MANAGERIAL PERCEPTIONS OF LOCAL COLLABORATION: THE ONTARIO HEALTHY BABIES/ HEALTHY CHILDREN EXAMPLE

JUDITH M. DUNLOP

MANAGERIAL PERCEPTIONS OF LOCAL COLLABORATION: THE ONTARIO HEALTHY BABIES/ HEALTHY CHILDREN EXAMPLE

by

(c) Judith M. Dunlop

A thesis submitted to the

School of Graduate Studies

in partial fulfillment of the

requirements for the degree of

Doctor of Philosophy

School of Social Work
Memorial University of Newfoundland

September, 2002

St. John's Newfoundland

Abstract

This research study explored state mandated local collaboration in the Healthy Babies/Healthy Children (HBHC) Program in Ontario. A conceptual framework was developed from the theoretical and empirical literature on interorganizational relations, collaboration and community social work practice. Qualitative content analysis was used to examine managers' perceptions of the environmental pre-conditions and interactional processes that influenced local collaboration in HBHC networks, within the context of federal funding reductions and the province of Ontario's downloading of financial responsibility to municipalities.

Analysis resulted in the reconceptualization of the conceptual framework into six themes of collaboration. Three environmental pre-conditions were: 1) Historical Conditions, 2) Institutional Conditions, and 3) Financial Conditions while three collaborative processes were: 4) Operational Processes, 5) Organizational Processes and 6) Relational Processes.

This study confirmed that a history of working together locally was an important influence on collaboration, suggesting that collaboration may be a learned practice skill requiring commitment, loyalty and time. This study also confirmed that central government mandates for collaboration are not as important as local autonomy and decision making. The data suggested that central governments should resist a "cookie cutter" approach. The province did not recognize the need for administrative resources. This lack of administrative funding for the HBHC program drained the resources of public health units/departments and

the HBHC managers. In addition, the exclusive funding through public health units/departments created some local resistance. The findings confirmed that the rewards of membership in a collaborative network can outweigh associated demands. This study mirrors the variation in formalization reported in the collaboration literature. Most HBHC managers believed that collaboration is facilitated when network members all have similar decision-making power for their organizations. Two new collaborative process themes (Organizational and Relational) emerged. The organization of HBHC networks was not top down. Local sites decided how to structure their HBHC network. The organizing process increased stakeholder representativeness, communication and decision-making. Existing interpersonal relationships were important in the development of HBHC networks. Most had established patterns of working together and shaped the HBHC network to fit the existing local culture of informality or formality.

The management skills needed to facilitate interorganizational collaboration are not exclusive to any group be they public health nurses or social workers. As governments increasingly mandate collaboration as a mechanism for integrating health and social services, social workers will need managerial competencies in collaborative practice at institutional and community levels. While it appears that public health managers were unaware of social work community practice models, this study illustrates the need for a renewed commitment among social work practitioners and educators to rebuild community social work practice.

Acknowledgments

The dedication and devotion of my thesis supervisor, Dr. Leslie Bella was critical to the completion of this PhD degree. I am grateful to Dr. Bella whose standards of excellence and dedication to my learning made the journey intellectually stimulating, challenging and ultimately successful. I would like to acknowledge the contributions of my supervisory committee members, Dr. Carolyne Gorlick, who encouraged me to pursue a PhD and who has been generous with her expertise and support throughout the journey. Appreciation is also due to Dr. Frank Hawkins who was a supervisory committee member for a period of time at the beginning of the research process. I would like to acknowledge the support of Dr. Rosemary Cassano, who generously provided her knowledge and expertise to the supervision of my PhD internship.

My appreciation is extended to the Social Sciences and Humanities Research Council of Canada who supported this research through a Doctoral Fellowship (Award No. 752-97-1504). I also want to thank the public health managers who gave generously of their time and energy throughout the research process.

Finally, I would like to acknowledge the contributions of family, friends and felines. I thank my friends for their love and support and for listening while I obsessed about the research. A special thank you to my friend Tom whose generous financial and emotional support has sustained me throughout the years. Finally, thank you to my daughters Rebecca and Amanda whose love and devotion have always been there for me. Your faith in me helped me to believe it was possible.

Table of Contents

List of Tables

List of Tables

List of Figures

List of Appendices

Chapter 1 Theoretical Framework

1.0 Introduction to the Research Study

The deficit reduction policies of federal and provincial governments have led to a resurgence of interest in collaboration for service integration to meet the needs of children and families (Bailey & McNally-Koney, 1996; Weil, 1996). This dissertation research explored state mandated local collaboration for service integration in the Healthy Babies/Healthy Children (HBHC) Program in Ontario. A conceptual framework, developed from interorganizational, collaboration and community social work theories, identified pre-conditions and processes shown in the literature to influence collaboration. This conceptual framework was the basis for questions which addressed public health managers' perceptions of what environmental pre-conditions and collaborative processes facilitated and/or constrained local collaboration in their implementation of the HBHC Program.

Increasingly, state mandates for collaboration are coupled with downloading of financial responsibility for services to local communities. Many recent government initiatives have mandated local collaboration as a condition of funding new programs. The lack of conceptualization of how interorganizational collaboration is implemented among community partners is an emerging research problem in social work (Graham & Barter, 1999; Bailey & McNally-Koney, 1996; Mizrahi & Rosenthal, 1993). Although social workers have the historical background and conceptual models to lead collaborative efforts, they are not at the forefront of collaboration for service integration.

Social workers may work in interorganizational arenas where there appears to be little recognition (by other disciplines) of their community practice skills. Community intervention has not been given much attention by social work education in Canada since the mid-1970's and consequently is not well known either inside or outside the profession. On the other hand, nursing education in Canada and the United States has moved toward community organization. In Ontario (the province of this study) the focus of social work is on regulatory practice in child protection while public health nurses carry out prevention and family support programs. However, social workers should contribute to service reform for children and families by using their community practice skills (Bailey & Koney, 1996; Weil, 1996). For social workers to find their occupational niche in the current era of resource reductions and downloading, they also need to increase their knowledge and skills in collaborative practice. Empirical research, such as this study of the pre-conditions and processes of collaboration in the HBHC Program, is needed to prepare social workers for multidisciplinary practice in collaborative networks.

This exploratory study, using qualitative content analysis, examined managers' perceptions of environmental pre-conditions and collaborative processes that influenced collaboration in the HBHC Program. The data were collected using semi-structured telephone interviews with public health managers responsible for the HBHC Program in Ontario. Respondents included twenty-two managers from the public health units/departments in the seven Public Health Planning Regions across Ontario. The conceptual framework, developed for this study from the interorganizational, collaboration

and community social work practice literature, provided the foundation for the interview guide used to explore public health managers perceptions of local collaboration.

The context for this study of local collaboration in the HBHC networks is situated within the wider perspective of an era of downloading in Canada that has influenced child and family policy in Ontario. The Canada Health and Social Transfer (CHST, 1996) reduced federal funds for health, post-secondary education and social assistance. In turn, the provincial government of Ontario cut social programs through downloading of financial responsibility to the municipal level. This study includes an outline of federal and provincial influences on child and family policy in Ontario and a description of the HBHC Program which further contextualizes this exploration of local collaboration in Ontario.

A thematic analysis of the data gathered from public health managers led to the reconceptualization of the pre-conditions and processes found in the original conceptual framework. Six themes were found to influence collaboration in the HBHC networks: 1) Historical Conditions; 2) Institutional Conditions, 3) Financial Conditions, 4) Operational Processes, 5) Organizational Processes and 6) Relational Processes. Conclusions are drawn regarding the contributions of this research to knowledge about the pre-conditions and processes that influence local collaboration. The implications of this study are suggested for: 1) knowledge development in collaboration theory, 2) further research on collaboration and 3) social work practice at policy and community levels.

Chapter 1 synthesizes the theoretical and empirical literature on interorganizational

theory, collaboration theory, and community social work practice and presents the conceptual framework for the study. The conceptual framework, based on the research literature identified: 1) *pre-conditions* that motivate agencies to work together collaboratively and 2) *interactional processes* that facilitate or constrain collaborative relationships.

Chapter 1 also addresses the need for social work leadership in managing collaborative networks. Historical and contemporary social work practice with communities and the importance of community intervention in an era of downloading and state mandated collaboration are considered. By capitalizing on their professional knowledge and skill in community practice, social workers can play a major role in the complex challenges of meeting the needs of children and families. The social work profession should be recognized for its contribution of community practice theory to knowledge development in collaboration research. Since there is little research on the contributions of community social work practice models to collaboration theory, this study is one attempt to find a niche for social work in an era of downloading and devolution.

1.1 Interorganizational Theory and Collaboration

In this chapter, theoretical and empirical research literature on interorganizational and collaboration theory is reviewed. This study is based on the literature that identified: 1) *pre-conditions* that motivate agencies to work together collaboratively and 2) *interactional processes* that facilitate or constrain collaborative relationships. The conceptual framework for this study (see Table C.1.1) identifies: 1) environmental pre-

conditions and 2) collaborative processes that were the basis for the questions in the HBHC Interview Guide (Appendix C.3.A.7).

While no one theory provides a foundation for understanding collaboration, resource exchange and institutional theory were used in this study of the HBHC Program (Alter & Hage, 1993; Meyers, 1993; Gray & Wood, 1991; Provan & Milward, 1991) to develop the conceptual framework. Institutional theory (organizations engage in interorganizational relations to increase their legitimacy and influence) was used to develop the pre-conditions of *mandatory/voluntary context* and *legitimacy of convening organization.*

Second, resource exchange theory (exchanges between organizations as they seek to secure or maintain resources) was used to develop the collaborative processes of *sufficient resources* (see Table C.1.1 - Collaborative Processes). Third, collaboration theory was used to develop one of the pre-conditions in the conceptual framework, *history of previous collaboration (*see Table C.1.1 - Environmental Pre-conditions*)*. Finally, collaboration theory was used to develop seven collaborative processes: 1) *membership participation, 2) decision-making levels, 3) communication style, 4) formality/informality of links, 5) common purpose, 6) costs and benefits of membership and 7) stakeholder representativeness* (see Table C.1.1 - Collaborative Processes).

Table C.1.1

Conceptual Framework For Study Of Local Collaboration: The Healthy Babies/ Healthy Children Program

Context of Downloading	Environmental Pre-Conditions	Collaborative Processes
National • (Canada) **Provincial** • Historical • Contemporary **Provincial Government** • Devolution of Public Health • State-mandated HBHC networks **Public Health Planning Regions** • Geographic Location of Health Units/Departments **Stakeholders in this Study** • Local HBHC Managers	• History of Previous Collaboration • Mandatory/Voluntary Context • Legitimacy of Convening Organization	• Stakeholder Representation • Membership Participation • Costs & Benefits of Membership • Decision-making Levels • Communication Style • Formality/ Informality of Linkages • Common Purpose Development • Sufficient Resources

1.1.1 Resource Exchange Theory

Resource exchange theory looks at the environmental pre-conditions under which organizations are willing to collaborate. It is based on assumptions of organizational environments as resource pools and has informed much of the empirical and theoretical work on interorganizational relations since the 1960's (Alter & Hage, 1993; Gray, 1989; Mulford, 1984; Van De Ven & Ferry, 1980; Aldrich, 1979; Paulson, 1976; Warren, 1973, Levine & White, 1961). Initially, resource exchange theory looked at dyadic relationships between a main (focal) organization and one other organization (Aldrich, 1979; Gans & Horton, 1975; Warren, 1967; Levine & White, 1961). Later, multiple interorganizational relationships became the focus of theory development (Schopler, 1987; Galaskiewicz, 1985; Provan, 1983; Scott & Meyer, 1983; Whetten, 1981; Meyer & Rowan, 1977).

Resource exchange suggests that even though there are benefits to resource exchange relationships, organizations try to maximize their autonomy (Ring & Van De Ven, 1994; Mizruchi & Galaskiewicz, 1993; Oliver, 1990, 1991). First, they try to maintain control over their resources. Second, they may co-operate with *only one* other organization to share resources. Finally, *and only if necessary*, will they enter voluntarily into resource exchanges with multiple organizations (Thompson, 1967).

In the past, collaborative groups emerged from resource exchange needs that compelled organizations to search for others with resources in their interorganizational environment (Ring & Van De Ven, 1994; Mizruchi & Galaskiewicz, 1993; Oliver, 1990, 1991). As resource scarcity increases in the early 21st century, organizations must now try to

increase and/or maintain their power in an increasingly competitive service environment.

1.1.2 Institutional Theory

Institutional theory addresses the adaptations made by organizations as they attempt to gain legitimacy in the external environment (Gray & Wood, 1991). When organizations are vulnerable, they try to affiliate with more powerful partners or modify their organizational characteristics to increase their compatibility within the institutional environment (Provan & Milward, 1991; Oliver, 1990; DiMaggio, 1988; Scott, 1987; Galaskiewicz, 1985). When organizations enter into collaborative relationships (committing their time, resources and personnel), they give up some of their power to external constituents. When governments impose mandates on organizations, (such as the HBHC Program), they reduce their autonomy with directives designed to: 1) legally require service co-ordination, 2) prescribe conditions for funding, 3) force interorganizational relationships and, 4) enforce standards of service.

Mandates change interorganizational behaviour as less powerful organizations attempt to join with those they perceive as more powerful, to increase their legitimacy and secure future resources. The position of the lead agency within the interorganizational environment may be altered by the government mandate and dedication of funding for collaboration. First, the lead organization is accountable to an external institution that may not be well regarded by stakeholders in the local community network. Second, the exclusive dedication of resources may force alliances between local organizations and the lead agency that result in conflict. Finally, although the lead organization's legitimacy may be enhanced by external mandates

and financial resources, local stakeholders may resent the lack of control over collaboration and obstruct planning for system reform.

As financial responsibility for health and social services is downloaded to local levels, mandatory collaboration is increasingly used by government to reform the service system. The legal mandates imposed by government pre-determine what organizations will have resources and power and those that will be subordinated. This study used institutional theory to explore state mandated collaboration that bestowed power and resources on one local convening organization (public health units/departments).

1.2 In Search of a Theory of Collaboration

Interorganizational relations (IOR) theory spans three decades and multiple approaches including: 1) resource exchange theory (IOR are motivated by the need to acquire resources thus producing interdependency) (Aldrich, 1979; Pfeffer & Salancik, 1978; Levine & White, 1961), 2) contingency theory (IOR are contingent on changes in an organization's life cycle) (Lawrence & Lorsch, 1967), 3) transaction cost theory (IOR dependencies based on costs and benefits of relationships) (Williamson, 1986) and 4) institutional theory (prevailing norms determine IOR) (Oliver, 1991; Scott, 1987).

This diversity of interorganizational theories is problematic to understanding collaboration. Interorganizational theory has potential to provide a framework for understanding how collaborative relationships are formed, how they change over time and how they are influenced by interorganizational structures (Ring & Van De Ven, 1994;

Alter & Hage, 1993; Gray & Wood, 1991; Gray, 1989; Tjosvold, 1986). Numerous studies have addressed process oriented elements of collaboration (Lasker, Weiss & Miller, 2001; Dunlop & Angell, 2001; Mitchell & Shortell, 2000; Harbert, Finnegan & Tyler, 1997; Lasker, 1997; Gray & Wood, 1991). But few studies link the interorganizational literature with research on collaboration. However, in the early 1990's, one of the leading scholars in the collaboration field proposed an integrative framework for interorganizational theory and research on collaboration (Gray & Wood, 1991).

Several other studies have used interorganizational theories to explore collaboration, but these have resulted in diverse explanations for interorganizational collaboration (Reitan, 1998; Gray & Wood, 1991; Oliver, 1990). Despite past and current interest in organizational interactions, no comprehensive theory of collaboration has yet been developed. Collaboration theory is embryonic but scholars do agree that dimensions such as: 1) pre-conditions, 2) processes, 3) developmental stages, 4) structures and 5) outcomes all need to be explored (Reilly, 2001; Reitan, 1998; Gray & Wood, 1991; Sofaer & Mrytle, 1991). Recently, collaboration research has addressed concepts such as synergy and leadership (Lasker, Weiss, & Miller, 2001; Mitchell & Shortell, 2000). Consequently, although collaboration is emerging to address system reform efforts, theory development is lagging behind practice. The need for practice-oriented theory on collaboration that is derived from data and informs practice has been identified in the literature (Huxham & Vangen, 2000, Mitchell & Shortell, 2000).

1.3 Research on Collaboration: Need for a Consistent Framework

Social welfare policy in the 21st century is increasingly linked to collaborative mechanisms as human services are restructured. There is renewed interest in getting organizations to work together on system reform to address social problems too complex to be resolved by one organization acting alone. Although collaboration is promoted by government, there is considerable confusion about its definition. First, as previously discussed, few studies apply interorganizational theory to collaboration. Second, the lack of empirical evidence on collaboration has limited scholarly contributions to theory and practice development (Graham & Barter, 1999; Rivard, 1999; Provan & Sebastian, 1998; Reilly, 1998; O'Looney, 1994; Gray & Wood, 1991). Third, scholars from diverse disciplines such as public policy, social work, nursing, medicine, sociology, psychology, political science, education and business use the term differently (e.g., public health literature defines collaboration as the process of structurally integrating organizations in health alliances while business literature defines collaboration as the process of building work teams). This does little to advance the development of a unified theory of collaboration. Lastly, for social workers, collaboration requires negotiating in cross-disciplinary territory. There is little research to support social work's claim of competency in organizing community collaboratives. Some social work research has addressed theoretical and practical questions on the factors that facilitate collaborative processes at the local level (Mizrahi & Rosenthal, 2001; Mulroy & Shay, 1998; Mulroy, 1997; Mulroy & Cragin, 1994). This research identified the need to apply community social work methods to

collaboration by pointing out critical areas for social work research and intervention.

1.4 Collaboration - Pre-Conditions and Processes

A meta analysis by Mattesich and Monsey of the research literature on collaboration produced a categorization of nineteen factors that influenced the success of human services collaboration (1992). This meta-analysis, grouped these nineteen factors into six categories: 1) environmental (the geographic location and social context of collaboration); 2) membership characteristics (skills, attitudes and opinions of individuals involved in collaborative group; 3) process/structure (management, decision-making and operational systems of a collaborative effort; 4) communication (channels used by collaborative partners to send and receive information and formality/informality of communication) 5) purpose (collaborative vision and specific tasks); and 6) resources (financial and human resources necessary to develop and sustain collaboration) (Table C.1.2.)

Drawing on the meta-analysis research of Mattessich and Monsey (1992), a conceptual framework (see Table C.1.1) was developed for this study that contained three environmental pre-conditions and eight collaborative processes used to explore public health managers perceptions of local collaboration in the HBHC Program in Ontario.

Table C.1.2

Six Categories Of Factors That Influence The Success Of Collaboration

Environment	**Membership**	**Process/Structure**	**Communications**	**Purpose**	**Resources**
History of Collaboration in the community	Member trust	Member stake in process and outcomes	Open/Frequent Member Communication	Attainable Goals	Sufficient Funds
Collaborative seen as leader	Representative group	Group Flexibility	Informal/Formal links	Shared vision	Legitimacy of Convenor
Political/social climate favorable	Member Benefit	Multiple decision-making levels		Mission different from participating Organizations	
	Member Compromise	Clear roles and policy guidelines			
		Member adaptability			

Mattessich & Monsey (1992)

1.4.1 Environmental Factors Influencing Collaboration

Environmental pre-conditions determine if, how, when and under what circumstances stakeholders will come together and (in the case of mandatory collaboration) who will have the leadership role. Environmental pre-conditions are defined in this study as factors in the environment that act as incentives and disincentives for organizations to work together. Collaboration is influenced by conditions in the environment such as: 1) a history of previous collaboration, 2) the mandatory/voluntary context and 3) the legitimacy of the convening organization.

1.4.1.1 History of Previous Collaboration

In this study, the history of previous collaboration was defined as the nature and type of past interpersonal and professional relationships and their influence on collaboration. Collaboration theory suggests that working collaboratively in the past leads to interpersonal relationships between members of the interacting organizations that facilitate collaboration (Dunlop & Angell, 2001; Gray, Duran, & Segal, 1997; Harbert, Finnegan, & Tyler, 1997; Mattessich & Monsey, 1992). In times of environmental turbulence, collaborative leaders will target their networking efforts to those they know personally and who share their loyalties and personal values. Relationships based on a history of respect and trust are incentives that encourage collaboration among autonomous organizations. A history of collaboration (in the formative phase) appears to be an important pre-condition that facilitates common goals. However, this history will not insure collaboration over the long term. Positive interpersonal relationships that develop between network partners facilitate

future collaboration. When past interactions have been characterized by conflict, collaboration is constrained. Many collaborative efforts fail (some estimates suggest up to fifty per cent do not survive their first year) (Kreuter, Lezin, & Young, 2000; Wandersman, Goodman, & Butterfoss, 1997). Unless managed well, conflict between collaborative partners can undermine local implementation of networks (Mitchell & Shortell, 2000; Kegler, Steckler, McLeroy & Malek, 1998).

This research asked questions about the previous collaboration history of local HBHC networks. How did collaboration happen before HBHC? Were there previous local initiatives (e.g., Community Action Programs and/or Better Beginnings, Better Futures Programs) that mandated collaboration? Was there a history of Children Services Advisory Groups (CSAG) prior to the implementation of the HBHC network? Did the community have its own previously established organizational structures and processes for planning local children's services before HBHC?

1.4.1.2 Mandatory vs Voluntary Context

In this study, mandatory collaboration was defined as the nature and degree of a formal government mandate and how the mandate influenced local collaboration in the HBHC networks. Voluntary collaboration was defined as the nature of and degree to which informal agreements, operations and relationships characterized collaboration in the HBHC networks.

Opinions differ about whether collaboration should be based on voluntary or mandatory participation. Proponents of voluntary approaches argue that collaborative

mechanisms should be organized by local communities as a "bottom-up" approach to system reform based on agreements between stakeholders (Melaville & Blank, 1993; Kretzmann & McKnight, 1993; Melaville, 1992; Bruner, 1991). Conversely, others propose that the current political environment necessitates mandatory collaboration as "top down" control by central government to ensure system reform as financial supports diminish (Poole, 1997; Bailey & McNally-Koney, 1996; Woodard, 1995).

In this study, institutional theory was used to define the mandatory context for local HBHC networks. A formal government mandate was defined as a legal requirement that forced organizations to work together. These mandates can be used as a condition of funding and/or to force interorganizational relationships. Mandatory collaboration has been associated with improvements in service delivery for children and families. The legal mandate for collaboration gives stakeholders more "clout" in advocating for a reformed service system (Sarbaugh-Thompson, 1999; Melaville, 1992, 17). Nonetheless, mandatory collaboration puts pressures on organizations in the local community who may resist or obstruct its implementation by non-participation and/or non-compliance (MacNair, Gross, & Daniels, 1995; MacDonald, 1994; Melaville, 1992).

The voluntary context was defined as the degree of informal agreements, operations and relationships that characterized HBHC networks. Written, formal agreements among organizations may have contractual authority but this does not suggest that they are synonymous with mandates. This type of agreement signifies that organizations have given

their official sanction but that participation is voluntary (Woodard, 1994; Alter & Hage, 1993; MacNair, 1993).

This study asked questions about how the government mandate and voluntary agreements affected local collaboration. Did a government mandate facilitate or constrain the development of collaborative inter-organizational relationships at the local level? Were there voluntary agreements between HBHC network members and if so, how did these agreements affect local collaboration?

1.4.1.3 Legitimacy of Convening Organization

In the meta-analysis research carried out by Mattessich and Monsey (1992) shown in Table C.1.2, the legitimacy of the convener is not designated as an environmental pre-condition. Rather, it is one of the resource factors influencing collaboration. In this study, the legitimacy of the convening organization designated by state mandate is considered an environmental pre-condition (see Conceptual Framework for HBHC Program, Table C.1.1). The legitimacy of convening organization was changed from a resource factor to a pre-condition in this study to reflect institutional theory. Institutional theory defines legitimacy as the consensus that exists in the local environment when an organization has a legitimate right to exist and deliver specific programs. In this study, the legitimacy was defined as the extent that individuals and organizations agreed that public health units/departments had the support from other organizations to lead the implementation of HBHC. This research used the government mandate and its effect on the legitimacy of the convening organization as a pre-condition that could be assumed to facilitate or constrain local collaboration.

Research suggests that the legitimacy of leadership for convening organizations is enhanced by government support (Reilly, 1998; Fleishman, Mor, Piette, & Allen, 1992). However the designation of a lead organization by government does not ensure a smooth trajectory from mandate to local consensus: rather, local collaboration is highly dependent on state and local leadership negotiations, context and stage of development (Ledwith, 1999; O'Looney, 1994).

Institutional theory research proposes that convening organizations can exercise their influence in the interorganizational domain by: 1) formal authority, 2) negative sanctions for non-participation, 3) having expertise and credibility and 4) persuasion (Wood and Gray, 1991). Whether collaboration is mandatory or voluntary, other stakeholders may refuse to participate if they reject the legitimacy claims of the convening organization.

This suggested a number of questions which are relevant to state mandated collaboration in the HBHC networks. Did the institutional mandate affect the ability of the convening organization (public health units/departments) to implement the HBHC Program? Did the past reputation (legitimacy) of the convening organization affect local collaboration? What effect did the institutional mandate have on previously established local relationships?

1.4.2 Interactional Processes Influencing Collaboration

A number of interactional processes were important to this research on collaboration as shown in the conceptual framework for the study (Table C.1.1). The collaborative processes in this study were conceptualized as: 1) stakeholder representation, 2) membership

participation, 3) costs and benefits of membership, 4) decision-making levels, 5) communication style, 6)formality/informality of linkages, 7) common purpose development, and 8) sufficient resources.

1.4.2.1 Stakeholder Representation

The collaborative group should be constructed of representatives from each segment of the community. Stakeholders are defined as "any person, individual, organization, community or government that is affected or can affect the deliberations about [sic] and potential solution to the issue that requires the collaborative process " (Finn, 1996, p. 156). Each stakeholder brings an interpretation of the problem and the solution (based on individual assumptions, beliefs and values) to the collaboration table. Stakeholder representation may include: 1) individuals (acting in their own interests) 2) community representatives (individuals who represent the interests of community groups) and 3) organizational representatives (individuals who represent their organization's interest). Stakeholders agree to become involved in collaboration to gain information, negotiate for resources, act as advocates or to position themselves favourably in the community.

Organizations may be mandated to collaborate or may perceive that there are risks for nonparticipation. Organizational representatives may focus on collaboration as a cost-effective way to provide services. In contrast, individuals and community representatives may view collaboration as a way to provide more comprehensive services to children and families with complex needs (Hassett & Austin, 1997; Meyers, 1993).

Research questions in this study addressed how stakeholder representation influenced collaboration. Did the composition of stakeholders in the collaborative group influence collaboration? Were specific sectors represented equally in the collaborative network? Were these stakeholders mandated by the state or recruited by the convening organization (public health units/departments)? How did the convening organization (public health/departments) recruit stakeholders?

1.4.2.2 Membership Participation

The issue of membership participation concerns the actual individual participation in the collaborative process. As previously noted, the terms stakeholder and member were used interchangeably in this study. In contrast to stakeholder representation, which addressed the representation of sectors in the network, membership participation concerns itself with the nature and type of participation of members (Bailey & McNally-Koney, 1995). In this study, managers were asked whether members participated in the network as consumers, advocates, community members or organizational representatives.

Collaboration research has addressed the differential participation of members (Mattessich, Murray-Close, & Monsey, 2001; Castelloe & Prokopy, 2001; Provan & Sebastian, 1998). Some studies suggest that organizations will participate as core members if they have strong ties to a network related to their service needs (Provan & Milward, 1991).

In this study, three dimensions of membership were considered: 1) how and when members were recruited to the network, 2) their differential participation and 3) how they perceived their role. Research questions explored membership participation in HBHC networks. Did members participate as parents and/or consumers? Did members participate as advocates? How did organizational members identify their participation? Did members identify dual roles (e.g. service provider and advocate)? Did the network have members who identified themselves as community representatives?

1.4.2.3 Costs and Benefits of Membership

In this study, *costs of membership* were defined as the real or perceived negative effects of participation in HBHC networks that may accrue to individual members or their organizations/groups. *Benefits of membership* were defined as the real or perceived positive advantages of participation in HBHC networks that may accrue to individual members or their organizations/ groups. The benefits of participation in collaboration (such as increased knowledge and facilitation of referrals) have been found to outweigh the costs for participants (Lasker, Weiss, & Miller, 2001; Mattessich, Murray-Close, & Monsey, 2001; Wandersman, Goodman, & Butterfoss, 1997). Costs to members participating in collaborative networks include: 1) the amount of time and resources that must be diverted to network activities and away from their own priorities and 2) the loss of autonomy of decision making over their own activities (Kegler, Steckler, McLeroy, & Malek, 1998; Wandersman, Goodman, & Butterfoss, 1997; Alter & Hage, 1993, Alter, 1990).

Questions in this study addressed the costs and benefits of membership participation in the HBHC networks. Was the promise of increased co-ordination considered a benefit by organizational members? What were the benefits and costs for the convening organization (public health units/departments) for providing leadership to the collaborative network? Did members consider the time required for participation one of the costs of collaboration? Were members willing to devote their time and resources to network development?

1.4.2.4 Decision Making Levels

In this study, decision making was defined as the type, level and influence of decision making power that characterized the HBHC network. This study considered: 1) the type of decisions network members made (advisory, planning, information sharing, joint resources), 2) the level of decision making power of organizational members, and 3) the influence of the level of decision making power on HBHC network development.

Decision-making authority is defined in the literature as the number of *levels* through which a decision must pass and the type of control systems that are employed across institutional environments (Powell, 1988). Organizations protect their interests by centralizing decision-making within their boundaries but they constrain collaborative development by limiting the authority of members participating in the network. Decentralized decision-making promotes negotiation and communication among network members and increases member participation (Dunlop & Angell, 2001; Mattessich, Murray-Close, & Monsey, 2001; Mitchell & Shortell, 2000).

In this study, research questions explored decision-making levels and their influence

on mandatory collaboration in the HBHC networks. How many levels of decision-making authority were represented in the collaborative network? Did organizational members have the authority to make decisions for their organizations? Did the convening organization have some final decision-making authority for network decisions? Did the provincial government make decisions for local networks through their accountability procedures?

1.4.2.5 Communication Style

In this study communication style was defined as the open or filtered nature of communication between local managers, the provincial consultants and local HBHC network members. Open communication is defined as information that is given in its original state without adaptation. Filtered communication is defined as information that is summarized, interpreted, consolidated, delayed or sent only to specific organizational members (Rogers, Howard-Pitney, Feighery, Altman, Endres, & Roeseler, 1993; Aldrich & Herker, 1977). Communication style (open or filtered) is an operational process that builds collaborative relationships by allowing members to reduce misunderstandings, develop a common language and reduce conflict.

This research study addressed the open and filtered nature of communication and how these communication styles influenced local collaboration. Questions in the interview guide addressed communication between: 1) the HBHC managers and the provincial HBHC consultants; 2) the HBHC managers and members of the local network and 3) the members of the HBHC network themselves. How did local HBHC managers make decisions about what, when and how provincial level information would be transmitted to local networks?

Did managers communicate openly with the provincial HBHC consultants and did they perceive that provincial consultants were open with them? Did managers perceive that network members communicated openly with each other at HBHC meetings or was communication filtered during network meetings?

1.4.2.6 Formality/Informality of Linkages

In this study, formality of linkages was defined as the degree of formalization of the operational processes (e.g. terms of reference, minutes, agendas, service agreements and bylaws) and organizational structures (e.g. umbrella committees, sub-committees, working groups, multi-site networks) of HBHC networks. This study defined informality of linkages as the degree of informality of the operations (e.g. informal service co-ordination, no written agreements) and organizational structures (informal networks) that characterized local HBHC collaboration.

Research has produced conflicting findings on the influence of formalization of operational processes on collaboration. Some studies suggest that standardizing the basis of exchange through formal procedures, agreements and structures facilitates collaborative efforts (Bailey & McNally-Koney, 1995; Meyers, 1993; Mattessich & Monsey, 1992; Gans & Horton, 1975). Other scholars argue that unnecessary formalization and structure are counter-productive and propose that interorganizational groups (such as collaborative networks) should remain flexible in order to adapt to the changes in the environment (MacNair, Gross, & Daniels, 1995; Ring & Van De Ven, 1994).

Formal collaborative structures are characterized by the organizational integration of previously separate administrative and service delivery systems (service integration, network structures, coadunation) (Bailey & McNally-Koney, 2000; Holosko & Dunlop, 1992; Zuckerman & Kaluzny, 1991). In contrast, informal collaborative structures are based on informal agreements to work together with no structural integration of separate organizations (alliances, collaborative networks coalitions, partnerships and consortia) (Bailey & McNally-Koney, 2000; Mandell, 1999; Mizrahi & Rosenthal, 1993; Dhuly, 1990; Roberts-De-Gennaro, 1987). These informal interorganizational arrangements accomplish their goals through formal or informal agreements and interpersonal relationships.

Questions in this study explored the influence of formal and informal operational processes on local collaboration in the HBHC networks. How did the level of formality or informality affect local collaboration? Were formal agreements mandated by the provincial government? Were there differences between local communities in the level of formality and informality of the HBHC network operations?

1.4.2.7 Common Purpose Development

In this study common purpose was defined as the extent to which individual members of the collaborative developed: 1) a voluntary consensus on their common goals and 2) how the state mandated goals influenced the development of common goals in the HBHC network.

Collaboration studies demonstrate a wide range of goals for common purpose development. Some goals identify a long-term approach (e.g. integrated services) while others are more short-term and specific (e.g., economies of scale for cost-effective joint purchasing). Primarily, research studies address voluntary collaboration where there is agreement that previously separated organizations need to come together and identify their common purpose (Graham & Barter, 1999; Bailey & McNally-Koney, 1996; Mizrahi & Rosenthal, 1993; Zuckerman & Kaluzny, 1991; Roberts-DeGennaro, 1987). In voluntary collaboration, groups may not begin with common goals, but eventually they must find common purpose or collaboration will fail. There is little research concerned with the influence of state mandates (with centrally determined goals) on local collaboration. It is recognized, however, that local collaboratives must align their purpose with the external community in order to secure resources and accomplish collaboration (Kreuter, Lezin, & Young, 2000).

This research study explored how the development of common purpose influenced mandatory collaboration in the HBHC networks. Did the convening organization attempt to align the common purpose of the local HBHC networks with state-mandated goals? Did local collaborative networks have previously established goals for child and family service reform? Was there conflict between program managers and network members over the determination of goals for the HBHC network? Was there conflict between the provincial consultants and local networks about the goals for HBHC collaborative networks?

1.4.2.8 Sufficient Resources

In this study, "sufficient resources" was defined as the nature and extent of resources provided by the provincial government for the HBHC Program and the influence of these allocations on the HBHC networks. When mandates co-exist with the provision of funds, they act as a powerful incentive for providers to collaborate for service system improvement (Gray, Duran, & Segal, 1997, MacDonald, 1994). Specifically, research identifies the positive influence on collaboration when a paid administrator is responsible for network development and maintenance (Mulroy & Shay, 1998; Mulroy, 1997; Mulroy & Cragin, 1994). The author's planning experience with collaborative networks in North Carolina and Ontario supports the dedication of resources as a positive influence on local collaboration (Dunlop & Angell, 2001; Weil & Dunlop, 1996; Dunlop & Holosko, 1995).

This study of the HBHC networks addressed how the provision of resources influenced collaboration. Was the state mandate for collaboration tied to funding for the development of the HBHC network? Did the exclusive dedication of resources to the public health units/departments for the HBHC Program influence local collaboration? Did other organizations in the local community contribute resources (financial, in-kind, personnel) to the development of the HBHC network?

1.4.3 Summary of Pre-Conditions and Processes of Collaboration

In this study, environmental pre-conditions were used to explore the motivations of individuals, community groups and organizations in the HBHC networks in Ontario. While resource exchange and institutional theory offered insight into the motivation for

collaboration, they did not address how members of a network worked together once they have decided to collaborate. The interactional (collaborative) processes of collaboration were developed from institutional and collaboration theory. The environmental pre-conditions and collaborative processes identified in the conceptual framework (Table C.1.1) were then used to explore mandatory local collaboration in the HBHC Program in Ontario.

1.5 Local Collaboration: Social Work for the 21st century

1.5.1 Introduction

With cuts in transfer payments, a focus on privatization of health and social services and downloading, the current climate has been characterized by some as the "devolution revolution" (Bailey & McNally-Koney, 1996; Nathan, 1996). Social workers and other human service professionals have been forced to respond to the deficit reduction agendas of national and regional governments who have downloaded financial responsibility for health and social services to local communities (Segal & Brzuzy, 1998; Fisher & Karger, 1997; Weil, 1996). Increasingly, governments have mandated local collaboration in an attempt to reduce duplication and increase efficiency in service systems (Kenny, 1998; Pulkingham & Ternowetsky, 1997; Panet-Raymond & Mayer, 1997; Cairns, 1996; Teeple, 1995). This transfer of financial responsibility from federal to provincial and local levels has created an opportunity for social workers to use their expertise in community organization and planning. Social workers need empirical research, such as this study of the HBHC Program, to increase their understanding of collaboration, improve their reputation with other disciplines and find their occupational niche in the collaboration arena.

In this study, there were no social workers in the sample who were managers of the HBHC program. Since the HBHC Program was designed as a joint responsibility between the Ministry of Health and Long Term Care and the Ministry of Community and Social Services, the lack of social work managers was an unexpected finding. Social workers, invested in community practice, should be concerned that there was no place for their expertise in this example of state mandated collaboration in Ontario.

1.5.2 Community Organization Practice in Social Work

Social work=s history of planning with communities for social change spans over one hundred years (1869-1999) and a variety of goals and strategies for community intervention (Mizrahi & Rosenthal, 2001; Weil, 1996; Garvin & Cox, 1995; Tester, 1991; Betten & Austin, 1990; Lees & Mayo, 1984; Thomas, 1983; Alinsky, 1971; Rothman, 1964; Ross, 1955).

In the late 1800's and early 1900's, the development of local social welfare services reflected the emerging social, political, and economic liberalism of the era. Increasingly, voluntary organizations were unable to respond to the needs of the poor in their communities and local authorities were required to provide assistance (Gladstone, 1995). The Charity Organization Society and the Settlement House Movement were actively involved in their own versions of local social welfare provision. In the late 19th century, workers associated with the Charity Organization Society, directed their charitable efforts to the unemployed and the poor.

In contrast, workers in the Settlement House Movement established themselves in

neighbourhoods and provided leadership so local residents could learn how to address their own problems. Unlike the Charity Organization Society that focused its attention on individual indigents and co-ordination of poor relief, the Settlement House Movement directed its resources to neighbourhoods. Settlement House leaders organized small groups who targeted neighbourhoods for collective action on social problems.

In the 1920's, social workers became preoccupied with professionalization. This led to an emphasis on casework, especially psychiatric casework. Settlement houses gradually became institutionalized and turned their attention away from advocacy efforts to engage in educational and recreational programs (Trattner, 1999). In the 1930's, a theoretical model of community organization was developed for co-ordination among social welfare agencies. In 1939, this co-ordination model was institutionalized in the social work profession as a method of community organization practice.

In the 1940's and 50's, community organization expanded. By the mid-1950's, a social planning model was introduced with three approaches: 1) reform, 2) planning and 3) process (Ross, 1955). By the late 1950's, the Alinsky model of community organization (social action), translated labour organizing to neighbourhood organizing (Alinsky, 1971).

Since the 1960's, community organization theory and practice has included two approaches: 1) the pluralist social planning model (Netting, Kettner, & McMurtry, 1998; Rothman, 1996; 1979; 1964; Rothman & Zald, 1985; Taylor & Roberts, 1985; Lauffer, 1981; Gilbert & Specht, 1977; Warren, 1973, 1967;) and 2) the radical social action model

(Mullaly, 1997; Mondros & Wilson, 1993; 1994; Reisch & Wenocur, 1986; Craig, Derricourt, & Loney, 1982; Mayo, 1975; Alinsky, 1971). Social planning models within the pluralist tradition propose that no one group has more power than another to influence the development of social policy. Thus, the rational technical model of social planning is based on incremental change and consensus politics. Radical social work models emphasize social action and advocacy planning that utilize conflict strategies to redistribute power from institutions to communities for social justice.

Rothman (1964), building on community practice models of the 1950's, developed a social planning model that emphasized fact gathering and rational decision-making and an expert role for social workers with technical skills of research, analysis and program development (Rothman, 1964; Ross, 1955). Rothman's original conceptualization consisted of three models of community organization: 1) locality development, 2) social planning/policy and 3) social action. This framework has been the cornerstone for exploring community practice since the 1960's.

The first model, locality development, builds community capacity by recruiting a broad base of community stakeholders who engage in an interactional process of identifying and solving their own problems. The second, model, social planning/policy, uses fact gathering, technical experts and rational decision making to solve community problems. The third and final model, social action, advocates for changes to unequal power relationships between disadvantaged groups and institutions.

In the 1960's and 1970's, the development of advocacy planning advanced social

action in community organization practice (Rothman, 1979; Mayo, 1975; Alinsky, 1971). The social and political changes in the 1960's encouraged the development of conflict models of practice that promoted fundamental changes in the political, economic and social structures of society. Radical or structural social work models challenged the top-down policy making of government. These advocacy models emphasized critical thinking, conflict strategies and structural change as the goal of community social work practice.

During the 1980's, radical community organization and feminist approaches offered action groups an opportunity to advocate against the oppressive structures of the state (Panet-Raymond, 1989, Adamson, Briskin, & McPhail, 1988; Friedmann, 1987; Van Den Bergh & Cooper, 1986; Lees & Mayo, 1984). In addition, pluralist approaches to community organization continued to be revised and developed (Rothman & Tropman, 1987; Taylor & Roberts, 1985).

In the 1990's, as interorganizational collaboration became more prevalent as an instrument of public policy, new conceptualizations were developed based on planning for integration of services with constituencies of community leaders and human service providers (Popple, 1996; Rothman, 1996; Weil & Gamble, 1995). In response to criticisms that earlier social planning models were too rigid and categorical, Rothman's model was reconstructed in the 1990's making it more flexible and developmental. These changes blurred the rigid categories of planning, development and change, thus aligning this model with the views of others (Tester, 1997; Weil, 1996; Hyde, 1996; Wharf, 1992).

In the late 1990's to early 21st century, social work scholars have identified a variety of community practice models to respond to the complex challenges of mandatory collaboration and system reform (Mizrahi & Rosenthal, 2001; Bailey & McNally-Koney, 2000; Wharf & Clague; 1997; Tester, 1997; Poole, 1997; Popple, 1996; Weil, 1996; Hyde, 1996). One response to the challenges of the 1990's has been the development of new community social work models based on feminist and constructivist principles which interpret diversity as a strength and attend to gender, race, class and particular contexts of place. Dominelli (1996, 1990) identified important elements for collaborative community social work practice as: 1) community care, 2) community development, 3) community organizing, 4) community class based organizing, 5) community race based organizing and 6) community gender based organizing. Other scholars incorporated diversity in their conceptualizations of practice to propose models of: 1) community development, 2) organization of organizations, 3) self-help and mutual aid and 4) organization of identity (Miller, Rein, & Levitt,1990).

In the early 21st century, community social workers may use traditional social planning models to support government mandates for the implementation of integrated service delivery systems (Poole, 1997; O'Looney, 1997, 1994; Weil & Dunlop, 1997; Alter & Hage, 1993; Zuckerman & Kaluzny, 1991). On the other hand, they may choose to carry out radical planning through social action projects that advocate for services for children and families in local communities (Tester, 1997; Mullaly, 1997; Weil & Gamble, 1995; Kretzmann & McNight, 1993; Alexander, 1992; Friedmann, 1987).

1.5.2.1 Social Work Expertise in Collaboration

While social work professionals claim expertise in interorganizational collaboration and social planning, there is little recognition among other disciplines of social work's contribution. As health and social service organizations are integrated at the local level, managerial roles are being filled by non-social workers from a variety of disciplines (Bickman,1996). More specifically, the nursing profession, drawing upon health promotion models, has strategically positioned itself for a predominant role in organizing local communities for system reform (Dunlop & Angell, 2001; Poole, 1997). In spite of its long history and expertise in organizing communities, this study of the HBHC Program affirms that social workers have not been assertive in creating a niche for themselves in the collaboration arena.

In this study, little recognition was found of the contributions social work has made to community planning and organizing. Although some leading public health scholars refer to Rothman's typology of community organization, they do not identify these concepts a originating from social work scholarship (Mitchell & Shortell, 2000; Minkler & Wallerstein, 1997; Labonte, 1997). Anecdotal evidence in this study of HBHC suggests that public health nurses interpret social work as clinical practice. While they did recognize the family assessment skills of social workers, they did not refer to either historical or contemporary community social work models.

1.5.2.2 In Search of a Niche for Social Work Practice

As governments mandate local collaboration to reduce duplication and increase efficiency in service systems, they provide fertile ground for social work approaches based on collective action. Local collaboration, as a mechanism of social policy implementation, is still an unfamiliar phenomenon for social workers. Social work's goal of social justice conflicts with state goals of efficiency and deficit reduction. Social work values and ethics that promote fairness in the distribution of societal resources are counter-productive to agendas of downsizing and dismantling of the social welfare state. The downloading agenda of government, while transferring power from national to provincial and local levels, has unwittingly created an opportunity for social workers to bring their community organizing, planning, inter-disciplinary and advocacy skills to the forefront. The social work profession, despite its proud history of community practice, has remained invisible to other disciplines as a leader in local collaboration.

1.5.3 Social Work Macro Practice in an Era of Downloading

1.5.3.1 Multi-Disciplinary Practice

Local collaboration as a mechanism of social policy has been identified across the multidisciplinary literature (Dunlop & Angell, 2001; Graham & Barter, 1999; Mandell, 1999; Nutbeam & Harris, 1995; Dunlop & Holosko, 1995; Labonte, 1994; Alter & Hage, 1993; Milio, 1988). Scholars have identified a range of issues that influence inter-professional collaboration: 1) the propensity for professionals to use joint planning to further their own self-interest, 2) the lack of cohesiveness between managerial level and direct

service level professionals, and 3) the use of experiments where initial suspicion gave way to inter-professional collaboration (Bella, 1996; Casto, 1994; Leathard, 1994; Ovretveit, 1993; McGrath, 1991).

Increasingly, however, the profession of social work has attempted to clarify its approach to interdisciplinary practice. As social work in the era of downloading is forced to respond to the restructuring of health and social services, the issue of multiskilling practice has been promoted. This approach, also called cross-training, is defined as an interpersonal process where members of different professions develop skills that are outside their original discipline through the process of working together (Rock, 2001).

In Canada social workers have, through their national association the Canadian Association of Social Work (CASW), identified their support for an interdisciplinary approach to service delivery system reform. However, they do not agree with the implementation of multiskilling (Shera, Meredith, Bogo, McDonald, & Michelski, 2000; CASW, 1998). Collaboration does not mean that one profession would replace another; rather it works well when it incorporates the differential expertise of multiple professions.

Multidisciplinary collaboration requires practice methods that bring together different disciplines at the community level and then incorporate their diverse perspectives into a common vision. This version of social work practice in the 21st century will draw on the skills of community organizing, negotiation, conflict resolution, outreach, cultural competency and boundary spanning (Dunlop & Angell, 2001; Lasker, Weiss, & Miller,

2001; Mizrahi & Rosenthal, 2001; Mitchell & Shortell, 2000, Bailey & McNally-Koney, 2000).

1.5.3.2 Social Planning Models: Rational & Radical

Social planning oriented to social needs is being challenged in the current era of downloading. Community social workers are engaged in planning under a variety of auspices, with ideological commitments ranging from conservative to radical. Social work practice within a rational-technical planning model assumes that existing institutions are capable of serving societal interests. Rational planning models use social planning and quantitative methods (Reilly, 1998; O'Looney, 1997, 1994; Rothman, 1996; Kaluzny, Zuckerman, & Ricketts, 1995; MacNair, 1993). Rational planning maintains the status quo by using "experts" to advise government and implement public policy (Friedmann,1987).

While rational planning models provide rules for systematic choice, increasingly planning activity is an interpretive process based in social, political and economic contexts (Alexander,1992). Advocacy planning assumes that there is an unequal distribution of power and resources. This model requires that planners advocate for the interests of those less powerful (Mullaly, 1997; Panet-Raymond & Mayer, 1997; Poole, 1997, 1995; Hyde, 1996; Alexander, 1992; Friedmann,1987). Social workers, as advocacy planners, challenge institutions by working with less powerful interests. Social workers, as potential leaders of collaboration, must understand the politics of planning. Collaborative planning among

organizations is a critical strategy for meeting the needs of children and families in the 21st century.

1.5.3.3 Potential for Social Work Leadership

State-mandated collaboration creates new opportunities for social workers to use their expertise in community organizing within a turbulent environment that demands competence and creativity. Collaboration in this era of downloading requires leadership that fosters trust and respect among disparate partners. New leadership competencies for collaboration identify the need to: 1) develop a common language to bridge gaps between different professions, 2) synthesize different and conflicting perspectives, 3) use creativity in creating alternatives and 4) identify ways to combine community resources (Dunlop & Angell, 2001; Lasker, Weiss, & Miller, 2001).

The social work profession should be recognized for its contribution of community practice theory to knowledge development in collaboration research. The development of social work leadership in community practice has been the subject of much debate within social work education. Recently, educators proposed a shift away from 1960's adversarial strategies to consensus-oriented strategies such as collective action, community building, and community empowerment to resurrect interest in community practice within social work educational institutions (Ryan, DeMasi, Heinz, Jacobson, & Ohmer, 2000).

1.5.3.4 The Practice of Boundary Spanning

Boundary spanning practice is attracting increasing attention as collaboratives are formed to respond to government strategies of decentralization and downloading (Dunlop &

Angell, 2001; Lasker, Weiss, & Miller, 2001; Mitchell & Shortell, 2000). Social workers, as boundary spanners, work on the boundaries between their organization and its environment. Usually they are not prepared for managing these interorganizational relationships. They must juggle commitments to their employers (where they have interpersonal and role attachments) and their collaborative network (where interpersonal and role attachments also exist). Boundary spanning roles are identified as the broker (building and maintaining a power base) and 2) the innovator (managing change and creative thinking) (Edwards & Yankey, 1991).

Boundary spanning is integral to social work practice with collaboratives. Collaboration requires management skills (e.g., negotiation and conflict resolution) to join diverse partners in local communities (Lasker, Weiss, & Miller, 2001; Mizrahi & Rosenthal, 2001; Mitchell & Shortell, 2000; Dunlop & Schopler, 1996). Collaborative mechanisms, used to respond to government strategies of downloading, hand over to social workers the opportunity to re-engage with their historical territory as leaders in community organization.

1.5.4. Summary of Social Work and Local Collaboration

The resurgence of interest in community organization heralds a critical turn for community social work practice in the 21st century. Increasingly, state mandates for collaboration are coupled with downloading of financial responsibility for services to local communities. Although social workers have the historical background and conceptual models to lead collaborative efforts, they are not at the forefront of collaboration for service

integration. By capitalizing on their professional knowledge and skill in community practice, social workers can play a major role in the complex challenges of meeting the needs of children and families. This study of the pre-conditions and processes of collaboration found no social workers employed as managers in the HBHC program in Ontario and no indication that public health managers in the HBHC program were aware of current or historical social work practice with communities.

There is little research on the ways that social workers with community practice skills can and should participate in developing the local collaborative processes associated with the era of downloading. The social work profession needs to promote community social work to respond to a rapidly changing practice environment where other disciplines have already staked their claim of competency.

1.6 Summary

This chapter examined the environmental pre-conditions and collaborative processes that influenced collaboration in the HBHC Program in Ontario and situated this exploration in a current context characterized by downloading. The conceptual framework for the study was developed from the theoretical and empirical research on interorganizational and collaboration theory (Table C.1.1). This study addressed the need for social work leadership in managing collaborative networks. Since there is little research on the contributions of community social work practice models to collaboration theory, this study is one attempt to find a niche for social work in an era of downloading and devolution.

Chapter 2 The Setting: Local Collaboration in Ontario

2.0 Introduction

The implementation of local collaboration in Ontario can be seen within the larger context of an era of downloading in Canada. The Canada Health and Social Transfer (CHST, 1996) reduced federal funds for health, post-secondary education and social assistance. In turn, the provincial government of Ontario cut social programs through downloading of financial responsibility to the municipal level. This changing health and social service environment is the context for local collaboration within HBHC.

The HBHC Program in Ontario is a prevention/early intervention initiative for children (0-6 years old) and families which includes: 1) universal screening, 2) public health nursing, 3) lay home visiting, 4) case management and 5) collaborative network development. The focus of the study is the mandatory collaborative network that must be constructed among local organizations that serve children in the target age group and their families. The HBHC Program uses local collaboration as the mechanism for co-ordinating and integrating services for children and families. Mandatory local collaboration in the HBHC Program has been carried out in an early 21st century Ontario characterized by a neo-conservative agenda of privatization, erosion of universal programs and limiting of services to specific populations.

The implementation of the HBHC Program in Ontario reflects new child and family policies that require mandatory collaboration for service integration at the community level. In 1997, to reform the child and family service system, the

Conservative government of Ontario created a new Office of Integrated Services for Children (OISC) within the Ministry of Health and Long Term Care.

At a *provincial level*, this agency (OISC) is responsible for the integration of children's services in the Ministry of Health and Long-Term Care, Ministry of Community and Social Services, Ministry of Education and Ministry of Training, Citizenship, Culture and Recreation. At a *local level,* the public health units/departments are responsible for implementing the HBHC Program and leading the development of local integrated service delivery systems for children and families. The Office of Integrated Services for Children was part of the "government's long-term commitment to strengthen and integrate children's services through partnerships at the community level" (Ontario Children's Secretariat, 1998).

As collaborative planning groups are increasingly used to implement social policy, the social work profession in Ontario can position itself to respond to system reform. The enactment of social work legislation in Ontario through the Social Work and Social Service Work Act, 1998 officially recognized the profession. Although social workers have a long history of organizing communities, they are not at the forefront of leading collaborative initiatives such as the HHBC Program. This lack of involvement may reflect that the scope of social work practice (e.g. individual, family, community, organization and policy) is not known by other disciplines or funders. Further, the Regulated Health Professions Act of Ontario which governs regulated professions excludes social workers thus marginalizing the profession within health system

restructuring. Social work legislation of 1998 offers the potential for social workers to strengthen their presence in the multidisciplinary arena of local collaboration in Ontario.

2.01 Ontario in an Era of Downloading

Whether in response to federal reductions in transfer payments or in response to neo-conservative agendas that attempt to stop state intervention in the free market system, neo-conservative rhetoric has become reality in Ontario. For forty-three years, (1942-1985), the Conservatives reigned in Ontario, bringing to the political arena a particular neo-conservative ideology that responded to Ontario voters' needs for efficiency in government and centrist economic and social policy (Rovinsky, 1999).

From 1985 to 1995, as neo-conservatism incubated, Ontario contended with globalization of the economy, the Canada-United States Free Trade Agreement and the recession of 1990-1992. In 1995, Ontario was ripe for the "Common Sense Revolution" of the Conservatives. By moving the party to the right, the Conservatives engaged the business community, who opposed the NDP government, and the North American Free Trade Act of 1994 (Ontario Progressive Conservative Party, 1995).

The Conservative government sensed a change in the culture as Ontario became increasingly individualistic and entrepreneurial (Jeffrey, 1999). The twenty-one per cent (21%) cut to social assistance in their first week of office revealed the Conservative government's neo-conservative agenda, reminiscent of the Poor Laws. The subsequent re-election of the Conservative government in 1999 showed that both neo-conservative

agendas and public opinion in Ontario supported cuts to health, education and social services.

In the late 1990's, the Conservative government of Ontario showed its commitment to downloading of financial responsibility to municipal governments and local communities. This was partly in response to the reduction of federal transfers to the province and partly in a response to neo-conservative agendas of reducing government support for citizens and increasing reliance on the private market. The Conservative government justified reduction in social provision with references to previous governments' overspending, high taxes and deficit financing.

In July of 1995, the Conservative government in Ontario planned to cut $1.884 billion from government expenditures, reduce taxes and deregulate to increase employment and balance the budget in five years (Government of Ontario, 1995). The fiscal measures were directed at low income people, with a twenty-one per cent (21 %) reduction in social assistance rates (Moscovitch, 1997). The province cut transfers to municipalities by twenty-two per cent (22%) in 1996-97. The total cut in provincial transfer of funds to municipalities was almost forty-three per cent (43%) over two years (1996-1998). The November, 1996 provincial Budget reduced provincial income tax by thirty per cent (30%) over a three year period (Moscovitch, 1997). Despite promised tax cuts, sixty-eight per cent (68%) of Ontarians believed that the government was moving too fast to implement its Common Sense Revolution (Mackie, 1997).

The Conservative government chose to restructure the health care system following the reduction in federal transfers. They also decided to decrease provincial taxes. The introduction of the Omnibus Bill (Bill 26, 1995) increased the power of the central government and facilitated reform of services and a neo-conservative agenda of privatization. Bill 26 (1995) gave sweeping powers to the Minister of Health to eliminate hospital boards and take over hospitals directly, to shut down, run, merge and determine services. In addition, the government reduced the number of District Health Councils (responsible for identification of local health needs and recommendations for resource allocations) from thirty-three county councils to sixteen regional units that had to recommend allocations for multiple geographical counties.

The First Minister's Meeting in February, 1999 negotiated more federal funding for health care. The 1999 Federal Budget announced a one time CHST supplement for Health Care of $3.5 billion (Government of Canada, 1999). This federal supplement may have encouraged Ontario to increase health spending. The 1999 Ontario Budget increased funding for Ontario's health care by $300 million (Government of Ontario, 1999).

In 1999, the HBHC Program changed from its original mandate in 1997 as a targeted screening program for high risk newborns. There were difficulties implementing the HBHC program as it was originally designed. Public health supported this shift to a universal program that would allow public health nurses to contact all new mothers and babies in Ontario. When this post-partum enhancement component was

added it shifted HBHC to a universal program that guarantees a phone call and follow-up visit for every new mother within 48 hours of discharge from hospital. This change in program reflects the rhetoric of child and family policy in Ontario that focuses on the Conservative government's promise to "provide families with greater opportunities to raise healthy, well-adjusted children" (Ontario Children's Secretariat, 1998).

Funding for the HBHC Program was $10 million annually in the first program year 1997-1998. In the 1998-1999 program year, funding was increased to $20 million annually. The allocation of this enhanced funding to public health units/departments is shown in Table C.2.1.

A post-partum enhancement component was added to the HBHC Program in the 1999 Ontario Budget with an additional $45 million to improve post-natal care for mothers and their newborns. Subsequently, the 2000 Ontario Budget increased program funding for HBHC to $67 million annually for the fiscal year 2000-2001. This increased funding for HBHC appears to reflect the Harris government's need to promote health services in order to take advantage of the federal government's 1999 budget which returned Canada Health and Social Transfer cuts to the provinces but specifically earmarked those funds for health care (Government of Canada, 1999).

Table C.2.1

Healthy Babies/ Healthy Children - Allocation of Enhanced Funding (1998-1999)

Public Health Unit	Base (1998/99)	Enhanced (1998/99	TOTAL
Algoma	$128,779	$103,442	$232,221
Brant	$100,813	$93,147	$193,960
Durham	$371,526	$235,950	$607,476
Elgin-St. Thomas	$58,935	$79,310	$138,245
Bruce-Grey	$99,9115	$105,085	$205,000
Haldimand-Norfolk	$69,863	$86,402	$156,265
Haliburton-Kawartha-Pine Ridge	$112,890	$112,024	$224,914
Halton	$212,197	$150,054	$362,251
Hamilton-Wentworth	$484,323	$280,385	$764,709
Hastings-Prince Edward	$122,331	$104,326	$226,657
Huron	$33,382	$67,564	$100,946
Kent-Chatham	$88,838	$89,323	$178,161
Kingston	$147,959	$110,037	$257,996
Lambton	$91,720	$90,276	$181,996
Leeds, Grenville, Lanark	$112,877	$103,068	$215,945
Middlesex-London	$360,804	$204,952	$565,756
Muskoka-Parry Sound	$55,650	$78,421	$134,071
Niagara	$302,127	$202,685	$504,812
North Bay	$77,075	$76,467	$153,542
Northwestern	$78,114	$99,888	$178,002
Ottawa-Carleton	$621,060	$314,240	$935,301
Oxford	$68,815	$83,925	$152,739
Peel	$783,265	$476,624	$1,259,888
Perth	$47,546	$72,198	$119,744
Peterborough	$91,951	$86,932	$178,883
Porcupine	$88,203	$97,056	$185,259
Renfrew	$70,141	$86,320	$156,461
Eastern Ontario	$153,035	$138,127	$291,162
Simcoe	$256,448	$186,846	$443,294
Sudbury	$168,021	$142,299	$310,320
Thunder Bay	$123,582	$112,495	$236,077
Timiskaming	$36,840	$62,882	$99,722
Waterloo	$331,133	$227,503	$558,636
Waterloo-Dufferin	$155,063	$126,927	$281,990
Windsor -Essex	$336,395	$204,059	$540,454
York Region	$397,950	$293,725	$691,675
Toronto	$3,160,438	$1,515,031	$4,675,469

Source: Children's Secretariat (1999)

The government also increased the budget for Children's Aid Societies and proposed to spend an additional $170 million for the period 1998-2001. Reform of child protection included: 1) a standardized risk assessment instrument, 2) training for child protection staff, 3) a child protection database, 4) hiring of additional front-line protection staff, 5) amendments to the Child and Family Services Act (CFSA, 1984) and, 6) increased rates for foster parents (Government of Ontario, 2000).

There is an apparent dissonance between neo-conservative agendas of downloading and resource reductions on the one hand and increased budgets for Children's Aid Societies and the HBHC program on the other. The rhetoric accompanying the HBHC program suggests that it is a universal family support program for all mothers with new babies, however the reality is that the program targets families at risk and uses state power to coerce "undeserving" parents into programs for "deserving" children. The Harris government has institutionalized a neo-conservative agenda with its restructuring of social welfare in Ontario through policies that target poor families and give government more control over their behaviour (Kitchen, 1997). A critical examination of child and family policies in Ontario suggests that while funding has been increased for particular childrens' services, this does not reflect a progressive government agenda. Rather, it is a return to a punitive set of policies that target families at risk and promote intrusive measures of social control. In addition to increased funding for Children's Aid Societies and HBHC, the Ontario government has also expanded

regulatory services through the reintroduction of mandatory home visits to social assistance recipients and a provincially sponsored toll-free welfare snitch line.

After the introduction of the Canada Health and Social Transfer (CHST, 1996), the Conservative government of Ontario used deficitism to shift costs to local municipalities. The Omnibus Bill 26 (1995) allowed the government to sidestep standard legislative procedures (Rovinsky, 1999; Jeffrey, 1999; Weinroth, 1997). Bill 26 has been called the "bully bill" because it violated parliamentary practice and eroded the democratic process (Jeffrey, 1999). This bill centralized decision-making on the reform of public services in Ontario and gave unprecedented power to individual ministers of government (e.g., the Minister of Health was given the right to release the confidential medical records of patients and to unilaterally tell hospitals what services they could provide) (Ontario Legislative Assembly, 1995).

The Conservative government agenda significantly altered the landscape of provincial and municipal relationships in funding, management and delivery of Ontario's social, community and health services. The Social Contract Act of the NDP government had attempted to rein in the so-called MUSH sector (municipalities, universities, school boards and hospitals). These agencies were the recipients of provincial grants and transfers, amounting to over thirty per cent of provincial expenditures over which the province had little control (Melchers, 1999). When the Conservatives defeated the NDP, they cut transfers and restructured municipalities, school boards and hospitals. The Provincial-Municipal Roles and Responsibilities framework provided a definitive

overview of the transfer of responsibilities for social, community and health services from the province to municipalities (Government of Ontario, 1998). The roles and responsibilities of provincial and municipal governments for public health are outlined in Appendix C. 2.A. Provincial authority for public health is legislated (Services Improvement Act, Health Protection and Promotion Act , Tobacco Control Act, Immunization of School Pupils Act, Municipal Act, Ontario Water Resources Act, Day Nurseries Act) and described in Mandatory Programs and Services Guidelines (Government of Ontario, 1997).

Historically, public health units/departments in Ontario were autonomous corporations or local Boards established under the Health Protection and Promotion Act of 1983. The province had funded 75 per cent of the cost of public health programs (exceptions were 100 per cent funding for HBHC, Immunization, Preschool Speech and Language, Speech and Audiology). In 1998, the government regulated public health but (with specific exceptions) did not fund it (Government of Ontario, 1998). A year later, the province announced they would pay 50 per cent of the cost of some mandatory public health programs (Government of Ontario, 1999). (See Table C.2 2).

2.1 Child and Family Policy in Ontario

2.1.1 Introduction

The era of downloading in Ontario shifts social provision, with the Conservative government's targeting of poor parents and children as a major theme in social welfare restructuring. Ontario was influenced by a variety of federal government policies

Table C.2.2.

Per Cent of Provincial Funding of Public Health Programs in Ontario (1997-1999)

PROGRAM	PRE-1998	1998	1999
GENERAL PUBLIC HEALTH PROGRAMS	75:25 Provincial/Municipal	100 % Municipal	50:50 Provincial/Municipal
SPECIFIC PUBLIC HEALTH PROGRAMS:			
1)Sexual Health	100% Provincial	100 % Municipal	50:50 Provincial/Municipal
2)Children in Need of Treatment (CINOT)	100 % Provincial	100 % Municipal	50:50 Provincial/Municipal
3)Public Health Research, Education and Development Program (PHRED)	100 % Provincial	100 % Provincial	50:50 Provincial/Municipal
4)Preschool Speech and Language(PSSL)	100 % Provincial	100 % Provincial	100 % Provincial
5)Speech and Audiology (S/A)	100 % Provincial	100 % Provincial	100% Provincial
6)Vaccines	100% Provincial	100 % Provincial	100% Provincial
7)Healthy Babies/ Healthy Children (HBHC)		100% Provincial	100 % Provincial

- Pre-1998 Funding for the City of Toronto was 40:60 Provincial/Municipal
- Source: Public Health Branch, Ministry of Health and Long-term Care, (2000)

such as the National Strategy on Healthy Child Development and the National Children's Agenda. Over the past decade, the Federal, Provincial and Territorial governments have committed themselves to various social policy initiatives designed to reduce child poverty. An overview of child and family policies and programs initiated during the last decade provides the national context for exploring the child and family policy in Ontario (Table C.2.3)

2.1.2. Federal Child and Family Policy Initiatives (1990's to 2001)

The United Nations International Year of the Child in 1989 focused interest in children at risk in Canada. The federal government ratified the United Nations Convention on the Rights of the Child and established a Children's Bureau within Health Canada to co-ordinate children's programs across federal government departments. In 1991 a federal report was released was to become the hallmark of the federal government's focus on child poverty during the next decade (Health Canada, 1991). During the period 1991-1997, the federal government initiated a number of national policies and programs that addressed the needs of children namely: 1) Brighter Futures: Canada's Action Plan for Children, 2) Community Action Programs for Children (CAP-C), 3) Aboriginal Head Start Program and 4) the Canada Pre-Natal Nutrition Program (CPNP) (Table C.2.3).

Table C.2.3
Chronology of Federal Child and Family Policy
(1989-2000)

DATE	EVENT
1989	United Nations International Year of the Child
1989	Members of House of Commons vote unanimously to eliminate child poverty by the year 1999
1990	World Summit for Children. Report: World Declaration on the Survival, Protection and Development of Children and Plan of Action.
1991	Canada Ratifies United Nations Convention on the Rights of the Child. Federal government established a Children's Bureau for follow up on Canada's follow up World Summit.
1991	Sub-committee on Poverty of the Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women: Report: Canada's Children: Investing in our Future (Ottawa)
1991	Campaign 2000 began as an cross Canada public education movement to build support for an end to child poverty
1991	The Federal government convenes the first National Expert Working Group to carry out consultation with provinces on discussion paper. A vision of Health for Children and Youth in Canada.
1992	Federal government announces: Brighter Futures. Canada's action plan for children.
1993	Federal government abolished Family Allowances Act (1945)
1995	Federal Government establishes Community Action Program for Children (CAP-C)
1995	Government of Canada establishes Aboriginal Head Start Programs
1995	Health Canada report outlines National Goals for Healthy Child and Youth Development: Report: Turning Points. Canadians from coast to coast set a new course for healthy child and youth development.
1996	National Longitudinal Survey of Children and Youth (Statistics Canada)
1996	Canada Health and Social Transfer (CHST) replaces Established Program Financing (EPF) and Canada Assistance Program (CAP) by establishing cash and tax transfers for health, post-secondary education and social assistance/services
1997	Federal government establishes Canadian Pre-Natal Nutrition Program. Managed jointly by Federal and provincial-territorial governments
1997	Federal government provides enforcement of new Federal Child Support Guidelines through Family Orders and Agreements

Table C.2.3
Chronology of Federal Child and Family Policy
(1989-2000)

1997	National Council of Welfare. Report: Healthy Parents, Healthy Babies
1997	Federal-Provincial-Territorial Council of Ministers on Social Policy Renewal: Report: 1) A National Children's Agenda - Developing a Shared Vision, 2) Supplementary Report: A National Children's Agenda - Measuring Child Well Being and Monitoring Progress
1997	Federal government announces National Children's Agenda (NCA). Responsibility given to Federal-Provincial-Territorial Council on Social Policy
1998	National Longitudinal Survey of Children and Youth (NLSCY). Data presented at "Investing in Children: A National Research Conference, 1998).
1998	Introduction of National Child Benefit by federal government. Funds provided in Canada Child Tax Benefit and Supplementary Benefits.
1998	Expansion of Aboriginal Head Start program to on-reserve First Nation's children and families
1999	National Children's Agenda Report: Developing a Shared Vision released by Federal-Provincial-Territorial Council on Social Policy
1999	Federal /Provincial Territorial Advisory on Population Health. Working Group on Healthy Child Development. Report: Investing in Early Child Development: The Health Sector Contribution.
2000	Federal government announces establishment of Five Centres of Excellence for Children's Well Being.

Sources:
Government of Canada (1999) Guide to Federal Programs and Services for Children and Youth
McMaster University Research Unit on Health and Social Service Utilization
Beauvais, C. and Jenson, J. (2001)
Jenson, J. and Thompson, S. (1999)
Government of Canada (1992) Brighter Futures. Canada's Action Plan for Children
National Council of Welfare (1997)
Statistics Canada (1996)

The government also proposed National Goals for Healthy Child and Youth Development (Federal, Provincial and Territorial Advisory Committee on Population Health, 1995)

In addition to federal initiatives, a national social movement to end child poverty began with Campaign 2000. In an all party resolution in the House of Commons on November 24th, 1989, the federal government expressed its intent to end child poverty by the year 2000. Campaign 2000, an intersectoral coalition of organizations across Canada was formed to respond to the lack of progress made by the federal government in its promises to end child poverty.

Despite some federal movement on children's issues, support decreased for children and families. In 1993, the federal government abolished the Family Allowance Act of 1945, ending one of the most popular universal programs developed during the World War II. In Ontario, despite economic growth, the decline in child poverty has been minimal. In 1989, one in 10 children lived in poverty; in 1999, one in six children lived in poverty (Campaign, 2000).

During the period 1997 to 2000, potentially beneficial child and family policies were initiated by the federal government. The pressures of the Federal-Provincial-Territorial Council of Ministers on Social Policy Renewal led to a new National Child Benefit System in the 1997 Federal Budget. This had three main objectives:
1) preventing and reducing poverty, 2) promoting workforce participation and 3) reducing overlap and duplication of child related benefits (Battle & Mendelson, 1997).

In addition, in 1997 the First Ministers identified the need for the federal government to make a commitment to early child development. In 1999, the government announced the National Children's Agenda, setting out actions needed to achieve four goals for children: 1) good health, 2) safety and security, 3) success at learning and 4) social engagement and learning (Federal Provincial Territorial Council on Social Policy Renewal, March, 1998). In 1999, the First Ministers committed to investing in child health (Federal/Provincial Territorial Advisory Committee on Population Health, Working Group on Healthy Child Development, September, 1999). In 2000, the federal government established five Centres of Excellence for Children's Well-Being, to address their needs and promote healthy child development.

2.1.3 Ontario Child and Family Policy Initiatives (1984 to 2001)

In 1988, under a Liberal government, a number of provincial initiatives addressed service delivery for children and families in Ontario (Table C.2.4). First, a comprehensive study of childhood disorders and service utilization was undertaken (Boyle & Offord, 1987). Second, a review of the social assistance system proposed 174 reforms (Government of Ontario, 1988). Third, in 1989, the provincial government created the Supports to Employment Program (STEP) (Moscovitch, 1997). Finally, in 1990 under the NDP government, the Ministry of Community and Social Services proposed a focus on: 1) children's entitlements, 2) shifting of responsibility for health and social services from provincial to municipal levels of government through

decentralization or devolution, and 3) increasing integration among provincial government ministries (Ministry of Community and Social Services, 1990)(Table C.2.4.)

A number of significant policy and programs developed over the next five years during the time of the NDP government (1990-1995)(See Table C.2.4). In 1990, Better Beginnings, Better Futures, an interministerial program between Health, Community and Social Services and Education, was implemented across eight communities in Ontario. In 1992, the Ministry of Health piloted a six year demonstration project, Best Start Community Action for Healthy Babies in two communities.

Several policy initiatives reflected the NDP government's focus on child and family policy. Within the Ministry of Community and Social Services, two more social assistance reform reports were produced. In 1993, the Working Group for Children of the Premier's Council on Health, Well Being and Social Justice identified a healthy child development policy as their priority. In May, 1994, the Children and Youth Project Steering Committee of the Premier's Council on Health, Well Being and Social Justice set directions for child and family policy in Ontario, including: 1) a population-based approach, 2) focus on measurable outcomes, 3) community responsibility, 4) focus on the determinants of health and 5) inter-ministerial links to foster community innovation (Offord & Knox, 1994).

During 1995, the federal government funded the Community Action Program for Children (CAPC) in seventy demonstration projects across the province of Ontario. After the election of the Conservative government in 1995, the provincial government,

Table C.2.4
Chronology of Child and Family Policy in Ontario
(1984-2001)

DATE	EVENT
1984	Child and Family Services Act, 1984
1985	Minority Liberal government elected in Ontario.
1987	Majority Liberal government elected in Ontario
1988	Ontario Child Health Study (Boyle & Offord, 1988)
1988	Transitions: Report of the Social Assistance Review Committee. Ministry of Community and Social Services
1988	Formation of Advisory Committee on Children's Services. Ministry of Community and Social Services.
1988	Investing in Children: New Directions in child treatment and child and family intervention. Ministry of Community and Social Services
1990	Majority New Democratic Party government elected in Ontario
1990	Children First. Report of the Advisory Committee on Children's Services. Ministry of Community and Social Services
1990	Better Beginnings, Better Futures. Funded in eight communities in Ontario chosen as high risk. Children involved will be monitored as part of a 25 year longitudinal study. Ontario Ministry of Community and Social Services.
1991	Back on Track. Advisory Group on New Social Assistance Legislation. Ministry of Community and Social Services, Toronto
1991	Premier's Council on Health, Well Being and Social Justice. Report of the Working Group on Children. Recommended priority for action: Development of a healthy child development policy.
1992	Best Start Community Action for Healthy Babies. Provincial Ministry of Health demonstration project focused on maternal-newborn health in two sites 1992-1998.
1992	Time for Action: Advisory Group on New Social Assistance Legislation. Ministry of Community and Social Services

Table C.2.4
Historical Chronology of Child and Family Policy in Ontario

1994	The Children &Youth Project Steering Committee of the Premier's Council on Health, Well Being and Social Justice. Yours, Mine and Ours (Offord, D. and Knox, M., 1994). Province of Ontario
1995	Conservative government elected in Ontario
1995	Federal Funding for Community Action program for Children (CAPC). Funding for 70 projects for high-risk families in Ontario.
1996	Ontario Child Mortality Task Force, established by the Office of the Coroner for the Province of Ontario, Ontario Association of Children's Aid Societies with support from the Ministry of Community and Social Services. Review of children who had died from January 1st 1994 to December 31st, 1995
1996	Pre-School Speech and Language Initiative. Government of Ontario
1997	Invest in Kids Foundation developed training programs: 1) Family Home Visitors (1997), 2) Post-partum nurse home visitors (1999) and 3) Intervention with High Risk Families (2000). Received $10 million dollar grant from Province of Ontario
1997	Federal Funding for Canada Pre-natal Nutrition Program. Funds Ontario community projects to improve birth outcomes through nutrition
1997	Making Services Work for People. A new framework for children and for people with developmental disabilities. Province announces lead role for the Ministry of Community and Social Services (COMSOC).Government of Ontario (April, 1997)
1997	Report: Ontario Child Mortality Task Force Report (July, 1997)
1997	Office of Integrated Services for Children established by the province of Ontario. Focus: Early intervention programs for children across four Ministries: Health, Community and Social Services, Education and Training and Citizenship, Culture and Recreation
1998	Proclamation of Ontario Works Act, a mandatory work for welfare program
1998	Expansion of Federal Aboriginal Head Start Program. Eight pre-school programs funded in Ontario
1998	Province of Ontario Announces funding over three years of 180 million to Children's Aid Societies:
1998	Province of Ontario established Ontario Children's Secretariat
1998	Province of Ontario Appoints First Minister Responsible for

Table C.2.4
Chronology of Child and Family Policy in Ontario

1999	Conservative government re-elected in Ontario.
1999	Learning, Earning and Parenting (L.E.A.P.). Mandatory Ontario Works program requiring teen mothers on welfare to stay in school and take parenting courses. Ministry of Community and Social Services
1999	Final Report: McCain, M.N. & Mustard, J.F. (1999) Early Year's Study: Reversing the Brain Drain. Ontario Children's Secretariat
1999	Amendments to the Child and Family Services Act (1984). Focus of amendments: Best interests of children must come first.
2000	Government of Ontario announces $20 million dollars for Four Point Plan for Children's Mental Health
2000	Ontario's Promise Government of Ontario announces 2 million dollars over three years. Goal to channel private sector charitable donations to public sector.
2001	Early Year's Challenge Fund Call for Proposals by Minister Responsible for Children. Early Year's Challenge fund Program Guidelines (May 29th, 2001).
2001	Ontario Children's Secretariat - Province of Ontario. Announce local planning process for Early Year's Centres across Ontario. Each local plan will be reviewed and approved by the Minister and Ministry Responsible for Children

Sources: Government of Ontario
McCain, M.N. & Mustard, J.F. (1999)
Ralph, D. (1997)
Johnson, L.C. & Barnhorst, D. (1991)
Ontario Children's Secretariat
McMaster University Research Unit on Health and Social Service Utilization
Health Canada
Beauvais, C & Jenson, J. (2001)

through the Ministry of Health, established the Pre-School Speech and Language Program in 1996. In addition, in 1996, the Ontario Child Mortality Task Force was established by the Conservative government to review the deaths of children in the province from January 1st, 1994 to December 31st, 1995.

The period 1996-2001, with the Conservatives in power, included significant steps toward provincial policies investing in children. The Conservative government responded to the Child Mortality Task Force (Office of the Chief Coroner of Ontario, 1997) which recommended targeting those "at risk". This was a major shift in child and family policy in Ontario and has been accompanied by major funding initiatives.

Conservative government reforms to local services for children and families included: 1) the HBHC Program which created local collaborative networks, 2) a child welfare reform initiative that includes a standardized risk assessment tool, training for child protection workers and a child protection computer data base, and 3) Early Years Challenge Fund and Early Years Centres.

An additional $11.3 million was designated for child protection with the addition of 185 workers and 39 supervisors. In 2001, additional funding of $123 million brought total spending for child protection to $772 million a year. Government initiatives in 1998 included an additional $2.5 million for child nutrition programs. The HBHC Program funding was $67 million annually for the fiscal year 2000-2001. The Early Years Challenge Fund was provided with $30 million annually by the provincial government with matching contributions required from local communities.

The political mechanism created to implement the government's child and family policy, with its focus on at risk families, is the Ontario Children's Secretariat. This assigns the Minister Responsible for Children a key role as the government's advocate for Ontario children. The principal functions of the Children's Secretariat are: 1) to work with other government ministries to develop a unified approach to provision of services and 2) to generate public awareness of supports available for children. The Children's Secretariat is an attempt to force separate bureaucracies dealing with children's services to plan together for service integration. It also gives the government a platform for informing the public of its commitment.

The HBHC Program in Ontario springs from a context of similar maternal and child health programs over the past thirty years. For example, the Montreal Diet Dispensary had a home visiting and nutritional supplement program for women with high risk pregnancies from 1963 to 1990. Similarly, the Healthiest Babies Possible Program of the Vancouver Health Department offered food supplementation and counseling to women with high risk pregnancies from 1977 to 1990. In addition, the Resource Mothers Program of Norfolk, Virginia is a similar example from the United States. Finally, the HBHC program was influenced by the Toronto's Healthiest Babies Program (Toronto Board of Health, 1997).

Funding for the HBHC Program, which screens all newborns born in hospitals in Ontario, had a commitment of $67 million dollars annually by 2000-01 (Table C.2.5). Established in 1997, HBHC screened all babies and targeted families for further

Table C.2.5
Healthy Babies/ Healthy Children Program History
(1997-2001)

DATE	EVENT
APRIL, 1997	Province of Ontario announces $10,000,000 million dollar Healthy Babies/ Healthy Children (HBHC) Program. Joint program of Ministry of Community and Social Services (COMSOC), Ministry of Health and Long Term Care (MHLTC). Local Health Units/Departments designated as lead agency for implementation of program.
JUNE, 1997	Implementation Working Group - Mandate to review the literature on screening and assessment tools and to make recommendations on HBHC Screening and Assessment Tools.
JULY, 1997	Public Health Research Education and Development Program (PHRED). Report of review of literature on definitions of "At Risk" and "High Risk" for the HBHC Program (Hanvey, L. and Stewart, P. 1997).
AUGUST , 1997	Toronto Board of Health. Report "Healthiest Babies Possible, June 1994 -June, 1996". Distributed report to all health units/departments in Ontario, MHLTC, COMSOC and the Office of Integrated Services for Children (OISC)
OCTOBER, 1997	Development of Implementation Guidelines for the HBHC Program
NOVEMBER, 1997	Implementation Working Group Report: Healthy Babies, Healthy Children Rationale for Screening and Assessment Tools. (Hanvey,1997)
DECEMBER, 1997	Evaluation Plan for Phase I - Reporting on activities and target group of the HBHC Program
JANUARY, 1998	HBHC Program begins
FEBRUARY, 1998	Introduction of HBHC Monitoring Report Template and Instructions for submission by local health units/departments
MAY, 1998	First Quarterly Monitoring Report on HBHC to be submitted
MAY, 1998	Phase II Guidelines for HBHC Program
MAY, 1998	Program Enhancement for HBHC: Increases of: 1) $10,000,000 in 1998/99; 2) $20,000,000 in 1999/2000;3) $10,000,000 in 2000/01
JULY, 1998	Interministry Working Group and Office of Integrated Services for Children. Background paper on HBHC Early Identification Process

Table C.2.5
Healthy Babies/ Healthy Children Program History
(1997-2001)

DATE	EVENT
MARCH, 1999	Implementation Guidelines for HBHC Post-partum Enhancement Component of HBHC Program - Universal support and access to all families following the birth of a child
MARCH, 1999	Integrated Services for Children Information System (ISCIS). Information Technology Plan
MAY-JUNE, 1999	Provincial Consultation on identification component of Healthy Child Monitoring System (6 weeks to 6 years)
JUNE, 1999	Development of ISCIS Stage 1A User Manual and Training Ministries of Health, Community and Social Services, Education, Citizenship, Culture and Recreation
APRIL, 2000	Implementation Guidelines for Early Identification Component of HBHC Program
APRIL, 2000	Announcement of $4,000,000 dollars for the evaluation of HBHC Program: (Applied Research Consultants and the Centre for Families, Work and Well-Being at the University of Guelph). Proposed Completion Date - April 2001.
JUNE, 2000	Announcement of Infant Hearing Program to be implemented by Health Units. Universal Infant Hearing Screening, Assessment and Communication Development.
SEPTEMBER, 2000	Implementation Guidelines for Pre-natal component of HBHC Program
DECEMBER, 2000	Pre-natal Implementation Report submitted to the Integrated Services for Children Division by December 31st, 2000
APRIL, 2001	Report to OISC on Service Integration from the System Linked Research Unit on Health and Social Service Utilization (McMaster University)
MAY, 2001	First Evaluation Report on the HBHC Program sent to local health units/departments for review and feedback
MAY, 2001	Development of Service Co-ordination Framework for HBHC Program

Sources: Office of Integrated Services for Children
Toronto Board of Health
Public Health Research Education and Development Program
McMaster University Research Unit on Health and Social Service Utilization

intervention on the basis of risk factors such as low birth weight, age of mother, congenital anomalies and family status. In 1999, a post partum enhancement component was added guaranteeing that every new mother in Ontario will receive a phone call and a follow-up visit from a public health nurse.

The program is still based on a screening and referral system for high risk families, but has shifted back to a universal public health visiting program to reduce stigmatization and facilitate access to high risk families. In 2000, a number of enhancements to the HBHC Program were announced including: 1) Early Identification (April, 2000) 2) Infant Hearing Screening (June, 2000), and 3) Pre-natal care (September, 2000) (Table C.2.5).

2.2 Public Health in Ontario

Local public health units/departments are organized into seven regions (See Table C.2 .6). Under the Health Protection and Promotion Act (HPPA) (RSO,1997), local Boards of Health must have elected Municipal and appointed Provincial representation, requiring one less Provincial Appointee than elected Municipal representative. Provincial representatives are usually appointed for a two year term which may be renewed once. Municipal representatives are usually appointed for the duration of their term in public office. Within regional government structures, local Departments of Health are required, under HPPA (1997), to have a public health sub-committee of regional council that is comprised of elected municipal representatives.

Table C.2.6

Public Health Units/Departments by Public Health Planning Regions

Health Planning Region	Public Health Unit
Central East	Regional Municipality of Durham Health Department Haliburton-Kawartha, Pine Ridge District Health Unit Peterborough County-City Health Unit Simcoe County District Health Unit York Regional Health Services Department
Central South	Brant County Health Unit The Regional Municipality of Haldimand-Norfolk Health Department Region of Hamilton-Wentworth Social Services and Public Health Services Division Regional Niagara Public Health Department
Central West	Halton Regional Health Department Regional Municipality of Peel Health Department Regional Municipality of Waterloo Community Health Department Wellington-Dufferin-Guelph Health Unit
East	Eastern Ontario Health Unit Hastings-Prince Edward Counties Health Unit Kingston, Frontenac and Lennox and Addington Health Unit Leeds, Grenville and Lanark District Health Unit Region of Ottawa-Carleton Health Department Renfrew County and District Health Unit
North	Algoma Health Unit Muskoka-Parry Sound Health Unit North Bay and District Health Unit Porcupine Health Unit Sudbury and District Health Unit Timiskaming Health Unit Thunder Bay District Health Unit
South West	Bruce, Grey, Owen Sound Health Unit Elgin-St. Thomas Health Unit Huron County Health Unit Chatham-Kent Health Unit Lambton Health Unit Middlesex-London Health Unit Oxford County Health Unit Perth District Health Unit Windsor-Essex County Health Unit
Toronto	Toronto Public Health

The Board delegates responsibility to administer the Mandatory Programs and Services (1997) to the Medical Officer of Health who is the Chief Executive Officer of the Health Unit/Department.

In 1983, the Health Protection and Promotion Act (HPPA) introduced fundamental changes to the public health nursing role in Ontario. This shifted a geographically based district practice to a program focused practice (Falk-Rafael, 1999). These changes created a population-based approach for public health nursing and a mandate for community development. Provincial guidelines during this period encouraged nurses to reduce or eliminate home visiting and to focus their work with community groups. In 1987, administrative and legal powers were given to the Chief Medical Officer of Health position in Ontario through restructuring of the Public Health Branch of the Ministry of Health. In the same year, the new Mandatory Programs and Services and Guidelines (1987) were instituted which effectively eliminated most maternal and child health home visiting programs. This history provided fertile ground for public health nurses' support for the Conservative government's HBHC Program.

2.3 The HBHC Program

2.3.1 Provincial Office of Integrated Services for Children (OISC)

In 1997, the Conservative government appointed the first Minister Responsible for Children and created the Children's Secretariat. The Office of Integrated Services for Children is within the Ministry of Health and Long Term Care. OISC is responsible for promoting the integration of children's services in the Ministries of Health and Long-

Term Care, Community and Social Services, Education and Training, Citizenship, Culture and Recreation (Appendix C.2.B). The Assistant Deputy Minister responsible for the Office of Integrated Services for Children reports to the individual deputy ministers of Health and Long-Term Care, Community and Social Services, Education and Training, Citizenship, Culture and Recreation. The OISC has as its priority the integration of health, education, recreation and social services for families at risk. The mechanism for carrying out this integration goal is to bring together the four ministries to improve local service co-ordination and integration at the community level.

The OISC has the lead role to: 1) integrate policy development for health, social services, recreation and education, 2) identify service delivery strategies that ensure integration and, 3) to ensure that funding facilitates local integration of children's services. In its lead role, it approves the annual budget and operating plans for HBHC sites and monitors evaluation.

The parallel provincial child welfare reform initiative rests within the Ministry of Community and Social Services. Little collaboration is evident between the Office of Integrated Services for Children and the Ministry of Community and Social Services on the risk assessment tools and integrated implementation. This lack of joint planning suggests unresolved inter-ministerial struggles and differing organizational perspectives on who should lead the reform of children's services. As a consequence, the two child and family system reform initiatives, HBHC and Child Protection, remain distinct tracks at both provincial and local levels.

The oversight role of reviewing and assessing the funding and accountability mechanisms for service integration (under HBHC) is the responsibility of the Office of Integrated Services for Children (OISC). This creates a new centralized accountability mechanism for public health, outside local municipal control.

2.3.2 Mandates and Unique Local Responses to Collaboration

The researcher addressed the implementation of the HBHC Program in Ontario as part of an internship. Program managers of five HBHC Programs were asked to describe how their communities had responded to the provincial mandate. This brief exploration suggested that those organizations who had collaborated previously on child and family initiatives found it easier to implement the HBHC program. Organizations in the community had approached the collaborative component in unique ways. Some engaged physicians as leaders in the collaborative and others used existing co-ordinating organizations as the structure for implementation of HBHC.

These unique local responses support the theoretical and practice literature on collaboration. This literature identifies conflicting opinions about whether collaboration is possible if it does not spring voluntarily from local stakeholders or whether it is possible to create some mediating influence when mandatory collaboration is imposed. The uniqueness of local community response is primary for some community researchers, while others insist that effective inter-organizational linkages can be created between centralized planners and local implementers. The need for conceptualization of

how mandatory collaboration is implemented is an emerging research problem that this study explored.

2.3.3 The HBHC Program Description

The HBHC Program is a joint prevention/early intervention initiative between the Ministry of Health and Long Term Care and the Ministry of Community and Social Services within the Office of Integrated Services for Children. It is designed for all families with children, prenatal to age six, who are considered at risk. The community-wide planning component requires that all local organizations that provide services to families and children (prenatal to age six) collaborate on an effective system of screening and early intervention (See Figure C.2.1).

The HBHC Program consists of: 1) a community collaborative with responsibility for the development of an integrated service delivery system for children and families; 2) a linkage component to connect children to appropriate supports and services in the community; 3) screening at birth to identify high risk families with children (prenatal to age six) through the use of the Parkyn Screening Tool (Appendix C.2.C), 4) lay home visiting and, 5) case management (Office of Integrated Services for Children, 1999).

Provincial guidelines require local health units/departments to lead the community implementation planning process for HBHC in partnership with area offices of the Ministry of Community and Social Services and other organizations that serve children and families.

HBHC Service System

Family

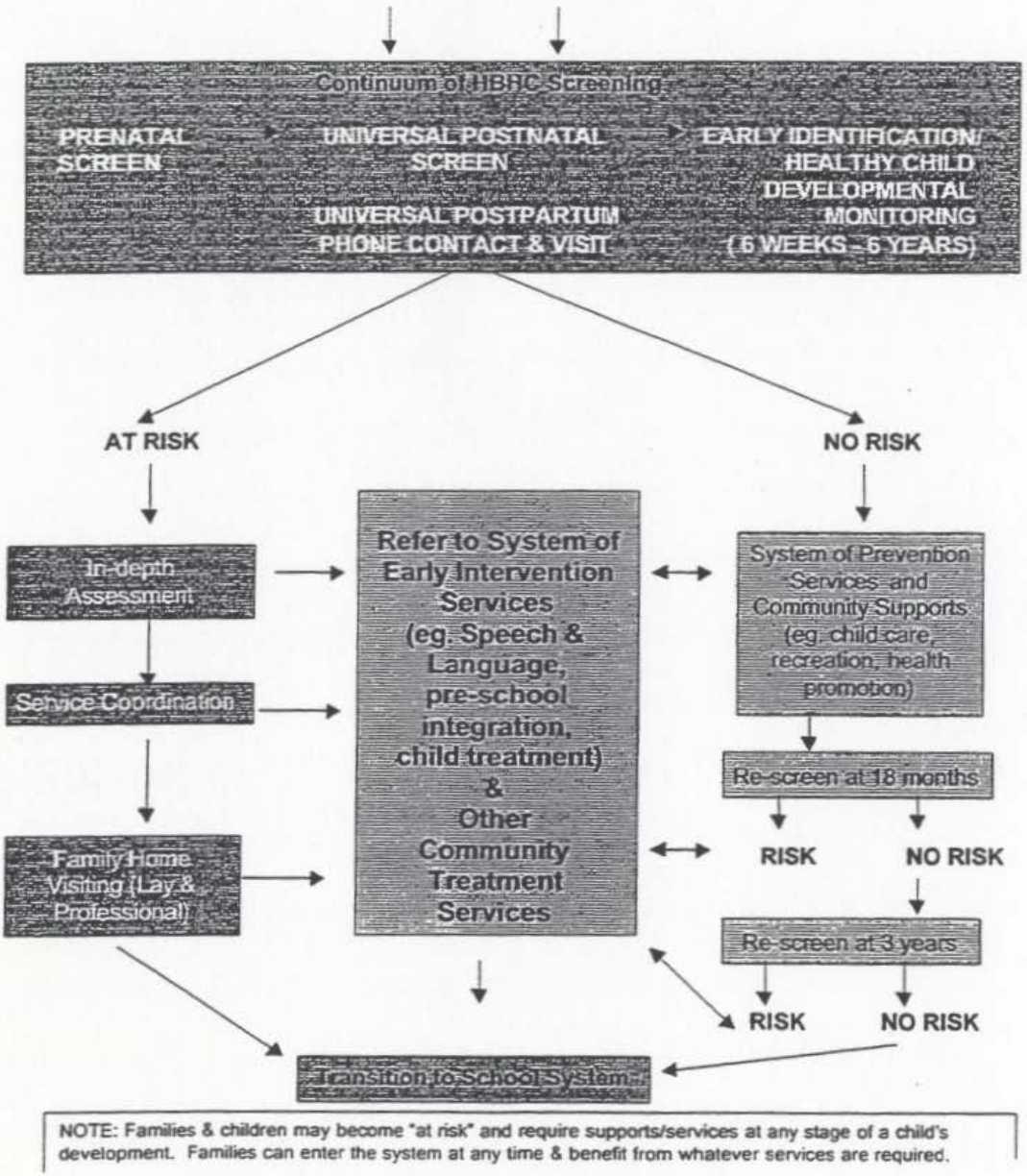


Figure C.2.1

2.3.4 Administration of the HBHC Program

Public health units/departments are responsible for planning and implementing the HBHC Program in accordance with provincial Guidelines. The specific demands of the HBHC program in the areas of evaluation, planning and responsibility for developing the collaborative network are too heavy to be added to the duties of the HBHC managers. The province did not fund the administrative costs of the program but expected health units to use municipal resources for administrative costs. In spite of increased allocations for HBHC from 1998-2001, local public health units/departments still have to take resources away from their other mandatory programs to cover administrative costs.

2.3.5 Provincial Evaluation of the HBHC Program

The provincial evaluation of HBHC Program began in January, 1998 and involved all health units/departments. Quarterly statistical reports on the activities and target group of the program were required. Provincial data includes all live births in the health unit catchment area including both those in hospitals and home births attended by midwives and physicians.

In the first phase of the evaluation, the Integrated Services for Children Information System (ISCIS) was initiated to: 1) centralize screening and assessment results to monitor babies/ families at risk, 2) track referrals, service delivery and linkages and, 3) aggregate HBHC program data for planning and evaluation. At the time of the completion of this study in 2002, ISCIS was being used in health units/departments across the province.

On April 1, 2000 the government announced a $4.4 million evaluation of the HBHC program to be completed by April, 2001. The process and outcome evaluation was carried out across the 37 public health unit/department areas in Ontario and examined the organization and delivery of the program, the network of service providers and the integration of prevention and early intervention services in each local community.

This evaluation provides information on: 1) the program's progress and outcome, 2) specific information on service improvements for local providers and 3) a framework for future evaluations. The primary focus of the evaluation is on program delivery outcomes and not on the collaborative network process. At the time of the acceptance of this thesis in 2002, the provincial evaluation of the HBHC Program had not been released by the Province of Ontario to the public and was not available.

This study of the HBHC Program takes a managerial orientation to the collaborative network and focuses on the perceptions of public health managers regarding factors that have influenced collaboration. The provincial evaluation addresses different research questions using different methodologies. The complementarity of the provincial evaluation and this research study will enhance understanding of the HBHC Program in Ontario.

2.3.6 HBHC and the Changing Context for Collaboration

A variety of opinions exist on why local collaboration is a priority in the downloading environment of early 21st century Ontario. One view is that mandated collaboration attempts to compensate for system failure (MacDonald, 1994). Despite a neo-conservative agenda that is shifting social provision in Ontario to a market based model, children represent a category of deserving poor, who, in the minds of most citizens, are entitled to public funds and a good start in life. The HBHC Program may also compensate for the Conservative government's early hospital discharge programs, with HBHC backing up short maternity stays in hospital.

The HBHC Program in its initial conceptualization was designed to identify high risk families in a non-stigmatizing way and to prevent child abuse through early intervention. However, screening of all newborns resulted in targeting at risk families for further intervention, shifting public health nursing away from a population based approach. The postpartum component which guarantees every mother and baby a follow-up visit was added in 2000 as a universalizing, non-stigmatizing early intervention component to encourage participation by high risk families. This approach also has the potential to follow up on risk factors that may be missed in the hospital screening. The guidelines for the HBHC program also suggest that it is an attempt to transfer responsibility for integration of the child and family service system to local communities.

This research study of the mandatory HBHC collaborative network explores the perceptions of public health managers about how environmental and interactional process factors have influenced local collaboration in this era of downloading in Ontario.

Local collaboration in Ontario has been shaped by changes in government funding. First, new provincial policy has mandated a primary leadership role for the Ministry of Health and Long Term Care and a secondary role to the Ministry of Community and Social Services. Second, the transfer of authority from provincial to local governments has been accompanied by funding cuts. Finally, there has been a shift to privatization of health and social services and the consequent creation of practice opportunities within the private sector. These are the trends at work in the province of Ontario where health system reform is a primary goal of government (Ontario Health Services Restructuring Commission, 2000).

2.3.7 Social Work Practice with HBHC Program

Public health units/departments throughout the province have few social workers. Most community development positions in health units are filled by Health Promotion Specialists with training in Health Promotion Studies or Health Education. This lack of social workers in public health (in the United States, public health social work is common) is a drawback in the current multiskilling environment with its focus on cross disciplinary fertilization of theories, models and skills. The Canadian Association of Social Workers is concerned that multiskilling is driven by economic considerations and is designed to deprofessionalize service (CASW, 1998). Multiskilling is seen as

weakening the unique contributions and practice skills of the social work profession.

It appears that fears about multiskilling and a lack of knowledge of community social work have worked against the inclusion of social workers in the collaboration environment that characterizes the public health system in Ontario.

Initiatives of the Ontario Association of Social Workers (OASW) provide further evidence of the professions' involvement with institutional health rather than community health. These include linkages with the Ontario Hospital Association, responses to the proposed legislation (Personal Health and Information Protection Act, 1997), membership on Ministry of Health and Long Term Care committees such as Health Card Validation and the development of common assessment instruments in Long Term Care.

The Ontario Association of Social Workers is addressing the erosion of social work leadership in health care through its Social Work in Health Care Committee. This focus on positioning social work within the health care system is being carried out in a province that increasingly appears, from an analysis of budgets, to define social work as a regulatory function limited to child welfare. Initiatives to declassify positions and contract out services and use para-professionals (in the HBHC Program) also mitigate against involvement of social workers.

Social work and public health appear to be operating in separate spheres and at opposite ends of the social welfare continuum, with public health carrying out the prevention/early intervention services and social work focused on treatment or tertiary services. The HBHC collaborative networks are based on legislation (Health Protection

and Promotion Act, 1997) and regulations (Government of Ontario, 1997) that give public health units/departments the mandate to lead collaboration for service integration at a local community level. Ontario views social work as having a social control function rather than doing prevention.

2.4. Social Work in an Era of Downloading

The resource reductions and downloading have a profound impact on social work practice and education. First, because those with health care training control collaboratives concerned with prevention, interdisciplinary work will become an important part of community organizing and planning. Second, service integration will require strengthened local governance and public support to increase local resources.

The HBHC Program is an example of state mandated collaboration that provides an opportunity for the social work profession to utilize its community organization, planning and advocacy skills. As local collaborative networks become responsible for planning and finding scarce resources to meet the needs of children and families, social work planning and advocacy skills will be critical to successful implementation.

Although the leadership for state mandated collaboration has been invested in public health managers, there are opportunities for community social workers to use their knowledge and skills in organizing, planning and administration. Social workers have, throughout their history, played a key role in planning for co-ordination of services and advocating for populations who are disadvantaged.

Social workers, as planners may use a rational planning approach to integrate health and social services or may use advocacy planning to challenge institutions by supporting local community collaboratives. Social workers should be acknowledged as leaders in collaboration based on their knowledge and skills of community organization, advocacy and social planning. What is troublesome is that, despite its proud history of community organization, planning and advocacy, the social work profession appears invisible in the leadership of collaboratives in Ontario.

Chapter 3 The Research Study

3.0 Introduction

This study examined the perceptions of public health managers about factors that influenced the implementation of local collaboration in the Healthy Babies/ Healthy Children (HBHC) Program. A qualitative study was designed to explore the development of mandatory local collaboration in the HBHC program across a sample of managers of the thirty-seven public health units/departments in Ontario. To define the aspects of interorganizational collaboration to be studied, the literature on interorganizational theory, collaboration theory, and community social work practice was reviewed. A conceptual framework was developed to guide the exploration of environmental pre-conditions and collaborative processes that influence interorganizational collaboration.

3.1 Design of the Study

This qualitative content analysis examines managers' perceptions of environmental pre-conditions and collaborative processes that influence collaboration in the HBHC Program. The data were collected through semi-structured telephone interviews with public health managers. An interview guide (see Appendix C.3.A.7) was developed with a combination of open-ended and focused questions based on dimensions of collaboration identified from the literature reviewed in Chapter 1. Respondents included a sample of twenty-two managers in the seven Public Health Planning Regions across Ontario.

Content analysis is a research method that utilizes a set of procedures to make valid inferences from a text. Carney (1972) explains that content analysis provides both a frame of reference and a method for asking an established set of questions of a body of text. The method is much like passing a soil sample through more and more discrete screens so that every part of the sample is exposed to the same analysis and similar patterns within the sample may be extracted (Carney, 1972).

Content analysis deals with written materials in the form of text. At the heart of this method are three critical steps: 1) developing content labels which derive from the theoretical questions of the research as a whole; 2) coding of the text and 3) interpreting the patterns found in the data. Generally accepted methods in content analysis include quantitative and qualitative methods and choice of the most effective method has to be appropriate to the required analysis. Qualitative content analysis in this study began with pre-determined categories derived from the theoretical literature on interorganizational relations and added code categories that emerged from the data.

Qualitative research methods have a wide application within the social sciences and humanities. The purpose of research utilizing these qualitative content methods is to investigate entirely different questions on alternative levels than those which is afforded through strictly quantitative methods. This research method makes researcher bias explicit. One of the limitations of this method is that the research results are not generalizable. Qualitative content analysis is the appropriate choice when the research goals are to identify and describe patterns in the data.

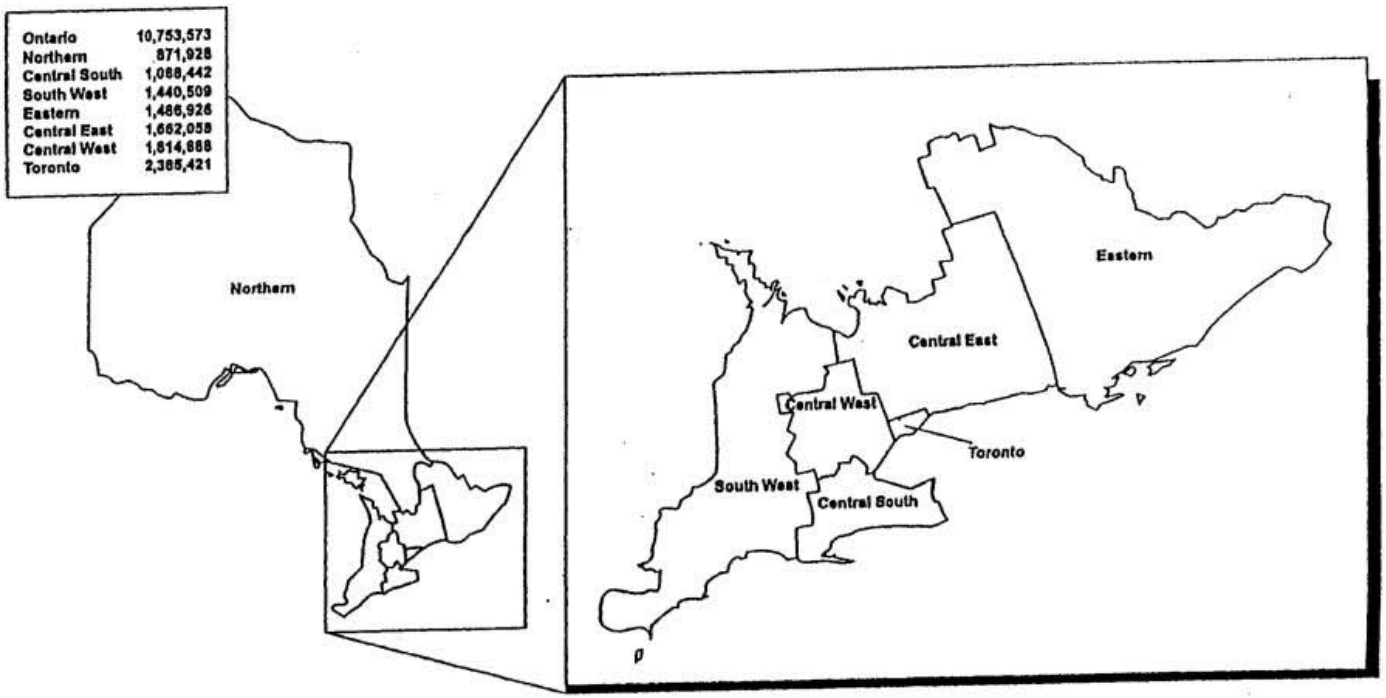
3.2 Setting and Population

3.2.1 Public Health Planning Regions

A sample of twenty-two public health managers were chosen because the provincial Ministry of Health and Long Term Care in Ontario mandated public health units/departments to take responsibility for the HBHC Program. This mandate assigns each public health unit/department a lead role in local development of collaboration for planning for integration of child and family services. The seven Public Health Planning Regions contain forty-two public health units/departments and sub-units as shown in (Figure C.3.1).

All public health units/departments are located in one of these seven Public Health Planning Regions (PHPR). A randomized fifty per cent plus one sample of these forty-two public health areas was drawn from each of the seven Public Health Planning Regions, creating a sample of twenty-two public health managers of HBHC. These managers became key informants because of their responsibility for developing the collaborative network in their geographical district.

Population of Ontario, 1996 — Seven Public Health Planning Regions



Source: 1996 Census, Statistics Canada

Figure C.3.1

Random selection of the health units/departments was utilized to minimize researcher bias and give each health unit/department within each region an equal chance of being selected. Although such randomization is more compatible with a quantitative rather than a qualitative methodology, the decision was made for political reasons, to address researcher bias and to promote trustworthiness (Padgett, 1998). Since the researcher was well known to a number of public health units in the province of Ontario, randomization of the sample reduced distortion the researcher might bring to the interview data. Politically, it addressed assumptions that only people known to the researcher had been included.

The random sample was drawn using an internet resource, Research Randomizer (http://www.randomizer.org/form.htm) which created a fifty per cent plus one sample of health units/departments in each region from the forty-two health unit/department codes that were submitted. The sample for this qualitative study was designed to balance the need for both breadth and depth in understanding the perceptions of managers about the factors that influence collaboration.

The sample is large enough to permit a thematic analysis based on the environmental pre-conditions and collaborative processes which have been shown in the conceptual framework to influence collaboration (Table C.1.1). On the other hand, the sample is small enough to allow for a deep exploration of the meaning of collaboration to public health managers and how the local context has shaped their experience. Each key informant was interviewed to determine perceptions of the factors that facilitated or

constrained collaboration, based on their position as convenors of the collaborative network. The public health managers were in the initial stages of developing government mandated collaborative networks for service integration during the period of this study (January 1, 1998 to June 30, 2001).

3.3 Study Methodology

Other methods considered for this study were key informant interviews with other community stakeholders involved in collaboration in each locality and/or a survey questionnaire to investigate collaboration in each community. In view of the stage of the collaborative initiative, the public health managers were identified as the most relevant stakeholders for this study. Although a survey questionnaire of public health managers was considered, telephone interviews allowed the researcher to explore in more depth the perceptions of collaboration with those responsible for its implementation. The decision to interview by telephone was based on cost factors such as the researcher's out of province location and the resources necessary to travel large geographical distances for personal interviews.

Data collection tools used for this exploratory study included: 1) Participant Profile Data Form (Appendix C.3.A.5), 2) HBHC Collaborative Network: Stakeholder Participation Checklist (Appendix C.3.A.6) and 3) telephone interviews with twenty-two public health managers of the HBHC Program in Ontario. The interview guide contained: 1) open ended (#'s 3-7) and 2) semi-structured questions developed from the conceptual framework for the study (#'s 8-22) (Appendix C.3.A.7).

3.3.1 Research Questions

The research questions address collaboration in two dimensions that are shown in the literature to influence collaboration: 1) environmental pre-conditions and 2) collaborative processes, asking: 1) What environmental preconditions do public health managers perceive facilitated and/or constrained local collaboration in their implementation of Healthy Babies/ Healthy Children? and 2) What collaborative processes do public health managers perceive facilitated and/or constrained local collaboration in their implementation of Healthy Babies/ Healthy Children? Possible factors were derived from theoretical frameworks in Chapter 2 that focus on the pre-conditions that motivate stakeholders to work together and the interactive processes that facilitate successful collaborative relationships at the local level. While no one theory has been established in the literature as the foundation for understanding collaboration, this study was based on assumptions that resource exchange and institutional theory offered the potential for understanding collaboration in an era of downloading.

Resource exchange theory based on concepts of exchange and interdependency was used to address the environmental pre-conditions that bring organizations together to secure additional resources in an era of downloading. Environmental pre-conditions such as: 1) the past history of collaboration, 2) mandatory/voluntary context of collaboration and 3) legitimacy of the convening organization, the experiences of public health

managers were used to interpret how environmental pre-conditions influenced adaptation to government mandates for local collaboration in the HBHC Program.

In addition to environmental pre-conditions, a number of collaborative process factors were utilized in this study. Institutional theory provided a perspective on how organizations may adapt to a change in their interorganizational environment, such as government mandates that require organizations to collaborate at a local level. Characterizations of the collaborative process that represent institutional responses to change in the interorganizational environment include factors such as: 1) how stakeholder representativeness influences collaboration, 2) how membership participation influences collaboration, 3) organizational costs and benefits for participation in collaborative ventures, 4) the ability of collaboratives to develop common goals, 5) decision-making and its influence on collaboration, 6) communication styles and collaboration, 7) how the informality or formality of linkages influences collaboration and 8) provision of resources and how they influence collaboration. The factors believed to influence collaboration were organized into a conceptual framework, and structured into an interview guide that asked public health managers about the environmental and collaborative process factors that influence collaboration in the HBHC Program. The key concepts for this study are defined on the following pages and are also part of the HBHC Research Protocol (Appendix C.3.A.).

3.3.2 Key Concepts in the Study

Terms	Definitions
Environmental Pre-conditions	Factors in the environment that act as incentives and disincentives for organizations to work together.
Previous Collaboration	The nature and type of past interpersonal and professional relationships in local communities and how these previous relationships influenced collaboration in the HBHC network.
Mandatory Collaboration	The nature and degree to which a formal government mandate affected collaboration in local HBHC networks.
Voluntary Collaboration	The nature and degree to which informal agreements, operations and relationships characterize collaboration in local HBHC networks.
Legitimacy as Lead Organization	The extent to which individuals and organizations agree that public health has the legitimacy and status as an organization to lead the implementation of the HBHC Program

Terms	Definitions
Collaborative Processes	The operational, organizational and relational processes that facilitate interorganizational collaboration.
Stakeholder Representation	A process of recruiting stakeholders who as individuals, organizations and community groups have an investment in and influence on the process and outcome of collaboration in the HBHC network.
Membership Participation	The nature and type of membership participation in the HBHC network. The identification of participation in the HBHC network as consumer/advocate, community or organizational representation.
Costs of Membership	The real or perceived negative effects of participation in the HBHC network that may accrue to individual members or their organizations or groups.
Benefits of Membership	The real or perceived positive advantages of participation in the HBHC network that may accrue to individual members or their organizations and groups.
Decision-making Influence	The stage, level and influence of decision making power that characterizes the HBHC network. The decision making stage of network development (advisory, planning, information sharing, joint resources). The decision making power of HBHC network members including indications of authority to make decisions for their organizations. The influence of decision-making power on collaboration in the HBHC network.

Terms	Definitions
Communication Style	The open or filtered nature of communication between local managers, the provincial government and local HBHC network members. Indications that managers share information openly with the provincial government and the local networks. Indications that managers filter the content, timing and target of their communications with the provincial government and the local network
Formality of Linkages	The degree of formalization of the operations of the local HBHC network (terms of reference, minutes, agendas, service agreements, bylaws). The degree of formalization of interorganizational relationships in the local HBHC network through the use of organizational structures (committees, sub-committees, working groups, umbrella organizations, multi-site networks, service co-ordination networks).
Informality of Linkages	The degree of informality of the operations and organizational structures of the local HBHC network that characterizes the local community (informal relationships, informal service co-ordination, no written agreements).
Common Purpose Development	The extent to which individual members of the collaborative have developed: 1) a voluntary consensus on their common mission and goals in the local HBHC network and 2) the extent to which government mandated goals have influenced the development of common mission and goals in the local HBHC network.
Sufficient Resources	The nature and extent of resources provided by the provincial government for the implementation of the HBHC Program in local communities. The impact of resource provision for HBHC on local public health organizations and local communities.

3.4 Methodological Issues

3.4.1 Consistency and Dependability of Results

In a qualitative study, the interpretation of data is dependent on the context. The interpretive lens should be made explicit through the use of reflective field journals which document the meaning of the data to the researcher. Guba and Lincoln (1994) suggest addressing dependability or consistency of results rather than reliability. A thick description "audit trail" is used to ensure dependable results by describing the context of the research, the subjective location of the researcher and the representation of meaning, thus making the research process transparent to the reader (Denzin, 1978). A detailed description of how the data were collected, how categories were derived and how decisions were made throughout the inquiry is included in this chapter. This commitment to a strong qualitative methodology should provide acceptable dependability and consistency.

3.4.2 Transparency in Research Process

Not all phenomena are accessible to the investigator's direct observation. Therefore, data must often be collected by asking people who have experienced certain phenomena to interpret and report their perceptions of the experience. This research study approached a sample from a population of individuals presumed to have undergone certain experiences and interviewed them concerning these experiences. An assumption was made that these public health managers, because of their strategic positions in the

Healthy Babies/ Healthy Children Program, were the most knowledgeable about pre-conditions and processes of local collaboration.

Two sets of field notes identified emotional or intellectual responses: 1) during the interview process and 2) after the interview was completed. During the interview process, I made notes on my own responses and my perceptions of managers' responses to each individual question. After the interview was completed, I noted my emotional/intellectual responses, the level of interaction between us during the interview, linkages to other interviews, thematic indicators and points to bring into subsequent interviews. Since I received the Participant Profile Data sheet prior to the interview, I knew the background of the manager. During the scheduling and/or the preliminary stages of the interview, most managers identified that they had some indirect or direct knowledge of my public health consulting in Ontario. I discussed with managers my social work practice experience, interest in maternal and child health and my internship with HBHC. I also indicated that I had reviewed the program documentation from 1998 to 2001. My field notes reflect that my public health background and internship with HBHC encouraged managers to discuss the program. I assumed that this background and knowledge was responsible for the 100 per cent response of the sample to my interview request. My perception is that it created some measure of trust and facilitated the interview process itself. Managers were interested that I was a Canadian (Ontarian) who was currently working in the United States. I reflected in my field notes that my out of

country status increased managers' efforts to share information to "help" me understand what was going on "at home" (in Ontario).

The field notes reflect that my being a social worker did not seem to inhibit the discussion of HBHC. Some managers stated that public health needed to hire social workers to carry out family assessments. I noted that managers were generally unaware of community social work practice but perceived that HBHC needed clinical social work assessment and intervention skills.

These two sets of field process notes:1) during and 2) after the interview were then used to analyse my responses to each interview and to plan for subsequent interviews. The field notes identified areas for further exploration in subsequent interviews (e.g., Early Years was not part of the first interview but was added to subsequent interviews). The field notes also tracked how the researcher's knowledge of the theoretical literature on collaboration and experience with public health consulting in the specific geographical location of the interview shaped interpretations of the data.

The field notes revealed elements of my bias as a social worker. I reflected on how my views about collaboration were influenced by past experience. As an experienced community social worker, I assumed that nurse managers would bring an administrative perspective to the implementation of the HBHC program but would be uncomfortable with the community organization skills needed to develop local partnerships. This bias was confronted when managers in this study revealed their

interest and expertise in community organization (this was unexpected and based on my erroneous assumptions).

As a practitioner, I wanted to understand how local collaboratives are formed and how they work together to plan for system reform. I undertook this research because I was concerned that social workers, with a long history of community planning, did not seem to be bringing their social planning knowledge and experience into the health and social service reform environment in an era of downloading. In the field notes, I noted that the research had forced me to examine my bias that social workers should have the leadership role in building collaborative networks because of our historical and theoretical experience with community organization.

In addition, since the literature on collaboration was in its initial stages, I wanted to explore collaboration in the Canadian context and to document an example of mandatory collaboration for service integration in child and family services. After twenty years of community social work practice with voluntary collaboration, my assumptions about mandatory collaboration were untested. The research literature on collaboration failed to provide guidance on mandatory collaboration. The embryonic nature of the literature provided me with an opportunity to explore this new area, that of mandatory collaboration.

The field notes reflect my perception that little was hidden during the interviews especially in those instances where the researcher had been known directly or indirectly since 1986 as a public health consultant working in the province of Ontario. It was

important to make visible within the research process why I was interested in this aspect of HBHC, how previous experience with the program and with community collaboration influenced the study and how the development of the theoretical framework influenced the research process. In the interview, the respondents and I discussed: 1) our mutual interest in maternal and child health, 2) our past history of working in health and social services in Ontario and 3) our past knowledge and/or experience working in the same communities. In addition, we talked about health and social service professionals that we both knew in common. We also discussed: 1) my HBHC internship experience, 2) the difficulty of accessing information from government websites while in the United States and 3) how geographical distance from Ontario had shaped my interpretations of the program over the two years I had been out of the province (1999-2001).

3.5 Limitations of the Methodology

This qualitative study has strengths and weaknesses. It does allow for theoretical development and recognizes the inter-subjective and reflexive nature of the qualitative research process. This study fits within the constructivist paradigm wherein the subjectivity of the researcher is made explicit and the construction of meaning is co-created through a dialogical relationship between researcher and respondent. Results from this study cannot be generalized to other settings, but provide some insights into collaboration among human service organizations in Ontario. These insights enhance knowledge of how one example of mandatory collaboration was implemented and may (subsequently) increase understanding of collaboration in other contexts.

Interpretations of the implementation of local collaboration were limited to only one set of stakeholders (public health managers). This does not take into account either the consumer perspective and/or the opinions of other local stakeholders (e.g., hospitals, physicians, Children's Aid Societies or Infant Development Programs. The inclusion of other members of the local HBHC network would expand the data beyond an individual managerial level. The recognition that the public health mandate was central justified interviews with public health managers alone. Future research on collaboration in the HBHC Program would address this limitation and explore the experiences of a variety of stakeholders in the local collaboratives.

3.5.1 Advantages and Disadvantages of Data Collection Method

3.5.1.1 Advantages

The personal interview is an interpersonal role situation in which an interviewer asks questions designed to elicit answers pertinent to the research questions. The semi-structured interviews in this study involved previously identified managers of HBHC and proceeded on the basis of an interview guide specifying topics related to the research questions.

The advantages of the telephone interview were its flexibility in allowing the researcher to enter into a dialogue with HBHC managers to access their perceptions on the meaning of local collaboration in the HBHC Program. In this study there was a 100 per cent response to requests for the telephone interviews with managers. In most instances, the

respondents appeared comfortable in the interview, supplied supplementary information and joined with the researcher in a conversation about collaboration.

3.5.1.2 Disadvantages

Disadvantages associated with the use of personal interviews are its higher cost as the researcher must carry out in-depth interviews either face to face or over the telephone, creating a large base of information and using a great deal of time in collecting the data. The weakness of this form of data collection is the risk that interviewer bias will influence the respondents and change their reporting based on what they believe the interviewer may or may not be looking for from their experience. In this study, given the richness of the data obtained, it appeared that the telephone relationship was comfortable for managers, but I was aware that I was only hearing their own perceptions and they may have wanted to present themselves as favourably as possible. I reflected on this bias in the reporting of managers and noted that other stakeholders in the community may have had a different (less positive) point of view on the implementation of the network. There is an inherent bias in gathering data on from only one source. However, the use of field process notes both during and following the interview assisted the researcher in her attempts to uncover bias (either on the part of the managers or the researcher) that could influence the interpretation of the results.

The disadvantages in telephone interviews such as those conducted in this study are the loss of non-verbal information and visual cues. It was impossible to observe whether the respondent was carrying out other tasks while being interviewed or what the non-verbal

responses may have been to the researcher's responses or probes for more information. My perception is that managers were generally willing to share information because I was geographically distant and because the telephone provided some level of anonymity for them. Participants may have been reticent to share information that they thought if reported might identify them or their public health unit/department (I turned off the tape recorder when they asked that things be considered off the record and marked my notes accordingly to reflect our agreement about the confidentiality of the information they had shared). Although confidentiality and privacy have been addressed in the research protocol, the lack of anonymity present in the personal interview was a concern. Although telephone interviews are not the preferred method for most qualitative research, in this study they did not appear to overly constrain the discussion.

3.5.2 Other Methods Considered for the Study

Mailed survey questionnaires are a relatively low-cost tool. The greater anonymity reduces biasing error, and allows the respondents to give a considered answer to the question and to consult others on responses. Cost efficiencies allow greater accessibility to a larger number of respondents. This method was not selected for this study because of the following disadvantages. The survey method requires simple questions and offers no opportunity for probing. Supplementary data could be lost. As well, the researcher has no control over who fills out the questionnaire and cannot control for the effects of differential respondents. Surveys are also known for their low response rates. This weakness could result in an inadequate data base.

One of the factors identified in the literature, as a weakness of the survey method is participants' concern with the sponsorship of the research and how this may affect respondents. Given that the HBHC Program was being evaluated by the OISC, using a variety of quantitative and qualitative methods, a decision was made that the collection of data through personal interviews would allow the researcher to explain the differences between this independent outside research being conducted for the Ph.D. thesis and the evaluation research conducted by the Office of Integrated Services for Children. Other research on response rates has suggested that without an inducement to respond (such as being given a copy of the report or believing that the research will be helpful in the future), the negative aspects of responding may discourage responses. This research protocol sets out clearly the benefits of participation and offers the participants a summary of the findings from the completed study.

3.6 Procedures for Conducting the Study

The procedures to insure the ethical conduct of this research are outlined in the HBHC Research Protocol (Appendix C.3.A.). This addressed the:1) Harms and Benefits, 2) Free and Informed Consent and 3) Privacy and Confidentiality sections contained within the Tri-Council Policy Statement (1998) issued by the National Council on Ethics in Human Research (NCEHR). This Protocol was approved by the Interdisciplinary Human Subjects Review Committee of Memorial University of Newfoundland.

3.7 Pre-test of Proposed HBHC Interview Guide (Appendix C.3.A.7)

Two pre-test telephone interviews were conducted in July, 2000 with former

public health managers who had been responsible for the collaborative network in the HBHC Program. One manager had left the program six weeks before the pre-test interview and the other had returned from secondment. All research tools, (Introductory Letter, the HBHC Study Information Sheet, the HBHC Study Consent Form, the Participant Profile Sheet and the Collaborative Network Stakeholder Participation Checklist) were reviewed in the pre-test and changes were made to make them more user friendly.

The introductory letter was shortened and a new Information Sheet for managers was developed. The introductory letter was amended to identify that OISC would have no access to the raw data and was not sponsoring the research. This addition clarified the differences between this study and the provincial evaluation research. As well, the Introductory Letter now included a promise to send them key findings from the study as a continuation of the potential benefits of participation to public health units/departments in Ontario. The need for a witness on the Consent Form was deleted as unnecessary and potentially inhibiting to participation The Participant Profile Data sheet discussed the teaching health unit/department (PHRED Program) which was under review by Ontario government but since the question was peripheral and controversial, it was eliminated. The federal Community Action Programs (CAPC) and Pre-natal Nutrition Programs (CPNP) were added to the HBHC Network Stakeholder Participation Checklist. The Ministry of Community and Social Services was also added. Other alterations

included changing terminology to reflect common usage in Ontario. The Pre-test also suggested that these forms should be returned before the interview to save time.

This Pre-test confirmed that the interview questions were clear and easy to answer. To clarify the unit of analysis, the term "HBHC"collaborative network was used throughout since potential respondents are involved in a number of other collaborative activities in HBHC (i.e, Working Group, Case Management Program). The idea of "costs" of collaboration was clarified to help managers understand this referred to more than financial costs.

3.8 Interviews with HBHC Managers

A sample of twenty-two public health managers from the seven Public Health Planning Regions in Ontario was interviewed for this study. The length of the interviews ranged from 45 minutes to 3 hours. All of the twenty-two managers identified in the sample participated in the study. There were no substitutions and no managers declined to be interviewed (a 100 per cent response rate). All the twenty-two managers returned the Participant Profile Data Form, the HBHC Collaborative Network: Stakeholder Participation Checklist, and the Informed Consent Form before the interview was conducted. The interviews were conducted during January (16th, 18th, 19th, 22nd, 25th, 26th), February (2nd, 6th, 7th, 9th, 12th, 19th, 27th),March (2nd, 28th), May (23rd, 25th) and June (5th and 6th) of 2001. The researcher, to protect the confidentiality of the managers, transcribed the audiotapes herself.

After the interview was completed, a second set of field notes were made that

identified: 1) new information about the HBHC Program itself or developments in services in Ontario that respondents had shared during the interview, 2) perceptions about the interview questions (e.g. which questions seemed of most/least interest to managers), 3) reflections on "surprises" that the researcher experienced during the interview (e.g. managers were more community focused than the researcher had expected), 4) the researcher's responses to the openness that characterized the interview process (e.g. requests that comments be on/off the record), 5) reflections on the process of the interview (e.g. whether the respondent wanted to follow the interview guide in a formal or informal way) and 6) reflections on new information that needed attention in subsequent interviews (e.g. Early Years Initiative).

Managers were very interested in participating and despite busy schedules were available for interviews during the scheduled times (some of which were conducted after hours in the early evening). Some managers commented that they wished the OISC evaluation had addressed the questions in this study. Most managers reported that they appreciated the opportunity to share their views on the HBHC Program.

The field notes reflect two instances where managers seemed less willing to share their views. My interpretation was that time pressures and/or lack of knowledge of and trust in the researcher led to interviews that were less conversational and more structured. There was little encouragement for the researcher to comment or ask further questions. I listened very carefully to the tone of voice, manner of responding and any questions that were asked about the interview guide. I reflected on my responses to these interviews

and compared them to the others, noting the differences in receptivity to the researcher, managerial style, formality/informality and willingness to share information.

3.9 Description of the HBHC Managers

Data on the HBHC Program managers were gathered using the Participant Profile Data Sheet (Appendix C.3.A.5). The data on stakeholder participation was gathered using the HBHC Collaborative Network: Stakeholder Participation Checklist (Appendix C.3.A.6) and is reported in Chapter 5.

Data were gathered on several aspects of the HBHC program managers' education, experience and organizational responsibility using the Participant Profile Data Sheet (Appendix C.3.A.5). Participants provided information on: a) years of public health nursing, management and community collaboration experience, b) the official title in their organization that signified responsibility for HBHC, c) their professional degrees and d) any community development training.

3 9.1 Nursing, Management and Community Experience

As shown in Figure C.3.2, the mean number of years of public health nursing experience among participants was 8.78 with a range from one to 21 years. The mean number of years of public health management experience was 6.35 with a range from .58 to 16 years. Management experience with the HBHC Program ranged from .58 to 4 years with a mean of 2.46 years. Participants were also asked to report on their experience with collaboration either as a leader or member of a community group. Managers reported a range from 1 to 14 years with a mean of 6.43 years of experience

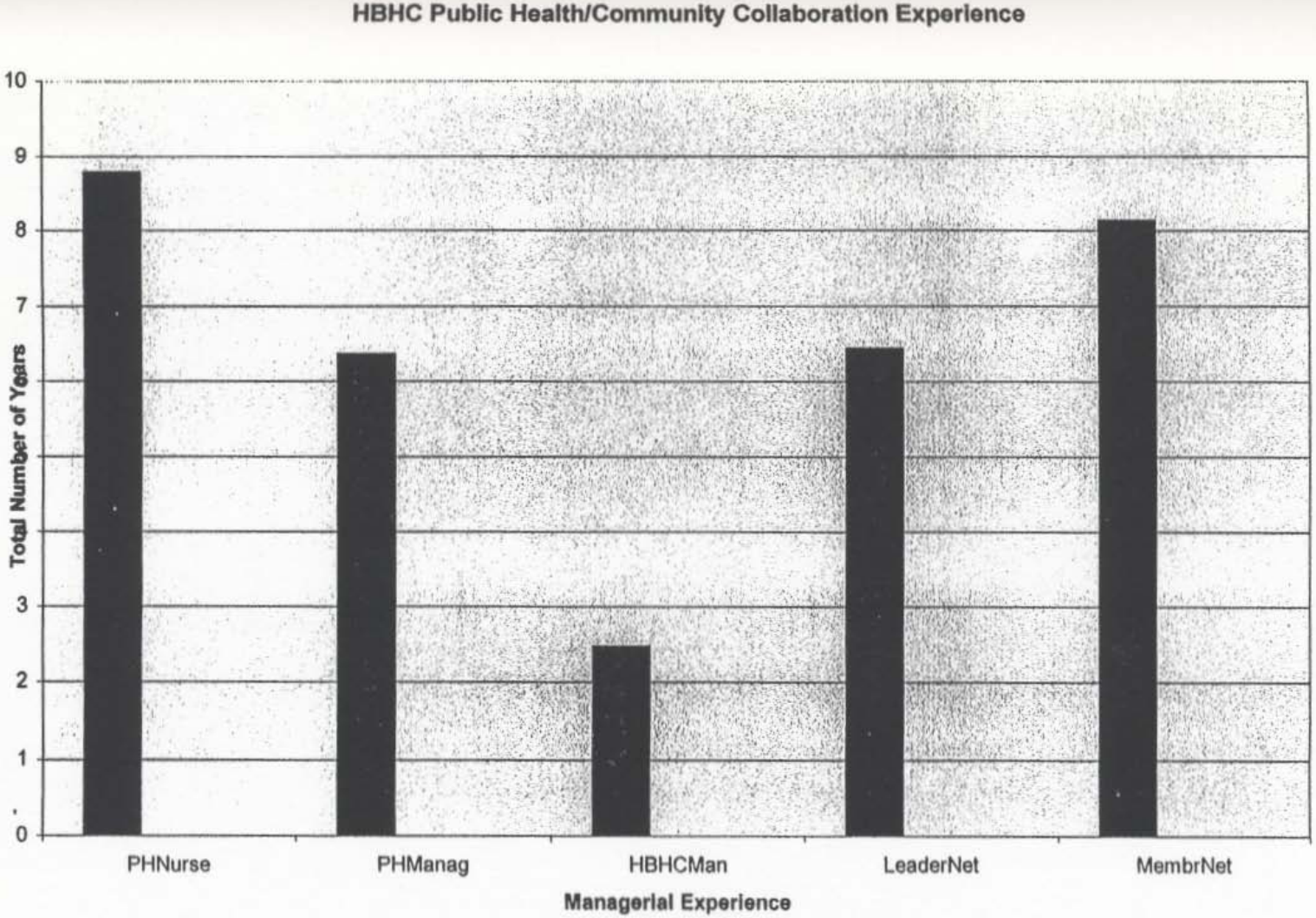

HBHC Public Health/Community Collaboration Experience
10
9
8
7
6
5
4
3
2
1
-
0
Total Number of Years
PHNurse
PHManag
HBHCMan
LeaderNet
MembrNet
Managerial Experience

Figure C.3.2

leading community collaboration (Figure C.3.2). Managers' experience in a community collaborative group was reported to range from 1 to 20 years with a mean of 8.12 years of membership. Although the range of experience of managers was broad (from 1 to 14 years), most managers had been in management prior to the HBHC Program (an average of eight years). This management experience can be assumed to have influenced their approach to their role in implementing the HBHC Program.

3.9.2 Official Title

Fifty-five per cent (55%) of HBHC managers reported "Manager" as their official title in the organization. Twenty-two per cent (22%) of the management responsibility for the HBHC program was carried out by participants who had the title of "Director" in their organization. Seventeen per cent (17%) of HBHC managers were called "Co-ordinators" in their organization and eight per cent (8%) of managers had the title of "Supervisor" (See Figure 3.3.).

3.9.3 Professional Degree

As shown in Figure C.3.4, managers reported a variety of degree types. Forty-five per cent (45%) of HBHC managers had a Bachelor of Science in Nursing, thirteen per cent (13%) reported another undergraduate degree (e.g. one manager had a Bachelor of Social Work). For those with graduate degrees, eighteen per cent (18%) of managers had a Master of Science in Nursing. Eighteen per cent (18%) of managers reported another graduate degree (e.g. Master of Education). Eleven per cent (11%) of nursing managers had other qualifications such as R.N. and Diplomas in Public Health Nursing.

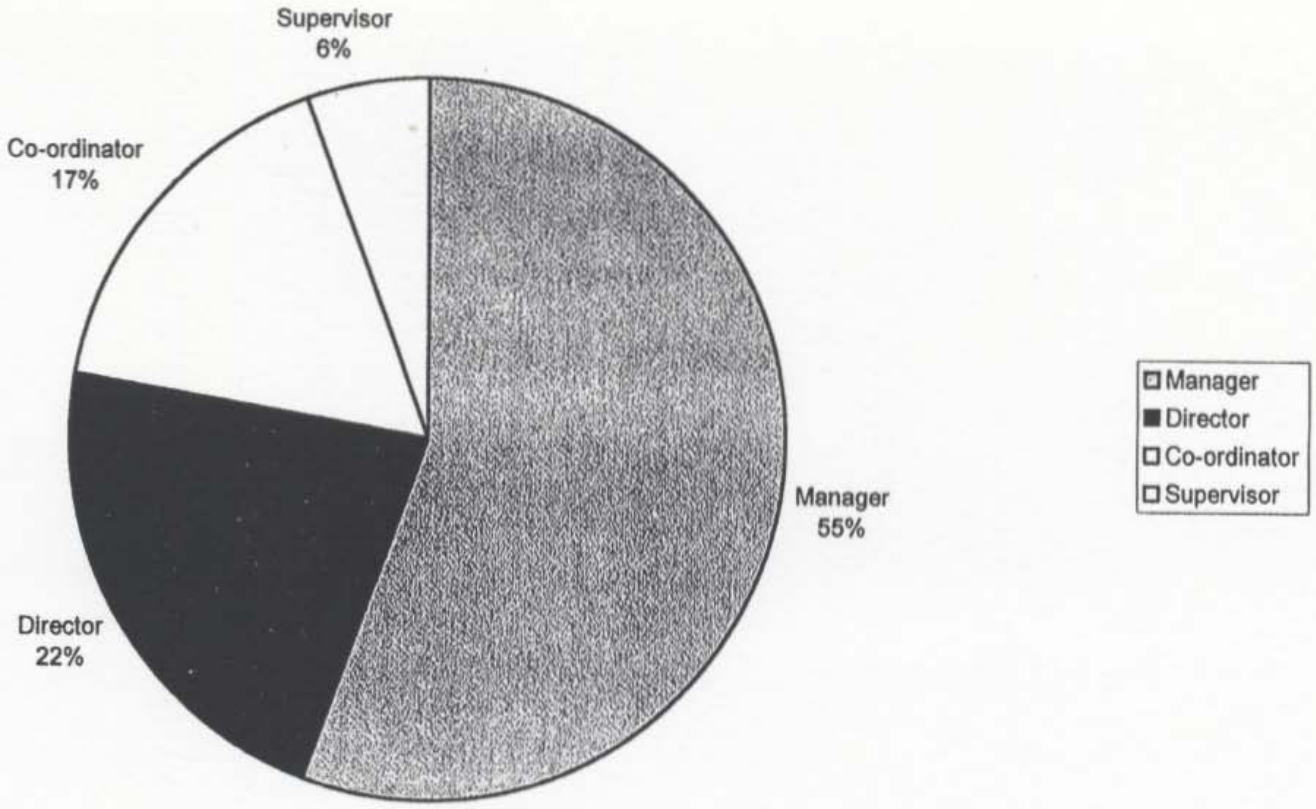

HBHC Responsibility by Official Title
Supervisor
6%
Co-ordinator
17%
Director
22%
Manager
55%
Manager
Director
Co-ordinator
Supervisor

Figure C.3.3

HBHC Managers Professional Degree by Type

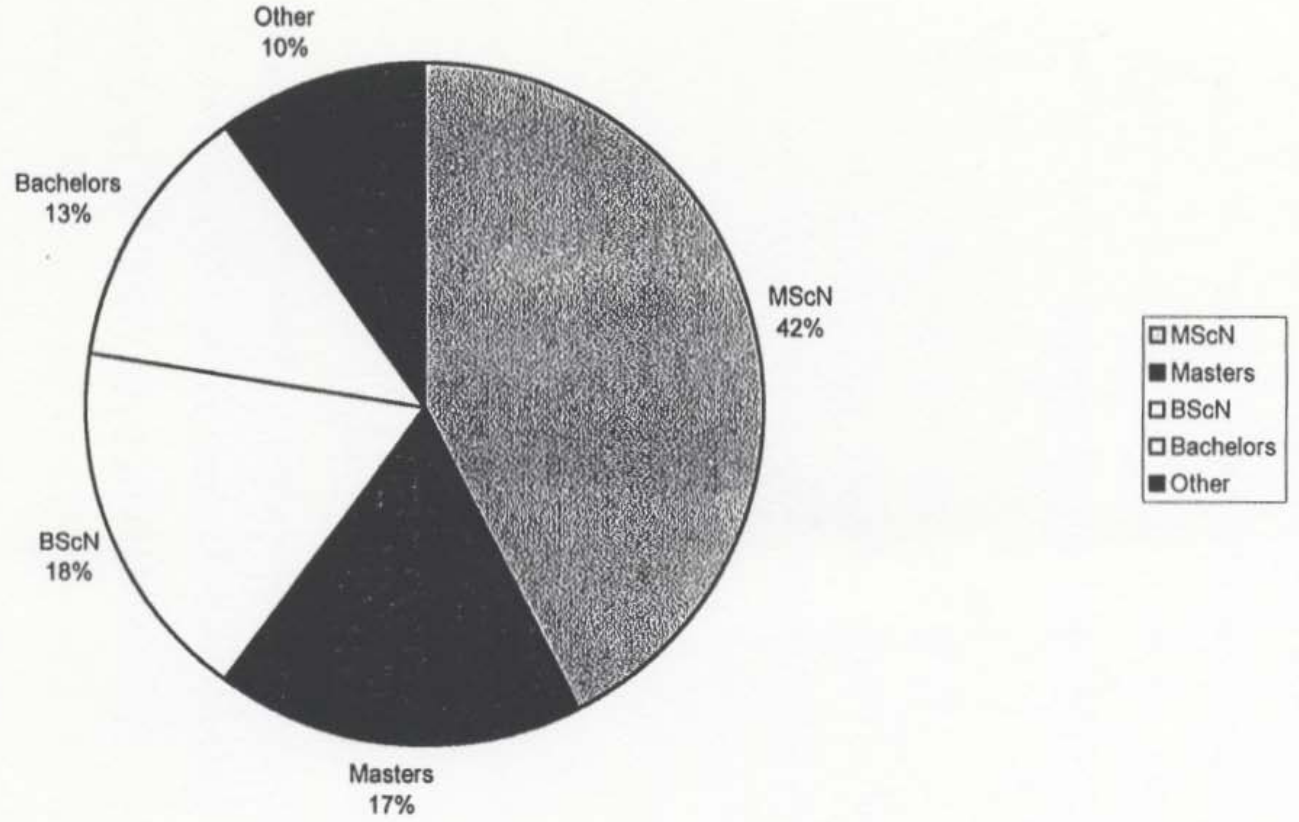


Figure C.3.4

The data showed that sixty-three per cent (63%) of the managers had a nursing degree (45% with Bachelor's degree and 18% with a Master's degree). Thirty-six per cent (36%) of managers had a graduate degree in either nursing or another discipline. In contrast, only one manager representing thirteen per cent (13%) had a social work degree (BSW).

3.9.4 Community Development Training

Thirty-seven per cent (37%) of managers reported that they had attended community development workshops throughout their professional careers (See Figure C.3.5). Eighteen per cent (18%) of managers reported that community development training was part of the university courses they took for their undergraduate and graduate degrees. Fifteen per cent (15%) reported that they had participated in community development training offered as in-service by their organizations. Another fifteen per cent (15%) of managers, had not participated in any community development training throughout their career. Six per cent (6%) of managers stated that community development had been part of their community college curriculum. Nine per cent (9%) of managers reported other community development training activities, such as related reading materials. Thus, seventy per cent (70%) of managers had experienced community development training prior to the implementation of the HBHC Program either through:1) university education, 2) professional development activities outside their organization or 3) continuing education workshops within their organization.

HBHC Manager Community Development Training by Type

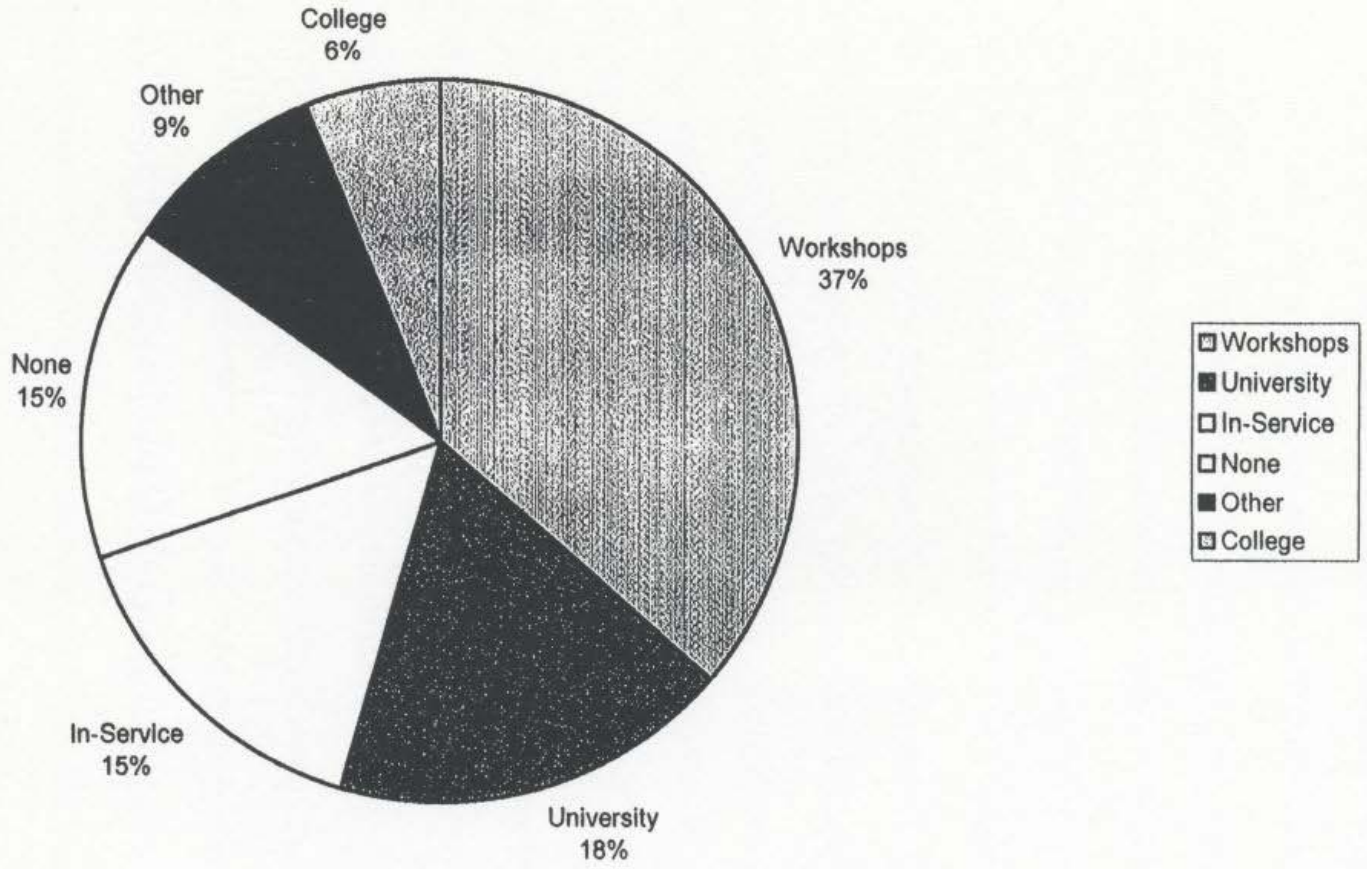


Figure C.3.5

In summary, this section of the chapter has examined the HBHC program manager's education, managerial and community experience and participation in community development training. Descriptive statistics on the mean number of years of nursing, managerial and community collaboration experience were presented. In addition, the differential use of the title Director, Manager, Supervisor and Co-ordinator reported by managers across the study sites was outlined. Finally, information on the previous community development training experienced by seventy per cent (70%) of the public health managers was reported. It is important to note that all public health managers in this study had a nursing background and most had a number of years of managerial experience prior to the implementation of the HBHC Program. In addition, the majority of public health managers had previous community development training and experience either participating in or leading local collaborative initiatives prior to being given the responsibility for implementation of the HBHC collaborative network.

3.10 The Data Analysis Process: Coding and Re-coding

The interviews were audiotaped after receiving a consent form from the participants. The researcher, to protect the confidentiality of responses, transcribed the audiotapes. Coding of interviews was managed through a computerized data analysis program (Ethnograph). This allowed the researcher to review text, mark segments according to established codes and then display, sort and print segments in any order or sequence. All the participants' responses to specific interview questions were contained within one Ethnograph text file.

The first phase of the data analysis is summarized in Table C.3.1. The first round of data analysis included a non-computer scan of the interview material to exclude extraneous material such as superfluous words (e.g. "um" and "ah"), and comments about the weather. The result of this non-computer review of the data and exclusion of extraneous material led to a total of 1,031 pages of interview text (Table C.3.1 - Phase I-Step One).

The second round of data analysis consisted of a scan of the data of answers to questions (#8-22 in the interview guide) using a set of 183 codes developed based on the environmental and collaborative process factors from the conceptual framework for the study (Appendix C.3.A.7) (Table C.3.1-Phase I-Step Two).

The third step of data analysis was a scan of the data from questions (#'s 8-22). Following this scan, eight new code words were added to reflect emergent themes and sub-themes from the data. The code book was amended to reflect a total of 191 codes at this stage (Table C.3.1-Phase I-Step Three). Coding schemes were subsequently revised with additions, deletions and recoding of data as new themes and sub-themes emerged.

Table C.3.1
Data Analysis Steps - Phase I

STEP ONE
NON-COMPUTER SCAN OF INTERVIEW MATERIAL TO REMOVE EXTRANEOUS MATERIAL NOT RELATED TO RESEARCH QUESTIONS: RESULT - 1,031 PAGES OF INTERVIEW DATA

STEP TWO
DEVELOP CODES FOR CONCEPTUAL FRAMEWORK QUESTIONS QUESTIONS # 8-22 TOTAL NUMBER OF CODES: 183

STEP THREE
SCAN OF INTERVIEW DATA FROM QUESTIONS # 8-22 NEW CODES ADDED: 8 TOTAL NUMBER OF CODES: 191

STEP FOUR
SCAN OF INTERVIEW DATA FROM OPEN ENDED -QUESTIONS # 3-7 DEVELOP CODES FROM DATA -TOTAL NUMBER OF CODES DEVELOPED: 49 TOTAL NUMBER OF CODES: 240

STEP FIVE
SCAN INTERVIEW DATA ON ALL QUESTIONS #3-22 RECODE DUPLICATIVE CODES: REDUCE BY 7 CODES TOTAL NUMBER OF CODES- 233

STEP SIX
THEMATIC ANALYSIS REVEALS CENTRAL PATTERNS OF SIMILARITY IN THE DATA FROM EACH QUESTION ETHNOGRAPH USED TO AFFIRM THEMATIC ANALYSIS OF DATA IDENTIFY TWO MOST NUMEROUS CODES IN EACH QUESTION # 3-22 TOTAL NUMBER- RESULT 40 CODES

STEP SEVEN
CREATED NEW DATA FILES CONSISTING OF SEGMENTS ASSOCIATED WITH THE 40 CODES IDENTIFIED IN STEP SIX AND ORGANIZED BY CODES INSTEAD OF QUESTIONS

STEP EIGHT
FORTY HIGH FREQUENCY CODES FROM QUESTIONS #3-22, DEFINED AND CLASSIFIED ACCORDING TO THEMES AND SUB-THEMES OF COLLABORATION (Table C.3.2) (Table C.3.3)

The fourth step of data analysis used Ethnograph to review answers to the open-ended questions (#'s 3 -7). New themes were coded. Coding of open ended questions added 49 new codes expanding the code book to 240 codes. At this point, the expanded code book contained: 1) codes (183) from the conceptual framework for questions (#'s 8-22), 2) codes (8) that emerged from the data in questions (#'s 8–22) and 3) codes (49) that emerged from the data on the open ended questions in the interview guide (#'s 3-7). (Table C.3.1. - Phase I - Step Four)

The fifth step consisted of a computerized scan of the data on all the questions (#'s 3-22) using the code book containing 240 codes. Seven duplicative codes were found and were re-coded. This reduced the code book to a total of 233 in this fifth stage of data analysis (Table C.3.1-Phase I -Step 5).

. In the sixth step, the code counting function of Ethnograph (this function of Ethnograph generates a numerical count of the codes by their frequency of occurrence) was used to identify recurrent themes in the data within each question.

Throughout both the collection of data and the transcription of the data, process analysis notes were used to record the researcher's perceptions and interpretations of what she was hearing and seeing in the data. This revealed patterns of similarity (and some difference) in the responses of managers which suggested two or three central themes in each question. Other coded segments were less recurrent and appeared to fall away from central importance in the data. The code counting function of Ethnograph affirmed this thematic pattern by calculating the frequency of occurrence of the coded

segments both open ended (#'s 3-7) and semi-structured (#'s 8-22) questions.

In this stage of data analysis, the top two code frequencies listed by Ethnograph in each file were then extracted and used to develop a new code book containing 40 codes that represented the major themes to be used for further analysis (Table C.3.1.- Phase I - Step Six).

It is important to comment on the methodology used in this step of the analysis. The Ethnograph List Code function was used to identify the frequency of occurrence of the coded segments as a descriptive support to the qualitative method. It does not suggest that the study used quantitative content analysis with its focus on manifest content, sampling units and reliability and validity (Rubin & Babbie, 2001, Krippendorff, 1980). In this qualitative study, the codes represented the latent content in the data or the interpretation of meaning of the managers' responses (Rubin & Babbie 2001).

The seventh step consisted of the creation of new data files which contained all the code segments associated with the 40 codes identified previously in Table C.3.1 (Data Analysis Steps -Phase I - Step Six). These comprised the top 40 code frequencies found in the data (based on the top two frequently occurring codes found in data from each question #'s 3-22). In this way, the data was extracted as it related to the codes, not as it related to the specific questions. The result was that the original text files, developed from the responses to questions in the interview guide were segmented and restructured to reflect the 40 code categories (Table C.3.1-Phase I-Step Seven).

In the eighth step of the data analysis, (Table C.3.1.-Phase I-Step 8) a thematic

analysis of the data was carried out which resulted in the forty high frequency codes from questions (#'s 3-22) being defined and classified according to themes and sub-themes of collaboration. These forty themes are defined and categorized in Table C.3.2.

Table C.3.2, portrays for each question (#3-7) the most recurrent themes: 1) the interview guide question, 2) the concept name (code) and concept (code) description along with its frequency of occurrence in the data for that question, and 3) its theme and sub-theme category.

In addition, Table C.3.2, portrays for each question (#8-22): 1) the interview guide question, 2) the analytical question, 3) the concept name (code) and concept (code) description along with its frequency of occurrence in the data for that question, and 4) its theme and sub-theme category.

In Table C.3.3. (Reclassification of Concepts into New Themes and Sub-Themes by Interview Question) an overview of the reclassification of the concepts is displayed in chart form that outlines the concepts by: 1) interview guide question, 2) conceptual framework identification, 3) six themes of collaboration (Historical Conditions, Institutional Conditions, Financial Conditions, Operational Processes, Organizational Processes and Relational Processes) and 4) sub-themes within the six themes of collaboration.

Table C.3.2
Identification of Concepts, Themes and Sub-Themes by Interview Question - (# 3-22)

QUESTION # 3:

Interview Guide Question			
Could you elaborate on the involvement you have had in the past three years with the provincial Office of Integrated Services for Children (OISC)?			
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Prescribe	50	References to the prescriptive nature of the mandate/guidelines for HBHC, meeting the needs of provincial office of OISC, determination by central office of OISC not local and references to having to do things that they were told to do by central office (OISC)	INSTITUTIONAL CONDITIONS Provincial Mandate
Contact with Provincial Consultants	43	References to contact with provincial offices of OISC through contact with the consultant by phone, provincial meetings, site visits by consultant, and changes/reductions in consultants at OISC	INSTITUTIONAL CONDITIONS Consultant's Role

Table C.3.2

QUESTION # 4:

Interview Guide Question			
To what extent has the provincial OISC helped you in implementing the local collaborative network?			
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Implementation Guidelines	22	References to guidelines from provincial office (OISC) including: references to time lines prescribed, lack of clarity of guidelines, changes in guidelines, lack of knowledge about what it takes to implement guidelines, expansion of guidelines.	INSTITUTIONAL CONDITIONS Provincial Mandate
Prescribe	17	References to the prescriptive nature of the mandate/guidelines for HBHC, meeting the needs of provincial office of OISC, determination by central office of OISC not local and references to having to do things that they were told to do by central office (OISC)	INSTITUTIONAL CONDITIONS Provincial Mandate

QUESTION #5:

Interview Guide Question			
In what ways could the provincial OISC have been more helpful in implementing the local collaborative network?			
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Implementation Guidelines	30	References to guidelines from provincial office (OISC) including: references to time lines prescribed, lack of clarity of guidelines, changes in guidelines, lack of knowledge about what it takes to implement guidelines, expansion of guidelines.	INSTITUTIONAL CONDITIONS Provincial Mandate
Prescribe	27	References to the prescriptive nature of the mandate/guidelines for HBHC, meeting the needs of provincial office of OISC, determination by central office of OISC not local. References to having to do things that they were told to do by central office (OISC)	INSTITUTIONAL CONDITIONS Provincial Mandate

Table C.3.2

QUESTION # 6:

Interview Guide Question			
Has your collaborative network development been successful? Please explain your definition of success.			
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Membership Commitment	34	References that indicate local commitment to HBHC (e.g. attendance at meetings, stated local ownership, commitment to implementation, goals, principles). References that indicate local network commitment to children and families and HBHC as a mechanism for service integration	OPERATIONAL PROCESSES Membership
Organizing Network Structures	31	References to process used for organizing into structures for networks, either existing or needed (e.g. joining, linking, umbrella, co-ordination)	ORGANIZATIONAL PROCESSES Type/ Level Structure

QUESTION # 7:

Interview Guide Question			
If you were designing an ideal collaborative network for Healthy Babies/ Healthy Children, what would it look like?			
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Organizational Structures	18	References to structural properties for implementation of HBHC network (e.g. committee, sub-committee, interagency, working group, task group, co-ordinating councils). References to structural properties of other initiatives in the community that have been utilized to implement the HBHC network	ORGANIZATIONAL PROCESSES Organizational Type/Level
Inclusive Membership	19	References to who should be included in the HBHC network (e.g. consumers, parents, sectors, front-line staff, managers, other professionals, other organizations). References to stakeholders who are missing from the HBHC network. References to who should not be included on the HBHC network.	OPERATIONAL PROCESSES Membership

Table C.3.2.

QUESTION # 8 - HISTORY OF PREVIOUS COLLABORATION

Interview Guide Question		**Analytical Question**	
To what extent have stakeholders worked together before HBHC in your local community?		How does a previous history of working together influence HBHC collaboration?	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Previous Collaboration on children's services	40	References to previous collaboration on services (Best Start Programs, Better Beginnings, Better Futures, Success by Six, references to federal Community Action Programs (CAPC) and Community Prenatal Nutrition Program (CPNP)	HISTORICAL CONDITIONS Service Provision History
Past Interpersonal/ Professional Relationships	37	References to past interpersonal or professional relationships between network members. Indicators of whether these past relationships facilitated or hindered collaboration in the HBHC network.	RELATIONAL PROCESSES Previous Relationships

QUESTION # 9 - PREVIOUS HISTORY INFLUENCE

Interview Guide Question		**Analytical Question**	
How do you see this previous history influencing the collaborative process in HBHC?		How does a previous history of working together influence HBHC collaboration?	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Collective History	25	References to perceptions that the collective history of service providers has influenced local collaboration in HBHC	HISTORICAL CONDITIONS Previous Collaboration
Known to each other	14	References to relationships where people have known each other for a period of time and how this influenced collaboration in the HBHC network	RELATIONAL PROCESSES Previous Relationships

Table C.3.2

QUESTION # 10 - MANDATORY/VOLUNTARY CONTEXT OF COLLABORATION

Interview Guide Question		**Analytical Question**	
In your view, how has the government mandate facilitated or constrained the developments of the HBHC collaborative network in your community?		How does the imposition of a state mandate influence HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Constraints of Provincial Mandate	29	References that the mandate made collaboration more difficult at the local level	INSTITUTIONAL CONDITIONS Provincial Mandate
Provincial Government Communication	27	References to the lack of collaboration between ministries at the provincial level of government or OISC and impact on local community. References to silos at provincial level of government.	INSTITUTIONAL CONDITIONS Institutional Communication

Table C.3.2.

QUESTION # 11 - LEGITIMACY OF CONVENING ORGANIZATION

Interview Guide Question		**Analytical Question**	
To what extent have local stakeholders accepted the mandate for public health to lead implementation of the HBHC and how has this affected collaboration in your community?		How does the reputation of the lead organization in the community influence HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Legitimacy/ Relationships	27	References that the central mandate given to public health for local implementation of HBHC program has affected the legitimacy of public health and affected relationships between public health and other service providers in local community.	RELATIONAL PROCESSES Previous Relationships
Legitimacy/ Barriers	26	References to barriers experienced by public health after the central mandate dictated that they should lead the implementation of HBHC Program(e.g., local Ministry of Community and Social Services rivalry, stakeholder resistance to government mandate).	RELATIONAL PROCESSES Previous Relationships

Table C.3.2

QUESTION # 12 - STAKEHOLDER REPRESENTATIVENESS

Interview Guide Question		**Analytical Question**	
How would you describe the process for identifying and recruiting stakeholders for the collaborative network?		How does the representativeness of stakeholders influence HBHC collaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Stakeholder Recruitment	32	References to activities used to recruit stakeholders (e.g. letters, phone calls, community meetings, personal contact, pre-existing networks)	OPERATIONAL PROCESSES Membership
Stakeholder Evolution	19	References to the recruitment of new stakeholders as HBHC Network has evolved over time	OPERATIONAL PROCESSES Membership

QUESTION # 13 - MEMBERSHIP

Interview Guide Question		**Analytical Question**	
In your perception, how do members participate in the collaborative network: a) as individuals b) as representatives of their group or organization c) as consumers or advocates		How does the type of membership participation influence HBHC collaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Organizational Representatives	20	References that network members are representatives of their organization.	OPERATIONAL PROCESSES Membership
Parents Not Represented	14	References that parents are not included in the network. References to reasons for parent non-participation if invited and/or reasons why parents are not invited to participate	OPERATIONAL PROCESSES Membership

Table C.3.2

QUESTION # 14 (a) - BENEFITS OF MEMBERSHIP IN HBHC NETWORK

Interview Guide Question		**Analytical Question**	
a) What do you perceive to be the main benefits for stakeholders who participate in the collaborative network?		How are the organizational and/or individual costs and benefits of member's participation related to HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Multiple Site Networks	20	References that indicate that multiple site HBHC networks were necessary to strengthen relationships with other organizations at a local level	ORGANIZATIONAL PROCESSES Organizational Complexity
Improved Service Co-ordination	16	References that indicate that one of the rewards of participation in the HBHC network is improved service co-ordination and access to services among agencies in the local community (e.g. joint protocols, referrals, sharing resources such as translators)	OPERATIONAL PROCESSES Membership

QUESTION # 14 (b) - COSTS OF MEMBERSHIP IN HBHC NETWORK

Interview Guide Question		**Analytical Question**	
b) What do you perceive to be the main "costs" to stakeholders who participate in the collaborative network?		How are the organizational and/or individual costs and benefits of member's participation related to HBHC collaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Demands of Network Participation	27	References to the amount of time it costs to participate in the HBHC network. References that network participation takes time away from other demands of work	OPERATIONAL PROCESSES Membership
Emotional aspects of collaboration	19	References to the emotional aspects of collaborative relationships (e.g. building trust). References to the time it takes to build collaborative relationships and to learn how to work together.	RELATIONAL PROCESSES Interpersonal Relations

Table C.3.2

QUESTION # 15 - PROVINCIAL GOALS FOR HBHC

Interview Guide Question		**Analytical Question**	
In what ways have the provincially mandated goals for HBHC collaborative network changed and/or expanded over the past three years?		How does the development of common goals influence HBHC collaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Provincial Expansion of HBHC Program	17	References that indicate that provincially mandated goals for HBHC have expanded from its beginning, the addition of program components. References to the impact of this expansion on local communities	INSTITUTIONAL CONDITIONS Provincial Mandate
Confusing Multiple Mandates	17	References that indicate that multiple mandated networks introduced by the provincial government have confused network members and the local community (e.g. Early Years, HBHC, Early Identification Component of HBHC)	INSTITUTIONAL CONDITIONS Institutional Communication

Table C.3.2

QUESTION # 16 - LOCAL COMMON GOALS

Interview Guide Question		**Analytical Question**	
In what ways has the collaborative network developed a common purpose unique to the local community?		How does the development of common goals influence HBHC collaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Community Goals	17	References to the development of ownership of common goals for local community planning. References to perceptions that it was not just HBHC provincial goals that were implemented.	HISTORICAL CONDITIONS Commitment to Local Goals
Community Uniqueness	12	References to the uniqueness of local community who are not just implementing mandate. References that HBHC implementation was not cookie cutter but based on unique characteristics of communities, (e.g.multiple networks, counties, neighbourhoods)	HISTORICAL CONDITIONS Commitment to Local Goals

QUESTIONS # 17 DECISION-MAKING LEVEL

Interview Guide Question		**Analytical Question**	
To what extent are members of the collaborative network able to make decisions for their organizations?		How does the level of decision-making authority of members influence HBHC collaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Decision Type	27	References to the types of decisions that network members have been asked to make (e.g. advisory, planning, information sharing, joint training, joint resources)	OPERATIONAL PROCESSES Decision-Making Stage

Questions 17 and 18 were collapsed into one question during the analysis of data with the top two codes from the merged files being used

Table C.3.2

QUESTION # 18 - DECISION MAKING POWER

Interview Guide Question		**Analytical Question**	
How do you think decision-making power or lack of power influences the collaborative process?		How does the level of decision-making authority of members influence HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Managerial decisions	41	References that indicate managerial level decision makers on the HBHC network who have the authority to make decisions for their organizations. References to how the decision making level of managers influences local collaboration	OPERATIONAL PROCESSES Decision-Making level

QUESTION # 19 - COMMUNICATION STYLE

Interview Guide Question		**Analytical Question**	
Would you describe the communication as open or filtered between: a) the local HBHC program manager and the OISC b) the local HBHC program manager and the HBHC collaborative network c) the members of the HBHC collaborative network themselves		How does the style of communication influence HBHC colaboration.	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Communication Managers/Network	37	References that indicate that the relationship between the HBHC manager and the members of the HBHC network was based on open communication	RELATIONAL PROCESSES Interpersonal Relations
Communication Managers/OISC	28	References that indicate that local HBHC managers are open and do not filter their communication with provincial OISC consultants.	INSTITUTIONAL CONDITIONS Institutional Communication

Table C.3.2

QUESTION # 20 - FORMALIZATION OF NETWORK

Interview Guide Question		**Analytical Question**	
Describe the extent to which formal agreements (e.g. written letters of understanding, terms of reference) have been utilized in the HBHC collaborative network.		How does the formality/informality of the linkages between members of the network influence HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Formal Terms of Reference	26	References that indicate that HBHC network has formal terms of reference	OPERATIONAL PROCESSES Formalization
Formal Service Protocols	29	References to the development of formal protocols between network partners (e.g. service agreements between hospitals and public units/departments)	OPERATIONAL PROCESSES Formalization

QUESTION # 21 - INFORMALITY OF THE NETWORK

Interview Guide Question		**Analytical Question**	
Describe the extent to which informal agreements characterize the operations of the HBHC collaborative network.		How does the formality/informality of the linkages between members of the network influence HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Informal Network Relationships	17	References to informal relationships that exist between members both within and outside the network. References to informal relationships that characterize the interactions of the local community.	RELATIONAL PROCESSES Interpersonal Relations
Informal Service Planning	10	References that indicate that service co-ordination and/or planning between network members that is not formalized or written down in an agreement	OPERATIONAL PROCESSES Formalization

Table C.3.2.

QUESTION # 22 - SUFFICIENT RESOURCES

Interview Guide Question		**Analytical Question**	
To what extent do you believe provincial provision of resources to the public health unit for administration of the HBHC has affected stakeholder participation in the collaborative network?		How does the amount of resources contributed by the state affect HBHC collaboration	
Concept	**Frequency of Occurrence**	**Characteristics**	**Theme/Sub-Theme**
Administrative Resources	73	References to allocations of resources or no allocation of resources for administration of the HBHC Program. References to issues of funding between provincial government (OISC) and local HBHC Programs around resource utilization	FINANCIAL CONDITIONS Administrative Funding
Resource Conflicts	62	References to administrative resources contributed by local public health units/departments to the HBHC Program. References that indicate that there are not enough resources given to health units to meet HBHC program demands. References that indicate resistance by other service providers to the exclusive dedication of HBHC resources to Public Health	FINANCIAL CONDITIONS Public Health Resources

Table C.3.3

Reclassification of Concepts into New Themes and Sub-Themes by Interview Question

Question #	Conceptual Framework	Historical Conditions	Institutional Conditions	Financial Conditions	Operational Processes	Organizational Processes	Relational Processes
3 Open -Ended -OISC			Prescribe Contact with Provincial Consultants				
4 Open-Ended -OISC			Implementation Guidelines Prescribe				
5 Open-Ended - OISC			Implementation Guidelines Prescribe				
6 Open-Ended - Success					Member Commitment	Organizing of Network Structures	
7 Open-Ended - Ideal					Inclusive Membership	Organizational Structures	
8	History of Previous Collaboration	Previous Collaboration on Children's Services					Past-Interpersonal/ Professional Relationships
9	History of Previous Collaboration	Collective History					Known to each other
10	Mandatory/ Voluntary Model		Constraints of Provincial Mandate Provincial Government Communication				
11	Legitimacy of Convening Organization						Legitimacy/ Relationships Legitimacy/ Barriers
12	Stakeholder Representativeness				Stakeholder Recruitment		

Table C.3.3
Reclassification of Concepts into New Themes and Sub-Themes by Interview Question

Question #	Conceptual Framework	Historical Conditions	Institutional Conditions	Financial Conditions	Operational Processes	Organizational Processes	Relational Processes
13	Membership Participation				Organizational Representatives Parents Not Represented		
14 (a)	Membership Benefits				Improved Service Co-ordination	Multiple Site Networks	
14 (b)	Membership Costs				Demands of Network Participation		Emotional aspects of collaboration
15	Common Purpose Development		Provincial Expansion of HBHC Program Confusing Multiple Mandates				
16	Common Purpose Development	Community Goals Community Uniqueness					
17 &18	Decision-making Levels				Decision Stage Managerial Decisions		
19	Communication Style		Communication Managers/OISC				Communication Managers/Network
20	Formality/ Informality of Linkages				Formal Terms of Reference Formal Service Protocols		
21	Formal/Informal Linkages				Informal Service Planning		Informal Network Relationships
22	Sufficient Resources			Resources: Administrative			

This section of Chapter 3 describes the process of categorizing the forty themes shown in Table C.3.2 and Table C.3.3. First, data was reviewed in light of the empirical and theoretical literature on factors that influence collaboration to identify factors relevant to mandatory collaboration. This review resulted in categorization of the data into four themes, namely: 1) Historical Conditions (a past history of working together on local collaborative initiatives), 2) Institutional Conditions (influence of mandate on relationships of authority and accountability between the central government and local HBHC programs), 3) Financial Conditions (provincial allocations for the implementation and expansion of the HBHC program and the impact of allocations on local HBHC networks) and 4) Operational Processes (interactional processes of decision-making, membership recruitment and retention, communication and the formalization/non-formalization of network operations carried out to sustain the HBHC network).

Second, data was reviewed and categorized in terms of operational activities that facilitated or constrained collaboration namely: 1) stakeholder representation, 2) membership participation, 3) costs and benefits of membership, 4) decision-making levels, 5) communication style (open or filtered), 6) formality/ informality of linkages, 7) common purpose development, and 8) sufficient resources. Although the conceptual framework had identified these eight activities as collaborative processes, the data from this study tended to center on three dimensions of operational processes: 1) membership, 2) formalization/non-formalization and 3) decision-making. Notably, the list does not

include all operational activities identified in the conceptual framework. Further analysis of the data yielded new organizational and relational themes of collaboration that led to the categorization of two more major themes of collaboration not evident in the original conceptual framework: 5) Organizational Processes (facilitating stakeholder participation and the operational processes of the HBHC network through organizational structures and sub-structures) and 6) Relational Processes (history, nature and quality of the interactions between the members of the HBHC network). Therefore, some of the previously identified operational processes (common purpose development, communication style, formality/informality of linkages and sufficient resources) were reclassified and regrouped to form the six new themes of collaboration (Historical Conditions, Institutional Conditions, Financial Conditions, Operational Processes, Organizational Processes and Relational Processes).

What was re-categorized? First, the findings on common purpose development were incorporated into the discussion of Historical Conditions. Second, an analysis of the data on sufficient resources suggested its importance: accordingly, Financial Conditions became one of the six major themes of collaboration. Third, an exploration of the data on communication style suggested that this was applicable to professional and interpersonal relationships: as a result, this discussion was incorporated into the Relational Processes theme of collaboration. Finally, some of the data on the informality/formality of linkages led to the construction of a new theme of collaboration, namely Organizational Processes. Other data from the informality/formality of linkages

was incorporated into the formality dimension of Operational Processes.

In the ninth step (Table C.3.4-Phase II, Step 9) and the tenth step (Table C.3.4.-Phase II, Step 10), the data was classified as shown in Table C.3.4. - Phase II.

In step eleven (Table C.3.4-Phase II, Step 11), the interview data were scanned within and across each question (#'s 3-22) to identify relevant segments that were not picked up in the top two high frequency codes used for the prior thematic analysis of the data. Within this step of the analysis, 171 coded segments were identified as containing relevant material. These segments of the interview text were re-coded and incorporated into the data base for the final round of analysis.

The result of this step of the analysis was that 22 codes (9 % of the total number of 233 codes identified) were excluded from the analysis. Thirteen of the 20 questions had codes excluded from the data analysis. Examples of codes excluded were issues such as leadership, terms of membership, volunteer resources, refreshments and references to the diffuse nature of government goals for the HBHC program. The rationale for presenting an overview of the excluded codes is that they represent issues on which most managers had not elaborated during the interviews (which were conducted between January to June, 2001). This non-response was assumed to indicate managers' lack of interest in particular aspects of collaboration. This excluded material is discussed in Chapter 6. This information was then used to discern whether the roles, functions and tasks of collaboration that most public health managers did not address are represented in the social work literature. The implications for community social work practice were

Table C.3.4.
Data Analysis Steps - Phase II

STEP NINE
REORGANIZED DATA ASSOCIATED WITH TOP TWO HIGH FREQUENCY CODES FROM EACH QUESTION # 3-22 INTO THREE NEW ENVIRONMENTAL PRE-CONDITION THEMES AND SUB-THEMES OF COLLABORATION (Table C.4.1)

STEP TEN
REORGANIZED DATA ASSOCIATED WITH TOP TWO HIGH FREQUENCY CODES FROM EACH QUESTION # 3-22 INTO THREE NEW COLLABORATIVE PROCESS THEMES AND SUB-THEMES OF COLLABORATION (Table C.5.1)

STEP ELEVEN
SCANNED INTERVIEW DATA WITHIN AND ACROSS EACH QUESTION (#3-22) IDENTIFIED RELEVANT SEGMENTS FOR INCLUSION THAT WERE NOT PICKED UP IN TOP TWO HIGH FREQUENCY CODES RECODED 171 CODES AND INCLUDED CODE SEGMENTS IN ANALYSIS - PHASE II EXCLUDED 22 CODES (9% OF 233 CODES IDENTIFIED)

STEP TWELVE
SIX THEMES OF COLLABORATION: THREE ENVIRONMENTAL PRE-CONDITIONS (HISTORICAL, INSTITUTIONAL, FINANCIAL) AND THREE COLLABORATIVE PROCESSES (OPERATIONAL, ORGANIZATIONAL, RELATIONAL)

developed from this excluded data to demonstrate the differences between how public health managers and social workers might approach local collaboration.

In the final step, step twelve (Table C.3.4.-Phase II -Step 12), the results of the thematic analysis of the data in this study were configured into a Matrix of Six Themes of Collaboration: 1) Historical Conditions, 2) Institutional Conditions, 3) Financial Conditions, 4) Operational Processes, 5) Organizational Processes and 6) Relational Processes. This matrix organizes the results of the data analysis and provides an outline for the discussion and conclusions related to the six major themes and their sub-themes of collaboration.

Two other areas of analysis were originally planned. The research plan, initially, included comparison between the data and the developmental stages of collaboration identified in the literature. However, given the early stage of development of the HBHC networks, such an analysis appeared premature. In addition, data analysis by Public Health Planning Region was also planned but abandoned due to a concern with confidentiality.

Chapter 4 The Pre-conditions of Collaboration

4.0 Introduction

Chapter 4 identifies the three environmental pre-condition themes (Historical, Institutional and Financial) and their dimensions found to influence collaboration in the Healthy Babies/ Healthy Children (HBHC) Program in Ontario (Table C.4.1). Environmental pre-conditions are defined as the factors that initially motivate organizational interaction. Based on the literature, this study assumed that collaboration could be influenced by factors such as: 1) previous history 2) voluntary/mandatory nature of collaboration and 3) the legitimacy of the convening organization.

The Historical Conditions theme was developed from the data in this study and extended the literature on collaboration that identifies "previous history" as a factor that facilitates collaboration (Mattessich & Monsey, 1992, 10). Similarly, the Institutional Conditions theme reflects the research literature and the debate on whether mandates or voluntary participation influence the development of local collaboration.

Table C.4.1
Three Environmental Pre-Condition Themes of Collaboration

Historical Conditions	Institutional Conditions	Financial Conditions
Service Provision History	**Provincial Mandate:** Prescriptive Nature of HBHC Program Implementing the Collaborative Network Program Expansion	**Administrative Funding:** Lack of Administrative Funding
Previous Collaboration	**Consultant's Role:** HBHC Consultant Communication HBHC Consultant Changes	**Public Health Resources:** Need for Additional Public Health Funds Exclusive Dedication of HBHC Resources
Commitment to Local Goals	**Institutional Communication:** Interministerial Communication: OISC Multiple Provincial Initiatives Provincial Level Communications	

Finally, data from this study suggested that Financial Conditions should be re-classified as a new pre-condition theme of collaboration. Previously, "sufficient resources" had been identified as one of the collaborative process factors in the conceptual framework for the study (Mattessich & Monsey, 1992, 10). In this study, it was determined that this category (sufficient resources) did not capture elements in the data that addressed the exclusive dedication of public health resources or the need for public health to supplement the HBHC budget. Consequently, sufficient resources was re-conceptualized as a new theme of collaboration in this study called Financial Conditions.

4.1 Historical Conditions

Historical conditions in this study are defined as a past experience of working together collaboratively at a local community level. The Historical Conditions theme and dimensions developed from the data in this study reflect factors identified in the conceptual framework (history of previous collaboration, influence of previous history and common purpose development). The history of previous collaboration was identified as a environmental pre-condition in the conceptual framework. The *influence* of previous history was a secondary question that was added to the interview guide. Common purpose development was identified in the conceptual framework as a collaborative process factor. An analysis of the data in this study led to the re-

classification of common purpose from a collaborative process factor to one of the dimensions (Commitment to Local Goals) within the Historical Conditions theme.

The reason for this re-conceptualization of common purpose was that almost all local communities had their own vision, mission and goals for the development of the child and family service system and were resistant to the imposition of centrally determined goals for the HBHC program. The literature identifies "voluntary" common purpose as one of the factors that facilitate collaboration. For local HBHC networks, it was the pre-condition of the mandate and the establishment of their own local goals that affected the implementation of the HBHC network, not the voluntary coming together to decide on a "common purpose"

Finally, managers identified the impact of public health maternal and child home visiting programs on the implementation of the HBHC Program. Communities where maternal and child health had been disbanded had two contrasting responses: 1) either local stakeholders did not understand the public health role in HBHC or were unhappy about public health being given the exclusive mandate for delivery of the HBHC Program or 2) they considered the HBHC Program a welcome enhancement to the service delivery system for children and families (regardless of whom had auspice for the program).

Three dimensions of collaboration related to a history of working together were found in the data and explored within the Historical Conditions theme: 1) Community

History: Service Provision History, 2) Community History: Previous Collaboration and 3) Community History: Commitment to Local Goals (Table C.4.1).

A unique characteristic of some local communities was their public health unit/department's decision to disband their maternal and child health home visiting program with the shift to population health in the mid-1980's. Not all health units/departments gave up their maternal and child health home visiting program, and where it remained, collaboration changed little or was enhanced by home visiting by public health nurses as part of the screening and assessment component of HBHC.

However, managers varied in areas where maternal and child health home visiting had not been a public health function over the past decade.

> *In this health unit we were one of the few ones that were still doing one to one home visiting...so when Healthy Babies came it was nothing new because we had kept one to one visiting.*

They said that some communities had little understanding of maternal and child health home visiting as a public health function and were confused by HBHC. Other communities were fearful that once again public health would raise expectations only to later disband HBHC. Nonetheless in the majority of study sites, managers' perceived that public health's mandate for HBHC was unchallenged and network members welcomed the new resources.

Managers identified that, in some communities, federally and provincially funded home visiting programs were also operating. Most communities with federal Community Action Programs Canada (CAPC) and provincial Best Start programs had been working

collaboratively prior to HBHC and recognized their common interests. There were few problems resolving parallel mandates for home visiting, noted by one manager:

> *So we had a CAPC program who had a long history of working together closely with the health department so basically when we got our funding they were more than happy.*

Another manager said:

> *Before HBHC, we worked fairly extensively...before we had a whole series of initiatives...we had a coalition that formed to write the proposal for Best Start funding [sic] (a provincial prevention initiative in Ontario) so many of the people that we have around the table for HBHC either they or their organization would have been involved in that first attempt to put a proposal together.*

In this study, the majority of HBHC networks comprised people who had already been working together to develop the children's services system across time and space. The federal CAPC and provincial Best Start programs discussed previously represented only part of the local history of collaboration. Local collaboration also responded to government initiatives such as Ontario's Better Beginnings, Better Futures program and the federal government's Brighter Futures programs.

Notwithstanding these government initiatives, almost all local communities in this study had also developed other local collaborative projects. A number of children's services projects had been initiated locally over the years. In addition, local communities also had experience with large scale community planning councils. Managers described

variants of the disbanded provincially funded Children's Services Council persisting in many communities.

> *We have a good background in this area of working collaboratively in our community.*

> *We were a productive interagency group with some key players that we already had good relationships with and then we had various other partners that we worked with so we just called them all up and said "let's sit down here".*

So, collaboration was not a new experience for most local communities. Managers said that the provincial guidelines for HBHC were not always helpful because their existing way of working at the local level was more informal. Faced with the mandate, most communities continued to work together within their previously established patterns and subsumed the guidelines for HBHC into their local form of collaboration.

> *Guidelines have been a mixed blessing...our community is a rural with a history of working together. The guidelines were not always supportive of the ways that we would make things work.*

While most communities in this study had been working together prior to HBHC, parallel mandates of federal, provincial and local initiatives created a disjointed planning process that required more systematic collaboration.

> *There are still lots of fractured groups that tend to meet. All those different groups would benefit from being tied to an active network.*

Managers identified that previous collaboration sometimes created conflict. This negative history was a barrier to be overcome before the network could function.

With previous history, there is always baggage because politically how your agency sits in the community versus if your agency has done damage to another inadvertently..that type of thing...that was all there across the table.

Several managers said that they had no previous history of collaboration and this generally led to a much slower process in implementing the network.

We are still building the trust within the community and I think that if there had been an existing committee that had been working together on issues before, maybe this piece would not have been so difficult for us.

Almost all managers said that their community was able to engage in HBHC network development because they had previously established local goals for the reform of the child and family service system. Managers perceived that, although the mandatory guidelines for HBHC contained provincially determined goals, the previous local goals established by the community were more important than the mandate in promoting collaboration.

We have changed ours here and there in that we are meeting the mandated goals but we are also meeting the goals of the members around the table.

In this study, community ownership of HBHC appeared relatively achievable in local sites with a previous history of attempts to reform the children's services system.

One manager put it this way:

> *We were a really productive interagency group with some key players and we already had good relationships. We had worked on various tables before so we just called them up and said let's sit down here. So we have had everything prior to provincial announcements.*

Managers agreed that local communities struggle with their own vision and goals. They stated that local networks may adopt the guidelines of the HBHC program, but most importantly, they are focused on the needs of the community. A further discussion of the findings and the interpretation of their relevance to the collaboration theory literature is provided in the summary of the pre-conditions of collaboration at the end of Chapter 4 and in Chapter 6.

4.2 Institutional Conditions

Institutional conditions in this study are defined as the relationships of authority and accountability between the provincial government Office of Integrated Services for Children (OISC) and the local community networks. The Institutional Conditions theme and dimensions were partially based on factors in the conceptual framework (voluntary/mandatory model, common purpose development and communication style), and partially from open ended questions that asked public health managers about their involvement with the provincial Office of Integrated Services for Children. A voluntary/mandatory model of collaboration was identified in the conceptual framework as an environmental pre-condition of collaboration in Chapter 1. Common purpose development and communication style were identified as collaborative process factors in

the conceptual framework and these were re-categorized in this study and used to create the Institutional Conditions theme.

4.2.1 Effect of the Government Mandate on Local Communities

Based on the data from this study, the effect of the government mandate on local communities is explored in three dimensions: a) prescriptive nature of the HBHC Program, b) implementing the local collaborative network, and c) program expansion.

There was little disagreement among managers about the power of the provincial Office of Integrated Services for Children (OISC) to prescribe guidelines for local communities, monitor the activities of networks through required reports and direct the development of signed protocols between service providers.

Managers agreed that the initial guidelines issued by OISC recommended the composition of the required local network, but provided little else in terms of support or direction. However as the initiative progressed, direction from the central office became more prescriptive and network development became more complicated. Local HBHC managers found the provincial OISC's "cookie cutter" approach inconsistent with community ownership of the collaborative process. They also found the OISC becoming increasingly directive, with little leeway for a unique local response to the program. As monitoring by the provincial government became more institutionalized, one respondent noted:

> *It is actually a tightening in terms of their government control of what is happening at a local level.*

The majority of managers perceived the mandate as overly prescriptive. There was recognition in a few communities however, that the collaborative network would not have come together without direction from the provincial government. The mandate had forced to the table people who otherwise would not have been there.

> *I actually think it helped you know on the one hand, we all hate to be told what to do but on the other hand, it did push everybody to the table and in a sense made everybody play ball.*

Managers said that as the program continued and expanded, agencies were required to develop service protocols. This provincial directive compromised local autonomy and collaboration. As one manager remarked:

> *They were requesting protocol agreements again really from their perspective not from the community perspective... not what the community needed to do, it was collaboration based on their (OISC) requirements.*

Managers' perceived that the prescriptive nature of the program worked against the flexibility required to design something workable and responsive to local situations. They stated that some communities resisted government interference as a general strategy.

> *There is a common philosophy of being fed up with the government, particularly the provincial government at this point in time so they have that common understanding and they can banter back and forth and it is really here we go again and let's not focus too much on this piece because at the next co-ordinating meeting the rules will change.*

Most managers suggested however, that the directives contained in the guidelines had been developed with too little planning, demanded too much from networks and compromised local autonomy.

They were unrealistic and it just had the flavour of a legislated approach.

Managers differed in their views of how the mandate affected the development of the local collaborative network. The data suggested that for most communities with a history of collaboration, the mandate constrained the development of the HBHC network. Further, the data suggested that the mandate did not solve jurisdictional problems between provincial ministries which continued to play out at the local level. In commenting on the resistance to mandated collaboration, local managers explained:

> *If you don't have local collaboration there is no way in the world that government can mandate it. It is like mandating that you are nice so I don't think it (mandate) has made a difference.*

According to managers, forcing people to work together at the HBHC planning table ignored the reality that local communities need to decide what form of collaboration will work best. They believed that, rather than provincial interference to resolve issues of local collaboration, the mandate complicated network development. They said that the mandate created geographical and duplicative problems for local networks. Further, they thought that the different geographical boundaries of various ministries created representation problems. In addition, managers identified that both the provincial Children's Secretariat and the OISC mandated collaborative planning for children's services. These parallel mandates complicated HBHC network development at the local level.

Despite these difficulties, some managers recognized that the mandate did facilitate network development in communities without a history of previous collaboration.

> *I think where there was nothing in existence it made things flourish and where there was something in existence, it did not always help.*

Managers also said that the mandate had facilitated community partnerships because it demonstrated the seriousness of government intent to establish local collaborative planning for children's services.

> *If money got tight or if there was a squabble over whose role was what, it could split people off for a while but if you are mandated to be at the table and you don't get any funding by running off and doing your own thing, you do it by collaborating and working together and I don't think that has been a bad thing.*

As indicated in the data, the mandate for collaboration was a double edged sword for local managers. On one hand, it facilitated collaboration by forcing people to come together. On the other, it decreased local autonomy and neglected the lessons of history in local communities. The disparate jurisdictional and geographical boundaries of local communities did not go away because of mandated collaboration.

For almost all managers, the mandate complicated their work with local communities and constrained local collaboration. Anectodal data suggests that managers perceived negative changes in some of their relationships with local service providers. Where previously they may have worked collaboratively with others (e.g., hospitals and Children's Aid Societies) now the mandate forced the relationship. The imposition of a mandate for service provision without accompanying resources had a negative impact on

previously established relationships. Managers perceived that few communities found the mandate helpful. Almost all the managers said that: 1) the mandate was unnecessary for sites with a previous history of collaboration and 2) intrusive in communities with a history of resistance to provincial government directives.

Managers believed that one of the main difficulties faced by local communities was the introduction of new HBHC guidelines with unrealistic time lines. They agreed that the rapid expansion of the program with the addition of components such as: 1) the pre-natal screening component (identifies high-risk families before birth), 2) the post-partum service enhancement component (provides follow-up telephone calls and/or visits by public health nurses to all mothers within 48 hours of giving birth), and 3) the universal hearing screening component (provides assessment and communication development services to all new babies) caused frustration among local network members and compromised local ownership. Consequently, some local networks were less willing to take government directives seriously. As one respondent noted:

> *Things usually come out from them (OISC) fast and furious...they send us part of a program that needs to be implemented and it should have been done yesterday.*

There were also, however, positive responses to program expansion reported by managers. Because the program expansions incorporated a large number of services, people had begun to formally consider service co-ordination. As well, service providers were evolving and changing their attitudes to working together because of the expectations for the network.

Well the additional components are there now so the breadth of services that the network or advisory committee reflects is actually broader. You have to get your head around the guidelines. The seed has been planted but the time lines need to be more realistic.

Nonetheless, it was apparent from the data, that the speed of program expansions was problematic. Given the time it takes to develop collaboration among network members, managers were unhappy with being forced to perform in a climate characterized by unrealistic expectations for implementation. Managers reported:

In the sense that it is truly a coalition, the speed with which this has been implemented has frankly taken a toll on me.

Just when you think you have a handle on it and you are just beginning to say we are almost there, there is another one.

In general, managers blame the rapidity of the program expansions for forcing collaboration that is counter-productive to local community ownership of the initiative. They stated that they were worried about the quality of the program components that could be developed within the unrealistic time frames. Despite this uneasiness, they felt they had not compromised the program or their professional standards but had instead devoted more and more of their own time to ensure quality.

4.2.2 The Role of Provincial HBHC Consultants

Despite these difficulties in implementing the government mandate, managers did acknowledge the responsiveness of the provincial consultants of OISC. Provincial consultants used a variety of contacts to : 1) share information on new program developments, 2) clarify expectations in the provincial guidelines for the program and

3) problem-solve conflicts about budgets, data management and communication with other ministries and provincial associations. Using mechanisms such as provincial meetings, site visits, individual consultation and regional meetings, consultants acted as conduits between local communities and the provincial OISC. As shown in Table C.4.2, managers perceived that provincial consultants used multiple strategies to try and link provincial directives and local implementation in the HBHC Program as shown in Table C.4.2.

One strategy that managers believed was missing was the use of information technology. Managers said that OISC could have developed a web site and email list to link programs. They mentioned that Healthy Communities, CAPC, and CPNP all have a web site where questions and other information can be posted, enabling managers across the province to learn from each other.

Although, managers appreciated the efforts and timeliness of consultant feedback, they were frustrated by multiple changes in provincial consultants. First there was a revolving door syndrome (they would establish a working relationship with consultant and then that person would leave and be replaced). Second, the staffing complement of consultants was reduced at the same time that the program was rapidly expanding. Finally, consultants were reassigned to new communities, stressing the relationship between the provincial office and the local managers. Managers felt these changes were detrimental to the program:

Table C.4.2

Contact Activities between
Provincial Government Consultants/Local HBHC Programs

Type of Contact	Description of Contact
Regional Conference Calls	Consultants set up conference calls at a regional level between program managers
Individual Telephone Consultation	Phone calls between consultants and local program managers regarding guidelines, budgets, ISCIS data base, problem-solving, clarification
Regional Meetings	Regional model of consultation introduced and regional meetings replace provincial meetings
Individual Site Visits	Consultant made visits to local HBHC programs
Individual Email contact	Contact between consultant and local program managers through e-mail correspondence
Provincial Meetings/Presentations	Consultants arranged formal presentations on new guidelines and budgets and brought local program managers to Toronto
Provincial Memos	Consultants sent information memos on emerging guidelines/changes to local program managers
Provincial Training	Consultants arranged training for local program managers on new guidelines for HBHC program and ISCIS data base implementation.
Provincial Advisory Committees	Consultants organized provincial advisory committees and solicited feedback selected program managers.
Provincial Meetings of Public Health Nursing Directors	Consultants presented information on HBHC implementation to local public health nursing directors.

There was someone who came and met with the network and that was helpful..... but unfortunately very soon after that she was no longer our consultant and somebody else was and then the consultants ended up going from four or five to two people.

It was somewhat difficult to try to get up to speed on who was who and who did what and just when you thought your might have that piece in place, that person left and somebody else came... a lot of people at the provincial level have come and gone or whose roles have changed significantly.

Although managers recognized that consultants often did not know or could not share information, they acknowledged the swiftness of responses to local questions and concerns:

She is very reachable so if we have a question we can email her or we can telephone her and she responds very quickly.

There has been a good exchange of information so phoning down and getting responses back even if the response is "good question, I don't know the answer" or conflicting information. I must admit they have been very open to answer questions even if it has not been helpful.

Managers perceived an implicit, and in some cases explicit, understanding that the consultants were acting within a highly charged provincial environment and had little scope for independent information sharing or decision making.

I know they have pressures above them to push out programs and plans before they are really well thought out and that again creates all kinds of problems for us

Despite these constraints, the majority of managers found provincial consultants very helpful in clarifying program directives. The consultant's role was primarily

information sharing and clarification on the guidelines and budget, but the intensity of contact varied across the province.

> *They provided a fair amount of guidance and support and training around the program.*

> *The consultant we have right now is really terrific. She has been here three times in about a year and a half so it has been very good and we have called her many times and she has done the best she could for us.*

Others said that they had little involvement with provincial consultants:

> *It was kind of left up to you to design the implementation according to your community needs, they would give you advice if you called about clarification on pieces but I think so much was happening in HBHC that there were times they were not clear on what it was.*

Managers identified that as the program rolled out across the province, the provincial consultant's role shifted toward accountability and reporting requirements. They stated that this was most pronounced after the Integrated Services for Children Information System (ISCIS) data base became operational and enabled centralized monitoring of local programs. Managers stated that the ISCIS data base, introduced before it was perfected, was a source of frustration between the provincial office and local programs. Managers expressed concerns about the confidentiality of the data requested by provincial consultants and resisted provincial pressure for disclosure in order to maintain their professional ethics.

> *I have a big concern with client confidentiality in terms of what they are asking us to do in terms of gathering information.*

I find that some of the questions are really intrusive and I don't know if they need to know that.

As consultants adopted a more intense monitoring role, managers said that they (managers) experienced more pressure in their relationship with OISC. Evidence of this frustration is shown in their comments:

When you try to explain why it might take a little longer to implement a new initiative because of some of the politics going (local) there is ...you sort of feel like there is a token or very superficial level of understanding.

4.2.3 Institutional Communication

The third dimension representing environmental conditions found in this study to influence local collaboration was communication. Within this area, three specific institutional communication issues were reported by managers to be of importance: a) inter-ministerial communication at provincial levels, b) multiple provincial initiatives and c) provincial level HBHC communications strategy.

Managers said that the lack of inter-ministerial communication within the Office of Integrated Services for Children affected their efforts to implement HBHC at the local level. They stated that the vertical communication between provincial ministries and their local agencies was either non-existent or created confusion within communities. They believed that this was most pronounced between the Ministry of Community of Social Services (MCSS) and their local representatives. Managers identified that MCSS had a differential approach to working collaboratively with HBHC across the various regions. They stated that some MCSS representatives were actively involved while

others were either minimally involved or hostile to the initiative. Managers were acutely aware that other service providers involved in the HBHC program were not receiving information about the mandate for local collaboration. This occurred across specific ministries associated with the OISC, including institutional sections of the Ministry of Health and Long Term Care, Ministry of Community and Social Services, Ministry of Culture, Citizenship and Recreation and Ministry of Education. As noted by one respondent:

> *There is a lot of discussion that goes on between the different ministries at the level of the OISC but a lot of that does not get filtered down.*

Managers would like to have seen more clarification about the HBHC program from OISC, with clear direction on service co-ordination, not just to health units but to other ministries (e.g. hospitals, school boards and MCSS agencies). As one manager said:

> *So we are going and talking to our colleagues and they don't have a clue what we are talking about ..they are still waiting for people at the top to say yes, you should do this, this is important.*

> *Working with provincial associations, physicians, hospitals, education, MCSS not just leaving it to local networks. There needed to be some leadership by the OISC to say this is important and we are going to support and move this along.*

As well, almost all the managers said that OISC could have done more to clarify the mandate of networks. Guidelines were ambiguous and kept changing, which did not help with implementation. They believed that, if the guidelines had been clearer, it

would have been easier to communicate with local partners even if interministerial communication were missing.

> *From the very beginning the guidelines were so vague and then they started changing them so people in the community have become frustrated that you have not been able to give a consistent message from day one.*

On the other hand, several managers found the guidelines helpful, especially because they required that the network be implemented as part of the HBHC Program. Nevertheless, most respondents felt that the HBHC Guidelines were too vague, not consistent, and not well developed at a policy or program level before distribution by OISC.

> *They have to practice what they preach...there is an expectation that we will collaborate...in an integrated fashion...then the directives they give to individual agencies have to be consistent.*

The data in this study showed that, prior to HBHC, local communities were involved in COMSOC's collaborative network, Making Services Work for People (MSWP). Managers agreed that once HBHC was introduced, the MSWP initiative was given less prominence. Managers perceived that the government announcement that the Early Years Initiative was to be sponsored by the provincial Children's Secretariat and implemented by public health caused confusion among local service providers. First they were concerned that the parallel mandates in various guidelines were not recognized. Second, they had difficulty explaining that public health was to implement both initiatives (HBHC and Early Years). Third, they stated that the fragmentation of the

Early Years Initiative (sponsored by the Children's Secretariat) and the HBHC Program (sponsored by the OISC) created duplicative mandates for collaboration at the local level, and resultant conflict for local communities. Managers noted:

> *That is when you start to hear things like get your act together at the provincial level, we were seeing really good things come through that OISC and then this (Early Years) comes along and ... sometimes you wonder what is going on up there.*

> *Where we go from here I guess will depend on this Early Years thing which is through the Children's Secretariat and I am not so sure and I don't think that I understand why they did that through another branch.*

Managers said that the lack of a provincial communications strategy to introduce the HBHC Program to the community at large and to targeted professional groups was an obstacle to local collaboration. A number of communication and marketing strategies could and should have been developed at a central level and dispersed throughout the province. A mass media campaign targeted to the whole community should have explained the Healthy Babies/ Healthy Children Program.

> *In fact from day one there was not any clear communication to anybody who this OISC was, certainly not to service providers who when they talk about them people look at us, other service providers look at us with really blank looks.*

Instead, managers stated that they had too much responsibility for developing their own local promotional materials, logos and media campaigns. The responsibility for this communications strategy placed an unnecessary burden on managers. Managers

stated that since the program was provincial in scope, it should have had a consistent marketing campaign across the province.

> *The idea of the program was provincial and that is was supposed to be easy for people to move from my area to your area .... but when you have different logos, it loses some of that.*

Managers indicated that in other large-scale provincial initiatives, such as the Heart Health Campaign, media campaigns were developed centrally by provinical marketing experts and this kind of government support should have been provided to local programs.

> *Media information should have been better ....it just seems to have been handed off as a local program and I think there should have been more media promotion about it.*

Managers believed that the lack of a province wide marketing strategy for HBHC was not the only communication void constraining local implementation. As the program unfolded, it became increasingly difficult for managers to engage the mandatory stakeholders. They stated that hospitals responsible for carrying out screening of all new mothers, were notably uninformed of provincial expectations for their participation. Further, they stated that, Boards of Education and Municipal Recreation Departments were difficult to recruit, even though their respective Ministries of Education and Training, Citizenship, Culture and Recreation were part of OISC. Managers felt that OISC should have been working with provincial associations (hospital, medical) and

other professional groups to support participation in HBHC at the local level. As one manager stated:

> *They have a lot more work to do provincially with the Medical Association or maybe working more at a provincial level with hospitals to encourage their involvement.*

In summary, this study identified institutional conditions that played an important role in the implementation of the local collaborative network in the HBHC Program. Managers cited the government mandate for collaboration on local communities, the role of provincial consultants from the Office of Integrated Services for Children and how interministerial communication all influenced local collaboration. The government mandate for the HBHC program constrained local collaboration because it was too prescriptive and too compromising of local autonomy. As the role of the provincial consultants shifted from facilitative to directive, they became a constraining influence on local collaboration. The lack of consistency of both the numbers and designation of consultants to specific communities was also a barrier to collaboration. It was difficult for managers to know whom to call for answers to questions since consultants were being reduced or reassigned during the period when program components were being added. The lack of inter-ministerial communication at the provincial level created barriers to implementing mandatory local collaboration. Finally, the lack of a provincial marketing strategy to introduce Healthy Babies/ Healthy Children as a province-wide early intervention program constrained the implementation of the local HBHC Program.

4.3 Financial Conditions

Financial Conditions are defined as the resource availability (or lack of resources) that influence local collaboration by either motivating or constraining participation in interorganizational relationships such as the HBHC network. Sufficient resources were identified as a collaborative process factor in the conceptual framework. Analysis led to the re-classification of this process factor as an environmental pre-condition that influenced local collaboration in the HBHC network. The term sufficient resources was not expansive enough to incorporate findings that suggested that the exclusive provision of resources and need for dedication of local funds to HBHC were also resource dimensions that influenced collaboration. In this study, managers stated that provincial allocations for the implementation of HBHC created resource conflicts. They believed that the exclusive allocation of HBHC resources to public health did not always engender positive community response. In addition, they identified that the lack of administrative funding for developing and managing the HBHC network had drained local public health resources.

Three dimensions of collaboration related to the provision of resources for the HBHC program were found in the data: 1) lack of administrative funding for HBHC network (e.g., administrative salaries, room rental, photocopying, postage), 2) need to use local public health funds that were allocated for other programs and 3) exclusive dedication of HBHC resources to public health units/departments (Table C.4.1.).

4.3.1 Lack of Administrative Funding

Managers often expressed their frustration with the lack of funding for administration in the HBHC budget. They agreed that the overlapping provincial initiatives (e.g. HBHC, MSWP and Early Years) burdened managers. The demands of the HBHC network and mandatory participation in parallel mandates strained their time and energy:

> *It has been very stressful because it is not only HBHC but many other initiatives ...they are exciting and terrific directions...and you want to take advantage of them but you don't get any staffing or administration to do it and yes, it becomes overwhelming.*

In this study, the data suggested that provincial government expansion of HBHC also strained the capacities of managers and network members. Without budget allocations for the development of the HBHC network, members participated as an in-kind service. Managers stated that they were stretched thin trying to facilitate the huge workload associated with HBHC:

> *They have cut funding toward administration so there is no funding there at all and there used to be a little bit at the beginning but really little and now it is totally eliminated so you have to do everything as a manager....they just increase your amount of work.*

Managers stated that initially, a small amount of funding was provided for administration of the HBHC program. More recently, they stated, the provincial government only funded direct service costs. Managers found the provincial government inconsistent in its messages regarding the budget:

There was a formal decision made at the provincial level that you could in fact use some dollars for management....and there was inconsistency in information that would come ...for example one budget came in bits and pieces and it was very clear you could not have any management/administration costs.

HBHC managers had strong opinions on funding of network activities. In their view, the provincial budget for HBHC should include funding for network costs such as management salaries, administrative support, community development support and meeting costs. The majority of managers perceived the expectations of the provincial government regarding network development as unrealistic. Some, but not all, said that there was little understanding at the provincial level of either the time or complexity involved in developing local collaboration in HBHC. As one manager stated:

In a very broad kind of way, there is a lack of understanding at the provincial level (OISC) for the amount if time it takes to work with communities and I say that on two levels, one the amount of staff time it takes to actually host meetings and develop plans and so on but also in a longer time sense, here are the guidelines and we want you to implement it in two months and bring the community together to create a plan so certainly there have been a number of examples where unrealistic expectations for community collaboration have been there.

Managers believed that in order to take substantial action in network development, they need resources. The majority of managers said that if the provincial government is serious about mandating local collaboration in the HBHC program, then they must be willing to dedicate resources to its development and maintenance. To summarize managers' perceptions:

If we think it is important to have these kinds of collaborative partnerships going then we have to be willing to invest the time in them and the ministry (OISC) has to be willing to fund the time.

4.3.2 Need for Additional Public Health Funds

Manager's identified that HBHC began as a 100 per cent provincially funded program to be administered by public health units/departments in Ontario. They stated that as the program unfolded across the province, it became clear that health units had to absorb the cost of the administrative functions associated with HBHC. They commonly recognized that HBHC has been a huge strain on public health resources.

It is not 100 per cent funded, it is subsidized by all health departments I am sure and I think as they roll it out across the province, they have been very lucky and they have a very, very committed group.

It has absolutely been devolved as well.. just as all the other public health programs.

It is a huge issue...because we are being asked to subsidize a program with a provincial mandate...it affects me...because I work an awful lot of hours...they are asking a lot from the people who are in the program because they are not willing to cover the administration costs.

Two types of resource demands were stated by managers. First, the provincial database program (ISCIS) used for monitoring HBHC had no initial budget allocation for data entry or training. Second, overlapping initiatives instituted by the provincial government have mandates that also require managers' involvement.

There has been a huge underresourcing of the administration costs to HBHC and they (OISC) can stand there and say you can absorb it and I know they are saying it and not believing it but the fact remains that in this political climate where we downsize management, province could not put forth a program that had increased administration time.

Finally, managers expressed concern that HBHC was taking time, energy and resources away from other health unit/department programs.

I should mention first that you basically have to rob your other programs and that is not fair because other programs are all equally as important as this one.

Many times managers referred to the devolution of public health and stated that the lack of administrative funding for HBHC was no different from other downloaded programs (such as ambulance services). From their perspective, HBHC emanates from larger social, economic and political arenas whose downloading policies influence HBHC implementation across local communities. One manager noted:

It is privatization and downloading while funding sources were being cut back dramatically. Some service providers who could support these families are no longer in existence.

4.3.3 Exclusive Dedication of HBHC Resources

Managers identified that funding for HBHC was given to public health as the convening organization. They stated that some community partners, who were dealing with fiscal restraints in their own programming, were unhappy about this exclusive dedication of funding for HBHC. Managers perceived that the allocation of substantial resources by the provincial government to public health units/departments

represented a change in the local fiscal environment. Local service providers, such as hospitals, were expected to provide services to support the program but received no additional resources for this program addition. At a community level especially, managers perceived that some service providers felt that HBHC was taking over and being funded for too many services while their programs were being cut back. They agreed that the screening and early identification demands associated with HBHC put greater stress on other service providers without giving them access to additional funding. Managers indicated resistance from community partners:

> *Here we go again, you are the ones with all the money*
> *and now you are asking us to free up some staff time to do this.*

The data showed that not all community partners were upset about resource allocations. Managers found those who had been involved in community collaboration were the most accepting. They tried to explain the funding of HBHC to others as a logical decision because of the provincial public health infrastructure. Some managers identified that the Medical Officer of Health was instrumental in engaging stakeholders for the local HBHC network. They perceived that most organizations viewed the resource allocations in a positive light because they were happy to have public health doing home visiting again. Nevertheless, managers acknowledged that the implementation of HBHC put a strain on relationships as other local service providers competed for resources.

As long as we stayed in the area of babies and pregnancies
and breast feeding, when they added the early identification piece.. ...
we are going beyond the newborn, then we are going to have trouble.

4.4 Summary of the Pre-Conditions of Collaboration

This chapter has explored Historical, Institutional, and Financial Pre-conditions found to influence collaboration in the HBHC Program. First, the data in this chapter has suggested that having worked together previously on collaborative networks was an important influence on local collaboration in the HBHC network in the present. Second, the history of public health service delivery in the local community was important to local collaboration. This service provision history (as a factor that influences local collaboration) was not identified in the research literature on collaboration reviewed in Chapter 2. Although literature on mandatory collaboration is not well developed, researchers have been exploring the influence of the status and legitimacy of the convening organization on collaboration. In this study, the status and legitimacy of the convening organization (public health units/departments) appeared to be linked to their history of service provision. While this particular phenomenon is not prevalent in collaboration research, it suggests that this is one area of research on mandatory collaboration that could be a productive area for inquiry. Third, this chapter has shown, local communities with a history of working together had their own local goals for reforming the service system and these were an important influence on collaboration. Although common purpose is considered in the literature to be an important influence on

collaboration (Meyers, 1993; Gray, 1989), research on the distinction between local goals and state mandated goals for collaboration was not included in the literature review for this study. Collaboration research has primarily addressed voluntary collaboration in the past. As state mandated collaboration increases in the era of downloading, it appears that research on the local expression of the mandate would be productive. In this study, the majority of local communities had established their own local goals and enfolded provincially mandated goals within their locally determined initiative. Further studies on how communities mediate the tensions between their local needs, goals,and vision, and those of a centrally determined program could be productive.

This study suggests that a relationship history, whether based on mutual respect or more conflictual feelings, influences local collaboration. The data in this study affirms other research that suggests that a history of working together at a community level influences collaboration (Dunlop & Angell, 2001; Polivka, Dresbach, Heimlich, & Elliott, 2001; Harbert, Finnegan, & Tyler, 1997; Mattessich & Monsey, 1992; Oliver, 1991; Galaskiewicz & Shatin, 1981). More specifically, the importance of previous community collaboration in this study is supported by literature that suggests that a history of working together *encourages* collaboration (Gray, Duran, & Segal, 1997).

In this study, the focus on the unique local history of each community contributed to understanding local collaboration and highlighted questions in the research literature about the influence of community culture. Managers in this study identified that local traditional approaches to planning for children's services were in place before the

provincial government mandated HBHC network development. In addition, local community collaboration has been shaped by previous children's services projects initiated by federal and provincial governments.

One factor identified in the literature is the community receptiveness to working together to build collaborative partnerships (Lasker, Weiss, & Miller, 2001; Harbert, Finnegan, & Tyler, 1997; Mattessich & Monsey, 1992). Other studies have identified a number of factors that complicate local collaboration such as: 1) a previous history of difficult relationships, 2) lack of time, 3) geographical barriers and 4) numerous partnerships requiring many of the same stakeholders (Mattessich, Murray-Close, & Monsey, 2001; Lasker, Weiss, & Miller, 2001; Mitchell & Shortell, 2000). Managers in this study also identified localized configurations of conditions that influence local collaboration including: 1) multi-site networks 2) parallel mandates, 3) alternative networks, 4) previous experience with collaboration and 5) commitment. They believed that the implementation of the HBHC network was dependent on these local conditions.

From the perspective of Institutional Conditions, three dimensions were found in the data to influence collaboration: 1) government mandate, 2) the role of provincial consultants and 3) institutional communication. Managers stated that the mandate for HBHC was too prescriptive, constraining implementation and compromising local autonomy. Further, the data in this study suggested that the change in provincial consultants from a facilitative to directive role influenced local collaboration. The role of the provincial consultants in this study, represented "top down" control by central

government. The findings from this study extend knowledge about central/local relationships because they identify that a "top down approach" by central government created conflict and resistance to collaboration in the local community. This resistance to "top down" mandates confirmed other research that suggests that reliance on formal mandates are non-productive (Ring & Van de Ven, 1994). Further, this study supports research that suggests interpersonal relationships are a more positive influence on local collaboration than external mandates (Gray, Duran, & Segal, 1997; Huxham, 1996; 1993; MacNair, 1993). The resistance of some local communities to the provincial mandate in this study is similar to other research that has suggested state mandated collaboration can create resistance among stakeholders and hinder collaboration (Woodard, 1994; Alter & Hage, 1993; MacNair, 1993; Melaville & Blank, 1993).

Finally, managers indicated that the lack of communication between provincial ministries and the lack of a province-wide marketing campaign for the HBHC program negatively influenced local collaboration. This finding emerged from the data and was not part of the original literature review in this study. It may suggest, however that mandatory collaboration creates governance issues for centrally determined programs that require local collaboration. Further exploration of these governance issues would be a productive area for future research on state mandated local collaboration.

The lack of inter-ministerial communication identified by managers in this study raises questions about how the co-ordination of communication both internally within

government departments and externally between multiple sites can be developed to promote local collaboration.

The final pre-condition theme of collaboration, Financial Conditions, included three dimensions. First, the study found that the lack of administrative funding provided by the provincial government for the management of the HBHC Program was unrealistic and constrained implementation. Managers invested with the responsibility for development of the mandated HBHC needed resources to implement local collaboration. In this study, the data on lack of administrative funding confirms findings in the literature that identify inadequate financing of administrative and management functions as a barrier to interorganizational collaboration (Mitchell & Shortell, 2000; Payne, 1998).

This study affirms previous research that identified the importance of having a paid administrator as a factor in successful collaboration (Mulroy & Shay, 1998; Mulroy, 1997; Mulroy & Cragin,1994). Second, the lack of administrative funding for HBHC was a drain on the resources of public health units/departments. Finally, the data in this study suggested that the exclusive dedication of funding for HBHC to public health units put stress on other service providers who had to respond to demands for increased service without additional funding.

Questions in the research literature about the need to link mandates and provision of funds were also raised by this study (Mitchell & Shortell, 2000; Payne, 1998). This study suggests that the ability to build local collaboration was constrained by the level of

resources provided by the provincial government. Research elsewhere has shown that the combination of state mandates and state funds acts as a powerful incentive for collaboration on service integration (MacDonald, 1994). In this study, the lack of adequate funds constrained local collaboration. This confirmed other research literature that suggests state mandates do not act as an incentive for local collaboration unless they are accompanied by adequate resources.

Chapter 5 The Processes of Collaboration

5.0 Introduction to the Collaborative Processes

This chapter describes the collaborative processes identified by managers as influencing mandatory collaboration in the HBHC Program (Table C.5.1). Collaborative processes are defined as interactional processes that constrain or facilitate the formation and maintenance of interorganizational relations. The conceptual framework for this study was based on factors found in the literature to influence collaboration, such as: 1) stakeholder representation, 2) membership participation, 3) costs and benefits of membership, 4) decision-making levels, 5) communication style, 6) formality/informality of linkages, 7) common purpose development, and 8) sufficient resources.

Operational Processes, the first theme within "collaborative processes", was conceptualized from data based on questions linked to the conceptual framework for this study. The Operational Processes theme reflects findings in the research literature that support the influence on collaboration of such factors as: stakeholder representativeness, membership participation, membership costs and benefits, decision making levels and formality/informality of linkages (Mattessich & Monsey, 2001, 1992; Provan & Sebastian, 1998; Wandersman, Goodman & Butterfoss, 1997; Ring & Van De Ven, 1994).

Organizational Processes, the second theme within "collaborative processes", is a new collaborative process theme and derived from the data in this study. As outlined in

Table C.5.1

Three Collaborative Process Themes Of Collaboration

Operational Processes	**Organizational Processes**	**Relational Processes**
Membership	Organizational Structures	Previous Relationships
Formalization	Level of Structure	Interpersonal Relations
Decision-making	Complexity of Structure	

Chapter 3, this organizational dimension of collaboration was not part of the original conceptual framework that shaped the interview guide. The Organizational Processes theme suggests that researchers should look beyond the integration of organizational structures and consider the organizing processes of collaboration into structures and sub-structures (Rubin & Rubin, 2001; Bailey & McNally-Koney, 2000; Alter & Hage, 1993; Mizrahi & Rosenthal, 1993; Zuckerman & Kaluzny, 1991).

Third, another new theme of collaboration, Relational Processes, was also developed from the data. This relational dimension of collaboration was not part of the existing conceptual framework that shaped the research questions. Although several studies have addressed interpersonal relations and collaboration, this study suggests further research on the interpersonal relations would be productive for collaboration theory (Dunlop & Angell, 2001; Rivard, 1999; Seabright, Levinthal, & Fichman 1992; Oliver, 1990).

5.1 Oeperational Processes

An analysis of the data that were re-classified within the Operational Processes theme (membership participation, membership costs and benefits, decision-making levels, formality/informality of links and stakeholder representation) led to the development of three sub-themes: 1) membership, 2) formalization and 3) decision-making (Table C.5.1).

5.1.1 Membership

Membership is defined in the literature as an internal dimension of collaboration that refers to issues such as consistency of membership, whether members are participating as individuals or organizational representatives and whether there are membership cliques within collaborative groups (Mattessich & Monsey, 2001;1992; Provan & Sebastian, 1998).[1]

The data suggested that three dimensions of network membership influence local collaboration: a) how stakeholders were recruited to participate in the network, b) the representativeness of sector stakeholders who participated in the network and c) the rewards and demands of network membership (Table C.5.1).

Stakeholders were recruited for the HBHC network both by managers and by existing network members using various strategies and targets using formal and informal activities targeted to stakeholders at individual, organizational, community and government levels.

Managers employed formal mechanisms such as letters, information packages and community workshops (Table C.5.2). They also engaged members through personal contact such as telephone calls and face to face meetings. In many cases, they used sequential strategies such as formal letters of invitation followed up by phone calls, or

[1]Managers did not distinguish between stakeholders and members in their responses and consequently this study blends these two concepts in the results and conclusions.

Table C.5.2

Stakeholder Recruitment Activities

Local HBHC Collaborative Network Stakeholder Recruitment Activities	
Type of Recruitment Activity	**Target of Recruitment Activity**
Telephone Calls	Service Organizations
Face to Face Meetings	Service Organizations
Committee Liaison	Interpersonal relationships of Network Members
Community Workshop	Community-wide Invitation
Professional Relationships	Service Organizations
Request to Administrators	Administration of Service Organizations
Invitations to Municipal Departments	Local government departments
Specific Letters of Invitation	Specific stakeholders identified in HBHC guidelines
Specific Information Packages	Specific stakeholders identified in HBHC guidelines
Medical Officer of Health Letters of Invitation	Service Organizations and Municipal government departments
General Information Packages	Local professionals and other children's services providers
General Letters of Invitation	Local professionals and others children's services providers
Sequential Strategies: Phone Call followed by Formal Letter of Invitation	Service Organizations
Network Participation Commitment Form	Stakeholders committed to participation in HBHC Network
Public Health Staff Liaison	Specific Organizations that work with public health
Sequential Strategies: Informal Recruitment at Meetings followed by Formal Letter to Organization	Attendees of local interagency meetings
Personal Contact	Interpersonal relationships of HBHC Manager

informal contact with stakeholders at other community meetings, followed by a formal letter to their organization. There were some weaknesses in recruitment to the HBHC network. Most managers reported little success in recruiting parents/consumers. Some parents/consumers provided ad hoc feedback on plans, but this was not reported across most study sites. Similarly, while there was little recruitment of community members at large, some networks had community representation. A community member chaired the HBHC network in only two sites across the sample. The majority of managers reported following provincial guidelines for HBHC network composition. However, several managers experienced recruitment barriers because: 1) they were new to the area with no previous history with local stakeholders, 2) there was a small pool of people to draw on in rural areas, 3) parallel provincial mandates were taxing local organizations and, 4) the rapid expansion of HBHC was a barrier to recruiting local stakeholders.

The representativeness and evolution of membership on the HBHC network were important issues emerging from the research. Managers completed a HBHC Stakeholder Checklist (Appendix C.3.A.6). Stakeholders in the HBHC networks were then categorized by the researcher into the following sectors: 1) health, 2) social services, 3) education, 4) recreation, 5) housing, 6) developmental disabilities, 7) childcare, 8) local centers, 9) Community Action Program Canada (CAPC) and Community Pre-Natal Nutrition Program (CPNP), 10) multicultural, 11) religious,12) business/service clubs and 13) other (Table C.5.3).

Table C.5.3
Stakeholder Involvement in HBHC Network by Sector

SECTOR	STAKEHOLDERS BY SECTOR
1) **HEALTH**	Hospitals Public Health Adolescent Pregnancy and Parenting Groups Children's Mental Health Centers Family Physicians Midwives Substance Abuse Programs
2) **SOCIAL SERVICES**	Ministry of Community and Social Services Children's Aid Societies Non-Profit Family Counseling Family Support Agencies Infant Development Programs Domestic Violence Programs Adolescent Crisis Services Employment Programs
3) **EDUCATION**	Boards of Education (Public and High Schools)
4) **RECREATION**	Recreation Services (YWCA/YMCA/Municipal)
5) **HOUSING**	Housing Co-operatives Homeless Shelters
6) **DEVELOPMENTAL DISABILITIES**	Developmental Disabilities Services
7) **CHILDCARE**	Child Care Providers
8) **LOCAL CENTERS**	Teen Centers Family Resource Centers Neighbourhood Resource Centers
9) **CAPC/CPNP**	CAPC/CPNP Programs
10) **MULTICULTURAL**	Multicultural Associations
11) **RELIGIOUS**	Churches/Religious Institutions
12) **BUSINESS/SERVICE CLUBS**	Local Businesses Local Business Associations Service Clubs
13) **OTHER**	Politicians, Professional Associations, Justice System, Media, Community Care Access Center, District Health Council, Ministry of Citizenship, Culture and Recreation, First Nations Groups and Speech and Language Services

The per cent of stakeholders participating in the HBHC Collaborative Network by local community sector is shown in Figure C.5.1. Almost a third of the network was comprised of social service participants with just over one-quarter from the health sector. Eleven per cent (11%) of network participation was from local health and social service centers (e.g. Family Resource Center, Teen Health Center, Neighbourhood Center, Community Health Center). The other sectors each accounted for less than ten per cent (10%) of the membership.

The majority of stakeholders participating in the HBHC network represented their organizations with little involvement of community members, parents or advocates. While managers used the composition guidelines provided by the provincial government, they also tailored the membership to fit their own local community.

> *Most people are there as representatives of their organization.*
>
> *I would say from my observations that they participate as members of their group or organization.*

Most managers perceived the lack of parent/consumer participation as a drawback. They reported that they tried to have parent participation. Unfortunately daytime meetings that would require time off work made it difficult for parents to attend. As one manager noted:

> *We have tried to approach parents that we have ourselves been involved with rather than going to the community at large, it is very difficult we know from past experience with committees to try and recruit parent representatives.*

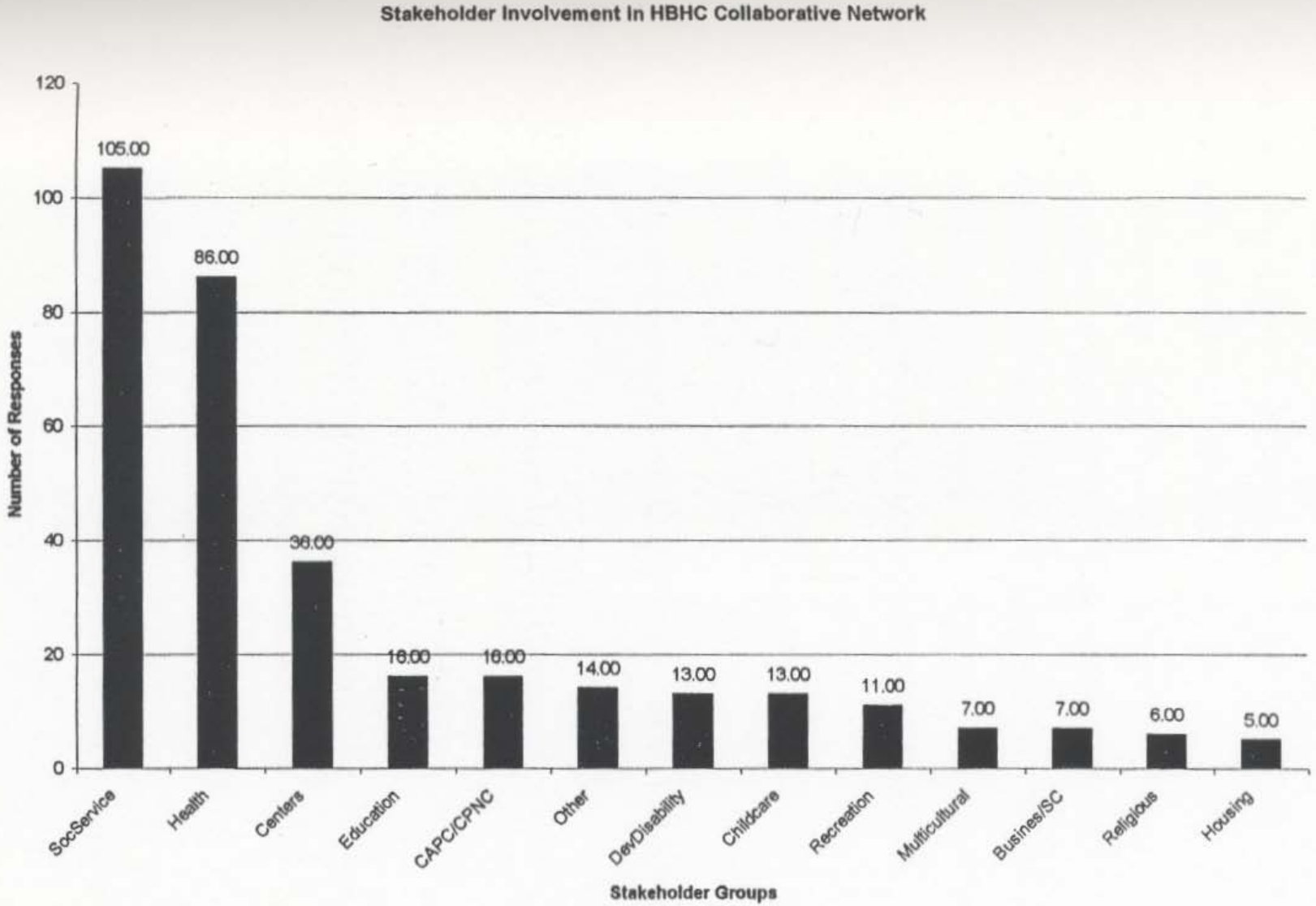

Stakeholder Involvement in HBHC Collaborative Network
Number of Responses
120
100
80
60
40
20
0
105.00
86.00
36.00
16.00
16.00
14.00
13.00
13.00
11.00
7.00
7.00
6.00
5.00
SocService
Health
Centers
Education
CAPC/CPNC
Other
DevDisability
Childcare
Recreation
Multicultural
Busines/SC
Religious
Housing
Stakeholder Groups

Figure C.5.1

The majority of managers perceived the lack of parental involvement as a weakness of their network. Some felt, however, that the network was not at the appropriate stage for parental involvement. Managers saw stakeholder participation as an evolving process for most networks. In some communities with previously existing networks, new stakeholders were recruited for specific HBHC program expansions. This evolution in stakeholder participation may be as important as (if not more important than) the actual count of representation. By evolving and changing, the network may be able to recruit stakeholders committed to its changing mandate and strengthen its broad-based community representation.

> *You have to sit down and talk about who is doing what in terms of early identification and who is missing from the table and revise your membership accordingly.*

In other communities, managers said that committees or networks were expanded to bring necessary stakeholders together.

> *Continually adding partners someone will say well, we should have this group represented and the group is always in agreement.*

> *Broaden that steering committee to bring it all to the table so we get other partners and stakeholders are we expand.*

Data on members of HBHC networks suggested that the evolutionary nature of stakeholder participation is an important influence on collaboration. Two other influences on stakeholder representativeness were considered important by managers. First, the mandatory guidelines for participation were adapted to fit the unique configuration of local sites. Second, managers identified barriers to participation by

parents such as: a) the lack of mandated parental involvement b) the generally acknowledged difficulties with parent recruitment and/or c) the resistance of some managers to parent involvement.

Managers found it difficult to cope with all the responsibilities associated with the time consuming and complex tasks of the HBHC network. Barriers included problems such as: 1) overlapping networks, 2) initiating networks, 3) extensive number of meetings and 4) covering large geographical distances. A number of managers talked about the need for agency and community recognition that long-term collaborative processes are complex and time-consuming.

> *Don't have a lot of time available so there is a real sort of pulling here and there, you have to be committed to devoting the time and you have to have support from your own agency or even within your own agency that this is worth spending time on.*

> *Does take time, joint planning, joint community initiatives do take that time, it would be much more efficient in terms of my time to just be able to have the reins and run with it.*

The research questions on membership assessed managers' perceptions of the demands and rewards for participation in the HBHC Network. Managers' responses identified many more rewards than demands associated with local collaboration. From the program managers' perspective, there were individual, organizational and community rewards associated with participating.

As shown in Table C.5.4, stakeholder participation increased community level activities such as networking, collaboration, joint training and joint proposals.

Table C.5.4

Membership Rewards: Participation in HBHC Network

TYPE OF BENEFIT	LEVEL OF BENEFIT	
	INDIVIDUAL/ ORGANIZATION	COMMUNITY
1. Networking	X	X
2. Joint Proposals		X
3. Reduce Duplication		X
4. Increased Commitment to Children/Families		X
5. New Relationships	X	X
6. Learn From Each Other	X	X
7. New Information	X	X
8. New Ideas	X	X
9. Assist Organization Goals	X	
10. Increased Collaboration	X	X
11. Increased Ease -Referrals	X	X
12. Joint Training		X

Managers also reported rewards such as achieving local goals of reducing duplication and increasing co-ordination of services for children and families.

> *The main benefits would be networking.....planning a system of services although we are at the infancy stages of this piece so I think that is coming.*

> *I think the networking is really important because it is one place where you see a lot of people that you need to see and therefore if you come a little early or stay a little after the meeting, you can always grab somebody and take care of something that needs to be done.*

At an individual level, managers increased their knowledge, developed new relationships and enjoyed the opportunity to learn from each other and share resources. From an organizational perspective, membership in the network had: 1) increased the ease of referrals between agencies, 2) improved service co-ordination and 3) created shared resources. Participation in the HBHC collaborative network facilitated organizational goals because it provided a forum for networking where agencies learned about new programs being developed by their partners. It also offered an opportunity for organizations to plan joint training and program proposals.

> *It is stimulating and challenging and we are sharing resources and learning it has opened up a very good world to work in.*

5.1.2 Formalization

The formality/informality of linkages was identified in the conceptual framework as a collaborative process factor. Two questions (# 21 and # 22) in the interview guide asked managers the describe the extent to which formal or informal agreements and procedures characterized the HBHC network. Data showed that the majority of networks

did have formalized agreements and/or procedures for carrying out their activities. This study affirms the work of other scholars who suggest that standardizing interorganizational exchange through formalized agreements facilitates collaboration (Meyers, 1993, Mattessich & Monsey, 1992). Three dimensions of the sub-theme of formalization, developed from the data in this study, are identified as: 1) type of documentation and 2) source of documentation and 3) service protocols (Table C.5.1).

Managers agreed that the type of documentation created by HBHC networks had diverse levels of formalization across the study sites. Most managers indicated that their local community had developed terms of reference for the HBHC network. The data suggests that this was the common denominator for formalization. Managers stated that these terms of reference were used to develop a sense of ownership and commitment to the HBHC networks and to clarify their goals. Managers indicated that, for some networks, the formalization of the HBHC network appeared to increase over time as provincial guidelines for program expansion were incorporated and local network operations became more complex.

> *The advisory committee is pretty structured with an organizational chart and terms of reference.*

> *We have vision principles, terms of reference for each committee, when we strike a work group to work on a project, they come out with a workplan, we develop a workplan annually for the whole network, each subcommittee.. we have a report from each project area of each committee and we create an annual report.*

The data revealed that in instances without a "formal network culture", managers created formal monitoring strategies that outlined how network members would work

together (e.g. terms of reference, membership voting rules, formal membership letters, elections for executive committee, Robert's Rules of Order) as outlined in Table C.5.5. As well, they created a wide range of formal documents that defined how the network would function and report its progress (e.g. agenda, minutes, sub-committee reports, annual reports, workplans, and annual meetings).

> *Yes absolutely, lists of members, minutes are circulated, and there is an agenda and terms of reference.*

The data suggests that a majority of communities had complex and formal procedures and structures representing various organizational levels (e.g., umbrella groups, sub-committees, working groups). It appears that, in communities with pre-existing children's services networks, there appeared to be a more formal process, reflecting previous experience with collaborative ventures. Similarly, in communities with multi-site networks, managers identified formalized reporting procedures to facilitate communication between primary and secondary organizational structures.

The data suggests that, generally speaking, those networks that were incorporated into previously existing collaborative organizations were more formal, assuming an operational style constructed over time.

Table C.5.5
Indicators of Formalization: HBHC Network

Type of Formalization	Organizational Level
Agenda	HBHC Network
Annual Meeting	HBHC Network
Annual Report	HBHC Network
Budget	Public Health Unit/Department
Elections for Executive Committee	HBHC Network
Executive Committee	HBHC Network
Formal Membership Letter	HBHC Network
Formal Membership Lists	HBHC Network
Formal Minutes	HBHC Network
Funding Proposals	HBHC Network
Implementation Plan	HBHC Network
Letters of Support	HBHC Network
Logic Model	HBHC Network
Membership Voting Rules	HBHC Network
Operational Plan	Public Health Unit/Department
Operational Plans	HBHC Network
Organizational Chart	HBHC Network
Robert's Rules of Order	HBHC Network
Service Agreements	Public Health Unit/Department
Service Co-ordination Forms	HBHC Network
Service Co-ordination Guidelines	HBHC Network
Signed Service Contracts	Public Health Unit/ Department
Signed Service Protocols	Public Health Unit/Department
Sub-committee Report - Verbal	HBHC Network Sub-Committee
Sub-committee Report - Written	HBHC Network Sub-Committee
Sub-committee Terms of Reference	HBHC Network Sub-Committee
Sub-committee Workplan	HBHC Network Sub-Committee
Terms of Reference	HBHC Network
Vision Principles	HBHC Network
Workplans	HBHC Network

We use what you would use in any organization, we use formal workplan, formal year end report and we have a planning meeting at the beginning of the year...a strategic approach, so where are we now, what are the needs out there, where do we want to go..and then everybody goes and alters their committee work.

From the local program manager's perspective, the negotiation of service protocols with network members was a critical element of local collaboration. As part of the government mandate for the HBHC program, they represented an agreement on the service exchange relationships between network members in local communities. Even though they are required by the provincial government, some managers stated that their formal nature and extensive development time made them difficult to implement. Others suggested that the protocols helped to streamline the service co-ordination piece of HBHC and clarified referral mechanisms between agencies.

A number of managers had signed agreements with their community partners such as hospitals and Children's Aid Societies (CAS):

It is an important step because a protocol is an agreement and people sign it and then you have the mechanism for at least some accountability, I like it.

However, many managers did report that the collaborative process leading to the development of the formal protocol was time consuming and difficult. Moreover, some service providers resisted signing protocols once they were created.

We have formal protocols but they are not signed, there is still that resistance and hesitation.

The ones we were worried about we did straight away so the CAS we had to do within the first few months ...the ones I was less worried about I have been a little slower in doing and we are working on those, we probably have ten draft protocols right now in the works.

Manager's identified HBHC service protocols as important mechanisms for promoting collaboration. At the same time, they (managers) believed that one needed to be realistic about the time and organizational constraints that accompany collaborative processes such as formal service protocols.

5.1.3 Decision-making

Decision making was identified as a collaborative process factor in the conceptual framework for this study. Two associated questions were used in the interview guide. Question # 17 addressed the type of decisions that network members were asked to make and Question # 18 addressed the decision making level of network members. Decision making type was initially defined as the type of decisions that network members have been asked to make relevant to the HBHC Program. After analysis of the data, decision making type was re-interpreted as decision-making stage. This appeared a more relevant term, given that HBHC networks were at an early stage of development and did not require complex or resource allocation decisions. Decision making level is defined as the level of organizational decision-making power of HBHC network members and their influence on collaboration. The findings from this study affirm previous research that identified decentralized decision-making (interpreted in this study as managerial authority to make decisions for their organizations) as a factor that promotes collaboration (Dunlop & Angell, 2001; Mitchell & Shortell, 2000).

Thus, two dimensions within the decision-making sub-theme of Operational Processes were identified: 1) decision-making level (based on the question from the conceptual framework) and 2) decision-making stage (a reconceptualization of the original decision making type) (Table C.5.1). The majority of managers reported that their networks contained managerial level members who were able to make decisions for their organizations. This heterogeneity of decision making power was considered a strength, as articulated by managers:

> *Off the top of my head I think that when the decision-making power exists within the group or around the table, the collaboration process is enhanced.*

> *Well because if we have the main decision makers they are the ones who have the influence on development and implementation of any policy and practices that we come up with ...so things go smoother.*

A few managers identified a combination of managerial and direct service level members. In these situations, where there were varying levels of decision-making power, the work of the network appeared to be slowed down.

> *Because there are different levels of agency representatives around the table, they don't all have the same decision-making power. They go back to their agencies to get approval.*

While managers stated that lack of decision-making power appears to hinder collaboration, there were some concerns about the exclusivity of managerial representatives on the network. First, a few managers said that decisions made at network meetings were not shared with direct service staff. Second, a few managers felt

that they needed the input of direct service staff to make good decisions about the HBHC program:

> *Direction does not get filtered down to the front lines and it is no one's purposeful intent, it just happens and more effort needs to be made if we are going to see change at the front line worker level.*
>
> *I would like to see more front line participation or an indication that the ideas that are talked about at the table are actually passed on to the front line.*

Decision-making was related to the developmental stage of the HBHC network. The majority of managers stated that their networks were advisory or information sharing at this early stage of the HBHC program. They indicated that there had been few, if any, discussions or decisions related to resource demands and that network participation to date had not required resource decisions from organizations.

> *We are not saying like contribute 1/3 of your budget to this process I mean basically we fund with the bit of money we have through HBHC.*
>
> *We are not in the integrated model and we are not looking at duplications yet.*

Managers believed that the type of decisions networks are making appear to be non-threatening and indicative of a beginning stage of collaboration:

> *Not at the stage we are at. We are not interfering because it is not impacting on their resources.*
>
> *It depends on what kinds of decisions you are making, it is like it is not as if you are making funding decisions.*

While managers perceived that having managerial level decision makers facilitated collaboration, they were concerned that this exclusive participation might lead to a lack of staff participation and commitment.

Finally, the data suggests that the decision-making activities of network members were predicated on the developmental stage of the HBHC program. Given the advisory and information sharing activities of the HBHC networks, managers stated that there were few decisions made that could threaten organizations at financial or service levels.

5.2 Organizational Processes

The Organizational Processes theme of collaboration was conceptualized in part from the data that emerged from the open ended questions in the interview guide (#6 and # 7) that asked managers to describe their definition of successful collaboration and their ideal network and in part in response to a question (#14 a) based on a factor in the conceptual framework that asked about membership participation in the HBHC network.

The Organizational Processes theme was a new classification developed from the data in this study which challenges the collaboration literature to consider organizational processes as another influence on collaboration that may be as relevant as the current interest in the integration of organizational structures (Bailey & McNally-Koney, 2000; Alter & Hage, 1993; Zuckerman & Kaluzny, 1991). Organizational processes were defined here as the process for developing organizational structures and sub-structures that facilitated communication, stakeholder participation, community ownership and the accomplishment of tasks in the HBHC network. Three sub-themes within the

Organizational Processes theme of collaboration were developed from the data in this study: 1) diversity of structure, 2) level of structure, and 3) complexity of structure (Table C.5.6).

5.2.1 Diversity of structure

A wide variety of organizational structures was utilized by local sites to promote collaboration (see Table C.5.6). Many managers indicated that they had highly formalized organizational processes which led to a variety of structures such as advisory committees, executive committees, steering committees, sub-committees, work groups, and network of networks.

> *So the tables that existed before 1997, when they announced HBHC, we have now all integrated into one organizational structure.*[2]

> *What people suggested was a steering committee with smaller sub-committees ...so we had a network of networks because we had people that were representatives of the various constituent networks.*

The terminology used by managers to describe the HBHC networks (such as advisory committees, steering committees, networks, work groups) also varied across the study sites. An interpretation of the data suggests that, since the provincial government did not require a specific organizational structure, managers organized mandatory collaboration in ways that were responsive to local needs.

---

[2] The term table means local planning table and is often used in Ontario by health and social service providers.

Table C.5.6
Organizational Structures: HBHC Network

Diversity of Structure	Level of Structure	Complexity of Structure
Ad Hoc Committees	Sub-structure	Single/Multiple Sites
Advisory Committee	Primary Structure	Single/Multiple Sites
Children's' Services Committee	Primary Structure	Single Site
Coalition	Primary Structure	Single Site
Committee of the Whole	Primary Structure	Single Site
Community Advisory Committee	Primary Structure	Single Site
Early Intervention Network	Primary Structure	Single Site
Early Years Steering Committee	Primary Structure	Single Site
Executive Committee	Sub-structure	Single Site
Individual Task Groups	Sub-Structure	Single/Multiple Sites
Multiple HBHC Networks	Sub-structure	Multiple Sites
Network of Networks	Primary Structure	Single Site
Steering Committee	Primary Structure	Single Site
Sub-Committee	Sub-structure	Single/Multiple Sites
Umbrella Structure	Primary Structure	Single Site
Working Group	Sub-structure	Single/Multiple Sites

It appears that the strength of this approach, from an organizational perspective, was that managers could link the HBHC network with other local collaborative organizations. A number of managers referred to umbrella organizations, defining those as larger community planning networks to which the HBHC network was linked. One manager explains:

> *We can't just go and create a HBHC network because politically that would not work and it would be duplicating people's time and that kind of thing so the other thing that we have done more so now that we have the time to do it properly is to set up working groups from members of the HBHC Steering Committee to do ...now everybody is more ready to do the work and sees how it fits and that kind of thing so we have ad hoc work groups.*

5.2.2 Level of Structure

One of the themes that emerged from the data was the use of sub-structures such as task force and work groups to carry out specific development activities (See Table C.5.6). Managers said that using a variety of formal structures and sub-structures enabled them to position the HBHC network in local communities. They joined previously existing networks by becoming a sub-committee. They linked HBHC network to others in a network of networks and they used differential participation to promote collaboration by designing structures that met less often. Managers used a variety of task forces and work groups to accomplish activities related to service provision such as protocol development, service co-ordination planning and case management program development.

Managers believed that the organizational process of breaking down into work groups facilitated the network's ability to respond to changing circumstances such as the rapid expansion of the HBHC program.

> *Yes an organizational structure where you have sub-committees within sub-committees I am sitting on a subcommittee looking at case management and each of these subcommittees then has their own workplan, terms of reference but they devise that themselves and they meet for a particular length of time and report back to the committee as a whole we have been very careful to make sure everything is formalized.*

> *You know everybody is realizing that they cannot be sitting on a half dozen committees and manage an agency at the same time so the potential for collapsing some of these committees or turning them into work sub-committees really appeals to the directors of agencies*

5.2.3 Complexity of Structure

Managers outlined the complexity of organizational structures developed for multi-site networks (See Table C.5.6). Working across large geographical distances and providing staff support to multiple networks and problems with different ministerial boundaries were also complicating. Managers responded to this complexity in a variety of ways. One strategy was to use existing networks already in place in local communities:

> *As communities, they have worked fairly well together which is probably why we ended up going back to some existing committees to use them as our advisory committees*

In other locations, managers had created co-ordinating structures with representation from each individual network:

Each network has a history so you build on that history and so the speed at which the networks are developing are different and you can't push some of them to move whereas others would see themselves as quite forward thinking

Some managers were working with individual communities that did not have an organizational structure. They spoke about their long term goal of co-ordinating these separate networks into a structure that facilitated the operations of the network. Finally, some managers had joint representatives between their separate networks to share information and co-ordinate their work together.

They have their own sort of network group and we have representatives from that sit on our network and then I would sit on their network so there is a real meshing of information

In summary, this section of Chapter 5 has examined the Organizational Processes that created structures and sub-structures as a mechanism to formalize the operations of the HBHC Network. Findings suggest that HBHC network structures were organized differently based on factors such as: 1) pre-existing children's services networks, 2) the multi-site nature of the HBHC networks and 3) the level of formalization that seemed appropriate to the local community.

5.3 Relational Processes

The Relational Processes theme of collaboration was categorized from the data gathered on the environmental pre-conditions and collaborative process factors in the conceptual framework. Relational Processes was not a pre-existing element in the original conceptual framework but was a new classification developed from the data in this study that confirms previous research suggesting personal and professional

relationships between community members can facilitate or constrain on collaboration (Dunlop & Angell, 2001; Ring and Van De Ven, 1994; Mizruchi & Galaskiewicz, 1993; Oliver, 1991). Relational Processes have been defined as the history, nature and quality of the interactional relationships between the members of the HBHC collaborative network.

Data from questions in the interview guide based on two factors from the Environmental Pre-Conditions in the conceptual framework, namely: 1) previous collaboration (Questions # 8 and # 9) and 2) the legitimacy of the convening organization (Question # 11) were used to construct the sub-theme (Previous Relationships) and dimensions of previous relationships.

The second sub-theme (Interpersonal Relations) of the Relational Processes theme of collaboration was constructed from data on questions in the interview guide based on three factors identified in the conceptual framework as Collaborative Processes, namely: 1) membership costs (Question #14 b), 2) communication (Question # 19) and the formality/informality of linkages (Question #21) (see Table C.5.1).

Examining the data on these questions led to an exploration of two dimensions of relational processes: 1) previous relationships and 2) interpersonal relations.

5.3.1 Previous Relationships

A description of previous relational processes is presented using three elements: a) relationships of trust, b) previous collaborative relationships and c) public health relationships.

The majority of managers identified that they were able to build on their pre-existing relationships with local organizations. Managers believed that trust was one of the most important influences on collaboration and must be established over a long period of time. One manager compared the relational processes in their network to family relationships:

> *It is very much a long term process and that takes a lot of time and it almost like family relationships or marriage. There are a lot of things that are in common like developing a sense of trust, finding out each other's strengths and weaknesses.*

Other managers thought that the non-bureaucratic culture in their communities facilitated the development of trust because people could communicate openly. They did not have to be cautious about who was at the network table. In networks where people know each other well, they were able to keep the lines of communication open.

> *There must be a culture in this area that allows us to talk openly not competitively, we are not as turf minded or bureaucratic.*

> *Well the trust piece, we are still building that trust within the community and I think that if there had been an existing committee that had been working together on issues before, may be this piece would not have been so difficult.*

While the majority of managers confirmed the importance of trust in network relationships, a few managers found that a history of working together could also lead network members to be wary and non-trustful of each other.

> *There is a history of things between agencies and that definitely influences because it takes longer for you to clear some of that away and to be able to get on with it.*

Managers stated that they knew each other from working collaboratively in the past[3]. From the program managers' perspective, the time spent working with each other bolstered their knowledge and trust of each other and their collaboration skills:

> *We were a really productive interagency group with some key players that we already had good relationships with and we have various other partners that we worked with on various tables before so we just called them up and said "let's sit down here"*

> *We have a good background of working collaboratively in our community. We have had table, we have gotten different agencies together to develop a proposal.*

> *It made it easy because people knew each other so they walked into the room and it was like hi, hi, hi and they just carry on... so I think that people already knew each other and that history helped people to understand the structure.*

Managers perceived that the majority of relationships between public health and other community organizations were generally positive. They stated that public health had a great deal of credibility as the legitimate choice to provide the maternal and child health services of the HBHC program. Managers agreed that most public health units/departments had worked collaboratively with key stakeholders in the past. It appears that these historical and positive relationships with community partners facilitated the implementation of the HBHC network. As one manager noted:

---

[3] The previous collaboration sub-theme discussed within Historical Conditions in Chapter 4 refers to the local history of collaborative projects carried out by the community but does not address the relationship aspects of collaboration directly.

Something we did here and I think that is probably true across the province because you have to work with your own community partners so when we started the HBHC steering committee we had a fair amount of credibility and this is a group that not only were we used to working with them they were fairly used to working with each other as well.

Some managers had difficulties with their community partners around the implementation of the HBHC program. They stated that community partners questioned why public health would give up postpartum visiting services and then return to home visiting with the HBHC program. As one manager explained:

There is some frustration about inconsistency about what you are doing and not doing and part of that is a OISC problem too, how come five years ago you were not doing postpartum visits.

5.3.2 Interpersonal Relations

The majority of the managers believed that interpersonal relationships had influenced local collaboration in the HBHC program. The data suggested that four dimensions of interpersonal relations influenced collaboration: a) informal relationships b) local relationships c) open communication in relationships and d) conflict in interpersonal relationships.

Some managers stated that their collaborative networks had developed informal interpersonal relationships. They believed that the informal nature of these network relationships could be considered a strength that facilitated the operational processes of collaboration. They stated that participants in the HBHC network did not have to change their traditional informal manner of relating to each other to satisfy a provincial mandate. A number of managers thought that trust had developed over time and that they had

developed an informal way of problem solving that fostered local ownership of HBHC. For these managers, the informal nature of interpersonal relationships positively influenced collaboration.

> *I think that is almost a strength of the whole program, the informal agreements ...some one will say that is not problem, I can do that.*

Managers indicated that interpersonal relationships had helped them to achieve collaboration in specific geographical areas. Managers said that, in small rural areas, it was easier to break down barriers and get people working together within their own local community (e.g. county). Managers believed that interpersonal relationships in small local areas allowed network members to have more face to face contact with each other which led to more understanding, trust and rapport. As one manager commented:

> *We are small enough in this area, perhaps....and not as bureaucratic that we can look each other in the eye and talk and talk sense.*

In addition, managers said that interpersonal conflicts appear to be resolved more quickly in small local communities where it is difficult to avoid face to face contacts. There are few barriers to shield conflicts between local stakeholders. As one manager explained:

> *Because of the small rural nature, I mean if people are ticked, they tell you and you know them well enough to know that and it doesn't go too far before you deal with it....or you will go to another meeting and someone will tell you, so and so is really ticked with you.*

Research questions addressed the communication style between program managers and members of their HBHC networks. The data from the managers indicated the importance of open communication in the development of positive interpersonal

relationships. In general, program managers identified their commitment to openly sharing information with their HBHC collaborative network. A number of managers agreed that they would not hold anything back from network members regarding the operations of the HBHC program. Most managers circulated all provincial documentation with the network (after it was approved for release) and kept network members informed of any problems they were experiencing with the HBHC program. A number of managers expressed their professional commitment to being as honest as possible in their relationships with local network members. Most managers indicated that the development of honest and open relationships between public health and community partners involved in the HBHC network was of primary importance.

> *My approach with them is very open dialogue and I share my frustrations with them and they share theirs and I don't find myself defending anything... My own sense is that they are very open, they have been there a long time and know each other.*

Managers indicated little interpersonal conflict among organizational members of the HBHC network. Where conflict was experienced, it was attributed to difficulties around HBHC resources. Some managers found community partners threatened by the funding announcements and expansion of the HBHC program. Managers stated that some organizations resented funding to the health units and felt that they (the organizations) could have carried out the HBHC program themselves. As resources were diminishing for a number of local organizations, funding for the HBHC program was expanding.

The idea that there had been job losses and then you had an agency that was getting so much so there was some difficulty to get through there.

In summary, the Relational Processes theme of collaboration has been examined showing how local communities utilized their previous relationships and interpersonal relationships to help implement the HBHC network.

5.4 Summary of the Processes of Collaboration

In this study, data on the first dimension (membership) within Operational Processes suggested that managers approached the recruitment of network members using a strategic and sequential process. Although managers described their recruitment targets as individual, organizational, community and government level stakeholders, they were not very successful in recruiting parents and consumers. Second, stakeholder participation as an evolutionary process in this study is similar to other research that suggests that recruitment of network members is strategic and evolutionary (Castelloe & Prokopy, 2001; Provan & Sebastian, 1998). Finally, this study suggests that, managers perceived the rewards of participating in the network (e.g. increased knowledge and service co-ordination) outweighed the time and resource demands of collaboration. This finding supports other research on membership benefits (rewards) (Lasker, Weiss, & Miller, 2001; Wandersman, Goodman, & Butterfoss, 1997; Shortell & Kaluzny, 1994; Mattessich & Monsey, 1992). More specifically, the data supports other research that suggests the time demands required for collaboration are a constraining factor (Mattessich, Murray-Close, & Monsey, 2001; Alter & Hage, 1993). In this study, HBHC

program expansion, parallel mandates (the Early Years initiative) and increased referrals due to HBHC screening burdened local network members. Managers reported that local communities tried to mediate the negative effects of time demands by: 1) restricting meeting times, 2) joining agendas from disparate initiatives, 3) completing HBHC work at meetings for other purposes and 4) using short-term work groups to reduce the time required for network participation.

Within the second dimension (formalization) of Operational Processes, this study found more formal documentation of operational procedures characterized those networks that were: a) incorporated into previously existing collaborative organizations and b) in communities with multi-site networks. In addition, the negotiation of mandatory service protocols (formal agreements) positively influenced collaboration in this study and affirms other research that suggests that the formalization of procedures and agreements facilitates collaboration (Lasker, Weiss, & Miller, 2001; Mitchell & Shortell, 2000; Wandersman, Goodman, & Butterfoss, 1997; Meyers, 1993; Mattessich & Monsey,1992; Gans & Horton, 1975). Despite research that identifies excessive formalization as counter-productive for collaboration (Ring & Van De Ven, 1994; MacNair, 1993), the data in this study identified formalization as a positive influence in some HBHC networks.

Within the final dimension (decision-making) of Operational Processes (decision-making) two areas of decision-making influenced collaboration in this study: 1) decision-making stage and 2) decision-making level. HBHC networks in this study were at an

early developmental stage where the type of decisions they were making were non-threatening (e.g., decisions on program development and joint training but not on financial allocations). Although, this study found data on decision-making stage (type), it was only minimally concerned with addressing the types of decisions made within the developmental stages of collaboration.

The majority of managers perceived that managerial level decision makers were needed to expedite decisions in the HBHC network. Decision making authority is defined as the number of levels that a decision has to pass through in an organization's control system (Powell, 1988). This study affirms other research that suggests decentralized decision-making promotes negotiation and member participation (Mattessich. Murray-Close, & Monsey, 2001; Kegler, Steckler, McElroy, & Malek 1998).

The second "collaborative process" theme, Organizational Processes was conceptualized from the data and was not part of the conceptual framework. This study suggests that local communities utilized a range of organizational structures and sub-structures to facilitate the organizational and operational processes of the HBHC networks. Second, the data suggested that HBHC networks were organized at different levels in local communities. Some HBHC networks were incorporated into pre-existing organizations as a sub-structure while others organized their own network and tailored their level of formalization to respond to local considerations. Third, organizational complexity characterized the HBHC networks across the study sites. Organizing multi-

site networks across large geographical areas and conflicting ministerial boundaries required the organization of complex multi-site and multi-level structures and sub-structures.

The emergence of this Organizational Processes theme of collaboration in this study raises questions about the primary focus of collaboration research on structural integration of network organizations (Bailey & McNally-Koney, 2000; Mitchell & Shortell, 2000; Alter & Hage, 1993; Zuckerman & Kaluzny, 1991). In the development of the conceptual framework for this study, HBHC networks were assumed not to be at a stage of development where organizational structures could be explored. However, the data in this study supports research to identify the activities of collaboration within initiating as well as later developmental stages (Mitchell & Shortell, 2000; Florin, Mitchell & Stevenson, 1993). The data from this study suggests that future research on the organizational processes of collaboration may be an important complement to the more prominent studies on the structural integration of organizations (Bailey & McNally-Koney, 2000; Mitchell & Shortell, 2000; Kaluzny, Zuckerman, & Ricketts, 1995; Alter & Hage, 1993; Zuckerman & Kaluzny, 1991).

The final "collaborative process" theme (Relational Processes) was categorized from the data in this study and was not a pre-existing element in the original conceptual framework. In the first dimension (previous relationships) of Relational Processes, this study suggested having a previous relationship with other members of the HBHC network influenced local collaboration. Managers reported that trusting relationships

required time, but once established, were an important influence on collaboration. In addition, this study identified that collaboration was enhanced by a past experience of working together and getting to know each other. The past relationships established between public health units/departments and community organizations were another positive influence on collaboration. This study affirms other research that suggests that trust is an important component of collaborative relationships (Lasker,Weiss, & Miller, 2001; Mitchell & Shortell, 2000; Kegler, Steckler, McLeroy, & Malek 1998; Alter & Hage, 1993; McKinney, Morrisey, & Kaluzny, 1993).

In the second dimension (interpersonal relationships) of Relational Processes, managers identified trust between network members as an important platform for skill development in collaboration. This study suggested that interpersonal relationships are uniquely shaped by the "culture of formality or informality" in each local community. Other research has found that interpersonal relationships influence collaboration and may be more important than formal mandates (Gray, Duran, & Segal, 1997; Huxham, 1996). More specifically, managers in this study believed that small local areas promoted more face to face contact which in turn led to interpersonal relationships that facilitated collaboration. At an anecdotal level, the data suggested that there were differences between communities in the value they placed on informal or formal relationships. In rural and ethnic communities, there was a culture of informality that facilitated collaborative relationships. Alternatively, urban areas were more likely to value

formalization of interactional relationships, operational processes and organizational structures.

In this study, most local communities had established interpersonal relationships based on trust and open communication with little conflict between network members. This study affirmed previous research that argues personal and professional relationships between community members can facilitate or constrain collaboration (Dunlop & Angell, 2001; Ring & Van De Ven, 1994; Mizruchi & Galaskiewicz, 1993, Oliver, 1991).

Chapter 6 Discussion: Implications for Policy, Practice, Research and Theory Development

6.1 Implications of Findings Concerning Historical Conditions

The historical dimensions of collaboration and program delivery are critical to understanding implementation of the HBHC network. Other studies have shown that a history of collaboration has been an important pre-condition to collaboration in the present (Harbert, Finnegan, & Tyler, 1997; Gray, Duran, & Segal, 1997). This study also confirms that a past history of working together influences local collaboration. The data reflects managers' views that collaboration is a skill that is learned, through practice, over time by working together in collaborative networks. The twenty-two communities in this study had diverse collaboration histories. The majority of HBHC networks consisted of people who had worked collaboratively in the past to develop children's services. Thus, almost all managers agreed that collaboration, whether mandatory or voluntary, was not new. Local collaboration as part of federal and provincial government mandates and other community initiatives (Children's Services Councils, etc.) was a well established pattern in most of the communities in this study. Data suggested that some communities had complex, formal structures that facilitated collaboration, while others had created more informal ways of working. In most communities, managers tried to integrate the HBHC network into an pre-existing community planning group for child and family services to limit duplicate collaboration.

Given their past work together, most managers reported that these local communities had well established goals for the reform of the child and family service

system. The provincial guidelines developed for the HBHC program were adapted to fit local scenarios, rather than the reverse. In the literature, the development of common purpose is considered essential to collaboration (Meyers, 1993; Gray, 1989). This may be much more important in voluntary collaboration than in this state-mandated example. In this study, local communities with a history of collaboration already had developed their own local vision and goals. They did not need central government directives. The response to state mandated goals in this study was simply to encapsulate HBHC goals into existing community networks. Most managers thought that the public health unit/department as the convening agency did not have to sell local stakeholders on the mission of HBHC. Rather, local communities had already established (on a voluntary basis) a common purpose for children's services reform.

In other communities, with previous negative experiences of collaboration, managers reported that this history made implementation of the HBHC network more difficult, in spite of the government mandate. As the literature suggests, it is not enough to engage willing stakeholders in collaboration; it is also necessary to "enfold and pacify potential enemies" (Morgan, 1986, 173). It appears, from this study, that managers focused on their vision and goals for improving services for children and families as a strategy for resolving past conflicts between stakeholders in local communities.

Managers reported differences in implementing the HBHC program between communities who had never given up their historical public health home visiting services and those who had stopped home visiting during the 1980's and shifted to population

health approaches. In communities where established home visiting programs had required collaboration between service providers (e.g., public health and Community Action Programs Canada, (CAPC)), there was more receptivity to the HBHC Program. Managers perceived that local stakeholders actually welcomed HBHC as enhancing existing home visiting services. Stakeholders already had well established collaborative relationships and HBHC could be enfolded into the community infrastructure.

On the other hand, communities who had abandoned home visiting programs and championed population health approaches found implementation of HBHC more difficult. Managers in communities who had given up home visiting programs during the 1980's reported barriers to implementation of the HBHC program. Stakeholders struggled to understand the new mandate of public health and lacked a history of working together collaboratively on home visiting initiatives.

This study suggests that future research on collaboration should consider the service provision history of the convening organization when decisions are made about leadership of state mandated collaboration. Local stakeholders appeared to accept public health unit/departments as the convenors of HBHC collaborative networks where their credibility as service providers was established.

The data suggests that central government mandates were less important than the previous collaboration history of communities. This raises the possibility that differential responses from communities should be considered in central government planning guidelines. First, local communities should have an opportunity to identify existing

planning groups and to incorporate new mandates into present structures to prevent duplication of collaboration. Second, central government should respond differentially to local communities who have previous experience with collaboration and to those that do not. Third, implementation guidelines should consider the program delivery history of each community and the differential responses that may occur when central government designates convening organizations. To impose the same expectations and time lines for implementation on all HBHC networks was unrealistic and counter-productive to program goals.

6.2 Implications of Findings Concerning Institutional Conditions

Institutional conditions are defined as the relationships of authority and accountability between the central government Office of Integrated Services for Children (OISC) and the local HBHC networks. Three themes related to the control and direction of the Healthy Babies/ Healthy Children (HBHC) program by central government have been explored: 1) the effect of the government mandate on local communities 2) the role of provincial HBHC consultants and 3) the differentiation of central/local responsibilities

Almost all managers agreed that state mandated collaboration in the HBHC program created an institutional environment that constrained the development of local collaboration and changed interorganizational relationships in local communities. First, they reported that they experienced the mandate as very prescriptive with centrally determined goals and implementation parameters. Second, they stated that the role of the provincial consultants was controversial and was seen in the later stages of

implementation as overly directive rather than facilitative. Third, they identified a lack of provincial government support for centralized marketing and linkage building among programs. Finally, managers suggested that the lack of communication and integration between the provincial level Ministries (Ministries of Health and Long-Term Care, Community and Social Services, Education and Culture and Citizenship) and between the Office of Integrated Services for Children (OISC) and other provincial level associations created barriers to local collaboration.

State-mandated collaboration met with a differential response from managers in the sample. Some managers stated that communities were indifferent to or supportive of the mandate and simply enfolded it. For others, the resistance to government intrusion created local solidarity. For some, the mandate pushed people together who had had no history or desire for collaboration until it became mandatory (a few communities had not developed a network despite the mandate). For several others, the mandate was not enough to convince them to come together to work with the HBHC program.

Although there were different responses to state mandated collaboration, almost all managers reported that the mandate constrained their implementation of the HBHC program. In this study it appears that, no matter the mandate, local solutions to local problems must be uniquely configured to match community needs and stakeholder preferences. The findings suggest that local collaboration (whether interpreted as mandatory or voluntary) was influenced by the expertise, community knowledge and interpersonal relationships in each unique community.

Several managers thought that the mandate had facilitated collaboration in their communities. Anecdotal data from this study suggests that there was linkage between positive attitudes towards the state mandate and those managers with little management or local community experience. In a few communities, where the manager was new to the area or had little management and community development experience, the presence of a state mandate was viewed as facilitative of collaboration. Several managers suggested that it forced people to work together who would have resisted a voluntary collaborative initiative. Despite these few instances of positive regard for the mandate, almost all the managers agreed that it constrained their attempts to implement the local HBHC network

It appears that the mandate could not force people to work together who did not wish to. A few managers reported that the stakeholders in their community were not willing to engage in HBHC network activities. Further, the data suggests that service agreements developed at the direct service level may be the best place to begin state mandated collaboration. This study showed that developing service protocols between two agencies was difficult, but not impossible. Although many managers reported that they did not have signed protocols, they did comment on how difficult they found the process of developing service agreements between organizations.

Managers viewed these service agreements as a learning experience in collaboration that allowed them to work out relationships on a one to one basis. Almost all managers viewed service agreements as a step that would enhance future planning for

service integration (one of the goals of the mandated HBHC Program). As Woodard (1995) noted, such service agreements can reinforce mandated ties. This study confirms the proposition that mandated service agreements between agencies can be an important pathway to collaboration in communities with no history of successful collaboration. In this study, service agreements were also viewed as important by communities whose collaborative relationships were well established before HBHC.

Mandated collaboration also heralded a change in programming for public health. The prescriptive nature of the HBHC program was experienced by managers as provincial command and control. First, the HBHC program, with its focus on targeting, was a shift from the population-based approach of public health. Second, local managers found the ISCIS data base (that centralized program monitoring and accountability for HBHC) to be intrusive and potentially compromising of client confidentiality. Third, managers were adamant that the mandate for HBHC should not turn public health into an agent of social control to supplement the work of local child protection agencies. Their professional ethics surrounding client confidentiality and quality of services guided their implementation of the HBHC program. Some managers felt that the information requested by the provincial government was too intrusive and they used their professional judgment about the level and scope of information exchange that was necessary to meet provincial requirements and to protect client confidentiality.

Relationships between local managers and the central government also reflected differential responses to provincial oversight. Managers stated that, initially, the

provincial OISC consultants were almost peripheral to the work of the HBHC network. Most managers believed that provincial consultants tried to be helpful during the implementation process, but concluded that they had little power to influence provincial government decision-making. In general though, local managers felt that there was no need for consultation on the implementation of HBHC networks from the provincial Office of Integrated Services for Children. More to the point, they felt this would have intruded on the knowledge and skills of public health staff and local managers. At an anectodal level, it appeared that managers who were experienced with collaboration neither believed the expertise existed at the provincial level nor desired interference with the HBHC network. For others with less management experience, the lack of consultation on collaboration by provincial consultants was an issue. This suggests that provincial level consultation on the collaborative network should be available upon the request of the local HBHC manager.

Clarification of the roles and responsibilities of provincial consultants and local managers would have increased the targeting of those communities requiring more intensive consultation. Some managers were still struggling with collaboration and would have welcomed more assistance from provincial consultants. It appears that the mandate for collaboration was initially of less interest to the provincial government than the actual implementation of the direct service level of HBHC. Consequently, what did evolve in the local communities was based on local conditions and local expertise.

The data suggests that two areas (marketing and linkage building) required more

provincial government support for local communities. Managers stated that each program had to develop its own media campaign for HBHC. Because of the time and money needed to create local HBHC materials (including a logo), local media campaigns were not viewed as efficient or effective to implementation of HBHC at local or provincial levels. Managers suggested that other public health programs in Ontario (e.g., Heart Health) have been developed and marketed through a central government resource that provided province-wide marketing programs and communication support to local programs, thus ensuring a consistent message across the province.

The second area of linkage building addresses innovation and diffusion of the HBHC program across the province. Without official regionalization of HBHC, program managers did not share information in a structured way, although managers in some regions met each other informally without provincial consultants. Information technology (e.g., websites that answered frequently asked questions, email lists, list-serves, chat rooms) could have been used to promote program innovation and knowledge diffusion across HBHC sites in the province.

The provincial government created parallel mandates for local collaboration between the HBHC Program and the Early Years initiative introduced in 2001. The Early Years initiative also required mandatory local collaboration but used government (Order-in-Council) appointments to establish the collaborative group and its paid co-ordinator. With Early Years, the provincial government seemed to have shifted the mandate for local collaboration for service integration from HBHC to this new initiative.

At the same time as the introduction of the Early Years initiative, the number of HBHC provincial consultants was reduced, which lessened their availability and helpfulness to the local HBHC networks. When the governance of the Early Years initiative was given to the Ministry of Community and Social Services, the HBHC managers found themselves interacting with another set of consultants from another central Ministry. As responsibility for local collaboration shifted to the Early Years initiative, the role of the provincial HBHC consultants became more regulatory, concerned more with fiscal and program monitoring.

The provincial government changed the interorganizational environment at a local level by designating public health units/departments as the lead local organization in the HBHC Program and the Early's Years initiative. Initially, the Ministry of Community and Social Services was expected to provide co-leadership to HBHC but this study suggests that this joint partnership was difficult in a number of communities. Managers agreed that, once released, the Early Years Study (McCain & Mustard, 2000) appeared to be the provincial government's blueprint for reform of children's services. The overlapping provincial mandates for HBHC and Early Years created local confusion as public health managers struggled to explore and explain their respective mandates and accountability frameworks. Local communities also had to try to understand the complexity of these parallel mandates. Managers identified the need for local autonomy and a strong community voice in the era of downloading and resource scarcity of the early 21st century.

The data from this study suggests that as the Ontario government funded and promoted the growth of regulatory services such as HBHC and Children's Aid Societies, they decreased resources for voluntary non-profit agencies, creating a service environment conducive to privatization. While only one Canadian example, this study suggests state-mandated collaboration can re-engineer the autonomy, service system and interorganizational environment of local communities.

6.3 Implications of Findings Concerning Financial Conditions

The exclusivity of the provincial allocation of HBHC resources to public health did not always engender positive community response. In addition, the lack of administrative funding for developing and managing the HBHC network has been a drain on local public health resources. Did the infusion of government funds influence HBHC implementation? Specifically, are resources an environmental pre-condition that motivate organizations to collaborate? Is a state mandate enough to produce local collaboration or must mandate and resources be tied together?

The data in this study suggests that, without the financial resources dedicated to the HBHC program, local stakeholders may have been much less willing to collaborate. Managers perceived that the infusion of new money for services that accompanied the HBHC program encouraged participation in the HBHC collaborative network. Downloading in Ontario reduced funding for health and social services and created pressures on local service systems. Local responses were both positive and negative, but resource provision profoundly altered interorganizational relationships for public health

units/departments and their community partners. The HBHC program placed public health at the center of health and social service co-ordination in local communities and altered their previously existing relationships with service providers such as hospitals and Children's Aid Societies. There were tensions between public health and Children's Aid Societies as managers tried to maintain the family support orientation of the HBHC Program. They were uncomfortable with the in-home component of HBHC being used as a first-level assessment for child protection and that their staff was spending too much time in court testifying in child protection cases.

The screening component of the HBHC Program brought service providers such as hospitals and Children's Aid Societies into close contact with the program and required they develop mandatory service protocols. This created human resource demands on their organizations. Many managers reported that the dedication of resources for HBHC to public health units/departments strained relations between some hospitals and public health units/departments. Hospitals were required to screen all in-hospital births without resource allocations from the provincial government. In spite of these pressures, communities were also positive about public health returning to maternal and child health home visiting and welcomed the additional resources in HBHC to do so. These findings are not generalizable to other contexts and do not prescribe how government should carry out financing of local initiatives. However, this study does illuminate the complexity of this issue and identifies positive and negative aspects of resource provision by central government.

The need for administrative funding was another serious problem. A central government, serious about mandatory collaboration in HBHC, should have funded administration of the local collaborative network. However, the downloading of public health programs in Ontario has been associated with resource allocations confined to direct services. Costs for administration and delivery of programs and services have been absorbed by local governments. Managers revealed that public health units/departments shifted scarce resources from other programs to fund the administration of the HBHC Program. Managers suggested that it seemed like the HBHC Program had taken over and that other mandatory programs were being marginalized.

This study showed administration of the HBHC network to be complex and demanding for managers. The demand on HBHC managers increased with the Early Years initiative as they were required to participate in another mandatory collaborative initiative. The HBHC collaborative network was difficult to develop without funding for administration and without provincial government recognition of the complexity of local network development. As outlined in Chapter 5, Managers reported that administration was a huge drain on both the financial resources of the public health units/departments and on the personal resources of the HBHC managers themselves.

Consequently, as the HBHC program continued to expand, the lack of administrative funding for network development became an even more serious impediment to local collaboration. Local collaborative networks were required to take

more and more responsibility as the program expanded but without the resources to implement the mandatory components. In spite of these costs, most local service providers supported the HBHC network. Further investigation will be needed to see if local stakeholders can maintain their commitment to the HBHC network without funding for collaboration.

6.4 Implications of Findings Concerning Membership

Managers described the recruitment of members to the HBHC network as a strategic and sequential process that utilized a variety of formal and informal techniques of engagement[4]. They experienced some barriers to recruitment of the stakeholders mandated in provincial guidelines. These barriers became more pronounced once the Early Years initiative was implemented and these parallel mandates (HBHC and Early Years) overburdened community capacity for collaboration. Moreover, the rapid expansion of the HBHC program negatively influenced collaboration as demands for interorganizational participation by stakeholders increased dramatically.

Most managers agreed that there were barriers to the recruitment of parents and/or consumers to the HBHC network. The extent of the problem for managers depended on their philosophy of parent/consumer involvement in collaboration for service integration. Managers reported different approaches to the inclusion of parents/consumers in their HBHC network. Many managers reported that they were

---

[4] As reported previously in Chapter 5, the terms stakeholder and membership were used interchangeably throughout this study.

disappointed that they could not recruit parents and/or consumers. They believed that parent/consumer advocacy would strengthen planning for local needs of children and families in their HBHC network. In a few instances, managers had set up mechanisms where parents and consumers could provide ad hoc input to HBHC planning even though they were not part of the official network. Several managers felt that parent/consumer participation in the HBHC network would constrain collaboration and believed that either consumers/parents should have a separate working group or be added to the network at a later developmental stage. The data suggests that managers, who were interested in parent/consumer involvement in HBHC networks, perceived that their recruitment efforts were complicated by the fact the provincial guidelines for the HBHC program did not specifically include these groups.

The demands associated with member participation are defined in the literature as the time and resource obligations that accompany a commitment to participate in a collaborative network (Mitchell & Shortell, 2000). The rewards of participation are defined as the benefits that accrue to members through actively engaging in interorganizational network relationships (Mitchell & Shortell, 2000). In this study, managers reported that demands of membership participation in the HBHC network were increased by the parallel mandates created between the HBHC and Early Years Initiative which produced a seemingly overwhelming volume of meetings. One overarching problem was the extensive amount of time members had to commit to participation in the HBHC collaborative network.

One very important difference between the time demands of managers and network members was the complexity of management responsibility for the development and implementation of the HBHC network. Managers had more to do than just direct the HBHC program. They also had responsibility for clarifying the increasing scope of the HBHC program as it expanded and the parallel mandates of HBHC and Early Years that were confusing to local communities. With each program expansion, resource reduction and parallel mandate, it became increasingly difficult for managers to find the time required for collaboration in the HBHC network.

This study did not explore either central government or local network perceptions of the costs associated with the multi-dimensionality of their role with the HBHC networks, but this should be the subject of further research. Notwithstanding increasing complexity, HBHC managers were convinced that both the professional and personal demands associated with collaboration were outweighed by the rewards of collaboration for the children and families of their local communities.

Overall, in the managers' view, rewards for HBHC network members outweighed the associated demands on network members' time and resources. Managers identified the rewards of membership participation in the HBHC network at individual, organizational and community levels. They cited examples of rewards such as: 1) increased communication between service providers, 2) increased ease of referrals between service providers and 3) increased knowledge about the programs and services offered by other agencies. This is consistent with the literature which suggests that

interorganizational collaboration seemed most meaningful to service providers when it increased service co-ordination, reduced duplication and eased referral mechanisms. In this era of devolution, where funding for health and human services in Ontario has been reduced, the rewards of membership participation in the HBHC network appear to local managers to partially counteract these reductions by increasing service co-ordination and joint planning and training among organizations.

Local managers saw the increased interdependence of organizations at the local level as a reward of HBHC network participation. Managers believed the HBHC program (despite its exclusive funding to public health) substantially enhanced the service system through its provision of new programs. However, it also altered resource exchange relationships and some created conflict in previously established relationships between public health and other service providers (e.g., hospitals and Children's Aid Societies).

6.5 Implications of Findings Concerning Formalization

The formalization of the HBHC networks varied across the study sites, reflected the diversity of local communities and appeared to evolve. First, the rapidly expanding guidelines for the HBHC program required more complex formal agreements in local communities. For example, the negotiation of service agreements between two service providers helped build collaboration skills that were useful in the HBHC network. Second, geographical complexity compelled multi-site networks to formalize their operational processes and structures to facilitate communication and decision making.

Finally, some HBHC networks were enfolded into local organizations with existing formal structures and procedures for collaborating on children's services.

The varied level of formalization in HBHC networks identified in this study mirrors the variation reported in the collaboration literature. Formalization of exchange relationships has been found to facilitate and constrain collaboration (Ring & Van De Ven, 1994; Meyers, 1993; Mattessich & Monsey, 1992; MacNair, 1993). In this study, the level of formalization was site dependent but anectodal examples suggested that rural and ethnic communities tended to be more informal while urban centers were more likely to formalize their operational processes and structures.

Although the HBHC networks were state mandated, according to managers, this mandate only indirectly influenced the structure and processes of collaboration in local communities. HBHC guidelines did not specify particular structures or operational procedures. Hence, the formality/informality of HBHC networks was based on unique local parameters such as: 1) existence of a previous network, 2) the existence of multi-site networks that covered large geographical areas and separate counties and 3) attitudes of local stakeholders towards formalization.

But is formality/informality related to stages of collaboration or to a particular geographical context? In this study, a number of pre-existing networks, beyond the beginning stage of collaboration, had formalized their operational processes to manage local collaboration. Formalization of the operational processes of collaboration may be site-dependent and reflect the formal/informal culture of a community. Needless to say,

this study was not structured to identify a causal link between formality/informality and developmental stages or geographical context. However, anecdotal data suggests that urban/rural/ethnic communities took different approaches to formality/informality of structures, processes and relationships in the HBHC network. Although this study did not address these differences, this would be a productive area for future research.

This study excluded the service components of the HBHC program. However, ultimately various components cannot be isolated as they exert an interactive and developmental effect on each other. So it is here, as an aspect of formalization, that service components play an important role in this exploration of collaboration. Provincially mandated service protocols provided a mechanism for collaboration between public health managers and individual organizations. It appears that, in dyads, local network members practiced their collaboration skills. These newly acquired skills could then be used to facilitate the operational processes of the HBHC networks.

A striking aspect of this dimension of operational processes was the multiplicity of types of formalization utilized by HBHC networks. These were organized into indicators of formalization in (Table C.5.5). The decisions that HBHC networks made about formalization merit further investigation in the future to determine how local community characteristics, (e.g. previous history of collaboration) may have influenced this operational process.

Given that the provincial guidelines contained no directives on organizational structures and processes for the HBHC network, the variation in formalization across the

study sites was not surprising. Notwithstanding the provincial evaluation of the HBHC program outlined in Chapter 3, the diversity of formalization across the networks would make evaluation difficult. This thesis research could not explain the adoption of formal or less formal mechanisms by HBHC networks. Previous research suggests that formalization may be positively related to effective collaboration (Rogers, Howard-Pitney, Feighery, Altman, Endres, & Roeler, 1993). The indicators of formalization from this study could be used in the future to gather qualitative and quantitative data across the HBHC sites to explore the relation between formalization and collaboration.

6.6 Implications of Findings Concerning Decision-making

Two dimensions of decision making: 1) decision making stage and 2) decision-making level were clearly articulated by the managers. They perceived that HBHC networks were at an early *decision-making stage* of development wherein the network decisions were relatively benign, did not require resource commitments and thus were not threatening. Most managers reported that network members were asked to make decisions on program development and joint initiatives such as training, but not on administrative issues like budgets and hiring of staff. It appears that the HBHC networks, at the time of this study, were advisory to the public health units/departments. There was a perception though that as the HBHC network moved to achieve its goal of service integration, decision-making would become more complicated as organizations addressed service duplication and restructuring. This study could not address decision-making type and its influence on collaboration within developmental stages but this

could prove fruitful for future research (Bailey & McNally-Koney, 1995; Florin, Mitchell, & Stevenson, 1993).

The exploration of *decision-making level* revealed diverse opinions about the level of decision makers who should participate in a HBHC network. Most HBHC managers believed that collaboration is facilitated when network members have approximately the same amount of decision making power (management-level) in their agencies. To expedite network progress, managers need to make commitments for their organizations. Second, managers can ensure that network decisions are communicated to relevant direct service staff. Third, the network needs members with authority to commit resources as they move toward service co-ordination and joint training. Finally, managerial level participants can attend more consistently because they are not carrying responsibility for direct service.

Although most managers did not discount the views of direct service providers, parents, consumers, lay home visitors and community members, managerial level participation was seen as strengthening network decision-making. However, for some communities, managers felt that the participation of direct service providers, consumers, parents, and lay home workers was critical to HBHC network decision making.

While not fully explaining disparate opinions about the level of decision-maker required in the HBHC network, preference for managerial level decision makers may have been shaped by previous local collaboration and by expediency. Also some managers present rival arguments that HBHC decision-making should be inclusive of

parents, consumers, direct service staff, lay home visitors, community members and managers. HBHC program guidelines do not address the decision-making level of network participants. Local autonomy in this matter prevails.

6.7. Implications of Findings Concerning Organizational Processes

The literature on collaboration described the formal/informal nature of the structural integration of collaborative arrangements. While a variety of formal (service integration, network structures, coadunation) and informal (alliances, collaborative networks, coalitions, partnerships and consortia) forms were described, the research questions did not address structural integration directly. Given that HBHC networks were at an early stage of development, an assumption was made that it would be premature to address dimensions of organizational structure. Instead, questions that addressed the formal/informal nature of collaboration in the HBHC networks were used to capture data on this phenomenon. However, these questions yielded data that suggested organizational structures were important in this study of state-mandated collaboration. The assumption that it was premature to explore the structural components of HBHC networks was wrong: rather, organizational processes were found to influence collaboration in this study. Accordingly, organizational processes became one of the six major themes in the model of collaboration developed from the research study. The data in this study suggests that local collaboration (whether interpreted as mandatory or voluntary) was influenced by the expertise, community knowledge and interpersonal relationships in each unique community. The organizational structures utilized in the

HBHC network were characterized by type of structure, level of structure and complexity of structure (Table C.5.6).

The finding of diversity of structural forms reflects the encompassing of the HBHC network within the "culture of formality/informality" existing in local communities. There were limited resources available for HBHC network development. Nevertheless, local sites reconfigured their existing community collaboratives to incorporate or initiate the HBHC network.

In the previous section on formalization of *operational* processes, diversity was a prevalent theme. Managers reported that a wide variety of organizational structures were utilized by HBHC networks. Provincial guidelines did not dictate the type of organizational form for the HBHC network. From a community organization perspective, the structuring of differential participation in HBHC networks was an important finding in this study. Through a variety of structures and sub-structures, the HBHC network organized stakeholders by: 1) incorporating them into previously existing children's services co-ordinating groups, 2) creating mechanisms for information sharing and decision-making across large geographical areas with multiple sites, 3) creating "umbrella" organizations that served as a network of networks, and 4) increasing local collaboration by creating structures and sub-structures where differential participation required more or less involvement in collaboration.

Organizational structures that were designed as umbrella organizations or a network of networks facilitated information sharing. Indeed, this was critical with

HBHC program expansions and the introduction of the Early Years initiative. The complexity associated with HBHC networks that spanned large geographical areas, diverse political boundaries or complicated local government bureaucracies required local solutions. Thus, organizational structures evolved that reflected the integrity of the state mandated HBHC network within the context of the local social, political and economic environment.

The variety of organizational processes revealed in this study suggest community organization models based on locality development. The organization of the activities and communication channels of the HBHC networks into existing or newly created structures was not a top down implementation process. Although provincial government directives had encouraged the use of pre-existing community collaboratives, this study found that local sites decided for themselves how to structure the implementation of the HBHC network. These organizational processes resulted in differentiated structures to support network activities and prevent collaboration collapse. Community organization skills were evident across the sites as complex structures and sub-structures were developed in response to unique local contexts.

Communities carried out organizational processes in various ways. However, this study suggests that the process of organizing the activities and communications of networks into organizational structures and sub-structures positively influenced stakeholder representativeness, communication and decision-making across the sites. The presence of pre-existing organizational structures appeared to facilitate network

development. Other characteristics of the local community such as: 1) large geographical areas that required multi-site networks and 2) the level of formalization of organizational processes that represented the local site also played a role in structuring networks. This study suggests that further research on this organizational process dimension of collaboration should explore its implications for collaboration and community practice theory.

6.8 Implications of the Findings Concerning Relational Processes

Chapter 5 suggested that several aspects of interpersonal relations influence local collaboration. Although several studies have addressed interpersonal relations and collaboration, further research is needed to develop collaboration theory in this area (Dunlop & Angell, 2001; Seabright, Levinthal & Fichman, 1992; Oliver, 1990). In this study, a relational theme of collaboration was developed from the data gathered from managers. This relational dimension of collaboration was not part of the existing conceptual framework developed in the review of the literature and shaping the research questions. So, this is the second theme of collaboration that emerged directly from the data. The relational dimension of collaboration is therefore notable.

A history of interpersonal relationships among managers and other service providers was perceived by managers as an important catalyst in the development of HBHC networks. However, relational processes were not without conflict. Communities with a history of collaboration most often identified the positive influence of trusting relationships, but managers also reported instances of resistance to the

mandate, funding and continual expansion of the HBHC program.

The data suggests that the continual expansion of the HBHC program altered previous interorganizational relations in local communities. In some cases, dissonance developed between the HBHC program and local hospitals. Some local hospitals found the screening responsibility for the HBHC program burdensome, especially without financial compensation. In addition, continual HBHC program expansion created tensions between public health and other community partners as service demand increased because of the screening component of HBHC, while government resources for non-profit providers decreased.

Managers perceived that interpersonal relationships between themselves and other service providers were characterized by a high degree of trust developed through working on previous collaborative ventures. This study points out the importance of communication to the development of trust in interpersonal relationships.

The communication style of HBHC managers was explored at three levels: provincial, local and network. Most managers perceived themselves as very open in their communications with provincial consultants. They reported that they confronted provincial officials on rapid program expansions, budget allocations and unrealistic time demands for implementation. On the other hand, managers suggested that consultants could not reciprocate with open communication because of political constraints. These constraints interfered with trust building in the relationships between managers and consultants.

The communication between the local managers and network members was reported by managers as open. For example, they indicated that they distributed to network members all the documentation they received from the provincial office of OISC. This included copies of guidelines for the expansion of the program, correspondence and, in many cases, copies of the budget for the HBHC program. This is not to say that the managers reported that they released guidelines to local communities while they were in draft form and not approved by the provincial office. Most managers perceived that they communicated openly with local network members and few reported that they had filtered the content or timing of information to local communities.

This study suggests that open communication between managers and network members created a dimension of trust in local relationships. How, then, did this openness of communication influence collaboration in the HBHC network? First, it created transparency at the local level, thus allowing local network members to know exactly the parameters established by the provincial government mandate. Second, it encouraged a sense of belonging among network members who could identify with the difficulties HBHC program managers faced in response to provincial mandates. Finally, it illustrated HBHC managers' commitment to local autonomy and local decision-making: indeed, open communication appears to have minimized community resistance to mandatory collaboration.

The previous discussion considered some of the ways that trust and open communication influenced relational processes, but this does not exhaust the conclusions

from this study. The multi-dimensionality of relational processes was confirmed by another pattern, informality, which emerged from the data in this study.

Finally, informality characterized some, but not all, of the collaborative networks. It appears that informality is part of a culture of "community organization" that has developed in some local sites. Some managers stated that the ease with which people called on each other for assistance, coupled with their mutual support of the HBHC network, reflected the community's valuing of informality. It is assumed that these interpersonal relationships reflect the informality that comes from knowing and trusting each other as people rather than as role occupants. Managers perceived that the loyalty engendered in some of these HBHC networks offset worries about competition and conflict and solidified commitment to local collaborative efforts. They believed that network members relied on each other, understood each others' organizations and trusted that their mutual commitment to children and families would overshadow whatever problems were created by the government mandate.

In general, most local sites had already established patterns of interaction from working together on previous initiatives. They simply proceeded to enfold the HBHC network into their communities, shaping it to fit the existing local culture of informality or formality. So, local history and local autonomy again shaped collaboration in the HBHC networks.

If we are to understand the importance of these relationships, be they formal or informal, some of the interpersonal connections between local community members will

have to be explored in future research on collaboration. This study was one step in illustrating the importance of informal relationships and their influence on local collaboration. This study did not identify the type of community that adopted these informal relationships, but does provide fruitful topics for research in the future.

6.9 Summary of Data Excluded from Thematic Analysis

Nine per cent (9%) of the data collected through interviews with the managers of HBHC was excluded from the analysis in this study. Although it was possible to include more than ninety-percent (90%) of responses in the development of the six major themes of collaboration, data for twenty-two codes was minimal. Excluded data can be clustered into four areas: 1) leadership, 2) advocacy, 3) planning and 4) membership.

In the first area, leadership, it appeared that managers were not interested in expressing their views on leadership in the HBHC collaborative network. Few managers were participating in provincial level advisory committees to the Healthy Babies/ Healthy Children Program. They did not identify their participation as building leadership that could be useful at the local level or could describe their participation in detail. This suggests that little attention was directed to the concept of recruiting community leaders to the HBHC during the period of this study (1998-2001). It is unknown whether the Early Years initiative, which appointed community leaders to its advisory committee through Order-In-Council appointments, influenced this aspect of collaboration.

The perceptions of those managers who did mention leadership was that it needed to be informal since they believed that neither strong leadership nor a lack of leadership

positively influenced local collaboration. The interpersonal relations focus of managers as previously reported may have influenced managers. They may have preferred not to engage in leadership discussions which would set them apart from their network members and/or bring up issues of power. Or perhaps, since the managers were operating in a mandatory environment, they were more comfortable not pushing the leadership question but simply presenting themselves as informal leaders who were encouraging not directing network operations.

Second, the excluded data contained comments on the need for advocacy for children in local communities. The rival viewpoints of managers about the inclusion of parents and/or consumers has been previously discussed. Managers, concerned with advocacy, reported a number of issues: 1) the lack of involvement of multi-cultural populations, 2) the potential intrusiveness of HBHC in client's private lives and 3) the dual role of service providers who identified themselves as both provider and advocate. Although, advocacy issues were excluded from the analysis in this study, some managers did attend to the need for inclusiveness and advocacy in collaborative practice.

Since HBHC networks had mandated service provider participation, it might be assumed that client engagement was secondary for managers. In addition, Ontario subsequently created an Aboriginal HBHC program. Managers suggested that this changed their previous focus on engaging native communities. Few managers mentioned the need for advocacy and their concerns about the direction of the HBHC network and its lack of inclusiveness and parent/consumer involvement.

Third, the study excluded data concerning community planning processes such as:1) central government goals, 2) decision-making context, and 3) organizational autonomy.

In terms of the first community planning issue, managers were concerned about the diffuse nature of central government goals for HBHC. They perceived that the lack of clarity of the central government goals and language changes in government implementation guidelines complicated local planning (e.g., Phase I-HBHC Collaborative Network changed in Phase II to Integrated Services for Children Committees).

In the second community planning issue, managers thought that network decision making was constrained by the unpredictable legislative and funding changes of the provincial government. They suggested that local organizations operated in a turbulent environment where decisions made one day would be changed the next. They believed that this uncertainty constrained local HBHC network member's ability to provide input into local collaborative planning.

In the third community planning issue, managers perceived that network members recognized how mandatory collaboration compromised their organizational autonomy. They suggested that organizations feared that the state mandate would force the scrutiny of each other's policies and procedures in order to develop service protocols. Finally, some managers believed that organizations were afraid of losing their identity because mandatory collaboration in the HBHC network required them to abandon their individual

pursuit of funding.

Finally, some data on membership, relevant to the operational processes of community planning, received minimal attention from HBHC managers. In general, membership questions elicited large amounts of data. However, the following membership issues were rarely mentioned and were excluded from reported results: 1) membership terms (i.e. the length of time of participation), 2) initial core implementation group, 3) volunteer resources (e.g. provided supplied meeting rooms, photocopying, staff resources), 4) meeting refreshments (as rewards of participation), and 5) network cliques (i.e. sub-sets of members that allied with each other).

In summary, this exclusion of data represents the minimal responses of managers. This apparent inattention given to these collaboration issues by public health managers has implications for development of social work practice in collaborative networks.

6.10 Limitations of the Research Study

This research is one example of state mandated collaboration that was implemented in the province of Ontario. There are limitations inherent in qualitative research methods such as those used in this study, notably that findings are context dependent (i.e., Ontario from 1998-2001). This study does however contribute to the literature on collaboration. Theoretical knowledge about collaboration is generally based on case study research. The six themes of collaboration found in this study extend knowledge of collaborative practice.

In addition, the results of this study are based on the perceptions of a sample of

individual public health managers who are responsible for the implementation of the HBHC program. One of the methodological limitations of this study was the decision to only include public health managers. Consequently, the data collected, based on the perceptions of HBHC managers, reflects their bias about how they operationalized their responsibility to implement the program. The research would have been strengthened by the inclusion of the total population of public health managers responsible for HBHC implementation rather than a fifty plus one per cent sample of the population. Moreover, the findings are based solely on the perceptions of managers responsible for the implementation of the HBHC program. The perceptions of other community stakeholders about the pre-conditions and processes that influenced collaboration in the local HBHC network were not included. Consequently, the findings reflect the particular orientation of public health units/departments in the sample and the common responses of the managers of the HBHC program. The managerial orientation of these public health stakeholders does not take into account the opinions of other service providers or of consumers. The study would have been enhanced by data from wider sources such as HBHC network members, HBHC direct service staff and home visitors and parent representatives, board members/administrators of public health units/departments and the policy makers within the Office of Integrated Services for Children.

Future research could gather data on rural/urban differences across Ontario (Polivka, Dresbach, Heimlich, & Elliott, 2001). Additionally, an in-depth case study of urban/rural differences and their effect on local collaboration could inform practice as

state mandates for collaboration are increasingly used for service integration in urban and rural communities.

In addition, another level of analysis looked promising. The research proposed to analyze the data according to the managerial experience and education of managers of HBHC. As outlined in Chapter 3, only a small number of managers had less than the mean of 6 years of experience. This level of analysis was not carried out, but future research could address level of managerial experience and education and its impact on implementation of state-mandated collaboration. Anectodal data in this study suggests that less experienced managers viewed the mandate as a tool to bring resistant stakeholders into the HBHC network. On the other hand, more experienced managers did not place the same importance on the mandate but simply adapted it to fit their local community.

. Finally, the study could have been strengthened by use of a wider variety of methods and data sources such as: 1) secondary data review of (e.g. minutes, proposals, budgets and other documentation associated with the HBHC network) and 2) primary data collection with other stakeholders (e.g. survey questionnaires and focus groups of network participants).

6.11 Summary of Implications for Future Research

The area of formalization of operational processes and recruitment of stakeholders for the HBHC network offers another potential research pathway. One of the strengths of this research was the identification of indicators of formalization of

operational processes and identification of the strategic and sequential recruitment activities of HBHC managers. These indicators of formalization and stakeholder recruitment activities could be operationalized as quantitative measures that would provide province-wide data on these dimensions of collaboration through a survey questionnaire.

Further research is also needed to address the influence of organizational structure on collaboration. There was no a priori attempt to gather data on this aspect of collaboration. However, interesting findings suggested that managers used their community organization skills to organize local stakeholders. They created a diversity of organizational forms (e.g., umbrella organizations, multi-site networks, working groups) and offered differential levels of participation in the network (e.g., minutes only, quarterly information sharing meetings). Collaboration theory addresses the level of integration of organizational structures in collaboration but pays little attention to the processes used to organize collaboration at the local level.

Other studies have identified that the relational processes of collaboration should be explored in future research (Dunlop & Angell, 2001; Rivard, 1999; Payne, 1998; Ring & Van De Ven, 1994; Oliver, 1991). It was outside the scope of this study to explore social relations in depth, but future research on the relational processes associated with collaboration seems indicated, given their thematic importance as identified in Chapter 5.

Finally, a number of future research pathways should be explored. One of these is the unit of analysis that will best capture the representation of collaboration in local

communities. This study used aggregated individual level responses. Future research should attempt to triangulate the data by using both individual-level and network-level responses to accurately portray local collaboration across the study sites in Ontario. Because of constrained research funding, it was not possible to collect and analyze more than individual level responses. Further research could include a more inclusive study population by conducting interviews with the population of managers across the HBHC sites. This proposed research would also focus more intensively on the six themes of collaboration by incorporating other units of analysis (network), secondary data sources (such as minutes, terms of references, implementation plans, protocols, reports), and key informant interviews (e.g. policy makers and network members) and additional methods (such as focus groups and surveys).

The provincial evaluation of the HBHC program also addressed the development of the collaborative network within local communities. Although the results of this evaluation were not available at the time of the completion of this study (see Chapter 2 for discussion of the provincial HBHC evaluation), further research on the HBHC program should compare findings of the HBHC evaluation with research study.

6.12 Implications for Theory Development

The data collected in this study consisted of interviews using questions based on a conceptual framework developed from the literature on factors found to influence collaboration. This conceptual framework consisted of three dimensions from the literature that were defined for this study as pre-conditions of collaboration: 1) history of

previous collaboration, 2) mandatory/voluntary model and 3) legitimacy of the convening organization. An analysis of the data in this study led to a re-conceptualization of two of these dimensions into two new themes of collaboration (Historical and Institutional Conditions). In addition, the data analysis yielded a new pre-condition theme (Financial Conditions). The re-conceptualization of these three new themes of collaboration has been discussed extensively in previous chapters.

In addition, the conceptual framework for this study contained eight dimensions from the literature that were defined for this study as collaborative processes that facilitated or constrained the operations of collaborative networks namely: 1) stakeholder representation, 2) membership participation, 3) costs and benefits of membership, 4) decision-making levels, 5) communication style, 6) formality/informality of links, 7) common purpose development and 8) sufficient resources. An analysis of the data in this study led to a re-conceptualization of the collaborative processes identified in the conceptual framework into a new operational process theme of collaboration (Operational Processes), as discussed in previous chapters. In addition, an analysis of the data led to the creation of two new collaborative process themes (Organizational and Relational) that were not part of the original conceptual framework also discussed extensively in previous chapters.

The Organizational Processes theme of collaboration emerged from the data in this study as previously discussed. Although the literature on organizational structures was reviewed, neither the original conceptual framework nor the subsequent interview

specifically addressed this dimension of collaboration. The importance of the organizational processes used to create collaborative network structures and sub-structures was unforeseen and unexpected. Across the local sites, collaboration was enhanced through the creation of primary and secondary network structures created to respond to local communities. While collaboration theory does address the structural integration of organizations and the stages of development of integration, there is little that addresses the actual organizing processes used by managers to facilitate structure development in collaborative networks. What did emerge in this study were descriptive accounts of the organization and maintenance of a variety of complex and multi-site structures that support the importance of context to implementation of collaboration. The diversity and complexity of structures found in this study confirms collaboration research that suggests that the degree of formalization of collaborative structures must be matched to the characteristics of the participants and the local environment (Mitchell & Shortell, 2000).

The Relational Processes theme of collaboration also emerged from the data in this study. The data suggested that several aspects of interpersonal relations influence local collaboration. The relational processes theme was not a pre-existing element in the conceptual framework, but confirms previous research (Dunlop & Angell, 2001; Rivard, 1999; Payne, 1998; Ring & Van De Ven, 1994; Oliver, 1991) identifying the importance of this dimension of collaboration. Research questions on communication, the legitimacy of the convening organization and the extent of informality in network relationships

yielded data on interpersonal relations and collaboration. These findings were then used to explore two dimensions: 1) previous relationships and 2) interpersonal relations. These relational processes have been extensively discussed in previous chapters.

The importance of the interpersonal perspective in this study contributes to the recent knowledge about the dynamic and interactive nature of collaboration and its inherent managerial challenges. Both the negative and positive aspects of state-mandated collaboration and its effect on interpersonal relationships were highlighted by managers in this study. Although there were different perceptions in the data about whether the mandate facilitated and/or constrained relational processes, almost all the managers suggested that the mandate constrained collaboration in their local community. They also reported on the importance of the interpersonal perspective in collaborative network development. Despite the focus on a small sample of public health managers, the study adds important information to collaboration research and has implications for theory development, research and practice.

The findings on facilitators and barriers to collaboration extend collaboration theory by challenging the assumption that a previous history of working together will always promote collaboration. Analysis of data in this study showed that a negative history of working together may constrain local collaboration. When community stakeholders come to the collaboration table, they bring their past history of community relationships with them. If this history includes negative experiences, then collaboration will not move forward until this conflict is resolved. In this study, managers suggested

that they used a variety of negotiation, mediation and conflict resolution skills to resolve conflicts between their organization and other service providers in the lcoal community.

In general, collaboration theory has not focused on the specific differences between implementation of networks in urban and rural communities. This study did not examine urban/rural differences but did identify a sense of uniqueness and difference across local communities. The responsibility for collaborative networks that cover large geographical areas made communication difficult, increased time and travel pressures and required complex management skills to deal with jurisdictional fragmentation across multiple sites. As identified above, an in-depth analysis of rural/urban differences in building collaborative networks could enhance theoretical knowledge about the management of interorganizational collaboration in diverse locations.

The literature on the developmental stages of collaboration was discussed as one dimension to be explored. The unique history and development of HBHC networks precluded this type of analysis because HBHC networks were diverse across the province. Local sites had unique histories of previous collaboration, or lack of it, which was a major influence on implementation of the HBHC network. At this early stage of development, the influence of a previous history of collaboration and previous interpersonal relationships were found to be important facilitators of local collaboration. This study could not address the factors that influence collaboration within developmental stages, but this could prove fruitful for future research (Bailey & McNally-Koney, 1995; Florin, Mitchell, & Stevenson, 1993).

6.13 Implications for Social Work Practice

The practice issues concern the management of collaborative networks designed to promote the integration of health and social services at local community levels. They are relevant to social work practice within institutional and community settings at policy and community levels of intervention. The complex management tasks associated with collaboration suggest that social workers need to build practice competency in its promotion. The suggestions also support the need for social work education to develop policy and community practice curriculum designed to strengthen management competencies in the area of collaborative practice. Collaborative practice in social work requires curriculum development that addresses knowledge and skills in areas such as: 1) multidisciplinary practice, 2) planning for integrated service delivery systems, 3) conflict resolution, 4) negotation, 5) mediation and 6) leadership. Social work's historical commitment to community practice has always been at the core of the profession. These suggestions are presented to enhance understanding among social work practitioners and educators about the management challenges of building local collaborative networks in an era of downloading.

State mandates have forced local communities to reform child and family service systems while national and provincial governments shift the burden of social provision to local government. As governments increasingly mandate collaborative networks as a mechanism for integrating health, social service and educational policies and programs,

social workers will be needed who can provide managerial competencies in collaborative practice at institutional and community levels.

As previously discussed, managers reported that had they were overloaded with responsibility for the HBHC program. They indicated that sufficient resources are needed for the development and administration of local HBHC collaborative networks. The data suggests that the tasks of stakeholder recruitment, organizational development and planning for integrated service systems are too complex to be carried out without specific resources dedicated to the administrative role. Managers stated that these kind of collaborative initiatives need to have a full time co-ordinator's position to carry out the community organization functions required for collaboration. To illustrate, they used the example of the Early Years initiative where a full time co-ordinator's position was funded. Interpretations of the responses of the HBHC managers suggest that central government agencies need to be realistic about what can be accomplished in collaborative networks when the responsibility for building such networks for service integration are not given sufficient funding. More specifically, this study concluded that the dedication of administrative resources to fund the implementation of the collaborative network should have been a priority for a provincial government serious about integrating services for children.

Managers in this study identified specific functions and roles that the provincial office (OISC) could have carried out to improve local communities' abilities to implement the networks. More specifically, a mass media campaign targeted to the

whole community would have been the best vehicle to explain the Healthy Babies/ Healthy Children Program.

Managers suggested a number of ways that the provincial OISC could have supported their local initiatives. An interpretation of their responses led to the conclusion that centralizing functions such as 1) marketing, 2) training, 3) evaluation, 4) information dissemination and 5) education would have ensured a more consistent, organized response by local HBHC sites across the province. Managers stated that since this type of centralization was already established for other Ontario public health initiatives, (e.g., Heart Health), it would have been easy to adopt this model for HBHC. They believed that centralizing the marketing function would have provided a consistent message about the HBHC program across the province, supported the work of local networks and contributed valuable resources to local communities.

Managers identified the need for a concerted effort by provincial level managers to work with provincial associations of service providers (e.g., physicians, audiologists, hospitals) so that negotiations between the provincial government and associations did not jeopardize the relationships in local communities.

From an interpretive framework, it is difficult to assess whether the provincial government concerned themselves with designing specific functions that should be carried out by the central office and those that should be the responsibility of local communities. It would have been helpful if the division of functional responsibilities between central policy makers and local implementors had been addressed. The

development of interorganizational linkages between the provincial government, provincial associations, local service providers and the HBHC managers and networks could have been negotiated by the Office of Integrated Services for Children in a more structured and integrative model.

Managers believed that in many of the HBHC sites, the lack of communication between the ministries comprising the HBHC program (Ministry of Health and Long-Term Care, Ministry of Community and Social Services, Ministry of Education and Ministry of Citizenship and Culture) compromised local implementation. They reported that jurisdictional boundaries at the local level complicated and even prohibited participation because the geographical service areas of each ministry involved were not compatible.

This study suggests that, although managers did their best to work within these geographical complexities, the resolution of these boundary issues should have been addressed by the Office of Integrated Services for Children before the province wide implementation of the HBHC Program. Since the ultimate goal of the HBHC collaborative network was the development of an integrated children's services system, these jurisdictional boundary issues should have been negotiated among the ministries prior the implementation of local collaboration.

Managers suggested that provincial level HBHC consultants needed to be more realistic about how they were going to manage communication between provincial level ministries and local communities. They reported that the introduction of a parallel

mandate (Early Years Initiative) caused confusion and conflict at the local level. Further, they felt that the fragmentation of these two initiatives within separate ministries (HBHC in Ministry of Health and Long Term Care and Early Years in Ministry of Community and Social Services) was a great concern to local communities but was not recognized as a problem at the provincial level.

This study found that some degree of horizontal communication at the top and at the bottom, but lack of vertical communication between central bureaucracies and local organizations contributed to conflict and strain among HBHC network members. The data suggests that HBHC managers were very well informed by the OISC and the Ministry of Health and Long-Term Care about program expansions and changes. This was not the case with other local service providers whose respective central bureaucracies (Ministries of Community and Social Services, Education and Training, Citizenship, Culture and Recreation) did not inform them of changes. This created difficulties for local managers as funding and program changes affected other service providers who were uninformed of these changes. Planning for the HBHC network at the provincial level should have included a task force or work group whose primary purpose was to insure that inter-ministerial communication facilitated rather than constrained, implementation across the province. A more sophisticated planning process (such as the long-term care initiative of 1990) was needed within the provincial Office of Integrated Services for Children to facilitate inter-governmental linkages, planning and communication.

Managers in this study were reticent to discuss the concept of leadership in interorganizational collaboration. As previously noted, an interpretation of the data that was excluded in this study suggests that the mandatory nature of the HBHC program may have influenced their perception of themselves as leaders. Perhaps it was the word, *leader*, that they found difficult since the word may have suggested something more directive than they intended. No direct questions addressed leadership of the collaborative network. Rather, the concept arose in discussion. The leadership skills of public health managers reflected their administrative competencies rather than a community planning orientation to practice. This is not to say that they were not successful in organizing the HBHC networks. More to the point, it is a comment on their perceptions of their role as managers of the HBHC program and all its components.

Some managers may have been uncomfortable with the word leader because they had a community empowerment or "bottom up" approach to network development. Many public health managers in this study were comfortable with advocacy roles. In retrospect, this study could have explored collaboration using empowerment or conflict theory, either in place of or as well as an organizational theory perspective. More public health managers than the researcher expected were committed to client and systemic advocacy. Public health managers could benefit from progressive models of social work practice (e.g., social action). Although the advocacy strategies of HBHC managers did not reflect models of social work practice, they were strategic and political.

The implications for social work practice suggest a need for leadership that can

bring stakeholders together to work in multi-disciplinary and multi-sectoral collaboratives. The new management skills required for interorganizational collaboration are based on relationship building and community building. Social work seems well suited to the non-bureaucratic type of leadership that will be required for collaborative practice.

Social work leaders of collaborative networks will be required to engage a broad base of stakeholders through outreach activities, bring together diverse partners to build consensus and transform local communities through collective action. The type of leadership necessary for building collaborative networks can be found in the social work skills of community organizing, negotiation, conflict resolution, outreach, cultural competency and boundary spanning (Dunlop & Angell, 2001; Lasker, Weiss, & Miller, 2001; Mitchell & Shortell, 2000; Chrislip & Larson, 1994; Mizrahi & Rosenthal, 1993).

Boundary spanning is another management competency that is emerging in the literature as an opportunity for social workers to play a part in revitalizing community (Dunlop & Angell, 2001; Lasker, Weiss & Miller, 2001; Weil, 1996; Edwards & Yankey, 1991). Community practice as a boundary spanner requires social work leaders to build relationships among diverse partners in uncertain and competitive environments (Dunlop & Angell, 2001; Dunlop & Holosko, 1995). Boundary spanning, as a community practice skill, allows social work leaders to bridge these diverse perspectives and to build collaboration through relationships based on trust and respect.

The lack of data on leadership in this study of local collaboration suggests that the

social work profession may still be able to find a niche for its community practice skills in the restructuring environment of the early 21st century. Trends in nursing have addressed the need to shift from institutional to community based settings and identified the need for nurses to upgrade their qualifications to work in the community. More recently, the collaboration literature has addressed leadership issues by using the concepts of synergy and facilitator to discuss leadership roles (Lasker, Weiss, & Miller, 2001). Social work, with a proud history of community organization, must seize the leadership opportunity or risk being marginalized in an era characterized by downloading and restructuring of health and social services.

In this study, the inclusion of consumers, parents and advocates was minimal at best. Most managers expressed the need to solve this participation problem in the future. Managers reported that there were potential channels open to consumers, parents and advocates through ad hoc mechanisms but recruitment plans did not include specific instructions for involving parents, consumers and advocates. It appears that the state mandate for collaboration in the HBHC network did not include the possibility for the kind of grassroots collaboration that might have been formed by consumers, parents and advocates not associated with service organizations. Social workers would note the exclusion of diverse groups of stakeholders which constrains potential to build community capacity to promote social and economic justice. This suggests that advocacy may be needed to insure the inclusion of parents, consumers and community members in the HBHC networks.

The findings from this study imply that local collaboration in the HBHC program could have benefitted from a community development approach to build inclusiveness. Social work practitioners should use community development as a strategy for increasing democratic participation in local collaboration. Recent scholarship on collaboration suggests that many different voices need to brought together to build community capacity (Lasker, Weiss, & Miller, 2001; Labonte, 1997; Minkler & Wallerstein, 1997; Mattessich & Monsey, 1992).

Transformation for social change could be effected through a community development approach to collaboration. Locality development, a community development model, builds community capacity by recruiting a broad base of stakeholders who engage in an interactional process of identifying and solving their own problems. (Rubin & Rubin, 2001; Rothman, 1996; Weil, 1996; Adamson, Briskin, & McPhail, 1988; Taylor & Roberts, 1985). This approach provides opportunities for people to identify problems and take collective action to improve their social conditions. Community development approaches to collaboration would bring together a diversity of individuals, organizations and community stakeholders in advocacy coalitions to transform the way that communities define problems and devise solutions (Lasker, Weiss, & Miller, 2001; Mayo, 1997).

Whether mandated or not, the development of local community collaboration requires the advocacy skills of community practitioners. It is imperative that the social work profession stake a claim that reflects their professional history of advocacy and

community development before the restructuring of the health care system excluded social workers from practice with communities (Levin, Hebert, & Nutter, 1997).

Managers reported that they had organized HBHC networks using a variety of activities, sources, sequences and varying levels of participation. They suggested that they made a distinction between those stakeholders who had to be involved at the outset of the collaborative process and those whose participation was more issue focused and secondary to the network. Although managers believed that they needed to set up differential participation to achieve a broad base of support in the HBHC network, they did not perceive that they were using recruitment strategies that could be identified as community organization models such as locality development, social planning and/or social action (Castelloe & Prokopy, 2001; Garvin & Cox, 1995; Rothman & Tropman, 1987).

Managers reported that they planned for differential participation of stakeholders. However, they did not suggest that this differential recruitment was designed to enlist the support of powerful individuals, organizations, institutions, community members and parents/consumers in the community. The managerial orientation to network development in this study appears congruent with the rational planning model. For social workers this is typified in the profession's community organization model of social planning with its focus on task accomplishment and a belief in the technical skills of the planner (Rothman & Tropman, 1987).

Unfortunately, it appeared there was no recognition by public health managers of

the community organization models that characterize current and historical community social work practice (Weil, 1996; Garvin & Cox, 1995). It appears that, just as community organizing is coming to the fore, community social work seems remote from the action. An alternative to social planning offered by social work could be the community organization models based on locality development (organizing community) and social action (community empowerment) that identify the need to expand community involvement to address problems and take collective action (Rothman, 1996; Poole, 1997, 1995; Rothman & Tropman, 1987).

The management and administrative skills needed to facilitate interorganizational collaboration for service integration are not exclusive to either public health nurses or social workers trained in administration. Social workers have community organization process skills that concentrate on: 1) engaging a broad base of stakeholders (individuals, organizations, institutions, community members and consumers/advocates) and 2) building relationships among stakeholders for the purpose of collective action. These skills may give social workers a niche in future collaboration initiatives. While it appears that public health managers were unaware of social work community practice models, this study illustrates the need for a renewed commitment among social work practitioners and educators to rebuild community social work practice.

Bibliography

Adamson, N., Briskin, L. & McPhail, M. (1988). Organizing for change: The contemporary women's movement in Canada. Oxford: Oxford University Press.

Aldrich, H. (1979). Organizations and environments. Englewood Cliffs, NJ: Prentice-Hall.

Aldrich, H. & Herker D. (1977). Boundary spanning roles in organizational structure. Academy of Management Review, 2, 217-230.

Alexander, E. R. (1992). Approaches to planning. Introducing current planning theories, concepts and issues (2nd ed.). New York: Gordon and Breach Science Publishers.

Alinsky, S. (1971). Rules for radicals. New York: Random House.

Alter, C. (1990). An exploratory study of conflict and coordination in interorganizational service delivery systems. Academy of Management Journal, 23 (3), 478-502.

Alter, C. & Hage, J. (1993). Organizations working together. Newbury Park, CA: Sage Publications.

Bailey, D. & McNally-Koney, K. (2000). Strategic alliances among health and human services organizations. From affiliations to consolidations. Thousand Oaks: Sage Publications.

Bailey, D., & McNally-Koney, K. (1996). Interorganizational community-based collaboratives: A strategic response to shape the social work agenda. Social Work, 41 (6), 602-611.

Bailey, D., & McNally Koney, K. (1995). An integrative framework for the evaluation of community-based consortia. Evaluation and Program Planning, 18 (3), 245-252.

Barr, C., & Huxham, C. (1996). Involving the community: Collaboration for community development. In C. Huxham (Eds.), Creating collaborative advantage (pp. 110-125). London: Sage Publications Ltd.

Battle, K., & Mendelson, M. (1997). Child Benefit Reform in Canada: An evaluative framework and future benefits. Ottawa: Caledon Institute of Social Policy.

Beauvais, C., & Jenson, J. (2001). Two Policy Paradigms: Family Responsibility and Investing in Children. Ottawa: Canadian Policy Research Network.

Bella, L. (1996). Profession as ideology: Doctors, social workers and nurses. In B. Kirwin (Ed.). Ideology, development and social welfare. Canadian perspectives (3rd ed)(pp.144-164). Toronto: Canadian Scholars Press.

Betten, N. & Austin, M. (Eds.) (1990). The roots of community organizing: 1917-1939. Philadelphia: Temple University Press.

Bickman, L. (1997). Resolving issues raised by the Fort Bragg evaluation: New directions for mental health services research. American Psychologist, 52 (5), 562-565.

Boyle, M. H., & Offord, D. R. (1987). Ontario Child Health Study. Hamilton: Child Epidemiology Unit, Department of Psychiatry, McMaster University.

Brown, G., Byrne, C., Roberts, J., Gafni, A., Majumdar, B., Kertyzia, J.(2001). Sewing the Seams. Hamilton, Ontario: McMaster University, System-linked Research Unit on Health and Social Service Utilization.

Bruner, C. (1991). Thinking collaboratively: Questions and answers to help policy makers improve services for children. Washington, DC: Education and Human Services Consortium.

Cairns, D. (1996). Rediscovering democratic purpose in British local government. Policy and Politics, 24 (1), 17-27.

Campaign 2000 (2002). Bold plan of action required to address child and family poverty, June, 2002. [On-line]. Available: http://action.web.ca/home/c2000/alerts.html,8/17/2002.

Canadian Association of Social Workers (1998). CASW Statement on Multiskilling, November, 1998. [On-line]. Available: http://www.casw-acts.ca/RecPubs.htm, 2/25/2000.

Carney, T. F. (1972). A technique for systematic inference from communications. Winnipeg: University of Manitoba Press.

Castelloe, P., & Prokopy, J. (2001). Recruiting participants for community practice interventions: Merging community practice theory and social movement theory. Journal of Community Practice, 9 (2), 31-48.

Casto, M. (1994). Inter-professional work in the USA. Education and practice. In A. Leathard (Ed.), Going inter-professional. Working together for health and welfare (pp. 188-205). New York: Routledge.

Chrislip, D. & Larson, C. (1994). Collaborative leadership. How citizens and civic leaders can make a difference. San Francisco: Josey-Bass Publishers.

Craig G, Derricourt, N., & Loney, M. (Eds.). (1982). Community work and the state. London: Routledge & Kegan Paul.

Denzin, N. K. (1978). The research act: A theoretical introduction to sociological methods. (2nd ed.). New York: McGraw Hill.

Dhuly, M. J. (1990). Building coalitions in the human services. Newbury Park, CA: Sage Publications.

DiMaggio, P. J. (1988). Interest and agency in institutional theory. In L. G. Zucker (Ed.), Institutional patterns and organizations (pp. 3-22). Cambridge, MA: Ballinger.

Dominelli, L. (1996). Deprofessionalizing social work: Anti-oppressive practice, competencies and postmodernism. British Journal of Social Work 26, 153-175.

Dominelli, L. (1990). Women and community action. Birmingham: Venture Press.

Dunlop, J.M.. & Angell, G.B. (2001). Inside-Outside: Boundary spanning challenges in building rural health coalitions. Professional Development: The International Journal of Continuing Social Work Education 4 (1), 40-48.

Dunlop, J.M., & Holosko, M. (1995). Community social work practice: Health promotion in action. In M. Holosko & P. Taylor (Eds.), Social work in health care (pp. 626-363). Toronto: Canadian Scholars Press.

Dunlop, J.M., & Schopler, J. (1996, February). Inside-Outside: Boundary spanning challenges for community coalitions. Paper presented at the Annual Program Meeting of the Council on Social Work Education, Washington, DC.

Eden, C. (1996). The stakeholder/collaborator strategy workshop. In C. Huxham (Ed.), Creating collaborative advantage (pp. 44-56). London: Sage Publications.

Edwards, R.L. & Yankey, J.A. (1991). Boundary spanning skills. In R.L. Edwards & J.A. Yankey (Eds.) Skills for effective management (pp. 27-116). Silver Spring, MD: NASW Press.

Falk Rafael, A. R. (1999). From rhetoric to reality: The changing face of public health nursing in southern Ontario. Public Health Nursing, 16 (1), 50-59.

Federal-Provincial-Territorial Council on Social Policy Renewal (1998), March 13th, 1998. [On-line]. Available:http://socialunion.gc.ca/news/98mar13e.html.

Federal-Provincial-Territorial Advisory Committee on Population Health (1999). Investing in early child development: The health sector contribution. Working Group on Healthy Child Development. Ottawa: Minister of Supply and Services Canada.

Federal-Provincial-Territorial Advisory Committee on Population Health (1995). National goals for healthy child and youth development. Working Group on Healthy Child and Youth Development. Ottawa: Minister of Supply and Services Canada.

Finn, C. B. (1996). Utilizing stakeholder strategies for positive collaborative outcomes. In C. Huxham (Ed.), Creating collaborative advantage (pp. 152-165). London: Sage Publications.

Fisher, R., & Karger, H. J. (1997). Social work and community in a private world. Getting out in public. New York: Longman.

Fleishman, J. A., Mor, V., Piette, J. D., & Allen, S. M. (1992). Organizing AIDS service consortia: Lead agency identity and consortium cohesion. Social Service Review, 66 (4), 547-570.

Florin, P., Mitchell, R., & Stevenson, J. (1993). Identifying training and technical assistance needs in community coalitions: A developmental approach. Health Education Research, 8 (3), 417-432.

Friedmann, J. (1987). Planning in the public domain: From knowledge to action. Princeton, NJ: Princeton University Press.

Galaskiewicz, J. & Shatin, D. (1981). Leadership and networking among neighborhood human service organizations. Administrative Science Quarterly, 26, 434-448.

Galaskiewicz, J. (1985). Interorganizational relations. Annual Review of Sociology, 11, 281-304.

Gans, S. P., & Horton, G. T. (1975). Integration of human services. New York: Praeger.

Garvin, C. & Cox, F. (1995). A history of community organizing since the civil war with special reference to oppressed communities. In F.Cox, J. Erlich, J., Rothman, and J. Tropman (Eds.) Strategies of community organization (5th ed.)(pp. 64-99). Itasca: Illinois: F.E. Peacock.

Gilbert, N. & Specht, H. (1977). Planning for social welfare. Issues, models and tasks. Englewood Cliffs, NJ: Prentice Hall.

Government of Canada (1992). Brighter Futures. Canada's action plan for children. Ottawa: Minister of Supply and Services Canada.

Government of Canada (1995). Budget Plan. Ministry of Finance. Ottawa: Supply and Services Canada.

Government of Canada (1999). Budget 99 Interactive. [On-line]. Available: http://www.fin.gc.ca/budget99/multimedia-e/health3-e.html.

Government of Ontario (2000). Ontario government tips scales in favour of child protection, March 27, 2000. [On-line]. Available: http://www.newswire.ca/government/ontario/english/releases/March2000/27/c7544.html.

Government of Ontario (1999). 1999 Ontario Budget. Ministry of Finance. [On-line]. Available: http://www.gov.on.ca/FIN/bud99/nr5.htm.

Government of Ontario (1998). Provincial-Municipal Roles and Responsibilities for social and community health services. (No. 98-003). Toronto: Queen's Printer for Ontario.

Government of Ontario (1997). Mandatory Health Programs and Services, Family Health Program, Child Health Component. Public Health Branch, Ministry of Health and Long-term Care. Toronto: Queen's Printer for Ontario.

Government of Ontario (1988). Transitions. Report of the Social Assistance Review Committee. Ministry of Community and Social Services. Toronto: Queen's Printer for Ontario.

Government of Ontario (1995). 1995 Ontario Budget. Ministry of Finance. Toronto: Queen's Printer for Ontario.

Graham, J. R., & Barter, K. (1999). Collaboration: A social work practice method. Families-in-Society: The Journal of Contemporary Human Services, 80 (1), 6-13.

Gray, B., Duran, A., & Segal, A. (1997). Revisiting the critical elements of comprehensive community initiatives. Washington, DC: U.S. Department of Health and Human Services.

Gray, B., & Wood, D. J. (1991). Collaborative alliances: Moving from practice to theory. Journal of Applied Behaviour Science, 27 (1), 3-22.

Gray, B. (1989). Collaborating. Finding common ground for multiparty problems. San Francisco: Josey-Bass Publishers.

Guba, E.G. & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin and Y.S. Lincoln (Eds.), Handbook of qualitative research (pp.105-117). Thousand Oaks, CA: Sage Publications.

Hanvey, L (1997). Healthy Babies, Healthy Children. Rationale for Screening and Assessment Tools. Unpublished manuscript.

Harbert, A. S., Finnegan, D., & Tyler, N. (1997). Collaboration: A study of a children's initiative. Administration in Social Work, 21(3/4), 83-107.

Hassett, S. & Austin, M. J. (1997). Service integration: Something old and something new. Administration in Social Work, 21 (3/4), 9-29.

Health Canada (1999). Guide to Federal Programs and Services for Children and Youth (2nd ed.). (Cat. No. H39-403/1999E). Ottawa: Minister of Public Works and Government Services Canada.

Health Canada (1998). Community Action Program for Children (CAPC). Preliminary findings of the national evaluation. Ottawa: Health Canada. Unpublished manuscript.

Health Protection and Promotion Act (1997). Revised Statutes of Ontario, 1997, cH7. [On-line]. Available: http://gateway.ontla.on.ca80/hansard/35_parl/session3/justice/j028.htm.

Holosko, M..J. & Dunlop, J.M. (1992). Evaluating inter-organizational approaches to service delivery: A case example of the Family Violence Project in Kent County. Canadian Journal of Program Evaluation 7 (2), 115-129.

Huxham, C. & Vangen, S. (2000). Leadership in the shaping and implementation of collaboration agendas: How things happen in a (not quite) joined-up world. Academy of Management Journal, 43 (6), 1159-1175.

Huxham, C. (1996). Collaboration and Collaborative advantage. In C. Huxham (Ed.), ___ Creating collaborative advantage (pp. 1-19). London: Sage Publications.

Huxham, C. (1993). Pursuing collaborative advantage. Journal of the Operational Research Society, 44 (6), 599-611.

Hyde, C. (1996). A feminist response to Rothman's "The interweaving of community intervention approaches". Journal of Community Practice, 3 (3/4), 127-146.

Jeffrey, B. (1999). Hard right turn. The new face of neo-conservatism in Canada. Toronto: Harper Collins.

Jenson, J., & Thompson, S. (1999). Comparative Family Policy: Six Provincial Stories (Research Report No F/08). Ottawa: Canadian Policy Research Networks Inc.

Johnson, L. C., & Barnhorst, D. (Eds.). (1991). Children, families and public policy in the 90's. Toronto: Thompson Educational Publishing.

Kaluzny, A. D., Zuckerman, H. S., & Ricketts III, T. C. (Eds.)(1995). Partners for the dance. Forming strategic alliances in health care . Ann Arbor, MI: Health Administration Press.

Kegler, M. C., Steckler, A., McLeroy, K., & Malek, S. H. (1998). Factors that contribute to effective community health promotion coalitions: A study of 10 Project ASSIST Coalitions in North Carolina. Health Education and Behaviour, 25, 338-353.

Kenny, S. (1998). Community welfare organizations in Australia: Activism or industry. Community, Work & Family, 1 (2), 179-195.

Kitchen, B. (1997). "Common Sense" assaults on families. In D. Ralph, A. Regimbald, & N. S. Amand (Eds.), Mike Harris's Ontario: Open for business, closed to people (pp. 103-113). Halifax: Fernwood Publishing.

Kretzmann, J., & McKnight, J. (1993). Building communities from the inside out. A path toward finding and mobilizing a community's assets. Evanston, IL: Northwestern University, Center for Urban Affairs and Policy Research, Neighbourhood Innovations Network.

Kreuter, M.W., Lezin, N.A. & Young, L. A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. Health Promotion Practice 1, 49-63.

Krippendorff, K. (1980). Content analysis. An introduction to its methodology. Newbury Park: Sage Publications.

Labonte, R. (1997). Community, community development and the forming of authentic partnerships: Some critical reflections. In M. Minkler (Ed.), Community Organizing and community building for health (pp. 88-102). London: Rutgers University Press.

Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. Health Education Quarterly 21 (2), 253-268.

Lasker, R., Weiss, E., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. The Millbank Quarterly, 79 (2), 179-205.

Lasker, R. D. (1997). Medicine and public health. The power of collaboration. New York, NY: New York Academy of Medicine. Committee on Medicine and Public Health.

Lauffer, A. (1981). The practice of social planning. In N. Gilbert & H. Specht (Eds.) Handbook of the Social Services (pp 588-197). Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Lawrence, P. & Lorsch, J.W. (1967). Differentiation and integration in complex organizations. Administrative Science Quarterly, 12, 1- 47.

Leathard, A. (1994). Conclusion and future agendas for inter-professional work. In A. Leathard (Ed.), Going inter-professional. Working together for health and welfare (pp. 206-231). New York: Routledge.

Ledwith, F. (1999). Policy contradictions and collaboration in community mental health services in Britain. International Journal of Public Sector Management, 123, 236-248.

Lees, R. & Mayo, M. (1984). Community action for change. London: Routledge & Kegan Paul.

Levin, R., Herbert, M., & Nutter, B. (1997). Preparing social work students for the new realities in health care practice. Implications for field education. Canadian Social Work Review 14 (2), 167-183.

Levine, S., & White, P. (1961). Exchange as a conceptual framework for the study of interorganizational relationships. Administrative Science Quarterly, 5, 583-601.

MacDonald, M. (1994). Reinventing systems: Collaborations to support families. Cambridge, Massachusetts: Harvard Family Research Project.

Mackie, R. (1997, December, 16). Tories moving too fast for voters. The Globe and Mail, p. A3.

MacNair, R. H. (1993). Patterns of organizing for community human service planning: A statewide survey. In T. Mizrahi & J. D. Morrison (Eds.), Community Organization and Social Administration (pp.87-106). New York: Haworth Press.

MacNair, J.H., Gross, J. & Daniels, M.C. (1995). State promotion of community advocacy organizations: A comparative analysis of four case studies in Georgia. Journal of Community Practice, 2 (2), 77-97.

Mandell, M. P. (1999). Community collaborations: Working through network structures. Policy Studies Review, 16 (1), 43-64.

Mattessich, P. W., & Monsey, B. R. (1992). Collaboration. What makes it work? A review of research literature on factors influencing successful collaboration. St. Paul, MN: Amherst H.Wilder Foundation.

Mattessich, P.W., Murray-Close, M, & Monsey, B.R. (2001). Collaboration: What makes it work (2nd ed.). St. Paul, MN: Amherst H. Wilder Foundation, Wilder Research Center.

Mayo, M. (1997). Partnerships for regeneration and community development. Critical Social Policy, 17, (3), 3-26.

Mayo, M. (1975). Community development: A radical alternative. In R. Bailey & M. Brake (Eds.), Radical social work (pp. 129-144). New York: Random House Inc.

McCain, M. N., & Mustard, J. F. (1999). Reversing the Brain Drain. Early Years Study. Final Report. Toronto: Ontario Children's Secretariat, Government of Ontario.

McGrath, M. (1991). Multidisciplinary teamwork. Community mental handicap teams. Aldershot: Avebury

McKinney, M.M., Morrissey J.P., & Kaluzny, A. D. (1993). Interorganizational exchanges as performance markers in a community cancer network. Health Services Research, 28, 518-539.

Melaville, A. I., & Blank, M. J. (1993). Together we can: A guide for crafting a profamily system of education and human services. Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement and U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Melaville, A. I. (1992). What it takes: Structuring interagency partnerships to connect children and families with comprehensive services. Washington, DC: Education and Human Services Consortium, U.S. Department of Education and U.S. Department of Health and Human Services.

Melchers, R. (1999). Local governance of social welfare. Local reform in Ontario in the nineties. Canadian Review of Social Policy, 43, 29-57.

Meyer, J. M., & Rowan, B. (1977). Institutionalized organizations: Formal structures as myth and ceremony. American Journal of Sociology, 83, 340-363.

Meyer, J. W., & Scott, W. R. (1983). Organizational environments, ritual and rationality. Beverly Hills, CA: Sage Publications.

Meyers, M. K. (1993). Organizational factors in the integration of services for children. Social Service Review, 67 (4), 547-575.

Miller S., Rein, M., & Levitt, P. (1990). Community action in the United States. Community Development Journal, 23 (4), 356-368.

Milio, N. (1988). Strategic lessons for public policy to promote health: Early case studies and future work. Innovation, 2, 145-166.

Ministry of Community and Social Services. (1997). Making Services work for people. A new framework for children and for people with developmental disabilities. Toronto: Queen's Printer for Ontario.

Ministry of Community and Social Services. (1997). Reinvestment strategy for children and youth. Queen's Park: Government of Ontario.

Ministry of Community and Social Services (1990). Children First. Report of the Advisory Committee on Children's Services. Queen's Park: Government of Ontario.

Minkler, M., & Wallerstein, N. (1997). Improving health through community organization and community building. A health education perspective. In M. Minkler (Ed.), Community organizing and community building for health (pp. 30-52). London: Rutgers University Press.

Mitchell, S., & Shortell, S. (2000). The governance and management of effective community health partnerships: A typology for research, policy and practice. The Millbank Quarterly, 78 (2), 241-289.

Mizrahi, T., & Rosenthal, B. (2001). Complexities of coalition building: Leader's successes, strategies, struggles and solutions. Social Work, 46 (1), 63-78.

Mizrahi, T., & Rosenthal, B. B. (1993). Managing dynamic tensions in social change coalitions. In T. Mizrahi & J. D. Morrison (Eds.), Community Organization and Social Administration: Advances, trends and emerging principles (pp. 11-35). New York: Haworth Press.

Mizruchi, M. S., & Galaskiewicz, J. (1993). Networks of interorganizational relations. Sociological Methods & Research, 22 (1), 46-58.

Mondros, J.B. & Wilson, S.M. (1994). Organizing for power and empowerment. New York: Columbia University Press.

Mondros, J., & Wilson, S. M. (1993). Building high access community organizations: Structures as strategy. In T. Mizrahi & J. D. Morrison (Eds.), Community organization and social administration. Trends and emerging principles. (pp. 69-88). New York: The Haworth Press.

Moscovitch, A. (1997). Social assistance in the new Ontario. In D. Ralph, A. Regimbald, & N. St-Amand (Eds.), Mike Harris's Ontario: Open for business, closed to people (pp. 80-91). Halifax: Fernwood Publishing.

Mulford, C. (1984). Interorganizational relations. Implications for community development. New York: Human Sciences Press, Inc.

Mullaly, R. (1997). Structural social work. Ideology, theory and practice (2nd ed.). Toronto: Oxford University Press.

Mulroy, E., & Shay, S. (1998). Motivation and reward in nonprofit interorganizational collaboration in low-income neighborhoods. Administration in Social Work, 22 (4), 1-17.

Mulroy, E. (1997). Building a neighborhood network: Interorganizational collaboration to prevent child abuse and neglect. Social Work, 42 (3), 255-265.

Mulroy, E., & Cragin, J. (1994). Training future community-based managers: The politics of collaboration in a turbulent urban environment. Journal of Teaching in Social Work, 9 (1), 17-35.

National Council on Welfare (1997, Summer). Healthy Parents, Healthy Babies. Ottawa, Ontario: Author.

Nathan, R. P. (1996). The "devolution revolution": An overview. In Rockefeller Institute Bulletin. Symposium on Federalism (pp. 5-13). Albany: State University of New York. Nelson A. Rockefeller Institute of Government.

Netting, F. E., Kettner, P., & McMurtry, S. (1998). Social work macro practice (2nd ed.). New York: Longman.

Nutbeam, D., & Harris, E. (1995). Creating supportive environments for health: A case study from Australia in developing national goals and targets for healthy environments. Health Promotion International, 10 (1), 51-59.

Office of Integrated Services for Children. (1999). Implementation Guidelines for Healthy Babies/Healthy Children Program Phase I and Phase II. [On-line]. Available: http://www.gov.on.ca/MOH/english/pub/child/intserv.html.

Office of the Chief Coroner of Ontario (1997). Ontario Child Mortality Task Force - Final Report. Toronto: Office of the Chief Coroner of Ontario

Offord, D., & Knox, M. (1994). Yours, Mine and Ours. Ontario's Children and Youth - Phase One. Toronto: Children and Youth Project Steering Committee, Premier's Council on Health, Well-being and Social Justice. Toronto: Government of Ontario.

O'Looney, J. (1997). Marking progress toward service integration: Learning to use evaluation to overcome barriers. Administration in Social Work, 21 (3/4), 31-65.

O'Looney, J. (1994). Modeling collaboration and social services integration: A single state's experience with developmental and non-developmental models. Administration in Social Work, 18 (1), 61-86.

Oliver, C. (1991). Network relations and loss of organizational autonomy. Human Relations, 44 (9), 943-961.

Oliver, C. (1990). Determinants of interorganizational relationships: Integration and future directions. Academy of Management Review, 15 (2), 241-265.

Ontario Association of Social Workers (1999). Collective responsibility is needed to protect children. [On-line]. Available: http://www.newswire.ca/releases/December1999/06/c1611.html.

Ontario Association of Social Workers (1995). Historical summary of pursuit for Social Work Regulatory Legislation. Toronto: Author

Ontario Children's Secretariat (1998). Ontario government business plans (1998-1999). Children's Secretariat. [On-line]. Available: http://www.gov.on.ca/MBS/english/press/plans98/chi.html.

Ontario Health Services Restructuring Commission (2000). Looking back, looking forward. Seven points for action. [On-line]. Available: http://www.hsrc.gov.on.ca/17/2/2002.

Ontario Legislative Assembly. (1995). Official report of debates (Hansard). (Vol. 1:258).

Ontario Progressive Conservative Party (1995). The Common Sense Revolution. Toronto: Author.

Ovretveit, J. (1993). Co-ordinating community care: Organising multidisciplinary teams and care management in community health and social services. Buckingham: Open University Press.

Padgett, D (1998). Qualitative methods in social work research. Thousand Oaks, CA: Sage Publications.

Panet-Raymond, J., & Mayer, R. (1997). The history of community development in Quebec. In B. Wharf & M. Clague (Eds.), Community organizing. Canadian experiences (pp. 29-61). Toronto: Oxford University Press.

Panet-Raymond, J. (1989). The future of community groups in Quebec. The difficult balance between autonomy and partnership with the state. Canadian Social Work Review, 6 (1), 127-135.

Paulson, S. K. (1976). A theory and comparative analysis of inter-organizational dyads. Rural Sociology, 41, 311-329.

Payne, C. (1998). The Massachusetts Community Health Network Area Initiative. A community/government partnership. Dissertation Abstracts International, 59 (03) (University Microfilms No. AAT-9826119).

Pfeffer, J., & Salancik, G. (1978). The external control of organizations. A resource dependence perspective. New York: Harper and Rowe.

Polivka, B., Dresbach, S., Heimlich, J., & Elliott, M. (2001). Interagency relationships among rural early intervention collaboratives. Public Health Nursing, 18 (5), 340-349.

Poole, D. (1995). Building community capacity to promote social and public health. Challenges for universities. Health and Social Work 22 (3), 163-170.

Poole, D. (1997). Achieving national health goals in prevention with community organization: The "bottom-up" approach. Journal of Community Practice, 4 (2), 77-92.

Popple, K. (1996). Community Work: British models. Journal of Community Practice, 3 (3/4), 147-180.

Powell, W. W. (1988). Institutional effects on organizational structure and performance. In L. Zucker (Ed.), Institutional patterns and organizations: Culture and environment (pp. 115-136). Cambridge, MA: Ballinger.

Provan, K. G. (1983). The federation as an interorganizational linkage network. Academy of Management Review, 8 (1), 79-89.

Provan K.G., & Sebastian, J. G. (1998). Networks within networks: Service link overlap, organizational cliques and network effectiveness. Academy of Management Journal, 41 (4), 453-463.

Provan, K. G., & Milward, H. B. (1991). Institutional level norms and organizational involvement in a service-implementation network. Journal of Public Administration Research and Theory, 1 (4), 391-417.

Public Health Research Education and Development Program (1999). A systematic review of the effectiveness of peer/professional 1:1 interventions targetted towards mothers (parents) of 0-6 year old children in promoting positive maternal (Parental) and/or child health/developmental outcomes (March 1999). Public Health Branch, Ontario Ministry of Health, Toronto, Ontario.

Public Health Branch, Ministry of Health and Long-term Care (2000). Provincial Funding of Public Health Programs (1997-2000). Toronto: Government of Ontario.

Ralph, D. (1997). Introduction. In D. Ralph, A. Regimbald, & N. St-Amand (Eds.). Mike Harris's Ontario. Open for business. Closed to people (pp 13-19). Halifax: Fernwood Publishing.

Regulated Health Professions Act (1991). Legislation. Health Professions Regulatory Advisory Council. [On-line].

Available:http://www.hprac.org/english/Profile/legislation.htm.

Reisch, M., & Wenocour, S. (1986). The future of community organization in social work: Social activism and the politics of professional building. Social Service Review, 60 (1), 70-93.

Reilly, T. (2001). Collaboration in action: An uncertain process. Administration in Social Work, 25 (1), 53-74.

Reitan, T. (1998). Theories of interorganizational relations. Social Service Review, 72 (3), 285-309

Ring, P., & Van De Ven, A. H. (1994). Developmental processes of cooperative interorganizational relationships. Academy of Management Science, 19 (1), 90-118.

Rivard, J. (1999). Factors associated with change in interagency collaboration within a child mental health service system demonstration. Dissertation Abstracts International 59 (8). (University Microfilms No. AAT- 9902510).

Roberts-DeGennaro, M. R. (1987). Patterns of exchange relationships in building a coalition. Administration in Social Work, 22 (1), 59-67.

Rock, B. (2001). Social work under managed care. Will we survive, or can we prevail?. In R. Perez-Koenig and B. Rock (Eds.). Social work in the era of devolution. Toward a just practice (pp. 67-92). New York: Fordham University Press.

Rogers, T., Howard-Pitney, B., Feighery E., Altman D., Endres J. & Roeseler, A. (1993). Characteristics and participant perceptions of tobacco control coalitions. Health Education Research: Theory and Practice, 8 (3), 345-357.

Ross, M. (1955). Community organization: Theories, principles and practice. New York: Harper & Rowe

Rothman, J. (1996). The interweaving of community intervention approaches. Journal of Community Practice, 3 (3/4), 69-100.

Rothman, J. (1964). An analysis of goals and roles in community organization practice. Social Work, 9 (2), 59-67.

Rothman, J. (1979). Three models of community organization practice: Their mixing and phasing. In F. Cox, J. Erlich, J. Rothman and J. Tropman (Eds). Strategies of community organization (3rd edition) (pp 25-45). Itasca, IL: F.E. Peacock.

Rothman J. & Tropman, J. (1987). Models of community organization and macro practice. In F. Cox, J. Erlich, J. Rothman and J.Tropman (Eds.) Strategies of Community Organization (4th edition)(pp 3-25). Itasca, IL: F.E. Peacock.

Rothman, J. & Zald, M.N. (1985). Planning theory in social work community practice. In S. Taylor and R. Roberts (Eds.) Theory and practice of community social work (pp.125-153) New York: Columbia University Press.

Rovinsky, D. J. (1999, November). The ideological origins of Mike Harris. Paper presented at the Biennial Conference of the Association for Canadian Studies in the United States, Pittsburg, Pennsylvania.

Rubin, H. J., & Rubin, I. S. (2001). Community organizing and development (3rd ed.). New York: MacMillan.

Rubin, A., & Babbie, E. (2001). Research methods for social work (4th ed.). Toronto: Nelson Thomson Learning.

Ryan, W., DeMasi, K., Heinz, P., Jacobson, W., & Ohmer, M. (2000). Aligning education and practice: Challenges and opportunities in social work education for community-centered practice. Milwaukee: Alliance for Children and Families.

Sarbaugh-Thompson (1999). Dimensions of collaboration and family impacts. Administration and Society, 31 (2), 222-246.

Schopler, J. (1987). Interorganizational groups: Origins, structures and outcomes. Academy of Management Review, 12 (4), 846-56.

Scott, W. R., & Meyer, J. W. (1983). The organization of societal sectors. In J. W. Meyer & W. R. Scott (Eds.). Organizational environments: Ritual and rationality. Beverly Hills, CA: Sage Publications.

Scott, W. (1987). Organizations: Rational, natural and open systems (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Seabright, M. A., Levinthal, D.A., & Fichman, M. (1992). Role of individual attachments in the dissolution of interorganizational relationships. Academy of Management Review, 35 (1), 122-160.

Shera, W., Meredith, G., Bogo, M., McDonald, L. & Michalski, J.H. (2000). The future of social work practice and education in Canada: Preparing for the next millennium. Toronto, Ontario: University of Toronto, School of Social Work, Centre for Applied Social Research. [On-line]. Available:http://www.casswacess.ca/Projects/Sector20STudy/Eng/millenium.htm.

Shortell, S. & Kaluzny, A. (1994). Organization theory and health services management. In S. Shortell & A. D. Kaluzny (Eds.), Health Care Management.Organization Design and Behavior (3rd ed.)(pp. 1-25). New York: Delmar Publishers Inc.

Social Work and Social Service Work Act (1998). Statutes of Ontario, 1998, c31. [On-line]. Available: http://gateway.ontla.on.ca80/hansard/35_parl/session3/justice/j028.htm

Sofaer, S., & Myrtle, R. C. (1991). Interorganizational theory and research: Implications for Health Care Management, Policy and Research. Medical Care Review, 48 (4), 371-409.

Statistics Canada (1998). Assaults against children and youth in the family. Canadian Centre for Justice Statistics, March 1998. (Cat. No. 85-002-XPE, 17 (11). Ottawa: Author.

Mullaly, R. (1997). Structural social work. Ideology, theory and practice. Toronto: Oxford University Press.

Taylor, S. & Roberts, R. (1985). Theory and practice of community social work. New York: Columbia University Press.

Teeple, G. (1995). Globalization and the decline of social reform. Toronto: Garamond Press.

Tester, F. (1997). From the ground up: Community development as an environmental movement. In B. Wharf and M. Clague (Eds.). Community organizing: Canadian experiences (pp. 228-247). Toronto: Oxford University Press.

Tester, F. (1991). The globalized economy: What does it mean for Canadian social and environmental policy. Canadian Review of Social Policy, 27, 3-12.

Thomas, D. (1983). The making of community work. London: George Allen & Unwin.

Thompson, J. D. (1967). Organizations in action. New York: McGraw-Hill.

Toronto Board of Health (1997). The effectiveness of health professional home visits and milk coupons in the prevention of low birthweight: A cohort study of the City of Toronto Healthiest Babies Possible Program. Toronto: Author. Unpublished manuscript.

Tjosvold, D. (1986). The dynamics of interdependence in organizations. Human Relations, 39 (6), 517-540.

Trattner, W.I. (1999). From poor law to welfare state: A history of social welfare in America (6th ed). New York: The Free Press.

Van Den Bergh, N. & Cooper, L.B. (Eds.). Feminist visions for social work. Washington, DC: NASW Press.

Van De Ven, A. H., & Ferry, D. L. (1980). Measuring and assessing organizations. New York: John Wiley & Sons.

Wandersman, A., Goodman, R. M., & Butterfoss, F. D. (1997). Understanding coalitions and how they operate. In M. Minkler (Ed.), Community Organizing and community building for health (pp. 261-277). London: Rutgers University Press.

Warren, R. (1973). Comprehensive planning and co-ordination: Some functional aspects. Social Problems, 20, (3), 355-363.

Warren, R. (1967). The interorganizational field as a focus for investigation. Administrative Science Quarterly, 12, (3) 396-419.

Weil, M. and Dunlop, J.M. (1997). Family Centered Practice Community Planning Manual. Chapel Hill, NC: University of North Carolina at Chapel Hill, Community Social Work Program.

Weil, M. (1996). Model development in community practice: An historical perspective. Journal of Community Practice, 3 (3/4), 5-68.

Weil, M. & Gamble, D. (1995). Community practice models. In R. Edwards (Ed.) Encyclopedia of Social Work (19th edition) (pp. 577-594). Washington, DC: NASW Press.

Weinroth, M. (1997). Deficitism and Neo-conservatism in Ontario. In D. Ralph, A. Regimbald, & N. St-Amand (Eds.) Mike Harris's Ontario: Open for business, closed to people (pp. 54-68). Halifax: Fernwood Publishing.

Wharf, B., & Clague, M. (1997). Lessons and Legacies. In B. Wharf & M. Clague (Eds.), Community Organizing. Canadian experiences (pp. 302-325). Toronto: Oxford University Press.

Wharf, B. (1992). Communities and social policy in Canada. Toronto: McClelland & Stewart Inc.

Whetten, D. A. (1981). Interorganizational relations: A review of the field. Journal of Higher Education, 52 (1), 1-28.

Williamson, O. (1986). Economic organization: Firms, markets and policy control. Washington Square, New York: New York University Press.

Wood, D. J., & Gray, B. (1991). Toward a comprehensive theory of collaboration. Journal of Applied Behavioural Science, 27 (2), 139-162.

Woodard, K. L. (1994). Packaging effective community service delivery: The utility of mandates and contracts in obtaining administrative cooperation. Administration in Social Work, 18 (2), 17-43.

Woodard, K. L. (1995). Introduction and acceptance of inter-organizational agreements: The experience of seventy-five administrators in one county. Administration in Social Work, 19 (4), 51-93.

Zuckerman, H., & Kaluzny, A. D. (1991). Strategic Alliances in Health Care: The challenges of cooperation. Frontiers of Health Services Management, 7 (3), 3-23.

APPENDICES

PROVINCIAL ROLES AND RESPONSIBILITIES

SCOPE	PUBLIC HEALTH - Includes programs which address i) Chronic Diseases and Injuries, ii) Family Health and iii) Infectious Diseases. As municipalities currently have a funding relationship with public health, and service delivery will continue to be done by Board of Health staff, the main change on January 1, 1998 is that municipalities will fund 100% of program costs (which until then were cost-shared or 100% funded by the province)											
OVERALL FUNCTIONS	**PROVINCIAL LEGISLATIVE FRAMEWORK**			**FUNDING**			**SERVICE SYSTEM MANAGEMENT**				**SERVICE DELIVERY**	
Program Specific Functions	**Strategic Directions**	**Setting Policy Direction**	**Setting Expectations**	**Cost-Sharing**	**Asset Ownership**	**Revenue Generation**	**Service System Planning**	**Allocation/ Reallocation of Available Resources**	**Ensuring Service Quality**	**Governing the Service System**	**Administering the Program**	**Delivering Services to Clients**
Provincial Role	Set policy objectives within context of government direction and priorities and Ministry Business Plan	Establish program policies, program design and implementation planning framework to achieve policy objectives Determine governance and accountability framework Identify and develop new program initiatives	Set performance requirements through legislation, regulations, standards, accountability mechanisms Establish minimum standards for each mandatory program and service Set protocols Set reporting requirements	No provincial cost-sharing 100% provincial funding of Healthy Babies/Healthy Children, unorganized territories (interim), and vaccines for immunization	N/A	Develop regulations that stipulate where fees cannot be charged by municipalities	Ensure seamless cross-boundary system Set guidelines Set provincial priorities for public health system, informed by liaison with provincial- and federal- level stakeholders and participation in national-level projects and decisions Chief MOH advises government on public health issues	Determine appropriate allocation and contracting for 100% provincially funded programs only (e.g., Healthy Babies, Healthy Children) and for unorganized territories as an interim measure	Develop and implement monitoring system Develop and implement enforcement framework Provide professional expertise and consultation Disseminate epidemiological information and recommendations for disease control Resource linkage for environmental health and toxicology issues in public health	Appoint provincial members to Boards of Health (where applicable) Minister approves entity with responsibility for public health (e.g., Public Health Boards, upper-tier municipalities, CMSMs)	Develop and operate provincial technology system for surveillance and reporting of reportable diseases (some systems, e.g., RDIS, IRIS, subject to provincial direction) Develop protocols Develop tools, manuals, etc. Surveillance of diseases and risk factors for communicable and non-communicable disease Consultation with field	Provide direct assistance in emergency situations, (e.g., disease outbreaks) where there is a risk to health Involvement in official provincial emergencies Power to act if local entity unable or unwilling to do so Direct service at provincial level (e.g., province-wide immunization programs)
Degree of Provincial Authority	Direct	Direct	Direct	Direct	N/A	Direct where regulations apply	Direct	Direct - for 100% funded programs only	Direct compliance with legislation and standards	Direct	Direct	Support/Direct by exception or in extraordinary circumstances
Source of Provincial Authority	Legislation - HPPA, SIA, Tobacco Control Act (TCA), Immunization of School Pupils Act, Municipal Act, Ontario Water Resources Act, Day Nurseries Act Mandatory Programs and Services Guidelines Protocols			Legislation - SIA and regulations	N/A	Regulation to be developed	Mandatory Programs and Services Guidelines	Regulation (HPPA)	Legislation - HPPA, SIA Mandatory Programs and Services Guidelines	Legislation - HPPA, Bill 103 - City of Toronto, and other relevant regional/ municipal acts SIA	Mandatory Programs and Services Guidelines Protocols	Mandatory Programs and Services Guidelines Protocols
Key Changes	No change: province will continue its current role of establishing the legislative framework and setting minimum standards for public health			Province no longer cost-shares funding for public health programs; retains 100% funding responsibility for some programs and stipulates program exemptions from user fees			No change	Province no longer approves public health budgets except for 100% provincially funded programs	New compliance provisions in SIA	Minister can approve additional entities as Boards of Health (e.g., municipal councils)	No change	

Glossary: Direct - Primary role in instructing another to carry out an activity in a specified way
Influence - The authority to provide advice to another with obligation to consider the advice carefully. This does not imply the other organization must follow the advice.
Support - The provision of information, services, interpretation, monitoring, training, or other non-intrusive activity

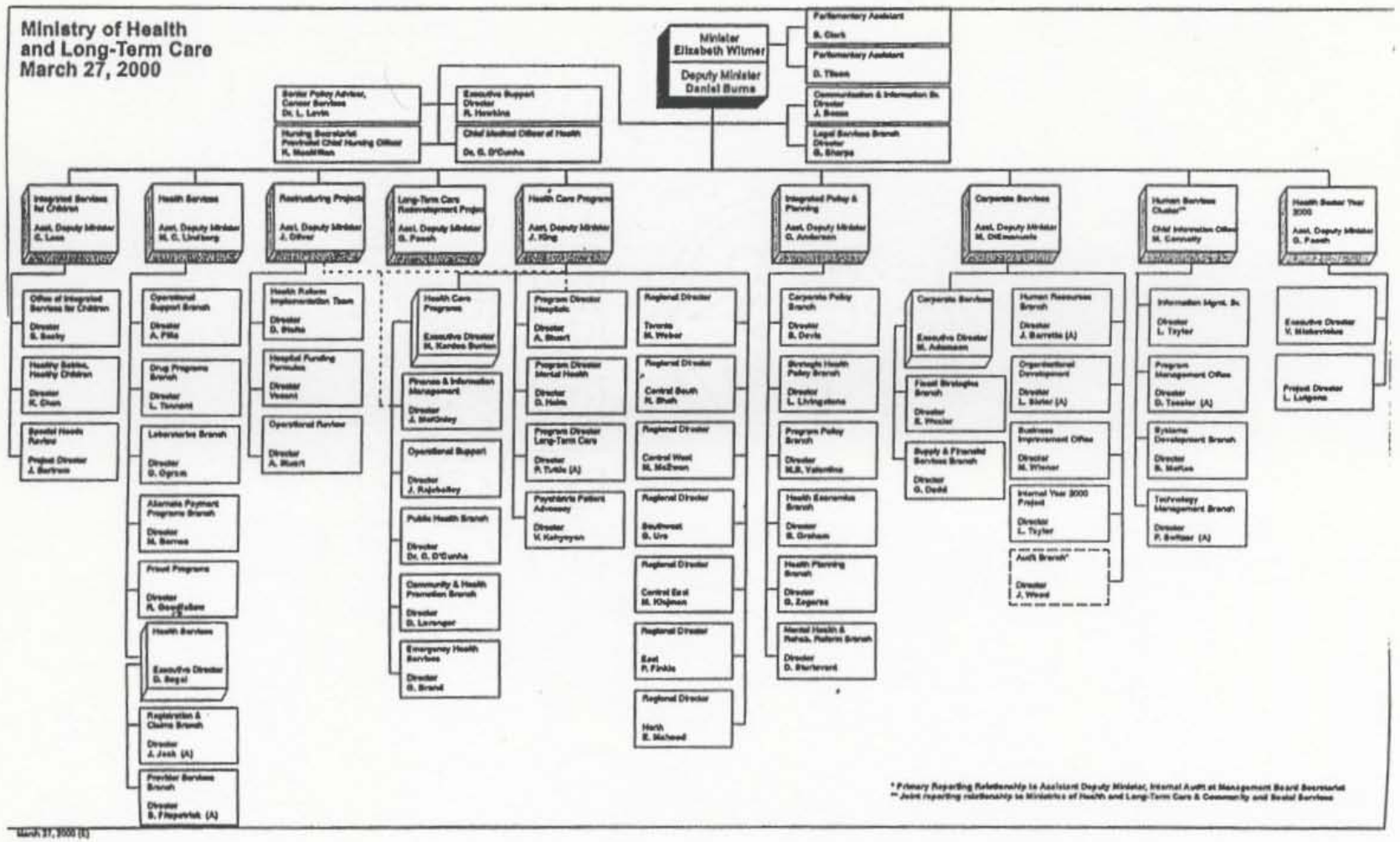
* Transition Period is January 1, 1998 - December 31, 1999

MUNICIPAL ROLES AND RESPONSIBILITIES

SCOPE	PUBLIC HEALTH - Includes programs which address i) Chronic Diseases and Injuries, ii) Family Health and iii) Infectious Diseases. As municipalities currently have a funding relationship with public health, and service delivery will continue to be done by Board of Health staff, the main change on January 1, 1998 is that municipalities will fund 100% of program costs (which until then were cost-shared or 100% funded by the province)											
OVERALL FUNCTIONS	**PROVINCIAL LEGISLATIVE FRAMEWORK**			**FUNDING**			**SERVICE SYSTEM MANAGEMENT**				**SERVICE DELIVERY**	
Program Specific Functions	**Strategic Directions**	**Setting Policy Direction**	**Setting Expectations**	**Cost-Sharing**	**Asset Ownership**	**Revenue Generation**	**Service System Planning**	**Allocation/ Reallocation of Available Resources**	**Ensuring Service Quality**	**Governing the Service System**	**Administering the Program**	**Delivering Services to Clients**
Municipal Role	Participate in policy forums/ advisory committees	Participate in policy forums/ advisory committees Input into new provincial program initiatives	Participate in joint workgroups Participate in task group studies	Full municipal funding - municipal apportionment in accordance with legislation and regulation	Full responsibility for asset ownership, use, allocation and any liabilities	Decide which programs are subject to fees consistent with provincial direction which excludes certain programs and services from user fees	Identify broad priorities/ issues and local directions consistent with provincial strategic direction and community needs Business planning Co-ordination with other sectors, agencies and volunteer/ community groups/ coalitions Policy development and priority setting	Develop and manage annual budget to meet local priorities and requirements of the Mandatory Health Programs and Services Guidelines	Operational plans to implement local priorities and mandatory programs Internal controls to ensure that provincial standards are being met Provide reports for provincial use as requested Set local procedures and protocols to ensure the provision of services	Create local governance policies, by-laws Determine/ establish management and accountability structures for the service system Manage the service system	The entity approved as the Board of Health manages local administration and delivery of services, contracts and relationships with other providers Collect and use community health status data to develop programs to effectively address local needs Input into reportable diseases surveillance system	The entity approved as the Board of Health identifies appropriate methods and locations for service delivery within provincial and local expectations Identify clients
Degree of Municipal Authority	Influence	Influence	Influence	Influence/Direct where agreement	Direct	Direct within regulations	Direct	Direct	Direct	Direct	Direct	Direct
Source of Municipal Authority	Legislation - SIA, HPPA	Legislation - SIA, HPPA	Legislation SIA, HPPA	Legislation - SIA, Municipal Act, and other relevant regional acts	Legislation - Municipal Act, Bill 103 - City of Toronto and other relevant regional acts, HPPA	Legislation - HPPA, SIA, Municipal Act Other relevant regional acts	Mandatory Programs and Services Guidelines Municipal Council	Legislation - SIA Municipal Council	Legislation - HPPA, SIA Mandatory Programs and Services Guidelines Municipal Council	Legislation - HPPA, SIA, Bill 103 - City of Toronto, Municipal Act and other relevant regional acts Municipal Council	Legislation - HPPA, SIA Mandatory Programs and Services Guidelines	Mandatory Programs and Services Guidelines Entity approved by Minister (e.g., Public Health Boards, Municipal Councils, CMSMs)
Key Changes	No change			Full funding responsibility for public health (with some exceptions)			No significant changes - full responsibility for local service system management and delivery	Budget approved by municipal council	Ensuring compliance with SIA and HPPA provisions	Minister can approve entities as additional Boards of Health (e.g., municipal councils)	No change	

Glossary: Direct - Primary role in instructing another to carry out an activity in a specified way
Influence - The authority to provide advice to another with obligation to consider the advice carefully. This does not imply the other organization must follow the advice.
Support - The provision of information, services, interpretation, monitoring, training, or other non-intrusive activity

* Transition Period is January 1, 1998 - December 31, 1999


Ministry of Health
and Long-Term Care
March 27, 2000
Minister
Elizabeth Witmer
Deputy Minister
Daniel Burns
Parliamentary Assistant
S. Clark
Parliamentary Assistant
D. Tilson
Communication & Information Sv.
Director
J. Beaus
Legal Services Branch
Director
G. Sharpe
Senior Policy Advisor,
Cancer Services
Dr. L. Levin
Nursing Secretariat
Provincial Chief Nursing Officer
K. MacMillan
Executive Support
Director
R. Hawkins
Chief Medical Officer of Health
Dr. G. D'Cunha
Integrated Services for Children
Asst. Deputy Minister
G. Lees
Health Services
Asst. Deputy Minister
M. C. Lindberg
Restructuring Projects
Asst. Deputy Minister
J. Oliver
Long-Term Care Redevelopment Project
Asst. Deputy Minister
G. Pasieh
Health Care Programs
Asst. Deputy Minister
J. King
Integrated Policy & Planning
Asst. Deputy Minister
G. Anderson
Corporate Services
Asst. Deputy Minister
M. DiEmanuele
Human Services Cluster**
Chief Information Officer
M. Carnevale
Health Sector Year 2000
Asst. Deputy Minister
G. Pasieh
Office of Integrated Services for Children
Director
S. Beeby
Healthy Babies, Healthy Children
Director
K. Chan
Special Needs Review
Project Director
J. Bertram
Operational Support Branch
Director
A. Pike
Drug Programs Branch
Director
L. Tennent
Laboratories Branch
Director
G. Ogram
Alternate Payment Programs Branch
Director
M. Barnes
Travel Programs
Director
R. Goodfellow
Health Services
Executive Director
D. Segal
Registration & Claims Branch
Director
J. Josh (A)
Provider Services Branch
Director
S. Fingerhut (A)
Health Reform Implementation Team
Director
D. Wells
Hospital Funding Formulas
Director
Vacant
Operational Review
Director
A. Rusnak
Health Care Programs
Executive Director
H. Kardos Burton
Finance & Information Management
Director
J. McKinley
Operational Support
Director
J. Rajchelley
Public Health Branch
Director
Dr. G. D'Cunha
Community & Health Promotion Branch
Director
D. Lorsinger
Emergency Health Services
Director
G. Brand
Program Director Hospitals
Director
A. Stuart
Program Director Mental Health
Director
D. Hains
Program Director Long-Term Care
Director
P. Tuttle (A)
Psychiatric Patient Advocacy
Director
V. Kahgayan
Regional Director
Toronto
M. Weber
Regional Director
Central South
R. Bhatt
Regional Director
Central West
M. McEwen
Regional Director
Southwest
B. Ure
Regional Director
Central East
M. Khajmon
Regional Director
East
P. Finkle
Regional Director
North
E. Michaud
Corporate Policy Branch
Director
B. Davis
Borough Health Policy Branch
Director
L. Livingstone
Program Policy Branch
Director
M.R. Valentine
Health Economics Branch
Director
S. Graham
Health Planning Branch
Director
G. Zegarac
Mental Health & Rehab. Patient Branch
Director
D. Rotterveel
Corporate Services
Executive Director
M. Adamson
Fiscal Strategies Branch
Director
E. Wexler
Supply & Financial Services Branch
Director
G. Dodd
Human Resources Branch
Director
J. Barrette (A)
Organizational Development
Director
L. Slater (A)
Business Improvement Office
Director
M. Wisner
Internal Year 2000 Project
Director
L. Tayler
Audit Branch*
Director
J. Wood
Information Mgmt. Sv.
Director
L. Tayler
Program Management Office
Director
G. Tessier (A)
Systems Development Branch
Director
B. Mellon
Technology Management Branch
Director
P. Switzer (A)
Executive Director
V. Misbertelau
Project Director
L. Lutgens
* Primary Reporting Relationship to Assistant Deputy Minister, Internal Audit at Management Board Secretariat
** Joint reporting relationship to Ministries of Health and Long-Term Care & Community and Social Services
March 27, 2000 (E)

Ontario

Ministry of Health
Ministère de la Santé

Healthy Babies, Healthy Children Postpartum Screening Tool

Outil de dépistage post partum
Programme "Bébés en santé, enfants en santé"

Name of mother / Nom de la mère | Name of father / Nom du père

A. Children with Congenital or Acquired Health Challenge / Enfants ayant un problème congénital ou un problème de santé acquis

		Rating	Score
1.	Major *(probability of permanent disability)* e.g., Down syndrome, cerebral palsy Problème majeur (probablement une invalidité permanente), p.ex : syndrome de Down, infirmité motrice cérébrale	9	
2.	Moderate *(correction may be possible)* e.g., cleft palate, loss of limb Problème modéré *(remède possible)* p.ex. : fente palatine, perte d'un membre	6	

B. Development Factors / Facteurs de développement

3.	Low birth weight / Poids de naissance insuffisant : a) 0 – 1499 gm / 0 à 1 499 g	9	
	b) 1500 – 1999 gm / 1 500 à 1 999 g	8	
	c) 2000 – 2499 gm / 2 000 à 2 499 g	6	
4.	Complications of pregnancy: / Complications dues à la grossesse :		
	a) Infections that can be transmitted in utero and may damage the fetus *(e.g., AIDS, rubella)* Infections pouvant être transmises in utero et porter atteinte au foetus *(p.ex. :SIDA, rubéole)*	9	
	b) Drugs *(e.g., alcohol or drug abuse diagnosed in mother)* Drogues *(p.ex. : abus de drogues ou d'alcool diagnostiqué chez la mère)*	9	
5.	Complications of labour and delivery: / Complications durant le travail et l'accouchement :		
	a) Labour requiring mid forceps, including breech delivery, or emergency caesarean Travail nécessitant l'extraction par application de forceps à la partie moyenne, y compris accouchement par le siège ou césarienne d'urgence	4	
	b) Infant trauma or illness *(e.g., convulsions, respiratory distress syndrome)* Traumatisme ou maladie du nouveau-né *(p.ex : convulsions, syndrome de détresse respiratoire du nouveau-né)*	6	
	c) If Apgar less than 7 at 5 min., deduct score from 10 Si l'indice d'Apgar est inférieur à 7 à 5 min, déduire la note de 10		
6.	Family history of a genetic health challenge that may affect development *(e.g., deafness, mentally challenged)* Antécédents familiaux, soit une maladie génétique pouvant influer sur le développement *(p.ex. : surdité, difficultés mentales)*	4	

C. Family Interaction Factors / Facteurs d'interaction avec la famille

7.	Age of mother / Âge de la mère a) 15 and under /15 ans et moins	9	
	b) 16 or 17 / 16 ou 17 ans	8	
	c) 18 or 19 / 18 ou 19 ans	5	
8.	Social situation: / Situation sociale : a) One parent family with adequate support / Famille uniparentale avec un soutien adéquat	2	
	b) One parent family – no support / Famille uniparentale sans soutien	7	
	c) Two parent family – no social support and/or severe isolation related to culture, language or geography Famille avec deux parents sans soutien social ou isolement intense dû à la culture, la langue ou la géographie	4	
9.	Financial difficulties / Difficultés financières	3	
10.	No prenatal care before sixth month / aucuns soins prénatals avant six mois	4	
11.	Mental illness/mental challenge in mother and/or father: / Maladie mentale ou problème mental chez la mère ou le père : Double score if both parents positive in a) or c) / Doubler le score en cas de réponse positive pour les deux parents aux questions a) ou c)		
	a) Schizophrenia or bipolar affective disorder / Schizophrénie ou trouble affectif bipolaire	7	
	b) Postpartum depression or psychosis / Dépression du post partum ou psychose	9	
	c) Mentally challenged parent / Parent aux prises avec des difficultés mentales	6	
12.	Prolonged postpartum maternal separation: / Séparation post partum prolongée avec la mère :		
	a) With frequent infant contacts *(visits or phone as feasible)* Contacts fréquents avec le nouveau-né *(visites ou coups de téléphone lorsque cela s'avère possible)*	2	
	b) Little or no contact / Peu de contact, si ce n'est aucun	6	
13.	Assessed lack of bonding *(e.g., minimal eye contact or touching)* / Absence de liens affectifs notée *(p.ex. : contact visuel ou tactile minime)*	6	
14.	Other, e.g., marital distress, low education status, failure to thrive, parenting difficulties, family violence, prenatal class attendance, high stress related to delivery, maternal smoking during pregnancy, maternal undernutrition Divers p.ex : problèmes conjugaux, sous-scolarisation, retard staturo-pondéral, rôle parental posant des problèmes, violence familiale, participation à des cours prénatals, stress aigu dû à l'accouchement, mère fumant durant la grossesse, malnutrition de la mère		
	Specify reason / Raison spécifique : _____ *(Score 0 to 9 / note de 0 à 9)*		

Priority score: 9 and over = high | 6 to 8 = moderate | 3 to 5 = low | 0 to 2 = minimal
Évaluation prioritaire : 9 et plus = élevé | 6 à 8 = moyen | 3 à 5 = faible | 0 à 2 = minime

Total Score / Note totale

This information is collected under the authority of Ontario Regulation 585/94 of the Health Cards and Numbers Control Act and the Health Protection and Promotion Act. It will be used for postpartum identification of overburdened families, and for statistical purposes. For more information please contact:

Les présents renseignements sont recueillis en vertu de la Loi sur la protection et la promotion de la santé et du Règlement de l'Ontario 585/94 pris en application de la Loi sur le contrôle des cartes Santé et des numéros de cartes. Ils serviront à l'identification post partum des familles en situation précaire et à des fins statistiques. Pour de plus amples renseignements, prière de communiquer avec :

Health Unit Address label

Direct referral to: / Dossier référer à :
☐ CAS / Société d'aide à l'enfance ☐ Infant development program / programme de développement du bébé ☐ other / autre _____

Signature | Date

3460-64 (97/12)

Healthy Babies, Healthy Children Postpartum Screening Tool
Programme "Bébés en santé, enfants en santé" – Outil de dépisatge post partum

Instructions for Completion / Instructions pour remplir le formulaire

Note: Please score *all* items. Do *not* stop scoring when the total reaches 9. This information will assist Healthy Babies, Healthy Children staff.

Information should be on the Kardex, the Ontario Antenatal Record, or Nursing Admission History.

A1 Major congenital or acquired health challenge *(probability of permanent disability)*
Include: Down syndrome, birth asphyxia, etc.

A2 Moderate congenital or acquired health challenge *(correction may be possible)*
Include: cleft palate, loss of limb, etc.

B4a Complications of pregnancy: Infections that can be transmitted in utero and may damage fetus
Include: rubella, AIDS, cytomegalovirus, congenital herpes.
Exclude: Hepatitis B, if child received prophylaxis; herpes, unless acquired.

B4b Complications of pregnancy: Drugs
Include: drugs that were abused during pregnancy, including alcohol.
Exclude: small amounts of over-the-counter drugs, cigarette use.
(Note: cigarette use is included in C14: Other)

B5 Complications of labour and delivery:

a Labour requiring mid forceps, including breech delivery; or emergency caesarean.

b Infant trauma or illness
Include: convulsions, respiratory distress syndrome.

B6 Family history of a genetic health challenge that may affect a child's development, but may not be detectable at birth *(e.g., deafness, mentally challenged)*
Include: grandparents, aunts, uncles or any close family.

C8 Social situation: is the social support enough for mother? If mother says she has no support when she takes baby home, mark "No support".

C9 Financial difficulties
Include: families receiving social assistance; working parents in occupations where income is known to be quite low.

C11 Mental illness/mental challenge in mother and/or father:

a, b Can sometimes be determined by noting medications of mother.

c Mother has difficulty learning new information.

C12 Prolonged post partum maternal separation (5 days or more)
Include: mothers sent home while baby is still hospitalized; often applies to mothers where baby has been sent to another hospital.

C13 Assessed lack of bonding *(e.g., minimal eye contact or touching between mother and newborn)*
Include: where the lack of bonding has been so apparent that it has been assessed by someone and noted on the record somewhere.

C14 Other: marital distress, low education, failure to thrive, parenting difficulties, family violence, prenatal class attendance, maternal smoking during pregnancy, previous neonatal death, high stress related to delivery, maternal undernutrition. This information may be on chart, or through observation or conversation. Score with a 9 if very concerned.

Remarque : Veuillez noter toutes les questions. Veuillez *ne pas* vous arrêter lorsque le total atteint 9. Les présents renseignements offriront une aide au personnel chargé du Programme "Bébés en santé, enfants en santé".

Les renseignements devraient figurer sur le cardex, le dossier prénatal de l'Ontario ou le dossier médical à l'intention des services infirmiers.

A1 Problème congénital ou de santé acquis majeur *(probablement une invalidité permanente)*,
y compris : syndrome de Down, mort apparente du nouveau-né, etc.

A2 Problème congénital ou de santé acquis modéré *(remède possible)*:
y compris : fente palatine, perte d'un membre, etc.

B4a Complications dues à la grossesse : infections pouvant être transmises in utero et porter atteinte au foetus, *y compris* : rubéole, SIDA, cytomégalovirus, herpès congénital.
Exceptions : hépatite B si l'enfant a bénéficié de prophylaxie; herpès, sauf l'herpès acquis

B4b Complications dues à la grossesse : drogues
y compris : les drogues ayant fait l'objet d'abus durant la grossesse, alcool inclus.
Exceptions : petites quantités de médicaments grand public, cigarette. *(Remarque : la cigarette est incluse à la question C15 sous Divers).*

B5 Complications durant le travail et l'accouchement :

a Travail nécessitant l'extraction par application de forceps à la partie moyenne, y compris accouchement par le siège ou césarienne d'urgence

b Traumatisme ou maladie du nouveau-né, soit : convulsions, syndrome de détresse respiratoire du nouveau-né.

B6 Antécédents familiaux, soit une maladie génétique pouvant influer sur le développement de l'enfant, mais que l'on ne peut pas automatiquement déceler à la naissance *(p.ex. : surdité, difficultés mentales)*, soit les grand-parents, les oncles, les tantes, ou tout autre membre de la famille proche.

C8 Situation sociale : la mère dispose-t-elle d'un soutien social adéquat? Si la mère déclare qu'elle n'a aucun soutien lorsqu'elle ramène son enfant à la maison, indiquez "aucun soutien".

C9 Difficultés financières : familles recevant une aide sociale; parents exerçant une métier à faible revenu.

C11 Maladie mentale ou problème mental chez la mère ou le père :

a, b On peut parfois les déceler en prenant note des médicaments utilisés par la mère.

c Mère ayant du mal à assimiler de nouveaux renseignements.

C12 Séparation post partum prolongée avec la mère *(au moins 5 jours)* : mères retournant à la maison dont l'enfant est toujours hospitalisé; ceci s'applique souvent aux mères dont l'enfant a dû être envoyé dans un autre hôpital.

C13 Absence de liens affectifs notée *(p.ex. : contact visuel ou tactile minime entre la mère et le nouveau-né)*, y compris lorsque l'absence de liens affectifs entre la mère et le nouveau-né est tellement apparente que quelqu'un l'a remarquée et l'a consignée sur le dossier.

C14 Divers : problèmes conjugaux, sous-scolarisation, retard staturo-pondéral, rôle parental posant des problèmes, violence familiale, participation à des cours prénatals, mère fumant durant la grossesse, mort néonatale préalable, stress aigu dû à l'accouchement, malnutrition de la mère. Ces facteurs peuvent figurer dans le dossier ou peuvent avoir été observés visuellement ou dans la conversation. Mettez un 9 si vous êtes très concerné(e).

MANAGERIAL PERCEPTIONS OF STATE-MANDATED COLLABORATION: THE ONTARIO HEALTHY BABIES/ HEALTHY CHILDREN EXAMPLE

RESEARCH STUDY PROTOCOL

List Of Appendices

HBHC Research Study Protocol

Table Of Contents

1.0 Introduction to the Research Study

This research protocol outlines the dissertation research to be conducted by Judith Dunlop, a Ph.D. candidate in the School of Social Work, Memorial University of Newfoundland and Assistant Professor, School of Social Work, University of Maine. The research supervisor for the study is Dr. Leslie Bella, Professor, Memorial University of Newfoundland.

The study will examine the perceptions of public health managers about the factors that influence the implementation of local collaboration in the Healthy Babies/ Healthy Children (HB/HC) Program.

2.0 Key Concepts in the Research Study

Terms	**Definitions**
Environmental Pre-conditions	Factors in the environment that act as incentives and disincentives for organizations to work together.
Previous Collaboration	The nature and type of past interpersonal and professional relationships in local communities and how these previous relationships influenced collaboration in the HBHC network.
Mandatory Collaboration	The nature and degree to which a formal government mandate affected collaboration in local HBHC networks.
Voluntary Collaboration	The nature and degree to which informal agreements, operations and relationships characterize collaboration in local HBHC networks

Terms	Definitions
Legitimacy as Lead Organization	The extent that individuals and organizations agree that public health has the legitimacy and status as an organization to lead the implementation of the HBHC Program.
Collaborative Processes	The operational, organizational and relational processes that facilitate interorganizational collaboration.
Stakeholder Representation	A process of recruiting stakeholders who as individuals, organizations and community groups have an investment in and influence on the process and outcome of collaboration in the HBHC network.
Membership Participation	The nature and type of membership participation in the HBHC network. The identification of participation in the HBHC network as consumer, advocate, community or organizational representative.
Costs of Membership	The real or perceived negative effects of participation in the HBHC network that may accrue to individual members or their organizations or groups.
Benefits of Membership	The real or perceived positive advantages of participation in the HBHC network that may accrue to individual members or their organizations and groups.
Decision-making Influence	The stage, level and influence of decision making power that characterizes the HBHC network. The decision making stage of network development (advisory, planning, information sharing, joint resources). The decision-making power of HBHC network members including indications of authority to make decisions for their organizations. The influence of decision-making power on collaboration in the HBHC network.

Terms	Definitions
Communication Style	The open or filtered nature of communication between local managers, the provincial government and local HBHC network members. Indications that managers share information openly with the provincial government and the local networks. Indications that managers filter the content, timing and target of their communications with the provincial government and the local network.
Formality of Linkages	The degree of formalization of the operations of the local HBHC network (terms of reference, minutes, agendas, service agreements/bylaws). The degree of formalization of interorganizational relationships in the local HBHC network through the use of organizational structures (committees, sub-committees, working groups, umbrella organizations, multi-site networks, service co-ordination networks).
Informality of Linkages	The degree of informality of the operations and organizational structures of the local HBHC network that characterizes the local community (informal relationships, informal service co-ordination, no written agreements).
Common Purpose Development	The extent to which individual members of the collaborative have developed: 1) a voluntary consensus on their common mission and goals in the local HBHC network and 2) the extent to which government mandated goals have influenced the development of common mission and goals in the local HBHC network
Sufficient Resources	The nature and extent of resources provided by the provincial government for the implementation of the HBHC Program in local communities. The impact of resource provision for HBHC on local public health organizations and local communities.

3.0 Research Questions

The research questions address two dimensions that have been associated in the literature with collaboration: 1) environmental pre-conditions and 2) interorganizational processes. Collaboration in the HB/HC Program was addressed by asking a sample of public health managers of HBHC Programs the following broad research questions on the pre-conditions and collaborative process factors influencing collaboration:

1) What environmental pre-conditions do public health managers perceive facilitated and/or constrained the implementation of local collaboration in their implementation of Healthy Babies/ Healthy Children?

2) What collaborative processes do public health managers perceive facilitated and/or constrained the implementation of local collaboration in their implementation of Healthy Babies/ Healthy Children?

4.0 Research Process

A random sample of twenty-two public health managers were selected on the assumption that public health units/departments have responsibility for the mandated Healthy Babies/Healthy Children program designated by the provincial Ministry of Health and Long Term Care in Ontario.

A random 50 plus one per cent sample of health units/departments and sub-units in each of the seven Public Health Planning Regions was selected. The Seven Public Health Planning Regions are shown in Appendix C.3.A.1. There were forty-two Ontario public health units/departments and sub-units listed. All public health units/departments and sub-units in Ontario are contained within one of seven Public Health Planning Regions.

An Interview Guide has been developed which contains a combination of open-ended and focused questions based on environmental pre-conditions and collaborative processes identified in the literature (Appendix C.3.A.7). Qualitative content analysis will use pre-determined categories derived from the theoretical literature on interorganizational relations and interview data from the open-ended questions. The instruments and documents to be sent to participants are contained in Appendix C.3.A. These include: 1) Introductory Letter to Participants (Appendix C.3.A.2), 2) Informed Consent Form (Appendix C.3.A.3), 3) Information Sheet for Public Health Managers (Appendix C.3.A.4), 4) Participant Profile Data Form (Appendix C.3.A.5) and 5) HBHC Collaborative Network: Stakeholder Participation Checklist (Appendix C.3.A.6) and 6) Interview Guide for Public Health Managers (Appendix C.3.A.7).

4.1 Harms and Benefits (Section 1.C1, p.1.5). Tri-Council Policy Statement (1998). National Council on Ethics in Human Research (NCEHR).

There is some risk to participants despite written assurances by the researcher that neither individuals nor health units/departments and sub-units will be identified. Any information that would identify individual public health managers or public health

units/departments and sub-units will be amended to protect the confidentiality of the respondents. Informed Consent will be sought before research interviews begin. The Introductory Letter, Information Sheet for Public Health Managers and Informed Consent Form indicate the purpose of the research and the expected risks and benefits of the proposed study (Appendix C.3.A). Although, participants are told in the Informed Consent Form that their names and the specific public health units/departments and sub-units in the sample will not be named, there is a risk that people may assume they can identify which opinions were held by which participants. Further, there may be some risk if the findings are critical of the implementation of mandatory collaboration by Public Health Units/Departments and sub-units across the province of Ontario.

The Informed Consent Form outlines the steps to be taken to protect the identities of individual participants and the public health units/departments and sub-units. The participants will be given copies of the Introductory Letter, Information Sheet, Informed Consent Form, Participant Profile Data Form, HBHC Collaborative Network: Stakeholder Participation Checklist and Interview Guide for Public Health Managers prior to the interview and will be given an opportunity to ask questions about the interview (Appendix C.3.A).

Originally, it was proposed that the data would be reported by region which meant that respondents could be more easily identified than if the data were to be reported as provincial data. It was assumed that the 50 per cent plus one random sample of public health units/departments and sub-units protected participants as the sample contained

contained more than one health unit/department and sub-unit in all regions of the province. At the time of the implementation of the research protocol, this regional analysis was not carried out. An application to conduct the research was required within one of the seven planning regions. This application was approved on the condition that the confidentiality of the planning region was protected. Since it was impossible to report on more than one health unit/department within the region, the regional analysis was not conducted. The interview text was not analyzed by region thus protecting the confidentiality of respondents by insuring that themes will be difficult to attribute to a particular health unit/department and sub-unit. The participants will be asked about their individual experience with the HBHC Program's local collaboration, but no data will be linked to individuals and the findings will be written so that individual public health units/departments and sub-units will be difficult to identify. All identifying information will be removed and any quoted material will be written so that it cannot be attributed.

No information on individual clients or clients as a group will be elicited during the interview. Information is based on the perceptions of public health managers about how collaboration has been implemented in their local areas. No names of individuals and/or organizations, agencies, community groups or consumer advocates who are participating in the collaborative will be used in the research findings. There is still some risk, however, that people may attribute certain opinions to specific individuals or public health units/departments and sub-units at a regional level despite the researcher's attempts to minimize this risk through non-identifying information.

The benefits of participation for individuals interviewed are increased knowledge about the collaborative process and successful implementation of collaboration in the reform of child and family service systems. The benefits for the public health units/departments and sub-units are increased understanding of the factors that influence successful collaboration. Since mandatory local collaboration is increasingly a condition of government funding for new programs, exploration of the environmental pre-conditions and collaborative processes and stages will support collaborative practice in public health.

The public health units/departments and sub-units will be informed in the introductory letter that they will receive a summary of the key research findings when they are published. The proposed research will increase the public health unit/department and sub-unit's understanding of the factors that influence successful collaboration and improve public health manager's collaboration skills at a local level. The research study will also document a variety of responses to local collaboration in the Healthy Babies/ Healthy Children Program in Ontario, and support improved collaborative network development in local communities. The public health managers will be advised in the Informed Consent Form that the results of the proposed study will be published as a doctoral dissertation and may be published as journal articles and book chapters. They will be also be informed that the researcher may present the findings at conferences and utilize the findings on collaboration to consult with other agencies in the United States and Canada.

4.2 Free and Informed Consent (Section 2, p.2.1) Tri-Council Policy Statement (NCEHR) - Informed Consent (Section 2.D, pp.2.5-2-8)

The Introductory Letter to Participants (Appendix C.3.A.2) and Informed Consent Form (Appendix C.3.A.3) and Information Sheet for HBHC Public Health Managers (Appendix C.3.A.4) indicate the purpose and expected risks and benefits of the study. The Introductory Letter and Informed Consent Form invite participants to inquire about the research before consenting to the interview and provide the name and phone number of a third party, Dr. Rosemary Cassano, Associate Professor, School of Social Work, University of Windsor. The consent forms advise participants that they may withdraw from the study at any time up to the publication of the thesis.

Participants are public health managers in public agencies in Ontario and the consent form outlines steps to protect the identities of individual participants and the public health units/departments and sub-units. Participants are told in the consent form that their names and the specific public health units/departments and sub-units in the sample will not be named. The participants are warned in the Introductory Letter, Information Sheet for HBHC Public Health Managers and Informed Consent Form that, although the researcher will not identify them as individuals nor their public health units/departments and sub-units, there is some risk that people may guess about the opinions expressed. They are cautioned that some may attribute statements, even if incorrect, to certain individuals or certain public health units/departments and sub-units.

The Interview Guide, Introductory Letter to Participants, Informed Consent Form, and Information Sheet will be sent to public health managers prior to conducting the telephone interview. A random sample of twenty-two public health managers of HBHC will be contacted to ascertain their interest in participating and an interview date will be scheduled.

The participants will be asked to review the Interview Guide, Participant Profile Data Sheet and HB/HC Stakeholder Participation Sheet (Appendix C.3.A.) prior to the date of the interview. The Participant Profile Data Form and the HBHC Collaborative Network: Stakeholder Participation Checklist and Consent Form can be returned by fax before the interview date. The interviews will be conducted from the researcher's office on the date scheduled and will be audiotaped if the participant consents.

4.3 Privacy and Confidentiality (Section 3, pp. 3.1-3.6)
Tri-Council Policy Statement (NCEHR)

The interview transcription and process notes will be kept separate from the record to promote confidentiality of the data. The researcher will do the transcribing of the audiotapes and the transcription, process notes and audiotapes will be kept in a locked file cabinet. Audiotapes will be destroyed upon successful defense of the thesis.

A description of participants will be prepared from the Participant Profile Data Sheet and will insure that no identifying information is used which might compromise the confidentiality of participants. A description of the local stakeholders participating in the collaborative network will be prepared from the Stakeholder Participation Checklist to

The researcher's process notes of the interviews will be completed as soon as possible after data collection to ensure the relevant details are remembered and documented. All process notes will be labeled with the date and identifying information. The database will consist of the transcripts of the interviews. A record sheet of the interview and process notes will be prepared that lists the date of the interview, the person interviewed, the health unit/department and sub-unit and the code assigned to the individual interview. The interview transcription along with the process notes will be coded with the number assigned to the individual health unit/department and sub-unit.

HEALTH UNITS BY 7 HEALTH PLANNING REGIONS

Health Planning Region	Public Health Unit
Central East	Regional Municipality of Durham Health Department Haliburton-Kawartha, Pine Ridge District Health Unit Peterborough County-City Health Unit Simcoe County District Health Unit York Regional Health Services Department
Central South	Brant County Health Unit The Regional Municipality of Haldimand-Norfolk Health Department Region of Hamilton-Wentworth Social Services and Public Health Services Division Regional Niagara Public Health Department
Central West	Halton Regional Health Department Regional Municipality of Peel, Health Department Regional Municipality of Waterloo, Community Health Department Wellington-Dufferin-Guelph Health Unit
East	Eastern Ontario Health Unit Hastings-Prince Edward Counties Health Unit Kingston, Frontenac and Lennox and Addington Health Unit Leeds, Grenville, and Lanark District Health Unit Region of Ottawa-Carleton Health Department Renfrew County and District Health Unit
North	Algoma Health Unit Muskoka-Parry Sound Health Unit North Bay and District Health Unit Northwestern Health Unit Porcupine Health Unit Sudbury and District Health Unit Timiskaming Health Unit Thunder Bay District Health Unit
South West	Bruce, Grey, Owen Sound Health Unit Elgin-St.Thomas Health Unit Huron County Health Unit Chatham-Kent Health Unit Lambton Health Unit Middlesex-London Health Unit Oxford County Health Unit Perth District Health Unit Windsor-Essex County Health Unit
Toronto	Toronto Public Health

Memorial
University of Newfoundland

School of Social Work

I am interested in the factors that you perceive have facilitated or constrained the implementation of the Healthy Babies/ Healthy Children collaborative network in your local community. This research on local collaboration in HBHC in Ontario is being carried out to complete my Ph.D. in Social Work at the School of Social Work, Memorial University of Newfoundland. Dr. Leslie Bella, Professor, School of Social Work, Memorial University of Newfoundland is the faculty supervisor for this research study. The Office of Integrated Services for Children, Ministry of Health and Long-Term Care is aware of this research and has provided helpful background information on the program but will not have access to any of the data and is not sponsoring the research. The findings from this research on the collaborative network will be sent to all HBHC program managers in Ontario.

The interview will take about one hour and should only be completed by the public health manager with direct responsibility for the collaborative network in the HBHC Program. Enclosed are an **Interview Guide** that contains a set of questions, a **Participant Profile Data Sheet** on your experience and a **Checklist of Stakeholder Participation** for the collaborative network in your local community. I have also included an **Informed Consent Form** and an **Information Sheet** that explains further the purpose of the research and the conditions of your participation.

I will look forward to your participation in this study. I will be calling you to discuss a potential date and time for our interview. If you have any questions, please contact Judith Dunlop at the University of Maine, School of Social Work at (207) 581-2397 or at home at (207) 866-4058 or by email at jdunlop@maine.edu If you wish to speak to a third party about this research, please contact Dr. Rosemary Cassano, Associate Professor, School of Social Work, University of Windsor, Windsor, Ontario at (519) 253-4232 x 3080.

Yours truly.

Judith Dunlop M.S.W.,
Ph.D (Candidate)

Leslie Bella, M.S.W., Ph.D.
Professor

HBHC RESEARCH STUDY
INFORMED CONSENT FORM

I understand that this research is being conducted as part of the Ph.D. thesis requirement by Judith Dunlop, M.S.W., Ph.D. (Candidate) who is a doctoral student in the School of Social Work at Memorial University of Newfoundland. The official title of the study is *Public Health Manager's perceptions of factors that influence local collaboration: The Ontario Healthy Babies/ Healthy Children example in Ontario.* I understand the purpose of this research is to better understand the process of collaboration in Ontario. I understand that if I participate, I will be asked questions about my experience with the Healthy Babies/ Healthy Children collaborative network as shown in the Interview Guide provided to me. I understand that I may refuse to answer any question in the Interview Guide and may withhold information from the Participant Profile Sheet.

I understand that I will be asked to participate in one telephone interview lasting about one hour and that this interview will be tape recorded and transcribed by the researcher. These tapes and the transcribed data will be stored by the researcher in a locked file cabinet. The transcribed data will be retained indefinitely by the researcher, while the tapes will be destroyed after the defense of the thesis. I will receive no compensation for my participation.

I understand that there is a some level of risk involved if I agree to participate in the study. If I agree to participate in the study, identifying material will be removed from the interview text and no data will be linked to me as an individual participant or to the public health unit. The final results of the study will be written that individual managers and individual public health units will be difficult to identify. There is some risk however, that people may incorrectly attribute opinions to individuals or public health units even though non-identifying information is reported.

I understand that participating in this research project may be beneficial to me. I may increase my own knowledge about the collaborative process and will also be providing valuable information on how to successfully implement collaboration which may improve services for children and families.

I understand that the findings from this research will be published as a doctoral dissertation and may be published as journal articles and book chapters. I understand that the findings from this research will be presented at conferences and may be used for to provide consultation to other agencies.

I understand that my consent to participate can be withdrawn by me or by the public health unit at any time up to the completion of the thesis without losing any benefits to which I may be entitled. I have been given the right to ask and have answered my questions regarding this study. I have been offered the opportunity to contact a third party, Dr. Rosemary Cassano, Associate Professor, School of Social Work, University of Windsor, Windsor, Ontario for further information about this research. I have read and understood this consent form

_____ _____

Participant Date

INFORMATION SHEET FOR HBHC PUBLIC HEALTH MANAGERS

What is the purpose of this study?

To explore the factors that public health managers of Healthy Babies/ Healthy Children programs in Ontario perceive have facilitated or constrained implementation of the collaborative network in their local community.

Why should I consider this study important?

Recently many government initiatives have mandated the inclusion of local collaboration as a condition of funding new programs. This dissertation study explores the pre-conditions and processes of collaboration that influence successful collaboration. The study will help to promote an understanding of local collaboration in the province of Ontario. The findings from this research will be published as a doctoral dissertation and may be published as journal articles or book chapters. The findings may also be presented at conferences and may be used to provide consultation on collaboration for other agencies in the Canada and the United States.

What will I have to do to participate in the research?

- Review the questions in the Interview Guide to prepare your responses for the telephone interview
- Complete the Participant Profile Data sheet and the Stakeholder Participation Sheet and return by fax or answer at the beginning of the interview
- Sign an Informed Consent Form and return to the researcher.
- Complete a one-hour telephone interview to share your perceptions as a public health manager responsible for HBHC about the environmental and collaborative process factors that have influenced the implementation of the collaborative network in your local community.

How will you insure that my answers will remain confidential? All the information that you provide will be treated confidentially. I will code the information you provide so that it cannot be traced back to you or to the public health unit. Absolutely no identifying information regarding individual responses will ever be released or published. All identifying material will be removed from any individual quotes so that no individual and no public health unit can be identified. There is some risk however that people may try to guess and incorrectly attribute opinions to certain individuals or public health units despite attempts to protect the confidentiality of participants.

Do I have the choice of withdrawing from the study if I want to: Yes, the choice whether or not to participate is up to you. You may withdraw from the study at any time up to the completion of the thesis.

How will this interview benefit my agency or me? We realize that your time is valuable and appreciate your assistance. A summary of the key findings from the research study will be sent to each HBHC Program Manager in the Province of Ontario and the Integrated Services for Children Division of the Ministry of Health and Long Term Care and will provide information on local collaboration in the Healthy Babies/ Healthy Children Program across the province of Ontario.

How much time will be required? The interview will take about one hour to complete.

If I agree, how will the interview process be handled? I will send the Interview Guide, Participant Profile Data Sheet, Stakeholder Participation Checklist and Informed Consent Form before the scheduled telephone interview time so that you will have an opportunity to think about what you would like to tell me. I will arrange the interviews at a time that is convenient to you and will place the phone call to you from my office. The Informed Consent Form can be mailed to me at my office at the School of Social Work, University of Maine, 5770 Social Work Building, Orono, ME, 04473 or faxed to my office at (207) 581-2396. The Participant Profile Data Sheet and the Stakeholder Participant Checklist can also be mailed or faxed to me before the interview or I can record your answers at the beginning of the telephone interview.

Who is conducting this study? Judith Dunlop M.S.W. is a Ph.D. Candidate, School of Social Work, Memorial University of Newfoundland. She has an extensive background in collaborative planning in the health and social service field in Canada and the United States. The study has been funded by the Social Sciences and Humanities Research Council of Canada through a doctoral fellowship awarded to Judith Dunlop. Currently, she is an Assistant Professor, School of Social Work, University of Maine. She is originally from the Province of Ontario and has worked extensively with public health units across Ontario since 1986 in various planning and development initiatives.

Is there someone I can contact if I want more information? For additional information, contact Judith Dunlop, at the School of Social Work, University of Maine at (207) 581-2397 or at home at (207) 866-4058 or by email: jdunlop@maine.edu If you wish to speak to a third party about this research, please contact Dr. Rosemary Cassano, Associate Professor, School of Social Work, University of Windsor, Windsor, Ontario at (519) 253-4232 x 3080.

PARTICIPANT PROFILE DATA FORM

General instructions

This participant data sheet is intended for public health managers of Healthy Babies/ Healthy Children programs and should be completed ***only*** by the person who is participating in the telephone interview. It includes questions that will help me to develop a profile of public health managers of HB/HC in the province of Ontario by identifying your education, employment and experience with collaboration at a local community level.

This part of the research should only take a few minutes to complete and can be faxed to me at (207) 581-2396 or reported during the first few minutes of the interview time.

All the information that you provide will be treated confidentially.

If you have any questions, feel free to contact Judith Dunlop between 9 am and 6 p.m. (Ontario time) at (207) 581-2397 or after 6:00 p.m. and weekends at home at (207) 866-4058 or by email at jdunlop@maine.edu.

PUBLIC HEALTH MANAGER PROFILE DATA

1) What is your official title as the person responsible for the Healthy Babies/ Healthy Children program?

_____

2) Please list your professional degrees starting with the most recent

_____

_____

_____

3) In years and months, how long have you worked as a public health nurse, ***excluding a management role***?
(Include leave of absence, e.g. maternity leave)?

_____Years _____Months

5) In years and months, have long have you been a public health manager?

_____Years _____Months

6) In years and months, how long have you been responsible for the HB/HC program? (Include leave of absence, e.g. maternity leave)

_____Years _____Months

7) Have you had any specialized training in community development?
If yes, please identify the type of training
(i.e., workshops, university course, college course, on site program)

_____
_____
_____
_____

8) Have you been in a **leadership role** in a community planning group prior to HBHC?
____Yes ____No

If yes, how many years and months have you had a **leadership role** in a community planning group?

Years_____ Months_____

9) Have you been a **member** of a community planning group prior to HBHC?

If yes, how many years and months have you been a **member** of a community planning group?

Years____ Months___

HBHC COLLABORATIVE NETWORK: STAKEHOLDER PARTICIPATION

Please check off the stakeholders who are participating in your HBHC collaborative network and add any others. You can fax the list to me at (207) 581-2396 or report on it during the interview time.

Stakeholders	Yes	No
Ministry of Community and Social Services		
Adolescent Crisis Service		
Developmental Disabilities Services		
Crisis Lines		
Police/Probation/Legal Sector		
Teen Centers		
Neighborhood Resource Centers		
Children's Aid Society		
Community Health Centers		
Family Support Agencies		
Family Physicians		
Non-Profit Family Counseling		
Family Resource Centers		
Multicultural Associations		
Infant Development Programs		
Child Care Providers		
Local Business/Business Associations		
Domestic Violence Programs/ Shelters		
Homeless Shelter		
Employment Services		
Adolescent Pregnancy and Parenting Groups		
Children's Mental Health Centers		
Hospitals		
Public Health Unit		
Midwives		
Media		
Substance Abuse Programs		
Boards of Education (public and high school)		
Recreation Services (YWCA/ YMCA, Municipal)		
Churches/ Religious Institutions		
Professional Associations		
Service Clubs		
Housing Co-operatives		
Politicians		
CAPC/CPNP		

INTERVIEW QUESTIONS FOR PUBLIC HEALTH MANAGERS

Introduction

Thank you for agreeing to participate and for your consent to a taped interview about the collaborative network in the Healthy Babies/ Healthy Children program. Before we begin, I would like to just confirm with you that you are willing for the interview to be taped at this time given the confidentiality protection outlined in the consent statement.

SECTION A - PARTICIPANT PROFILE DATA SHEET

1) If you have not returned the form, I would like to gather your responses to the questions as shown in the Participant Profile Data Form.

SECTION B - STAKEHOLDER CHECKLIST

2) If you have not returned the form, I would like to gather your responses to the HBHC Collaborative Network: Stakeholder Participation Form.

SECTION C - GENERAL QUESTIONS

Now I would like to ask you about your experiences with collaboration as the public health manager responsible for your local HBHC collaborative network.

3) Could you elaborate on the involvement you have had in the past three years with the provincial Office of Integrated Services for Children (OISC)?

4) To what extent has the provincial OISC helped you in implementing the local collaborative network?

5) In what ways could the provincial OISC have been more helpful in implementing the local collaborative network?

6) Has your collaborative network development been successful? Please explain your definition of success.

7) If you were designing an ideal collaborative network for Healthy Babies/ Healthy Children, what would it look like?

SECTION D - ENVIRONMENTAL FACTORS

History of Previous Collaboration

8) To what extent have stakeholders worked together collaboratively before HBHC in your local community?

9) How do you see this previous history influencing the collaborative process in HBHC?

Mandatory/Voluntary Context

10) In your view, how has the government mandate facilitated or constrained the development of the HBHC collaborative network in your community?

Legitimacy of convening organization

11) To what extent have local stakeholders accepted the mandate for public health to lead implementation of HB/HC and how has this affected collaboration in your community?

SECTION E - COLLABORATIVE PROCESS FACTORS

Stakeholder representativeness

12) How would you describe the process for identifying and recruiting stakeholders for the collaborative network?

Membership Participation

13) In your ***perception***, how do members participate in the collaborative network:

a) As individuals?

b) As representatives of their group or organization?

c) As consumers or advocates?

Costs and Benefits of membership

14) a) What do you perceive to be the main **benefits** for stakeholders who participate in the collaborative network?

b) What do you perceive to be the main **"costs"** to stakeholders who participate in the collaborative network?

Common Purpose Development

15) In what ways have the provincially mandated goals for the HBHC collaborative network changed and/or expanded over the past three years?

16) In what ways, has the collaborative network developed a common purpose unique to the local community?

Decision-making

17) To what extent are members of the collaborative network able to make decisions for their organizations?

18) How do you think this decision-making power or lack of power influences the collaborative process?

Communication Style

19) Would you describe communication as **open or filtered** between:

a) The local HBHC program manager and the Integrated Services for Children Division?

b) The local HBHC program manager and the HBHC collaborative network?

c) The members of the HBHC collaborative network themselves?

Formality/Informality of Linkages

20) Describe the extent to which formal agreements (e.g. written letters of understanding, terms of reference) have been utilized in the HBHC collaborative network.

21) Describe the extent to which informal agreements characterize the operations of the HBHC collaborative network.

Sufficient Resources

22) To what extent do you believe provincial provision of resources to the public health unit for administration of HB/HC has affected stakeholder participation in the collaborative network?

Thank you for your response to these questions.