structure, the Tri-Regional Alliance, each has operated separately to address the mandate to coordinate the specialized service system, in their respective Networks. As the outcomes vary across the three Networks, they have to be analyzed separately. This is also the case in the East Region CNSC. The South Eastern and Eastern CNSC evolved and developed separately over the first two years and thus the outcomes vary and are analyzed as separate cases.

CHAPTER 2

Central Region Community Network of Specialized Care

Introduction and Background

The Central Region of Ontario spans from Waterloo in the west, to Peterborough in the east, and from Toronto in the south to Penetanguishene and Haliburton in the north and is home to 6,369,000 individuals, fifty percent of the provinces population. Using the prevalence rate for developmental disability at 1 percent of the total adult population and 38 percent of that population having a dual diagnosis, it is estimated that this Region of Ontario has an estimated 63,690 individuals with a developmental disability and approximately 24,202 have a dual diagnosis The Region is divided into three geographic sub-regions, Central East, Toronto and Central West, each affiliated with a MCSS area office (Carver, 2005).

Prior to the formation of the CNSC, communities in the three-sub regions had their own varied structures and processes for identifying, coordinating, and planning service delivery for individuals with developmental disabilities and complex mental health needs and/or challenging behaviour (Carver, 2005). Each region had Developmental Services Planning Tables that addressed overall planning and coordination issues for the sector. Six, Dual Diagnosis Committees (DDC) were established in the region to coordinate access to specialized clinical services. DDC in two of the sub-regions created a local or service resolution process and in the third individuals accessed the system through "direct referral to one of the cross-sectoral specialized clinical services partnerships" (Carver 2005, 17). Each sub-region had a Service Resolution process in place to respond to complex service situations and two of the three established a regional table to address more difficult cases. While these structures facilitated service coordination in general, the cross-sector access processes were not well developed. Individuals with a developmental disability who required core and specialized mental health services from Ministry of Health and Long Term Care (MOHLTC) funded organizations "were challenged by the lack of a coordinated access system" (Carver 2005, 17).

According to the key informants, the unequal distribution of resources within the three sub- regions significantly impeded the service coordination and access mechanisms. Additionally collaboration was contingent on the relationships within the developmental services sector, including the local MCSS area office, and between the developmental and mental health sector providers. Engaging MOHLTC funded providers in collaborative planning, service coordination and delivery was challenging if they did not

perceive it their role, to serve individuals with behaviour problems that were an outcome of their developmental disability.

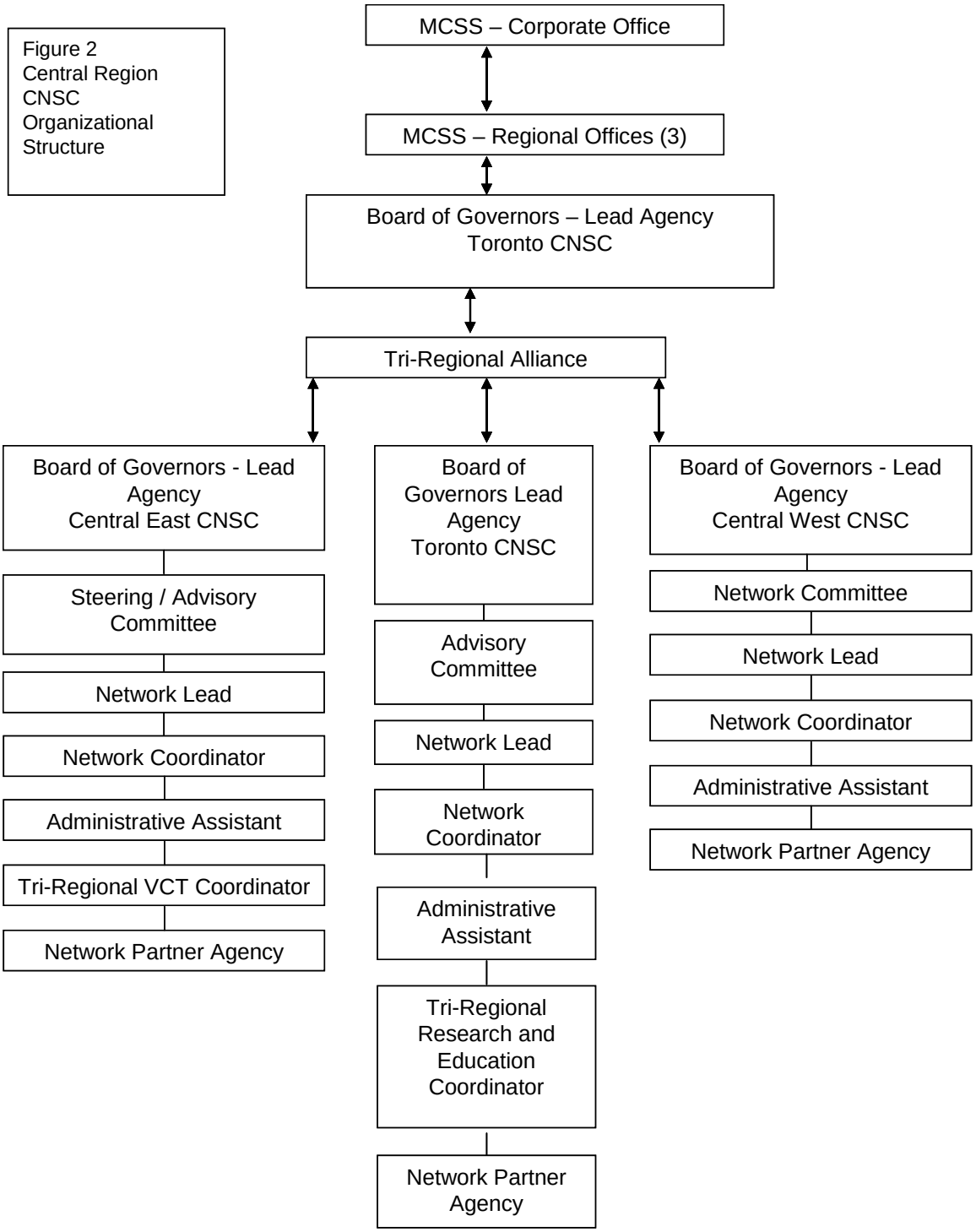
The absence of a full range of specialized services in most local areas resulted in significant waiting lists for "specialized assessment, consultation, treatment, case management, and residential treatment" (Central Region CNSC September 7, 2006, 6). All regions were in the process of developing a coordinated crisis response network. Specialized mobile outreach was not available in all communities which was critical for "access to tertiary-level care through specialized hospital-based programs" (Carver 2005, 17). Limited community resources, including appropriate residential placements and clinical supports contributed to the continued reliance on highly restrictive treatment, or custody settings when the individual was in crisis, rather than on community-based assessment, and early intervention services (Carver, 2005).

Specialized service providers across the region were teaching at universities and colleges and many developmental and mental health agencies were offering student placements to a broad range of professional disciplines and paraprofessional groups. However, there were not enough resources and knowledgeable practitioners to meet training and capacity-building needs. Recruiting and retaining qualified staff was an issue (Carver, 2005).

Organizational Structure and Accountability

After widespread consultations and a review of best practice, a two tier organizational structure was selected for the Central Region CNSC. The first tier is comprised of a CNSC in each of the three sub-regions, supported by a lead agency. A Tri-Regional Alliance (TRA) was created for the second tier to, address system-wide issues, build capacity within and across sectors and across sub-regions by creating linkages/connections, with a focus on education, research and evaluation (Central Region CNSC, September 7, 2006). The organizational structure for the Central Region CNSC is depicted in figure 2.

Figure 2
Central Region
CNSC
Organizational
Structure



A Network Implementation Advisory Committee, (NIAC) comprised of cross-sector regional service providers from each of the three sub-regions was convened in March 2006, to oversee the development of the Central Region CNSC. The NIAC developed a "conceptual framework identifying structures and functions for key network elements at the regional, tri-regional and provincial levels" (Central Region CNSC, September 7, 2006, 14). It was agreed that, the three CNSC would work collaboratively with existing core developmental, mental health, justice and primary care providers in their sub-regions, to plan, develop and coordinate the delivery of specialized services to individuals in the target population (Central Region CNSC, September 7, 2006).

The Tri- Regional Alliance Business Plan for, 2006/2007, 2008/2009, was developed by the NIAC. It delineates the; Network vision; principles; the three key structural elements of this CNSC, that is, the Tri-Regional Alliance (TRA), the three lead agencies and the three regional networks; the mandates, functions, goals, objectives, and strategies to obtain the anticipated outcomes for these two years of operation; and resource allocations. An annual Work Plan to address the specific functions and objectives was developed by the TRA and the three regional CNSC. Annual reports contain information on outcomes to inform and reform the multi-year Business Plan. A Logic Model was developed by the TRA to provide a blueprint for the relationship between overall goals, activities, outcomes, outputs and performance indicators for the TRA (Central Region CNSC, September 7, 2006).

In this model, the role of the three CNSC in the region is to identify the specialized clinical services needed in their respective sub-regions based on, the demographics and characteristics of the community and to build capacity to deliver the services, using existing resources. The CNSC monitor the service delivery system, to ensure that those in need have clear access to needed services and reports gaps and barriers to the Tri-Regional Alliance. Another function is to engage specialized service providers and academic/training organizations to deliver education and training programs suited to local needs and collaborate and link with research partners to ensure development of evidence-based research material (Central Region CNSC, September 7, 2006).

A Network Coordinator and Administrative Assistant resource each of the CNSC and a Video conferencing Coordinator and a Research and Education Coordinator are shared by the TRA and the three Networks. The TRA and the three Networks became fully operational in the spring of 2007 (Central Region CNSC, September 7, 2006).

The NIAC evolved into the Tri-Regional Alliance Advisory Committee. Membership includes the three Network Leads and Coordinators, the Video-Conferencing and Research and Education Coordinator, an academic and health sciences provider, a member from the research and evaluation community, a family member and a representative from the MCSS and the MOHLTC. Task groups and sub-committees were formed within the Education and Training Committee and the Evaluation and Research Committee to expedite the work of the TRA. These groups and sub-committees report on their progress at monthly meetings held by the three regional Network Leads and Coordinators. The three Network Leads attend regular meetings with the managers of three regional offices of the MCSS and the Network Leads and all of the Coordinators meet regularly with MCSS managers (Central Region CNSC, April 1, 2009-March 31, 2012).

"The governance model for the Central Region Network is a memorandum of understanding-based lead agency model with several key structural elements to ensure accountability for outcomes, at the regional and tri-regional levels" (Central Region CNSC September 7, 2006, 22). The formal accountability relationship is delineated in the Service contracts between the MCSS and the Board of Governors for the three Lead Agencies, which hold them accountable for the leadership, development, operation, attainment of outcomes and fiscal management of their individual networks, as well as that of the Tri-Regional Alliance. The three lead agencies sign a Partnership Agreement that establishes their joint responsibility for the operation and outcomes of the Tri-Regional Alliance. The Terms of Reference for the Tri-Regional Alliance identifies its roles and responsibilities in the Central Region CNSC, as well as the membership, and reporting requirements (Central Region CNSC, September 7, 2006).

The MCSS designated accountability for the funding allocation and performance outcomes of the Tri-Region Alliance to the lead agency for the Toronto CNSC. The funding to construct an infrastructure to build capacity through education and for the salary of the Education and Research Coordinator was also allocated to this lead agency. The MCSS designated accountability for the Videoconferencing technology, including the salary of the Regional Videoconferencing Coordinator to the lead agency for the Central East CNSC The three Networks in the Central Region will be analyzed as three separate networks because they operated separately to achieve the mandate to coordinate the specialized service system in their regions (Central Region CNSC, September 7 2006).

i) Central East Community Network of Specialized Care

Introduction and Background

The Central East Community Network of Specialized Care, (Central East CNSC) is made up of four geographic sub-regions; Simcoe County, Durham Region, York Region, "an agglomeration of counties referred to as the Four Counties HKPR (Haliburton, Northumberland, Kawartha Lakes, Peterborough)" (Carver 2005, 9). This region is home to approximately 1,884,000 people including a "significant Francophone population and First Nations communities" (Carver 2005, 9). Using the prevalence rate for developmental disability at 1 percent of the total adult population and 38 percent of that population having a dual diagnosis, it is estimated that 18,840 people have a developmental disability and approximately 7,159 of those have a dual diagnosis in this CNSC (Carver, 2005).

Prior to the introduction of the Community Network of Specialized Care (CNSC), the developmental service providers in the region had established many formal and informal collaborative partnerships and linkages. The first regional resource, the Developmental Services Regional Planning Committee, was created by the MCSS in 2000. It was and continues to be responsible for system planning, issue identification and funding allocation recommendations to the Ministry, for the Central East region (Reed, 2009). According to key informants, in October 2004, with funding from the MCSS, and its *New Places to Live*, initiative, developmental and mental health service providers collaborated and formed the Pineview Project Steering Committee, the second regional structure. This cross-sector committee developed, implemented and monitored a five bed transitional treatment home and a specialized Mobile Resource Team for the region. In addition to these two regional structures, each of the four geographic sub-regions in the Central East region had an active local Dual Diagnosis Committee and a local Developmental Service Planning Committee (Carver, 2005).

Findings from the Environmental Scan identified two MOHLTC and the eleven MCSS funded agencies that provided specialized services to the target population. In the opinion of respondents to the Reed (2009) evaluation, specialized service providers were present in all parts of the region and had a very strong capacity to deliver services. Tertiary, inpatient, outpatient and day treatment services were present in most parts and had moderate capacity. While crisis response services and specialized consultation/ assessment, brief intervention, multidisciplinary teams were present in all parts, they had limited capacity. Specialized case management and day and residential treatment were not present in all parts and where present had very limited capacity. A Regional Service Resolution mechanism was and continues to operate for complex cases that can not be resolved, at the local level. According to the key informants,

prior to the CNSC the collaborative-cross sector work at the local level, was based on, a spirit of cooperation because no formal requirement was in place, nor were resources available. Consequently the same level of coordination, collaboration and links was not present, across the four geographic sub-regions (Carver, 2005). .

Organizational Structure and Accountability

The Network Implementation Advisory Committee (NIAC) chose to use the infrastructure of the pre-existing Pineview Project Steering Committee to create the Central East CNSC. Each of the four geographic sub-regions in this Network, operate as a local service delivery network with their own access mechanism to specialized behaviour, case management services and case resolution. The CNSC brings them together at a systems level, by having the Network Coordinator facilitate referrals from the local case resolution committees to specialized resources, such as clinical assessments and clinical consultation, through video-conferencing, and access to the Mobile Resource Teams. The Network Coordinator also sits as a member on the Regional Case Resolution Committee to manage referrals and intake to the specialized treatment beds in the Region (Reed, 2009).

With the structure established the NIAC was replaced with a Steering/Advisory Committee, convened by the Network lead, to oversee the work of the CNSC, guided by Terms of Reference and detailed annual Work Plans. The Committee is comprised of eighteen members, fifteen voting partners and the Network Coordinator, Tri-Regional Alliance Videoconferencing Coordinator, MCSS Program Supervisor, all ex officio members. The Steering/Advisory Committee is co-chaired by a developmental and a mental health service provider and meets bi-monthly (Reed, 2009).

According to the key informants, in the spring of 2008, the Central East CNSC struck a regional Education and Training Committee by merging the four existing Dual Diagnosis Education Committees in the region. A Terms of Reference and Work Plan were created for the committee. Five sub-committees, ad-hoc working groups and task forces, were formed to support the work of the Education and Training Committee. The formal accountability relationships are described in Chapter 1 and the section on the Tri-Regional Alliance. In the case of the Central East CNSC, the Steering/Advisory Committee has an additional level of accountability, as it reports both to the TRA and to the Regional Developmental Services Planning Committee. Griffith (2007) and Reed (2009) conducted formal evaluations of this Network.

Results

The data was obtained from, the key informant interviews and secondary sources; the Reed evaluation (2009); the Central Region CNSC Business Plan, September 7, 2006; the Central Region Business Plan, April 1, 2009-2012; other Central East CNSC documents.

Historical relationship and collaboration between network partners

According to the key informants there are two pre-existing structures in this region that provided cross-sector partners in the Central East CNSC, with an opportunity to cooperate, coordinate and collaborate in developing resources to meet the needs of individuals with a DD and mental health and/or challenging behaviour. Many of the partners on the Central East CNSC Steering/Advisory committee are former members of the Pineview Project Steering Committee, and the history of positive collaborative activity has made it easier to participate in a coordinated effort to address the mandate, and goals of the Network. The Steering/Advisory committee is also connected to the Regional Developmental Services Planning Committee through reporting requirements, and the Network leads continued membership on the committee. The key informants shared that the Network lead was selected by his peers on the Regional Developmental Services Planning Committee, to devise a plan for a sum of money provided by the MCSS to address a service deficit in the region. In their opinion this demonstrates the legitimacy and trust between Network members, that have a history of collaboration.

Leadership

According to the key informants, the Lead agency and Network lead chosen by the MCSS have a long history of strong and productive local, regional and provincial cross and inter-sector collaboration, addressing the needs of individuals in the target population. The Network lead has participated on community boards and governance committees for decades and is recognized by his colleagues for his wisdom and expertise. He was selected by his peers in the CNSC, to head the Ontario CNSC. This individual is described by the key informants as a true champion, who devoted tremendous time, effort and energy during the planning phase, to elicit feedback from community agencies ensuring the vision, mission and goals of the Network were in line with their needs. This same level of commitment has continued as the Network lead has built capacity by collaborating with a broad range of cross-sector partners to create a strategic plan that has, increased and enhanced service coordination, built community capacity through training and education, evidenced by the Networks accomplishments that will be reported in the following paragraphs. According to the key informants the Network leads ability to focus on the needs of the individuals in the target population has helped mitigate conflicting agendas of Network partners and opposition to the new governance model. His knowledge of the pressure and gaps

in services has helped him secure many partners, through promoting the philosophy that no one agency can meet the complex needs of the individuals in the target group alone. He has helped the Network partners move out of their comfort zone and mind set and use different approaches to problem solve, while validating their opinions and ideas. The Network leads role is in-kind, and supported by the lead agency, he demonstrates that the CNSC cannot expect its partners to make a strong personal investment, if the Lead agency and Network Lead do not. An example of the in-kind resources provided by the Lead agency is funding for five specialized accommodation spaces.

According to the key informants, formal and informal leadership in the Central East CNSC is dispersed by the Network lead, among a core group of Network members including the Network Coordinator, MCSS Program Supervisor, and the chairpersons of the Network Steering/Advisory committee and the various sub-committees, task forces and work groups. In their opinion effective governance of this CNSC is contingent on this shared leadership.

The key informants consider the Network Coordinator an indispensable champion of the Network because of, strong leadership skills, which include written and verbal communication, facilitation, mediation, problem solving and patience. These skills are demonstrated in coordinating access to regional specialized resources, including crisis response and specialized accommodation. Partners are also continually engaged through the almost daily sharing of resource information and the frequent local and regional presentations about Network accomplishments, which is also a strategy to recruit new partners (Reed, 2009). In addition the key informants noted that the Coordinator helps to bridge communication between the MCSS and the other regional Network Coordinators.

The key informants describe the sponsorship and leadership of the MCSS Program Supervisor as vital to the Network. This individual is a committed, active participant, instrumental in creating the Clinical Providers Working Group to coordinate behaviour services in the region. He represents the CNSC on two Human Service and Justice Coordinating Committees, providing valuable links to the Crisis Coordinators, lawyers, Crown Attorneys, prosecution, and police. The other three MCSS Program Supervisors for the region and the regional manager attend the Regional Developmental Services Planning Committee meetings, where they are apprised on the ongoing work of the Network through information provided by the Network and Videoconferencing Coordinator.

According to the key informants, there are fourteen members on the Steering/ Advisory committee, eight representatives are from MCSS funded agencies, five, from MOHLTC funded agencies and one from an

agency dually funded by both ministries. They were selected by the Network lead for their; strong representation at an Executive Director level in the four sub-regions; their strategic skills, knowledge and expertise in dual diagnosis; and their links and connections to a broad spectrum of service providers, including the field of Probation and Parole, Autism Spectrum Disorder, and Seniors Citizens with mental health needs. All members have been on the committee since its inception, except one. According to the key informants they, reflect the mission and goals of the CNSC and have demonstrated an ability to work together, as indicated in the following example. The specialized services available from the, two Mobile Resource Teams (MRT), are still seen as somewhat inequitable, especially in the most rural and remote parts of the region. To address the service deficit, the committee is negotiating with the MCSS to develop a pilot project to combine the two MRT and make two of the residential treatment beds virtual. It has been a challenge to convince the Ministry that the virtual beds have merit, given their mandate to pay for heads on pillows. However, the Network committee believes that it is more responsive and individualized to bring treatment to a person in their home/community, rather than move the individual to a treatment facility and make them transition back home, where there are no appropriate community supports.

The following network partners are linked to the Steering/Advisory committee in a non-voting capacity; Community Crisis Response Network Chair, Central East Dual Diagnosis Education Committee Chair; Regional Case Resolution Chair; Regional Developmental Services Planning Committee Chair; TRA Education and Research Coordinator; TRA Videoconferencing Coordinator (Central Region CNSC, 2009-2012). According to the key informants, these regional ties are critical to address system level changes.

The key informants reported that, the Network lead selects the chairpersons of the sub-committees, task forces and work groups from the front line and middle management level of partner agencies because of their solid working knowledge of the specialized service needs of the target population. Introducing new members with strategic knowledge increases the quality of collaborative activity and provides an opportunity to, foster links between new and existing members and community agencies. Witnessing the beneficial outcomes of cooperative, coordinated and collaborative activity, in the opinion of the key informants, contributes to the success and sustainability of this CNSC. The following chart describes the number of members involved in the various sub-committees, task forces and work groups. Their level of connectedness to the Network is discussed in the following section.

Type of Involvement	Number of members involved
Regional Education and Training Committee	12 partners
Team Analysis and Community Treatment Committee (T.A.C.T) 4 sub-groups of T.A.C.T; Access and Process group; Staffing and Operations group; Evaluation and Discharge group; Person-Centred Planning group	11 partners 22 partners on the four sub-groups
Specialized Day Supports Task Group	9 partners
Collaboration and Research Committee	16 partners
Mental Health Beds and Discharge Planning Group	6 partners

According to the key informants, a critical element in the operation of the Network is the in-kind specialized resources that have been secured from, the following 17 partners.

Type of Specialized Resource	Number of Agencies
Broad spectrum of specialized services	1
Specializes in Autism Spectrum Disorder	1
Case management services	2
Tertiary care/dual diagnosis programs	2
Behavioural services	3
Specialized accommodation spaces	4
Primary care and community-based mental health services	4

There are 42 broad partners in the Central East CNSC (Central Region CNSC, 2009-2012) including, the members on the Steering/Advisory Committee, the subcommittees, task and work groups, the agencies that provide and access specialized resources and those on the periphery. The key informants have rated their level of connectedness to the Network as follows,

Rating	**Number of Partners**
Strongly Connected	12 partners
Moderately Connected	11 partners
Somewhat Connected	0 partners
Mildly Connected	16 partners
Not at all Connected	3 partners

Respondents to the Reed (2009) evaluation reported that "all providers at the Network Committee table feel committed to attending meetings and working together on shared tasks; there is some mutual responsibility, but work needs to be done on ensuring this is coming from all members"(Reed 2009,14). In the opinion of the key informants the partners they rated as strongly and moderately connected share accountability and responsibility for the goals and outcomes of this CNSC. There is solid cross-sector, cross-discipline and across and within agency representation. The reality is, that while the Memorandum of Understanding address the member's responsibility to commit specialized resources, the reality is that no one has unlimited resources to offer to the Network.

The key informants report that, ten agencies have accessed the specialized services and supports on behalf of the individuals they support, whose needs could not be met using local resources. To date, sixteen agencies have been able to meet the specialized service needs of the individuals they support. They report a good understanding and agreement with the goals of the Network and have the knowledge required to access the system, if necessary. Three community agencies that are described by the key informants as, "resource rich" elect not to collaborate in the Network because they are able to meet the needs of the individuals in the target population that they serve. They also demonstrate this insular behaviour at the Regional Developmental Services Planning Committee. In the opinion of the key informants, "these agencies operate as cliques" and their resources would be an asset and would contribute to the achievement of outcomes in the Central East CNSC.

Internal and External Alignment

According to the key informants the partners in the Central East CNSC established and support a regional access mechanism to specialized resources for the individuals in the target population that is coordinated with the access mechanism at the local service delivery level. The Network enhanced the existing Local Access Mechanism and Local Case Resolution process by providing individuals in need of specialized resources and or supports an opportunity to access clinical services through one of the two interdisciplinary MRT prior to going to Regional Service Resolution. Referrals for these clinical services go through the Local Case Resolution Committee. If they establish that the local resources are not available than a referral package is submitted to the Network Coordinator who forwards it to the appropriate MRT chairperson. The Central East CNSC also developed a standardized process for individuals seeking specialized crisis response services and a formal centralized access process to the seventeen specialized accommodation spaces, the referral and intake process being managed by the Network Coordinator. An Intake package that describes the referral process, roles and responsibilities of

service providers was developed and is widely disseminated by the Coordinator (Central East Network of Specialized Care, September 2008).

In the opinion of the key informants, by streamlining access to specialized resources, crisis response services and specialized accommodation spaces at the local and regional level, the Network and community partners are internally and externally aligned with the goals of the CNSC. Fourteen partners on the Steering/Advisory Committee were instrumental in developing the regional access mechanism to specialized resources and the protocol for crisis response services. Eleven Network partners participate in the Team Analysis and Community Treatment (T.A.C.T.) Committee and twenty-two partners participate in the four sub-groups of the T.A.C.T to develop the formal centralized access process to the seventeen specialized accommodation spaces, based on best practice. Seventeen agencies support the regional access mechanism by providing a range of specialized resources. This high level of in-kind support and active participation by the membership confirms the opinion of the key informants that alignment exists in this CNSC.

Informal Coordinating Mechanisms

The Collaboration and Research Committee (C.A.R.) was formed to, promote and implement research activities and common data and reporting systems, to identify gaps in services and to develop access protocols to increase clinical resources through videoconferencing (Central Region CNSC, September 7, 2006). The following barriers and gaps in services have been identified;

- Bed blocking
- Crisis services
- Primary health care
- Dual Diagnosis Justice Case management services
- Specialized Day Supports

The Network partners jointly developed the following programs to address these barriers and gaps in service. These achievements would not have been possible without a strong social control mechanism in this Network.

According to the key informants, inpatient treatment beds are blocked due to the lack of appropriate community residential placements. As mentioned in the section on alignment, a large number of cross-sector partners participate on the T.A.C.T. committee and the associated working groups, to develop a formal centralized access process to seventeen specialized accommodation spaces that are spread across

four developmental service agencies, one in each sub-region. They monitor the process and spaces to make sure they are being used effectively and efficiently (Central Region CNSC, September 7, 2006).

The Mental Health Centre Beds and Discharge Planning Group develops plans to move individuals in tertiary care mental health hospitals (legacy patients), to the community, unblocking hospital beds and making them available for appropriate utilization. Four of the seventeen specialized accommodation spaces have been given to legacy patients, reducing the wait time to one week for a bed at a tertiary care facility. The Network Coordinator participates in a Provincial Advisory Group to identify the number of legacy patients and strategize solutions.

According to the key informants the Network Lead and Coordinator work strategically with the Network partners, to resolve complex problems. For example, the Network partners deliberated about an individual with complex needs blocking a treatment bed. One agency, offered case management services, one behaviour services, another, psychiatric services and the Network lead negotiated with the MCSS for funding for a residential bed. By pooling resources, no one service provider was burdened with the full responsibility for the care of the individual.

Key informants report that participation in the Network has influenced the adherence to standards of the mental health Assertive Community Treatment Teams (ACTT). Clients are avoiding hospitalization because of the coordinated community response. Those hospitalized are staying for shorter periods of time, mitigating institutional effect and allowing for continuity of supports

The Central East CNSC, facilitated an inter-agency, cross-sector collaboration to develop a second regional MRT, linked to a, tertiary care mental health centre, a Schedule 1 hospital and a community-based health service. An evaluation of the MRT is underway to clarify roles, ensure consistency, and the efficient use of resources as a result of a report that specialized crisis services are not as available in rural and remote parts of region (Central Region CNSC, September 7, 2006).

The Community Crisis Response Network was created to support individuals in the target population during acute situational crises, using existing resources and cross-sector partnerships fostered by CNSC (Reed, 2009). This Network is staffed by four Crisis Response Coordinators, one for each sub-region, who are employed and supervised by a service delivery agency in their sub-region and report to the Network Coordinator, who holds administrative accountability. The Community Crisis Response Network is directly linked to the community mental health crisis response services in each of the four

sub-regions. A significant number of cross-sector and discipline, and inter-agency partners are involved in this joint program (Central Region CNSC, September 7, 2006).

To address the lack of Primary care practitioners (family physicians, family health teams, Community Health Centres, Nurse Practitioners) available to provide medical care to the individuals in the target population, a pilot project is being developed to bridge primary care health services with developmental services through physician education (Central Region CNSC, September 7, 2006).

The Dual Diagnosis Justice Diversion Case Management position funded by the MOHLTC is divided between the four sub-regions. Each Crisis Response Coordinator spend .25 percent of their time as a Justice diversion case manager, paid for by MOHLTC dollars and .75 percent of their time working as a Crisis Response Coordinator, paid for by Network dollars. The Case Managers are linked to the criminal justice system, and forensic services, with new links being created to the local police departments (Central Region CNSC, September 7, 2006).

The Specialized Day Supports Task Group was formed to; support and acknowledge community partners who deliver specialized day supports; develop an inventory of provider agencies; offer a forum for knowledge exchange; and dialogue and to ensure that specialized day programs are being used efficiently with no duplication of services (Central Region CNSC, September 7, 2006).

The key informants report that while the barriers are starting to move between the developmental and mental health sector providers there are still many obstacles impeding collaboration. It has been a challenge to implement the Joint Policy Guidelines, with the LHINs, as they have struggled to get established as an entity in the province. The Chief Executive Officers for all of the LHINs in the province have changed since their inception. This, and the fact that there are five Local Health Integration Networks (LHINs), located in the Central East region, all with different agendas, has impeded the work of the Network to meet the goal of breaking down the barriers. A meeting was held with a representative from a LHIN whose boundaries fall in both the Central East and North CNSC. The offer from the CNSC to resource their committee was not accepted but they have agreed to disseminate the Dual Diagnosis Guidelines with the CNSC. The other two LHINs have been plagued with internal problems and agreed to work with the Network to roll out the Guidelines, six months after the date they were to be implemented.

Resources

The Central East CNSC receives $299, 578 annually, in dedicated funds to cover expenses as described in chapter 1. The MCCS also provides funding for the; TRA Videoconferencing Coordinator's salary, videoconferencing technology, twelve specialized accommodation spaces, four Community Crisis Response Coordinators, and a sexuality consultant. The MOHLTC funds one full-time equivalent Dual Diagnosis Justice Diversion Case Manger position. (Central Region CNSC, September 7, 2006). According to key informants, in-kind resources are provided by the Lead agency, and Network partners supporting committee work and providing specialized resources.

The key informants provided many examples of the Network lead managing and distributing dedicated funds, human resources and in-kind resources, efficiently, to maximize the benefit to the individuals and the community being served and effectively and equally across the four sub-regions, as in the case of the Community Crisis Response Coordinators, the Dual Diagnosis Justice Diversion Case Manager position, the specialized accommodation spaces and the sexuality consultant for the region. However, despite the efforts of the Network leader to equalize resources across the four sub-regions, one sub-region that faces some unique challenges, given the nature and size of their population, feel that they do not receive adequate resources from the Network. They have two representatives on the Steering/ Advisory Committee to represent the needs of their sub-region but they continue to feel that their region is not being adequately resourced.

A centralized flexible fund pays for clinical assessments, consultation and resources, to cover gaps in services, all individuals in the target population having equal access to these funds. According to the key informants the sum of money available in the flexible fund is insufficient to address the gaps in resources.

The key informants report that working together has improved the use of resources, and the delivery of coordinated services to a very vulnerable population. An unforeseen benefit of the joint action has been a reduction in stress knowing that the individual you are responsible for is receiving the services they need. An understanding appears to be developing that a cost benefit relationship exists in a collaborative partnership and that, the benefits outweigh the costs.

Data indicates that the sexuality consultant has made significant accomplishments for the small investment of money. In the opinion of the key informants, if an agency had been created to oversee this position, it would have cost twice as much, for the same return. They offered examples of system level changes that could represent significant cost savings to the MOHLTC and result in appropriate services

and supports to individuals in the target population, such as developing community-based residential and clinical services for individuals currently residing in twenty-seven Dual Diagnosis beds in a tertiary care centre, that costs between one thousand and sixteen hundred dollars a day.

Conclusion

According to the key informants and secondary sources, a broad spectrum of Network partners from the developmental and mental health sector engaged in collaborative activity in two pre-existing regional structures, which they contend contributed to the rapid development and acceptance of the Central East CNSC. Their history of successfully sharing risks, resources and responsibility, to achieve common goals, established a foundation of trust, legitimacy, cooperation and coordination required in a collaborative alliance (Wood and Gray 1991, Provan and Milward 2000, Roussos and Fawcett 2000, Bryson, Crosby and Stone 2006).

The information provided by the key informants and the secondary sources, indicates that, the leadership demonstrates the core competencies related to effectiveness (Roussos and Fawcett, 2000) and employ strategic management tools to successfully integrate and coordinate a representative partnership. The composition, diversity and involvement of the partners, reflects the agenda of the Network, which is instrumental in addressing the Network mandate (Gray and Wood, 1991, Mitchell and Shortell 2000, Roussos and Fawcett, 2000, Agranoff and McGuire, 2001).

The key informants and secondary sources report that, the Central East CNSC successfully streamlined access to specialized resources, crisis response services and specialized accommodation spaces, at the local and regional level and actively supports the mechanism. It appears that the mission and purpose of this goal is shared by individual network and community partners, indicating that they are internally and externally aligned with this mandate of the CNSC (Mitchell and Shortell, 2000). The members of the Steering/Advisory Committee, the Team Analysis and Community Treatment Committee and the four sub-groups of the T.A.C.T were involved in this initiative, indicating a high level membership and community support.

According to the key informants and secondary sources, cross-sector network partners in the Central East CNSC have collaborated to develop a significant number of joint programs that address barriers and gaps in services, at multiple levels. While the Network lead secured formal agreements (Memorandum of Understanding) with six core developmental specialized service providers, including two mental health tertiary care providers (Central Region CNSC, 2009-2012), the key informants feel that the program

development is reflective of network partners cooperating, coordinating and collaborating informally, based on a strong foundation of trust, reciprocity and legitimacy, inculcated by the Network leadership (Mitchell and Shortell, 2000).

The key informants and secondary sources indicate that the Network lead manages and distributes dedicated and in-kind resources, efficiently, to maximize the benefit to the individuals and the community being served and effectively and equally across the four sub-regions, which legitimizes the Central East CNSC (Provan et al., 2007). This opinion is supported by the number and type of joint programs/resources that have been created with the available resources. The key informants suggest that as a result of the limited resources, particularly flexible funds, there continues to be gaps in services, which impacts network effectiveness. They believe that the MCSS expects network participants to volunteer their time and resources to do the work of the Network. The money for specialized resources has to go through an agency with its own board of directors, which can create a challenge to a seamless system, since agencies are governed differently. There is also an over reliance on agencies that are known to help. The limited dedicated resources from the MCSS, is further complicated by the Ministry's Transfer Payment Business Cycle, which requires the lead agencies to fund projects that overlap budgets. An ongoing concern expressed by the key informants is how this level of commitment can be sustained. All respondents agree that the MCSS must make a financial commitment to cover costs of the CNSC.

The key informants and secondary sources describe the Central East CNSC as a legally autonomous, formally established entity of partners, engaged in a non-hierarchical relationship, who collaborate to achieve a common goal and are governed by a central authority with dedicated resources. In their opinion this Network is effective because they have developed an access mechanism to an array of specialized programs/resources that is coordinated and seamless. Fragmentation, gaps and replication of services have been reduced. The individual partners working alone could not have established this system of specialized service delivery.

ii) Toronto Community Network of Specialized Care

Introduction and Background

The Toronto Community Network of Specialized Care (Toronto CNSC) is comprised of the former cities of Toronto, York, North York, Etobicoke, Scarborough, and the Borough of East York. Forty-six percent of the 2.5 million residents are from a Non Anglophone background (Carver 2005, 9). Using the prevalence rate for Developmental Disability at 1 per cent of the total adult population and 38 percent of that population having a dual diagnosis it is estimated that 25,000 people being served by this CNSC have a developmental disability and approximately 9,500 of those have a dual diagnosis (Carver 2005, 9).

Preceding the development of the Toronto CNSC planning, coordination and service delivery in the developmental service sector in this sub-region was fully integrated at the regional level. The Developmental Services Toronto (DSTO) strategic planning group comprised of thirty -two developmental service agencies and the Dual Diagnosis Implementation Committee of Toronto (DDICT) were two pre-existing regional entities that helped solidify formal and informal relationships, partnerships and linkages between developmental and mental health service agencies (Reed 2009, 44).

The Griffin Centre Community Support (Crisis) Network funded jointly by the MCSS and MOHLTC was instrumental in establishing access to three specialized service providers funded by the MOHLTC, ten funded by the MCSS and three jointly funded by both ministries. The access system was based on informal working agreements. While specialized service providers were present through out the sub-region they had very limited capacity (Carver, 2005).

This sub-region was also fortunate in having a Specialized Regional Response Team supported by an effective partnership between mental health, developmental and specialized providers. Crisis response services were provided by this team in all parts of the sub-region and had a very strong capacity. Seven specialized treatment beds were developed (across four agencies) with capital and operating funding from MCSS (Carver, 2005).

Regional Service or Case Resolution was a mandated function intended to develop across agency support plans for individuals with complex problems. There were no resources attached to the process and no administrative support. This made it difficult to coordinate supports, track and collect data on the work being accomplished through the resolution process (Carver, 2005).

The Dual Diagnosis Implementation Committee of Toronto (DDICT) partnered with an Academic Health Science Centre to develop a multi-level training initiative to build knowledge and skills of community agency training faculty, managers/supervisors, and front line staff. A developmental service agency was also providing clinical consultation and education and training via videoconferencing technology to a remote area in the province (Carver, 2005).

Tertiary care inpatient, outpatient, and day treatment was available in a moderate capacity across the sub-region. While a significant range of organizations offered community-based mental health services, only some had developed the capacity to effectively support individuals with developmental disabilities. Also specialized consultation/assessment was available in a limited capacity. According to Carver (2005) considerable work still needs to be done to integrate the access processes for specialized clinical services offered by both developmental and mental health services (Carver, 2005).

Organizational Structure and Accountability

The structure of the Toronto CNSC was developed by the Network Implementation Advisory Committee (NIAC). The decision was made to incorporate it, into two pre-existing regional structures, the Developmental Services Toronto (DSTO) strategic planning group and the Dual Diagnosis Implementation Committee of Toronto (DDICT) and to build onto existing relationships to create an access mechanism to specialized resources (Bricker, 2007).

In the Toronto region individuals in the target population can access a continuum of specialized and clinical services through any one of the five clinical providers or the Network Coordinator. For those individuals whose needs can not be addressed by local resources, the Toronto CNSC created cross-sector Clinical Conferences and a Regional Service Resolution process. The Network Coordinator screens referrals for Clinical Conferences, with the goal to link individuals to specialized services without the need for a conference. The Coordinator coordinates those referrals that require a Clinical Conference and either links the individuals to specialized resources directly or facilitates referrals from the Clinical Conference meeting to Service Resolution. The Network Coordinator is actively involved in the regional residential access processes to the sixteen specialized treatment beds, placed in three agencies across the sub-region (Bricker, 2008-2009).

With the network structure in place, the NIAC was replaced with an Advisory Committee. There are twenty-three members on the Advisory Committee, including the MCSS Program Supervisor, a MOHLTC representative, the Network Coordinator, the Tri-Regional Research and Education

Coordinator and Administrative Assistant, all, ex officio members. The Terms of Reference for the TCNSC were finalized in April 2008. The committee is chaired by a mental health tertiary care provider and meets bi-monthly (Reed, 2009).

The Toronto CNSC formed four task and ad-hoc working groups that are resourced by members of the Advisory Committee and the general membership. They are linked to resources in the community (Bricker, 2008-2009). Accountability for the Toronto CNSC is described in Chapter 1 and the in the section on the Tri-Regional Alliance. This Network participated in a formal evaluation conducted by Reed (2009).

Results

The following data was obtained from, the key informant interviews, and secondary sources; the Reed evaluation (2009), the Central Region CNSC Business Plan, September 7, 2006; Central Region CNSC Business Plan , April 1, 2009-2012; the Toronto CNSC, Annual Report 2007; Toronto CNSC Annual Report, 2008-2009.

Historical relationship and collaboration between network partners

According to the key informants, the developmental and health sector partners in the Toronto CNSC had an opportunity to collaborate through several pre-existing structures. The Developmental Services Toronto Organization (DSTO) strategic planning group has representatives from all of the development service agencies in the region. Many worked together on projects for the DSTO and some of those individuals are now active members of the Toronto CNSC. The Dual Diagnosis Implementation Committee of Toronto (DDICT) is another pre-existing regional structure that offered providers from both sectors an opportunity to work together towards common goals and some of the members are also active Network partners. Prior to the Toronto CNSC, the Griffin Community Support (Crisis) Network was informally coordinating access to specialized resources from sixteen cross-sector service providers. These providers are contributing specialized resources to the Toronto CNSC and are accustomed to collaborating. The Specialized Regional Response Team and the Regional Case Resolution process were supported by an effective partnership between mental health, developmental and specialized providers. The participants in these structures are now collaborators in the Toronto CNSC.

Leadership

According to the key informants, the Lead agency has a long history of strong and productive local, regional and provincial inter and cross-sector collaboration. This agency has spearheaded many important

initiatives that support the target population including the provision of clinical services through videoconferencing technology to remote and rural areas of Northern Ontario. The lead agency was selected by the MCSS to be accountable for handling the financial account for the Central East and Central West CNSC and the TRA.

The key informants report that the Network lead has extensive prior experience establishing and managing a Network, in the same geographic local. They report that he possesses the same level of leadership skills, as the Network Lead for the Central East CNSC, and is often consulted by his colleagues because of his expertise and knowledge. He has been instrumental in expanding linkages to include the primary care sector, and for keeping the focus of Network partners on the mission and goals of the Toronto CNSC. The Network lead includes the Network partners in developing the strategic plan and according to key informants there is a good understanding and agreement on the purpose and goals of the Network.

According to the key informants, formal and informal leadership in the Toronto CNSC is dispersed by the Network lead, among a core group of Network members including the Network Coordinator, MCSS Program Supervisor, and the chairpersons of the Advisory Committee, the task forces and work groups. In their opinion effective governance of this CNSC is contingent on this shared leadership.

The key informants have great regard for the Network Coordinator, whose strong leadership skills have facilitated the management of the access system to specialized resources. She is solidly established in her role in the Clinical Conference process, Regional Service Resolution, the regional residential access processes and collecting and communicating usage data. The Coordinator delivers orientation sessions about the Network and according to Reed (2009) and the key informants, the members have a solid understanding of the available specialized resources and access protocol (Bricker, 2008-2009).

The Chair of the Advisory Committee is considered a champion by the key informants, selected by the Network lead for her important and diverse mix of skills and expertise, and willingness and commitment as a sponsor and participant in network activities. This individual contributes to the efficacy and sustainability of the Toronto CNSC.

The key informants describe the relationship with the regional MCSS office and Program Supervisor as constructive and productive and vital to the success of this CNSC.

According to the key informants, eighteen partners participate in the Advisory Committee. Ten individuals represent seven MCSS funded agencies, six individuals represent five MOHLTC funded agencies, and two individuals are representatives of an agency that is dually funded by the MCSS/MOHLTC (Central Region CNSC, April 1, 2009-2012). Advisory Committee members represent core and specialized service providers from multiple sectors, as well as the academic and research sector. All members have been on the committee since its inception. According to the key informants they, reflect the mission and goals of the CNSC and have demonstrated an ability to work together. The Toronto CNSC is also closely linked to eleven local and regional developmental and mental health service planning, and coordinating groups and structures, and academic partners that are considered vital to the collaborative activity of the Network (Bricker, 2008-2009).

The informants report that the Chairpersons of the task forces and work group are strong, knowledgeable and committed partners in this CNSC, who successfully work with Network partners to accomplish the established goals. The following chart lists the number of members involved in the various task forces and work group.

Type of Involvement	Number of members involved
Access to Primary Care Project Workgroup	12
Day Treatment Task Group	9
Discharge Planning Task Group	10
Specialized Case Management Task Group	8

According to the key informants, twelve agencies provide a continuum of specialized services and supports to individuals in the target population, and six of those agencies provide more than one service.

Type of Specialized Resource	Number of Agencies
Crisis Response and Transitional Supports	3
Respite services	3
Day treatment	2
Case management services	3
Tertiary care (inpatient, outpatient)	3
Specialized accommodation spaces	4
Community-based clinical supports/services	7

Specialized service providers are struggling to provide resources to meet the Network demands, which the informants report is discouraging them from participating in the Clinical Conferences. To address this challenge, resources are discussed after the presenters have left, to encourage all network participants to share in the responsibility of service provision. Also the Network is pursuing those specialized service providers who have not signed Memorandum of understanding (MOU). Discussions are also underway to develop additional protocols to hold specialized service providers accountable for services agreed to in the MOU.

The key informants report that there are 36 broad partners in the Toronto CNSC (Central Region CNSC, April 1, 2009-2012) including, the members on the Advisory Committee, the task and work groups, the agencies that provide and access specialized resources and those on the periphery. The key informants have rated their level of connectedness to the Network as follows.

Rating	**Number of Partners**
Strongly Connected	9 partners
Moderately Connected	9 partners
Somewhat Connected	8 partners
Mildly Connected	8 partners
Not at all Connected	2 partners

Key informants for the Toronto CNSC, report that they have "a committed small core group of primarily specialized service providers to move the agenda forward, they are constant attendees at meetings and active participants that collaborate". This CNSC has strengthened links and formalized relationships with twenty-six organizations that offer a range of services to the Network including developmental, mental health, primary care, hospital and crisis services, through written Memorandums of Understanding agreements (MOU). Those that signed a MOU with the Griffin Community Support (Crisis) Network have the option of combining it with the Toronto CNSC, MOU. The number of organizations and individuals within organizations that are members of the Network is strong for the developmental sector and formal agreements have been obtained from two-thirds of the agencies. In the opinion of the key informants "this Network is a bit too DS centered, we are weak beyond a few mental health sector members and need to broaden into the mental health and justice sector, but we don't need tons of people around the table". They added that, "while there are, a few broad based participants, they don't always understand their role and there are no cliques or dyads".

Given the number of collaborative endeavours, clinical, and educational it would appear that there is a shared understanding, agreement, and willingness to participate in activities to meet the goals of the Network. Respondents in the Reed, 2009 evaluation, reported that the "Network partners are beginning to hold each other more accountable to work collaboratively and make best use of partnerships but it is not yet what it could or should be". "…we need to monitor that the resources we have are being utilized to their fullest. This requires a more in-depth understanding of what each partner can provide that is specialized and 'real' partnership and/or changing the way we work together… This will take more time than just the 2 years we have had" (Reed 2009, 40). They recommended that the profile of the Network be raised beyond the core services to engage the broader service community in its activities (Reed, 2009).

Internal and External Alignment

The Service Access process for specialized services in Toronto has been identified, mapped and documented in a procedure manual that includes information about roles and responsibilities and a basic service contract. Individuals with developmental disabilities and mental health needs and/ or challenging behaviours can access specialized services through any one of the five clinical providers or the CNSC Coordinator. For those individuals who have complex needs that can not be addressed by local resources, the Toronto CNSC created two processes, Clinical Conferences and Regional Service Resolution, each staffed by cross-sector partners with clinical expertise.

An access protocol was also developed to integrate the crisis response and transitional supports offered by the Griffin Centre Community Support (Crisis) Network (GCCSN) with the Toronto CNSC. The Network Coordinator is also actively involved in the regional residential access processes to the sixteen specialized treatment beds, placed in three agencies across the sub-region (Bricker, 2008-2009).

Seventy percent of the Network Coordinators role is screening and coordinating referrals to Clinical Conferences and Regional Service Resolution and linking individuals in the target population to specialized resources. She tracks and monitors information about individuals accessing specialized service and the outcomes for planning purposes. In 2008/09 there were 50 referrals to the Network coordinator; and 27 Clinical Conferences were held in a six month period. The evaluation by Reed, 2009, indicates that access to services has improved, and there is an increase in the number of clients that are being served (Reed 2009, 3).

According to the key informants, by introducing a multi-tier case resolution system, those individuals with less complex needs can efficiently and effectively access local specialized resources, with the

support of the Network Coordinator. The process has been streamlined for those with more complex needs, accessing clinical conferences before the more involved process of Regional Service Resolution.

Informal Coordinating Mechanism

According to the key informants, the Toronto CNSC created a Continuum of Services document to assist in the development of a plan to address barriers and gaps in the specialized service system (TNSC, 2008-2009). The following barriers and gaps have been identified.

- Primary and community mental health care
- Specialized Day Supports
- Specialized Case management services
- Bed blocking

Network partners collaborated to create the following joint programs that address these barriers between the sectors and gaps in service. These achievements would not have been possible without a strong social control mechanism in this Network.

To break down the barriers between the developmental sector, the specialized mental health facilities and community mental health programs, the Toronto CNSC developed the Access to Primary Care Project. Membership in the workgroup is comprised of a Community Health Centre, a developmental service agency, a tertiary care provider, and Network representatives. The goal of the project is to ensure access to timely, equitable, effective and patient-centered primary health care services for people with developmental disabilities by establishing links and relationships with Primary care providers including; family physicians, family health teams, Community Health Centres, and Nurse Practitioners. To address the lack of community psychiatrists, the Network is collaborating with tertiary care partners, the Inter-professional Education project and the Access to Primary Care Project. The Network received annualized funding in 2009, from the MCSS, for a Health Care Facilitator to ensure the health needs of individuals involved in the provincial facility closure initiative are being addressed (Bricker, 2008-2009).

To address the barriers between the developmental, mental health and justice sectors, a model for the Dual Diagnosis Justice Diversion Case Management position was developed, which divides the money between four existing dual diagnosis case managers, who operate across the various points in the justice system (police, crisis services, five Toronto Courts, Safe Beds, Crisis Housing programs, and detention facilities) and work closely with crisis prevention, pre and post-discharge diversion and release from custody. The model developed for the sixteen specialized accommodation spaces was a dispersal of funds

between three community-based agencies, with the beds being accessed through Service Resolution (Bricker, 2008-2009).

The Day Treatment Task Group was formed to develop a document defining the critical features of day treatment programs, in an effort to improve the capacity of network members providing the service (Bricker, 2008-2009).

The Specialized Case Management Task Group was charged with the task of describing the qualifications, experience, duties and professional development requirements of individuals providing intensive case management services to individuals in the target population. The Group is addressing the lack of, specialized developmental and mental health sector case managers with expertise in the complex needs of individuals in the target group, by organizing ongoing training and education opportunities (Bricker, 2008-2009).

The Service Resolution Committee tracks and informs the Service Provider Committee about the inappropriate placement of individuals in the target population in children's, hospital, short-term transitional treatment and crisis response safe beds, because of a lack of community-based placements. The problem is compounded because these beds are blocked from use, by those who need them. The Discharge Planning Task Group developed a guide to help agency staff understand their roles and responsibilities in discharging individuals in the target population from transitional treatment settings to ensure appropriate supports are in place and to keep the beds open for appropriate use (Bricker, 2008-2009).

Network partners are concerned that there are many health funded clinical providers that are unaware of the CNSC. In the opinion of the key informants, until the CNSC are considered a shared responsibility by the MCSS and the MOHLTC, the health care providers will not feel obligated to collaborate. An, additional barrier to collaboration are, the boundaries of the seven LHINs, which do not align with the boundaries of the three CNSC in the Central Region. This combined with the significant turnover, at the management level of the LHINs, has made it challenging to implement the Joint Policy Guidelines between the two ministries.

Resources

The Toronto CNSC receives the same annual funding as reported for the Central East CNSC. The MCCS also provides funding for the TRA Research and Education Coordinator and Health Care Facilitator's salaries, videoconferencing technology and twelve specialized accommodation spaces. The MOHLTC

funds one full-time equivalent Dual Diagnosis Justice Case Manger position. According to key informants, in-kind resources are provided by the Lead agency, and Network partners supporting committee work and providing specialized resources (Central Region CNSC, September 7, 2006).

Network resources are being used to pay for services and resources in the community for individuals transitioning from treatment facilities (TNSC, 2008-2009). The fiscal constraints to network integration identified by the key informants are an over reliance on in-kind support, not equally forthcoming from all network partners and insufficient fiscal resources from the MCSS/MOHLTC, to address gaps in service. In the opinion of the key informants, these gaps in services impede the effectiveness of the Toronto CNSC. The community service system does not have the capacity to serve all those in need and in the absence of a full range of specialized services and supports the Network cannot be effective. Despite the continued development of expertise within the developmental and mental health service provider system, the volume of specialized clinicians remains minimal, due to a lack of resources. This lack of capacity to meet demand, results in wait lists and challenging situations potentially escalating into crisis situations (Bricker, 2008-2009). According to the respondents in the Reed, 2009 evaluation, the large number of organizations partnering in this network gives the illusion that there is a significant amount of specialized services available. However, relative to the number of individuals with developmental disabilities and mental health and/ or behaviour problems, the available services are likely comparable to that of other regions (Reed, 2009).

Conclusion

According to the key informants, the Toronto CNSC is further along the continuum of development than its counterparts, due to the collaboration of Network partners in several pre-existing structures. Trust, legitimacy and reciprocity within sectors, was established in these environments and has enhanced collaboration across multiple sectors in the CNSC. This foundation has facilitated the formation of a collaborative alliance in the Toronto CNSC and advanced its ability to meet the goals of the Network (Provan and Milward 2000, Roussos and Fawcett 2000, Bryson, Crosby and Stone 2006).

The information provided by the key informants and the secondary sources, indicates that, the leadership demonstrates the core competencies related to effectiveness (Roussos and Fawcett, 2000) and employ strategic management tools to successfully integrate and coordinate a representative partnership. The composition, diversity and involvement of the partners, reflects the agenda of the Network, which is instrumental in addressing the Network mandate (Gray and Wood, 1991, Mitchell and Shortell 2000, Roussos and Fawcett, 2000, Agranoff and McGuire, 2001).

The key informants and secondary sources report that, the Toronto CNSC successfully streamlined access to specialized resources, crisis response and transitional supports by developing a mechanism that supports the effective and efficient use of resources. Data reported by the key informants, secondary sources and the external evaluation (Reed, 2009) suggests that this mission and goal is shared by individual network and community partners, indicating that there is internal and external alignment (Mitchell and Shortell, 2000).

According to the key informants and secondary sources, multi-sector partners have collaborated, to develop a significant number of joint programs that address barriers and gaps in services, at multiple levels. While twenty-six formal agreements have been signed (Central Region CNSC September 7, 2006) with network partners, it is the opinion of the informants that this factor is not related to accountability. Some of the partners with formal accountability are only mildly connected to the Network. They suggest that the cooperation, coordination and collaboration required to create the joint programs is closely related to norms of trust, reciprocity, legitimacy that exist in the Network and the history of previous collaboration (Gray and Wood, 1991, Mitchell and Shortell 2000, Roussos and Fawcett, 2000, Agranoff and McGuire, 2001).

The key informants and secondary sources indicate that the Network lead manages and distributes dedicated and in-kind resources, efficiently and effectively, to maximize the benefit to the individuals and the community being served (Provan et al., 2007). This opinion is supported by the number and type of joint programs/resources that have been created with the available resources. The key informants suggest that insufficient fiscal resources from the MCSS and the MOHLTC and an over reliance on in-kind support, not equally forthcoming from all network partners, creates gaps in resources, which impedes network effectiveness (Provan and Milward, 1995).

The key informants and secondary sources describe the Toronto CNSC as a legally autonomous, formally established entity of partners, engaged in a non-hierarchical relationship, who collaborate to achieve a common goal and are governed by a central authority, with dedicated resources. In their opinion this Network is effective because they have developed an access mechanism to a complex array of specialized programs/resources that is coordinated and seamless. Fragmentation, gaps and replication of services have been reduced. The individual partners working alone could not have established this system of specialized service delivery.

iii) Central West Community Network of Specialized Care

Introduction and Background

The Central West Community Network of Specialized Care is made up of five geographic sub-regions that have five of the seven fastest growing communities in the province, with the most significant growth occurring the past ten years. Using the prevalence rate for Developmental Disability at 1 per cent of the total adult population and 38 percent of that population having a dual diagnosis it is estimated that 20,280 people have a developmental disability and approximately 7,706 of those have a dual diagnosis (Carver 2005, 9).

Prior to the introduction of the Central West Community Network of Specialized Care (Central West CNSC) there were few regional planning and coordination committees or processes, in place. The only regular regional meeting was between, management staff at the Regional office of the MCSS and the developmental service sector Executive Directors, who met quarterly to discuss Ministry initiatives (Carver 2005, 9).

The environmental scan for the five sub-regions identified six specialized service providers funded by the MCSS, five funded by the MOHLTC, and one jointly funded. Specialized services such as case management, day and residential treatment, behavioural and crisis response services were not present in all of the sub-regions and where present, the capacity was very limited. The developmental service providers in the region had a history of working as five separate sub-regions. Local Developmental Service Planning Committees helped them to establish a system of informal collaborative partnerships and linkages within their sector and sub-region. The MCSS *Making Services Work for People*, initiative funded the equivalent of four full-time Service Resolution Facilitators to oversee the development of five different local case resolution processes, one in each of the five sub-regions (Carver, 2005).

Individuals requiring mental health services in the five sub-regions had access to four mental health tertiary care services that were located outside of the region, making them somewhat disconnected, in addition to having limited capacity. Four Dual Diagnosis Committees supported the five sub-regions, two offering regular training events for front-line staff working in core service agencies (Carver, 2005).

In response to a significant growth in population, the first regional resource was developed in the spring of 2006. It was a dual diagnosis service funded jointly by the MCSS and the MOHLTC, and offered the services of a multi-disciplinary clinical team, a specialized regional response team to address complex

service situations and the equivalent of four full time Resource Workers. Cross-sector relationships were also strengthened with the creation of a Crisis Network. Three other regional initiatives in place at the time were, Case Management Review, Case Management Competency Identification, and the Dual Diagnosis and Children's Mental Health initiatives. Most cross-sector initiatives appeared to start at the local level and then shared at the regional network level (Carver, 2005).

Organizational Structure and Accountability

According to the key informants, there was no regional planning structure in which to incorporate the Central West CNSC. The Network Lead established a Network Committee, in the fall of 2007, with twenty-one members, including the, Network Coordinator, Administrative Assistant and MCSS Program Supervisor, all ex-officio members. The committee developed a Charter for this Network that delineates a vision, values, mission, goals, member roles and responsibilities, and operational guidelines and a Business and Work Plan.

Each of the five geographic sub-regions in the Central East region have individualized local service delivery networks with their own access mechanism to specialized services supported by MCSS funded Service Resolution Facilitators and local case resolution committees. The Central West CNSC created a Regional Service Resolution Committee and with the support of the Network Coordinator it facilitates referrals from the five local case resolution committees to limited specialized resources, such as clinical assessments and access to specialized supports (Carver, 2005).

The Network committee is chaired by a developmental service provider and meetings were held monthly in the first year, every two months in the second year and discontinued in the third year, during the transition to the new lead agency. Five committees were developed to support work of the Central West CNSC. Accountability for the Central West CNSC is described in Chapter 1 and in the section on the Tri-Regional Alliance (Carver, 2005). This Network was informally evaluated by the Network Coordinator in 2008 and formally by Reed in 2009.

Results

The following data was obtained from, the key informant interviews, and secondary sources; the Reed evaluation (2009), the Central Region CNSC Business Plan September 7, 2006; the Central Region CNSC Business Plan April 1, 2009-2012; and Central West CNSC documents.

Historical relationship and collaboration between network partners

According to the key informants, prior to the creation of the Central West CNSC the developmental service providers in each of the five geographic sub-regions established a system of informal collaborative partnerships and linkages within their sector and sub-region, including a local case resolution process. To their knowledge the partners in this Network did not engage in mutually dependent relationships that involved sharing risks, resources and responsibilities to achieve a common goal, outside of their sector and sub-regions, prior to their participation in this Network. After the introduction of the CNSC the developmental services providers in the sub-regions continued to operate as they did historically, unconnected for the most part, from the Network.

Leadership

It is the opinion of the key informants, that the lead agency chosen to head this CNSC, for the first two and a half years, was the second choice of the MCSS. The preferred agency was not in a position to assume the leadership role, at the inception of the CNSC. In the spring of 2009, the designated lead agency was re-assigned to this MCSS transfer payment agency.

According to the key informants, the Network lead has exemplary knowledge of the developmental and mental health issues of the target population, which facilitated the work of the Network Coordinator in breaking down the barriers between the sectors. His solid leadership skills and commitment were considered an asset at the regional and Tri-Regional level where he was a champion of the vision and mission of the CNSC.

The Network Coordinator is also described as a champion by the key informants for her strong leadership skills including written and verbal communication, facilitation, mediation, problem solving and patience. Survey respondents in the Reed, 2009 evaluation, reported that the “Network Coordinator worked tirelessly in meeting and exceeding the original 3 pillars in the original business plan and has fostered and facilitated connections from the mental health and developmental sector and is a valued connecter across agencies, sectors and resources” (Reed 2009, 10).

According to the key informants, the regional office of the MCSS operates as five distinct sub-regions, setting the precedent locally to act in an insular fashion. The lack of collaboration from the local to the regional level of the ministry impeded the implementation of the Central West CNSC. It is the opinion of the key informants that the regional office of the MCSS did not share the vision and goals of the Central West CNSC or the potential of the Tri-Regional Alliance, resulting in a missed opportunity for the region

to access tremendous expertise and resources. There was a reluctance to support the initiatives recommended by the Network Lead and Network Coordinator, even those, that addressed the MCSS mandate to break down barriers between the developmental and mental health sectors. The unequal power yielded by the MCSS Program Supervisor prevented the issues from being forwarded to the Policy, Planning and Operations branches at the corporate level, for resolution.

Eighteen partners participated in the Network Committee; seven representatives from MCSS funded agencies, ten from MOHLTC funded agencies, and one representative from an agency that is dually funded by the MCSS/MOHLTC. They represent developmental and mental health service providers, local Developmental Services Planning Groups, local Case Resolution Committees, Access Centres, and ACT teams. All have been members since the inception of the Committee. The Central West CNSC is linked to twelve pre-existing, committees (Reed, 2009) that are vital supports to the Network (Central Region CNSC April 1, 2009-2012).

The following chart describes the number of members involved in the various committees/subcommittees and work groups established by the CNSC to support their work.

Type of Involvement	Number of members involved
Regional Service Resolution Committee	6
Education and Training Subcommittee	6
Assertive Community Treatment (ACT) Team Clinical Consultation Group	10
Tertiary Mental Health Providers Group	6
Trauma Working Group	5

The key informants report that there are 31 agencies across the developmental and mental health sectors, that are broad partners in the Central West CNSC, including, the members on the committees, subcommittees and task groups (Central Region CNSC, April 1, 2009-2012). The key informants have rated their level of connectedness to the Network as follows.

Rating	**Number of Partners**
Strongly Connected	6 partners
Moderately Connected	4 partners
Somewhat Connected	3 partners
Mildly Connected	4 partners
Not at all Connected	14 partners

According to the key informants, despite strong leadership skills, the Network Lead and Coordinator were unable to establish a collaborative partnership with agreement on a mission and goals for this CNSC. Although there are a large number of members, the majority participated minimally and or inconsistently. The Central West CNSC was able to collaborate with some active developmental and mental health agency partners, to jointly initiate programs that have contributed to some specialized resources at a regional level.

Internal and External Alignment

According to the key informants, the Central West CNSC was unsuccessful in establishing a regional coordinated access plan for specialized services because the majority of developmental service providers in the five sub-regions did not see the purpose of collaborating to create such a structure. The providers thought that the four MCSS funded Service Resolution Facilitators and local case resolution committees were adequately managing this function at the local level.

In an attempt to coordinate access to specialized services, the Network created a Regional Service Resolution Committee. The Network Coordinator facilitated referrals from the five local case resolution committees to limited specialized resources at the regional level, such as clinical assessments and access to specialized supports such as ACT teams and tertiary care settings. The committee established five different access processes to the Committee, for the five different sub-regions, which were used by the developmental service providers, at their discretion. By invitation the Network Coordinator attended case conferences held by the local case resolution committees, to problem-solve complex cases. The Regional Service Resolution Committee met monthly, gathered data about individuals accessing specialized resources, and discussed individual cases (Reed, 2009). According to the key informants, the four Service Resolution Facilitators started to participate on the Committee and indicated an interest in functioning as a team, when the Lead Agency was reassigned.

The Regional Service Resolution Committee collaborated to develop a formal access protocol to fifteen specialized accommodation spaces, created Terms of Reference for the Committee and collected usage data. The Committee partners are strongly connected to each other and the Central West CNSC (Reed, 2009).

Informal Coordinating Mechanisms

According to the key informants, the Central West CNSC identified the following barriers and gaps in the specialized service system.

- Specialized Case management services
- Specialized Accommodation
- Skilled service providers
- Network development

The Network lead and Coordinator were able to establish informal accountability between a small core group of partners who collaborated to create the following joint programs to address these barriers between the sectors and gaps in service.

The Network collaborated with a community mental health partner, to develop a Dual Diagnosis Justice Diversion Case Management position and a Dual Diagnosis Justice Case Management Regional Team. These resources enhanced service to the target population and helped break down the barriers between the developmental, mental health and justice sectors (Reed, 2009).

As mentioned in the section on alignment, the Regional Service Resolution Committee created a formal access protocol to fifteen specialized accommodation spaces (Reed, 2009).

The key informants reported that the, Network Coordinator collaborated with the Assertive Community Treatment (ACT) Teams to form an ACT Clinical Consultation Group. The group developed a consultation model for the ten ACT Teams in the region. Monthly meetings were held to teach skills to enhance their work with individuals in the target population. Links were established between the developmental services sector and ACT Team intake staff. The Central West CNSC was the only Network in the province to develop links to the ACT Team.

The Network partners established a Tertiary Mental Health Providers Group as an information sharing forum for dual diagnosis inpatient staff and regional dual diagnosis service programs. Links were established to, two Local Health Integration Networks (LHINs) and the Network Coordinator is a member of the Addictions and Mental Health Network Resource Group of one LHIN and on the System Integration Group for Mental Health and Addictions Education and Training Subcommittee, for the other. These are significant accomplishments given the challenges faced by other CNSC in establishing links to the LHIN (Reed, 2009).

The Central West CNSC: formed a Trauma Working Group to help people with developmental disabilities that have experienced trauma, access mainstream sexual assault and family counseling

services; facilitated a consultation process with the Tri-Regional Alliance, to review proposals for an Applied Behaviour Analysis unit, to fill gap in behavioural support services; assisted a Local Developmental Service Planning Committee with a funding application to a LHIN, to establish a crisis response system for individuals in the target group (Reed, 2009).

The Central West CNSC developed an Education and Training Subcommittee as a forum to discuss, plan, coordinate and promote training and education of community partners working with individuals with a developmental disability and mental health and or challenging behaviour. A Regional Education and Training Committee, was created to focus on knowledge transfer activities, work plans and Terms of Reference were developed for both (Reed, 2009).

On behalf of the Tri-Region Alliance, the Network Coordinator worked with curriculum consultants to develop and deliver the Effective Specialized Response (ESR) course. The Central West CNSC piloted the training with thirty developmental services and mental health agency staff. The Network Coordinator is a faculty member for ESR training and two new staff members from agencies in the sub-regions were recruited to the faculty team (Reed, 2009).

The key informants report that one of the five Local Developmental Service Planning Committees has two strong specialized service providers, one from each sector, that promote effective relationships across sectors in their sub-region. While the original lead agency was still involved, this body was collaborating with the Network to develop a cross-sectoral, integrated, collaborative planning body to identify and fill gaps in services in their local area (Reed, 2009). Another local Developmental Services Planning Committee was also collaborating with the Network to establish a Dual Diagnosis Cross-Sector planning group to develop collaborative approaches to service issues in their community. The Network Coordinator attended monthly meetings of three Human Service and Justice Coordinating Committees to establish links to the Network, as well as the meetings of a number of other regional committees (Reed, 2009).

Resources

The Central West CNSC receives the same annual funding reported for the Central East CNSC as well as funding for fifteen specialized accommodation spaces and videoconferencing technology from the MCSS. The MOHLTC funds one full-time equivalent Dual Diagnosis Justice Diversion Case Manger position (Central Region CNSC, April 1, 2009-2012). According to key informants, in-kind resources are provided by the Lead agency, and Network partners supporting committee work and providing specialized

resources. Network funds were used to fill service gaps by purchasing behavioural, forensic and psychological assessments for individuals in the target population (Reed, 2009).

Conclusion

According to the key informants and secondary sources, the partners in the Central West CNSC do not have a history of collaborative behaviour across the sub-regions. Despite strong leadership skills, the Network Lead and Coordinator were unable to establish a collaborative partnership with agreement on a mission and goals, because the majority of members participated minimally and or inconsistently. The five sub-regions continued to operate as they did historically, linked within the developmental or mental health service sector and unconnected to each other and the CNSC. In the absence of a coordinated access plan for the whole region, which involved agreeing on the mission and goals of the Network and sharing resources, the local communities continued to use their individualized access mechanisms. The Network Coordinator was unable to fulfill the function and mandate related to coordinating access protocols for specialized services because of the absence of internal and external alignment.

The Central West CNSC was able to collaborate with some active developmental and mental health agency partners, to jointly initiate programs that have contributed to specialized resources. No formal agreements were signed with these partners. Their collaboration was based on norms of cooperation and reciprocity. Respondents in the external evaluation by Reed (2009) reported that, the "Network did not develop enough to be effective and that pockets of people who are effective because of what they are doing, have sustained the network" (Reed 2009, 12).

Financial constraints were not discussed by the key informants. According to the key informants, the absence of support from the regional office of the MCSS is the primary constraint to the integration of the Central West CNSC. A second constraint is senior managers in the developmental sector, who have been embedded in a service delivery system for thirty years, unwilling to accept a new form of governance.

There is a lack of evidence to support that as a result of this Network, a coordinated, seamless delivery system exists, that delivers a complex array of community-based services, with reduced fragmentation, gaps and replication of services, and that what has been accomplished could not have been achieved by individual organizations working alone.

CHAPTER 3

East Region Community Network of Specialized Care

Introduction and Background

The East Community Network of Specialized Care is home to 1,631,579 of the provinces population (Eastern Ontario CNSC September 20, 2006, 11). It is comprised of the east and south east sub-regions, each affiliated with a MCSS area office. The South Eastern Community Network of Specialized Care (South Eastern CNSC) covers the counties of Hastings & Prince Edward, Lennox & Addington, Frontenac, Lanark, Leeds & Grenville. The Eastern Community Network of Specialized Care (Eastern CNSC) is located in a mixed rural and urban environment covering the Ottawa-Carleton region, Renfrew County, Stormont-Dundas- Glengarry Counties and Prescott-Russell. It is two-thirds larger than the South Eastern CNSC and serves a very different population, including a large Francophone community. Using the prevalence rate for developmental disability at 1 per cent of total adult population and 38 per cent of that population having a dual diagnosis, it is estimated that this region of Ontario has an estimated 16,315 people with a developmental disability and approximately 6,200 of those have a dual diagnosis (Eastern Ontario CNSC September 20, 2006, 11)

According to the key informants, prior to the creation of the South Eastern CNSC, the developmental service system was and continues to be organized based on a collaborative access model (single point access). Four planning areas called the Pressures and Priorities Committees, manage the entrance into the developmental service system. They are responsible for making referrals and linking individuals to generic, health, mental health and specialized developmental services. They also maintain a central wait list for residential and day programs and prioritize service needs. Case resolution occurs through a collaborative access process involving all developmental service agencies.

Pre-existing networks in this sub-region include, Local and Regional Dual Diagnosis Committees, Local Human Service and Justice Coordination Committees, Regional Human Service and Justice Coordination Networks, community mental health alliances, the Aging and Developmental Disabilities Network and Local Pressures and Priorities Group. These networks have “formal agreements, protocols and terms of reference and are comprised of a cross-section of representatives from the developmental services, mental health, allied health, educational and criminal justice sectors, as well as various provincial ministries” (Eastern Ontario CNSC September 20, 2006,45).

Another network that existed for thirty years prior to the CNSC is the South Eastern Ontario Community Research Alliance in Intellectual Disabilities (SEO CURA ID). This partnership is formalized by a liaison agreement between the Faculty of Medicine of Queen's University, Rideau Regional Centre (RRC), the South Eastern regional and corporate MCSS offices and Ongwanda (a community-based service agency) and has a mandate to provide education and research opportunities to students interested in working in the field of developmental disabilities with the support of three local hospitals (Eastern Ontario CNSC September 20, 2006).

According to the key informants, there was an awareness and acknowledgement at the local level, of the need for cross sector collaboration. However it was based on the goodwill of individuals rather than on government policy or initiatives and thus was not widespread. For the most part the mental health and developmental services sectors worked in silos.

Before the establishment of the Eastern CNSC, each of the four main communities in the geographic sub-region had a unique structure for meeting the needs of individuals with developmental disabilities and complex mental health and/or challenging behaviour. Developmental services were accessed through central points of intake in each community. Services were and continue to be available from an extensive number of transfer payment agencies, and outside paid resources each with their own mandate and structure. There was little in the way of specialized clinical services and specialized case management services were not available in a structured and systematic way. There was centralized access to mental health services through a partnership of community mental health agencies. The Eastern CNSC did not have the benefit of existing structures/groups such as Dual Diagnosis Committees to link to (Eastern Ontario CNSC September 20, 2006, 19).

According to the key informants, attempts at establishing a case resolution mechanism in this sub-region were unsuccessful because the necessary resources from the mental health and developmental service sector were unavailable. This region was particularly challenged by individuals who transitioned out of youth services at the age of sixteen, but were not eligible for adult services until the age of eighteen. These individuals commonly found themselves in crisis, due to the absence of services, but also because this was the typical age for the onset of mental illness.

Key informants reported that many of the agencies in the urban communities were started and continue to be managed by parents who worked hard developing them to assure that their children would be cared for. They control the board of directors and have a vested interest in keeping the resources of the agency

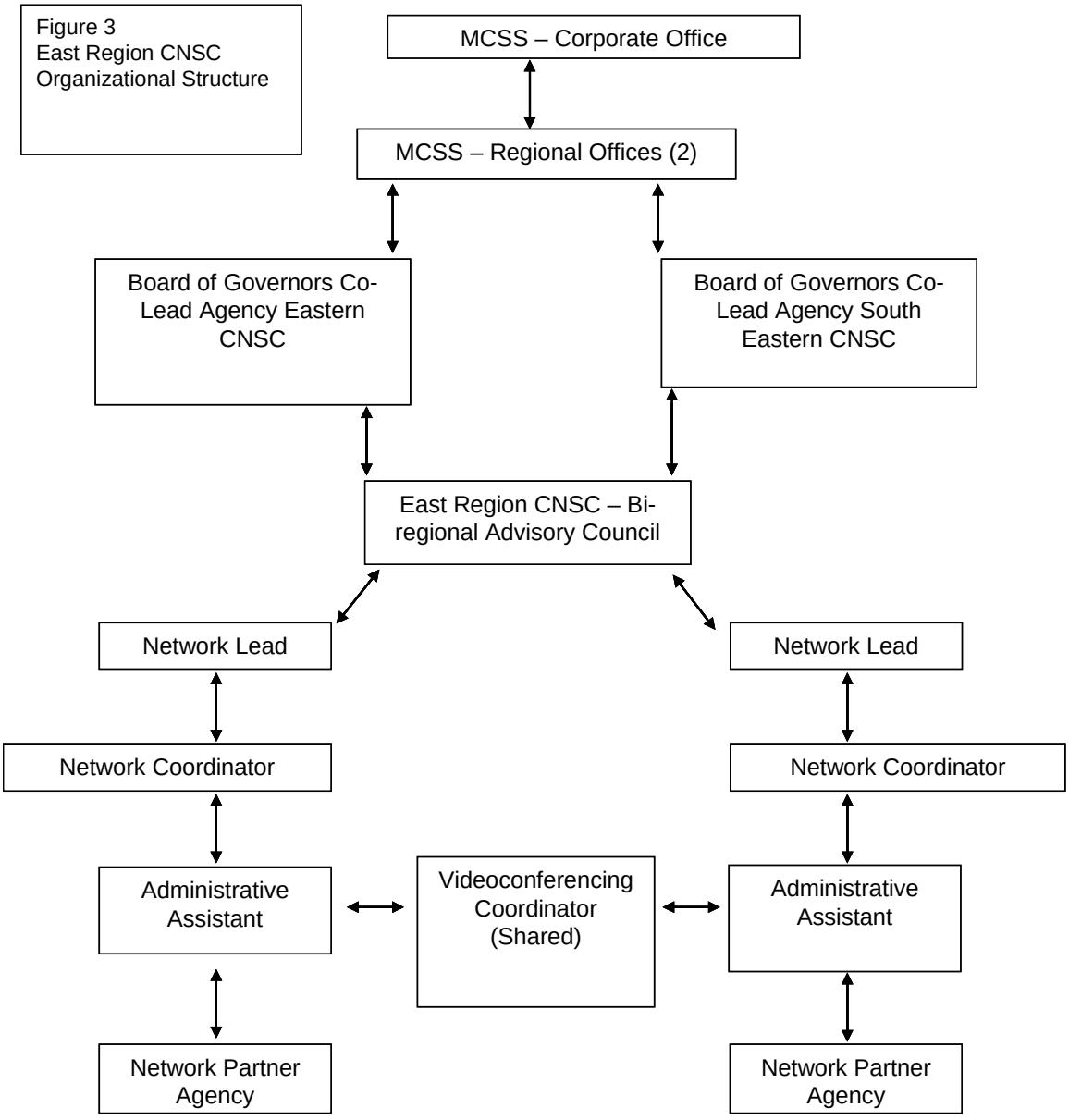
within the agency. Out of necessity, the rural communities are more community based and willing to share resources in order to survive.

Organizational Structure and Accountability

An Implementation Advisory Group was formed to guide the early stages of Network development. It was comprised of the Network Leads, Coordinator's, and MCSS program supervisors and a consultant, who was hired for one year, to help complete an Environmental Scan of the Region. The Implementation Advisory Group intended to develop, a Regional administrative structure for the East CNSC. However, during the initial Business Plan consultations, the local agencies in the South Eastern sub-region, "expressed a desired for the CNSC to assist in the streamlining and co-ordination of their efforts across the region and to serve as a conduit of communication between the various structures, networks and committees that already exist" (Eastern Ontario CNSC September 20, 2006, 12).They also did not feel it was the role of the Network to manage any of the service providers or agencies participating in the Network (Eastern Ontario CNSC April 1, 2009-March 31, 2012).

The Implementation Advisory Group chose a "Bi-Regional Advisory Council as the inter-regional mechanism for Network leadership of the East CNSC" (Eastern Ontario CNSC September 20, 2006, 37). An existing Advisory Committee in the South Eastern sub-region and an existing regional network in Eastern sub-region were selected to "serve as the local mechanisms that would provide advice to the Bi-Regional Advisory Council" on behalf of their communities (Eastern Ontario CNSC September 20, 2006, 37). The Bi-Regional Advisory Council guides the two co-lead agencies as they direct the work of the Eastern CNSC (Eastern Ontario CNSC April 1, 2009-March 31, 2012). Figure 3 depicts the organizational structure of this Network.

Figure 3
East Region CNSC
Organizational Structure



According to the key informants, the Council is composed of six core agency representatives, the Network Leads, Coordinators (ex-officio) and two Program Supervisors from the MCSS (ex-officio). During the Business Plan consultations it was decided that the work of the Network would be accomplished by task forces and committees, with members selected from the Bi-regional Advisory Council, the regional liaison groups and affiliate members. Four task forces have been established, each with Terms of Reference, and reporting responsibility to the Bi-Regional Advisory Council (Eastern Ontario CNSC, April 1, 2009-March 31, 2012);

Governance of the East Community Network of Specialized Care is through the Board of Governors of each of the lead agencies. A tri-party agreement between the two lead agencies and the MCSS holds the lead agencies accountable "jointly and separately for the provision of leadership and supports in meeting the goals of the Network" (Eastern Ontario CNSC September 20, 2006, 5). They are jointly accountable for, development, operation, attainment of outcomes, and fiscal management of the East CNSC. The formal accountability for the network structure is as described in Chapter 1. There have been no formal evaluations of this Network. As the South Eastern and Eastern CNSC operated separately for the first two years, it is necessary to analyze their results separately.

Results

The following data was obtained from the key informant interviews, and secondary sources; the Eastern Ontario CNSC Business Plan, September 20, 2006; the Eastern Ontario CNSC Business Plan 2009-2012 and; other East Region CNSC documents.

Historical relationship and collaboration between network partners

Partners in the South Eastern CNSC collaborated with, developmental service, mental health, allied health, education and justice sector representatives, in pre-existing networks prior to the creation of the East CNSC. Partners in the Eastern CNSC did not previously collaborate to any significant extent, due to the absence of regional structures and the insular nature in which services were delivered in the sub-region (Eastern Ontario CNSC, September 20, 2006). According to the key informants, there were some community members that informally shared resources out of necessity that were very supportive in the development of the Network.

Leadership

According to the key informants, the Co-lead agency selected by the MCSS to lead the South Eastern CNSC has a long history of providing a broad range of community-based supports to over 600 individuals

with developmental disabilities and their families. This agency was involved in placing fourteen individuals into community residences from one of the three remaining provincial institutions scheduled to close. It has also been a partner in the SEO CURA ID Network for thirty years. The Co-lead agency selected for the Eastern CNSC is a local multi- service agency, with a fixed point of responsibility and a no waiting list approach to service delivery. They provide holistic care to individuals with developmental disabilities and their families, individuals with complex needs being a priority for the agency.

In the opinion of the key informants, the Network lead for the South Eastern CNSC, was selected because of, his demonstrated ability in, inter and cross- multiple sector local, regional and provincial collaboration and his active participation in initiatives related to the transformation of developmental services. The Executive Director of the Co-lead agency in the Eastern CNSC was selected as the first Network co-lead. One and a half years into the development of this CNSC, the Co-lead agency made a decision in conjunction with the Bi-Regional Advisory Committee, to develop a new regional entity and delegated responsibility of the Eastern CNSC, to this new entity. The new Co-lead was selected to lead the Eastern CNSC because of his legacy in developing and delivering services to the most compromised of individuals.

The Network Coordinators are described as indispensable champions by the key informants, displaying exemplary written and verbal communication, facilitation, mediation and problem solving skills. In addition, it was noted that the East CNSC Coordinators facilitate the work of the other Network Coordinators in the province, from connections they have fostered in the mental health service delivery system, and from their system level work.

According to the key informants, the current MCSS Program Supervisors for the Eastern CNSC are champions, because of their leadership, sponsorship and commitment to the vision and mission of the Network. This was not the case at the outset which made it challenging to merge the two CNSC in the East region into one. Operationally, the two MCSS offices in the region had distinct cultures and structures that reflected the population base they served. The MCSS Regional office assigned to oversee the Eastern CNSC had a more directive approach, when developing the Network. This region is two-thirds larger than South Eastern CNSC and it was felt that the Network budget allocation should reflect that. According to key informants, the South Eastern office had a participatory, and collaborative, approach, and considered the opinions of others. A change of staff in the Eastern sub-region, compromise and common sense guided the two CNSC through some significant barriers.

According to the key informants, six community developmental service and mental health agencies have representatives on the Bi-Regional Advisory Committee, three from each region. Four representatives are from the developmental service sector and two are from the mental health sector. They were selected because of their links to existing committees and service networks and because they have decision making authority on behalf of their agencies. A larger number was not selected for the Committee, out of concern that time would be spent on communication rather than addressing the goals of the Network. The majority of members have remained in their capacity from inception. Those who have left did so because the Advisory Committee was not what they thought it would be, or other obligations precluded their participation. In the opinion of the key informants, the skilled membership of the Bi-regional Advisory Council helped the representatives from the two MCSS offices collaborate when there were problems at the outset.

The key informants report that the task force chairpersons are strong, knowledgeable and committed partners in this CNSC, who successfully work with Network partners to accomplish the established goals. The following chart describes the number of members involved in the various task forces.

Type of Involvement	Number of members involved
Systems Planning Task Force	12
Training & Education Task Force	12
Research & Practice Task Force	7
Videoconferencing Task Force	11

According to the key informants, specialized services in the South Eastern CNSC are available from seven specialized service agencies and from approximately twelve MCSS transfer payment agencies.

The key informants report that there are 83 broad partners in the East CNSC, including members of the Bi-Regional Advisory Committee, the task forces, providers and users of specialized resources, video conferencing host sites, participants in, education and training events (Eastern Ontario CNSC, April 1, 2009-March 31, 2012). They rated their level of connectedness as follows;

Rating	Number of Partners
Strongly Connected	6 partners
Moderately Connected	60 partners
Somewhat Connected	0 partners
Mildly Connected	17 partners
Not at all Connected	0 partners

Key informants for the East CNSC reported that they "selected a core group of ten to twelve partners out of approximately 83 broad members, to sit on the Bi-Regional Advisory Committee and to run some of the task forces". "Ten to twelve agencies are considered to be a manageable number to get things done". "There is equal representation from both the developmental and mental health sector and the members are also closely aligned with the justice, health and academic sectors". "Members were selected from larger more sophisticated agencies with the ability to look at multiple programming, rather than smaller agencies with only residential or day programs that wouldn't have a strong role with the target population, because they don't serve a core group of people who need specialized services". "The agencies were selected because they are the biggest providers of specialized services in the region they have strong links to planning committees and have decision making authority". "In addition they are consistently interested and there is a secondary group in the agencies that are available for regional meetings, to participate in education activities and connected to dual diagnosis and other committees". "The members of the Bi-Regional Advisory Committee are strongly connected to the Network, with consistent and regular attendance and participation in network activities".

"There are thirty-six developmental service agencies, eleven mental health agencies, five academic resources, and eight organizations from other sectors that are actively involved in, current East CNSC activities or initiatives". "An additional seventeen agencies are small organizations that offer single services such as a day or residential programs and only collaborate with the Network, if a client they serve requires specialized services". "There are a multitude of organizations in the Eastern region that offer programs and services, not all of which are relevant to individuals with developmental disabilities and mental health needs and/or challenging behaviour". "Thus not all of the agencies participate in nor benefit to the same extent from participation in the network" (Eastern Ontario CNSC April 1, 2009-March 31, 2012, 16).

A key informant noted that, "a cross-section of members from the Advisory committee, sit on the four Task Groups to provide a link between the two structures. The balance of the members on the Task Groups are representatives from agencies that are centrally connected to the core and have demonstrated a

consistent interest in the Network, are willing to represent the Network at cross sector regional meetings, and participate in education and training initiatives" (Eastern Ontario CNSC April 1, 2009-March 31, 2012, 15).

Internal and External Alignment

The South Eastern and Eastern CNSC developed and evolved separately for approximately the first two years because they were each at a different place along the continuum of specialized service development, and access mechanisms (Eastern Ontario CNSC, April 1, 2009-March 31, 201). According to the key informants, a clear intake and referral process for specialized services and a regional case resolution mechanism was in place, in the South Eastern Region prior to the creation of the CNSC. The South Eastern CNSC supports this existing mechanism (Eastern Ontario CNSC, September 20, 2006). The Eastern CNSC is in the process of establishing an access mechanism to specialized services. The Crisis Prevention and Intervention Program (CPIP), created by the Co-lead agency provides specialized clinical supports and services to individuals in the target population and coordinates access to specialized accommodations. A case resolution mechanism has recently been introduced at the access point to services in the eastern sub-region. The Network is collaborating with the Service Coordination agency and the vacancy and resource management entities of the planning tables in the sub-region to look at how resources can be enhanced and/or placed in prevention and resolution of individuals who have dual diagnosis and challenge the system. "Individuals with a dual diagnosis are being placed in priority sequence for vacancies in the system" (Eastern Ontario CNSC April 1, 2009-March 31, 2012, 28). A Regional Dual Diagnosis Advisory Committee was recently formed in the Eastern region to advance the Network agenda, through creating alliances with the developmental and mental health service sector, justice, and housing/municipal affairs at a systems/ resolution level. Each of the specialized dual diagnosis services has leadership level representation on the committee and the MOHLTC and the MCSS act in an ex-officio capacity. The Eastern CNSC acts as a coordinating mechanism for this group (Eastern Ontario CNSC, April 1, 2009-March 31, 2012).

The Network Coordinator for the Eastern CNSC is now linked to the English and Francophone community services planning tables in the four main communities of the sub-region. Participation at this system level is bridging the gap between the service providers and the CNSC. There is a shift in culture from working in isolation within one's own agency to joint ownership and accountability for the people who need service. There is recognition amongst cross-sector service providers, that they must formalize the way they work, to simplify access to specialized services for those with the most complex support needs, and to better manage limited resources (Eastern Ontario CNSC, 2009-2012).

An important aspect of an access mechanism to specialized service delivery in this region is the use of videoconferencing technology. Individuals and agencies in remote or under-serviced areas have increased access to specialized services because of eighteen videoconferencing sites across the region. "For example, one Speech Language Pathologist is now using videoconferencing in between face-to-face visits to agencies, to increase the level of service that she is able to provide. It is also being used to provide access to programs and services outside the region, including specialized treatment programs and medical specialists" (Eastern Ontario CNSC April 1, 2009-March 31, 2012, 24). The Network has increased the capacity of hundreds of caregivers and agency staff by offering training through VCT in their own communities, on topics relating to developmental disabilities and mental health issues (Eastern Ontario CNSC, April 1, 2009-March 31, 2012).

Informal Coordinating Mechanism

The East CNSC Systems Planning Task Force is conducting a Service Inventory and Mapping Project to identify what services exist in the developmental and mental health sectors, the presence of gaps and barrier, for the purpose of establishing a business case for service enhancements and additional resources (Eastern Ontario CNSC, April 1, 2009-March 31, 2012).

The following barriers and gaps in services have been identified;

- Specialized accommodation
- Crisis services
- Bed blocking
- Specialized case management services
- Primary health care
- Services to the Francophone community

According to the key informants the Network partners jointly developed the following programs to address these barriers and gaps in service. These achievements would not have been possible without a strong social control mechanism operating in both the South Eastern and Eastern CNSC.

Cross-sector partners in the South Eastern CNSC collaborated to develop, a four-bed, mid-term treatment home, for individuals in the target population, using specialized accommodation funds from the MCSS. Access to these beds is facilitated by a new regional access committee. The Eastern CNSC received funding for nine beds and collaborated with the MCSS regional office to invest these funds in The Crisis Prevention and Intervention Program (CPIP). A multi-disciplinary clinical team offers mobile clinical

supports, training and short term resources to help individuals and their families deal with challenging behaviours in their home. The CPIP also supports hospital staff treating crisis and long stay patients, and collaborates with emergency response systems. Flex funds have been used to purchase access to six "flex beds" for individuals in need of respite and emergency short term placements as an alternative to the emergency room and hospital admission and other services needed, but unavailable through in-kind services (Eastern Ontario CNSC, 2009-2012).

"The East CNSC is supporting two projects that will increase access to specialized resources and enhance capacity. *Into the Community at Last* is a demonstration project co-led by the CNSC and a community mental health agency that strives to demonstrate best practices for admission and discharge for three individuals who have a legacy of being "stuck" in the hospital system. The work will demonstrate a cultural shift in partnerships between hospital and community to collaborate in the support of these individuals in both settings" (Eastern Ontario CNSC 2009-2012, 24). The South Eastern CNSC is strategizing with the managers of two Dual Diagnosis inpatient units to improve patient movement through the program so that others in need can access the services.

The second project involves, cross-sector community leaders, who are collaborating to "establish standards of practice for "case management", type supports for people in the target population. They have launched training that includes, eight separate modules of best practice" (Eastern Ontario CNSC 2009-2012, 24).

The Eastern CNSC and the regional office of the MCSS consulted with the current mental health court support teams in the region, to determine the best use of funds for the Dual Diagnosis Justice Diversion Case Management position. A community mental health agency was selected to manage this position, which has been integrated into an existing front-line resource group of court support workers The Network has a service agreement with the agency, that holds it accountable for the quantitative and qualitative evaluation of the project and provision of data to the MOHLTC. The Network Coordinators holds administrative responsibility for this position (Eastern Ontario CNSC, 2009-2012).

The East CNSC is working with a post secondary institution to establish a Primary Care Consulting Program as a provincial demonstration project. The program will include a multi-disciplinary mobile team of experts in the field of developmental disabilities who will be available to assist family physicians and other allied health professionals in caring for individuals with developmental disabilities and dual diagnosis in the community (Eastern Ontario CNSC, 2009-2012).

A project is underway between the South Eastern CNSC and the Dual Diagnosis Advisory Committee to develop a structure that will be responsible for ensuring that individuals in the target population are discharged from inpatient mental health facilities connected to community-based cross-sector service providers. Progress towards this goal has been achieved in the Eastern CNSC through the work with mental health mobile crisis teams and psychiatry department of the acute care hospitals in the sub-region (Eastern Ontario CNSC, 2009-2012).

Building capacity between the developmental service and mental health sectors, to fill gaps in services has been challenging. “The two systems are vastly different in their terminology, approach to care and system development. Therefore, affecting change across the two systems is an extremely complicated and slow process” (Eastern Ontario CNSC 2009-2012, 5). The Dual Diagnosis guidelines have established the leadership role of the Network in bridging the two systems, but the funding to make the two systems work together is not available. While the MOHLTC is able to fund community mental health services for individuals being discharged from the hospital, the MCSS cannot provide the housing. Higher inter ministerial cooperation at a policy level is required to make the East CNSC effective in this role. The East CNSC has established solid links to the two Local Health Integration Networks in the region, through the implementation of the revised *Joint Policy Guideline*. As well, the Network is working closely with the two LHINs and the regional MCSS offices to transition individuals with a dual diagnosis from mental health inpatient facilities to community supports and services (Eastern Ontario CNSC, 2009-2012).

The East CNSC has taken the lead in developing a French Language Services network on behalf of the four regional CNSC in the province. Services to the large Francophone population in their region has been enhanced by locating a videoconferencing site in a Francophone agency that is linked to, French language service providers across the province. It also connects the Francophone population to French-language services in rural and remote communities. The East CNSC is heading the French Language Service initiative at the provincial level through the CNSC Ontario. A group worked with a consultant to review French Language Service needs and make recommendations to the Ministry. Based on the findings in the report, “CNSC-Ontario has recommended, a French-language resource for the Networks which would provide, training in French, access to educational and other resources in French, networking opportunities for Francophones working in the field, as well as an inventory of professionals able to provide service in French” (Eastern Ontario CNSC 2009-2012, 25).

Resources

The East CNSC receives $977,000 annually, in dedicated funds from the MCSS (divided between the Eastern and South Eastern CNSC), for; the salaries of two Network Coordinators and Administrative Assistants and one Videoconferencing Coordinator; Purchase of Services (including flex funding for training, consultation and crisis response); and other operating expenses. The MCCS also provides funding for; videoconferencing technology, and thirteen specialized accommodation spaces. The MOHLTC funds one full-time equivalent Dual Diagnosis Justice Diversion Case Manger position (Eastern Ontario CNSC, September 20, 2006). According to key informants, in-kind resources are provided by the Lead agency, and Network partners supporting committee work and providing specialized resources.

In the opinion of the key informants, the single best tool/resource the MCSS gave to the Networks was video conferencing technology (VCT). Training and education offered through VCT was the key to the rapid acceptance of the East CNSC and its quick success. It has had the greatest impact on service coordination, delivery and enhancement allowing small agencies that could not afford to send staff for training, to finally participate. It removed the travel barrier that prohibited staff in outlying communities from participating on regional and provincial committees. Families living in a location different from their children can now participate in clinical conferences via VCT.

The fiscal constraints to reducing the gaps in service, identified by the key informants are an over reliance on in-kind support, and the insufficient resources from the MCSS/MOHLTC. The key informants talked about the reality of the resources that the CNSC uses to coordinate and enhance specialized services. With some exceptions, they are being voluntarily offered by the governing boards of the participating agencies that decide if they want to offer resources, and what they offer. There are no consequences if they choose not to participate and the CNSC can not realign resources that do not belong to them. It is a challenge to fulfill the Network goals under these circumstances. Fortunately the member agencies in the East CNSC are willing to work together, openly discuss the limitations and problem solve.

Conclusion

According to the key informants, many partners in the South Eastern CNSC collaborated within and across multiple sectors, in several pre-existing structures and formal networks. The trust, cooperation, legitimacy and reciprocity they established in these relationships, transferred to the South Eastern CNSC and positively influenced its development and acceptance. Prior to the inception of the Eastern CNSC, partners did not collaborate to any significant extent, due to absence of regional structures and the insular

nature in which services were delivered in the sub-region. However, some of the members from the rural area shared resources out of necessity, which according to the key informants contributed to their cooperation in the Eastern CNSC.

The information provided by the key informants and the secondary sources, indicates that, the leadership demonstrates the core competencies related to effectiveness (Roussos and Fawcett, 2000) and employ strategic management tools to integrate and coordinate the membership (Agranoff and McGuire, 2001). The membership composition, diversity and participation in the South Eastern CNSC, is representative of the community and reflects the agenda of the Network. This is only the case for a core group of members in the Eastern CNSC, which the informants attribute to the absence of a collaborative history. The required composition, diversity and participation for an effective partnership, is still evolving (Gray and Wood, 1991, Mitchell and Shortell 2000, Roussos and Fawcett, 2000, Agranoff and McGuire, 2001).

According to the key informants and secondary sources, an access mechanism to specialized services and a regional case resolution mechanism, was in place, in the South Eastern Region prior to the creation of the CNSC. The Network supports this existing mechanism, indicating an agreement between the Network, its internal and community partners. An access mechanism in the Eastern CNSC, has been evolving over the past year, and has several critical components in place (Eastern Ontario CNSC, April 1, 2009-March 31, 2012). The key informants report that it has been a challenge to align the goals of the partnership with those of the wider community, who have a history of operating in silos (Mitchell and Shortell, 2000).

The key informants and secondary sources, report that multi-sector partners in the South Eastern CNSC and cross-sector partners in the Eastern CNSC have collaborated to develop a significant number of joint programs that address barriers and gaps in services, at multiple levels. According to the key informants, the East CNSC is acting as a third party to initiate the use of service agreements between developmental and mental health service providers, to ensure the needs of individuals with dual diagnosis, in the East region are being met (Eastern Ontario CNSC April 1, 2009-March 31, 2012, 25). To date, no Memorandum of Understanding, are signed between the Network and the specialized service providers in the region. The key informants suggest that the collaboration in the South Eastern and Eastern CNSC is based on norms of trust, cooperation, legitimacy and reciprocity (Mitchell and Shortell, 2000).

The key informants and secondary sources indicate that the Network co-leads manage and distribute dedicated and in-kind resources, efficiently and effectively, to maximize the benefit to the individuals and

the community being served (Provan et al., 2007). This opinion is supported by the number and type of joint programs/resources that have been created with the available resources. The fiscal constraints to reducing the gaps in service, identified by the key informants are an over reliance on in-kind support and the insufficient resources from the MCSS/MOHLTC.

The key informants and secondary sources describe the South Eastern CNSC as a legally autonomous, formally established entity of partners, engaged in a non-hierarchical relationship, to achieve a common goal, governed by a central authority with dedicated resources. In their opinion the South Eastern CNSC is effective because it supports an access mechanism to a complex array of specialized programs/resources that is coordinated and seamless. Fragmentation, gaps and replication of services have been reduced. The individual partners working alone could not have established this system of specialized service delivery. In the absence of an access mechanism that is coordinated and seamless and a reduction in the fragmentation, gaps and replication of services, the Eastern CNSC does not fit all of the criteria for being effective at this time.

CHAPTER 4

North Community Network of Specialized Care

Introduction and Background

The North Community Network of Specialized Care spans 800,000 kilometres with three defined geographic boundaries. The majority of the 839,549 residents live in cities and small communities that are separated from each other by a vast geography. This region is home to a significant Aboriginal and Francophone population (SPC, 2005). Using the prevalence rate for developmental disability at 1 percent of the total adult population and 38 percent of that population having a dual diagnosis, it is estimated that this Region of Ontario has an estimated 8,395 people with a developmental disability and approximately 3,190 have a dual diagnosis (SPC 2005, 2).

Six Local Developmental Services Sector Planning Tables in the Northern Region were and continue to be responsible for local community planning and service delivery for individuals with a developmental disability. They are situated in three geographic regions. Single Point of Access agencies in these three regions provide intake, coordinate access to multiple services including case management, as well as prioritizing and maintaining waiting lists. They make referrals to local area specialized services directly and or use the local case resolution processes for individuals with a dual diagnosis (SPC, 2005).

In Region 1 there are two agencies providing single point access for sixteen MCSS transfer payment agencies located in nine communities. Twenty three case managers oversee 531 active cases. In Region 2 there are four agencies providing single point access for thirteen MCSS transfer payment agencies located in six communities. Eighteen case managers oversee 564 active cases. In Region 3 there are ten agencies providing single point access for twenty-one MCSS transfer payment agencies located in fifteen communities. Thirty case managers oversee 1255 active cases (SPC, 2005).

Prior to the development of the North Community Network of Specialized Care (North CNSC), a strong Advisory Committee operated in the region with representation from; six MCSS funded service providers that sit on the Local Developmental Services Sector Planning Tables; three dual diagnosis clinical service providers funded by the MOHLTC; a standing member from the psychiatric community; a teaching member from a medical school and a representative from the MOHLTC regional office (SPC, 2005).

The range of specialized services available through, MCSS funded developmental service clinical providers, varies across the region and were limited at best. The cost and efficacy of developing,

delivering, sharing and maintaining specialized, clinical resources, for individuals with developmental disabilities and complex mental health and/or behaviour needs, was challenging. Relationships between specialized service providers were at an elementary stage of development. Core developmental services, in all areas, were stretched to the limit and beyond (Northern Network of Specialized Services, September 2006).

MOHLTC funded services were also limited. All three geographic areas reported a shortage of psychiatrists, psychologists, speech and language therapists and behavior therapists trained to work with individuals with a dual diagnosis. It was difficult to attract and maintain clinical specialists in this region due to the lack of support services, the high volume of service required, and insufficient funding (Northern Network of Specialized Services, September 2006).

Only some individuals in the target population had access to the MOHLTC funded, Assertive Community Treatment Teams (ACT). A local Dual Diagnosis Program had a year long waiting list. A major limitation was the lack of emergency and short-term residential placements with the capacity to provide assessment and stabilization for individuals with challenging behaviour. Specialized housing, crisis beds, and crisis response were for the most part non-existent. Individuals in the target population experienced a large number of health problems that generic health services did not know how to deal with. If funds were available, Purchase of Service (POS) agreements with private practitioners, in a variety of areas augmented or substituted for core services that were not available. In some cases there appeared to be a reliance on the POS models in lieu of developing locally based specialized services. According to the key informant's video conferencing was very beneficial in providing individuals in the target population and service delivery professionals, access to specialized services. However, the equipment varied in quality and reliability (Northern Network of Specialized Services, September 2006).

Responsibility for service provision to individuals in the target population was not clearly delineated between MOHLTC and MCSS funded service providers, complicated by different eligibility requirements, and working definitions of need. With some exceptions, partnerships with the justice and academic sectors were also at an elementary stage of development (Northern Network of Specialized Services, September 2006). The key informants shared an example of a Human Service and Justice Committees that had established an effective multi-sector partnership to divert individuals with a dual diagnosis from the court system.

The developmental service sector was not connected to hospital facilities, psychiatrists operating private practices, Family Health Networks, the three new Local Health Integrated Networks (LHIN's) or community mental health providers. The region is working to establish culturally specific services in the First Nations communities that are isolated by distance and land transportation. Most agencies reported offering services in English only and few offer programs geared specifically to the Francophone population. Several offer sharing circle workshops and traditional healing services for their aboriginal clients (Northern Network of Specialized Services, September 2006).

Organizational Structure and Accountability

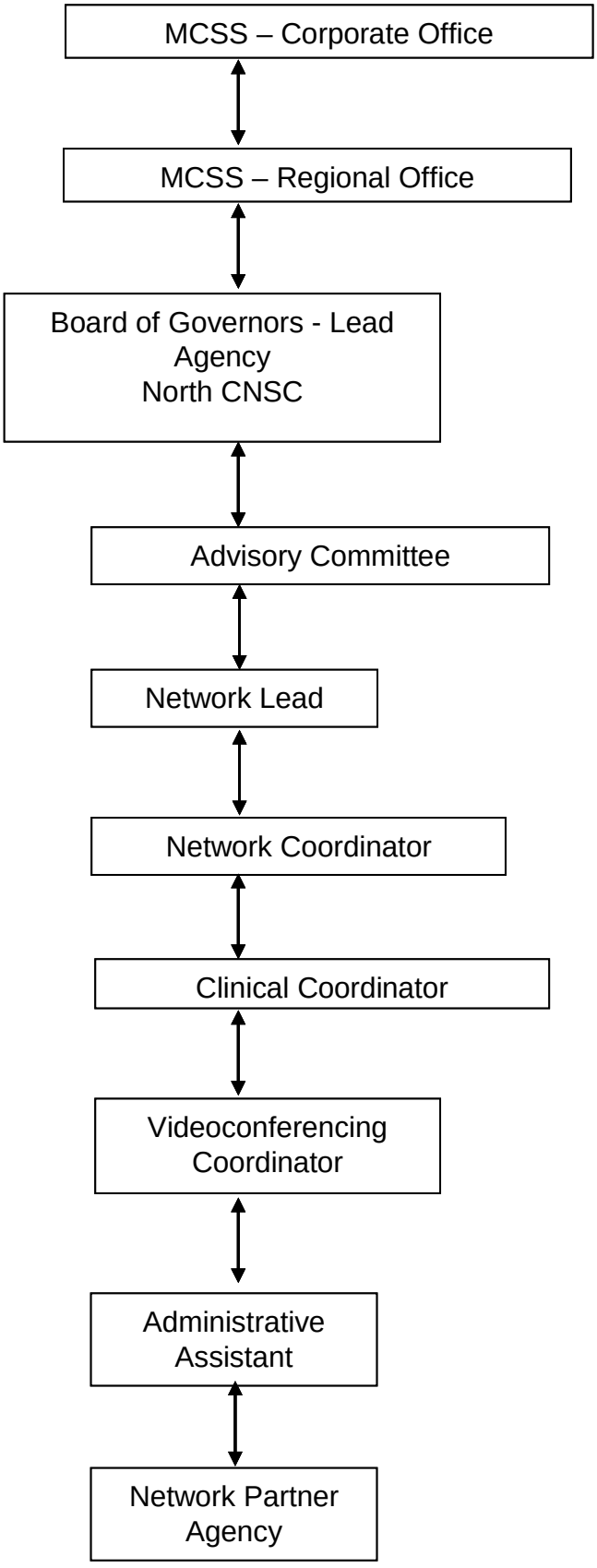
An Advisory Committee, referred to, as the Implementation Committee (IC), was created by the regional office of the MCSS, to assist in establishing the North CNSC. Members were selected that recognized the value of video conferencing technology (VCT) as a means of accessing specialized clinical services for individuals in the target population, due to the remote nature of this region and for their ability to ensure that the Network reflected the needs of individuals, families and communities being served (Northern Network of Specialized Services, September 2006).

Recognizing the unique service system in each of the six planning areas, the Network Lead and the IC engaged a consulting firm to assist in conducting extensive community consultation meetings/focus groups with staff from developmental service organizations and specialized service providers in each area. The goal was to understand the environment in which specialized services are being delivered. The information about the current strengths, limitations, opportunities and challenges supplemented the inventory of existing resources, partnerships, and networks, supplied by the Environmental Scan (Northern Network of Specialized Services, September 2006).

Incorporating the findings of the Environmental Scan and the consultation meetings, in September 2006, the IC developed a Business Plan to build local capacity both at a front line and specialized services provider level by supporting and building on the services that already exist within local communities. In keeping with this philosophy, the first priority of the Network was to enhance existing specialized services, by using Network funds to purchase clinical services. With their function complete the IC evolved into an Advisory Committee for the North CNSC, with many of the same members. The Regional Solutions Report 2005, prepared by the consultant who conducted the Environmental Scan, recommended that in order to ensure geographic representation and accessibility to service, a number of existing organizations and services across the region should be designated as "Specialized Clinical Service Providers" (SPC, 2005). Eight Developmental Clinical Service Providers funded by the MCSS

were selected as representatives of their organizations to sit on the Advisory Committee. There are a total of sixteen members, including the Network lead, a representative from the MOHLTC, the Network Coordinator and the MCSS Program Supervisor as ex officio members (Northern Network of Specialized Services, September 2006). The organizational structure is depicted in figure 4.

Figure 4
North Region CNSC
Organizational Structure



The North CNSC operates as a tertiary level service. Service providers seeking specialized services for individuals with a developmental disability and mental health needs and/or challenging behaviours, continue to make referrals to their local area specialized service providers directly and/or use the local case resolution processes. When local resources at both, a community and clinical level cannot adequately respond to the needs of the individual, the specialized service provider, acts in the capacity of a case manager and makes a referral to the North CNSC. The Network Coordinator, whose role it is to manage the referral process, provides access to highly specialized services attached to the Network in an equitable, and timely manner (Northern Network of Specialized Services, September 2006).

Two Committees were created to support the work of the North CNSC. An Operations Advisory Committee was created to "plan, develop and implement the Clinical Services Delivery of the CNSC as directed by the Lead agency" (Northern Network of Specialized Services (November 1, 2006): Terms of Reference Operations Committee, 1). A Training Committee was developed to, plan and implement cross-sector, collaborative, training for clinical and front line staff that, ensures progressive skill building, has web-based elements and uses videoconferencing. (Northern Network of Specialized Services (November 1, 2006): Terms of Reference Training Committee).

The formal accountability relationships are as described in Chapter 1. In addition, the North CNSC requests that key representatives from the MOH/LTC funded programs in the region, also sign an MOU (Northern Network of Specialized Services, September 2006). No formal evaluation of this Network has been conducted.

Results

The following data was obtained from, the key informant interviews and secondary sources; Northern Network of Specialized Services, September 2006 and; other documents related to the North CNSC.

Historical relationship and collaboration between network partners

According to key informants and secondary sources, many of the partners in the North CNSC collaborated with developmental and mental health clinical service providers, academic sector representatives and MCSS and MOHLTC managers, on a pre-existing Advisory Committee (SPC, 2005). This cross-sector entity provided an opportunity to collaborate in addressing the needs of the target population. Their relationship has continued in the North CNSC, and has encouraged new partners to engage in cooperative, coordinated, collaborative behaviour to meet the mandate of the CNSC.

Leadership

According to the key informants, the agency selected to lead the North CNSC has operated a specialized clinical support program for individuals with developmental disabilities, for over twenty-five years (Northern Network of Specialized Services, September 2006). The Lead agency is a strong sponsor and has provided the Network lead with the time and resources to fulfill his obligations to the Network.

The key informants concur that the Network lead is a "huge champion" who has taken the time to travel across the region many times over to consult with and include the local communities in developing their CNSC. He provides the leadership but the communities have ownership of the Network, which is structured to be responsive to the needs expressed by local consumers, agencies, and families. The key informants remarked that, the Network lead is able to see the big picture and uses his project management skills to break a task into manageable components in order to produce a viable outcome. He has used his partnership development skills to establish a strong and empowered Advisory committee, who work willingly as a cross-sector and cross- disciplinary team to accomplish the goals of the Network. There is no hierarchy in this Network everyone is considered an equal partner and a leader. The respect and consideration the Network lead demonstrates combined with exemplary communication skills, have contributed in the opinion of the key informants, to the effectiveness of this Network.

The key informants consider the Network Coordinator an indispensable champion of the Network because of, strong leadership skills, which include written and verbal communication, facilitation, mediation, problem solving, and patience. These skills are demonstrated in managing the referral process for specialized services, assisting in the preparation of the annual Business Plan and formalizing agreements with members of the Network. The key informants also regard the MCSS Program Supervisor as a champion whose wisdom, communication, negotiating skills and willingness to collaborate, have contributed to the successful attainment of Networks goals. According to the key informants, the Chair of the Implementation and Advisory Committee has been a key partner in the developmental sector for several decades. They regard him as a champion and a constant sponsor, whose, commitment, expertise and unending energy have provided the needed continuity for this endeavour and its ultimate effectiveness.

The Advisory Committee has sixteen members. There are representatives from, seven of the eight specialized service providers in the region, three MOHLTC Dual Diagnosis Programs, a standing member from the psychiatric community, a teaching member from a medical school, a MOHLTC representative, the Network Lead, Network Coordinator and MCSS Program Supervisor, both ex officio members.

According to the key informants, the members were selected by the Network lead because, collectively they offer a broad range of specialized services that are highly valued. They are well linked to cross-sector service providers, in a multitude of communities across the region, bridging the gap with the Network. In addition to these committee members, the North CNSC is strongly linked to the six Developmental Service System Tables, the MOHLTC Dual Diagnosis Teams and the Educational Institutions (two local universities and seven colleges) in the region (Northern Network of Specialized Services, September 2006).

The Chairpersons of the Operations Advisory Committee and the Training Committee are strong, knowledgeable and committed partners in this CNSC, who successfully work with Network partners to accomplish the established goals. The following chart describes the number of members involved in each of the committees.

Type of Involvement	Number of members involved
Operations Advisory Committee	12
Training Committee	8

The Operations Advisory Committee is comprised of key clinical supervisors/managers from each of the eight specialized services agencies, representatives from the MOH Dual Diagnosis Teams and from the Lead agency. Terms of Reference have been created for the Committee and it is accountable and reports to the Advisory Committee (Northern Network of Specialized Services, November 1, 2006: Terms of Reference, Operations Committee).

Membership on the Training Committee includes, representatives from: Clinical Services from each of the eight specialized services agencies, the MOHLTC Dual Diagnosis Teams, educational organizations, the Lead agency and staff that support front-line workers in group homes for individuals with a dual diagnosis. Terms of Reference have been created for the Committee and they are accountable and report to the Operations Advisory Committee (Northern Network of Specialized Services (November 1, 2006): Terms of Reference, Training Committee).

According to the key informants, the following specialized services, funded by the MCSS, are available across the region.

Type of Specialized Resource	Number of Positions (MCSS funded, Purchase of Service (POS))
Behaviour Therapy	15 Full Time Equivalent (FTE) (MCSS)
Psychology	4 FTE (MCSS) and 1.25 FTE (POS)
Psychiatry	0.1 FTE (MCSS) and 0.1 FTE (POS)
Speech Pathology	2 FTE (MCSS) and 1 FTE (POS)
CDA	2 FTE (MCSS)
Other: Nursing/OT/PT/Psychometrist/Social Work/Case Management	minimal

The key informants report that there are thirty agencies that are broad partners in the North CNSC, including, the members on the Advisory, Operations Advisory and the Training committees, and the agencies that provide and access specialized resources. The key informants have rated their level of connectedness to the Network as follows.

Rating	**Number of Partners**
Strongly Connected	12 partners
Moderately Connected	9 partners
Somewhat Connected	7 partners
Mildly Connected	2 partners
Not at all Connected	0 partners

According to the key informants, collectively the members of the Advisory Committee offer a broad range of specialized services that are highly valued and represent a multitude of communities from across the region. They are well linked to the cross- sector service providers in the region, bridging the gap with the Network. Attendance at meetings is consistent and strong for ninety percent of the members and they contribute enthusiastically to training initiatives. They are key players in referring individuals to the Network for specialized services and in providing specialized services. Several of the members have a long history of collaborating at a regional level. All but two of the members on the Committee are active at this time, one because of a change in funding status. A range of services based on best practice evidence have been developed and according to the key informants wait times for service have been reduced.

Internal and External Alignment

According to the key informants, the North region had pre-existing Local Developmental Services Sector Planning Tables, single point access agencies and local case resolution mechanisms, to coordinate services for individuals with developmental disabilities and mental health problems and/or challenging behaviours. The North CNSC enhanced this system by incorporating into the existing infrastructure. If appropriate specialized services are unavailable at the local level, the Network Coordinator can access specialized services and resources available to the Network on behalf of the individual. This has given the Network legitimacy at the community level. The Network Coordinator has created material explaining the process and referral forms to ensure efficient use of resources.

The key informants agree that videoconferencing, as a means of accessing specialized clinical services, such as assessment, consultation, and case review, from psychiatry, psychology, behaviour therapy, speech and language and other varied disciplines, has been the most significant contribution to the enhancement of specialized service delivery in this CNSC. Based on the success of a MCSS funded pilot project, linking individuals in the target population living in remote areas of the region, with clinicians providing specialized services in other regions of the province, the ministry funded twenty-three video conferencing sites for this CNSC. Individuals are connected to their local Specialized Service Provider (SSP) for Service and Support. If they are not able to obtain the services and supports they require at this level, the individual and the local SSP can access specialized services from the North CNSC and other Specialized Service Provider organizations in the North Network. If their needs remain unmet they have the option to access specialized services and supports available through the other three regional CNSC for the province.

Informal Coordinating Mechanism

The key informants reported that, the North CNSC is working closely with the MCSS in the development and implementation of the Client Information Management System (CIMS). This project is attempting to develop a common data system for all major service categories funded by MCSS, including developmental services. Currently, information regarding developmental services is available on various agency level websites across the North. Databases exist in some organizations that support record keeping and service utilization. However, this information has not been integrated between service providers. This task will require significant collaboration and an understanding of the need to collect consistent information for the purposes of monitoring outcomes at a client and network level

The North CNSC has identified the following barriers and gaps in the specialized service system.

- Specialized accommodation
- LHINS
- Community mental health resources
- Dual Diagnosis Justice Case management services
- Francophone, First Nations, Aboriginal communities
- Education and Training

According to the key informants, historically providers in the mental health and developmental sectors refused to accept responsibility for individuals with a developmental disability and mental health needs and/or challenging behaviours, believing it to be the others responsibility. The partners in the North CNSC have made significant progress in overcoming this attitude and jointly developed the following programs to address barriers and gaps in services. These achievements would not have been possible without a strong social control mechanism in this Network.

The Network convened an informal working group to develop an implementation plan for the six specialized accommodation spaces. One bed was assigned to each of the local developmental service planning areas and proposals from agencies interested in managing this initiative, were reviewed by the working group. The agencies selected, worked with their community partners to design a model for a short-term treatment and/or transition beds that engaged local and specialized service providers, and enhanced local capacity. Several of the beds were developed by MOHLTC funded agencies, to encourage cross-sector collaboration. The training and data collection template developed by the Network for the providers of the specialized accommodation beds, was well received (Northern Network of Specialized Services, September 2006).

The key informants noted that, the participating agencies struggled with implementing the initiative, due to the barriers between the two sectors, resulting is some of the beds being moved from mental health partners to MCSS provider agencies. In one case, with the assistance of the local community advisory committee, that has strong representation from the mental health and developmental sector, the Network was able to successfully move one of the beds within the same mental health facility. The facility provides the psychiatric care and consultation onsite and the Network parachutes in the developmental service support and provides training in dual diagnosis to the psychiatric team. With training and support from the Network, the initiative is a success and one of the key community partners in the collaboration became a member of the North CNSC Advisory Committee. The training has brought the two sectors together and has extended to include mental health and generic service providers in the community,

seeking information on developmental disabilities. This cross-sector collaboration has been hard to replicate in the other communities in the region, impeded by geography, and distance between mental health and developmental service providers.

According to the key informants, the community agencies participating in the accommodation initiative, indicated that individuals eligible for the beds have not used them because they want to receive services in their home communities, to avoid the transition required at the end of their treatment. There is no flexibility with the designated capital from the MCSS, to create virtual beds, which the service providers indicated would enhance service delivery.

The key informants report that there are three Local Health Integration Networks (LHINs) located in the region covered by the North CNSC. Attempts have been made to involve them in the Network, for the past three years. To date, one meeting, co-arranged with the Coordinator for the Central West CNSC, and a LHINS, whose borders cross both CNSC, has been held to discuss the implementation of the Joint Dual Diagnosis Guidelines. The Network lead addressed this issue, with community partners across the region, during consultation meetings for input into the 2009-2012 Business Plan. The LHINs have also been unresponsive in planning the community placement of thirty individuals, residing in a mental health centre scheduled to close. While there are beds in the community they are being blocked by individuals who are not appropriately placed, but have no where else to live. There is only one psychiatrist in the region that sees patients one day a week to prescribe medication. This resource deficit affects effective service delivery. The Network needs equipment for at least one more in-house video conferencing site for clinical consultation and training, to address the many small communities in the region that are unable to attract clinicians and or trained developmental service staff. Video conferencing is the only option for providing training to fly in communities. To address this challenge the video conferencing staff, have developed a significant amount of dual diagnosis training that is accessible online, on DVD and on the Ontario Telemedicine website. Many practitioners have benefited from this dual diagnosis training material.

According to the key informants, the Advisory Committee engaged the Regional Human Services and Justice Committees to work with the local development service planning table to determine the placement of the three full-time equivalent Dual Diagnosis Justice Case Manager positions. They have been spread across five agencies in the region, four MOHLTC funded, and one MCSS funded. MOHLTC funded agencies were selected because the Ministry funds mental health court diversion workers and it was seen as an opportunity to enhance cross-sector collaboration. The North CNSC is responsible for collecting the

data for this initiative, as required by the MOHLTC. As a result of this initiative, links to the local and specialized service providers, the MOHLTC diversion workers, the Office of the Crown Attorney and the local police have been established, breaking down multi- sector barriers. The data indicates that individuals in the target population are being diverted from the justice system.

The key informants report that, the North CNSC has made a commitment "to provide services that are culturally and linguistically sensitive, competent and appropriate" to the languages, culture and races in the region. The lead agency is "a designated agency under the French Language Services Act," and has worked with Aboriginal and First Nation communities for many years. To enhance service delivery to the Francophone, Aboriginal communities in the region, Aboriginal, First Nations and French language representatives are involved at the Network advisory level at all times. An agency that has worked with Aboriginal communities in this region has been consulted for their expertise. Clinical specialists who have experience and are able to work with French language and Aboriginal people, have been identified and a survey completed describing the specialized services that are being provided and or needed in other languages and cultures.

The North CNSC is partnering with two local universities and seven colleges, to train and build capacity in the community, by providing student placements. A number of agency staff, teach post secondary courses in developmental disability and several agencies have educational partnerships with post secondary institutions in the area of disability studies. The training committee has undertaken research in the area of best practices for models of care, support and intervention. Information is being collected from individual clinicians and clinical teams, and is being shared with front line staff (Northern Network of Specialized Services, September 2006).

Resources

The North CNSC receives $977,000 annually, in dedicated funds from the MCSS for the; Network Coordinator, Clinical Coordinator, and Videoconferencing Coordinator's salary; Purchase of Services (including flex funding for training, consultation and crisis response); and other operating expenses. The MCCS also provides funding for; videoconferencing technology and six specialized accommodation spaces. The MOHLTC funds three full time equivalent Dual Diagnosis Justice Diversion Case Manger positions (Northern Network of Specialized Services, September 2006). According to key informants, in-kind resources are provided by the Lead agency, and Network partners supporting committee work and providing specialized resources. The North CNSC uses flexible funds in the Network budget to purchase services when in-kind resources are not available. The fiscal constraints to network integration identified

by the key informants are inadequate resources from the MCSS/MOHLTC to address service gaps, and rules and regulations as to how money can be used.

Conclusion

According to the key informants, a large number of the North CNSC, Advisory Committee members participated in the pre-existing Advisory Committee. They credit this history of shared risks, resources, responsibilities and mutual dependency, on the solid foundation of trust, cooperation, legitimacy and reciprocity that exists in the Network. In their opinion it encourages and facilitates collaboration among Network partners to meet the mandate of the CNSC (Wood and Gray 1991, Provan and Milward 2000, Roussos and Fawcett 2000, Bryson, Crosby and Stone 2006).

The information provided by the key informants and the secondary sources indicates that, the Network lead demonstrates the core competencies related to effectiveness (Roussos and Fawcett, 2000) and employs, strategic management tools (Agranoff and McGuire, 2001) to successfully integrate and coordinate a representative partnership. The composition, diversity and involvement of the partners, reflects the agenda of the Network, which is instrumental in addressing the Network mandate (Gray and Wood, 1991, Mitchell and Shortell 2000, Roussos and Fawcett, 2000, Agranoff and McGuire, 2001).

The key informants and secondary sources report that, the North CNSC successfully streamlined access to specialized resources through the use of videoconferencing technology, at the local and regional level and actively supports the mechanism. According to the informants, the number of organizations and individuals within organizations that offer and access specialized services, reflects that, there is a shared understanding and agreement between individual Network and community partners, and the North CNSC, on this goal (Mitchell and Shortell, 2000).

According to the key informants and secondary sources cross-sector partners in the North CNSC have collaborated to developed a significant number of joint programs that address barriers and gaps in services, at multiple levels. While the Network has formalized agreements (Memorandum of Understanding) with ten organizations that offer a range of developmental, and mental health services, the key informants feel that the program development is a result of network partners, collaborating informally, based on a strong foundation of trust, cooperation, reciprocity and legitimacy, inculcated by the Network leadership (Mitchell and Shortell, 2000).

The key informants indicate that the Network lead manages and distributes dedicated and in-kind resources, efficiently and effectively, to maximize the benefit to the individuals and the community being served (Provan et al., 2007). This opinion is supported by the number and type of joint programs/resources that have been created with the available resources. The fiscal constraints to effective network integration, identified by the key informants, are inadequate resources from the MCSS/MOHLTC to address service gaps, and rules and regulations as to how money can be used.

The key informants and secondary sources describe the North CNSC as a legally autonomous, formally established entity of partners, engaged in a non-hierarchical relationship, to achieve a common goal and governed by a central authority with dedicated resources. In their opinion this Network is effective because they have developed an access mechanism to a complex array of specialized programs/resources that is coordinated and seamless. Fragmentation, gaps and replication of services have been reduced. The individual partners working alone could not have established this system of specialized service delivery.

CHAPTER 5

South Network of Specialized Care

Introduction and Background

The Southern Network of Specialized Care (SNSC) is comprised of the South West and Hamilton-Niagara regions and is home to approximately 2, 776,149 people living in eleven communities (census areas).Using the prevalence rate for developmental disability at 1 percent of the total adult population and 38 percent of that population having a dual diagnosis, it is estimated that this region of Ontario has an estimated 27,761 people with a developmental disability and approximately 10,549 of those have a dual diagnosis (South CNSC 2006-2009, 11).

The Environmental Scan described the developmental disability service delivery system prior to the introduction of the CNSC, as having three levels. The first was comprised of families caring for their adult children with developmental disabilities (DD). A range of community-based organizations, some specifically targeting the population, composed the second level. “The third level consisted of highly specialized services and supports that address the most severe and complex needs of people with developmental disabilities” (Rice December 16, 2005, 6-7).

Each of the nine MCSS funded Access/Contact Agencies that manage the service delivery system in this region, had a different evolution. They functioned as the intake and referral mechanism for individuals with DD and worked with the local developmental service providers to develop wait lists for services. In 2004-2005, ninety-seven MCSS transfer payment agencies across the region, provided a range of services to approximately 69, 400 people with a development disability (Rice, December 16, 2005). Individuals in the target group accessed specialized services, in the development sector, through referral from, general practitioners, developmental service agencies, Access/ Contact agencies, hospitals, mental health agencies, community organizations, school boards, families and caregivers. One of the sub-regions had three MCSS funded specialized service providers and the other sub-region had one (Rice, December 16, 2005).

In 2004-2005 the agencies providing specialized services, served a combined total of 3231 people. 62.5%, reported that the demand for specialized services exceeds their capacity on a regular basis. They identified a lack of day and recreational programs, respite services, transportation, especially in rural areas, crisis

services, staff trained to support individuals in crisis, and specialized residential treatment (Rice, December 16 2005).

Respondents participating in the Environmental Scan meetings suggested that the gaps in service were a result of insufficient funding, waiting lists and a lack of curriculum on developmental issues in the training and education of professionals. They reported that it was challenging to attract and retain qualified practitioners at all levels, when they are asked to work with complex individuals, in an inadequate service delivery system, without the necessary training" (Rice December 16, 2005, vi).

Individuals with a dual diagnosis were also eligible for services from MOHLTC funded agencies. However, developmental service agencies, families and key stakeholders indicated that, individuals in the target group had difficulty obtaining mental health services, especially hospital services. There was a "lack of integration between MCSS developmental and MOHLTC mental health services that appears to be the result of misperception about each sector's capacity and responsibility" (Rice December 16, 2005, v). "The consequences include; disconnected service provision at the local level; the lack of a long-term shared agenda for sustained, effective care and support; and a lack of long-term plan for dealing with increased needs" (Rice December 16, 2005, v).

While there are some examples of local groups developing within and cross-sector strategies to address the needs of this population, "there is no unified service system for people with a dual diagnosis" (Rice December 16, 2005, v). Access to developmental and dual diagnosis services was variable across the two regions and contingent upon: where the individual lived; the availability and ability of family to advocate on their behalf; the availability of resources in the community; and the relationship between the MCSS, MOHLTC, Education, Justice and their transfer payment agencies, the non- profit and private sectors (Rice, December 16, 2005).

"The continuum of care and support for these clients and their caregivers comes from diverse policy and program sectors and funding sources. Silo funding of Health and MCSS prohibit joint initiatives. This makes the provision of an effective and responsive continuum of services more complex" (Rice December 16, 2005, v).

Organizational Structure and Accountability

The MCSS selected two agencies to co -lead the South Network of Specialized Care (SNSC). The Network Co-Leads and representatives from the MCSS formed a Joint Implementation Committee (JIC)

to develop the structure for the SNSC and a Business Plan for 2006-2009. The JIC followed the recommendation in the Regional Solution Report, in building the foundation for the SNSC. They selected a two-tier system consisting of, eleven Local Service Delivery Networks (LSDN) in the first tier, and a Planning and Coordinating Network (PCN) in the second. The intent is to have the SNSC link the eleven communities in this region of the province (SNSC Business Plan, 2006).

Existing local community structures, such as Dual Diagnosis Communities, were identified by the local MCSS staff and the Network Co-Leads, as viable structures in which to integrate the functions and mandates of the SNSC. These entities became the LSDN with representation from local developmental and mental health agencies, access or contact agencies, police and corrections officers, health and education, that provide services to the target population. Five facilitators, funded by the Network, but hired and supervised by developmental service agencies, resource the eleven LSDN. Their role is to make the most effective use of resources, in meeting the specialized services needs of the target population, coordinating the use of crisis services and short term treatment spaces and providing limited case coordination functions (SNSC Business Plan, 2006).

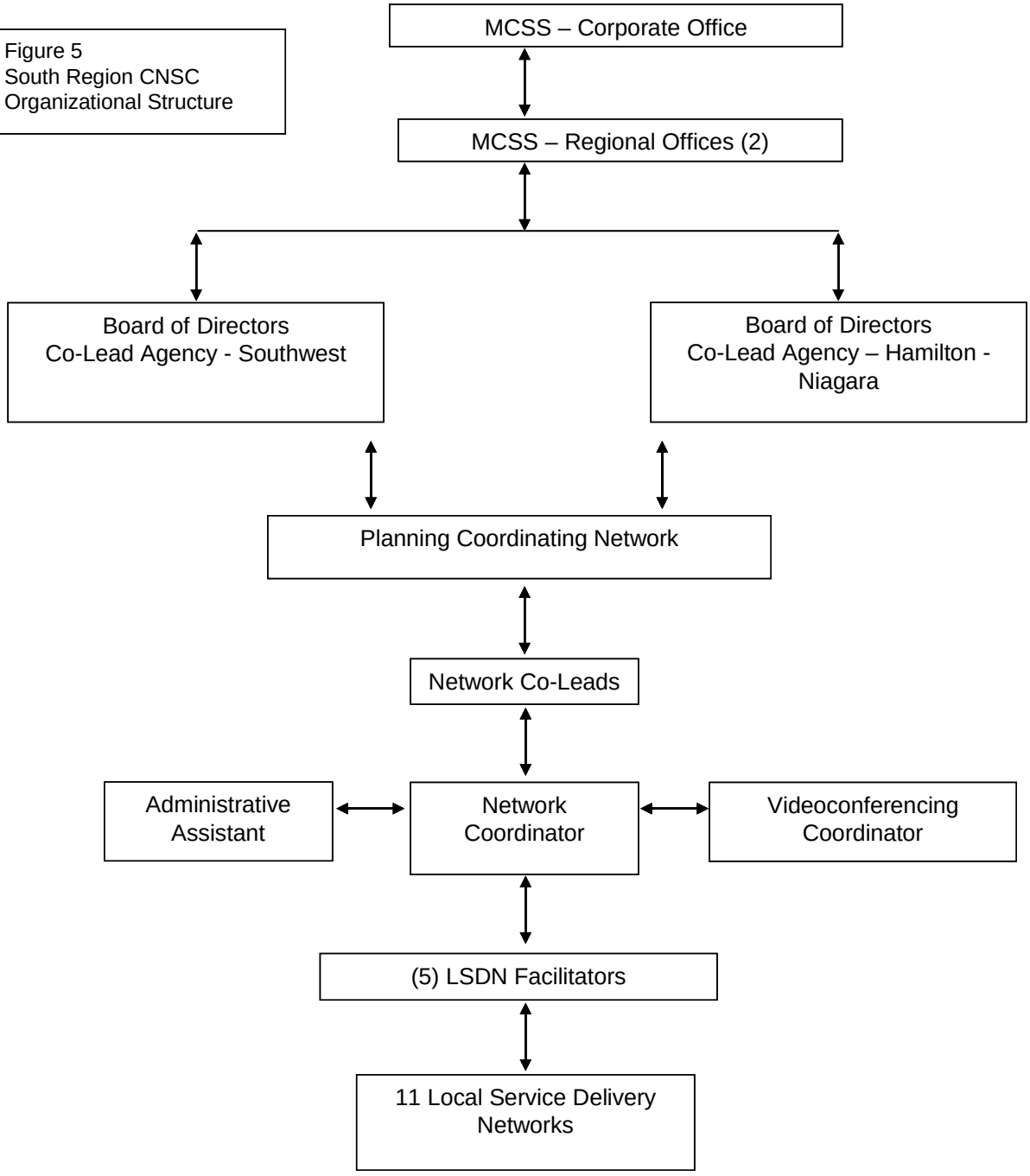
The Network Coordinator for the SNSC is responsible for supporting the work of the facilitators, and gathering information from them about the issues, gaps and priorities related to specialized services. The Network Coordinator conveys this information to the PCN, so that they can address these specialized service needs in their Work Plan for the SNSC. Bi-annual meetings are convened with the Facilitators and Network Coordinator, to share experiences and discuss best practice (SNSC Business Plan, 2006).

The PCN was developed to “provide advice to the Network Co-leads regarding the vision, direction; strategic objectives and business plan for the operation of the network” (SNSC Business Plan 2006, 12). There are fifteen members, including the two Co-leads, the Network Coordinator and two MCCSS Program Supervisors who are ex officio members. The PCN formed the Training and the Research sub-committees to support their work and they are resourced by members of the PCN (SNSC Business Plan, 2006).

Governance of the SNSC is through the Board of Governors of each of the lead agencies. It is articulated in a tri-party agreement between the co-lead agencies and the MCSS. The two lead organizations work jointly in developing and managing the SNSC and jointly and separately in providing leadership and services in meeting the goals and objectives of the Network. The MCSS designated the management of the budget to one of the Lead agencies on behalf of the Network, but both are accountable to the MCSS

for the Network resources. The Facilitators for the LSDN report to the Network Coordinator and are accountable to the agencies that provide supervision. The Network Coordinator is accountable to the Network Co-Leads and the PCN and provides administrative support for the Facilitators. The Network Co-Leads are accountable to the PCN and the MCSS (SNSC Business Plan, 2006). According to the key informants this Network was formally evaluated in 2009, but the results were not available for use in this study. The organizational and accountability structure is depicted in Figure 5.

Figure 5
South Region CNSC
Organizational Structure



Results

The data was obtained from key informant interviews and secondary sources; the South Network of Specialized Care Business Plan 2006, South Network of Specialized Care Business Report 2007/2008 and other documents related to the Network.

Historical Relationship and collaboration between network partners

According to the key informants, partners in five of the eleven LSDN participated in cross-sector collaboration prior to the involvement in the CNSC. These LSDN are actively engaged in meeting the mandate and functions of the CNSC in their local communities, which the informants report is facilitated by their prior relationships.

Leadership

According to the key informants, the Co-lead agencies are well established transfer payment agencies providing a broad spectrum of specialized services and supports to individuals in the target population. The Executive Directors of the Co-lead agencies were designated by the MCSS as the Network Co-Leads. One left his position in the spring of 2009 and has been replaced by the new Executive Director. They are described by the key informants as champions of the Network, whose exemplary knowledge of the developmental and mental health issues of the target population, and strong commitment and leadership skills have been critical to the implementation of the CNSC.

The Network Coordinator is also described as a champion by the key informants for her strong leadership skills, including written and verbal communication, facilitation, mediation, problem solving and patience. She positively impacts the Network through her regional and provincial representation on committees and boards. The key informants also regard the Facilitators and MCSS Program Supervisors, as champions for forging new territory in supporting the newly created LSDN in the region.

The key informants indicated that there are ten members on the PCN. Six members represent MCSS funded agencies, two members are from MOHLTC funded agencies, one member is from the Justice sector, and one from the academic sector. According to the key informants, the PCN members were strategically selected by the JIC because of their strong and credible regional representation, across the spectrum of developmental, health, justice, education and research services. Seven of the nine members have been on the PCN since its inception, one member resigned and the other was replaced with an individual from the same agency. According to key informants, members of the PCN are strongly connected to the Network, supporting the sub-committees. However, they struggle to understand their role

and function and the value and meaning of their work. Attracting and maintaining membership, motivation, involvement and attendance at meetings, is a challenge because the output and outcome of the work at this level, is not realized until system changes occur.

Structuring the Research and Training sub-committees helped to focus the work of the PCN.
The following chart describes the number of members involved in each of the committees.

Type of Involvement	Number of members involved
Research Sub-Committee	6
Training Sub- Committee	6

Each LSDN is comprised of the following partners.

Local Service Delivery Network	Number of Partners
LSDN 1	30 partners
LSDN 2	15 partners
LSDN 3	21 partners
LSDN 4	16 partners
LSDN 5	13 partners
LSDN 6	24 partners
LSDN 7	25 partners
LSDN 8	12 partners
LSDN 9	11 partners
LSDN 10	17 partners
LSDN 11	16 partners

According to the key informants, the critical work of the Network occurs at the level of the Local Service Delivery Network (LSDN). Coordinating and enhancing the delivery of specialized services for very complex and vulnerable individuals requires cooperation and collaboration across sectors, to identify service issues, gaps and barriers. In their opinion the communication and connection between the LSDN and PCN needs improving. Currently the facilitators shares information about gaps in services and

resources with the Network Coordinator, who conveys it to the Co-Leads and PCN. To improve the communication between the two tiers, the Chairs/Co- chairs of the LSDN will start meeting with the Co-leads twice a year, to discuss the successes and challenges of their respective LSDN.

The same format is not used to present the information about the composition, diversity and participation of Network partners, as in the other cases, because the LSDN are structures established to coordinate service delivery for individuals with developmental disabilities, residing in local communities. The Network mandate is an adjunct and only one element of their work. The eleven LSDN's operate autonomously and are not connected to each other or directly to the PCN at the time of the study. The ratings on participation and connectedness pertain only to their collaboration with the Facilitator and the other members of the LSDN, to address the mandate of the Network. The information from the key informants is grouped based on the ratings of connectedness**.**

In the opinion of the key informants, the LSDN in five communities are thriving, three are struggling and three are not viable, in addressing the mandate to, coordinate the specialized service system. The five LSDN that are described as thriving evolved from well established collaborative structures that have representation from health, mental health, and the developmental sector. These sectors have a history of collaborating within and across sectors and are strongly connected with other systems, such as local planning tables and Contact Agencies, within their community. The LSDN have willingly incorporated the Terms of Reference for the SNSC, and are engaged in the work required to fulfill the mandate, functions and goals within their local community.

The three Local Service Delivery Networks that, the key informants regard as struggling, evolved from long standing, community structures. According to the key informants, the members of the LSDN feel that the SNSC is duplicating the work of the existing structures, and therefore unnecessary. The members feel that using the Network funds to purchase more services and resources would have been a better investment. Thus, these LSDN have developed slowly and reluctantly, and control the agenda/goals. The members find the Network concept vague and as a result do not understand their role and function. Although there is an increase in collaboration between the mental health and developmental sector, it is negatively impacted by several key members from the developmental sector, who try to exclude mental health providers. Both sectors struggle to understand one another's work, but overall the mental health representatives, who are accustomed to collaborating at a systems level, are more willing and able to work together on the Network goals.

The three Local Service Delivery Networks that were not deemed viable by key informants have struggled with implementation. One LSDN is not yet operational because the Network mandate and goals have not fit into any of the existing local structures. A second is not thriving because the developmental service agencies are well connected through committee work and do not see the necessity of collaborating with mental health partners. The third LSDN has never functioned, because the structure in which it is placed does not support it.

Internal and External Alignment

According to the key informants, the goals of the SNCS are being addressed in a local capacity in five of the eleven Local Service Delivery Networks. All eleven LSDN operate independently of one another, with their own access mechanism to case resolution, at a local level. There is no sharing of specialized services and supports between the LSDN and once local resources are exhausted there is no regional mechanism with specialized resources.

The LSDN identified that individuals are inappropriately housed in hospital settings, correction facilities or with familial caregivers, because of a lack of appropriate residential resources. The PCN requested that, the regional office of the MCSS, create a regional case resolution mechanism for individuals in inappropriate residential settings. There is also a lack of support for agency staff providing residential services to individuals in the target population (SNSC Business Plan, 2007-2008).

Informal Coordinating Mechanism

According to the key informants, a barrier to addressing gaps in service is the lack of information about the barriers and gaps in the specialized service system in this region. Not all of the LSDN invite the facilitators to the "hard to serve conferences", where coordination and collaboration to deliver specialized services takes place. Thus the facilitators do not have data to report to the PCN, whose role it is to develop system level/regional solutions. The following barriers and gaps in the specialized service system were identified,

- Dual Diagnosis Justice Diversion Case Management
- Specialized Accommodation
- Regional specialized service system

Funds for the two, Dual Diagnosis Justice Diversion Case Manager positions, was given to a community agency, selected by the regional office of the MCSS, after reviewing proposals from interested parties. The agency is responsible for the data required by the MOHLTC. The regional office of the MCSS and

the co-lead agencies, distributed the funds for the ten specialized accommodation spaces to residential providers that, demonstrated the ability to develop residential treatment beds. The beds are accessed through the Local Service Delivery Networks (SNSC Business Plan, 2007-2008).

In the 2007-2008 fiscal year; five facilitators attended approximately 35 local case resolution meetings; videoconferencing technology (VCT) was used by specialized clinical service providers to consult with 137 new clients, and 216 existing clients, for a total of 643 hours of online service (SNSC Business Plan 2007-2008, 4); professional capacity was enhanced when six specialized clinical service providers consulted with each other about difficult and complex cases, and discussed treatment strategies with the teams providing services to clients, four also used VCT for team meetings, peer support and mentorship and to hold office to office training (SNSC Business Plan, 2007-2008). The key informants report that, although this Network has rich specialized services such as behaviour therapists, there is an insufficient volume. In the absence of a regional case resolution mechanism the LSDN have no access to additional services when the local specialized resources have been exhausted. The SNSC has requested that the regional office of the MCSS develop a regional access mechanism.

The SNSC is linked at the local, regional and provincial levels with Health (including the Local Health Integration Networks (LHINs), Long Term Care Facilities, Schedule One Health Facilities); Mental Health agencies; Correctional and Probation Services; Police; Education, at the local school level and post secondary institutions; Developmental Service agencies (including residential, case management and specialized service providers) (SNSC Business Plan, 2007-2008).

The Network Co-leads are members of the local and provincial Developmental Service/Executive Director Planning tables, OASIS, the Great Lakes Society, and the N.A.D.D. They collaborate with their counterparts from the three other regional CNSC in the province to address common issues such as video conferencing, research, best practice, staff recruitment and retention. They have collaborated with the regional CNSC to form the Ontario CNSC to address policy, programming and the funding of the Networks, at the corporate level of the MCSS (SNSC Business Plan, 2007-2008).

The Network Coordinator is: linked to the LHINs in the region; the four local and the provincial level Human Services and Justice Coordinating Committees (HSJCC); is an active board member of the Ontario Association for Developmental Disabilities (OADD) and N.A.D.D.; is an ad hoc member on all of the LSDN and some of the Developmental Service/Executive Director Planning tables; organizes networking events with MCSS funded clinical and behavioural specialized service providers to discuss

service system issues and; collaborates with the other Network Coordinators (SNSC Business Plan, 2007-2008).

The facilitators have established links to a number of local committees and structures. They are all members of their respective local HSJCC. Some also sit on the local Developmental Service/Executive Director Planning table and one is strongly involved in the Ontario Partnership on Aging and Developmental Disability. In addition there are 10 unique committees, in which one or another of the facilitators has membership. The facilitators are networking with Dual Diagnosis program staff from Schedule One facilities, the Canadian Mental Health Association and MCSS funded clinical and behavioural specialized service providers. The LSDN will be implementing the Dual Diagnosis Guidelines with the LHINs in their areas to help break down barriers between the developmental and mental health service sector (SNSC Business Plan, 2007-2008).

The PCN created a Training sub-committee to develop a regional training strategy for the SNSC. There is an annual training budget of $30,000.00 that is available for community/regional training and resource initiatives to promote education and training in identified areas of need. The Training sub-committee selects the recipients of the training funds (SNSC Business Plan, 2007-2008).

The PCN established a Research sub-committee to, develop, lead and guide a strategic research plan for the SNSC. In an effort to develop relationships with the academic and research community, an investigation of current research at the provincial, university, college and agency level was done. To establish a research strategy for the Network, a one day research forum was held in the fall of 2008 and 2009. In preparation for the initial forum, the facilitators distributed a questionnaire to community members and service providers to understand their interest and understanding of research in the community (SNSC Business Plan, 2007-2008).

A strategy to recruit and retain professionals to work in the field of developmental disabilities is being developed by the Network Coordinator, Facilitators and the Directors, Supervisors and Managers of MCSS funded clinical and behaviour specialized providers. A facilitator collaborated with a local Developmental Service Planning table to create a high school level career presentation in the field of developmental disabilities. The SNSC has collaborated with an academic institution to develop a dual diagnosis training curriculum for new probation officers across the province. Faculty from the academic institution have participated in workshops and seminars provided by the developmental services sector (SNSC Business Plan, 2007-2008).

Resources

The SNSC receives $977,000 annually, in dedicated funds from the MCSS for the; salaries of the Network Coordinator, five Facilitators, a full-time Administrative Assistant, and a part-time Videoconferencing Coordinator; Purchase of Services (including flex funding for training, consultation and crisis response); and other operating expenses. The MCCS also provides funding for the videoconferencing technology and ten specialized accommodation spaces. The MOHLTC funds two full-time equivalent Dual Diagnosis Justice Diversion Case Manger positions (SNSC Business Plan, 2007-2008).

Conclusion

According to the key informants and secondary sources, cross-sector partners in five of the LSDN, collaborated prior to their involvement in the CNSC. It is their opinion that it facilitated the willingness of these members to work together to address the Network mandate.

The key informants report that, eleven different models have been built into existing structures, to create the LSDN, each with their own personality, culture and history. Each LSDN operates an autonomous access mechanism to specialized services within their community. There is no system that coordinates specialized services across the entire Southern region. The key informants report that, ongoing resistance and tension between the developmental and mental health sectors, present to some degree in six of the eleven LSDN, has been a challenge to reconcile. Participants are beginning to understanding that the CNSC are not a crisis service, and that planning for the needs of the target population requires collaboration across the sectors at the local level. According to the key informants, the mission and goals of the CNSC are not aligned with those of the Network partners and the broader community.

The key informants and secondary sources did not provide information about cross-sector partnerships that created joint programs to address barriers and service gaps, with the exception of the Dual Diagnosis Justice Diversion Case Manager position and the MCSS funded specialized accommodation spaces. In the absence of this information it is difficult to establish the presence of any informal coordinating mechanism in the SNSC. It is possible that these mechanisms are present within the LSDN but not across the LSDN or between LSDN and the PCN.

There is no evidence to support that as a result of this Network, a coordinated, seamless delivery system exists at a regional level that can deliver a complex array of community-based services, with reduced fragmentation, gaps and replication of services, better than individual organizations alone. It is possible

that the partners in the LSDN have produced this system in their local communities but this information was not available for this study. Financial constraints were not discussed by the key informants or in the secondary sources and do not seem to be the primary factor related to network effectiveness.

CHAPTER 6

Findings, Analysis, Conclusions

The Community Networks of Specialized Care were established to coordinate the specialized service system for individuals with developmental disabilities and mental health problems and/or challenging behavior, by integrating existing but autonomous, community-based service delivery agencies in the developmental and mental health sector. In this chapter, the influence of five factors, on the effectiveness of the seven cases, the Central East, Toronto, Central West, South Eastern, Eastern, North and South Community Networks of Specialized Care, is analyzed, discussed and conclusions are made. This Chapter uses generic illustrations and quotes from the key informant interviews to highlight the findings. The identity of the key informants is protected because the information is presented across cases.

In Chapter 1, four outcomes are identified as measures of network effectiveness; shared accountability and responsibility for individuals and the system within the Network; specialized service options clearly defined and communicated; agency collaboration at multiple levels; gaps in services identified and plans developed (Reed 2009, 74).

The findings for the Central East, Toronto, South Eastern and North CNSC indicate that there is shared accountability and responsibility for the individual and the specialized service system in these Networks. The, inter and cross- sectoral partners in these four cases have clearly defined and communicated the specialized service options, collaborated to achieve the Network goals and identified and developed plans to address the gaps in services.

According to the findings, a core group of partners in the Eastern CNSC share accountability and responsibility for the individual and the specialized service system. The specialized service options are being developed by the, inter and cross-sector partners who are also collaborating to achieve Network goals and to identify and develop plans to address the gaps in services.

The findings for the Central West CNSC indicate that, only a small core group of partners share accountability and responsibility for the individual and the specialized service system. An attempt has been made to define and communicate specialized service options but in the absence of a representative inter and cross-sector partnership, it has been challenging to meet the Network goals, identify and develop plans to address the gaps in services.

The findings indicate that, the South Network of Specialized Care has a committed core group of partners that sit on the PCN, but they are indirectly linked to the specialized service system through the LSDN. Although five of the LSDN have partners that share accountability and responsibility for the individual and the specialized service system, it is restricted to their local communities. Specialized service options are defined and communicated within the LSDN, but not across the eleven LSDN or at a regional level. Inter and cross-sector partners in five LSDN are collaborating to achieve the Network goals and to identify and develop plans to address the gaps in services, in their local communities.

As noted in Chapter 1, it was hypothesized that, the CNSC will be effective if:

There are Network partners who engaged in mutually dependent relationships that involved sharing risks, resources and responsibilities, to achieve a common goal, prior to their involvement in the CNSC;

The Network lead, uses communication, facilitation, negotiation, and networking skills to recruit a strongly connected core group of partners willing to work as, cross-sector, cross-disciplinary teams, to achieve the goals of the Network and a broad spectrum of informal partners, who agree with and support the goals of the Network and are moderately to mildly connected;

There is a defined and supported structure that streamlines access to specialized resources;

Cross-sector network partners jointly create programs that address barriers and gaps in service at multiple levels;

There is a reduction in resource gaps, commensurate with the dedicated funds and human and in-kind resources secured and managed by the Network lead.

The findings for the Central East, Toronto, South Eastern and North CNSC, indicate that all have been equally effective in achieving the mandate to, coordinate the specialized delivery system for individuals with a developmental disability and mental health and/or challenging behaviours. The findings for the Central West, Eastern and South Community Networks of Specialized care indicate that they have not been effective in achieving the mandate.

The findings for the Central East, Toronto, South Eastern and North CNSC will be discussed first. These four cases have partners that engaged in formal and/or informal collaborative relationships, within the

developmental sector and across the mental health and developmental sector, prior to their collaboration in the CNSC. According to the key informants, these cases benefited from partners who had worked together to plan, implement and monitor resource development at a systems level, for individuals in the target population. It was noted by a key informant that, "Network partners who previously collaborated, has been integral to the Networks success". Another remarked that, "having providers who previously worked together at planning tables, helped the culture of joint planning". Bryson, Crosby and Stone (2006) suggest that these relationships provide partners with an opportunity to judge their legitimacy and whether they can be trusted (Bryson et al., 2006). The positive outcomes of prior collaboration, helped establish and solidify norms of trust, legitimacy and reciprocity, which these partners transferred to the CNSC. In the words of a key informant, "We have had to serve complicated people for years and we had to do it together, no one organization could do it alone. I learned this early on and brought this unique context to get people on board". In these four cases, there is "a shared responsibility and accountability for the outcomes of the Network" (Provan and Milward 2000, 255).

Roussos and Fawcett (2000) found that," leadership was the most often reported internal (organizational) factor for a partnerships effectiveness in creating community and system changes they are responsible for program managing and administering" (Roussos and Fawcett 2000, 385). Gray and Wood (1991), Mitchell and Shortell (2000), Agranoff and McGuire (2001), support this finding and suggest the way leaders govern and manage the network could impact effectiveness. The tasks identified by Mitchell and Shortell (2000) as important to effective governance are, "setting priorities for strategic goals; choosing the membership composition; obtaining financial resources; providing measures of accountability" (Mitchell and Shortell 2000, 243). Agranoff and McGuire (2001) discuss the importance of activating (identifying) and integrating the right compilation of participants and stakeholders, because they hold valuable resources, in the form of "money, information, and expertise, that can act as integrating mechanisms of networks" (Agranoff and McGuire 2001, 298). They argue that this is a prerequisite to successful inter-organizational policy formation and implementation (Agranoff and McGuire 2001). Roussos and Fawcett (2000), add that the resources need to be managed efficiently and effectively to benefit the entire population being served (Provan and Milward, 1995, Roussos and Fawcett, 2000).

The management skills that Mitchell and Shortell (2000) offer could contribute to effective partnerships are; obtaining agreement on the Networks priorities and goals with individual network partners, and the wider community (internal and external alignment); creating and maintaining partner interest and engagement; building collaborative sustainable relationships between network members based on norms of trust, cooperation and reciprocity" (Mitchell and Shortell 2000, 269); managing communication in the

partnership to address conflict and; devising a system to monitor progress, evaluate and report on outcomes (Mitchell and Shortell, 2000).

The key informants and secondary sources, attribute the effectiveness of the Central East, Toronto, South Eastern and North CNSC to the governance and management of these networks. The Network leads, use communication, facilitation, negotiating and networking skills, to recruit a diverse and representative membership that includes, a strongly connected, core group willing to work as, cross-sector, cross-disciplinary teams to achieve the mandate of the Network and informal partners, that are not actively involved in decision making but are informed and generally support network goals, priorities and activities and are moderately to mildly connected.

The key informants report that the Network leads in the four cases recognize the compilation of skills, knowledge and expertise required of the core group, if the Network mandate is to be achieved. According to a key informant, "it is essential to select leaders for the Steering/ Advisory /Network Committee, who demonstrate creativity and patience, are; strategic thinkers; linked and connected to a broad spectrum of service providers; committed to the mission, vision, and goals of the Network; have the ability to work together, and who can provide in-kind resources". "Also important is to select a diversity and mix of skills from across sectors so you have a variety of perspectives". Another key informant reported that, "the membership on the Committee changes based on learning who should be there".

The sub-committees, task forces, and work groups, are vital, focused, targeted and time limited vessels to facilitate goal achievement. A key informant reported that, "the people we brought in to accomplish the tasks of these, committees/task and work groups, were managers and clinicians, not necessarily heads of organizations because they understood the issues. This expands the partnership beyond the core group of strategic leaders, and protects them from being overextended". The following was noted by another informant, "connections made between network partners will be beneficial at a committee level and will have a positive impact on the front line and for consumers as well".

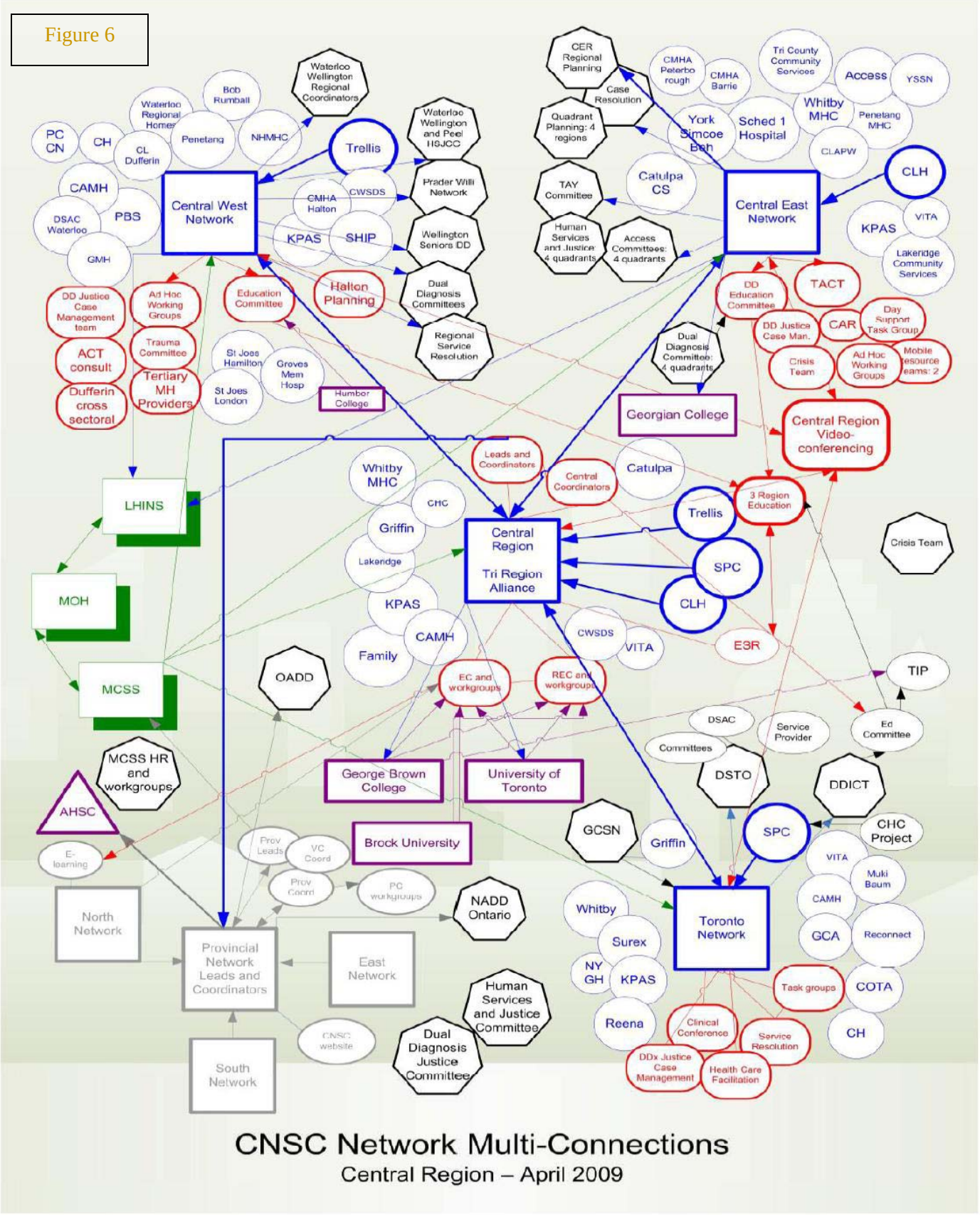
According to key informants, twelve out of forty-two members (28%) in the Central East CNSC are a strongly connected core group of cross-sector and cross-discipline partners, "who are invested in making this Network effective". "These partners regularly attend meetings and collaborate in activities that drive the Network". "They are there because they believe they have something to contribute and don't expect anything back". Eleven partners are moderately connected and sixteen are mildly connected because, "they use the Network supports and therefore collaborate based on need". "Twenty partners are on the

periphery, most know the Network exists, but they have not had to use the services to date". "Three of the twenty agencies are resource rich, are their own little community and function as cliques, communicating with each other at an Executive Director level, but operating separately".

A key informant for the Toronto CNSC, reports that, "nine of the thirty six partners (25%) are a committed strongly connected, core group of primarily specialized service providers who move the agenda forward, are constant attendees at meetings and active participants that collaborate". An equal number of partners are moderately, somewhat and mildly connected. In the opinion of a key informant, "a few of the broad based participants, don't always understand their role and there are no cliques or dyads in the Network". They also feel that, "this Network is a bit too DS centered, we are weak beyond a few mental health sector members and need to broaden into the mental health and justice sector, but we don't need tons of people around the table".

As part of the evaluation of the Central Region CNSC, Reed (2009) produced a chart of the members, committees and organizations involved in the three CNSC. This chart appears as Figure 6 and demonstrates how complex it is to identify the number of links given the large number of participants. For this reason, this study was able to complete only a cursory examination of the role of links between Network participants as a factor in connectedness.

Figure 6


CNSC Network Multi-Connections
Central Region – April 2009
Central West Network
Central East Network
Central Region Tri Region Alliance
Provincial Network Leads and Coordinators
North Network
East Network
South Network
Toronto Network
Trellis
Waterloo Wellington and Peel HSJCC
Prader Willi Network
Wellington Seniors DD
Dual Diagnosis Committees
Regional Service Resolution
CMHA Halton
CWSDS
KPAS
SHIP
Halton Planning
Education Committee
Humber College
Georgian College
Central Region Video-conferencing
Leads and Coordinators
Central Coordinators
Catulpa
3 Region Education
Crisis Team
SPC
CLH
VITA
ESR
TIP
Ed Committee
DSAC
Service Provider
Committees
DSTO
DDICT
CHC Project
GCSN
Griffin
Muki Baum
CAMH
GCA
Reconnect
COTA
CH
Task groups
Clinical Conference
Service Resolution
DDx Justice Case Management
Health Care Facilitation
Reena
NY GH
KPAS
Surex
Whitby
Brock University
George Brown College
University of Toronto
OADD
EC and workgroups
REC and workgroups
LHINS
MOH
MCSS
MCSS HR and workgroups
AHSC
E-learning
NADD Ontario
Human Services and Justice Committee
Dual Diagnosis Justice Committee
CNSC website
Prov Leads
VC Coord
Prov Coord
PC workgroups
Waterloo Wellington Regional Coordinators
Bob Rumball
Waterloo Regional Homes
Penetang
NHMHC
PC CN
CH
CL Dufferin
CAMH
DSAC Waterloo
PBS
GMH
DD Justice Case Management team
ACT consult
Dufferin cross sectoral
Ad Hoc Working Groups
Trauma Committee
Tertiary MH Providers
St Joes Hamilton
St Joes London
Groves Mem Hosp
CER Regional Planning
Case Resolution
Quadrant Planning: 4 regions
TAY Committee
Human Services and Justice 4 quadrants
Access Committees: 4 quadrants
Catulpa CS
CMHA Peterbo rough
CMHA Barrie
Tri County Community Services
Access
YSSN
Whitby MHC
Penetang MHC
CLAPW
York Simcoe Beh
Sched 1 Hospital
CLH
KPAS
VITA
Lakeridge Community Services
TACT
DD Education Committee
DD Justice Case Man.
CAR
Day Support Task Group
Crisis Team
Ad Hoc Working Groups
Mobile resource teams: 2
Dual Diagnosis Committee: 4 quadrants
Whitby MHC
CHC
Griffin
Lakeridge
KPAS
CAMH
Family

A key informant for the South Eastern CNSC offered that, they "selected a core group of ten to twelve partners (24%), out of approximately 50 broad members to sit on the Bi-Regional Advisory Committee and to run some of the task forces". "Ten to twelve agencies are considered to be a manageable number to get things done". "These agencies were selected because they are the biggest providers of specialized services in the region and they have strong links to planning committees and have decision making authority". "They are strongly connected to the Network, with consistent and regular attendance at committee meetings and participation in network activities". "There are thirty-six developmental service agencies, eleven mental health agencies, five academic resources, and eight organizations from other sectors that are actively involved in current East CNSC activities or initiatives" (Eastern Ontario CNSC April 1, 2009-March 31, 2012, 16). "An additional seventeen agencies are small organizations that offer single services such as a day or residential programs and only collaborate with the Network, if a client they serve requires specialized services" (Eastern Ontario CNSC, April 1, 2009-March 31, 2012). According to a key informant, "there are no cliques in the developmental sector partners because of the collaborative access model under which they work".

According to a key informant, "the members of the Advisory Committee in the North CNSC collectively offer a broad range of specialized services that are highly valued and represent a multitude of communities from across the region". "These twelve partners comprise forty percent of the membership, are a strongly connected core group and are well linked to the cross- sector service providers in the region, bridging the gap with the Network". "Attendance at meetings is consistent and strong for ninety percent of the members and they contribute enthusiastically to training initiatives". "They are key players in referring individuals to the Network for specialized services and in providing specialized services". "Several of the members have a long history of collaborating at a regional level".

These findings reveal that the Network leads in these four cases, consciously and deliberately select a core group of partners with the skills and commitment to help the Network fulfill its mission and a group of partners, who by design are more loosely connected to the Network, agree with and support the priorities and goals and provide or avail themselves of Network resources. Thus, the number of core and informal members varies depending on the needs of the Network partners. Based on the findings for these Networks, a stable, strongly connected core group of partners centrally connected to the Network and a group of partners who provide or access specialized resources for the target population is a strong predictor of effectiveness.

The key informants report that the Network partners in Central East, Toronto, South Eastern and North CNSC, determine and articulate a common mission for the Network, and establish a vision, with shared values, norms and rules, strategic goals, activities, outcomes and performance indicators. Referred to as internal and external alignment by Mitchell and Shortell (2000), the leadership attain alignment by using the management skills of "framing", "mobilizing" and "synthesizing", to, merge the values, norms, conflicting goals and perceptions, of individual partners, utilizing resources and equalizing power ,to foster cooperation and manage conflict (Agranoff and McGuire, 2001). The key informants believe that this has helped to generate an awareness of the Network, garner support and allies for sustained participation, and minimized diversions, opposition and conflicting agendas (Roussos and Fawcett, 2000, Agranoff and McGuire, 2001).

One key informant described the implementation process for their Network as follows; "Members were chosen because they could let the parochial side go-look at the larger system. The issue is not to look at what is happening in your own backyard, but what is happening across the region. We wanted to make sure we didn't build something based on what we thought was needed but based on the perceptions of the community. We started with the culture of engagement, ensuring we were always focused on the needs of the community and consumer not the Network, not what it looked like from above but from below. By doing it this way we could structure the Network so that it was responsive to the community, local consumers, agencies, families, bypassing, this is my turf and your turf. It was staged as a joint ownership of a system benefiting consumers, so the waiting list is reduced, types of services available are more appropriate for the needs, were not grasping in the dark so we can deliver a more credible service. Developing the Network in this way has made it effective, these are the factors."
According to the key informants, the Network leads share formal and informal authority with the Network Coordinators, MCSS representatives, members of the Steering/ Advisory/ Network committee, and chairpersons of the sub-committees, task forces and ad hoc working groups. This "dispersed leadership" described by Roussos and Fawcett (2000), Gray and Wood (1991), and Bryson, Crosby, and Stone (2006) increases the commitment of network partners, the legitimacy of the Network, and the acceptance of mutual dependency while allowing members to maintain their autonomy (Bryson et al. 2000, 47). Authority is transferred if a member is unable to fulfill their obligation to the Network, another critical element of effective leadership and networks.

The Committee meetings are held frequently to keep partners interested and engaged and to maintain their commitment (Mitchell and Shortell, 2000) but also with sensitivity to everyone's time limitations. At a minimum, forums are held annually with all constituents in the CNSC to inculcate the principal of shared

responsibility and to address concerns and reconfigure the goals as required. A key informant noted that "Network Coordinators and administrative support are essential to the operation of the Network. You can not rely on in-kind services for these tasks because the volunteers would quickly burn out".

The leaders in the four cases employ formal and informal mechanisms to integrate partners, according to the key informants. The formal mechanism is the service contract that the Network partners, as transfer payment agencies hold with their funding ministry/ministries, and the Memorandum of Understanding (MOU) that they sign with the Lead Agency and other Network partners. The informal mechanism is the process and outcome of the interaction and exchange between network partners when they voluntarily collaborate and share resources, "based on norms of trust, cooperation and reciprocity" (Mitchell and Shortell 2000, 268). Mitchell and Shortell (2000) refer to the "internalization of norms through leadership and socialization, as a social control mechanism" (Mitchell and Shortell 2000, 268), which is critical to the governance of community partnerships because members cannot be held to account based on formalized accountability structures. According to the key informants, the service contracts do not explicitly say that the service provider must deliver the specialized service through the CNSC. They can elect to provide the service as they have historically. The MOU is not a legally binding document and therefore members cannot be held to account for promised services. Given the limitations of formal accountability, the key informants believe that the effectiveness of the four cases results from a leadership that builds "collaborative, sustainable relationships between network members" (Mitchell and Shortell 2000, 269) that evolve into complex moral relationships. A key informant noted that, "there is mutual support between the partners in the Network, and there is always a sense that this is for the Network and no one individual, agency or area". Another stated that "this is what the Network is about, the sum of the parts being greater than the whole". A key informant recommended that the Network leads, "build relationships that empower key cross-sector members, so that they want to be at the table" and another suggested to, "get buy in from the stakeholders early on, by promoting that no member is better than another, everyone contributes in a way they can and everyone has a part to play".

The key informants report that the Lead agencies and Network leads are effectively, efficiently, and creatively managing resources to, create and support an access mechanism to specialized resources, create programs that address barriers and reduce gaps in services and resources. This has positively influenced the legitimacy and reputation of the Networks and reinforced that partners who trust and are mutually obligated to share resources will be more effective at achieving a goal together, than as separate organizations. One of the key informants offered that "the board of governors of the lead agencies must personally invest for others to follow suit and that without a strong investment of time, energy and

resources from all partners, the Networks will not work". Another key informant notes that, "with networks, there is never enough money, but the value of the network is to ensure that resources are used effectively to streamline access to specialized services. Wait lists are a reality and the CNSC are not a fix for lack of resources".

According to the information provided by the key informants and the secondary sources, the four cases demonstrate accountability to the partners and stakeholders for Network outcomes, by documenting, their goals, activities and performance indicators, in a logic model and/or annual Business Plans and tracking and reporting on progress towards outcomes and goals in their annual Business Plans and reports. It was noted by a key informant that, "many community members remarked after reading an annual report that they were impressed with what the CNSC has accomplished". The members said that, "for the first time there is a place where the complex needs of the target population are being talked about by agency representatives and there are dedicated staff and resources".
These four cases appear to be equally effective at achieving the Network mandate. The determinants of effectiveness are present to the same degree in each of the cases and no evidence indicated that one case stood out among the four.

According to the key informants and secondary sources, the partners in the remaining three cases, the Central West, Eastern and South Community Network of Specialized were unable to coordinate the specialized service system for individuals with developmental disabilities and mental health problems and/or challenging behavior, within the time frame of this study, because of unique issues.

In the case of the Central West CNSC key informants report that, six of the thirty-one Network partners (19%) are strongly connected to the Network. The strong core group collaborated with support from the Network Coordinator to, initiate a regional access mechanism to specialized resources, create some programs that addressed barriers and gaps in service and reduce some resource gaps. The ability of the core group members to affect system change was comprised by their small size. Efforts by the Lead agency, Network lead and Coordinator to establish a broad group of informally connected partners was unsuccessful because, "the individuals did not see the purpose and value of the Network and therefore their attendance at meetings and participation in Network activities was inconsistent and unpredictable".

In the opinion of key informants, the Lead Agency, and Network lead did not establish internal and external alignment in this Network, for the following reasons: "one member held the power, and did not support the activities required to achieve the mandate"; "many partners from the developmental sector

were unwilling to participate in the Network, in fact the mental health sector were more willing to collaborate to accomplish the goals of the Network"; "this Network did not have partners with a history of prior collaboration or a culture supporting cross-sector communication, cooperation or coordination"; "distinct planning tables within the sub-regions had a history of operating autonomously, which promoted this mindset". In the opinion of key informants all of these factors negatively impacted the effectiveness of the Network". The Lead Agency, Network Lead, Coordinator and MCSS Program Supervisor, for the Central West CNSC were reassigned, approximately three years after the implementation of this Network.

According to the key informants, the Network lead for the Eastern CNSC demonstrates the core competencies of effective leadership which, "has resulted in a strongly connected and aligned core group of partners from twenty mostly non-traditional agencies". They represent forty percent of the Network members and with the support of the Network lead and Coordinator are making strong and consistent progress towards the mandate to coordinate the specialized service system for the target population by, working to establish an access mechanism to specialized resources and creating programs that address barriers and gaps in service. A key informant noted that, "I know that if I need someone to help me because someone needs a place to live for two weeks, I can count on…..agency and they can count on the Network to pay for the extra staff to support him". They also report that, "it took fifty people, two years of hard work and hundreds of thousands of dollars, to organize the necessary specialized services in this Network."

According to key informants, "only fifty percent of the developmental service agencies support the biopsychological approach of this Network, the others subscribing to more traditional behaviour approaches". Also, "this Network continues to experience resistance from approximately thirty agencies, who are on the periphery of the Network. They operate as cliques, are autonomous and don't see it as their mandate to support people with a developmental disability and severe behaviours". "They approach the Network for resources on a, as needed basis". "These agencies are competitive, want a piece of the pie and people in their communities have been on a waiting list for specialized services for 6-10 years". "The Eastern CNSC is unique in that it has used Network funds in non-traditional ways to fill gaps in services, which according to key informants, is not always supported by the service providers in the sub-region. Although there is no history of prior collaborative partnerships, some community members informally shared resources and were very supportive of its development. Additionally, this Network is supported by the South Eastern CNSC, which has an extensive history of formal and informal collaboration. The key informants report that the presence of both factors has enhanced this Networks growth and development over the past year.

In the opinion of the key informants, it has been a challenge for the South Network of Specialized Care to meet the Network mandate because of the organizational structure selected by the Network Implementation Committee, which was recommended by the consultant who completed the environmental scan. Existing committees in the eleven communities were identified, and given the Network mandate, as an adjunct to their mission. Identified as Local Service Delivery Networks (LSDN) their work is supported by the five Facilitators. Even though the ten members on the Planning Coordinating Network (PCN) are strongly connected they represent five percent of the 200 members across the eleven LSDN and are not directly involved with the LSDN or the Facilitators. The Network Coordinator attends LSDN meetings bi-annually. Under these circumstances it is unclear how informal coordinating mechanisms and alignment can be established by the Lead Agency and Network lead, across the Network.

According to the key informants, five out of the eleven LSDNs evolved from well established structures with a history of collaboration within and across sectors and are actively engaged in addressing the goals of the Network. Four LSDN evolved from long standing, community structures, have a history of within sector collaboration but are not actively engaged in addressing the goals of the Network. Two LSDN are not viable structures and therefore cannot address the Network goals. The Business Plan for the Network, states that one of the roles of the PCN is to "coordinate the delivery of specialized services across the LSDN" (SNSC Business Report 2006). An access mechanism to share resources has not yet been established. Another role of the PCN is to address barriers and gaps in services at a systems level. The key informants report that it has been challenging to address this function because the LSDN have not shared information about barriers and gaps in services. In the absence of internal and external alignment and informal accountability across the LSDN, it is concluded that the mandate to coordinate the specialized service system has not yet been attained by the South Network of Specialized Care. As noted by one key informant, "it will take more than three years, to convince service providers that this Network is worthy of their time and resources".

This Network appears to be the least effective because they have not addressed the Network goals across the region. The only specialized resources available at a regional level are the specialized accommodation spaces funded by the MCSS and the services of a Dual Diagnosis Justice Case Manager funded by the MOHLTC. Therefore, when the LSDN have exhausted their local resources there are no regional resources available because the Network has not coordinated the specialized service system at a local and regional level. A key informant offers the following explanation, "The Network elected to focus on

developing an administrative structure first and linking with regional committees, whereas the other Networks chose to focus their energy at the local level first".

In the absence of previous collaboration Bryson, Crosby and Stone (2006) suggest that a partnership may take longer to evolve and network activities will involve less risk, until the trust and legitimacy are established between partners. This supports the experience of these three cases that do not have partners that previously collaborated and who report that the majority of Network partners are protective of their resources and unwilling to engage in mutually supportive behaviour. The partnership in each case is evolving and is at a different stage of development, contingent on their starting point.

In conclusion, two factors appear to be the most significant determinants of Network effectiveness, partners with a history of prior collaboration and Network leads who utilize communication, facilitation, negotiation and networking skills to recruit a broad spectrum and strongly connected core group of partners, who agree with the purpose and mission of the Network and form a collaborative alliance to fulfill the goals. Effectiveness does not appear to be related to the number of members in the core and informal groups. In the opinion of a key informant a defining factor for Network effectiveness is, "a Network where there is no hierarchy, where everyone is a leader, everyone has a part to play, everyone contributes in the way they can, and no one is better than another".

Mitchell and Shortell (2000) hypothesize that if a partnership is integrated and coordinated through a central authority, with high internal and external alignment they will have the best prognosis for sustainable and long-term success. The network partners in the Central East, Toronto, South Eastern and North CNSC are integrated and coordinated through an unbiased legitimate, central authority (Provan and Milward 1995, 26) that effectively governs and manages the partnership to achieve the Network mandate.

The absence of internal and external alignment in the Central West, Eastern and South CNSC resulted in internal conflicts and opposition to the network, as predicted by Roussos and Fawcett (2000) and Mitchell and Shortell (2000). Mitchell and Shortell (2000) suggest that, the role of alignment in network effectiveness should inform those engaging in collaborative endeavours.

Conclusions

The MCSS provided vague, overarching guidelines for the development of the four regional CNSC that permitted individual networks the flexibility to tailor the Network structure to fit their regional demands. A key informant reported that, "it was ideal and the first opportunity the service community could be

creative and responsive to the needs of the local region". They added that "given the variance across the regions, if a model had been dictated, the CNSC would have been impossible to implement".

However, only the four cases that demonstrate the presence of the five determinants of effectiveness appear to benefit from this loose model. They all had a pre-existing regional entity to use as the organizational structure for their CNSC, partners who collaborated in these entities and who share values, resources and a culture of working jointly to achieve a common goal.

The missing factors in the three cases that have not yet met the Network mandate to coordinate the specialized service system, is a pre-existing regional entity in which to establish the CNSC, individual partners who previously collaborated, who share the same values, a culture of working together and resources to achieve the goals of the Network.

Changing systems and establishing the value of the Network both for community partners and the MCSS, was summarized by one of the informants as a, "slow, difficult, frustrating and a monumental uphill battle". A discussion of the five top challenges offered by the key informants follows.

The key informants concur that the top challenge faced by all of the cases in the first year of operation was overcoming the resistance from the non-profit service providers who believed that the Network money should have been invested in programming. A key informant noted that, "this was compounded by a fear, that the Lead agencies were going to take it over and it would become their team, which would not serve anyone. But that didn't happen and as time has gone on that has been proven". "Because of this mistrust, it took at least a year for the Network to be implemented".

The other identified challenges to Network effectiveness relate to system issues. The first is limited specialized resources. According to the key informants, "the MCSS expects their transfer payment agencies to provide resources to the CNSC. "The reality is, agencies with their own board of directors make decisions about whether to share resources with the CNSC and the Networks have no control over the outcome". It is challenging for the Networks, who are charged with coordinating the specialized service system, if the agencies do not provide the required services and there are no consequences for their action. Thus, in reality, if a Network has failed to establish and support a coordinating mechanism that is resourced, it may be a result of system failure.

One of the strategies utilized by the CNSC to address the gaps in resources is to use Network flex funds to purchase services and supports from the private sector, increasing the frustration among the non-profit service providers that funds are being redirected to the profit making sector. The alternative is to build capacity in the non-profit sector through education and training initiatives, which does not typically produce immediate results. It is the opinion of the author of this study that purchasing services from the private sector should be a last resort because they are designed to compete in a market based economy giving them an unfair advantage over non-profit service providers. Also, the profit motive may undermine the altruism required of those providing services to vulnerable individuals, and the monitoring of service delivery would be untenable. One option is to restructure the service contracts between the MCSS and the transfer-payment agencies, to make funding contingent on the provision of specialized and core services to the CNSC and to formalize the Memorandum of Understanding so that Network partners can be held accountable for promised resources and participation. Another option offered by a key informant is to use the Network model, "to support and build capacity to provide services to this population in the mainstream health care system, and than the MOHLTC will have to be involved". This informant feels strongly that, "the Network should not support the segregation of people with developmental disabilities within the developmental service sector". "The focus should be on the individual's abilities and finding ways to get their needs met through mainstream services". "This could reduce some of the gaps in services and supports".

They second system challenge relates to the organizational structure of the MCSS. According to the key informants, the lack of communication within the Policy and Operation branches of the MCSS and between the corporate and regional levels is an impediment to Network effectiveness. One key informant stated that "it is an exclusive club, and that the MOHLTC, Justice and the Attorney Generals office cannot be expected to communicate and collaborate with the MCSS, when departments within the MCSS do not". In the opinion of a key informant, "the Policy group at the corporate level was responsible for developing the CNSC. Their role and ownership should have terminated when the initiative went to the Implementation/ Operation group. Both the Policy and Implementation/ Operation groups provided input into the Business Plan when it was the responsibility of the regional office and the CNSC. The two groups at the corporate level engaged in a power struggle with each other and with the regional office on how the CNSC should operate. We are project managed as opposed to being part of the whole, and not ingrained in the system. We need a voice at the very highest level".

All key informants stated that the significant turnover in MCSS staff at the corporate and regional level, negatively impacts network effectiveness. A key informant reported that, "at the corporate level, the two

Assistant Deputy Ministers (ADM) who created the CNSC understood the concept and fostered it were relocated to other ministries several months after implementation". "Their replacements have come from other portfolios and are unfamiliar with the sector and Network issues". "They too were moved within a year". "Similarly the policy people and the analysts in the ADMs office get divorced and are regularly moved to another portfolio". "Each CNSC has had a least three different Program Supervisors since the inception of the Networks and replacements have been selected from outside the MCSS, because they do not want them supervising their peers". "The tremendous loss of expertise and knowledge at all levels, the time required to train the new recruits, not only about the developmental sector but also the CNSC and the lack of continuity, interferes with the effective development and operation of the CNSC".

The third system challenge relates to the MOHLTC and the relationship between the MOHLTC and the MCSS. According to a key informant, "historically if you have a developmental disability and behaviour problems, you were dumped either in hospital or a prison. Agencies were unwilling or unable to serve these individuals, claiming they are not their clientele. Developmental sector providers argue that psychiatric issues belong in mental health system and the mental health system argues that they do not traditionally serve people with mental retardation, or if they do, they don't do it well, because they don't know what to do with them".

It has been challenging for the CNSC, to remove the barriers between the developmental and mental health sectors at a service delivery level, given this historical tension and the higher inter-ministerial cooperation required from the two different systems and two different funding bodies, which is absent. The key informants report varied experiences diminishing the barriers between the two sectors and it appears to be contingent on the personalities of the individuals working in these sectors. For example, the key informants for the Toronto, South Eastern and Northern CNSC report greater support from developmental sector providers, while the Central West and South CNSC, experienced greater support from the mental health sector, who they report are accustomed to working as a team. The key informants agree that, the Network partners across the seven cases are, "collaborating at grass roots level, but it needs to happen at a policy level".

The key informants concur that the lack of leadership at the corporate level of the MOHLTC, specifically the Local Health Integration Networks, is a serious impediment to the implementation of the Joint Policy Guidelines. It is the opinion of all informants that "the developmental sector is not a priority or an important investment for the MOHLTC and people with developmental disabilities are just a blip on their radar. This ministry has a history of providing funds at the front line with minimal involvement at the

corporate and policy level. Hospitals and divesting mental health centres, are the object of the MOHLTC/ LHINs right now". Until the ministries collaborate at a corporate and regional level, streamlining the specialized service system for individuals in the target population, will be compromised.

According to the key informants, one of the most significant outcomes of the lack of collaboration between the MCSS and MOHLTC is the blocking of active treatment beds due to the lack of appropriate community residential placements. The funding to create appropriate community-based placements across the province is not forthcoming from the MOHLTC and the resources required from the MCSS to support these individuals in the community are not available. Again experiences differ across the Networks, but the key informants agree that the partners are willing to develop plans for individuals but funding is not forthcoming from either one or the other or both of the ministries.

The final challenge to effectiveness discussed by the key informants is the sustainability of the CNSC. The key informants report that, "the core group driving the Network, are 65 years of age or older and destined to retire without replacements who share their passion, expertise and commitment". This comment reinforces the reality that the CNSC are contingent on the individuals involved in the Networks. An additional element of sustainability raised by the key informants is the need to have one vision for four regional CNSC in Ontario. Key informants remarked that it was challenging to organize at a provincial level because the focus has been on developing and establishing the Networks at a regional level. The Ontario CNSC have agreed on a, "new provincial initiative to develop guidelines for effective practice, by collecting information from individual clinical teams, about what works so others can benefit and learn from it, especially front line staff". The key informants believe that it is critical for the four regional CNSC to be organized at a provincial level to address the challenges poised by the organizational structure of the MCSS and MOHLTC.

The following recommendations for effective Networks are offered by the key informants:

- If your going to take the lead role be prepared to devote the time needed, especially early on in evolution, if not prepared to do the work required, don't take it on"
- "The lead agency has to have the infrastructure to manage the budget, solicit in-kind resources and complete the daily operational tasks"
- " Partners are needed with a "strong philosophy", "strong investment", "commitment", and a "board of governs who supports the philosophy, and provides the time and energy to do the work"

- “Partners are needed who have been in the business for decades, with knowledge of stakeholders, pressures, gaps, at the local, regional and provincial level”
- “Need a clinical group to tackle a political problem- it is a soft skill but one that is needed if Networks are to survive”
- “ It can’t be done unless everyone comes to the table”
- “Individuals partnering in the Networks need to have an innate dislike for tradition and must have the confidence to think outside the box”
- “Network partners must let go of the way things were done in the past, move out of their mind set and comfort zone to look at things differently”
- “Network leaders must listen and make sure you let people know their ideas and opinions are being heard”
- “Stay the course, and develop a strategic business plan”
- “Develop a meaningful data collection template, and conduct regular evaluations to make sure you are meeting the goals”
- “ Commitment from MCSS and MOHLTC for adequate, multi-year dedicated resources for the administration and operations of the CNSC and to meet the functions and mandates”
- “ collaboration with heath, education, justice and the primary care sectors”

A key informant stated that, “before the CNSC, individuals with developmental disabilities were not being served well in either system (developmental or mental health)”. “The CNSC have brought the developmental and mental health sectors together, they acknowledge the unique challenges and needs experienced by both sectors and recognize that they have to collaborate to effectively serve individuals with developmental disabilities and mental health and/or behaviour challenges”.

According to key informants, “effective networks have demonstrated that individuals in the target population are better served by Networks because a broader range of specialized services are now available to deal with wait lists for services, and clients are avoiding hospitalization because of the coordinated community response”. “Those requiring hospitalization are staying for shorter periods of time, mitigating institutional effect and allowing for continuity of supports”. These Networks have addressed the historic divide and according to a key informant, “acknowledged that individuals in the target population are a joint problem that can only be resolved by joint ownership of the solution, which includes sharing resources to create something that is going to work for consumers”. “At the end of the day this will make Networks successful”.

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Appendix A

INFORMATION AND INTERVIEW REQUEST LETTER FOR THE STUDY:
What Factors Contribute to the Effectiveness of Public Service Delivery Networks? The Case of Community Networks of Specialized Care in Ontario

WHO IS CONDUCTING THE STUDY
This research study is being conducted as the thesis requirement for the researcher's Masters Degree, in Public Policy and Administration, at Ryerson University.

WHAT IS BEING STUDIED
This study, aims to identify the factors that contribute to the effectiveness of public service delivery networks. It is being conducted because there is little empirical evidence to support the claim that, integrating an array of services through a network of provider agencies, results in a more coordinated seamless service system, with less fragmentation, gaps, and replication of services, and an increased capacity to plan for and address complex problems with improved client outcomes. Research is required to establish the effectiveness of network-level activities and structure and to identify which elements of networks produce meaningful outcomes. The Ontario Ministry of Community and Social Services (MCSS) was mandated to establish Community Networks of Specialized Care (CNSC) for mental health services across the province, as part of the transformation of the provinces development service system. This policy initiative is supported by Bill 77, Services and Supports to promote the inclusion of persons with Developmental Disability, 2008. This case, presents an opportunity to study the effectiveness of a social services delivery network. It will examine the development, evolution, structure, management and effectiveness of these networks from May 2006 until March 31, 2009.

INFORMATION COLLECTED
If you consent to this research study, you will participate in a semi structured interview with the researcher, in person or via video conferencing, at a time convenient to you. The quantitative and qualitative questions that you will be asked, have been developed using information from relevant public administration literature and government documents, such as the Business Plan and Data Collection template, created by the MCSS. The questionnaire will be provided in advance, so that you have prior knowledge of the questions that will be asked and can provide the researcher with any related documents, pertaining to the history, development and implementation of your network, such as environmental scans, organizational charts, annual budgets, annual performance reports, and evaluations, that will enrich the findings of the study. The interview will be audio recorded and transcribed by the researcher. It is anticipated that the interview will take approximately 1hour to complete. The information you and others provide will be summarized in the thesis, without names or any other personal identifiers, to ensure confidentiality and protect anonymity.

RISKS ASSOCIATED WITH PARTICIPATION:

Participation in this study is voluntary. There are no known problems or difficulties attached to your participation and you may end it at any time.

BENEFITS:

While there are no direct benefits to you at this time, this case study may provide valuable information to the Ontario MCSS, the CNSC, to other jurisdictions developing networks, and may contribute to the academic literature on network governance and administration.

CONFIDENTIALITY

The information you provide will be kept confidential, to the full extent allowed under law. The consent form and face sheet that contain your name will be kept in a locked filing at the home of the researcher. The audio tapes will be destroyed once they are transcribed. The questionnaire and audiotape transcription will be identifiable by your unique study identification number and will be kept in a different locked filing cabinet at the researcher's home. Access to your research records will be restricted to the researcher and thesis supervisor. All documents will be kept for 7 years following completion of the study and will be destroyed at that time.

If you are willing and interested in participating in this study please contact:

Christine Jaskulski,
Study Researcher, Ryerson University
(416) 535-8501 ext. 7816, or (416) 937-9649, or (416) 901-9511
Email: christine.jaskulski@ryerson.ca or Christine_jaskulski@camh

Appendix B

CONSENT FORM

What Factors Contribute to the Effectiveness of Public Service Delivery Networks?
The Case of Community Networks of Specialized Care in Ontario

You are invited to participate in a research study that aims to identify the factors that contribute to the effectiveness of public service delivery networks. This study is being conducted as the thesis requirement for the researcher's Masters Degree in Public Policy and Administration, at Ryerson University.

It is important that you read and understand this Consent Form. It provides information for you to decide whether you wish to participate in the study. If you have any questions after you read this form, please ask the researcher for clarification.

Purpose: This research study will examine the development, evolution, structure, management and effectiveness of Ontario's CNSC networks from May 2006 until May 2009. It is being conducted because there is little empirical evidence to support the claim that, integrating an array of services through a network of provider agencies, results in a more coordinated seamless service system, with less fragmentation, gaps, and replication of services, and an increased capacity to plan for and address complex problems with improved client outcomes. Research is required to establish the effectiveness of network-level activities and structure and to identify which elements of networks produce meaningful outcomes. This case study may provide valuable information to other jurisdictions developing networks, to the Ontario MCSS in evaluating its policy initiative and contribute to the academic literature on network governance and administration.

Information Collected: If you consent to this research study, you will participate in a semi structured interview with the researcher, in person or via video conference, at a time convenient to you. The quantitative and qualitative questions that you will answer have been developed using relevant public administration literature and information from the Business Plan and Data Collection template created by the MCSS. The questionnaire will be provided in advance, so that you have prior knowledge of the questions that will be asked. If you wish you can provide the researcher with any publicly accessible documents, such as the history, development and implementation of your network, environmental scans, organizational charts, annual budgets, annual performance reports, and evaluations, that will enrich the findings of the study. The interview will be audio recorded and transcribed by the researcher. Video conferencing files will be saved as audio files for transcription purposes. It is anticipated that the interview will take approximately 1 hour to complete. The information you and others provide will be summarized in the thesis, without names or any other personal identifiers to ensure confidentiality and protect anonymity.

Risks associated with Participation: Participation in this study is voluntary. There are no known problems or difficulties attached to your participation and you may end it at any time.

Benefits: While there are no direct benefits to you at this time, this case study may provide valuable information to the Ontario MCSS, the CNSC, to other jurisdictions developing networks, and may contribute to the academic literature on network governance and administration.

Confidentiality: The information you provide will be kept confidential, to the full extent allowed under law. The consent form and face sheet that contain your name will be kept in a locked filing cabinet in the

thesis supervisors secure office at Ryerson University. The audio tapes will be destroyed once they are transcribed. The questionnaire and audiotape transcription will be identifiable by your unique study identification number and will be kept in a locked filing cabinet at the researcher's home during data analysis, after which time they will be kept in the thesis supervisors secure office at Ryerson University. Access to your research records will be restricted to the researcher and thesis supervisor. All documents will be kept for 7 years, following completion of the study and will be destroyed at that time.

By signing below, I agree to participate in the study as described above

_____ _____

Signature of Study Participant Date

_____

Printed Name of Study Participant

_____ _____

Signature of Researcher Date

Contacts: If you have any further questions about this study please contact;

Christine Jaskulski, B.A., B.S.W.
Study Researcher, Ryerson University
(416) 901-9511
Email: christine.jaskulski@ryerson.ca

Carolyn Johns, Ph.D
Thesis Supervisor
Department of Public Policy and Administration, Ryerson University
416 979-5000 ext. 6146
Email: cjohns@politics.ryerson

If you have any questions about your rights as a study participant, you may contact:
Alex Karabanow,
Office of the Vice President, Research and Innovation
416 979-5000 ext. 7112
Email: alex.karabanow@ryerson.ca

Appendix C

FACESHEET FOR RESEARCH STUDY

What Factors Contribute to the Effectiveness of Public Service Delivery Networks? The Case of Community Networks of Specialized Care in Ontario

CNSC Region:_____ CNSC Implementation Date:_____

Name of Lead Organization: _____Study ID#_____

Name of Network Lead: _____Study ID#_____

Name of Network Coordinator: _____ Study ID#_____

Name of MCSS Program Supervisor: _____ Study ID#_____

Date of Interview: _____

QUESTIONNAIRE: Part 1 **Study ID#_____**

What Factors Contribute to the Effectiveness of Public Service Delivery Networks? The Case of Community Networks of Specialized Care in Ontario

NETWORK, DEVELOPMENT, PROPERTIES AND PROCESSES

A. Network Development and Evolution (Pre and Post 2006)

1. What is your background?

2. Can you provide a general description of your knowledge of the history of the development and implementation of your network?

3. Based on your knowledge how were services in your region delivered to individuals with a Developmental Disability, who have coexisting mental health and/or behavioural issues, prior to the establishment of the Community Networks of Specialized Care?

B. Network Structure and Function (May 2006-March 31, 2009)

1. Can you describe your network?

2. Can you describe the organizational structure that your network has adopted?

3. Can you describe the service delivery system in your catchment area/region?

4. a) Can you identify all of the network partners/members and specify which type of provider agency they are? (Developmental Service provider (DS), Mental Health Service provider (MHS), other provider, such as, family health team, LHIN, Justice or Educational organization)

   b) Please indicate how long each network partner/member has been part of the network.

   c) Please describe which network partners/members are linked and, how they are linked.

5. Overall how would you rate the level of connection among organizations in your network?

Strongly Connected	Moderately Connected	Somewhat Connected	Mildly Connected	Not at all Connected
5	4	3	2	1

6. What percentage of the Network members, are connected directly, and indirectly (through another organization), to your network?

7. What number/percentage of the organizations in your network, are more centrally connected to your network than others?

8. What percentage of your Network is comprised of fragments of unconnected organizations?

9. What percentage of your Network is comprised of dyads?

10. What percentage of your Network is comprised of a group(s) of agencies that are densely interconnected with one another but more sparsely connected to the network as a whole (defined as a clique)?

11. If there is a clique in your network, which types of organizations are involved?

12. How large are the cliques?

13. If there is more than one clique in your network, are they connected or fragmented?

14. If they are connected how much overlap exists between them, e.g. shared information or joint programs?

16. Describe any collaborative work with other CNSC.

C. Network Governance and Accountability Structure

1. What is the governance structure of your network?

2. Identify the different levels in the governance structure.

3. Describe the reporting relationship between the different levels in your governance structure.

4. Who is the network lead? Why?

5. Please identify all of the committees that exist in the network, the name of the agencies that are represented on the committee, their role and how long they have been involved.

D. Effectiveness of the Network

1. In your opinion, is the network effective? Why? Why not?

2. In your opinion, what factors enhance/contribute to network effectiveness?

3. In your opinion, what factors inhibit/challenge the effectiveness of the network?

4. How significant is the network lead in the effectiveness of the network?

5. What strategies/ behaviours/ tasks has the network used to make the network effective?

Study ID#_____

6. What has the Network tried, to overcome the challenges?

7. Is there unequal power in the Network? If yes, does this impact the effectiveness of the network?

QUESTIONNARIE: Part 2

A. The MCSS has a goal of service coordination as a primary measure of effectiveness.

1. Can you describe efforts and outcomes to achieve this goal?
2. What role do the network leads play in achieving this goal?
3. Has the network resulted in the breaking down of barriers between DS and MHS service providers? Why? Why not?

B. The MCSS has 'enhancing specialized service delivery' as another goal for the network.

1. Has your network achieved this goal?
2. Can you describe evidence of this (increased volume, range, outreach to specific groups, etc.)?
3. Has the network increased the capacity of network partners? Why? Why not?
4. Has the network enhanced service delivery to specific populations (Francophone, Aboriginal, Rural, other)?

C. The MCSS has a goal of training and building capacity in the community (i.e. outside/beyond the network). This can include training, research, and other capacity building efforts.

1. Has the network achieved this goal? Why? Why not?
2. Can you provide some examples? Evidence?