

AN AMALGAMATION OF FOUR SPECIALTY HOSPITALS LESSONS LEARNED

PAUL E. GARFINKEL, JEAN SIMPSON AND ANDREA BAUMANN*

Canadian healthcare is internationally known for a strong publicly funded system. However, in the last 30 years, Canadians have seen healthcare costs skyrocket and then gradually controlled (Evans 1992, 1998). The share of national income apportioned to healthcare almost doubled, from 5.4% in 1960 to 9.9% in 1991. Per capita expenditure quadrupled, from about \$500 to just more than \$2,000 (in constant 1986 dollars). Early in the 1990s, there began serious efforts to control these costs. For example, healthcare spending in this country increased at a rate of 11.2% per year from 1975 to 1991, far greater than either inflation or population growth would warrant. This spending increased at 2.9% per year from 1992 to 1995, and then at only 1.4% per year from 1995 to 1997.

In the late 1980s and early 1990s, every Canadian province established a major inquiry into its healthcare system. Every one of these inquiries reaffirmed a commitment to the fundamental principles of the Canadian system – universality, accessibility, comprehensiveness, portability, not-for-profit administration and public funding from taxation. However, they also concluded that much of the healthcare being provided in Canada was ineffective, unevaluated, unnecessarily expensive, or otherwise inappropriate. These inquiries all concluded that substantial improvements were needed in the way in which healthcare resources were provided and managed.

In the late 1980s, there was a movement to reform Ontario's mental health system. Epidemiologic data demonstrated tremendous unmet needs in this area. The policy of mental health reform was adopted by the provincial government in 1993 and reflected a 10-year plan to redirect care to those who needed it the most, to focus more extensively on acute care and community care and to promote client initiatives (Government of Ontario 1993). Also in the mid-1990s, a number of epidemiologic studies documented the alarming nature of the systemic problems in service delivery (Goering et al. 1996, Lin et al. 1996, Offord et al. 1996). Three people out of four who need

some service for addiction or mental illness were shown to receive absolutely no care at all, and for some groups the circumstances were even worse. For children, five out of six receive no care when it is required (Offord et al. 1987). For the elderly, for immigrant groups and for people who have both mental illness and an addiction, the figures are equally dismal.

In addition to this, when treatment has been provided, it has generally been fragmented, with little communication between components of the system of care. A number of reports in Toronto, including those of the District Health Council, emphasized the adverse effects of such fragmented care. The isolation of the addictions and mental health domains from each other in silos has been extreme, even though these fields have many overlapping issues. Furthermore, there has been little transfer of knowledge from the fields of research to frontline workers, patients and family members who could benefit from this information. There has been comparatively little in the way of research on the interface between mental health and addictions. There have been only modest levels of public advocacy. Data produced in the early 1990s were quite startling. They showed that \$4 per patient per year of public funds was used to support psychiatric research in Canada, a fraction of what other medical conditions receive (Lam and El-Guebaly 1994). The World Health Organization has estimated disability due to psychiatric disorders and addictions to account for 14% of disability worldwide (Murray and Lopez 1996). Funding for these disorders is not commensurate – in Ontario only 9% of healthcare funding, and only 4% of health research funding, is allocated to the mental health field.

THE MERGER PROCESS

It was the recognition of these problems, and the understanding that in relatively small institutions a disproportionate amount of funding may be absorbed by non-core demands, that led the founding organizations of the Centre for Addiction and Mental Health to discuss partnerships. The discussions began in 1995/96 among several eventual founders of the centre. For

example, in 1995, the Addiction Research Foundation (ARF) and The Clarke Institute of Psychiatry entered into discussions about sharing support services. For several months in 1996 three of the eventual four partners – the ARF, The Clarke and the Queen Street Mental Health Centre – entered into exploratory discussions. Shortly thereafter, the ARF decided that without a government mandate, it would not be able to accomplish its objectives or deal with its concerns, and so left these discussions. Queen Street and The Clarke then continued a comprehensive analysis leading to the eventual goal of merger of the two institutions. These discussions defined the vision, values and governance model for a combined organization. Shortly after, the Health Services Restructuring Commission mandated four partners to come together: the Donwood Institute, the ARF, the Queen Street Mental Health Centre and The Clark.

THE SETTINGS INVOLVED

As discussion progressed, it was evident that each partner had unique strengths. For example, Donwood had been established about 30 years prior to the merger as a clinical facility for addictions. In the mid-1990s, it had 47 inpatient beds, including 12 medical detoxification beds. It also had a number of ambulatory programs catering to special populations (e.g., cocaine users, lesbians/gays and African and Caribbean youth). The ARF was established in the mid-1940s by the Province of Ontario. While a clinical facility, at the time of the merger treatment was being conducted purely on an ambulatory basis. The ARF had strength in its outreach through the province, its prevention programs, its work on social policy and in aspects of research. It had been a collaborating site of the World Health Organization since 1977. The Clarke had been established by the province as a centre for psychiatric research in a clinical and teaching setting in the mid-1960s. Like the ARF, it had a strong emphasis on basic and clinical research as well as targeted clinical populations for the provision of care. At the time of the merger, The Clarke operated 103 beds and participated in the care of about 10,000 ambulatory and day patients each year. Some of The Clarke's forensic programming was already conducted at the Queen Street site. The Queen Street Mental Health Centre had a 150-year history of significant expertise in the care of the chronically mentally ill. While remaining a large provincially run psychiatric hospital, it had reduced its beds from a peak of several thousand to 400 in the 25 years prior to the merger, in keeping with the deinstitutionalization of the chronically ill during this time period. Queen Street had extensive programs in rehabilitation of the chronically ill, and in law and psychiatry, and smaller programs in psychogeriatrics, neuropsychiatry and developmental disability. Both The Clarke and Queen Street had strong records in teaching people from various disciplines, and The Clarke had been the lead site for the University of Toronto's Department of Psychiatry.

Each of the four partners had internal pressures pushing towards major change. The ARF (approximate budget at the time of the merger of \$30m) had been subject to a three-year financial constraint imposed by the Ministry of Health. This had resulted in a reduction of 28% of its budget and significant reductions in its provincial offices (ARF had halved to 12 its offices in different parts of Ontario). The Queen Street Mental Health Centre (budget of approximately \$68 million) was the largest of the 10 provincial psychiatric hospitals directly operated by the Ministry of Health. In addition to absorbing about a 17% reduction in its operating budget over the 1990s, Queen Street, like the other provincial hospitals, had to respond to changes in policy and the Conservative provincial government's desire to no longer directly operate these hospitals. The Clarke (budget of approximately \$30 million), while subject to modest budget reductions (4%) over the 1990s, found itself operating a small number of inpatient beds inefficiently, and no longer able to provide a full range of services or infrastructure for its priority programs. The Donwood, the smallest of the four partners (budget of \$7 million), had received an 11% cut to its operating budget over the mid-1990s, but had hoped to continue its independent path.

MERGING ADDICTIONS AND MENTAL HEALTH

A critical differentiating feature of this amalgamation was that it involved four specialty hospitals in the mental health and addictions fields. The two fields had developed along separate paths in many parts of North America over the previous 40 years, in part because of the perceived dissatisfaction of the addictions community within the mental health umbrella, and in part because of the success of the self-help movement in treating addictions. The self-help movement, derived from Alcoholics Anonymous (AA), emphasized a moralistic rather than a health stance, care through mutual support and little or no use of physicians or medication. The AA movement did not want alcoholism to be considered as a psychiatric problem. The addictions community in North America also resented the pathologizing of behaviour that they felt was a characteristic of the mental health field.

However, in the more recent past, several developments permitted a closer relationship between the two fields. First, the evolution within the addictions field of harm-reduction models, based on a health and public health framework, fostered such a rapprochement – these models are directly in keeping with the current multimodal treatments in the mental health field. Such approaches emphasize a variety of treatments based on empirical evidence of efficacy. Second, a scientific literature had been emerging demonstrating shared mechanisms in the pathogenesis of both addiction and mental illness. And, third, there was the appearance of many good epidemiologic studies demonstrating the prevalence of comorbidity (Regier et al. 1990, Ross et al. 1998). While this naturally varies by population sampled,

It is difficult to change the old-fashioned and mistaken views of mental illnesses and addictions – that mental illnesses must be hidden; that addictions are shameful; that both reflect moral weakness; that they are the parent's or the family's fault.

age and specific substance of abuse, in general 30% of drug abusers in community studies were found to have a life-time prevalence of some form of mental illness. In some clinical groups (heroin addicts on methadone), the figure was considerably higher (up to 70%); while in other groups, such as college-age marijuana users or adolescents who smoke, the figures were much lower. At the same time, clinicians everywhere in Ontario were lamenting the lack of treatment expertise and facilities for this large group in need of care. Because of this lack of expertise in addictions, clinicians pursuing training in clinical disciplines, such as psychiatry, were not being taught about these disorders, which then perpetuated the problem.

In spite of recognition of these factors favouring an integration, there was a strong feeling both within the addictions settings involved in the merger and in the community at large that a union would be a regressive step, and that mental health issues would dominate the agenda.

STIGMA AND PREJUDICE

Another important factor differentiating this merger from many other healthcare organizations in Ontario at the time was the relatively modest support that these hospitals had received from local community groups. The reasons for this varied, but in general it centred on the low levels of advocacy for people with addictions and mental illnesses due to the forces of prejudice and stigma.

Clinicians presently can do a lot more for people with mental illness and addiction than at any point in history. The scope of current treatments is powerful; our knowledge base has increased exponentially over the last decade and indicates that further breakthroughs are on the way. High-quality professionals now readily enter these clinical fields. In spite of this, it is difficult to change the old-fashioned and mistaken views of mental illnesses and addictions – that mental illnesses must be hidden; that addictions are shameful; that both reflect moral weakness; that they are the parent's or the family's fault.

Such stigma has its origins in lack of knowledge and an old-fashioned, moralistic view of these illnesses. While erroneous, it is a view that remains pervasive. Like all prejudice it has a base in ignorance. But the idea of losing one's mind is very frightening to all – mental illness produces behaviour we might be ashamed of; and it represents a loss of a core aspect of who we are as people. The fact that the causes and effects of mental illnesses or dependency have, in the past, not been well understood has added to these myths. We all fear the unknown. The fact that psychiatry,

its theories and its practitioners have seemed so different from our usual understandings has not helped either. At times, the impact on the family, in terms of what the broader community might think, and how this could affect future family relationships, has also been important. These explanations for why our society does not treat the mentally ill or addicted as we do other forms of human pain and suffering say much more about us, and our prejudices, than they do about the mentally ill or addicted.

Because of these attitudes, few people with any voice were therefore able or prepared to defend the place that provided care for them or their families. When advocacy groups were present, they tended to represent small numbers of the population served. The relatively small sizes of the organizations and their provincial responsibilities (for The Clarke and the ARF) meant their activities were spread thinly, and there was often not a strong local base of support. The fact that three of the four organizations were relatively newly established contributed to these low levels of community support.

THE HEALTH SERVICES RESTRUCTURING COMMISSION

The provincial government that took office in Ontario in 1995 established a commission with a four-year mandate to:

1. Make decisions on restructuring hospitals by directing hospital closures, amalgamations, program transfers and other necessary actions.
2. Recommend to the Minister of Health how to restructure the elements of the health service system.
3. Recommend reinvestment in the community that will lead to a comprehensive and integrated system.

The fact that this commission was purportedly at arm's length from the government itself, and had the authority to make changes, as well as the general perception that change was required, provided a strength to the enterprise that made reorganization possible when previous attempts at health services reform or integration were thwarted.

THE CHANGE PROCESS

Immediately after the commission issued its report on Metro Toronto in March 1997, concluding that the four parties should be merged, representatives of the four parties met to establish a steering committee to respond to the directive. The boards of the three organizations (Queen Street Mental Health Centre, being directly run by the government did not have an independent board, but rather a Community Advisory Board) approved

The Board Chairs, in particular, sent a very clear message that the amalgamation was to proceed because this was going to be valuable for the province as a whole, regardless of individual territories that might be affected. This stance minimized the types of resistance among staff.

in principle the creation of the new corporation and the formation of a joint Steering Committee to implement the directive.

The Steering Committee's composition was based on three representatives from each site – the Board Chair, the CEO and another Trustee. Queen Street was represented by the Ministry of Health, its Administrator and the Chair of its Community Advisory Board. Because the directives from the commission emphasized the teaching and research role for the new facility, the Vice-Provost Health Sciences and Dean of Medicine of the University of Toronto was also included as a member of the Steering Committee. The Steering Committee was given the responsibility to develop strategies and plans and to make recommendations to the three boards and the Ministry of Health that it considered necessary to successfully create the new Corporation. Specifically, its terms of reference were to:

- retain the professional services of any persons as may be required to advance the creation of the new Corporation;
- establish the Vision/Mission and Core Values for the new Corporation;
- develop a governance structure;
- establish subcommittees as may be necessary to facilitate the process leading to the creation of the new Corporation;
- undertake, or cause to be undertaken, the legal, financial and factual investigations (“due diligence”) necessary to determine the impact of the new Corporation on the four facilities;
- negotiate and prepare, or cause to be negotiated and prepared, any and all agreements governing, amongst other issues, the terms and conditions of the establishment of the Corporation, the name of the new Corporation, the first directors of the Board of Trustees, the governance, a management structure, and working structure of the new corporation; and
- do or cause to be done all other things necessary to successfully effect the creation of the new Corporation.

The Steering Committee made an early decision to retain as facilitators to the process two experienced individuals who had been previously involved in the merger discussions between The Clark, the ARF and Queen Street over the previous winter before the commission had issued its directives. This had the advantage that several of the partners knew and trusted the facilitators; but caused initial unease to the new addiction partner (Donwood) regarding a potential advantage for the groups that had worked previously with the facilitators. This

initial discomfort was compounded by two related phenomena: the ARF had been invited to the earlier discussions, but had left as described previously. The fact that this group was perceived to have left the original process precipitously contributed to early tensions in the new merger discussions. At the same time, the groups from Queen Street and The Clarke had spent considerable hours working on vision/mission and values, and governance sub-committees, and then on public consultations regarding these; they resented the feeling that this work was to now be discarded and had to begin afresh.

There was an initial distrust among the four partners regarding the process of the amalgamation, which led to a decision that the mission, vision and values work would not be delegated to subcommittees but would be handled directly by the Steering Committee. Some members felt it was not the Steering Committee's role to do this; rather they felt it was the new Board's responsibility. The Steering Committee's wish to maintain direct control of this critical aspect, and the conflict of so many other demands on the Steering Committee's time (they met at least three hours per week for 34 weeks) resulted in insufficient work being done on the core mission and values of the new Corporation – far less than one would ideally like when establishing such an enterprise. As a consequence, the early meetings of the Steering Committee did not address the major theoretical and philosophical issues that needed to be dealt with and contained a great deal of unspoken feeling as a result. In addition, by not having a subcommittee deal with vision/mission and values, an opportunity for broader stakeholder participation was lost. On the other hand, the Steering Committee did work on a document, “What We Are Building Together.” This was subject to significant external input and eventually became the basis for the new organization's Vision, Mission and Values.

The Steering Committee's meetings were greatly affected by several factors. The Board Chairs, in particular, sent a very clear message that the amalgamation was to proceed because this was going to be valuable for the province as a whole, regardless of individual territories that might be affected. This stance minimized the types of resistance among staff (including the CEOs) who had so much personally at risk. The clear and decisive support of the University was similarly important in emphasizing from the beginning the academic role of the new institution, in reducing movement of academic faculty to other teaching hospitals and in preventing other resistances by University faculty. The Ministry of Health also played a major role in the process. During the initial voluntary discussions, when there was a Steering

Committee formed for the Queen Street/Clarke/ARF explorations, the Ministry assigned its senior mental health officer, an assistant deputy minister, to the committee. This official made it clear that the Ministry was completely behind the merger process and the divestment of Queen Street. Later, when the final Steering Committee reconvened after the Health Services Restructuring Commission's report, the Ministry assigned one of its directors who also was committed to the process.

The process was significantly affected by several critical early decisions. At an initial retreat of the Steering Committee, it was agreed that (1) all four partners would be treated as equals regardless of size or previous roles and, that (2) decisions would be reached by consensus. The former was critical in clarifying that this was truly a merger of equals and that one partner could not dominate the process. The second principle, of obtaining a consensus, resulted in some decisions being drawn out over lengthy periods but diminished the potential power of coalitions to push forward particular local agendas.

The composition of the Steering Committee was a challenge. Many consumer groups as well as labour wanted to have direct involvement by having membership on the committee. However, it was felt that by seeking repeated broad public consultation there could be significant input from these and other groups, while the Steering Committee could be kept to a working size. The Steering Committee also decided not to permit delegates for absent members, in order to have continuity and a collegial process evolve.

SUBCOMMITTEES OF THE STEERING COMMITTEE

While the Steering Committee did not want to assign the Vision/Mission/Values work to a subcommittee, its members quickly understood the need to develop several subcommittees to manage aspects of the process. A communications firm was hired and a Communications Subcommittee, comprising the public relations staff of the four organizations, began to meet with the consultants. They published a regular newsletter informing staff of the merger developments and arranged for a series of public consultations at various stages of the process.

The CEOs began to meet as an Operations Subcommittee. This group began to catalogue the various programs the four partners offered, the space, capital and human resources, and also agreed to keep each other informed of any significant decisions that could affect the other parties. External consultants were recruited to do a space analysis. When this subcommittee was originally formed it did not include the facilitators; the latter were quickly added in order to minimize the difficulties between the parties. Staff from all four organizations were involved in task forces of this subcommittee; they also were involved in developing four new programs that captured need, as well as expertise, of the partners.

Much of the early work of the Steering Committee was inter-

nally focused. Time and effort were required for adjustment to the idea of the amalgamation, for adaptation to the sense of loss (all staff felt they were losing something, even when convinced of the overall benefits of the merger); and to the partners and the specific committee members. Because of the internal focus, more and more anxiety was voiced by staff, by patients and their families and by many community providers. These anxieties centred on such issues as a takeover by the mental health field of the addictions field; the sequestering of Queen Street's clinical resources for The Clarke's research and subsequent neglect of the chronically ill; the realignment of funds from the other three sites to meet the overwhelming needs of Queen Street; the medicalization of the field; the "privatization of care"; or the huge budget cuts that would surely follow. Community agencies and physicians feared the size and influence of the new organization. The Steering Committee attempted to deal with these anxieties by frequent public consultations and through its newsletter. Also, a small task force was asked to develop principles regarding the new Corporation's relationship with its community. This group developed a set of principles regarding "Network Participation and Collaboration" that were adopted by the Steering Committee and, early on, by the Board of Trustees of the new Corporation.

THE PHYSICIANS

The four organizations had very different approaches to medical staff. The two addictions facilities employed few physicians and were proud of having evolved to a less "medical" framework. Queen Street employed, or had on contract, about 30 full-time psychiatrists, and many part-time physicians. The physicians were members of a province-wide association, the Ontario Physicians and Dentists in Public Service (OPDPS), which had formed about a decade earlier and was perceived to have been very effective in improving salary and benefits for the doctors in the 10 provincial psychiatric hospitals. The Clarke, as a fully affiliated teaching hospital of the University of Toronto, did not employ its physicians. The approximately 50 full-time and 100 part-time psychiatrists were members of an academic financial partnership that pooled its income and expenses and that provided significant incentives for the academic enterprise, in keeping with the University of Toronto's principles regarding physician compensation.

The physician leaders of the four organizations – the chiefs of staff as well as the presidents of the medical staff organizations – established a group to develop medical staff bylaws and to examine financial issues. This group readily came together on developing a unifying set of bylaws around a single Medical Advisory Committee and Medical Staff Association for the new organization, but appropriately deferred the partnership discussions until months after the merger had been completed. At the same time, the Corporation felt it was important to be clear that a single group would represent the doctors, and this

The addictions group feared the remedicalization of their world. Almost everyone feared that the chronically ill would receive less than they had; there was a feeling that chronic patients always lose out when a change occurs, and especially when research could drain so much of the corporation's resources.

would be the Medical Staff Association, and that it would not be possible for the OPDPS to continue its representation. Several of the Queen Street psychiatrists resigned as a result. The corporation, in keeping with the University's principles, identified the need for one academic financial partnership.

THE PROFESSIONAL DISCIPLINES

In the mental health and addictions settings the interdisciplinary team is of even greater significance than in an acute-care general hospital. The Steering Committee, the physicians and the leaders of the professional disciplines wanted the new organization to reflect this fact. Two decisions were made to facilitate this. The Medical Advisory Committee would have membership, including voting privileges, from the leaders of the larger professional disciplines – with physicians exclusively voting on the process of physician credentialing and oversight. In addition, a new Clinical Practice Council representing all professional disciplines and interdisciplinary activities would be created.

FINANCES AND GOVERNMENT RELATIONS

While the common fear was that the merger was primarily about cost savings for government, the Steering Committee early on received reassurances that this was not the case. In fact, the savings that would accrue to the new corporation as a result of the merger would be used for improved programming. Three members of the Steering Committee negotiated with government representatives on the merger-related transition costs. It was recognized that the three unions representing staff at the founding sites would not likely all be labour representatives in the new corporation. As a result of the merging of the labour forces and labour harmonization that would occur after the new unions were in place, it was estimated that \$3 to \$6 million would be needed on an ongoing basis. Other merger-related costs (equalizing the pension plans, legal fees that the government previously covered for Queen Street, etc.) would amount to about \$2 million on an ongoing basis. In addition, there would be one-time severance costs of about \$3 million for staff not retained by the new organization.

Many of the one-time merger-related costs were to be covered by the government in a special restructuring fund set up by the province. With regard the ongoing costs, a number of formulas were suggested, but eventually both the government and the Steering Committee agreed to a simple arrangement. The Ministry of Health would cover the first year of the extra ongoing costs, and after that the new organization would be

responsible. This method had the advantage that it would provide a good "running start" to the organization, and there was confidence that the organizational merger would save considerably more than the calculated 6% (\$8 million of the combined base budget of \$130 million); any savings beyond these would then be converted to improved programming.

The one exception to this arrangement involved the land and the costs of the buildings. While The Donwood's property was owned by the new Corporation, the other three properties were government-owned. The Ontario Realty Corporation insisted on rents being paid (to a total of \$1.5 million per annum for the three properties). The Steering Committee arranged with the Ministry of Health to have extra funding provided for three years to cover these costs. After three years, the rental fees would become the Corporation's responsibility. Similarly, when an external review of the capital needs of the new organization was conducted, the Ministry of Health agreed to pay only \$5 million, rather than the \$8 million needed. Both these financial decisions have had a significant bearing on strategic planning for the organization around eventual site locations.

PROTECTION OF SPECIAL INTERESTS

As noted earlier, all of the participants felt they were losing something significant. Often this was an abstraction, the sense of one's work no longer being valued; the identification with a name, or a particular program, a particular culture or community. For the staff, there was a more concrete fear of potential job loss, particularly at the senior-management level.

But there were other levels of concern related to models of care. The addictions group feared the remedicalization of their world. Almost everyone feared that the chronically ill would receive less than they had; there was a feeling that chronic patients always lose out when a change occurs, and especially when research could drain so much of the corporation's resources. The Steering Committee spent a great deal of time on these latter concerns; the former were not directly discussed.

The approach to protecting the addictions field first took the form of discussions around maintaining separate budgets for a fixed period of time; for example, the proposal that for three years the addictions resource would be protected in a separate envelope. Advocates of this approach emphasized that this would send a good message out to the addictions community, and that it would enable the new team to get to know one another before significant changes were made. Those not wanting this approach

felt there could be sufficient checks and balances through the proper development of a representative Board and feared that this model could perpetuate old allegiances among the Board and senior managers, as well as handicap the new management team in making the significant changes that all members of the Steering Committee knew were required quickly. A second approach was considered, and this was to have in the bylaws of the new organization a need for a supermajority vote (e.g., 80%) on critical issues of resource allocation. Again, it was decided that this

would perpetuate the old loyalties among Board members (“I represent the addictions”), rather than encourage Board members to develop a sense of responsibility for the new organization as a whole. Early on, it was suggested that the organization be represented by co-CEOs – one each from mental health and from the addictions community. This was rejected as unworkable. Over time, it became clear to the Steering Committee that a thoughtful approach to board representation and renewal was the preferred way to deal with this issue. At the same time, there was agreement reached that, at least for the first three years, the addictions would be represented by a distinct division within the new organization’s management structure.

CREATION OF THE BYLAWS: GOVERNANCE MODEL

While the bylaws of the new organization considered many typical issues, only the governance model will be discussed here. It was felt that a board of 16 to 20 individuals would be the preferred size. But in assigning board members to the new organization, it was felt that a respect for the four founding partners required that they each have three members on the new board. This equal-numbers approach was in keeping with the Steering Committee’s overall philosophy and in contrast to some other mergers at the time, which often assigned board representation according to size of the budget of the partners. This was felt to be a statement of creating a new community based on equals. The strategy was greatly aided by the fact that the largest partner, Queen Street, was not represented by a board of trustees. In order to bring in new views, it was also decided to allocate four positions to members selected from the community at large. In addition, there were four ex-officio members: the Vice-Provost of the University, the CEO, the Physician-in-Chief and the President of the Medical Staff Association. There was also consideration given to limit the previous partners’ representations to two each, in order to emphasize the future, and to limit the size of the board. In the end, the group felt that the traditions of the founding organizations had to be represented in the short-term by having three representatives each. As for all boards, members were to be selected because of generic attributes and skills, as well as for constituency base. However, this new board would also be composed of at least 30% of its elected members, bringing the experiences and perspectives of patients, clients or family members. Because of the provincial mandate of the new organization,



TELEHEALTH & MULTIMEDIA

FIRST INTERNATIONAL CONGRESS
ON
Telehealth and Multimedia Technologies

AUGUST 16, 17 & 18, 1999

Shaw Conference Centre • Edmonton, Alberta, Canada

www.telehealthcongress.com

EARLY SUPPORTERS INCLUDE

• University of Alberta • The International Society for Telemedicine • Economic Development Edmonton •
• Government of Alberta • Private Industries •

ORGANIZED BY THE

 **University of Alberta**  **TRI** Telehealth Technology Research Institute

it was also felt to be imperative to have representation from regions outside the Greater Toronto Area.

A Nominating Committee was formed with representatives from all four founding partners, including past board members not involved in the merger. They polled the existing Board members of the founding partners, and constructed a slate of candidates for the new Board. Also, advertisements were placed in local newspapers for the four new community representatives. Eighty-eight applications were received.

In order to deal with board renewal, a progressive electoral college model was adopted with little dissent. It had been suggested by the work for the earlier Queen Street/Clarke discussions and had also been used effectively by one of the local teaching general hospitals. The former CEO of that organization described its advantages and disadvantages to the Steering Committee. While considerably more cumbersome than a straight nominations committee approach, this model allows for many stakeholders to have a vote on the nominations slate put forward by the nominating committee. It enabled the definition of 70 voting members of the Corporation from various constituencies – 14 representing patients and clients of the organization; seven from families; 12 from community mental health and addictions agencies; six from public health; five from social service agencies; 10 from agencies at large representing addictions, mental health, seniors and youth; four from the District Health Councils; and four each from the academic community and the organization's labour and non-union employees. This model was received very favourably by the staff and public when it was suggested in a series of consultations. It is thought that this will permit a greater focus on the needs and wants of all stakeholders.

CEO SEARCH

An international search was begun for an executive head about six months prior to the formal amalgamation and concluded about three months before the merger took effect. This is in contrast to several other mergers of this period, in which the CEO was not selected until some months after the formal incorporation of the new organization. While the latter may be more in keeping with the new board's responsibility, the former permitted the organization to have the clarity essential to begin the process of selection of a senior-management group and to have a "running start" in organization. The senior managers were then selected by competition internally; there was an external search only when a suitable internal candidate was not found.

THE FOUNDATION

At times, hospital mergers have had problems relating to the union of separate foundations and the resources each brings to the new organization. This merger had an advantage in that only one of the sites, The Clarke, had an active Foundation. Queen Street,

as a provincial hospital, had not been permitted to be engaged in fundraising; The Donwood had raised some funds for a new building; and the ARF had recently formed a foundation that was beginning to develop its approach to fundraising. This made the formation of a new foundation easier. After the formal merger, The Clarke Foundation Board began a process of redefining its role to support the priorities of the new Centre; it rewrote its bylaws to reflect this, changed its name and accepted new Board members who could relate to the broader mandate. A capital campaign had been planned over the previous year by The Clarke Foundation. Support for this campaign was reworked to reflect the addictions as well as mental health issues, and the campaign was begun with only a few months lost due to the merger.

THE EXPERIENCE THROUGH THE PROCESS

While there is considerable variability from person to person in going through a process such as this, certain themes are common, at least from the point of view of executive/managers. Navigating an experience such as a merger requires a thinking about healthcare that is quite different from the type of thinking and skills required of such people in the day-to-day running of individual organizations. Often such managers have been very adept in furthering their hospital's interests, at times with little concern for the larger picture. The pre-merger Steering Committee work required a regional or provincial view to emerge and a broader consideration of benefits than previously. Most people wish to rise to this challenge, but there are many issues that may intervene.

Intellectually, concerns for one's personal job security and the need for one's work to be valued through the new organization are closely tied with concerns for close colleagues and friends who are going through the same experience. Loyalty and belief in the mission of the earlier organization are intertwined, at times leading to a defensive stance and a resistance to change, associated with the desire to continuously emphasize how wonderful every aspect of the old way of doing things was.

Affectively, the common response is of anxiety regarding all the levels of change and the perceived personal and interpersonal threats. Also, there is anger at one's powerlessness in the circumstance, as the process of change begins to have a life of its own. As the events unfold, there is often guilt at being involved in the new process while some very capable colleagues are not. Mixed with this is often an additional sense of guilt and shame if one feels one's institution is somehow not getting its proper due (and everyone feels this at some point). Loyalty to the old institution and investment in the amalgamation and restructuring are experienced in a fluctuating and conflictual fashion. At an interpersonal level these feelings are compounded by the nature of the dealings with external rivals and the historical rivalries that are now covered over in the name of partnership. The overall experience of the senior manager/executive can be extremely lonely and

isolating. There is little that can be shared with others within the organization; or even with colleagues on the outside.

KEY CONSIDERATIONS TO SUCCESS

When reviewing the above issues, there are some points to emphasize regarding the success of this particular project:

1. The four institutions involved had complementary skills; there was modest overlap in their areas of specialization. At the same time, there was a recognition that they dealt with many shared problems.
2. There were significant external (throughout the province) and internal forces pressing for a merger.
3. Each of the organizations had rather modest community support.
4. The early decisions to treat all four partners as equals regardless of size or previous roles, and to reach decisions by consensus, provided sufficient comfort to enable the Steering Committee to progress in its work with minimal resistance.
5. The early development of a set of principles regarding Network Participation helped the community to see the new corporation as a collaborator or partner, rather than going its own independent way.
6. A progressive Board structure and method of renewal also

emphasized that the corporation was serious about a new way of doing business.

7. Equal board representation among the partners emphasized the forward-looking and equal aspects of the partnership. The fact that the largest partner was directly operated by the government and without a Board of Trustees aided this considerably.
8. Frequent consultations with staff were intended to keep people informed and reduce anxiety related to the environmental uncertainty; this initiative, however, was only modestly successful.
9. An international search for the new CEO aided the perception and recognition of the organization's quest for excellence. Holding this prior to the formal merger enabled an initial structure to develop around a senior-management team early in the process.
10. The development of an Operations Subcommittee brought the four organizations together to respond to very real operational issues. Staff at various levels became involved in the merger.
11. Recruiting to all senior-management positions, rather than appointing, set a framework of fairness, and this carried on as the structure unfolded at other levels.
12. The Foundation's adopting the new organization's priorities as its mandate was important for the public education

National Symposium

Y2K Hospital Contingency Planning Readiness: The Final Stage

Benchmark Your Contingency Plans And Evaluate Your Legal Responsibilities

July 6, 7 & 8, 1999 • Holiday Inn on King • Toronto

COMPARE YOUR Y2K READINESS TO LEADING HOSPITALS WHILE...

- **Developing** clear audits of your Contingency Plan
- **Recognizing** Year 2000 legal risks and solutions for healthcare providers
- **Gaining insight** on your supply chain concerns
- **Hearing** from actual peers and colleagues
- **Examining** the impact of the ice storm with your Y2K Contingency Plan

Plus!

An exclusive presentation from Year 2000
Project Director, Dwain Shaw
of Medical College of Georgia, U.S.

Developed by:



Official Publication:




To request further information please call us toll free at 1-800-941-9403 or visit our website at www.iir-canada.com

and fundraising components of the Corporation; this was facilitated by the fact that only one of the partners had an active foundation at the time of the merger.

WHAT TO DO DIFFERENTLY

While the process described was considered a success, at least in the short term, there are several aspects that, if done differently, could have improved a difficult year:

1. The critical melding of different roles and cultures could have been greatly aided by more early work on vision/mission by a subcommittee of the Steering Committee with broader representation. This would have prevented some of the difficulties experienced by the new organization over the following year. On the other hand, the stance taken did force the new Board to recognize its responsibilities in facing these issues.
2. Communication was a significant problem – both internally and to the community at large. While a consulting firm was retained, the parties involved were in no way prepared for the magnitude of the communications task, particularly considering the multiple sites and stakeholders involved.
3. Baseline measures should have been obtained on relevant themes, issues and outcomes to be assessed over time. This would have provided a clearer opportunity to determine which aspects of the merger were successful. Since everyone involved in the Steering Committee becomes very preoccupied in the day-to-day management, consultants should be retained to ensure an evaluation piece.
4. At the start of the process, a recorder should have been designated. A process of this complexity and impact requires a historian to benefit future generations.
5. Careful thought should have gone into developing methods of providing support for those involved.

The new corporation was formed by the amalgamation of three partners in January, and then accepted Queen Street upon its divestment on March 9, 1998. It has been named The Centre for Addiction and Mental Health. While subject to the usual growing pains of a new enterprise, its early development has been greatly improved by the very successful work prior to the merger itself. 



PAUL E. GARFINKEL

Dr. Paul E. Garfinkel is Professor and Chair, Department of Psychiatry, University of Toronto, and President and CEO of the Centre for Addiction and Mental Health.



JEAN SIMPSON

Jean Simpson is Executive Vice-President and Chief Operating Officer for the Centre for Addiction and Mental Health, the position she held at The Clarke Institute of Psychiatry prior to the merger.



ANDREA BAUMANN

Dr. Andrea Baumann is a Member of the Board of Trustees at the Centre for Addiction and Mental Health and was the Past Chair, Board of Trustees at The Clarke Institute of Psychiatry.

* The authors wish to acknowledge the members of the Steering Committee who were so helpful in the process described:

- | | |
|-------------------------|--------------------|
| Professor Arnie Aberman | Mr. Steven Sharpe |
| Ms. Nora McCabe | Mr. Dennis Helm |
| Mr. Bill Currie | Ms. Allison Stuart |
| Ms. Maureen Quigley | Dr. Perry Kendall |
| Ms. Pamela Fralick | Mr. David Weinberg |
| Mr. Graham Scott | Dr. David Korn |
| Mr. Chris Gadula | |

The authors also wish to thank Bill Currie, David Goldbloom, Herb Solway and David Weinberg who commented on an earlier draft. The views expressed here are those of the authors and are not necessarily reflective of the Steering Committee as a whole.

REFERENCES

- Evans, R.G. 1998. "New Bottles, Same Old Wine: Right And Wrong On Physician Supply." *Canadian Medical Association Journal* 158(6), 757-9.
- Evans, R.G. 1992. "Canada: The Real Issues." *Journal of Health Politics, Policy and Law* 17(4), 739-62.
- Goering, P., Lin, E., Campbell, D., Boyle, M.H. and Offord, D.R. 1996. "Psychiatric Disability in Ontario." *Canadian Journal of Psychiatry*, 41, 564-71.
- Government of Ontario. 1993. *Mental Health Reform: Ontario Ministry Of Health. Putting People First: The Reform Of Mental Health Services In Ontario.* Toronto, ON: Queen's Printer for Ontario.
- Lam, R.W. and El-Guebaly, N. 1994. "Research Funding of Psychiatric Disorders in Canada: A Snapshot, 1990-1991." *Canadian Journal of Psychiatry* 39, 141-6.
- Lin, E., Goering, P.N., Offord, D.R., Campbell, D., and Boyle, M.H. 1996. "The Use Of Mental Health Services In Ontario: Epidemiologic Findings." *Canadian Journal of Psychiatry*, 41, 572-7.
- Murray, C.J.L. and Lopez, A.D. 1996. "The Global Burden of Disease." In *Global Burden of Disease and Injury Series.* Harvard University Press, pp. 1-43.
- Offord, D.R., Boyle, M.S., Campbell, D., Goering, P., Lin, E., Wong, M., and Racine, Y.A. 1996. "One-Year Prevalence Of Psychiatric Disorder In Ontarians 15 To 64 Years Of Age." *Canadian Journal of Psychiatry*, 41, 559-63.
- Offord, D.R., Boyle, M.H. and Jones, B.K.R. 1987. "Psychiatric Disorder And Poor School Performance Among Welfare Children In Ontario." *Canadian Journal of Psychiatry*, 32, 518-25.
- Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., and Goodwin, F.K. 1990. "Comorbidity Of Mental Disorders With Alcohol And Other Drug Abuse: Results From The Epidemiologic Catchment Area (ECA) Study." *Journal of the American Medical Association*, 19 (264), 2511-18.
- Ross, H., Glaser, F., and Gormanson, T. 1988. "The Prevalence Of Psychiatric Disorders In Patients With Alcohol And Other Drug Problems." *Archives of General Psychiatry*, 45, 1023-31.